PRIMARY CARE AND THE NHS REFORMS: A MANAGER'S VIEW

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I hope the reader finds the effort worthwhile. In any case, any blame for misinterpretation, misconception or simple error is entirely mine; at no point should the reader consider that I am speaking for After Today Management, Dyfed Powys Health Authority or any other organisation.

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FOREWORD

Writing on the future of Primary Care Groups/Trusts, and of Labour's health service reforms in general, invites subsequent ridicule by those blessed with the clarity of vision hindsight provides. The fact is that only the brave or foolish posit with any certainty how these latest changes to the UK National Health Service (NHS) will unfold. Nevertheless, this paper paints some scenarios, and at the end attempts to predict the future of the reforms.

It is ironic that the same politicians who are so keen to express their confidence and belief in the UK's system of primary care to the rest of the world have instigated a series of reforms which will potentially fundamentally change it. Underlying all the reforms of the Labour government is a tension between what might be labelled the control and command mindset and a model emphasising delegation, innovation and local empowerment. The author does not attempt to reconcile these two but instead highlights the dichotomy and gives his view of the likely winner in what remains an enduring battle for supremacy.

In the first chapter of this book an attempt has been made to set Labour's recent NHS reforms into a general policy context. Significant features include: vehement public opposition to the 'internal market'; a desire to increase the accountability of clinicians within both primary and secondary care; and the consequences of the well established dissonance between the rhetoric politicians adopt when discussing the NHS and a more objective analysis of the issues. This first chapter also highlights that much of what the current government presents as a radical departure from Conservative policy can, in many cases, be seen as an extension of those same policies and mindsets. Whilst to some this is of little consequence – merely reflecting the realities of political presentation, which by its nature requires simplification and selectivity – this text endeavours to show that this is an important feature of the reforms. It points to a sustained tension between what is being said in public about the nature and direction of NHS policy and its reality for staff and patients.

The first chapter ends with a review of the new performance assessment framework (PAF) as a mechanism for holding NHS organisa-

tions accountable for, and improving, their performance. The technical difficulties in producing a robust performance mechanism are highlighted and the question asked as to whether in reality government ministers and NHS Executive will fall back upon the traditional measures of NHS performance – waiting lists, financial position etc. – whilst paying lip service to a 'balanced scorecard' approach.

The second chapter looks at Primary Care Groups (PCGs) in some detail. There is particular consideration given to the economic model which underpins PCGs and the Primary Care Trusts (PCTs) into which they are intended to develop. The strengths and weaknesses of such an approach are considered. Alongside the inherent problems of a devolved model of commissioning for a health service which places universality and uniformity of provision as 'core values', the tensions relating to the manner and timing of the reforms are explored. This chapter establishes the aim of effective management of the clinical process as lying at the heart of the reforms. This tends to be an overarching concern that all governments have with their health care systems. Thus, Labour's reforms can be seen as part of an international drive to place accountability and responsibility, incentives and penalties, at the door of those who most directly commit resources: clinicians in general and primary care general medical practitioners (GPs) in particular.

The third chapter examines the manner in which Wales, Scotland and Northern Ireland are taking forward the reforms. Significant variations from the English model are discernible, particularly in Scotland.

The fourth chapter provides some practical advice to those charged with taking forward PCGs (and their Celtic cousins) in terms of make or break issues – managing referrals, construction of a Health Improvement Programme, understanding the financial position, etc.

Chapter 5 is given over to prescribing, given its importance both within general practice and to government if it is to keep costs under control. Issues relating to setting and then managing practice level budgets are considered, as are the options available to PCG executives

when prescribing patterns deviate from plan. This chapter concludes by considering the potential for PCGs to use disease management programmes and considers why there has been so little progress in this area to date.

The final chapter looks to the future. The similarities and differences between PCGs/PCTs and American Health Maintenance Organisations are explored in this context. A growing role for a mixed private/public model of health care provision is considered, as is an imposition of a command and control system set squarely within the public sector.

Overall, the aim is to give credit where sensible changes have been put forward and levy criticism in equal measure where it is due. Hopefully, the reforms will have been seen within a context that may sometimes be provocative but will also be informative.

1 THE POLICY CONTEXT

'The White Paper… forms the basis of a long term programme to improve the NHS through evolutionary change rather than organisational upheaval.'[1]

It has long been apparent to the staff of the UK National Health Service (NHS) currently struggling with a plethora of policy initiatives – of which some 86 circulars and 186 press statements from the Department of Health (DoH) in the first three months of 1999 give some indication[2] – that the above statement was at best an early manifestation of the current government's capacity for optimism. This has rather set the tone for much of the ensuing reform of the NHS under Labour.

Some might defend the aforementioned number of circulars as evidence of a listening government taking an evolutionary approach. Notwithstanding the accuracy or otherwise of this position, it does not necessarily preclude further upheaval. This helps set the remarks of the Chief Executive of the NHS Executive, Alan Langlands, into context when he told delegates at the NHS Confederation conference in May 1999 to '…focus on the targets that matter. Screen out some of this stuff from the Department of Health if you don't like it'. In a subsequent article in 'The Stakeholder'[3] he was asked what he meant: 'My point is that there is a danger in a system which has a huge amount of policy development and guidance pouring out of it – there's a danger that will eclipse local initiative, effort, even the real objectives of improving health and tackling inequalities'. He went on to make clear that it is the embarrassment of guidance that is the problem, rather than the goals themselves.

1.1 The legacy of Adam Smith

The conceptual core, if not the subsequent management, of the Conservative reforms of 1990 was relatively clear: that is a belief that the use of market mechanisms would make the NHS more efficient. Indeed, it might be said that its guiding principle was rooted in the

explicit acceptance of Adam Smith's observation that 'It is not from the benevolence of the butcher, the brewer or the baker that we expect our dinner, but from their regard to their own interest.'[4]

People often feel deeply uncomfortable about what remains the core operative principle of capitalism and hence the proposal to create an internal market in the NHS would always be highly controversial. I am reminded of Parris's general observation that '…our morality does not mesh with our economic system; but because we need both they cohabit in an awkward marriage based on silence.'[5]

With regard to the NHS at least, the proposed 'marriage' was particularly awkward and was met with anything but silence. Labour have been consistent – both in opposition and in government – in their condemnation of the Conservative reforms. What has always been less than clear is what replaces Adam Smith? On face value, it is the belief that collaborative behaviour produces better outcomes than competitive behaviour (and moreover that it is the morally acceptable mechanism for providing a national health service).

Underlying this is the commonly held view that health care is different from other goods and services. This is further reinforced by the observation that health care providers are in an unnaturally strong position vis a vis the consumer in terms of knowledge – often reinforced by geographic and skills quasi-monopolies. Hence, few deny that markets in health care often operate inadequately and one does not have to adopt a more general anti-market position to conclude that their operation is inherently problematic. However, none of the above in itself presents an a priori case that Labour's alternative will necessarily work more effectively.

It will be apparent to those with experience of working in the NHS or, indeed, public bodies in general, how great a challenge creating and sustaining a collaborative environment is. What has been conveniently overlooked in the desire to demonise the internal market philosophy is that inter-organisational/clinical rivalry pre-dates the reforms. Indeed, many commentators would argue that highly competitive behaviour is integral to both medical and management training/cul-

ture. In a previous article I observed that:

'The creation of Trusts merely served to provide a flag around which these competitive forces could rally and identify with. When politicians state their intention to abolish competition per se, they might just as well announce they intend to outlaw greed, as an equal expression of a well meaning but factitiously unrealistic objective.'[6]

Whether such an environment would lead to the myriad problems of the NHS (and local government) being satisfactorily tackled is another matter, again:

'The expectation that an imploration for collaboration can effectively replace market mechanisms in general, and contracts in particular, demonstrates that one can find no clear dividing line between wishful thinking and government policy. This approach is rather like cold fusion. It's cheap, convenient, has no nasty side effects – and it doesn't work.'[7]

Returning to the quotation at the start of this paper, it seems particularly disingenuous to suppose that this veritable revolution in organisational behaviour was not going to result in substantial change. In any case, one of the distinguishing features of the subsequent implementation of Labour's reforms has been the sustained and undignified spectacle of numerous professional and organisational groups squabbling over the membership and powers of Primary Care Groups (PCGs). Hardly the most auspicious beginning to the collaborative nirvana of the post-market NHS! Plus ça change?

1.2 Understanding Labour's reforms

Labour's reaction to the Conservative attempts at NHS reform has already been described above. If we are to understand Labour's own reforms we have to both understand their context and set aside rhetoric to determine the underlying thrust of the initiatives. What models underpin the reforms? What is the government hoping to achieve? What changes are they expecting? In this regard, much of what politicians state through press releases, media interviews and

prefaces to policy documents are often of limited value. Successful political presentation typically requires reiteration of powerful simplistic messages; a process which is unlikely to shed much light on what has always been a complex policy environment.

In their enthusiasm to press home their advantage over an unpopular government Labour publicly rubbished the Conservatives' reforms almost in their entirety. Subsequently, they have taken up and expanded upon the principles of some key Conservative reforms. At the same time, they have been adamant that they have done no such thing, but instead have created a 'third way'. That Labour have, to date, shown themselves to be consummate masters of presentation and 'spin' must not distract us from the actual thinking and policies since May 1997.

'The Economist' undertook a rather tongue in cheek analysis:

'The internal market of the NHS, introduced by our Conservative predecessors, was such a brilliant idea that we are going to keep it – in fact we are going to extend it' said Frank Dobson, the Health Secretary. Well, all right, he said no such thing. But this fictional quotation is closer to the truth than Mr. Dobson's claim ... that his White Paper 'abolishes the wasteful and bureaucratic competitive internal market.' Rather than being scrapped, the market is being modified, in some ways for the better, in others for the worse ... it proposes to maintain the split between buyers of treatments ... and sellers. The buyers will still decide what to buy and will still be able to switch between sellers. This, whatever Mr. Dobson says, is what is commonly known as a market.'[8]

Other commentators[9,10] have come to similar conclusions. What other elements of the reforms can be seen as an extension of the Conservative reforms and what parts can genuinely be seen as new thinking? These key features are summarised in Box 1.

Some key features are clearly a further extension of Conservative policy. With some changes in presentation it is relatively easy to imagine the White Paper The New NHS: Modern, Dependable'[11] and its Celtic cousins[12,13] being products of a Conservative administration.

Box 1 **The evolution of NHS reforms in the 1990s**

Conservative reform	→	**Labour reform**
Purchaser/provider split	→	Remains
Medical audit	→	Clinical governance
Fundholding/Total Purchasing Pilots	→	Primary Care Groups
Internal market	→	'The third way'
'Health of the Nation'	→	Expanded commitment to tackling inequalities and a 'healthier nation'
Efficiency via competition, tariffs, private finance initiative (PFI), league tables	→	Efficiency via national reference costs, PFI, 'name and shame'

The use of language would be different, as would the manner in which the ideas would be framed. Whether this is a strength or weakness is not at issue here. The purpose is to note the fact, not pass judgement on it.

Clinical governance, the creation of the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) have their foundations in the introduction of formal medical audit in the 1990 reforms. There is no discernible difference between the two parties on this issue. The purchaser/provider split remains. There seem to be clearer differences on the abolition of the internal market until one remembers the observations previously quoted. In any case, the internal market was a strange creature with some doubt as to whether there was any real commitment to operate a market in the first place. An environment of periodic political intervention seems to have been inevitable because, despite an apparent intention in the original Conservative reforms to diffuse decision making (and blame) to 'the market', the political nature of the NHS kept

dragging ministers back into the firing line. Hence the market was never allowed to operate freely.

Labour have certainly been keen to present this element of their reforms as distinct from what has gone on before. Commentators are unsure if it merely repackages the Conservative reforms, is a cleverly disguised return to Labour's traditional command and control mentality, or is a genuine new paradigm in health policy. Light[14] has coined it a move from 'managed competition to managed co-operation' which is a phrase I think best fits policy makers' intent. Conceptually, this is the replacement of the internal market by a system of partnerships with penalties, with a regulatory framework which will legitimise structural change and direct intervention where deemed necessary. It must be acknowledged that this is a different philosophy to 'Thatcherism' even if for those working in the NHS the end result feels pretty much the same.

Management consultants Newchurch & Co. have argued that the government has set out to move responsibility for the NHS's performance, funding and resources from ministers '... squarely onto the shoulders of the NHS and its clinicians and managers'[15]. Klein and Maynard, in contrast, believe that the reforms will focus on ministers. 'For implicit in the White Paper is a command and control model of central management which will not only test the capacity of ministers but ensure that the spotlight remains firmly fixed on them as they are seen to carry direct responsibility for every weakness and every failure in the NHS'.[16]

Both commentators would surely agree about the potential for a control and command mindset to dominate – whatever the original intention. Labour's reforms will further increase the politicisation of a service which was already over-dependent on politicians to effect change – and this is likely to further promote centralisation. This is a dilemma and an in-built tension which we shall return to time and again throughout this paper, particularly in relation to the role of PCGs. To quote Klein once more, this time in a more recent article in 'The Guardian':

'Ministers appear to be operating under the delusion that they can actually control what happens in the NHS: that, for example, the tide of waiting lists will turn if only they give the command. Consequently, if things go wrong, if standards are not achieved, if services fall short of expectations, there will be no ambiguity about who carries the blame: the Secretary of State. And the effect will be compounded if it turns out that the Secretary of State's decision to limit the use of Viagra proves to be a precedent for the future. If central government takes responsibility, for the first time ever, for explicit rationing decisions, it will give dramatic visibility to resource constraints, which in the past were blurred by being left to individual clinical decisions. In short, the prospect is one of ever-increasing political overload, as economic parsimony becomes ever more expensive politically.'[17]

A new regulatory framework is less controversial and yet it clearly can be discerned as a further development of Conservative attempts to introduce a more rigorous scrutiny of NHS efficiency and effectiveness. This has its historical roots in the Griffiths[18] management reforms and the original purchaser/provider split. Overt use of the market to drive change and promote efficiency is publicly rejected, but we are assured that many more aspects of performance are going to be intensively and publicly measured. The desire to use an enhanced set of performance measures to replace competitive forces was increasingly evident in the latter years of the Conservative government. Newchurch's analysis is revealing:

'This approach will still ... result in winners and losers, successes and failures, created by the pressure of collaboration, partnership, performance measurement and continual scrutiny. Given in practice the almost complete absence of effective market forces over the last few years, the new regime might prove a lot more uncomfortable.'[19]

The key to success of this part of the reform programme will be in the attention to detail. As the saying goes 'the devil is in always in the detail'. The internal market didn't work for many reasons – not least political intervention – but it certainly didn't fail due to over-regula-

tion (as opposed to inconsistent interference). Price did not equal cost. Trusts typically apportioned costs in a way advantageous to the Trust in question[20] and still do. Redefinitions of workload were legion. The secretiveness of Trusts with regard to their costing and pricing structures was an affront to the notion of public sector accountability and deprived purchasers of information they required to undertake their role effectively. Trusts often behaved in a way they thought the private sector operated, rather than the reality of companies' relationships in a typical market. In 'Managed Care: Practice and Progress'[21] I compared the behaviour of some managers to '... the values of 19th century robber barons – conflict, ruthlessness and a capacity for taking advantage of any perceived weakness of the other party – based on the mistaken belief that this is how businesses operate. This oscillates with an ironic tendency towards seeking bureaucratic redress from the 'centre' when intimidation fails.'

Such behaviour and attitudes would almost certainly not be tolerated in the US health care system, a conclusion which may come as a surprise given its reputation as a market 'red in tooth and claw'. However, the US health care market is heavily regulated at the microeconomic level. For example, hospitals treating Medicare patients (over-65s covered by the Federal Insurance Programme) have to submit their claims in a prescribed manner, by a certain time, and receive a predetermined standard payment. There are no incomplete and inaccurate codings here, if the provider intends to get paid and does not want to suffer heavy fines or even a prison sentence for fraud. The failure to achieve such a seemingly simple state of affairs in the UK was not – as is often wrongly diagnosed – a failure of the internal market, but rather a failure of the centre to assert proper regulatory control. There is an important lesson here for Labour, but it is precisely in this area that the lack of clarity about the 'how' takes the edge off fine sounding objectives.

Labour are clearly not short on ideas and initiatives. Some of them, however, like the continued obsession with waiting lists and ad hoc developments like walk-in centres '... appear to be directed as

much at the spin doctors as their medical counterparts'[22]. Many of these ideas (such as NHS Direct, the two issues above and the quality agenda) can be seen as a continuation of the consumerism that first appeared in the NHS in the 1980s. At the same time Labour must keep NHS (if not total health care) expenditure under control. Indeed, they must regain control, as there are clear signs that the service in some areas is operating with recurring and growing deficits. This was recently highlighted by the Health Financial Management Association (HFMA), whose survey of 50% of NHS Trusts and 60% of Health Authorities indicated a projected £200 million income and expenditure deficit for 1999/2000.[23]

Ham, like every other commentator, believes this '... hinges on ministers finding the right levers to bring about change'[24]. The use of central direction has already been noted. However, a reform process which was reliant on the brilliance of ministerial intervention over a prolonged period would appear to be a recipe for disaster. The much trumpeted performance assessment framework (PAF)[25] must deliver on its declared objectives if the 'third way' is to be distinguishable from the 'old way'.

1.3 A new performance framework?

The replacement of the largely unlamented NHS purchaser efficiency index[26] has been welcomed. However, whilst there is a general view[27] that moving from a narrow focus on activity and financial targets to a wider view of what the NHS is seeking to achieve is a good idea, it is likely to prove much more difficult to define, collect and monitor the necessary measures to do so. In part, we are back to the devil being in the detail. There are clearly formidable statistical problems involved, to which one could add long-standing concerns with the quality of data and the fact that in most areas (as McKee and Sheldon[28] point out) the 'correct' rate for the intervention in question is either not known or subject to dispute.

A legitimate concern must be that a combination of the practical problems with collecting the qualitative measures and the continued

predisposition of politicians and managers to focus on 'bottom line' (and, they believe, understandable) activity and financial items will make this another example of 'old actions speaking louder than new words'.

There are six areas where performance should be assessed according to the PAF: improving the health of the population; fair access to services; effective delivery of appropriate care; efficiency; patient/carer experience and health outcomes. Cynics will point out that most of the quantitative indicators are little changed and that the 'health' ones are open to argument as to cause and effect, meaningfulness, etc., and are handicapped by the long time frames required to judge success or failure.

This needs to be of concern to PCGs as well as Trusts and Health Authorities as the PAF is promoted as a key component (alongside clinical governance and the bodies that will set and monitor standards) for assessing performance and driving improvements. To the methodological issues already referred to can be added the suspicion that underlying the PAF is the kind of thinking referred to by Samuel Brittan in 'Capitalism with a Human Face'.[29] That is, the misplaced confidence amongst modern politicians that they can '... make deep seated problems go away by a few tactical gimmicks which can be applied costlessly by a few clever men in an office.' Instead, as Richard Smith, the editor of the 'BMJ', has been at pains to point out, most problems in Britain '... including those of the health service, are deep rooted and not easily solved.'[30]

Concern with the PAF as an adequate tool for accountability focuses on its propensity to use measures which NHS bodies can little affect, and thus it seems unreasonable to hold the NHS accountable for them, whilst at the same time diluting the focus on those measures that they can effect and should be held accountable for. The net effect can undermine, rather than strengthen, public accountability. This is not an academic concern, as the PAF is meant to install a more appropriate stimulus and discipline to performance as a substitute for market forces. Yet the PAF's design seems to be aimed principally at

Health Authorities, resulting in an insufficient focus on the accountability of NHS Trusts. The principal focus should be on performance against 'industrial type' indices of efficiency – such as staff whole time equivalents per occupied hospital bed and per 100 discharges/deaths; waiting times for certain types of treatment; and clinical outcomes – rather than disease incidence in the local population. Thus the focus should, in effect, be on judging NHS organisations' efficiency and effectiveness in the treatment of illness rather than the general promotion of the nation's health. None of these comments should be taken as a rejection of the PAF concept. Rather, the concern is that the current mix of indicators lacks focus and may dilute the impact of those PAF measures with which NHS bodies may truly be held to account.

1.4 Where are the incentives?

The next concern surrounds the whole issue of making change happen. Implicit in having a framework against which organisations are judged is the reward of success and remedial action in cases of failure. This turned out to be the Achilles heel of the internal market, with no-one knowing how to handle the losers. This contrasts with politicians' natural propensity to declare that 'All have won and everyone must have prizes'. This cannot be appropriate where the measures under scrutiny relate to such issues as survival rates for breast and cervical cancer and the efficiency with which public bodies provide services. The lack of measures to motivate change, especially for primary care will be returned to. For now, the issue is the determination of ministers to back real, as opposed to cosmetic, change in the face of professional and public opposition. On the evidence of its first two and a half years in office the signs are at best equivocal. However, there is certainly a lot of emphasis on the need to make changes, and it is too early to judge the Blair administration, given that, at the time of writing, it is only half way through its five year term. There is also the question of what objectives are being pursued when change is considered. The government has emphasised its ambition to tackle health

inequalities and promote the public health agenda. The White Paper(s) and subsequent circulars are riddled with references to 'integrated care', 'joined up thinking' and 'collaboration', with the objective of working towards maximising 'health' rather than just 'health care'. The post of Minister for Public Health was seemingly created with just such an intention. However, talk is cheap. Smith[31] has observed that 'Politically, the main output of the NHS seems not to be better health but shorter waiting lists.'

The Minister for Public Health has struggled to make any impact[32] whilst the recent report on inequalities in health by Sir Donald Acheson and his colleagues[33] was met with a response from government which might be best described as lukewarm. The NHS Confederation described the Acheson Report as 'the most authoritative and radical report on health since the Black Report'[34] and it looks very much as if it will share a similar fate.

1.5 The 'real' agenda

When 'The New NHS' White Paper and its Celtic equivalents were first published, they seemed to be signalling a new direction. In other words, however much the content could largely be described as a repackaging of existing (Conservative) policy, psychologically it felt different. In the same way, although it was the Conservatives who produced the 'Health of the Nation' White Paper[35] and in Wales the much praised (at least in academic circles) concept of concentrating resources on 'adding years to life and life to years'[36], it was Labour who were considered the party truly interested in pursuing such policies.

The complexity of Government policy with regard to the NHS provides an operating environment that is likely to disappoint the idealists. Those who think the primary task of PCGs is to 'discover' local health needs, set this together in a Health Improvement Plan (HImP), ensuring it fits into the White Paper 'Saving Lives: Our Healthier Nation'[37], and write up applications for Health Action Zones, Healthy Living Centres and the like, are in for a rude shock. No

doubt the centre will say it wants all those things, and more. Evidence of collaboration with local government, an emphasis on prevention and health promotion, involvement with users, carers and the public. In fact, the centre has always asked for these things. It is like a mantra for the NHS and helps explain why the documents it produces always have the same 'feel', are usually overlong and make rather turgid reading.

Ms. Jowell, then Minister for Public Health, stated in the 1998 Nye Bevan Memorial Lecture that '... for the first time a British Government sets out a determined strategy for tackling inequalities...'[38]. Instead, they have shown rather more determination in trying to tackle the traditional millstones of NHS performance: waiting lists, pay, efficiency, emergency admissions and (arguably) funding. If PCGs wish to tackle the deep-rooted and multi-factoral causes of poor and inequitable health in their area they would be well advised to ensure, first, that they have a grip on the above issues.

In this regard, even quality issues – which have seen a genuine increase in importance – take second place. Indeed, although times may be changing, the best evidence from America (where its reputation for litigation, consumerism and high cost medicine would lead one to expect the boundaries of assessing quality and using this to choose providers to be set) is that quality plays a subordinate role to access and price. This is not to deny the fact that the quality agenda is growing in importance but, significantly, the Clinical Initiatives Centre (CIC), which is a sub-group of The Advisory Board Company (an organisation with a membership of some 2,500 US health care organisations), concluded that: 'In the realm of choosing providers and plans, it appears that consumers respond most to service and convenience rather than clinical data.'[39]

In essence, in the most sophisticated and expensive health care system in the world the modus operandi remains an initial quality screen with the focus of attention quickly turning to price and access issues. Hence the CIC conclusion that '... the unfortunate truth [is] that high quality is not rewarded by the market'.[40] Another observation will

also sound familiar to UK providers:

'Much to the chagrin of providers who have hoped to succeed on their clinical quality alone, the rational strategy from a purely economic standpoint has been a de minimis one, focusing on meeting relatively low thresholds in the few areas frequently tracked and risk management as to egregious errors'.[41]

This still sounds counter-intuitive, given our perception of the US consumer as a seeker of high quality health care and of an industry that partly justifies the high proportion of gross national product that is devoted to it by a claim to be delivering excellent services. It starts to make more sense when one considers the experience of staff model Health Maintenance Organisations (HMOs where the doctors are salaried employees), who have tried to market themselves on the basis of the quality of the medical services they provide. It does not appear to work and a plausible explanation for its failure was given by David Bradford, CEO of Wisconsin's Family Health Plan Co-operative, quoted in 'Managed Care'.[42] He compared it to boarding an aeroplane:

'You want to take for granted that all airplanes have good maintenance, that they do not use substandard replacement parts, that the pilot is well trained and has not indulged in alcoholic beverages in the last 72 hours. The fact that those things are all crucially important to your safety becomes almost secondary because people want to take it for granted. Instead, they evaluate their airplane trip on whether they were served their soda and meal in a timely fashion and whether the flight attendants were nice.

In the same way, confident that American medicine is the best in the world, people assume that all medical quality is the same. 'So while we do a good job and can demonstrate it and measure it in ways that other people don't bother, when others don't bother, it's acceptable because it's assumed that if they were to bother to measure it, they would be as good as anyone else."

The point of quoting the American research in the context of a general discussion on government priorities and performance frame-

works is to emphasise that PCGs will have to operate in the real world, and this often confounds the expectations of policy makers and the hopes of academics. One last example should help make this point. Since the early 1990s the State of Pennsylvania has been '... awash in major clinical quality initiatives – all of which are aggregating, analysing and now publicising provider performance'.[43] These include mortality reports and Coronary Artery Bypass Graft (CABG) outcomes. In a 1998 'JAMA' study[44] researchers looked at the impact of these CABG outcome reports on patient choice of provider. Despite the heavy media interest, the researchers found that it made very little impression on the general public. The author's surprise is evident:

'Because of the extensive publicity given to the 'Pennsylvania Consumer Guide to Coronary Artery Bypass Graft Surgery' its five year track record, the salience of a major heart operation, and the five-fold (my emphasis) variation in mortality rates amongst hospitals, we expected that the Consumer Guide would be widely used by patients selecting providers for CABG surgery. We found just the opposite. It is striking that even among those who were aware of the Consumer Guide before surgery, almost no one used it in decision making.'

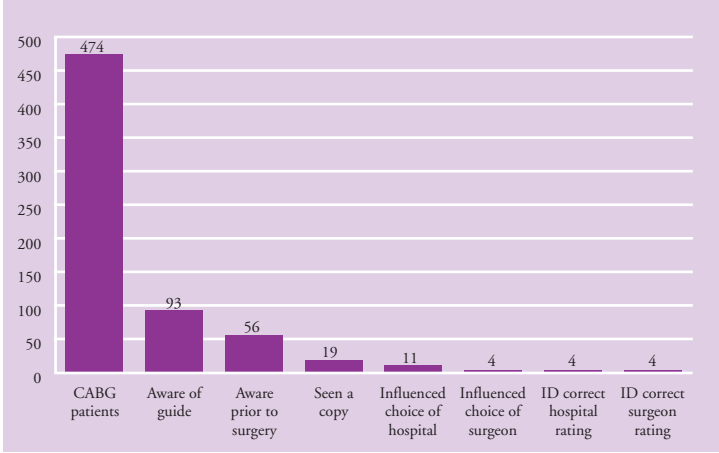
A full year's worth of CABG patients from four hospitals (474 patients) were interviewed:

- Of those, less than 20% were even aware that the study existed.
- Of that 20% (93) only 56 were aware of it prior to surgery.
- Of those, only 19 had actually seen a copy of the report.
- Of those, 11 said the report influenced their choice of hospital; four that it influenced their choice of surgeon.
- Finally, only 4 patients (less than 1% of the total) could correctly identify their hospital or surgeon's rating.

(See Figure 1).

The researchers went further and asked the patients if they would have wanted to see the results prior to choosing where to have their CABG (note the enhanced consumerism of the US where this question was posed to the patient rather than the referring GP or cardiol-

Figure 1 **Surveying CABG patients in Pennsylvania**



Source: Schneider, E., 'Use of Public Performance Reports', JAMA, 27 May 1998.

ogist as would more likely have been the case in the UK). The majority, 55%, said they would be very or somewhat interested in doing so. The researchers then asked 'Now that you know what the report could have told you, would you have chosen your surgeon or hospital based on that information?' Again, a majority (58%) said they definitely or probably would have changed.

Then the researchers asked 'Would you be willing to pay for the report, and if so, how much?'.

'What they found was that only 8% would be willing to pay more than $20. That is less than one tenth of one percent of the cost of a $25,000 CABG. Fully one third would pay nothing! To date, patients are largely deaf to the clinical data. Even when they do see it, it is not clear that they are choosing based on it. And that is because the average consumer finds little that he or she can understand or use in the clinical data.'[45]

Figure 2 shows a further breakdown of the patients' responses to the payment question. There is good reason to believe that there would be an even greater antipathy to contributing towards the cost of such reports in the UK given the widespread view that health services should be freely available.

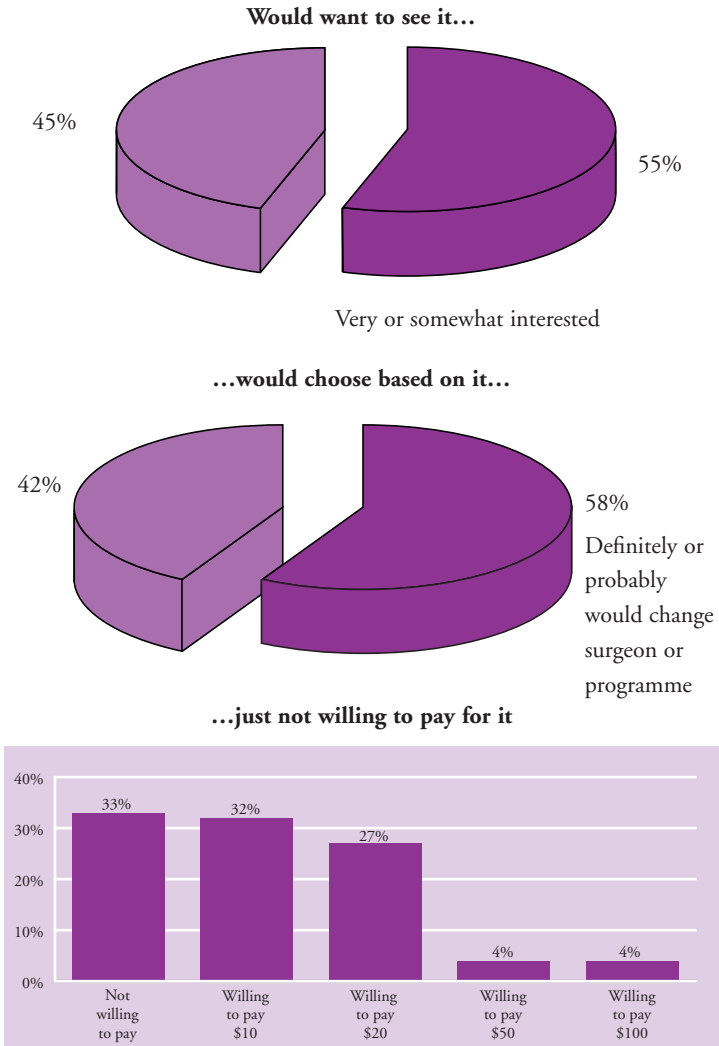
Moreover, the concern that the UK's high level performance indicators – typically described as 'league tables' by the media and regarded as such by many in the NHS – will ultimately confuse rather than inform, must be a real one. In the US at least, the situation remains that in general it is reputation, familiarity, ease of access and an awareness of 'brand' that sway patients (and referring clinicians) not data about outcomes. A study by The Kaiser Foundation supports this: 'It found that 74% of patients choose the familiar hospital over the higher rated one, 79% would choose the surgeon they have seen before even if that surgeon rates below others'[46] (see Figure 3).

Some readers, keen to protect local services, will be delighted by the results of that survey. Others might object that the performance assessment framework is designed to be utilised by the centre in its discussions with Health Authorities, Trusts and PCGs, and that in the UK they – not the patient – undertake the decisions which in other markets are assigned directly to the actual consumer of services.

Whilst the US has principally evoked a strategy of giving consumers information to facilitate their own choices, the UK was always going to go down a more collectivist route. Several key elements of the reforms have a strong top down focus: NICE, CHI, national service frameworks and the performance assessment process itself. The editor of the 'BMJ' editor believes that the principal problem with this is simply that '... Centralist direction is a poor way of solving the NHS's biggest problem, the fact that good practice may flourish in one clinic and fail to spread even to the clinic next door let alone the rest of the NHS. Meanwhile, poor practice gaily continues'.[47]

The gurus of 'learning organisations' believe that this problem must be embraced by the 'shop floor' and that little significant change

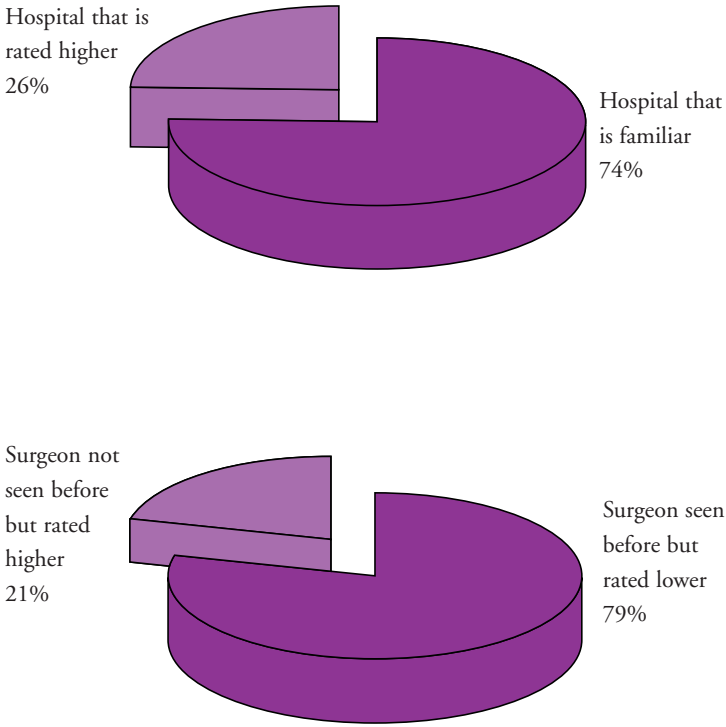
Figure 2 **Survey of demand for a consumer guide to CABG surgery**



Source: Schneider, E., 'Use of Public Performance Reports', JAMA, 27 May 1998.

can occur if it is driven from the top. It is in response to this problem that PCGs have in part been created and PCTs promoted. It is now time to look at this element of the reforms in more detail.

Figure 3 **Patient choices**



Source: Kaiser Family Foundation Survey, 1996.

2 PRIMARY CARE GROUPS

2.1 The evolution of PCGs

The genesis of PCGs, as has already been noted, can clearly be traced to the fundholding initiative begun in 1991. They have even more in common with the total purchasing pilots. Halpen[48] articulated the opinion of many when he wrote:

'The Government's use of PCGs as a mechanism for managing primary care is no more than a continuation of the policies of the previous government. Although GP fundholders revelled in their initial freedoms, it is clear that the move towards total purchasing (in whatever guise) was a clear precursor of PCGs.'

This is not a criticism per se unless one starts from a position opposed to any form of primary care based commissioning. This camp can raise some powerful arguments against embarking on such a course – not least that it may fatally undermine the patient-doctor ethic and relationship, but this is not the basis on which this text examines the government's reforms.

This paper's contention is that the economic model underlying the PCG concept is a readily understandable one. Moreover, it is from the same philosophical school as fundholding and has clear similarities with contracting arrangements now fairly common in the US. That model is supported and the introduction of PCGs is seen as a bold, imaginative piece of policy. As will become apparent, the manner of its implementation is regarded with substantially less enthusiasm.

It seems likely that those who put forward the PCG/PCT model had previously reached the following conclusions:

i) Funding must be based on a capitation formula. Funding based on historical spend (as fundholding was) creates insurmountable equity problems and distorts subsequent decision making.

ii) Clinicians, particularly doctors, commit the vast majority of health care resources. The only viable strategy for cost constraint and optimal use of resources is to make clinicians directly accountable (failing that, as accountable as possible) for resource use.

iii) Fundholding showed that many doctors were prepared to take on budgetary responsibilities and some proved particularly innovative. Although there were legitimate concerns about the incentive structure for primary care participation, there were relatively few practitioners who would never be prepared to participate on principle.

iv) The key to proper management of resources is a unified budget. Fundholding, with its ability to cost shift from fundholder to Health Authority budgets was flawed from the outset. As Light[49] has stated 'the key to managed care is a single budget so that costs cannot be shifted to someone else's budget'.

v) All practices need to be involved. Labour's opposition to fundholding was founded in part in the inevitable two tierism between fundholders and non-fundholders. To its credit, Labour seem much more determined to tackle quality and cost control issues in primary care as a whole. It wants to promote more uniform and consistent primary care services and commissioning. In pursuit of this aim PCGs are a more realistic vehicle than fundholding could ever hope to be.

vi) The new model needs to be better able to take forward the objective of getting NHS bodies to work in partnership with other bodies – particularly local government. A commissioning model based on individual practices (fundholding) was never going to be a realistic vehicle to deliver such a policy objective.

vii) There is an intrinsic attraction in decentralising responsibility for operational management, which PCGs help to retain, whilst hopefully ending the fragmentation of planning, funding and delivering health care which existed when there were some 3,500 fundholders and 100 Health Authorities.

viii) There are opportunities to reduce transaction costs created by fundholding, although the scope for these has been greatly exaggerated by politicians.

ix) There is a need to increase accountability of clinicians (particularly GPs) for the resources they commit and the decisions they

make. Fundholding proved a poor vehicle for such public accountability.

The White Paper[50] summarised some of the above thinking as follows:

'[PCGs] will have control over resources but will have to account for how they have used them in improving efficiency and quality. The new role envisaged for GPs and community nurses will build on some of the most successful recent developments in primary care. These professionals have seized opportunities to extend their role in recent years ... Despite its limitations, many innovative GPs and their fund managers have used the fundholding scheme to sharpen the responsiveness of some hospital services and to extend the range of services available in their own surgeries. But the fundholding scheme had also proved bureaucratic and costly. It has allowed development to take place in a fragmented way, outside a coherent strategic plan. It has artificially separated responsibility for emergency and planned care, and given advantage to some patients at the expense of others.

So the government wants to keep what has worked about fundholding, but discard what has not.'

2.2 PCG strengths

In theory there are four key strengths to PCGs which make it a particularly attractive model for government. These might be characterised as:

- Unified budget
- Inclusivity (no opt-outs)
- Critical mass
- Controllability

2.2.1 The unified budget

The importance of a unified budget has already been noted. Because (as with so much else) the White Paper did not set out much detail about the establishment or consequences of a unified budget, many

NHS staff are likely to regard this as of little interest to anyone other than accountants. However, its implications for both general practice in particular and the NHS as a whole are probably only equalled by the clinical governance initiative. As Majeed and Malcolm[51] writing in the 'BMJ' conclude:

'The main factor behind the introduction of unified budgets is the belief that making general practitioners accountable for the cost as well as the quality of health care will prove an effective method of tackling many of the problems facing the NHS.'

This, alongside clinical governance, is the principal vehicle by which those long-standing concerns of successive governments – cost constraint and medical practice variation – are to be tackled. Moreover, whilst clinical governance and the wider quality agenda have an ominous potential to raise costs, the unified budget delegated to PCGs and operating within cash limits helps both as a counterbalance and as a vehicle to help the centre keep control in a way that it was never able to do when fundholding existed.

Unified budgets are definitely a two edged sword for PCGs. On the one hand they increase flexibility to concentrate resources to areas deemed to be a priority. They break down artificial barriers to transferring funds between budgets which historically operated as a series of silos. For example, if one wishes to transfer an underspend in primary care prescribing to fund a waiting list initiative, then a unified budget allows this. Previously, outside of fundholding, such transfers were not possible. To quote 'The New NHS' once again:

'PCGs will take devolved responsibility for a single unified budget covering most aspects of care so that they get the best fit between resources and need. It will provide ... maximum freedom to use the resources available to the benefit of patients ...'[52]

This is a wholly sensible policy objective – whose logical extension would be a unified budget with social services (and even local government as a whole given the non-health care influences on health). However, the proposal to pool funds for general medical services (GMS) infrastructure with prescribing and hospital and community

health service (HCHS) budgets carries real risks for primary care in general and practices in particular. GP negotiators did not take long to realise that just as money could be directed into primary care under unified budgets, so it might be removed to fund overspends or priorities elsewhere.

To alleviate these concerns it was agreed to ringfence existing commitments within the GMS infrastructure budget and to increase these in future years in line with inflation. This has given some security to GPs that overspends elsewhere will not lead to direct cuts in their own services (and incomes) but it is far from the total insulation that GP negotiators would have liked. The protected part of the budget will rise in line only with inflation while the total budget will probably rise more rapidly than this. Moreover, the true ringfenced element in most places will not constitute the total amount intended for GMS infrastructure. Quite simply, GPs will be under pressure to control their prescribing and rate of hospital referral if they are to invest a greater proportion of their overall budget into primary care services, or even ultimately to protect traditional levels of investment.

The power of the above as a lever to change is often underestimated. The GMS infrastructure budget can be used to either enhance services in a practice (and its income) or conversely to hurt practices by cutting off their source of subsidy and funding. This is one of the few direct carrots or sticks available to PCGs. As Majeed and Malcolm state: 'PCGs could use financial incentives such as extra investment in a practice to reward those practices which prescribe and refer in line with locally agreed formularies and protocols.'[53]

Equally, funding can be refused and levels of support (outside of those protected) reduced for recalcitrant practices. This is an important capability given that the resource decisions taken by any one practice in a PCG will impact directly on the others in the group.

2.2.2 Inclusivity

Fundholding was always vulnerable to the charge that it was creating a two tier service and few felt comfortable with that situation.

Moreover, fundholding continued the tradition of general practices of seeing themselves as virtual islands, independent from each other and standing in semi-detachment from the rest of the NHS. The creation of PCGs represents the first serious attempt to move primary care out of its cottage industry roots and bring it into the NHS corporate culture. There are inherent tensions in the respective value bases, aims and general culture of NHS Executive, Health Authorities and general practice, which make genuine partnership (which after all is what the White Paper says underlies the whole reform process) difficult. This may well prove a bridge too far for general practice in general and PCGs in particular. However, it was vital that there were no opt out clauses available for practices if the government were to get to grips with the key issues of the NHS such as unexplained medical practice variation, promoting uniform standards in primary care, managing referrals, and controlling the rise in emergency admissions and prescribing. Hence:

'A striking feature of primary care is the wide variation between practices in the use of resources; and to many managers these variations suggest that resources are being used inappropriately by some general practices. Undoubtedly, one of the key factors behind the introduction of unified budgets is a desire to reduce these variations.'[54]

The introduction of a budget alongside the fact that now the resource decisions taken by any one practice in a PCG will impact directly on the others, transforms the relationships between practices. No longer islands, they have to be concerned with how well the PCG is doing as a whole and with any poorly performing practices within it, because at its most crude the Group can be dragged down by them.

This also helps to explain why GP involvement makes or breaks the whole reform process and why (much to the chagrin of many of the other professions and organisations) so much effort is devoted to obtaining and sustaining it. It boils down to the economic facts of life. GPs commit, principally through their referral and prescribing decisions, the vast majority of PCGs' (and hence NHS) resources.

Ultimately, it is GPs who will have to take responsibility for limiting (and in many areas reversing) the growth in prescribing costs and hospital expenditure. Important though joint working with social services is, and despite the inherent attractions of 'integrated care', it is here that the real battleground lies. This is the make or break issue for PCGs and probably for the reforms themselves.

Intimately linked with financial issues is the quality agenda. Once again it was apparent that this could not be successfully tackled unless general practice as a whole were engaged. If PCGs do the job (and are allowed to do the job) envisaged for them in the White Paper, there will inevitably be serious tensions developing within many of them. At that point the realisation that people simply cannot take their ball and leave the game will be crucial.

2.2.3 Critical mass

As has already been noted, general practice has historically been a 'cottage industry' in terms of the size and independence of its basic organisational unit: the practice. Commentators tend to be divided as to the degree that fundholders and total purchasing pilots were able to make significant changes to service provision, but the majority regarded them as being too small to effect change other than at the margin. That analysis typically overlooked the fact that some multi-funds were very large. However, the limited budgetary responsibilities (excluding emergency hospital treatment) would have reduced their potential for change.

American observers were particularly sceptical about the ability of practices on their own to effect significant change and that scepticism often extends to PCGs. For example Light[55] stated what for Americans represents a maxim not far short of an economic law:

'The first and basic lesson ... is that if a nation is going to use a purchasing approach to health care, the purchasers need to be large and strong, not small, local and weak like general practitioner fundholders, locality commissioning groups, or even the proposed primary care groups.'

This is based on US market experience which reinforces the idea that 'God is on the side of the big battalions'. Hence, during fundholding Weiner and Feris[56] had stated:

'With the advent of open contracting by District Health Authorities which may be bargaining on behalf of upwards of a hundred thousand persons, it is not clear that a lone budget holding practice with 12,000 patients and no negotiating expertise will have much power. In the US, most successful managed care hospital contracts involve far greater numbers.'

This view would probably have been correct if Health Authorities had been able to operate in a truly open contracting environment and, just as crucially, had a genuine will to make radical change. In reality the former condition never existed and considerable doubt must remain with regard to the latter. In other words, size is no guarantee by itself of being an effective agent for change. Professor Light may well be proved correct in his scepticism as to whether PCGs are of sufficient size for the task (see the discussion of PCG weaknesses below). However, they do have greater mass than was typical when fundholding existed and they will need it given the daunting agenda ahead of them. In response to these pressures '... PCGs themselves will inevitably merge. The current boundaries are often arbitrary – sometimes drawn to accommodate the 'culture' of individual practices – and many are simply too small. More important will be the GPs' realisation that they can have greater control and reduce costs if they combine.'[57]

So we can conclude that critical mass is needed, but the jury is out on whether PCGs, as they currently exist, are sufficiently robust to meet this need.

2.2.4 Controllability

An ability to exert control over primary care is a core expectation government has of PCGs, even if PCGs' constituent parties have other ideas! Many GPs believe PCGs will be a vehicle to exert pressure directly on government (particularly for increased funding) by making

resourcing decisions more transparent. PCGs are likely to be potent vehicles for this, particularly as the general public and the media tend to give much more weight to the pronouncements of clinicians on such issues than when Health Authorities make their periodic forays into this area.

However, we have already seen the importance attached to unified budgets and clinical governance as two mechanisms to force primary care to address issues central to any government: cost constraint and clinical quality. Reference has also been made to the control and command tendencies in the government's actions (rather than its rhetoric). Halpen[58] believes that 'it is probably through the accountability arrangements that the centre will begin to get its hands on the management of primary care'.

In addition, the line accountability of PCG Chairmen, and through them the PCG Chief Executives, to the Health Authority might lead one to conclude that '... the major freedom of PCGs will be the freedom to do as they are told'.[59] This is particularly so when one considers that this accountability sits alongside a Health Authority Health Improvement Programme for which much of the content will be determined by the centre's objectives; a financial regime which many ex-fundholders will find restrictive; and a management allowance which PCGs may well find is inadequate for the tasks and ambitions they set themselves.

If this turns out to be the case, ministers, civil servants and many NHS managers will be secretly delighted. In truth, many of those who are quite prepared publicly to proclaim their commitment to a primary care led NHS (a careless piece of rhetoric in any case) and to praise the GP based model of primary care provision, both dislike and distrust GPs as a body. They appear jealous of the freedoms given to GPs by their independent contractor status, disapprove of GPs' apparent lack of corporacy, regard their individualism as subversive and have a pseudo-ideological opposition to the private enterprise mindset that to date has characterised general practice in the UK.

The Labour government is attempting a reform of primary care

that is far more radical than anything the Conservatives ever dared to consider. The paradox is that the PCG model has been trumpeted as a triumph of devolutionism; that the changes are a result of 'grass roots' pressure for the reforms in question. The White Paper emphasised the view that commissioning should take place at a local level on the basis that clinicians are better judges of what is needed than remote, unresponsive Health Authorities. The seeming disenchantment with Health Authorities as ineffective agents for change has popular support, but traditionally these bodies have been hog tied by their dependence on political will to effect change. This is '... the Achilles heel of NHS commissioning ... When this is lacking (which is the norm) Health Authorities in particular are effectively neutered. There is no indication that this is set to change under a Labour government'.[60]

It is all rather schizophrenic. The centre is concerned about the ability of fundholders to destabilise Trusts by removing chunks of services independently from any 'master plan', so they create PCGs, part of whose raison d'être is to make necessary but as yet unimplemented changes to the current pattern of services. This then creates concerns that '...'autonomous' PCGs could inadvertently collapse the financial or clinical 'critical mass' of Trusts by moving even quite small 'chunks' of service around the system'.[61] To combat this the centre tries to ensure that a strong level of control exists from Health Authorities to ensure everyone toes the central line. Thus, ministers end up relying on organisations they spend much of their time deriding, to ensure that PCGs do not undertake innovative, radical change – despite having stated that this was what PCGs were created to achieve! Confused? So is the thinking. It is a classic example of wanting to have one's cake and eat it.

2.3 Weaknesses in the PCG model

Cracks in the thinking behind PCGs were beginning to appear in the preceding section. These are further explored below, with the weak-

nesses being summarised as follows:

- Inadequate incentives
- Unwillingness/inability to effect change
- Lack of corporacy
- Efficiency versus equity

To these issues, which might be described as inherent in the model, we can add weaknesses resulting from the manner in which the government has chosen to implement the reforms. This has significantly compounded the difficulties, to a point where conspiracy theorists wonder if PCGs have been set up to fail. These include:

- Overambitious timescales
- Debt
- Lack of focus

2.3.1 Inadequate incentives

The review of unified budgets undertaken earlier showed that there are some genuine incentives for PCGs to keep within budget and there is also the implicit threat of sanctions if it becomes apparent that clinical quality in primary care is falling below (as yet undeclared) minimum standards. However, these seem to many to be more stick than carrot in approach and many ex-fundholders in particular feel that direct incentives have been diluted, particularly at practice level. It will be apparent when the US experience with Health Maintenance Organisations (HMOs) is examined later that the incentives gap is a serious issue. Sussex[62] describes it thus:

'The ... weakness ... which will apply for all GPs, whether formerly fundholders or not, is the lack of direct incentives in the White Papers' world for individual practices to be economical in their use of health care services. Without the prospect of receiving clear benefits at the practice level, GPs may, quite reasonably, see keeping to a budget as pain without gain.'

On the issue of incentive payments to practices, the White Paper was atypically coy, talking only in the vaguest terms of '... efficiency incentives at both Group and practice level.'[63] To date, little further

flesh has been put on this barest of bones, yet the issue is central to making the reforms work. It is as if primary care professionals' (and particularly GPs') commitment to the objectives that government has set the NHS can be taken for granted – as self-evidently the only way to proceed.

Experience from fundholding and in areas such as prescribing should give policy makers cause for concern. Baines[64] and colleagues found that:

'The fundholders' potential for earning real and useable financial surpluses appears to have exerted a stronger and more rapid influence on behaviour than did the non-fundholders' prospects of generating purely nominal surpluses'.

This finding is supported by the evidence that, generally speaking, fundholding practices were more successful in controlling prescribing expenditure than non-fundholding ones.[65,66,67] Glennerster et al.[68] concluded that the inducement for non-fundholders to prescribe less in return for some vague benefit to primary care in the local area had no impact. This kind of finding should put the shivers down the spines of ministers, as the idea behind PCGs assumes such appeals to institutional altruism will work. Anyone who reads the professional journals, and in particular the mass circulation newspapers aimed at doctors, such as 'Pulse' or 'General Practitioner' will realise how dangerous an assumption that is.

2.3.2 Unwillingness to effect change

In human affairs it is often will, not logic, that is the deciding factor. This raises the question of what will motivate PCGs to take the decisions that others have shrunk from for years? This is clearly bound up with the incentives debate. Light[69] stated the problem simply when he wrote:

'... these new co-operative ventures require those who hold the budget to know what they want and to pursue value for money firmly. That means getting tough with high-spending GPs, underemployed surgeons, and incompetent managers. Will

'commissioning' turn out to be a vague fudge word for paying billions of pounds without stepping on anyone's toes and reducing waste?'

It is here that we run into two associated but also distinct problems with PCGs. The first and more fundamental is the question of willingness to make change happen. This is a theme that runs throughout this paper. The second is a question of PCGs' ability to act as effective agents for change.

On the first issue, experience of the fundholding scheme is again likely to be relevant. An article by Ellwood[70] entitled 'Have GPs been playing the market?' is particularly instructive. In a study of 35 fundholding practices in the West Midlands she found:

1 Prices applying to GP Fundholders (GPFH) fluctuated markedly but few changes in referral patterns occurred despite the potential for large savings.

2 GPs were keen to protect their local services and, although large savings could frequently have been achieved without excessive travel, prices were not a prime factor in referral decisions.

3 Service quality was regarded by GPs as the prime influence on referral choice but the quality measures themselves were subjective, historical ones. The use of such measures inevitably reinforces existing referral patterns unless there is a clear view that service quality is unacceptable.

4 Fundholders were more concerned with building relations and improving current service provision than playing the market. They continued to refer the vast majority of their patients to a small number of nearby hospitals.

One caveat needs to be made with regard to these findings: the practice budgets appear to have been generously funded. This begs the question whether more radical change would have occurred had this not been the case. Ellwood[71] herself commented that 'The financial pressure on GP budgets is increasing but as yet GPFHs respond by curtailing admissions rather than transferring to cheaper providers.'

If the NHS is to operate cost-effectively, whilst at the same time rejecting market mechanisms to force change, those making decisions

must be prepared to respond to cost/quality/access issues. In effect, there has to be a recognition that existing practices – referral and prescribing patterns, the way services are delivered – might have to change. Yet it is at precisely this point that primary care's role becomes problematical. Many GPs become fundholders with two primary aims – to ensure that the practice and its patients are getting the most out of the 'system' and to protect their local hospital. As I noted in 'Managed Care: Practice and Progress':[72]

'Local access naturally assumes a high priority. Most GPs are not nearly so concerned with ensuring macro-economic efficiency, ensuring supply meets available resources or even driving out poor quality providers (particularly if it compromises the access issue).'

The same dynamic holds true with PCGs and PCTs. The letters pages of the GP magazines are dominated by doctors expressing their determination not to be the ones to undertake the government's dirty work (on rationing, prescribing, service reconfiguration and the like) for them. The dangers, for a reform process which supposedly relies on the collaborative principle, is obvious. A 'BMJ' editorial[73] highlights the size of the task facing primary care:

'Whatever happens, the new primary care organisations will have to do a lot better than fundholders. Even the most sophisticated form of fundholding, total purchasing, has had little effect on clinical outcomes, the shape of secondary costs, or overall costs.'

Yet at the same time:

'Many GPs remain highly suspicious of the reforms and are threatening to withdraw co-operation unless their concerns over budgets, rationing and clinical freedom are addressed.'[74]

Back in April 1998 there was evident dismay when a telephone poll of 662 GPs showed 91% voting not to support the development of PCGs. Ministers responded by trying to reassure the profession that the reforms would not compromise their clinical freedom to refer and prescribe as they considered in the best interests of the patient. This reinforced the opaque statement in the White Paper itself that, although indicative budgets would be extended to individual practices

'... no individual element will be artificially capped'.[75]

However, as Sussex[76] observes:

'Budgets only act to restrain expenditure if those who determine expenditure perceive them to be genuinely fixed. Once budgets may evidently be broken with impunity, they can no longer achieve their purpose.'

Evasion of financial accountability is not so easy for Health Authorities (which have a statutory duty to remain within cash limits) and who will likely be held to account for the shortcomings of the PCGs operating within their boundaries. For this reason alone a number of commentators have been guilty of prematurely writing off Health Authorities' influence and role. It may yet prove the case that Health Authorities are used to drive change, with PCGs (and their Celtic equivalents) being used as a device to suck local professionals into the bureaucratic machine merely to endorse and implement central policy rather than initiating change from below. In this scenario, local initiative ends up being stifled behind a facade of local accountability. In any case, if PCGs prove to be unreliable motors for change, or indeed the principal obstacles to it, then Health Authorities are unlikely to disappear from the organisational map and may yet enjoy an unexpected renaissance.

2.3.3 PCG's ability to effect change

Light has written at length in a previous OHE publication about the conditions necessary for effective commissioning[77] and the issue was previously aired in the critical mass section above, so here I will endeavour to draw out the key points only. Light's main point has already been referred to: namely his view that a primary care based organisational model is not the best mechanism from which to commission services effectively. It should be noted that although Light's title mentions 'purchasing' the lessons transcend the internal market as the purchaser/provider split remains in the newly reformed NHS.

Writing in the 'BMJ'[78] in 1998 Light stated:

'Purchasers need to be large enough to rethink how high risk

groups of patients are treated and managed, create cross sectoral teams, handle risk, subcontract skilfully, and spread transaction costs over a reasonably large base.'

Commissioning is complicated, hard work. It requires sophisticated information systems and a highly skilled team of clinical and lay managers to make the desired changes happen. In contrast, PCGs seem to reaffirm the British preference for 'studied amateurism'. Board members are expected to shoehorn their new role into (at best) a couple of clinical sessions a week. Here the parsimony which government has adopted towards PCG management costs and board member reimbursement has been staggeringly short-sighted. Those charged with trying to develop the new organisations and the professional bodies' negotiators have had to fight every inch of the way to get funding.

Underlying the opposition to resourcing PCGs adequately, has been a deep antipathy to spending on 'management' – a view reinforced by optimistic claims that the dismantling of the internal market would necessarily reduce bureaucracy and hence free up funds for patient care. For Ministers, having painted themselves into this corner, there was further annoyance (and in some cases genuine bewilderment) that primary care professionals would not take on the new responsibilities envisaged for them merely out of public spiritedness. One suspects that much of the opposition to 'commercial' rates of reimbursement was (and remains) based on the non-executive model of participation in Health Authorities and Trusts. Traditionally, many Chairmen and Non-Executive Directors enjoy an independent income and their motivation to undertake such a role is supposed to come from a sense of civic duty, political inclination or the expectation of a 'gong' at some point in the future. Moreover, for the most part their role is as their title suggests: non-executive. Neither is likely to be the case for board members of PCGs. Underestimation of the size of the task, combined with inadequate resourcing, both personal and corporate, is likely to lead to a worryingly high level of burn out and drop outs.

2.3.4 Lack of corporacy

The non-hierarchical nature of primary care has already been noted. This enduring characteristic may be compounded by the fact that, in England at least, PCG boundaries are often artificial, in that the desire to produce groups of around 100,000 often resulted in groups larger than that which practices felt comfortable with but smaller than required to produce coterminosity with local government. In truth, there are pros and cons in either approach. The size desired by many in general practice is far too small if Professor Light et al. are to be believed, but the larger groups are starting to look uncomfortable and cumbersome.

Whatever the size of a particular PCG, its Board is a mass of potential (and actual) turf wars: the extended role of the community nurse versus the traditional role of the doctor; high street pharmacies versus dispensing GP practices; GP domination versus a more holistic view of primary care. This tends to make PCGs and their Celtic equivalents inherently unstable organisations. Although membership is unavoidable, active participation is not. Moreover, key elements of a PCG's leadership are having to undertake multiple roles: non-executive director, partner in a practice, clinical provider, commissioner of secondary health care services, representative of a particular interest group, and member of the local community. This brings together a potentially large number of conflicting interests, including differing views as to the prime purpose of PCGs. The emerging agenda is likely to create further tensions within PCGs.

Moreover the relationship between Health Authorities and PCGs/PCTs is prone to tension. These organisations make strange bedfellows given the often strained relationship between primary care practitioners and Health Authorities, compounded by the different cultural attitudes displayed on issues such as corporate governance and the bureaucratic regulation of public services. A tendency to mutual frustration and antipathy can result, particularly where there are 'zero-sum game' mindsets which see relationships between individuals and organisations as power struggles where success can only be achieved via

dominance over the other party.

The nature of the alliance between PCGs and local government is also an uneasy one. I doubt there are many readers naive enough to think that imposing a statutory duty of partnership solves the problem. As Webb[79] puts it: 'Exhortations to organisations, professions and other producer interests to work together more closely and effectively, litter the policy landscape.' The harsh truth is that the battleground of 'tough choices' on the limits of universal care, free at the point of use, are likely to be fought around the elderly – and this is the one area of significant overlap between the NHS and local government, particularly social services. The intellectual case for integrated care, joint budgets, lead organisations, etc., is readily understood, but if the argument for joint working is that convincing it begs the question as to why health and social services commissioning is not simply under one agency? The reality – that the two organisations jealously guard their positions – gives a better indication of the obstacles ahead.

In any case, local government officials may find it increasingly wearisome that PCGs are so preoccupied with health service issues that they spend little time worrying about 'health' issues per se. This is likely to be particularly true in the first few years as PCGs' agendas are dominated firstly with the practical issues relating to the transition from fundholding and subsequently by the practicalities of establishing Primary Care Trusts. PCTs are likely to be an enormously time consuming issue – further evidence, if any were needed, of the NHS's continued propensity (admittedly often at ministers' behest) to invest much of its emotional energy and management time in structural reorganisation. Before a PCT becomes operational, applications for Trust status must be made and a public consultation process undertaken; organisational structures agreed and implemented; staff transfer and recruitment processes agreed; a range of functions and resources have to be transferred, a Board established and accommodation issues identified and resolved. The list goes on.

When PCGs do move onto the wider agenda, conflict with local government over care to be given to the elderly, and who funds it, is

likely. Why should this be so? Firstly, it is a simple matter of where the NHS (or any other Western health system) spends most of its resources. The fastest growing sector of the population is the over-80 age group. By 2030 a third of the population will be of pensionable age.[80] 'The Economist'[81] quoted the following figures:

'The average person aged between 16 and 44 costs the NHS around £400 a year, whereas those aged 85 or more cost almost £3,000 a year each.'

Whilst studies in the US have shown that health care costs are greatest in the last year of life,[82,83] lengthening life spans will generally increase health care needs and hence costs, particularly for chronic illnesses and long term nursing care.[84] It is a sobering thought to consider the inverse relation between fatality and costs. As Bonneux and colleagues show, the highly lethal coronary heart diseases, causing nearly 19% of all deaths in the Netherlands (where the study was undertaken) account for only 2.7% of all health care costs. Mental disorders, mental handicap and dementia (all areas with a strong overlap with social services) are together responsible for only 0.6% of all deaths, but account for 26% of the allocated health care budget.[85] Indeed the elimination of coronary heart disease would substantially increase the burden on the health care budget as this would save few costs but would add a considerable number of life years. Whether this would be compensated for by an increase in individuals' economically active lifespans and reductions in payments of sickness benefits is not known. However, Bonneux et al. estimate that life expectancy would increase by about 1.9 years (2.5%) while costs would jump by about 6%.

Logically, if there are ever going to be substantial changes in the way the NHS is funded and delivered, if action is going to be taken over what are deemed to be ineffective treatments, or the question asked as to whether respite care should be available on the NHS, then it is likely that the focus of the rationing debate will initially fall on the elderly. If this occurs, the resultant debate will provide a true test for the corporacy of the public bodies involved and there can be genuine

concern that the current incentives are not strong enough to turn the rhetoric of joint working into reality.

Both the NHS and local government have a tendency to act like a series of fiefdoms and what is and is not provided by one or other body often has more to do with history than any allocative logic. Spending on social services per head of population is at least as diverse between local authorities as anything seen in the NHS. Dyfed Powys Health Authority, for example, shares coterminosity with four local government authorities. Their respective local authority social services department (SSD) expenditures in per head in 1998/99 were as shown in Table 1.

Is it merely a coincidence that the local authority with the lowest SSD expenditure (Powys) has the highest number of NHS care of the elderly GP beds in Dyfed Powys?

Table 1 **Social services department expenditures per head, 1998/99**

Carmarthenshire	£192.45
Ceredigion	£179.62
Pembrokeshire	£153.51
Powys	£149.39

2.3.5 Efficiency versus equity

Fundholding was opposed by Labour principally on the basis that it created a two tier service. Firstly it allowed fundholders' patients to be treated more quickly than patients from non-fundholding practices and secondly, through generous funding, it allowed some practices to generate savings which further accentuated the differences in funding relative to non-fundholders. Labour formally announced its intention to remove both types of inequity. Central to this was the abolition of fundholding, the introduction of common waiting times and equitable funding for patients of all types of practices.

However, as Bevan[86] explains, in reality, because of endemic variations in medical practice, government will have to choose between the two important policy objectives of the pursuit of equity and the drive for efficiency, and they take you down very different roads. Capitation based funding achieves financial equity but so long as there are differences in rates of referral between practices clinical equity for the patient will remain elusive. As elements of medical practice variation remain unexplainable, the problem is not resolved merely by observing that the resource allocation formula may not be sufficiently sensitive to morbidity or even relative provider costs.

The above also highlights the potential answer to the conundrum. Eliminate medical practice variation and you can achieve both policy objectives. Knowing the answer, however, does not really help with the practicalities of the NHS as it is now. It is akin to a view that the answer to war is for human beings to learn to live together in peace, and that is so self-evidently a desirable state of affairs that all that is required is for the parties in conflict to follow their true self-interest. For those engaged in the practical resolution of conflicts, this is of limited use. This is not to say that a policy aimed at reducing unexplained medical practice variation should not be pursued – indeed, it is central to achieving a more efficient and effective health service.

However, as Bevan[87] states:

'The government must choose initially between seeking clinical equity or financial equity for the new primary care groups. Because there are variations in medical practice, it is not possible to have both. Starting with an emphasis on clinical equity in effect means abandoning the policy of financial equity. It leads into the tragedy of the commons [overuse of a resource because no individual has an incentive to act responsibly] in which variations in medical practice are allowed to flourish unchallenged.'

The equity problem will be further aggravated by the fact that PCGs/PCTs will not be uniformly successful. Some will do a better job than their peers and this will have an impact on the quality and range of services provided for their patients. Labour may have thought

they had escaped from the market dynamic of winners and losers but they have not. Indeed, the further they allow PCGs/PCTs to operate autonomously, the more apparent the variations in performance between them will become. This creates a tension for a supposedly national health service which no amount of spin can resolve.

2.3.6 Over-ambitious timescales

To date, most of the strengths and weaknesses of the PCG reforms examined have been integral to the model itself. However, on the issue of the timescales in which PCGs have been established, government had control and the charge is a simple one: that the timescale was unrealistic. Detailed guidance on PCG membership functions, funding, method of operation, etc., took a long time to appear, leaving precious little of that commodity for PCG Boards to prepare for the 1st April 1999 nominal 'go live' date. A further major cause for concern has been the initial drive to move PCGs to Primary Care Trust (PCT) status. This has attracted much criticism and it is singularly disappointing that a party that spent so much of its time in opposition criticising the Conservative's penchant for rushing in unevaluated schemes, without the benefits of pilots, should take exactly the same kind of cavalier approach once in government.

Moreover, the introduction of Trusts in primary care – with their associated on-costs and their chequered history in the secondary sector (see Box 2) – seems a strange policy to pursue with such apparent vigour. The whole thing is reminiscent of Kenneth Clarke's supposed 'back of a beer mat' creation of the GP fundholding scheme.

There are essentially two problems here. The first, and more fundamental, is what kind of creature a PCT is intended to be. The second is the timetable to achieve it. The first has been at the heart of all the issues discussed in this paper. The problems the White Paper stated as needing to be addressed, and the apparent foundation for the PCG model, appeared to rest on the belief that a mechanism had to be found to intimately engage primary care – and particularly general practice – in the actual management of the NHS. The rhetoric led

Box 2 **NHS Trusts** 51

NHS Trusts as statutory bodies require their own Boards and separate financial reporting. These necessarily create a fixed cost element in terms of the creation and maintenance of each Trust – figures between £250,000 and £500,000 were used when Trust reconfiguration was being considered in Wales. The very fact that Trust mergers are taking place throughout the UK and are considered necessary are in part a demonstration that the creation of Trusts can create a new set of problems as well as acting as a mechanism for solving others. The Trust concept itself is arguably an organisational model designed to operate through a set of business relationships with other bodies. This created problems, for instance both with unplanned (at least by Health Authorities) developments by Trusts and taking forward retrenchment of services promoted by Health Authorities but opposed by Trusts. If the NHS is to return to a more planned environment, why promote an organisational model which emphasises the autonomy of its main agents: PCGs/PCTs?

one to believe that this was about engagement of clinicians to manage themselves, and through that to work as a partner with other bodies to manage the service.

As the reforms have unfolded there is a growing awareness that, in fact, an altogether different agenda may be being pursued: external management of primary care. At the time of publication, the issue hangs rather in the balance, but the capacity for command and control thinking has been highlighted at various stages in the text.

A 'Health Service Journal'[88] editorial expressed the latter interpretation with barely concealed glee. It is worth quoting at some length:

'Health Minister, John Denham, is proving himself a worthy successor to Alan Milburn in his ability to talk nonsense about handing powers to GPs while in practice ensuring that real decision making rests elsewhere ... GPs will not be able to veto progress of a PCG to PCT where public and broader professional opinion wants it to hap-

pen. And taken together with provisions of the Health Bill, all of this means GPs will most certainly not be in the driving seat of the new NHS ...

A large part of the reason some GPs now seem to find it so hard to believe that they will not stand alone in dictating the future direction of the NHS is that the government itself has done much to mislead them; not just in its rhetoric but in the concessions it rather foolishly made to the doctors in the governance of PCGs. If ministers had not conceded both majority membership and the absolute right to hold the chair on PCG boards, it would have been clearer from the start that GPs had no monopoly on leadership.

It is a disgrace and a short-sighted piece of political manoeuvring which led to the situation in which just two PCGs have nurse chairs. The government has only itself to blame for creating a cache of hundreds of GPs who, even before the reforms go live, already see power and responsibility for managing PCGs being taken away from them.

If, as Dr. Morris (Chair of the National Association of Primary Care) also believes, government thinking betrays 'a disturbing trend away from the practice as the basic unit', few tears will be shed outside general practice.

Whatever purpose independent contractor status and the mindset it produces may once have served, its usefulness to the health service has long since passed. Roll on the real integration of primary care and the rest of the NHS.'

This articulates a body of opinion as to what the introduction of PCGs and PCTs is really designed to achieve. It may well be right. It is also a guarantee for a bitter struggle with general practice. Journalists may think this good copy and long overdue payback for an arrogant professional group needing to be taken down a peg or two, but for those trying to make the NHS manage as best it can, it is likely to prove a nightmare.

Concerns about the issues outlined above are unsurprisingly causing many to have second thoughts about applying to become PCTs in the first place. Here, the problem with the timescales has aggravated

a basic flaw: PCGs and Health Authorities still do not really know very much about PCTs. Despite this, back in March 1999 it was reported[89] that the Department of Health claimed '... nearly 170 embryonic primary care groups have already formally expressed an interest in becoming PCTs, even before the guidance was issued.'

Here we have the crux of the problem. The approach of those 170 PCGs, the Health Authorities and the NHS Executive appears to have been to adopt St. Augustine's advice 'Credo et intelligam' – believe to understand. Instead, as understanding begins to dawn there is growing alarm about what everyone might be letting themselves in for.

Thus, the 'Health Service Journal' reported[90] in late April 1999: 'In the past few weeks, PCGs in areas as diverse as Tyneside and East Sussex have stepped back from expressions of interest in Trust status, having read ... recent guidance on PCT governance.' On 20th October 1999 the government announced that 68 Primary Care Groups would form up to 62 PCTs (of which 43 would be launched in October 2000, leaving just 19 to go forward in April 2000). Thus, over 100 PCGs dropped out between March and October 1999.

It did not help matters that the guidance did not appear until after the deadline for expressions of interest! The initial enthusiasm from within primary care for PCTs was somewhat ironic in any case, as those with experience of public accountability arrangements would guess that the move to Trust status would bring with it a need to demonstrate more corporate accountability – and this was always going to threaten the GP power base of PCGs. Hence, Stacey and Marchment[91] comment:

'Turkeys won't vote for Christmas and GPs won't vote for primary care trust arrangements that limit their power. They and their primary care group board colleagues already feel bounced into premature expressions of interest in trust status and are wary of any imposed trust model which fails to address adequately their full agenda and promote quality in the functions that they are to perform...

Untried and naive as PCGs may be, they are first steps into a corporate world for GPs and are developing an impetus towards autono-

my. The traditional NHS trust board and governance framework is simply not designed for primary care, won't work and won't command respect.'

It is not as if the move to PCT status removes accountability to Health Authorities. This is a much overlooked feature of the 1999 Health Act (which further casts doubt as to what organisation some groups are still hurtling towards). The original four stage process set out in the White Paper (see Box 3) seems a recipe for fragmentation and confusion which has been compounded by the decision to allow some PCTs to become operational from mid-financial year. This is a further complication on what is likely to be a patchwork spread of PCGs and PCTs operating both at different levels and differently within the same level, as local circumstances dictate. As part of this we will see some primary care organisations principally operating as commissioners of care whilst others will act both as purchaser and provider. To this can be added the tension generated by lack of clarity as to how the accountability process will actually operate.

The final chapter of this monograph looks at possible futures for the reforms in general and PCGs in particular. For the present the observation is simply made that there is no reason to reassess the opin-

Box 3 **The four levels of PCGs/PCTs**

Level 1: At minimum, act in support of the Health Authority in commissioning care for its population, acting in an advisory capacity.
Level 2: Take devolved responsibility for managing the budget for health care in their area, acting as part of the Health Authority.
Level 3: Become established as free-standing bodies accountable to the Health Authority for commissioning care.
Level 4: Become established as free-standing bodies accountable to the Health Authority for commissioning care, and with added responsibility for the provision of community services for their population.

ion expressed in a 'Health Service Journal' editorial[92] as far back as February 1998 that '... the parallels between 'Working for Patients' and 'The New NHS' are far too many for comfort ... The truth is that, as in 1989, the NHS is about to embark on a journey to who knows where, armed only with the sketchiest of blueprints riddled with contradiction and ambiguity.'

Dr. Harry Burns (Greater Glasgow's high profile Public Health Director) quoted in the same article put it more directly, if less politely '... it's a dog's breakfast, a recipe for chaos.'

2.3.7 Debt

Some PCGs will find themselves in the fortunate position of working through (sometimes with other agencies) how to spend growth monies most effectively and cementing this into their Health Improvement Programmes. Unfortunately, far more will be faced with the burden of a local health system in an expenditure/income imbalance. In a sizeable minority of cases the level of debt and recurring deficit will be of such magnitude as to overshadow everything else and fatally undermine confidence that a viable solution can be found. Indeed, many practitioners, believing that the debt position is unrecoverable, may conclude that they may as well be 'hung for a sheep as a lamb' and ignore calls for restraint.

This points to the unpalatable observation that, whilst a degree of financial difficulty may help to concentrate minds, at some point it threatens to become deeply dysfunctional. The term 'crisis' is overused in the NHS. However, when one reaches the situation where cash management becomes the necessary preoccupation of finance directors, because otherwise staff will not get paid, the capital budget is cut to get resources into the operating budget, and auditors threaten to qualify Trust and Health Authority accounts on the basis that they are no longer viable concerns, then perhaps the term 'crisis' becomes appropriate.

This now appears to be the case in NHS Wales where the newly formed Welsh Assembly will have to grapple with spiralling levels of

debt in at least two of the five Health Authority areas. The Comptroller and Auditor General's Report[93] for the 1997/98 Welsh accounts found that four out of the five Health Authorities and nine of the 29 Trusts in Wales incurred deficits in the year. Five of the Trusts had deficits in excess of £1 million. England, despite its lower funding level per head of population, seems in better financial health. The National Audit Office[94] found that '... overall, Health Authorities and NHS Trusts reported a significant improvement in current financial performance in 1997/98" ... with 'only' 48 of the 100 Health Authorities reporting a deficit for the 1997/98 year compared with 72 in 1996/97. Some 149 of the 425 English Trusts reported a retained deficit.

Whilst the financial position in England was considered to have improved, an accumulated deficit at the end of 1997/98 of £717 million, total potential clinical negligence liabilities of £1.8 billion, and a further set of clinical incidents '... which have occurred but have not been reported by the balance sheet date [which] could potentially amount to a further £1 billion'[95] constitutes no grounds for complacency. Just as worrying is the mechanism by which many organisations improved their financial position. Much of it is likely to turn out to be a mixture of non-recurring savings, debt write-offs and extra income from waiting list initiatives and the like. Much of that will act only as a short term diversion from tackling underlying overcapacity issues.

All the evidence points to an underinvestment in health care in the UK over a prolonged period. The primary indicators of this are:

- Deteriorating capital stock
- Chronic undercapitalisation (which a continued reliance on PFI does not so much disguise as highlight)[96]
- Generally low salaries (both within the UK economy and in comparison with other countries' health care staff)
- Modest prescribing expenditure (by international standards)
- Relatively low treatment rates (by international standards)
- High unmet needs
- Low morale

Far from recognising these issues, the Labour government has been

at pains to reject any notion that the current NHS is unaffordable or even seriously underfunded. It is ironic that Margaret Thatcher initiated the Conservative reforms of the NHS in response to the adverse publicity of a series of financially derived operational crises, but then effectively ignored the issue of resources. Now Labour have effectively taken the same approach. They seemingly ignore the potential of the reforms to further fuel a consumer driven demand for more resources.[97] Initiatives such as Walk-in Centres, whatever their benefits, are likely to further engender a desire for instant access to services (often from the 'worried well' rather than the 'apathetic sick') and beg the question as to why resources can be found to change the structure of primary care services, the nature of which we have been repeatedly told is the very foundation of a cost effective NHS. Many PCGs are likely to be pondering this question as they struggle to balance the books.

2.3.8 Focus

Finally, we come to a very British characteristic of health service reform: lack of focus. American health care organisations can be accused of many things but lack of focus on bottom line deliverables is not one of them. In contrast, in the UK we have a plethora of policy objectives vying for PCG attention: development of primary care, management of referrals, effective prescribing (within a budget), construction of the Health Improvement Programme, commissioning for health gain, meeting waiting list targets, addressing deficits, encouraging public participation, clinical governance, joint commissioning with local government, preparing to move to PCT status, the list goes on and on. Are these all priorities? What does it mean to say that they all are?

PCG board membership reflects a desire for inclusiveness that is likely to win more plaudits from social commentators than those who wished to see an organisational model which reflected the key tasks of PCGs. The author has previously made a similar point with regard to the organisation of Health Authorities.[98] At root, there remains a

propensity in the NHS to tackle any issue by setting up a committee. This is compounded by a desire (a type of political correctness with its historical roots in professional rivalries and demarcation lines) to select the committee's members according to interest group representation rather than a sober view of their ability to contribute. This leads to the type of thinking that creates a 35 strong committee representing 27 separate professions and organisations as a steering group to produce a cardiac national service framework for Wales (as distinct from England's own national service framework).[99] It is worth noting that this is a group which merely oversees the work of a series of sub-committees. When I observed that the team charged with oversight of the planning for the invasion of Europe had less than 35 individuals on it, a Chief Executive replied that tackling cardiac disease was a much more complex undertaking than D-Day. Whilst a sustainable, significant decrease in cardiac disease is undeniably a complex undertaking, a better approach would be to work out what levers need to be applied for each party to produce the desired outcome as part of an integrated approach, rather than take the view that the bigger the problem, the bigger the committee needs to be to work on it.

This chronic disease – like an arteriosclerosis of decision making – has plagued the NHS since its inception. There was a brief period around the time of the Griffiths management reforms in the 1980s when the culture looked set to change, but it has proved a false renaissance. It is a culture and environment that GPs in particular will find difficult to come to terms with, although they are as happy as any other profession to exploit it when it suits them. Moreover, it will be compounded by the input of local government officials whose culture and management processes often lead to decisions being deferred to councillors, i.e. bottom line they cannot speak for or commit their organisations in their own right.

How any of this squares up with the role that PCGs are expected (at least publicly) to perform is a moot point. There remains an enormous organisational development requirement, even as some of these groups prepare to move to Trust status.

3 THE CELTIC VARIANTS

With devolution looming large at the time when the Welsh, Scottish and latterly Northern Irish health service White Papers were framed, it should have come as no surprise to find that each wished to establish its own particular path and hence produce differences from England's 'The New NHS'. These Celtic variants vary in their departure from the principles set out in the English White Paper. Their common theme is a public commitment, and presumably determination, to operate the NHS through collaboration, partnership and planning, as opposed to competition. The proposed methods for achieving this, however, vary from one country to another. It is fascinating to see how each White Paper espouses the same value system, declares identical strategic objectives, rejects the philosophy of the internal market and then proposes a way forward distinct from the others – in Scotland's case quite radically so – without the slightest self doubt as to the logic of this. Seemingly, there are many roads to heaven, if only one to hell.

3.1 Wales

The Welsh approach is the easiest to summarise as it closely resembles England in its key characteristics. The Welsh White Paper 'Putting Patients First: The Future of the NHS in Wales'[100] effectively adopts the PCG model as its way forward. In Wales PCGs are called Local Health Groups (LHGs). As in England, they are operating initially as sub-committees of Health Authorities. Unlike England, there has been no attempt to be explicit about the stages by which LHGs may grow in autonomy and responsibility. The Welsh White Paper and subsequent guidance have been very coy about whether the expectation is for LHGs to become Trusts, punting this away as a matter for the Welsh Assembly to determine. If this leads the reader to suspect that Welsh policy makers have to date been less than enthusiastic about the Trust concept, you would be right. It is also worth noting that, unlike in England, there has also been little enthusiasm from the Assembly, government officials or GPs, for taking forward Personal

Medical Services Pilots, and to date none have been established in Wales.

LHG boundaries are coterminous with those of the unitary local authorities who are responsible, among other things, for social services. There are two local government officials (not councillors, despite intensive lobbying from that quarter) on each LHG board, one of whom also sits on the executive committee, which is the inner caucus of the LHG. One area of interest is that, unlike in English PCGs, although still heavily represented, GPs do not form the majority of either the LHG board or the executive committee, although they will provide the chairman unless a GP is not prepared to stand. Furthermore, the Health Authority has two officials on the board, one of whom is also on the executive committee, and the LHG general manager is directly accountable to the Health Authority chief executive.

Whatever the formal structure, the author's practical experience is that if the issues Health Authorities and LHGs intend to tackle are broadly as set out in this paper then the GP representatives still form the heart of the LHG and everyone knows it, even if some might resent it. This might serve to reassure English GPs reflecting on the proposed PCT governance arrangements. Except in those areas where general practice is manifestly weak, sub-standard and disengaged (a state of affairs which applies to some inner city and deprived areas but is certainly not the case for much of the UK), the sensible way forward is through a genuine partnership. If GPs walk away from either LHGs or PCGs/PCTs, then they are fatally weakened, unless primary care in the area in question is in such a poor state that it was never capable of reforming itself. In a normal environment, having an automatic majority is not practically that important, although it can seem so for those with little practical experience of the actual operation of NHS boards.

3.2 Scotland

The Scottish model is substantially different from the others. Even if Trish Groves, primary care editor of the 'BMJ' overstated matters

when she wrote that '... all forms of general practitioner commissioning will end'[101] there, it is clear that GPs' role in Scotland will be much more circumspect than anywhere else in the UK. Parston and McMahon, commenting on the reforms, declared that ' 'Designed to Care'[102] ... re-establishes the financial supremacy of Health Boards. But rather than 'a third way' the Scottish changes could easily become a step back towards the old command and control systems, in which decision makers far removed from patient care and service delivery determine resource allocation and thus service configuration ... But the biggest difference from the English approach is that Scottish general practitioners come across less as leaders of local services and more as subjugates to local planners and managers.'[103]

Health Boards (equivalent to the Health Authorities in England and Wales) will commission acute care. Scottish Primary Care Trusts are new statutory organisations which receive their funding from Health Boards. They will both commission and provide community health services, all mental health services, continuing care and primary care services based in general practice. (By contrast, English PCTs will not be responsible for providing mental health services.)

'Designed to Care' recommended, but did not insist, that GPs should form new bodies called local health care co-operatives (LHCCs) as part of the Scottish Primary Care Trusts, but '... gave no detailed vision of co-operatives' role, function or structure'.[104] This seems to have led to a degree of confusion at all levels, from GPs through to commentators, some of whom insist (like Groves) that '... there will no longer be commissioning in Scotland'[105] whilst the Scottish White Paper itself states that '... Co-operatives will have the right to hold a budget for primary and community health services, if they wish'.[106]

However, there is little doubt about the general intent. PCTs in Scotland, unlike England, will not commission acute care and the general aim of the Scottish White Paper is to create an environment where collective agreements can be constructed via a strong central lead. As fundholding covered less than 20% of the population of Scotland, pol-

icy makers evidently felt that there was little local enthusiasm for devolved commissioning.

It will be interesting to compare the relative fortunes of the respective models. GPs in Scotland will still be expected to manage prescribing budgets but in isolation from resources in the acute sector. It is not clear how the NHS in Scotland intends to tackle the issue of controlling referrals and medical practice variation other than through a common reliance on Health Improvement Programmes and the Scottish equivalent of NICE: the Scottish Health Technology Assessment Centre (SHTAC). Where are the incentives at ground level to make the system work? Moreover, Scotland's clinicians may well face a future where resources are set to fall. Scotland's health service is better resourced than in England and Wales, as Table 2 illustrates.

This will come under pressure as resources for Scotland are subject to the 'Barnett squeeze'. The Barnett formula is the mechanism by which the allocation of public funds for Scotland, Wales and Northern Ireland are derived. The formula is now being adjusted to take more regular account of population changes and this will in all probability adversely affect both Scotland and Wales. Even if the formula itself does not deliver a squeeze, English MPs, the media and even PCGs are likely to exert sustained pressure to try and ensure that one occurs. One by-product of devolution has been a growing awareness in England of the current disparity in resource use.

Table 2 **Relative expenditure per capita on the NHS, UK=100**

Year	England	Scotland	Wales	N. Ireland
1996/97	96	118	108	135

Source: Office of Health Economics, 1999.[107]

3.3 Northern Ireland

Northern Ireland's reforms are running significantly behind the rest of the UK, with any developments, whether or not along the lines of the proposals contained in 'Fit for the Future',[108] dependent on the new Northern Ireland Assembly which was, after much difficulty, set up in November 1999 and faces an uncertain future. The main proposals contained in 'Fit for the Future' were:

- The current health and social services boards to be abolished
- Primary care co-operatives to oversee commissioning
- Closer integration of health and social services
- Reduction, by merger, in the number of Trusts providing care from 19 to nine
- Bottom-up needs assessment and commissioning to be controlled by primary care professionals

One of the interesting things about Northern Ireland is that there is already much greater integration of health and social services than elsewhere in the UK, yet as Hazell and Jervis[109] have observed '... there have been few attempts to learn systematically from this experience.' Given the emphasis being placed UK-wide on joint working with local government, this makes little sense.

The other interesting feature of the original options contained in 'Fit for the Future' was the proposal that Local Care Agencies would embrace both the commissioning role of Health and Social Services Boards and the providing role of Trusts. This sounded rather as if health maintenance organisation (HMO) type entities combining purchaser and provider functions were to be established. The consultation paper was at pains to state that a clear separation between the two functions would be maintained via two operational arms, Primary Care Partnerships and providers, both of which would be part of and accountable to their parent Local Care Agencies. The consultation paper was suitably prosaic about how this would work in practice, but by the time the Government produced its own response to the consultation exercise they had drawn back somewhat from the idea of

combining purchaser/provider functions. Instead, with Local Care Agencies seen as strategic entities and local commissioning being delegated to co-operatives, Northern Ireland's reforms appear to be going down a similar road to England's. Time will tell.

4 WHAT SHOULD PCGS BE CONCENTRATING ON?

In the earlier sections of this paper an attempt was made to set the reforms in the context of overarching concerns that governments of all colours and persuasions have at present with their health care systems. Reinhardt has summarised this as a universal sense of malaise, frustration and discontent:

'That discontent is a standing invitation for would be reformers of the health system. At their core, all of the reforms being proposed pursue at least one common objective, namely greater accountability on the part of all actors in the health system for the resources they conscript.'[110]

With so many mixed messages surrounding Labour's reforms and such a potentially overloaded agenda, it is easy for PCGs to lose focus. PCGs need to be rooted in a concern to demonstrate efficiency, to stay within their unified budget, and also to demonstrate effectiveness (consistent medicine focused on the right things, at the right time, going to the right people and getting the right results). Everything else is secondary, but these objectives themselves cover a great deal of ground.

PCGs' priorities in achieving these objectives can be grouped under three main headings:

1 Creating and maintaining the organisation:
   - agreeing budgets, staffing and delegated powers
   - signing up to a 'strategic direction' which makes clear what the PCG is trying to achieve and whether it wants to become a PCT
   - making partnerships with other organisations a reality
   - construction, sign up and implementation of the local Health Improvement Programme

2 Clinical management:
   - clinical governance
   - primary care development and relationship with secondary care
   - interpreting and implementing NICE, NSFs and local treatment protocols
   - information (clinical coding, results reporting, etc.) and information technology (IT)

3 Financial and performance bottom lines:
- understanding the financial position
- management of GMS cash limited budget
- management of prescribing
- agreeing and monitoring incentive schemes
- management of admissions, referrals and waiting lists
- negotiating and meeting targets/performance agreement

This is by no means an exhaustive list, and that is the problem. Of the issues raised, this paper primarily concentrates on those grouped under the 'financial and performance bottom lines'. Space precludes anything other than an overview of the other areas, but an attempt has been made to highlight the key issues.

4.1 Creating and maintaining the organisation

It should be clear from what has already been written that keeping the various parties engaged in PCGs and their Celtic variants will be a considerable task in itself. I have already argued that PCGs are inherently unstable constructs – they must either keep evolving or implode. However, this is not the same as saying that they must become Primary Care Trusts. If you asked 100 PCG members what a PCT is and what it will do, you would get not far off 100 different answers. It would make little sense to insist that PCGs must evolve to PCTs if there is so little consensus as to what PCTs will be. I have heard enthusiasts stating they want their PCGs to become PCTs so that they can become independent of Health Authorities, but this is a questionable presumption when one reads in the Explanatory Notes to the Health Bill (enacted in 1999) that PCTs '... will be accountable to the local Health Authority and subject, like other NHS bodies, to directions given by the Secretary of State'.[111]

With often inadequate management budgets, uncertainty as to their exact role and responsibilities, and in many areas a mixed bag of primary care providers operating against a background of significant local health system financial deficits, it is clear that without compro-

mise and goodwill PCGs will not work. The danger is that with these pressures, so much emotional energy and time is taken up in the process of organisational survival that what the PCG has been set up to achieve is effectively forgotten. It could be argued that this is what has happened to the NHS in general and that Health Authorities in particular became public bodies whose principal interest was to counter threats to their own survival.

4.1.1 Agreeing budgets, staffing and delegated powers

The problems associated with inadequate funding have been highlighted throughout this paper and if left untackled by the centre are very likely to come back to haunt them. It is worth repeating that without compromise PCGs will not work. It remains to be seen if the government really wants them to work. If it does, it needs to recognise that what the NHS needs is not cheaper management but good management. The recent evaluation of the Total Purchasing Pilots[112] clearly demonstrated that a primary care based commissioning model was not going to be a cheap option.

Management budgets for PCGs vary widely across the country, as do delegated powers and staffing levels. Some 'Level 2' PCGs already have a well developed staffing infrastructure – dedicated finance, primary care development, administrative and commissioning staff and pharmaceutical advisors, operating from their own premises – and an extensive range of delegated powers. Others are effectively virtual organisations, still highly dependent on Health Authorities for basic support functions.

The smaller PCGs will struggle to operate within their management allowances and it is widely assumed that mergers between PCGs will follow, particularly if PCT status is sought. There are no firm cut-off points as regards the size that PCTs are supposed to be but, in practice, the smaller PCGs in particular will struggle to make the transition to PCT, assuming that they wish to do so.

4.1.2 Strategic direction

It is extremely important that the key stakeholders sign up to what their principal objectives are: what strategically they want to achieve and hence must do to get there. Originally, there was a natural assumption that the desired end point was to become a PCT. On reflection, this aim is not really an objective in itself but more a process. It begs the question 'become a PCT to achieve ... what precisely?' As previously noted, having belatedly asked the question, many in primary care are having second thoughts about rushing headlong into Trust status. Notwithstanding a desire for autonomy (which may prove a chimera) through Trust status, a PCG needs to consider what constitutes success: for itself, for its constituents and for the bodies that will hold it accountable. The challenge for a PCG is to successfully undertake the fine balancing act of keeping all of these parties relatively satisfied.

4.1.3 Making partnerships a reality

On the issues of partnerships and ensuring that the wider primary care community and the public itself are engaged in the PCGs' planning and activities, some will criticise the limited attention these have received in this paper. It is not that partnerships are considered unimportant. It is merely that, all too often, much of the brave talk of a partnership culture is found to be vacuous when one looks for concrete evidence. Sitting in meetings espousing one's commitment to collaborative working means little. True partnership is about sharing risk, sharing resources and subordinating individual organisational agendas for a common aim. At that stage, even those most vocal in their belief in partnerships may balk, particularly when it requires passing power and/or money to another agency.

The stresses likely to preclude getting a real partnership between PCGs and local government have already been noted. For PCGs, the initial objective must be to keep local government 'partners' engaged when so many meetings are likely to be dominated by pure health care issues. This is likely to be particularly the case at first, as PCGs' agen-

das reflect the issues created by the end of GP fundholding, the introduction of cash limited unified budgets, etc. PCGs would be well advised to limit themselves to producing a small number of limited but concrete pieces of evidence of genuine partnership, such as a number of social workers being based in primary care practices, or a cardiac health check programme undertaken at a pharmacy linked to a number of practices, for example.

4.1.4 Producing the Health Improvement Programme

The importance of the Health Improvement Programme has been emphasised in numerous circulars and speeches and PCGs may therefore feel that it is the most important single piece of work they will engage in. To be so, it is important that a PCG can undertake three key steps alongside the Health Authority and the principal local health care providers:

1 Identify a small number of significant local health issues which require attention, alongside national priorities.

2 Agree a resourced action plan to tackle these issues IN PRIORITY ORDER.

3 Set the actions needed to tackle health service delivery issues (for instance tackling overspending, above average levels of emergency admissions, etc.), within the context of the general health issues of the Health Improvement Programme. It is important that these do not end up being in effect two self-contained and conflicting documents with no recognisable inter-relationship.

PCGs and Health Authorities need to resist the temptation to start the Health Improvement Programme process with the clarion call to undertake a general needs analysis. Use what is already available. Pragmatically speaking, the last thing the NHS requires is people spending time and resources trying to discover more unmet need. Unless the Health Improvement Programme recognises resource and service issues and sets itself realistic objectives it will probably join the extensive library of worthy yet impractical and largely unread documents that prop up desks throughout the NHS.

4.2 Clinical management

There is insufficient space here to do justice to the importance of this area of a PCG's agenda and the main focus of this paper lies elsewhere, yet ensuring that the effective management of the clinical processes of care lies at the heart of the reforms themselves. The central pillar of this will be the requirement to first institute, then undertake, formal clinical governance.

4.2.1 Clinical governance

The importance of clinical governance for both primary and secondary care is self-evident, but the impact is likely to be the greater on primary care because it has such limited experience of systematic audit and even less of a culture of regulated, multi-practice evaluation.

The initial tasks for a PCG in respect of clinical governance raise two principal concerns: firstly the time and resource implications for clinicians of undertaking it properly; and secondly the danger that the concept merely becomes relegated to a stylised series of committees focused on the process, and not the outcomes, of clinical governance. The latter are principally functions of culture, motivation and experience, rather than time and money.

Many clinicians are very enthusiastic about the clinical governance initiative. They recognise that there is a need to demonstrate accountability for the quality of care and that this must involve all practitioners. They also recognise that it is long overdue and that the voluntary nature of audit in primary care to date (which tended to mean that those least needing to audit themselves did so) was as ineffective as it was unsustainable. However, that enthusiasm and commitment will wither if clinicians believe there is little recognition of the true costs of effective clinical governance. Unfortunately, at present, those fears look likely to be realised. This would be a tragic lost opportunity, from which all parties would suffer.

4.2.2 Primary care development/relationship with secondary care

It is extremely important that the focus for decisions on primary care development (and in places retrenchment) be with the PCG rather than the Health Authority. To enable this, the GMS cash limited budget and any earmarked, primary care related, development monies need to be delegated to PCGs. The importance of devolving both power and responsibility, rather than just one or the other, cannot be over-stressed. Health Authorities, for their part, have to be prepared to take risks – and devolution of budgets to largely unknown entities is a risk. Above all, they, and others, need to recognise that organisations do not mature unless they are given enough latitude and responsibility to a point where hard decisions have to be made, and where there are some tangible rewards for having done so.

The primary care development portfolio is key, as it provides one of the few visible forms of leverage that PCG leaders have with the practices in their Group. At its most basic, the budget represents resources that GPs want and by giving them out or withholding them behaviour can be influenced. An early challenge to PCGs will be to review the current distribution of GMS resources to practices. It is unlikely to be equitable and may well reflect the inverse care law: those with the most needy population have the fewest resources to care for them. Whether or not a PCG does anything about this will be a good indication as to whether these new organisations are fit to oversee the development of local primary care services.

It is also important that PCGs remember that they are charged with developing primary care as a whole, not merely general practice, and even within that not just to a medical model. One mechanism to help achieve this is to link development monies to Health Improvement Programme priorities. If the Health Improvement Programme has been constructed with any degree of rigour and multiparty involvement, issues relating to the role of dentists, pharmacists, and others should have come out.

Finally, the PCG will need to be mindful of the impact of developments in primary care on other sectors, particularly secondary care.

An oft heard criticism of GP fundholders was their propensity to remove elements of a service at full cost from Trusts, reprovide them at their practice or purchase them from the private sector, and leave the remaining element of services (now running below breakeven) at the Trust. Trusts for their part need to share the blame for acquiescing to such services being removed at or near full cost, rather than at the true marginal cost. They agreed to do so partly in the expectation that Health Authorities would make up the difference in funding and partly so as to not alienate fundholders, fearing they would take yet more of their business elsewhere. PCGs have to make the mental leap and recognise *that in such matters they are in effect the Health Authority.* As a result, for the first time, primary care may have an incentive to consider what the right balance between primary and secondary care actually is.

4.2.3 Evidence based practice

Interpreting and then implementing evidence based practice, whether national guidance from NICE, protocols forming part of National Service Frameworks or locally formulated, is a core function of PCGs. This will be key to implementing a meaningful model of clinical governance. Quality improvement and accountability depend on effective methods of changing performance. The consequence of this is a need for PCGs to establish systems for accountability that ensure poor performance is reported and corrected. As Baker et al.[113] note, the resulting workload will be tremendous if the job is done properly:

'The agenda for clinical governance is ambitious and the resources required to underpin it must not be underestimated or it will be programmed for failure from the outset. For example, the adoption of evidence based practice by a primary care group is a major undertaking. Many clinical and other staff will require education and training but the group itself is unlikely to contain people with the skill and time to deliver all that is required ... The information systems needed to support quality improvement and accountability must also be developed. Therefore, primary care groups will need considerable external support ....'

This reinforces the points previously made. As one of the agencies identified as providing external support was Health Authorities, and these are downsizing themselves, the danger remains that the reforms have established expectations that reality cannot match.

4.2.4 Information and IT

It will be obvious that the role envisaged for PCGs requires it to have good access to timely, accurate information (clinical, financial, managerial, soft and hard) and the skills to interpret it. It is also evident that this is a highly problematical area, deserving of a paper in its own right. For the present, the following issues are merely highlighted.

Firstly, it remains an unpalatable fact that information and IT management in the NHS has been a chronic underachiever. Much of the time, hoped for benefits have not been fully realised, costs have been higher than expected, and procurement and implementation timescales have gone way beyond initial plan. In truth, there is little reason to believe this will change much, notwithstanding the NHS Information and IT strategy, because the vision exceeds the system's ability to deliver it. Further, there would need to be a significant change in the culture of the NHS which is remarkably laissez faire about staff, and independent contractors, actually making use of the IT investment.

Secondly, there is the perennial concern about funding. A good illustration of this is the example of NHS Wales. Their information and IT strategy 'Better Information – Better Health'[114] finally appeared about six months after England's, and whilst not short of ambition, did not have any funding attached to it.

Finally, and perhaps most serious of all, there is the state of information management and IT in primary care itself, which might be described as anarchic. With the exception of Scotland, GP practices have a plethora of 'clinical'(sic) practice management systems. In this context, whether Scotland is better or worse off is not the issue – standardisation per se is certainly no guarantee of good quality software. It is the disturbing feature of many of the clinical systems in use today of the difficulty of getting meaningful and comparable clinical infor-

mation out of them that needs to be noted. Moreover, there are still some practices not computerised at all, and for those that are the usage of IT varies dramatically both between and within practices.

General practice has adopted the Read system of clinical coding (named after its inventor Dr. James Read) as its 'standard', although the use of Read within and between practices is anything but standard. However, secondary care uses the International Classification of Diseases/Operating Classification System (ICD/OPCS). Translating codes from one to the other remains problematical. The selling point of Read to general practice – its flexibility and comprehensiveness - may well prove to be its Achilles heel (see Box 4). The requirement now is to produce information that enables multi-practice audit and clinical management to occur and this requires standardised information. This in turn is made considerably easier if everyone enters the same information using the same codes for the same type of conditions, treatment, etc. Yet general practice typically does not do this.

Box 4 **The Read system**

The Read system has had more than its share of controversy. The arrangements by which the Read system was licensed and financed were subject to a critical report from the National Audit Office in 1998. More fundamentally, there have been long-standing, if muted, concerns about the design of the coding system in terms of its suitability to produce standardised, comparable information across practices and sectors (primary/secondary care). The recent announcement[115] that Read is to be incorporated into the US clinical coding system known as SNOMED-RT has been interpreted by the 'HSJ'[116] as marking '... the end of the NHS's decade-long commitment to its own 'electronic language of health' based on Read codes ... it will wither away over the next three years ... it will in effect become part of the rival US system'.

Some practices code in great detail, others not at all. One practitioner will code, say, asthma, using Read in one way up to one level, another will take a different route and may code to a different level again.

This points to one of the first tasks of PCGs: to achieve standardised and effective communication links between practices, and beyond. This links with the clinical governance agenda and, initially at least, PCGs would be wise to concentrate on trying to get a few conditions (e.g. diabetes) entered uniformly and the information shared. PCGs should resist the urge to go out and buy systems before they have really thought through what their information needs are, have experimented with trying to get practices to produce standardised information and have identified the total resource implications.

PCGs also need to consider the information and IT needs of primary care as a whole. What would be the benefits of linking pharmacies and dental practices with GPs' surgeries? What links in turn need to be made with Trusts? With such a large agenda, the best practical advice is to agree the big picture (know what you are ultimately aiming to achieve) but start small.

4.3 Financial and performance bottom lines

Understanding the financial position is an obvious objective for PCGs but one that is likely to prove problematical. Even those PCGs who have no further ambition than to remain at 'Level 1' (essentially advisory in nature), will want to know how much of a Health Authority's allocation of funds is nominally attributable to the PCG and how much is being spent on it. There are a number of technical and practical issues in this process which in total make this a difficult task to achieve to the satisfaction of all the interested parties. Many Health Authorities will have to break down historical volumes of activity and expenditures to the level of PCGs or below, preferably building up from individual practice level. The ability to do this quickly and accurately depends largely on the robustness of Health

Authorities' information systems, the skill of their information and finance staff, and the type of contracts already in place.

Another problem is that elements of many contracts will not be identifiable to a particular practice or PCG, namely: outpatients, unless the Trust is producing a patient data set; some or all of community activity, mental health and learning disabilities; Professions Allied to Medicine and diagnostics; ambulance services; and voluntary sector services. Whilst some of this information may be available for ex-fundholding practices, it needs to be available for all practices. In certain cases, apportionments will need to be made, and this can sow the seeds of continued disputes as to the apportionment formulae used.

Finally, there are the variations in both allocations and expenditure which occur year on year. These are a consequence of changes in the resource allocation formula and the peaks and troughs of high cost patient treatments. It is a natural desire of PCGs to want stability with regard to their financial position, but the greater the level of financial delegation (from Health Authorities to PCGs, from PCGs to practices) the more problematic, and likely, such fluctuations are. This is a feature well established in the insurance industry. HMOs also have considerable experience of this issue and this is a further reason why American commentators tend to be against commissioning being undertaken by small organisations.

Whilst some services are likely to remain centrally commissioned and hence in effect top sliced (normally due to their small numbers and high cost and/or the specialist nature of the service being commissioned), the problem with regard to identifying costs to PCGs and practices does not go away. Any time a budget comes under pressure – or even occasionally when monies are released due to a reduction in demand – people naturally want to know who is committing those resources. If a PCG cannot elicit answers to these questions, it will struggle to make the necessary changes.

PCGs also need to gain a sound understanding of the sometimes obscure relationship between the services that providers supply and

the prices they charge for them. GPs in particular have had a tendency to think in terms of discrete prices for individual transactions, rather than the idea of commissioning service capacity for a quantum of money. It is important for a PCG to gain an understanding, at least for its principal providers, of what range of services need to be purchased, how much it is reasonable to pay for it, and what that means in terms of necessary service change.

Establishing a view on the current efficiency of the services in question is obviously extremely important. However, those unfamiliar with the vicissitudes of Trust pricing and with inter-organisational benchmarking are likely to be dismayed as to how difficult it is to get clear answers to seemingly simple questions on provider efficiency. The ability to benchmark services has improved somewhat in the last few years. Previously, it was almost impossible because many Trusts would not release the information. But it is still handicapped by a reluctance to enforce standard service definitions and data collection. This is further compounded by the bizarre approach in England to Healthcare Resource Group (HRG) costing: allowing each Trust to effectively determine its own case weights instead of applying a nationally derived set. If this was not bad enough, the practice of only costing a certain (albeit increasing) number of specialties at HRG level allows resourceful accountants to move costs into areas of the Trust's operations that are not being benchmarked. This will always be a problem until Trust costing processes are subject to third party scrutiny.

All of the above undermines the establishment of external benchmarks which would help both PCGs and Health Authorities to evaluate provider performance and thus decide what changes are and are not reasonable to demand. The same problem applies on a wider scale with regard to elements of the PAF. It begs the question as to how this state of affairs has come about. In a previous article I offered the following explanation:

'In truth, it has suited the key vested interests – professionals, Trusts, Health Authorities and civil servants – to avoid clarity on per-

formance issues. Moreover, the professional group that has most obstructed the construction of robust benchmarks has been the accountants! It is ironic that their main objection (that benchmarks aren't sound because the information isn't collected in a standardised manner) is largely the result of their own failure to get to grips with a process they have unchallenged control of – cost accounting.'[117]

PCGs cannot afford for these practices to continue.

5 PRESCRIBING

This paper has emphasised the need to see the government's reforms within the context of a continued focus on cost constraint and its desire to 'control' clinical behaviour. Nowhere is this more evident than in prescribing. In relation to this, there are a number of tactical and strategic responses which PCGs are well placed to consider. Prescribing is an area where many GPs feel reasonably confident that they both understand it and can make an early impact on it. There is a body of evidence that many fundholders did just that[118,119] and through their efforts reduced prescribing costs.

I place considerable emphasis on the need for, and advantages of, PCGs getting an early grip on prescribing. However, an early 'health warning' is also appropriate. There is a very real danger that the focus of the health system, including PCGs, will be simply on cutting spending so as to reduce the costs of health care rather than trying to improve cost effectiveness. Moreover, that focus may simply be on reducing the costs of individual elements of health care provision without regard to whether the combined costs of all treatments relating to the disease process are set to rise as a consequence of the cost cutting measure in question. This is particularly likely to be the case with expenditure on drugs. Unfortunately, despite the potential of unified budgets, traditional 'silo thinking' (drugs budgets are for expenditure only on drugs, HCHS budgets are only for Trust services, etc.), reinforced by the restrictions of the annual funding cycle and break-even requirement, is likely to militate against 'joined up thinking' on prescribing matters. This is a subject returned to in the latter part of this chapter. Before looking at that, however, the effective control of prescribing is first reviewed.

5.1 Determining PCGs' and practices' funding allocations

By the time this paper is published, a large number of PCGs should be operating with a prescribing budget. For many, this will undoubtedly have been the source of much controversy and many are likely to

still be in dispute with their Health Authority about the underlying formulae. Some of these disputes will have been so intractable that a number of PCGs may simply refuse to have anything to do with the management of the prescribing budget, with a resultant increased risk of overspending very likely. For those that can agree the allocation formula, there are further hurdles to overcome in agreeing the management support required for the prescribing budget and in constructing a worthwhile incentive scheme to encourage individual practices and GPs to comply with the budget.

With regard to determining the prescribing allocation, a capitation based formula should be adopted. That this is not without its problems can be gauged by the title of Majeed and Head's[120] article in the 'BMJ' on setting prescribing budgets in general practice, namely 'Capitation based prescribing budgets will not work'. The article itself is excellent in its exposition of the reasons why capitation based formulas are being pursued and their flaws but, significantly, the authors do not propose an alternative. It is worth quoting them on the subject:

'... behind the increasing interest in capitation based budgets is the belief that such budgets will help to ensure that resources are allocated more fairly among general practices. There are wide variations in prescribing costs between general practices, and it is not clear whether these variations are clinically justified. To many people, these variations suggest that the prescribing of general practitioners is either inefficient or inappropriate.'[121]

What provokes particular cynicism from external observers is the way that these variations can be found across a whole range of practices. In the Dyfed Powys Health Authority area, for example, there are some dispensing practices with some of the lowest prescribing costs per head and others with amongst the highest. If a capitation based prescribing formula is not used, preferring instead to use historical expenditures to set budgets, the accusation that one is merely perpetuating unjustified variations – in effect rewarding high cost prescribers and penalising low cost ones – is difficult to avoid.

This still leaves the problem of which formula to use. The challenge is to try and reflect the impact of deprivation on general, and particularly chronic, illness on prescribing costs. Although there is general agreement that it is important that these features are recognised, there is much less agreement as to which measures to use and the weights they should carry. In rural areas, there is concern that the Townsend deprivation index is misleading. For example, it uses lack of car ownership as a deprivation measure, but in rural areas ownership of a car is common in all social groups, not least because public transport services are so poor.

In Dyfed Powys, there was considerable debate as to what deprivation measure to use and eventually a capitation formula was agreed which was essentially two thirds straight capitation, with the remaining third being based on an index weighted for each practice's position with regard to the number of people in its area who had declared themselves in the 1990 census to have a self-reported limiting illness. The move from historical budgets to those based on the above formula will be phased in over four years, so as to give practices more opportunity to adapt to these changes.

Dyfed Powys Health Authority also continued the practice (also recommended by Majeed and Head) of top-slicing reserves for expensive drugs and of adjusting allocations for those practices with nursing/residential homes in their area. Dyfed Powys's approach is used here only for illustrative purposes rather than being promoted as 'the only way to do it'.

5.2 Managing prescribing budgets

Once budgets have been established they have to be managed. In 1998, pharmaceuticals accounted for 12.6% (£6.1 billion) of total NHS expenditure,[122] whilst as far back as 1994 the Audit Commission estimated that prescribing costs could be reduced by about £425 million if all GPs prescribed in a similar manner to the 50 practices which the Commission identified as 'good' prescribers.[123]

The important yet subtle point is that 'good' prescribing is not necessarily cheap prescribing. Practitioners' principal fear is that pressure will be applied to make it so. Box 5 illustrates a range of measures and issues which a PCG may wish to consider in relation to prescribing. In addition to these are the activities of a multi-PCG Drugs and Therapeutics Committee of the sort described by Beard and colleagues,[124] a summary of which is shown in Box 6.

Some of the measures in Box 5 are controversial. For example, restricting the prescribing of over the counter medicines may well have a negative impact on the health of the poorest and most vulnerable elements of the community. There is also the question of whether PCGs or Health Authorities can in the final analysis restrict a practice's prescribing. The matter is likely to remain unresolved until tested in the

Box 5 **Features of a prescribing strategy**

- Promote generic prescribing
- Review repeat prescribing (typically accounts for 80% of costs)
- Targeting of selected practitioners
- Restrict prescribing of over the counter medicines
- Agree and enforce primary and secondary care formulary
- Tendering (e.g. for vaccines)
- Review specific use of certain drugs with a view to reducing over-prescribing
- Agree with hospital consultants type and duration of drugs to be prescribed by respective sectors with regard to drugs prescribed by respective practitioners
- Agree specific strategy for dispensing practices
- Investigate areas where greater use of prescribing could potentially reduce costs in other areas
- Partnerships with selected suppliers
- Disease management programmes

Box 6 **Possible activities of a multi-PCG drugs and therapeutics committee**

- Produce hospital and practice formulary
- Develop co-ordinated policies and treatment guidelines for optimal use of drugs
- Recommend procedures for the safe and secure handling of drugs
- Control the introduction of new drugs and formulations
- High level monitoring of PCG expenditures
- Supply information to prescribers on the most effective and economic use of drugs
- Address issues affecting the relationship on prescribing issues between general practice and secondary care
- Encourage and supervise research into drug evaluation and health gain

Source: Beard et al., 1998.

courts. For those particularly interested in this topic, a thoughtful article on it by Newdick[125] and the subsequent commentary by Hurwitz[126] are recommended.

Rather than restricting an individual practitioner's right to prescribe, the more likely tactic will be to exert pressure on the practice through a combination of: clinical governance scrutiny, education, review of the GMS cash limited budget (including making approval of funding applications for such things as improvement grants, additional primary care staff, training courses and computer equipment, conditional on prescribing targets being met), and perhaps even more controversially a quota on elective referrals. The last of these might be best dealt with through the clinical governance route and needs to be carefully handled to avoid the charge that this would create a two tier service which punishes patients of a particular practice. Whilst ultimately these problems may be unavoidable, it should be noted that

there is already a fourfold variation observed in outpatient referrals for elective treatment which creates its own inequity of access.[127]

The not inconsiderable impact of peer pressure can be added to these pressures, as individual GPs and practices are reminded that the PCG's financial health and ability to refer, and their own access to prescribing incentive monies, may be dependent upon getting the prescribing of recalcitrant practitioners under control. Such are the power and implications of the unified cash limited budget.

If these measures prove ineffective, or their use is deemed politically unacceptable, PCGs, PCTs and the reforms themselves will be in trouble. As Sussex[128] has previously pointed out, at first sight the dissolution of fundholding appears to have weakened direct financial incentives for practices to make prescribing savings. Many PCGs are projecting significant overspends on their prescribing budgets. The government's response to date has been to sympathise with PCGs' prescribing problems (such as the unexpected rise in the prices of some generic drugs experienced in late 1999) but to restate that budgets must be adhered to. The true test is likely to emerge at the end of the financial year when the implications of such overspends for services and incentive scheme payments become more apparent.

5.3 Disease management

The more ambitious PCGs will wish to give explicit consideration to the optimal use of drugs in the management of disease. In doing so, they will ultimately end up looking at the possibilities of disease management programmes. Prior to this they are likely to review the relationship between primary and secondary care prescribing. Joint formularies are one approach, even if, as Bosanquet cites, they have the distinct tendency only to 'stir up apathy'.[129] Perhaps more excitingly there may be opportunities to counter the tactic of drug companies promoting the use of a product at low cost to hospitals with high cost implications for primary care. With unified budgets PCGs now ultimately fund hospitals drugs budgets, so there is scope for them to

increase funding for (lower priced) hospital prescribed drugs so as to lessen the burden on the primary care prescribing budget, thus taking advantage of price differentials between the two sectors.

The most radical strategy is to enter into partnership with elements of the pharmaceutical industry to operate disease management programmes. Disease management itself is about more than just prescribing, but giving the optimal drug at the right time and ensuring patient compliance is an important component of it. The potential of disease management programmes can be gauged from this 'BMJ' editorial:[130]

'Increasingly, the main business of doctors is managing patients with chronic, not acute, diseases. Good clinical skills are needed to treat both acute and chronic disease, but organisational skills are especially important for managing patients with chronic illness. Classically, only half of patients with chronic disease are identified, only half of those identified receive treatment, and only half of those treated are treated adequately, meaning that seven eighths are not being optimally managed ... if those patients can be better managed then outcomes can be improved and costs reduced.'

Disease management initiatives to date have concentrated on conditions such as diabetes, cardiac disease, asthma, depression and the like. Properly designed, such programmes rely on aggressive prevention of complications as well as treatment of chronic conditions. The approach should be systematic, integrated, evidence based and aimed at the long term care of defined populations of patients. Drug companies are at the forefront of this approach because they believe that drug usage is sub-optimal in the management of such conditions. Moreover:

'Setting up 'disease management' programmes that operate across the boundaries of primary, secondary and community care requires high capital investment and state of the art information technology. Few health care providers can readily supply these. Pharmaceutical industries can. Hence the logic of contracting out services or setting up joint ventures.'[131]

If PCGs can improve the cost effectiveness of patient care through partnership with pharmaceutical or any other companies, why is this not being more aggressively pursued? There seem to be six principal reasons:

1 Commercial programmes need to be built on rigorous economic, as well as medical, knowledge of the entire course of each disease state. This creates an immediate barrier as we run into the problems of inadequate costing, different organisations caring for patients at various stages of the disease, and all the associated problems of releasing monies from savings in one area to pay for increased costs in another. This is a problem for every health care system in the world, many of which are currently showing an interest in disease management.

2 Disease management often requires up front additional investment for long term gain. This is problematical for most health care systems. In the US, for example, HMOs often hang back from disease management programmes because they suspect that the beneficiaries of their investment will be other HMOs as patients are essentially free to switch company. The patient enjoys better health as a result of the programme, but a rival then offers a cheaper premium (perhaps because they have not made that additional initial investment) to capture the business. The HMO is then left carrying the additional costs of more aggressive patient management. This points to a particular structural weakness of private insurance based health systems, in terms of their ability to focus on health care issues which require lengthy timescales to produce a return on the initial investment. In the UK this disincentive does not exist but the rigid and tight NHS annual funding cycle unfortunately more than compensates for this. Add the natural risk aversion of NHS management and it is not difficult to see why such programmes will struggle to get off the ground in the UK.

3 The central premise of disease management programmes can be questioned. As Richards[132] observes 'The jury is still out over whether reduced costs are sustained long term.' It has been pointed out that it

is the patient, not the disease that is being managed[133] and that, to a degree costs may be being deferred to a later date, not eliminated. Preventing disease may increase health care costs however much it benefits the individual patient.

4 Disease management is at root another form of capitation funding and is therefore about the sharing and management of risk. A PCG pays (say) a pharmaceutical company a fixed sum per head to manage diabetics in its area. The company in turn pays for any care given to those patients related to their diabetic condition. The company now has a major incentive to avoid hospitalisation of its diabetics as this will be expensive. It is likely to heavily promote patient education, primary care intervention, drug management, etc. All well and good so far, but the company is now exposed to genuine financial risk as its capitation funding may fail to cover actual costs. Many companies lose their enthusiasm for disease management programmes when this kind of arrangement is proposed. They are happy to contract for education support, but not to be 'at risk' for outcomes. This is another reason disease management programmes are a bit like teenage sex. Everyone talks about it but relatively few are actually doing it. As one US healthcare executive replied when asked if his organisation had any disease management contracts. 'No. Not until the pharmaceutical companies are prepared to go 'at risk'. Then I'll know they're serious and it's not just another marketing tool.'

5 Mason, Towse and Drummond, in a recent in-depth study of disease management[134] concluded that 'The key barrier to more disease management activity per se (irrespective of industry involvement) was the division between primary and secondary care'. This, combined with the aforementioned suspicion in the NHS of the pharmaceutical industry and government antipathy to such joint ventures, creates a difficult environment for disease management initiatives.

6 Finally, there is the problem that any private company prepared to take the risk will want considerable control of the patient management process. This threatens professional independence and so unsurprisingly the greatest resistance to such an initiative may well come

from the clinicians within a PCG itself. In America this is also a major issue as the following quote demonstrates:

'Many Managed Care Organisations (MCOs) have been reluctant to allow the manufacturer to literally manage patients. However, without the ability to intervene where appropriate, the manufacturer will not be able to add value required by the MCO. Ultimately, the MCO must render a business decision, weighing the benefits of pulling cost out of the system against the relinquishment of some control to the manufacturer. In theory, the more responsibility the MCO is willing to give the manufacturer, the better the capitation rate.'[135]

In the UK there is the added factor of government antipathy to 'privatisation' of the NHS (although its reliance on the Private Finance Initiative (PFI) for capital investment in the NHS sits uncomfortably with this). This makes it difficult for the pharmaceutical industry to know how to break into this potentially significant market. Government policy may effectively ensure that it cannot. However, this would be very short-sighted. It is illogical to automatically reject any initiative that can potentially improve patients' lives and reduce costs. It would be sensible to undertake some controlled pilots to assess the benefits and pitfalls of disease management partnerships between the NHS and the private sector. US health care companies, for their part, often try to deal with the problem of rising drug costs through a combination of contracting with specific suppliers to obtain larger discounts and by pushing the costs onto the patient. Neither is a practical, nor in the latter case necessarily desirable, proposition for the NHS in general and PCGs in particular. It is therefore time for a little more imagination to be shown.

6 FUTURES

Having spent some time considering the role of PCGs and their place in the latest round of NHS reforms, what does the future appear to hold for them? The tensions in PCGs have already been highlighted and the growing fears amongst practitioners about the form that PCTs might take. In essence, the dilemma is about knowing whether the command and control tendencies of the government and civil servants will dominate or whether the devolutionist rhetoric becomes a reality.

The one thing that most commentators agree on is that PCGs are not stable entities. Nor is the NHS a stable environment. The demands on it are too great, the funding problems too large and the expectation of government that the changes it desires will occur are so overwhelming that PCGs cannot be allowed to just jog along. PCGs cannot at the same time be both central to the delivery of the NHS agenda and peripheral to it in terms of engagement of those issues. In other words, if the majority of PCGs shy away from the hard issues and pull back from taking real responsibility – preferring instead the calmer waters of 'Level 1' (advisory body to Health Authority only with no delegated budgetary responsibilities) – the government is unlikely to shrug its collective shoulders and let the service drift along. Such inactivity would provoke a further reorganisation.

There have been a number of articles[136,137,138] speculating that PCGs may evolve into HMO type organisations. The first thing to be said is that the potential is there. In one sense the NHS in total is already operating as a managed care system. Health Authorities receive capitation funding; primary care doctors act as gatekeepers to the rest of the health services; care is from cradle to grave; etc. The key point about managed care in the US, however, is <u>not</u>, as Devlin and Smith[139] claim, that it brings together purchaser and provider in a single organisation (some HMOs are integrated entities owning both primary and secondary care facilities, but many own neither). The key point is that US managed care organisations aim to get providers, principally doctors and hospitals, to share risk on the costs of care. This is fundamental to understanding both managed care and, more

especially, capitation based funding arrangements. This is why Boland[140] states that:

'Capitation changes everything in healthcare ... Capitation is both a financial management system and a philosophy of care; *one without the other* (my emphasis) will not produce long term savings and better patient care.'

The two most important features of HMO style health care for the UK are: the importance of getting clinicians to share personal financial risk; and the quality risk inherent in a system which provides incentives not to treat. The latter is a well publicised feature of HMOs but the former is often overlooked this side of the Atlantic.

The American experience supports the view that clinicians need some of their personal income at risk. In 'Managed Care: Practice and Progress' a US executive summed up that attitude as 'You can go on about physician education as long as you like, but if you really want to grab their attention you have to go for their pocketbooks.' The US view on the incentive range considered to have the necessary effect is likely to make UK policy makers blink hard. A variable compensation rate in the 20-30% range is regarded as necessary. Variable compensation in the 5-15% range was considered 'completely wasted' in a recent US study.[141]

This only serves to highlight the lack of direct incentives in the current PCG system. This may in fact act as some comfort for those concerned that an HMO model for the UK will bring with it a propensity for cookbook medicine, greater management costs and control, and direct incentives to deny and skimp on care. Professional journals in the US commonly publish articles highlighting these dangers, both in theory and in practice.[142, 143, 144]

The reader may be thinking that it would be better to have salaried practitioners, so that then they would have no direct incentive to either under- or over-treat, and they would be easier to control as well. There can be little doubt that many policy makers think this a highly attractive idea. Again, perhaps US experience is instructive:

'... many physician organisations have argued that a salary arrangement is the most conducive system to a successful capitated arrange-

ment since physician compensation is not dependent on rendering a large volume of services. On the other hand, opponents of straight salary systems stress that physicians may not have the incentive to work hard. Some groups have, in fact, experienced a 20% or greater reduction in physician productivity shortly after they converted from a production to a salary system.'[145]

This is the essence of the problem of salaried doctors. How do you reward them for doing anything beyond the bare minimum of their contract of employment? The absence of fiscal accountability usually creates a 'business as usual' attitude that is unlikely to be conducive to either cost constraint or evidence based medicine. External controls reinforced by renewable contracts may act as genuine levers but this is an area where the NHS has been traditionally very weak. This is not a problem confined to clinicians but applies to all salaried workers, including NHS managers. A wide range of incentives to higher performance can be found in other sectors, including target-based payments, share options, commission on sales, etc. Whilst money is not the sole motivator of good or bad performance, and the benefits or otherwise of job security remain hotly contested in management circles, the NHS should have enough experience of trying to manage salaried clinicians (hospital doctors and public health physicians) to be aware of the problems of such an approach.

In summary, the UK could go down the HMO route, but it would be a mistake to think that a PCT will necessarily operate like a US style HMO simply because it shares some of the same features. The key is to understand what is motivating the behaviour being observed.

It is possible that the current reforms will move towards one of two 'models'. These represent very different views about the future of the NHS. They are:

- Pursuit of a private/public partnership model.
- Pursuit of a control and command, salaried practitioner model.

Both have the potential to descend into organisational chaos. To my mind the more exciting model, with the greater potential, is the private/public partnership.

Oldham and Rutter[146] have argued that the existing practice based structure of general practice, centred on the innovative spirit and flat management structure of the independent contractor, is ideally suited to the role required of modern primary care. There is considerable merit in the idea of franchising practices, and PCG/PCTs, to deliver services and control resources as outlined by Oldham and Rutter and in more detail by Meads.[147] The former propose that practices would apply for a 5-10 year agreement to deliver primary care within the boundary of the PCG or Trust:

'The requirements for granting a franchise would cover premises, demonstrable clinical governance, management systems, human resource and training policies. A practice may supply a plan to make up shortfalls before a given date for franchise renewal.'[148]

This concept can be taken forward to cover PCG/PCT and even acute Trust operations. This allows practices to combine together and even operate a mixed salaried/independent contractor model within the group. Private sector backed franchise bids would also be possible. This moves us away from Oldham and Rutter's original concept as it does not presuppose that the practice would continue to employ its own staff, or necessarily remain as independent contractors. It would allow the health system to remain publicly financed as at present but would break up the public sector monopoly in the provision of care. The public sector could also bid for the franchises and if they could offer the right mix of quality and efficiency they would have nothing to worry about. Ultimately, one might be able to let franchises and make payments on the basis of that holy grail of all health planners: their ability to manage disease and produce desired outcomes.[149]

The Personal Medical Services Pilot Schemes (of which a further 126 were announced in July 1999) could evolve into the kind of franchises described above. Although it sounds revolutionary, Hunter[150] has pointed out that:

' ... the NHS model looks increasingly anachronistic when surrounded on all sides by areas of public policy which are being subjected to 'third way' beliefs about the virtues of privatisation within a

framework of public funding and regulation ... If the Blair credo is 'what works is what matters' then the market-testing of health services cannot be ruled out.'

However, awarding franchises requires a degree of discipline in stating what services are to be delivered, at what cost and to what quality, that has hitherto been largely absent in the NHS. It would also make it difficult for governments to place mutually conflicting objectives on franchisees, which, whilst generating some much needed stability in the policy arena, is unlikely to be popular with the policy makers themselves. The need for clarity in terms of service provision becomes even more important when a franchise is revoked. It also raises issues of sovereignty in terms of who is empowered to make the decision. The business logic of the model is that a PCT could take away the franchise from an individual practitioner or practice if it fails to meet explicit criteria and the Health Authority can do the same for a PCT. However, what happens when the patients of the practitioner/practice(s) concerned do not want a change? This government's emphasis on the need for public engagement would lead one to conclude that such a process is likely to be expensive, drawn out, and messy.

In truth, this seems the less likely route that PCGs will travel. It appears more likely that the government will continue to try and move PCG/PCTs into a 'command and control' environment. Some will object that this is a misrepresentation of the government's intention; that there is, in fact, a viable 'third way' between 'command and control' and reliance on markets; and that, further, much modern management theory actively promotes an approach where the centre sets out policy and targets, exerts firm control where key variables are concerned, but otherwise operates in an environment of delegated accountability. The difficulty with this view arises with the practical application of such an approach in such a politically dominated environment as the NHS operates within. Nye Bevan's famous remark that 'every time a maid kicks over a bucket of slop in a ward, an agonised wail will go through Whitehall' captures the problem.

If the command and control mentality gains the ascendancy, then the Government may start to believe that they can carry forward their reform process with or without the GPs. This would be an extremely risky strategy to pursue, as neither GPs nor the wider primary care community can be bullied into participation in anything other than in the very short term. The result could be a spectacular confrontation with the British Medical Association, but it is just as likely that the slide will be in gradual stages. Independent contractors will start dropping out from board posts and PCGs will have increasing difficulty in filling them - this seems particularly likely if the remuneration remains low. That this will frustrate the objectives that the reforms were set up to achieve may take second place to 'a test of wills'. In any case, PCGs were never likely to act as '... passive executioners of the NHS disposing of the central tenets of equity and universal coverage and NHS care free at the point of delivery'.[151] More likely, they will, if independent contractors hold sway, act as highly articulate and vocal pressure groups to get resources to deliver the high quality, modern NHS that politicians like to tell us is our right.

7 CONCLUSION

Of course, it may be that nothing so dramatic as either of the two futures sketched out above occurs. Despite the many references to change in this text, the overall pace of change within the NHS tends to be glacial compared to most of the private sector. The term 'muddling through' is often used to describe both NHS policy and the service's reaction to it. Both of these traits may apply to this latest set of reforms.

We have seen that the policy context within which these reforms have been set reflects a longstanding desire to ensure cost constraint, improve clinical accountability and demonstrate effective management of the clinical process. The question was asked as to whether there were sufficient incentives within the reforms for the main agents – the clinicians – to deliver these objectives. The conclusion is that there has always been an incentive deficit within the NHS and that although progress has been made, particularly through the introduction of unified budgets and clinical governance, a serious gap remains.

Likewise, the intrinsic strengths and weaknesses of PCGs as organisational entities and as a mechanism for commissioning, coupled with the way in which the government has implemented its reforms, mean that a period of sustained turbulence looks to have set in. Many GPs are profoundly suspicious of the government's reform programme. At the same time, the Labour government has established expectations of the NHS within the public's mind that reality cannot match. PCGs will be expected to square the circle yet, as I have tried to show, they have little incentive to do so.

A number of practical considerations for PCGs were explored in Chapters 4 and 5, including prescribing which will be an early testing ground for whether PCGs are prepared and able to manage within a set budget and to tackle medical practice variation. PCG leaders will need to show clear focus, determination and imagination if they are to navigate successfully through the myriad objectives that PCGs have been set and deliver on the key issues. Even if they have the necessary motivation, it is doubtful that many have all the skills required for success.

Which brings us to the final conclusion that change, however its pace is perceived by those affected by it, is set to continue and as a result primary care will never look the same again.

GLOSSARY

Casemix
Frequency of patients falling into types according to some predetermined characteristics. There may be social, demographic or severity measures but the term is typically used in connection with measuring severity of illness via a case mix index. The higher the score, the greater the severity in terms of complexity of treatment.

Clinical governance
A framework through which NHS organisations, managers and clinicians are accountable for the quality of service delivery to patients. Clinical governance emphasises the need to create and foster an environment in which excellence in clinical care will flourish. This includes strengthening the existing systems for quality control, evidence-based practice, systematic clinical audit and education. Openness, comprehensiveness and clear lines of responsibility and accountability underpin the clinical governance concept.

Commission for Health Improvement (CHI)
A new national body to support and oversee the quality of clinical governance and of clinical services. Due to commence work on 1st April 2000, CHI will be a statutory body operating at arm's length from government. It will be empowered to undertake reviews of local implementation of clinical governance arrangements and make recommendations. As part of this it will also help identify and tackle serious or persistent clinical problems and undertake a programme of service reviews to monitor implementation of national service frameworks and National Institute for Clinical Excellence (NICE) guidance.

Corporate governance
A framework through which NHS organisations are accountable for standards in conducting corporate business, including meeting statutory financial duties.

Department of Health
A division of the Civil Service headed by the Secretary of State for Health. Responsible for health care in England. In Wales, Scotland and Northern Ireland this function falls within the overall responsibility of the Welsh Assembly, Scottish Parliament and Northern Ireland Assembly respectively, who have departments reporting to these bodies.

Diagnosis Related Group (DRG)
A system of classifying patients according to categories of diagnosis which should require very similar programmes of treatment and lengths of hospital stays. DRGs were introduced in the US as a method of prospective reimbursement for patients covered by Medicare (the over-65s Federally funded insurance programme) for inpatient care in the early 1980s and have been widely adopted by insurers and HMOs as a standard contract currency for inpatients.

Health Authorities
Currently there are 100 Health Authorities in England and five in Wales whose principal responsibilities are around the commissioning of services from providers (mainly NHS Trusts) in pursuit of national and local objectives, e.g. aiming to improve the health of the local population, reduce waiting lists. The introduction of Primary Care Groups and their Celtic equivalents raises the question of what role Health Authorities should take, should PCGs take over much of the commissioning function. The 15 Health Boards in Scotland and four Northern Irish Health and Social Services Boards perform functions equivalent to the English and Welsh Health Authorities.

Health Boards
See 'Health Authorities'.

Health and Social Services Boards
See 'Health Authorities'.

Health Improvement Programme
An action programme drawn together by a Health Authority, aimed at identifying major health and health care issues and resultant actions to tackle them. In producing a Health Improvement Programme, emphasis has been placed on the need to involve a wide range of partners in shaping and agreeing it.

Health Maintenance Organisation (HMO)
In the US, an organised system of health care that provides directly, or arranges for, a comprehensive range of basic and supplemental health care services to a group of people via a prepayment plan.

Healthcare Resource Groups (HRGs)
A conceptually similar system to DRGs, developed in England and adopted by the NHS Executive as the standard method of classifying inpatient episodes and day cases.

Hospital and Community Health Services (HCHS)
The main elements of these are the provision of hospital services, and certain community health services, such as district nursing. These services are provided in the main by NHS Trusts.

International Classification of Diseases – 10th version (ICD-10)
The current World Health Organisation system of coding diseases by diagnosis, now in its 10th revision. This coding system forms the basis of both DRG and HRG definitions.

Local Health Groups (LHGs)
Welsh equivalent of Primary Care Groups. LHGs are established and supported by Health Authorities (they are technically sub-committees of their host Health Authority). The LHG board brings together GPs, Health Authority officials, local government officials, nurses, dentists, pharmacists, opticians, the voluntary sector and a lay representative. GPs are heavily represented, but do not form the majority on either the LHG board or its executive committee.

Local Medical Committee
The statutory Local Representative Committee for all GPs in the area covered by a Health Authority. The Health Authority has a statutory duty to consult it on issues including GPs' terms of service, complaints and the investigation of certain matters of professional conduct.

Long term service agreements
Agreements between Health Authorities or Primary Care Groups and NHS Trusts on the services to be provided for a local population. These are meant to replace the annual contracts of the internal market and cover a minimum of three years with the aim of offering greater stability.

Medical practice variation
Clinicians are not uniform in their treatment of particular illnesses. Whilst some medical practice variation is probably both inevitable and desirable, its current extent is generally considered a major cause of both the composition and variation in costs and clinical outcomes. There is less consensus on what constitutes optimum clinical practice, which is hardly surprising as where strong consensus typically exists observed medical practice variation is usually small.

National Institute for Clinical Excellence (NICE)
A new, special Health Authority covering England and Wales, established to promote clinical excellence and cost-effective medicine. It will provide guidance and audit to the NHS on the clinical and cost effectiveness of various health interventions and technologies. It aims to disseminate this guidance to the NHS and monitor its impact (with the assistance of CHI). In Scotland this role will be performed by the Scottish Health Technology Assessment Centre (SHTAC).

National schedule of reference costs
A national cost benchmarking tool. The aim is for NHS Trusts to publish their costs on a consistent basis, and for the data to be pub-

lished in a national schedule of reference costs so that performance on efficiency can be compared.

NHS Executive
The NHS Executive is part of the Department of Health, with offices in London and Leeds and eight Regional Offices (also known as Regional outposts) across England. It supports ministers, is charged with strategic leadership of the NHS and performs a range of central management functions to the NHS.

NHS Trusts
NHS Trusts are public bodies providing NHS hospital and community health care.

Performance Assessment Framework (PAF)
A framework designed to give a rounded picture of NHS performance covering six areas: health improvement; fair access to services; effective delivery of appropriate health care; efficiency; patient/carer experience; and the health outcomes of NHS care.

Personal Medical Services Primary Care Act Pilots
The NHS (Primary Care) Act 1997 allows members of the NHS 'family' i.e. an NHS Trust, an NHS employee, a qualifying body and suitably experienced medical practitioners capable of providing general medical services, to submit proposals to provide services under a pilot scheme and contract directly with the Health Authority to do so. This allows pilots to move away from the restrictions inherent in the terms and conditions under which general practice operates (commonly known as 'The Red Book').

Primary Care Groups (PCGs)
PCG boards consist of between four and seven GPs, one or two community nurses, one local authority social services officer, one lay member, one Health Authority non-executive director and a Chief

Executive. They will contribute to the local Health Improvement Programme and ultimately have a budget reflecting their population's share of the available resources for hospital and community health services, the general medical services cash limited budget, and prescribing. PCGs will have the opportunity to apply to become free-standing Primary Care Trusts (PCTs). PCGs can operate at any one of four levels:

Level 1: At minimum, act in support of the Health Authority in commissioning health care services for its population, acting in an advisory capacity.

Level 2: Take devolved responsibility for managing the budget for health care in their area, acting as part of the Health Authority.

Level 3: Become established as free-standing bodies accountable to the Health Authority for commissioning care.

Level 4: Become established as free-standing bodies accountable to the Health Authority for commissioning care, and with added responsibility for the provision of community health care services for their population.

Primary Care Trusts (PCTs)

A new form of free-standing NHS trust accountable to Health Authorities for commissioning health care, and with added responsibility for the provision of community/primary care services for their population. The ultimate potential expression under the legislation of PCGs.

Read Coding

A system of clinical coding, named after its originator Dr. James Read, and widely adopted within general practice in the UK.

SNOMED

A US system of coding, designed with similar characteristics in mind to Read coding (highly flexible, capable of coding symptoms as well as diagnosis etc.).

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