

Local health drive

Changing places

But there is a hole in the plan to shift medical care out of hospitals

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POLITICIANS, like television producers, know where the action and glamour are in medicine. No exception, Tony Blair's government has long concentrated on hospitals in its drive to mend the National Health Service. The overriding political priority, backed by massive amounts of extra funding, has been to cut waiting times, improve services and rebuild facilities in big NHS acute-care hospitals.

Now Patricia Hewitt, the health secretary, wants a change of scene and a new direction. In what she calls a “major strategic shift”, medical care and resources are to be moved out of hospitals. Her aim is to put 5%—around £2.5 billion (\$4.4 billion)—of the hospital budget into primary-care settings, including 50 new “polyclinics” that will provide a bigger range of services than traditional GP practices.

If more is to be done outside big hospitals, there will be less need for grandiose rebuilding projects. Instead of planning to pay £12 billion to renovate hospitals over the next eight years, the government now intends to spend around £8 billion.

The reform offers greater convenience to patients, who will be able, for example, to get diagnostic tests done closer to home. More minor surgery will be done in doctors' offices and clinics, more post-operative follow-up outside hospitals. The government also wants to boost preventative care, on which Britain spends too little.

More effective prevention is likely to help constrain demand for treatments to deal with avoidable ailments. But the reform will also achieve more direct savings as activity shifts to cheaper facilities. The evidence of the past few years, when money has been poured into hospitals, has shown how costly and inefficient they are, says Nick Bosanquet, professor of health policy at Imperial College, London.

The reform is sound and long overdue, though arguably it lacks ambition. To shift only 5% of the hospital budget over a decade looks more tactical than strategic. But the real doubts are not about the end but about the means.

The government is clear that its new strategy will require further changes to the way medical

care is purchased in the NHS internal market. At present, the focus of commissioning is on hospitals, which are increasingly paid set fees for treatments based on average costs across the acute-care sector.

This new payments system is intended to encourage efficiency savings by hospitals, which will continue to face intense cost pressures in 2006-07, according to the King's Fund, a health-policy think-tank. But if a lot more is to be done outside hospitals, primary-care providers must be able to compete more readily. The government wants tariffs, in time, to reflect the most cost-effective forms of treatment, rather than the average across hospitals. That would help to move services into the community if that proved cheaper.

Who should provide this expanding care outside hospitals? At present, private GP practices dominate the primary sector, but they have no automatic right to it. Family doctors may be popular, but their opening hours are not. People are also fed up with struggling to make appointments.

The government is starting to challenge the grip of the small-business GP model in areas where there are relatively few family doctors. In Derbyshire, UnitedHealth Europe, a subsidiary of an American firm, looks set to win contracts to provide two GP practices. Hospitals are also keen on offering community services within primary care, according to John Appleby of the King's Fund. Ms Hewitt says she will consider such expansion plans on a case-by-case basis. Although there are risks that vertical integration might stymie competition, it is not clear why hospitals should be prevented from providing community services if they can do this more cheaply.

This highlights the central flaw in the government's strategy. "There is no proper policy on competition and no system for regulating it," says William Moyes, head of Monitor, which regulates the foundation-trust sector of hospitals that have greater freedoms. He would like Monitor's remit to be extended to oversee competition and performance across the NHS.

Whether or not Monitor's role is expanded, Mr Moyes has a point. There is a hole in the government's plan. If the realm of the marketplace is to be extended in the health service, it will require a new regulator to ensure fair competition and enforce financial discipline.

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