

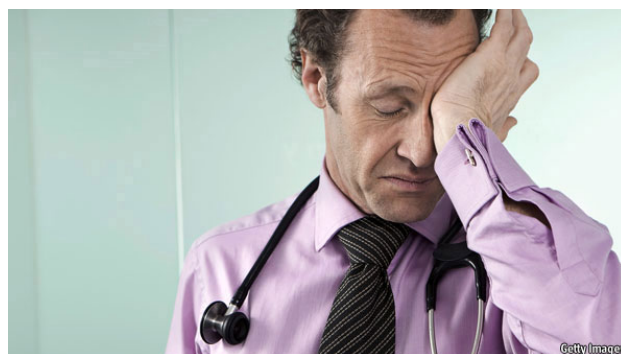
Reforming the NHS

Once more into the ring

A proposed overhaul aims to improve patient choice, promote competition and empower medical professionals. Again

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MORE than six decades after it was formed, and despite incessant tinkering, the National Health Service remains a work in progress. On July 12th the health secretary, Andrew Lansley, made public sweeping plans to reorganise who does what within it. The goal is to give patients more choice, to improve service by fostering competition and to boost efficiency in order to meet an ageing population's increasing needs without breaking the bank. Billed as the greatest shake-up of the NHS in a generation, its effects are likely to fall short of its ambitions.



Britain's health service, already big, has been growing at a phenomenal rate. Over the past decade its budget increased by over 6% a year, in real terms, to more than £100 billion, or \$150 billion, in England (to which alone the proposed reforms apply, as devolved bits of Britain can choose how they run health care). Even at this time of fiscal stringency NHS spending has been spared from cuts for the next five years.

Before the election in May that brought the Conservatives and Liberal Democrats to power, the Tory talk was all of stopping the “constant revolution” in health care. The Conservatives had attempted in the 1990s to free the NHS from direct management by health authorities, establishing a quasi-market in services. Tony Blair at first ditched these reforms but later attempted a further-reaching agenda to promote choice and competition. His successor as prime minister, Gordon Brown, was less keen, and reform all but stalled.

Now Mr Lansley wants to reshape the NHS in his turn, wresting commissioning power from managers in primary-care trusts (PCTs) and delivering it instead to family doctors, who are to club together in consortia to purchase care for their patients. General practitioners (GPs) in Britain, like primary-care physicians in Denmark and the Netherlands, have long acted as gatekeepers, controlling access to expensive hospital treatments through referrals. Mr

Lansley's reforms will hugely strengthen their role in deciding where the taxpayers' money is spent. Some 36,000 GPs will eventually have an £80 billion budget at their disposal to buy the hospital treatments and drugs their patients need.

Chris Ham, chief executive of the King's Fund, a health-policy think-tank, points out that this change will go down well with doctors who are suited to the task, but that many are not. The more modest version of the policy in the 1990s allowed GP practices to volunteer to become "fundholders"; this time, it would be mandatory to join a commissioning consortium.

These groupings would be roughly geographical, able either to purchase care and treatments directly, perhaps recruiting administrators from existing PCTs to help them, or to outsource the task to others, including private firms. A new body, an independent commissioning board, would be established to advise and monitor the consortia, and would itself purchase dentistry, pharmacy and ophthalmic services.

Once budgetary control has been handed to GP consortia, the ten strategic health authorities and around 150 PCTs are to be abolished. Local authorities will promote public health, in co-operation with central government. Services once run by PCTs, such as district nursing, will shift, and in some cases be provided by staff who leave the NHS to form not-for-profit outfits. All this, says Mr Lansley, will help to cut management costs by 45% over the next four years. Perhaps 25,000 jobs will go.

Mr Lansley wants to reform hospitals, too, as part of his ambition "to create the largest and most vibrant social-enterprise sector in the world". All NHS hospitals are to join the ranks of the foundation trusts, and thus to enjoy greater autonomy. Within three years, the cap on revenues from private patients that these hospitals are allowed to collect will go, provided they meet their NHS obligations and invest the income in improving facilities for all. And choice is to be extended. Patients may select their GP regardless of where they live, and together with their doctor choose treatments and consulting teams. To make those choices easier, more data on hospital results, infection rates, waiting times and so forth will be published.

Just as GP consortia take on responsibility for funding, however, that funding will be squeezed. The NHS will enjoy real increases over the next five years, but the increasing demands of an ageing population demanding the benefits of increasingly expensive technology mean it will have to do more for its money. Its chief executive, Sir David Nicholson, was already intending to make efficiency savings of up to £20 billion by 2014. These reforms may impose their own costs before savings emerge.

Will Mr Lansley's grand design end up as yet another distracting reorganisation, or is he thinking along the right lines? Promoting choice and competition should certainly raise standards. Recent research from the London School of Economics shows that competition among hospitals can improve care, efficiency and management. Work by the King's Fund

found that giving people choice helps to keep hospitals focused on what matters to patients.

There are questions, though, as to whether the new consortia will in fact add to market pressures. There seem no particular incentives for them to push for economies, unlike the experiment in the 1990s, when GP fundholders could benefit from savings they made. If they run out of cash, it appears that the GPs will not be at personal risk. If former PCT managers end up running the new consortia, it is difficult to see where improvement will come from; and as for the involvement of private-sector companies in the commissioning business, PCTs have long been at liberty to seek their services. Similarly, it is not clear how NHS hospitals that have failed so far to achieve foundation-trust status are to be raised to it. Consultation may provide answers to some of these questions.

Although the NHS needs improvement and the government is pulling some of the right levers to get it, the scale, pace and untested riskiness of the proposed changes give pause. James Gubb of Civitas, a think-tank, rightly points to the likelihood of disruption. There are reforms still in the works that might usefully have been completed first: reconfiguring how and where health care is delivered, for example, including closing less effective small hospitals. But perhaps that smacks too much of politically unpopular hard work.

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