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An ethical code for everybody in health care

A code that covered all rather than single groups might be useful

See p 1671

Perhaps there was a time when professional ethics alone gave health care a sufficient moral compass. If so, that time has passed. The fate of patients and the public's health depends now on interactions so complex that no single profession can credibly declare that its own code of ethics is enough. We think that we need an ethical code to cover everybody involved in health care, and we have embarked on the search for such a code.

Consider the following cases.

A doctor working in an NHS trust thinks it wrong that his patients will be denied a new treatment for cancer—despite the hospital formulary committee deciding that it should not be prescribed. Should he contact the local media? Should the trust punish him if he does?

A staff surgeon employed full time by a not for profit health maintenance organisation develops an approach to postoperative pain control for a surgical procedure that shortens average length of stay by 1.5 days. Is she ethically obliged to share information of her discovery with the world?

A British general practice that plans to become a fundholding practice deliberately keeps its prescribing costs high for a year so that it will receive a bigger budget in its first year as a fundholder (the budget is based on the previous year's activity). Is this defrauding other practices and health organisations or doing the best by the patients in the practice?

A health maintenance organisation considers investing in improvements in its system for caring for AIDS patients. The vice president for marketing warns that such improvements may lead to selective enrolment of unprofitable HIV positive members. Is the organisation ethically bound to improve its HIV care, even if that may reduce its financial viability?

An NHS trust hospital wants to open more private beds to generate income to underwrite other activities. Patients entering these beds will be treated more quickly than those entering NHS beds. How do the doctors and managers square this with a commitment to put clinical need first?

Newly published "league tables" (or "report cards") on healthcare providers in a region show extraordinarily good surgical outcomes in some facilities and much worse outcomes in others. The source data are held to be confidential by the auditing organisation. A hospital with poor outcomes requests information so that it can learn from high performers. Who, if anyone, is obliged to share that information? What if the performance difference is not in surgical outcomes, but rather in waiting time?

Managers of a health provider discover that one of their nurses was infected with HIV but had told nobody. Should they release the nurse's name to the media? Should they notify all those who may have been treated by the nurse even though the chances of anybody being infected are vanishingly small?

Should a health authority offer a new expensive treatment for Alzheimer's disease to all patients, even though it will mean diverting funds from elsewhere, including support for carers of patients with Alzheimer's disease?

A managed care organisation targets its marketing selectively to enrol well people and to avoid or discourage vulnerable populations. Is this marketing behaviour ethical? Does the answer depend on whether the organisation is owned by stockholders or not for profit?

These brief cases are not hypothetical. Each is based on actual circumstances known to us. All are characterised by trade offs between obligations to patients and to organisations, between proprietary knowledge and public knowledge, between competitive advantage and public responsibility, between duties to corporate collectives and duties to parties outside the collective, and between confidentiality and rights to information.

We find much confusion about such dilemmas among leaders and other stakeholders in health care. When one of us (DB) recently put the second of the above cases to 59 clinical and non-clinical healthcare executives at a meeting in America 83% said that the surgeon was ethically obliged to share her new knowledge. Yet only 56% claimed that the health maintenance organisation had the same obligation, implying different ethical standards for the organisation and the individual clinician.

The traditional professions have not remained silent about the moral issues raised by new forms of financing, competition, accountability, ownership, and control over decision making in medicine. The American Medical Association's committee on ethics has published guidelines for physicians in managed care systems, emphasising the duty of doctors to protect the interests of patients, presumably against forces that more easily lose sight of those interests. In Britain the BMA has repeatedly condemned a two tier health system that gives priority to patients of fundholding general practitioners. In Massachusetts a group of

clinicians has formed an "Ad Hoc Committee to Defend Health Care," accusing managed care systems and for profit medical care organisations of posing one of the most serious threats in history to the integrity of medical care. The American Hospital Association has developed a major initiative on corporate ethics, urging its members to develop formal, individualised ethics programmes, but not suggesting a uniform code of conduct for all.

We share a sense of urgency about the need for moral constraints on health care, but we do not believe that answers constructed by individual professions or trade associations will suffice. Statements of ethics that pit one stakeholder against another, as when doctors claim to protect patients against management's assaults, will deepen divisions and stall collaborative thinking. Furthermore, we gain little more than self satisfaction from codes of conduct that ignore inescapable circumstances, such as the social need to place limits on healthcare expenditure, the requirement for management in complex systems, and the strong cultural bias in some nations towards free market solutions.

We believe that, for many nations, an ethical code that applied to all those in health care would be timely and orienting. To be helpful, such a code must cut across disciplinary, professional, organisational, and political boundaries. It must be unifying in the sense that all who shape the experience of patients and the social investment in care can use it as a point of reference for their own difficult decisions. It should be a code that applies to systems, their leaders, and their participants, no matter what their degree or job description, binding and guiding equally doctors, nurses, other health professionals, healthcare managers and executives, regulators of care, and private and public payers.

We have proposed the idea of creating such a code in a letter to over 100 healthcare leaders and academics in a dozen countries. The replies were extensive, thoughtful, and consistently encouraging. Many felt that the question is urgent. Some liked the idea but were sceptical that such a code could be achieved. Respondents often raised the additional issue of implementation, reminding us that such a code ought not simply to sit on bookshelves but should be translated into specific actions and enforcement mechanisms, some voluntary and, perhaps, some mandatory. Others suggested a need to articulate the theoretical basis of such a code, beginning with the question whether health care is a right. Replies also mentioned potential differences in ethical frameworks between medical professionals and managers, between acute care and public health perspectives, and between developed and developing nations. In this issue Hurwitz and Richardson commend a single oath for all healthcare professions, arguing that it could heal split loyalties (p 1671).[1] Respondents informed us about other, similar efforts already under way, although almost all such cases appear to involve codes applicable to professions and disciplines, not to the system of care as a whole.

With this encouragement, we have decided to proceed with our inquiry, and we invite readers of the *BMJ* to write to us promptly with their own views about a code of ethics for all. Is one needed? What should it include? Who can create it, and to whom should it apply? Perhaps most important, how can it be implemented and become alive? We propose this inquiry to be international, yet we are aware that nations may differ in important and rational ways, even when it comes to ethics. Therefore, we welcome ideas about how a code of ethics might vary from nation to nation and culture to culture.

We will report back to readers on the correspondence we receive, and we will convene discussions in the months ahead among selected healthcare leaders, ethicists, and academics to explore how a code of ethics may be developed and implemented. We claim no special authority to devise or promulgate a code, but we want to try to start the process. Please let us know what you think.

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Social suffering: relevance for doctors

Healthcare professionals need to broaden their understanding of health and suffering

The term social suffering describes collective and individual human suffering associated with life conditions shaped by powerful social forces.[1] Unlike physical suffering or mental illness, it is largely unrecorded. New measures such as disability adjusted life years, designed to document the global distribution of morbidity in economic and individualistic terms, only barely represent a much more complex concept of suffering as a social experience and neglect most of what is at stake for people globally.[2] Yet more than ever social suffering requires scholarly attention to facilitate cross cultural discourse and peaceful development in an increasingly interdependent world.[1-3]

Social suffering has evolved from the state of ignorance, vulnerability to nature, and terror associated with naked tyrannical power in the dark ages to the diverse suffering associated with wealth creating progress since the Enlightenment.[2] In 16th century

Europe enclosure of common land dispossessed the poor. A century later the industrial revolution generated abysmal working conditions in European factories. Pervasive forces in the 20th century continue to inflict suffering worldwide.

Since the Enlightenment demands for respecting human dignity have progressively ameliorated indignities suffered under oppressive rulers, industrialists, and slave owners. The Universal Declaration of Human Rights and international law were expected further to reduce human suffering in the 20th century. But unprecedented population growth, ethnic and gender conflict, and global economic trends have rendered millions vulnerable to the ravages of exploitation, poverty, disease, genocidal slaughter, torture, and sexual abuse. Social suffering is now constructed on a greater scale than in the past through economic, military, and cultural forces which have become accepted as inevitable aspects of modern life.[2-5]

A recent volume of writings expands our understanding of social suffering at the personal level and in the context of moral and political communities.[1] Anthropologists describe how the media manipulate images portraying and trivialising terrible human suffering of distant peoples to propagate local political rhetoric. Media arousal of public emotions shapes perceptions of human problems and policy development for commercial or political purposes in highly industrialised nations.[1] Atrocities that the media choose to ignore—for example, the starvation and death of over 30 million Chinese in the 1960s—are even more terrifying.

Gender suffering is illustrated by the pain and suffering inflicted on the minds and bodies of thousands of Indian women subjected to violent sexual abuse as their country emerged from colonialism.[1] Political power manifests itself in the suffering of millions in China during a transformation driven by imperialism and Maoism.[1] Modern medical advances have altered patterns of life and death through new definitions of death to facilitate organ transplantation and through the consequences of life support systems, chemotherapy, transplantation, and immunosuppression.[6] The impact of medical progress on life and death is different in other cultures, for example, in Japan, even though it is a modern and secular society.[1] Intense suffering is intimately linked to violence built into the structure of society, as in Haiti.[1] Rwanda's tragedy is also being revealed in its full horror by those who have worked with victims of a genocidal war which decimated populations previously living peacefully together and permanently traumatised children by exposing them to the most brutal scenes and destroying their trust in adults (P Mugambo, unpublished data). Like the horrors of Bosnia,[7] these atrocities have yet to impinge fully on the hearts and minds of privileged peoples.

Our modern world is indeed frightening.[1 5] Graubard reminds us of how people in privileged countries are only fleetingly aware of the horrifying conditions of life for billions of others and react only intermittently to media portrayal of horrors, without any sustained attempts to understand or act on the ethnic, racial, religious, or political causes of such profound misery.[1] When such indifference is seen in Africa, a continent withering under a debt generating process resembling the slave trade,[8] we must ask what this tells us about our state of humanity. Moreover, we must ask what can be done, at a time in history when the nuclear stockpile, ecological degradation, population growth, the arms trade, large numbers of refugees, cultural conflict, the recrudescence of old and emergence of new infectious diseases, and widening economic disparities threaten rich and poor alike.[9]

At the end of a glorious, but also devastatingly cruel century, we have the opportunity to understand better our world view and to empathise with others.[3 10] Our collective futures—increasingly linked—are at stake.[11] The overlapping challenges for anthropologists, philosophers, physicians, social and natural scientists, and scholars in the humanities call for empathy and multidisciplinary collaboration in new kinds of research across diverse societies to enhance our understanding of, and ability to diminish, social suffering.[1] The exposure of social suffering during the apartheid era in South Africa, through the testimonies at the Truth and Reconciliation Commission, reveals the importance of public acknowledgment in dealing with human suffering.

Doctors may ask what relevance these considerations have to their daily practice of medicine. The answer lies in recognising that while modern medicine has done much to advance the health and prolong the lives of individuals, improving the health of populations will require profound social, economic, political, and cultural changes.[2 12 13] Healthcare professionals are challenged to broaden their understanding of health, disease, and suffering and of their role in society. At the end of an epic century (scarred by suffering of horrendous magnitude when doctors were coopted as agents of the state's infliction of suffering and racial practice[14]), healthcare professionals are challenged to broaden their understanding of health, disease, suffering, and of their role in society. Healthcare systems need the influence of social science research to extend their gaze towards the social construction of disease and suffering and to develop an approach to population health that could complement and enhance the care of individuals.

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Choosing the best research design for each question

It's time to stop squabbling over the "best" methods

Lots of intellectual and emotional energy, ink, paper, and readers' precious time have been expended comparing, contrasting, attacking, and defending randomised control trials, outcomes research, qualitative research, and related research methods. This has mostly been a waste of time and effort, and most of the disputants, by focusing on methods rather than questions, have been arguing about the wrong things.

Our thesis is short: the question being asked determines the appropriate research architecture, strategy, and tactics to be used—not tradition, authority, experts, paradigms, or schools of thought.

If the question is, "What is the importance of patient preferences in the choice of treatment for benign prostatic hyperplasia?" the appropriate study architecture, strategy, and tactics are those that identify and characterise the reactions of individual patients to their disease and their assessments of the risks and benefits of alternative treatments through open ended, in depth interviews (to the point of redundancy or saturation), with emphasis on variations in preferences among individuals. The fact that this array of approaches is called qualitative research is irrelevant to whether this is the best way to answer this question.

If the question is, "In men with benign prostatic hyperplasia is laser prostatectomy superior to transurethral resection of the prostate in terms of symptom relief, blood loss, and the length of catheterisation and hospital stay?" the appropriate study architecture, strategy, and tactics are those that assemble a group of individuals with this condition, randomise them (concealing the assignment code) to the alternative procedures, and achieve complete follow up of their subsequent outcomes. The fact that this combination of approaches is called a randomised control trial or efficacy research is irrelevant. Because it minimises the confounding of treatment and prognosis, a trial is the best way to answer questions of this sort (especially when several trials are combined into a systematic review or meta-analysis).

If the question is, "Are we providing effective care to patients with benign prostatic hyperplasia in our region, and are they appearing to benefit from it?" the appropriate study architecture, strategy, and tactics are those that succeed in assembling and describing patients with benign prostatic hyperplasia in a specified population, describing the interventions they receive and events they experience, and completing follow up to the ends of their lives or the study period, whichever is later. Variations in the rates with which they receive interventions shown in randomised trials to do more good than harm answers the first part of the question. (For interventions where randomised clinical trials have not been performed, the variations in treatment rates obtained by studies of the course of the disease may help create the sense of uncertainty that allows a randomised clinical trial to be initiated.) Disparities between interventions and outcomes or between the treatment patients receive and the treatment they prefer answer the second part and raise a further series of questions about why that might occur. The fact that this array of approaches is called non-experimental cohort study, outcomes research, or effectiveness research is irrelevant: these happen to be the appropriate methods for answering these sorts of questions.

The answers provided to each of these questions by the architectures we have suggested could in themselves generate questions whose answering requires a shift to another research method. Furthermore, all three questions could be addressed using other architectures, strategies, and tactics (including the solicitation of "expert" opinion) but, we suggest, not as well. Finally, we could try to answer them all with data already gathered for some other purpose.

Each method should flourish, because each has features that overcome the limitations of the others when confronted with questions they cannot reliably answer. Randomised controlled trials carried out in specialised units by expert care givers, designed to determine whether an intervention does more good than harm under ideal conditions, cannot tell us how experimental treatments will fare in general use, nor can they identify rare side effects. Non-experimental epidemiology can fill that gap. Similarly, because the theoretical concerns about the confounding of treatment with prognosis have been repeatedly confirmed in empirical studies (in which patients who accept placebo treatments fare better than those who reject them), non-experimental epidemiology cannot reliably distinguish false positive from true positive conclusions about efficacy. Randomised trials minimise the possibility of such error. And neither randomised trials nor non-experimental epidemiology are the best source of data on individuals' values and experiences in health care; qualitative research is essential.

But focusing on the shortcomings of somebody else's research approach misses the point. The argument is not about the inherent value of the different approaches and the worthiness of the investigators who use them. The issue is which way of answering the specific question before us provides the most valid, useful answer. Health and health care would be better served if investigators redirected the energy they currently expend bashing the research approaches they don't use into increasing the validity, power, and productivity of ones they do.

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Just what the doctor ordered—more alcohol and sex

Anything I want to do is illegal, fattening, or causes cancer in mice

See pp 1641, 1644, 1649, 1711

So the hedonists were right. At this time of year it is traditional, even in such an open minded journal as the *BMJ*, to warn with varying degrees of humour or pomposity about the dangers of overindulgence, from the hazards of obesity to the cure for hangovers. Eat, drink, and be merry, for tomorrow we die, has always carried with it the assumption that all three activities directly contribute to the undesired outcome. However, this issue of the *BMJ* contains intriguing suggestions that eating, drinking, and being merry (in this case a euphemism for sexual activity) defer mortality, presumably allowing added years of more of the same.

We read that alcohol makes you live longer (p 1664)[1] and, much more tentatively, so does sex (p 1641).[2] Last year we learnt that attending musical events or making music acted similarly.[3] The doctor who, in reply to the question, "Will I live longer if I give up drinking and sex?" replied, "No, but it will seem like it" may have been right all along. The only dissonant voice comes from the world of soap operas, which often seem to be dominated by sex and drinking and which seriously damage the health of their characters (p 1649).[4] So should we now be advising a sex, drugs, and rock 'n' roll lifestyle for the health benefits it brings?

Hedonism has always been a difficult subject. Auden's Oxford don who didn't feel quite happy about pleasure expressed the English sense of unease with the finer things in life. Likewise, the medical profession has taken an ambivalent stance towards hedonism. The concept of pleasure is so unfamiliar for many psychiatrists that Freud wrote possibly his least humorous article on the psychoanalysis of jokes,[5] while a contemporary professor of psychology has pointed out, with, we assume, his tongue firmly in his cheek, that happiness ought to be considered a psychiatric disorder.[6] Medical affective disorder, pleasant type, has yet to appear in the International Classification of Diseases, but it is statistically abnormal, consists of a reproducible cluster of symptoms, and is linked to abnormalities of cognitive brain function and cerebral brain flow.[6] The lunchtime habits of French doctors remind us of the origins of the term Rabelaisian (p 1711)[7] and are certain to attract the disapproval of their English colleagues and the total incomprehension of any American readers.

Medical interest in the study of pleasure began, strangely, with the absence of pleasure, or anhedonia. This term was first used by the eminent French psychologist Ribot to describe the case of a young girl who suffered from a loss of pleasure sense in the course of an apparent disorder of the liver.[8] However, medicine seemed unhappy with this simple concept. In his seminal paper "Anhedonia" Myerson reformulated it as "organic anaesthesia" together with "a disorganised spread of excitement." He acknowledged that anhedonia affected the desire for and satisfaction from food, drink, sex, and sleep. However, loss of energy was a central symptom in anhedonia: "The feeling of energy is low so that effort is painful, fatigue following rapidly upon exertion and having a peculiar painful component not present in ordinary fatigue." He concluded that "it is probable that what we call sadness is to a large extent the disappearance of the energy feeling." In fact, pleasure, or the lack of it, was "merely … neurasthenia in a different way."[8]

Loss of pleasure was thus another consequence of neurasthenia, which, ironically, was itself clearly seen as the result of overindulgence in life's many pleasures and generally blamed on modern civilisation.[9] The first half of this century saw the replacement of neurasthenia, the illness of excess, with depression, the illness of loss. Anhedonia become its cardinal feature.[10] However, it is becoming clearer that the shift from neurasthenia to depression, and hence from loss of energy to loss of pleasure, is merely replacing one overstretched concept with another. Anhedonia is almost certainly not a single phenomenon.[11] We are now beginning to appreciate the phenomenological and neurobiological separation of the concepts of loss of pleasure, depression, and loss of energy.[10 12 13]

But what of the presence of pleasure? We can define the different emotional, cognitive, and behavioural components of happiness[14]; we can even hazard a guess at the neurobiological substrates of mood states,[15] but people seem rarely actually to *be* happy.[6] The concept of "hedonic tone" has been introduced to measure the capacity to feel pleasure, and scales exist to quantify it.[16] It has been possible to quantify how enjoyable people find different activities—which of course varies widely. Nevertheless, the amount of pleasure people report on average from activities is very similar. Thus, the concept of the "pleasure quota" has been introduced, suggesting that people chose their pleasures carefully to achieve the required dose of "hedons."[17]

Although this might sound lighthearted, there are serious ramifications. Public health campaigns have often ignored people's requirement for pleasure. On drug abuse, unhealthy diets, sexual activities, and alcohol, the message has been clear: they are bad. Just say no. Except, as the hero in the cult 1990's film *Trainspotting* says about heroin, "People think it's about misery and deprivation and death and all that shite, which is not to be ignored, but what they forget [image of needle entering vein] is the pleasure of it all. Otherwise we wouldn't do it … Take your best orgasm, multiply by a thousand, and you're still nowhere near."[18] Among college students, about 90% report pleasure as a reason for drug use, compared with under 30% who cite stress or habit.[19] Ignoring this must surely serve to alienate the intended audience.

So, finally, what do we tell our patients now? We are left with a paradox, which the late and much missed Geoffrey Rose would certainly have appreciated.[20] What we thought was bad for you may actually be good for you, but it may not be good to tell you in case you do it too much, and it is certainly not good to tell you it is good for you if you do too much of it

already—assuming we could agree what was too much in the first place.

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Festive cheer for all?

Headaches for alcohol policymakers

See p 1664

Christmas and alcohol are inextricably linked. But the evidence based party goer has to weigh up a complex body of research. Like smoking, heavy drinking increases the risk of death from many causes. However, as Sir Richard Doll points out on page 1664, there is now convincing evidence that one can reduce one's risk of heart disease by drinking a moderate amount each day in middle and old age.[1]

For many people the emphasis on cardioprotective effects may bring reassurance, and for some this will be justified. For most people, however, the relevant comparison is not with non-drinkers but with "safe" drinkers.[2] From this viewpoint the excess of coronary heart disease deaths in non-drinkers is likely to be smaller than the excess of deaths from other causes in heavy drinkers. Furthermore, media euphoria over the cardioprotective effect obscures a more complex message. The evidence for a cardioprotective effect is largely based on studies of people aged over 40. Thus we do not know whether alcohol also reduces the relative risk of coronary heart disease in younger people. Even if it does, however, a reduction in risk becomes important only if the risk is significant to begin with, which is not the case for younger people. In this age group other causes of alcohol related death, especially accidents, are likely to outweigh any possible benefit.

A message that appears to promote drinking also risks simply moving the distribution of existing drinkers to the right, increasing the proportion of heavy drinkers without changing the proportion of abstainers.[3] This possibility is supported by a recent survey of English regions which showed that the prevalence of heavy drinking was associated with average alcohol consumption but not with the proportion of abstainers.[4] Furthermore, there are still many gaps in our knowledge of the cardiovascular effects of very high levels of consumption. The associations observed in published cohort studies are inconsistent with the huge changes in mortality from circulatory disease associated with changes in alcohol consumption in Russia in the 1980s and 1990s.[5] It is at least plausible that the cohort studies tend to exclude those who drink very heavily, especially in binges, so that the risks of very heavy drinking are underestimated. In contrast, heavy binge drinking is so common in Russia that the effect emerges at a population level. The suggestion that the pattern of drinking may be important is supported by the Kuopio heart study, which found a sevenfold increase in the risk of fatal myocardial infarction among those drinking six or more bottles of beer in a single session.[6]

While the health effects of alcohol consumption are much better understood than 10 years ago, the alcohol market is changing, with increasing numbers of sales outlets and promotion of new types of drink such as alcopops. This is against a background of evidence of increasing alcohol related harm, such as the rising death rate from cirrhosis in Britain.[7] International comparisons also give grounds for concern as a survey of European countries in 1993-4 found that the United Kingdom had some of the highest percentages of 15 year olds drinking at least once per week, with Wales having the highest levels seen anywhere.[8]

Our increasing knowledge of the health effects of alcohol has raised almost as many questions as it has answered. As Doll notes, we now need to understand the balance of risks and benefits of different levels of drinking at different ages for both men and women and learn more about the cardiovascular effects of very heavy drinking. We also need to know more about how

to change alcohol related behaviour. Is it possible to persuade older non-drinkers to drink a little for the benefit of their health, and is it possible to do this without increasing the number of people, especially teenagers, who drink at levels that are dangerous? Doll's message is clear: "In middle and old age some small amount of alcohol within the range of one to four drinks each day reduces the risk of premature death." [1] Researchers must now fill in the detail and help politicians in the difficult task of translating the evidence into an effective policy.

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New Labour, new NHS?

The white paper spells evolution not revolution

Since May the new Labour government has repeatedly pledged to abolish the reforms of the NHS carried out by the previous Conservative government in 1991. The internal market, competition, the business ethic, and general practitioner fundholding would be swept away and bureaucracy and inequities in access to care reduced. But with no new big idea to hand akin to the radical changes of 1991, and with an awareness that not all the reforms were bad after all,[1 2] this government had a problem. Should it believe its own rhetoric and reverse most of the changes, as promised, without anything new to replace them? Or should it swallow its pride, concede that some features of the internal market were worth keeping, and build on the best?

The result, published last week in the white paper, *The New NHS*,[3] is, of course, a compromise. The rhetoric is that the internal market, which supposedly resulted in damaging competition, has been abolished. In reality, competition was weak, the purchaser-provider split will remain, and purchasers will still have some choice between providers. So what's new?

Quite a lot. The main change concerns primary care. The chief responsibility for purchasing health care will move from the current 100 health authorities, 3600 fundholders, and 90 total purchasing pilots to 500 primary care groups each covering "natural communities" of roughly 100 000 people. Primary care groups are to consist of groups of general practitioners (around 50) and community nurses which will eventually hold a budget for virtually all hospital and community health services for the area plus the cash limited part of the general medical services budget—for example, for prescriptions and practice staffing. Health authorities will continue to purchase only selected specialist services, and fundholding will be scrapped from April 1999. The plan is for primary care groups to develop in four stages over the next five years: at a minimum they could leave all purchasing to the health authority and have an advisory role only; at a maximum they could purchase almost all services and merge with community trusts to form primary care trusts providing all primary and community health care. The overall budget for patient care will be cash limited, and the primary care groups will be able to keep any savings made. The current management costs of the health authority and fundholders will be pooled, capped, and shared out between the health authority and primary care groups through a process yet to be defined.

At first glance, this seems like a sensible evolution from the current plethora of purchasing models.[4] The trend has been for single practices to team up into groups and take on greater responsibility for either commissioning (through general practitioner to locality commissioning[5]) or purchasing (through fundholding to total purchasing[6]). What is new is that *all* practices in a natural community will be required to take part in primary care groups to reduce "two tierism." And there's the rub: what is the incentive for reluctant general practitioners to participate? On the one hand, since the primary care group will control the cash limited general medical services budget for all practices in the area, general practitioners will have an incentive to get involved to influence the flow of funds to their practice. But on the other hand, general practitioners, particularly those least experienced in purchasing, will need significant management and information technology support to participate. And here's the next rub: the implication in the white paper is that funds available to cover the management costs of the primary care groups and the health authority will be cut to pay for other goodies in the white paper. Without adequate management support, primary care groups will be a damp squib.

The second main change relates to health authorities. Eventually shorn of most purchasing responsibilities, their role of shaping, monitoring, and regulating local services will be strengthened. For example, as shapers they will be responsible for developing a

health improvement programme—a strategy for meeting population health and healthcare needs. They also have important new reserve powers to influence decisions on capital development and new consultant posts in NHS trusts. They have new statutory responsibilities to collaborate with other local bodies, including local authorities, primary care groups, and NHS trusts, for example in developing a health improvement programme. As regulators they will support and monitor primary care groups and have powers to intervene should they fail. These are all logical developments but raise questions about the capacity of health authorities to take on these new roles, especially with a reduction in management resources.[7]

The third main change relates to NHS trusts. While remaining semiautonomous, they will now have a statutory duty to collaborate with other NHS organisations, for example, in developing a local health improvement programme. Annual contracts with purchasers will be replaced by three year service agreements and payment for what were known as extracontractual referrals will be made by an undefined method of "retrospective" reimbursement (again to cut management costs). New measures of performance will emphasise outcomes—patients' experience of care, and access to care— rather than productivity. Importantly, no information will be classified as "commercial in confidence," so, for example, trusts will have to publish the costs of the treatment they offer and a national list of reference costs will be available for comparison.

These changes should bring NHS trusts in from the cold and encourage more openness and collaboration. Better information on comparative costs—which the 1991 reforms largely failed to produce—will strengthen the purchasers' hands to tackle less efficient trusts. The emphasis on measuring outcomes, rather than the number of patients treated, is also welcome. However, the white paper is silent on how payment for trusts will reflect this: rewarding trusts exclusively for higher productivity, as at present, will run against the efforts of primary care groups to treat more patients outside hospital. Retrospective reimbursement for extracontractual referrals could result in abuse, requiring arbitration. Five year agreements may be too cosy, slow down needed change, and prevent frustrated purchasers from seeking alternative providers.

The last main change relates to quality control. A new National Institute of Clinical Excellence is to draw up national evidence based guidelines on the costs and effectiveness of treatments. These will be used to help develop national service frameworks spelling out standards of quality and access to care in specific services, similar to the Calman-Hine recommendations for cancer care.[8] Using this information, a national inspectorate—the Commission for Health Improvement—will be responsible for developing and overseeing the quality of clinical care and tackling shortcomings. Chief executives of NHS trusts will be held to account for the first time for clinical quality of care, and health authorities and primary care groups will be able to call in the NHS Executive regional offices or the Commission for Health Improvement if a trust is failing to deliver.

The proposals amount to three main things: softening the harsher edges of the internal market by increasing collaboration and openness; involving all general practitioners in commissioning/purchasing; and strengthening central control over the quality of, and access to, clinical care. They rest on several beliefs, which, as in all policymaking, are the messy product of political values, aspiration, practical judgment, and evidence: that competition in the NHS has generated bureaucracy and inequity; that the most promising way to manage scarce NHS resources is through devolving budgets to clinicians; and that existing systems to monitor the quality of clinical care (Royal Colleges and General Medical Council take note) are poor.

But are they the right way forward? The content of the proposals looks sound. The overall way they will be introduced—bottom up evolution over 5-10 years rather than top down revolution overnight—is sensible and welcome. But their success rests on significant assumptions: that enough general practitioners can, or will, participate; that primary care groups will have enough bite to improve services and will manage budgets effectively; and that health authorities will be able to develop the new primary care groups into robust and cohesive organisations. There are also notable omissions. For example, there is nothing new on overall funding of the NHS except that the changes in themselves will save £1bn in bureaucracy over five years—a fiction since developing the primary care groups will need high start up costs. At best these reforms could give the service a real chance to manage scarcity better—through effective managed care. At worst they could just be the internal market with its motor removed, while perennial problems which undermine support for the NHS— haphazard rationing, financial deficits, the "winter crises," and lengthening waiting times—go unaddressed.

Finally, it is worth remembering that there are four separate white papers: *The New NHS* refers to England only. In Scotland's version, *Designed to Care*,[9] health boards, not general practitioners, will be the main purchasers, and instead general practitioners are encouraged to group into primary care trusts and form closer bonds with hospitals. This difference provides a useful opportunity for a natural experiment but undermines the notion of a one nation NHS emphasised so heavily by the current government. Then again, disgruntled general practitioners in England could always move north of the border.

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