

The new health authorities: moving forward, moving back?

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There is much to celebrate in the new white paper. The emphasis on quality and partnership both within and outside the health service is welcome. Longer term agreements will replace the stop-start demands of the annual contracting round, and the need for strategic coherence is recognised: indeed, this government is not afraid of the word "planning." But perhaps the most radical aspect of the white paper is its commitment to keep primary care "in the driving seat in shaping local health services." This will attract the most attention—not least because the "problem" of general practitioner fundholding was one of the main triggers for a review of the NHS. But it begs many questions:

- Will the new primary care groups really be in the driving seat?
- How will the groups relate to health authorities, local government, and voluntary agencies?
- What will be left for health authorities?

There are both functional and structural reasons why primary care groups may have less impact than expected. Skills in commissioning will be stretched to cover 500 such bodies. Recent work by the Audit Commission showed insufficient commissioning expertise for even 100 health authorities.¹ The problem will be compounded by capping of management costs and the aim of saving £1bn on bureaucracy. Given an additional tier and the resources needed to make the system work, such savings will be difficult to achieve.

The structural problems are possibly more profound. Serving populations as large as 100 000, primary care groups will lack the flexibility that individual fundholders had to move contracts between trusts. But neither will they have the leverage of health authorities, which have often been sole purchaser for local trusts. Primary care groups risk being neither "small enough to walk" nor "big enough to hurt."

Primary care groups may not have the power to make more than incremental changes to what and where services are provided. While they can "switch resources" between services and providers, the white paper also states they will have to "explore with health

authorities" any planned changes. This might mean a health authority veto. The contestability of services is further reduced by longer term agreements. All this adds up to reduced purchasing power. The trade off between this and greater stability for trusts lies at the heart of the white paper.

In time primary health care groups will be responsible for purchasing almost 90% of hospital and community care, so proper accountability is crucial. Health authorities will monitor their performance against targets set in health improvement programmes and will exercise some control through allocating resources and controlling the progress of groups up (and down) the four steps to complete autonomy. The precise form these powers take remains to be seen. Certainly, if primary care groups have their own budgets and accounting officers there will need to be independent financial audit.

The principle of joint planning between health and local government, backed by a statutory duty of partnership, is welcome, though this will also require careful regulation and financial scrutiny, particularly if budgets are pooled. An integrated approach between health and social services is necessary,² but given that primary care groups and health authorities will seldom be coterminous with local government bodies, it is not clear who will liaise with whom. Duplication and confusion are real risks.

So where does all this leave health authorities? It looks as though their key functions will be resource allocation, strategic planning through health improvements programmes, and some reserve powers over capital investment and commissioning of superspecialist services. This is starting to look familiar. If the envisaged process of consolidation should result in, say, 14 of these bodies, the re-creation of regional health authorities will be almost immaculate.

1 Audit Commission. *Higher purchase: commissioning specialised services in the NHS*. London: Audit Commission, 1997.

2 Audit Commission. *Coming of age: improving care services for older people*. London: Audit Commission, 1997.

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NHS Direct: managing demand

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The second 50 years of the NHS will see a very different relation between the service and the public it serves. One of the four key themes of the white paper is the introduction of NHS Direct, a 24 hour nurse led helpline. After piloting it will cover the whole country by 2000, as proposed in the chief medical officer's report on emergency services in the community.¹ However, NHS Direct is not solely about telephone advice lines. It should also herald a fundamental shift in the NHS where more public participation in health care can happen closer to home and where more care

can be delivered without face to face contact. It may well be the most important development this white paper has to offer.

NHS Direct has profound implications for the shape and purpose of the developing health service in general and primary health care in particular (especially if the gateway to the NHS moves from the surgery to the sitting room). A publicly led NHS may soon complement a primary care led NHS, where NHS Direct could help enable much more graduated access to the right care at the right time in the right way by the right person.

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It is important to shape this public involvement such that public health is promoted, balancing the public's demands with professionally defined needs.

The public is increasingly demanding convenience, quality, and explicitness and is less impressed by professional hierarchies (witness the increase in drop in health centres at London railway stations, nurse practitioners, and litigation). Far from being a threat we should perceive this evolution as part of the solution to managing ever increasing demand. Increasing expectations should be balanced with an increasing willingness and obligation to share responsibility for the decisions taken and the care offered. Access to interactive sources of information, be they telephone help lines or the world wide web clearly empowers the (potential) patient. Equally, it should also strengthen the role and influence of the health service to take its beneficence into the home—if the opportunity is seized thoughtfully. Telephone help lines are an important first step along this path.

We can now buy a mortgage and check a bank account over the telephone. We can access the internet (where health is one of the most common subjects) over the telephone. We also use it to request appointments with our family doctor; but to do anything different—like seek advice without seeking an appointment—has proved difficult. The potential to seek and give advice over the telephone, and triage accordingly, has really been grasped only by ambulance services and, more recently, by general practitioner cooperatives (many of whom have coped with increased contacts by reducing the number that are face to face). In North America, health maintenance organisations have long seen the value of a telephone service (highly integrated with good self care manuals) as part of a convenient and cost effective primary care service.² The directness can work both ways. As well as the potential for NHS Direct to facilitate diagnosis, treatment, and administration by providing easier access into the NHS, it also has the potential to look out into the community—for example, with better monitoring of frail members of the community.

As society changes, the role of a less paternalistic NHS must be to provide opportunities for people to

play a greater part in decision making. Instead of simply requesting, and waiting for, a general practice appointment, an outpatient appointment, or being seen in the accident and emergency department, individuals should be able to use NHS Direct for meaningful access to care, where good care often starts with simple advice. This care can range from advice on which part of their self care manual to consult (and, if necessary, phone back) to the immediate sending of an emergency ambulance.

The perennial fear is that increasing access increases demand. This may not be so.³ Managing demand by cutting supply may be effective for some services but it is hardly ideal in primary care. A better way of managing demand is to offer a more graduated access to health care, where patients are as aware of the risks and costs of health care as they are of the benefits, with incentives to match. This needs to acknowledge that most health care is administered without (or with minimal) professional intervention. The NHS needs to support and improve this by empowering self care, in order to spend its limited resources on services which it is uniquely placed to provide.

The three pilot sites should be studied carefully for the benefits, risks, and resource requirements. This assessment should pay particular attention to the effect NHS Direct has on the NHS as a complete system, not just as a isolated bolt on. As in all communications technology it should concentrate on communications, not technology. Perhaps most important, there is a real risk that many people may be disempowered by NHS Direct. Its development needs to address this crucial issue. Expectations and rights must be translated into responsibilities and participation. Only then will the second 50 years of the NHS contribute as much to the health of the public as the first 50. NHS Direct can be an important part of this process.

1 Chief Medical Officer. *Developing emergency services in the community*. London: Department of Health, 1997.

2 Sabin JE. "Mind the gap": reflections of an American health maintenance organisation doctor on the new NHS. *BMJ* 1992;305:514-6.

3 Flood AB, Wennberg JE, Nease RF, Fowler FJ, Ding J, Hynes LM. The importance of patient preference in the decision to screen for prostate cancer. Prostate Patient Outcomes Research Team. *J Gen Intern Med* 1996;11:342-9.

A hospital admission that changed my life

Only a bear for company I was only a toddler when I was admitted to a Sheffield hospital with poliomyelitis during the 1950s epidemic. My parents lived in Mexborough and did not have a car so they could not visit me every day. Today the hospital would have a room for my mother to sleep in and she would be able to spend all day with me. Instead, I was put in an isolation ward with a barrier nursing technique that no patient with AIDS would have to suffer today. My parents were given a number to look up in the national newspapers, where agonisingly they could see me gradually moving from "Critically ill" to "Improving" over several months. Mercifully, I have no memory of the lumbar punctures or the staff, apart from a vision of one white swathed figure. I remember a large white bed with a huge glass window behind it, through which I could sometimes see my parents waving at me. It is still part of my nightmares as I say "come round, come round." I knew the white figure could get out there. Why couldn't they come to me? Unhappiness and confusion with no one to love me or talk to—except my teddy bear. He was my only friend for those long dreary months. On the day of release

happiness changed abruptly to terror as my best friend was taken away and incinerated in the interests of infection control. A very sensible grandmother immediately rushed out and bought me the nearest lookalike she could find. Since then he has never left my side on holidays or conferences and is still the listener to all my tales of woe. My friends and colleagues think that I am crazy, but at least they now know why. I thank God that our treatment of children and those with infections is a lot more compassionate.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.