

“Dr” Lansley’s Monster

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What do you call a government that embarks on the biggest upheaval of the NHS in its 63 year history, at breakneck speed, while simultaneously trying to make unprecedented financial savings? The politically correct answer has got to be: mad.

The scale of ambition should ring alarm bells. Sir David Nicholson, the NHS chief executive, has described the proposals as the biggest change management programme in the world—the only one so large “that you can actually see it from space.” (More ominously, he added that one of the lessons of change management is that “most big change management systems fail.”) Of the annual 4% efficiency savings expected of the NHS over the next four years, the Commons health select committee said, “The scale of this is without precedent in NHS history; and there is no known example of such a feat being achieved by any other healthcare system in the world.” To pull off either of these challenges would therefore be breath-taking; to believe that you could manage both of them at once is deluded.

Like all the other structural reorganisations of the NHS, this one aims to improve health outcomes. What’s lacking is any coherent account of how these particular reforms will produce the desired effects, a point only underlined by the prime minister’s attempts to justify the reforms earlier this week.

This latest top down reorganisation has been whipped up in an awful hurry. It went unmentioned in the political manifestos of the coalition parties before the last general election, was specifically excluded in pledges given before and after the election, and didn’t make it into the Coalition Agreement of 20 May 2010. Yet less than eight weeks later, its outline emerged in the white paper “Equity and excellence: liberating the NHS.”

The NHS was unsurprisingly absent from the 2010 election campaign because satisfaction levels with the NHS were at an all time high, and for most of the electorate the NHS was a non-issue. In the words of Simon

Stevens, president of global health at UnitedHealth Group, a company that stands to benefit from the reforms, “The inconvenient truth is that on most indicators the English NHS is probably performing better than ever.”

The reforms put general practitioners in the driving seat. Out go strategic health authorities and 152 primary care trusts and in come several hundred general practitioner consortiums, responsible for commissioning £80bn (€95bn; \$1.6bn) of NHS care from “any willing provider.” As Kieran Walshe, professor of health policy and management, described in his BMJ editorial, it comes as but the latest in a bewildering array of forms and structures put in place to run primary care and commission secondary care. Since the introduction of the internal market in 1991, there have been family practitioner committees, health authorities, GP fundholders, total purchasing consortiums, GP multifunds, primary care groups, primary care trusts, and external commissioning support agencies. Yet, crucially, wrote Walshe, “we have little evidence to suggest that any of these organisational structures for commissioning are better or worse than others, or that the proposed new consortiums will work any better than the current arrangements.”

Informed opinion about GP commissioning, past and present, has been almost universally negative. The previous government’s primary care tsar branded practice based commissioning “a corpse not for resuscitation.” Last year’s health select committee report on commissioning concluded that “if reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon, after 20 years of costly failure, the purchaser/provider split may need to be abolished.” This year’s health select committee report on commissioning doesn’t suggest abolition, but neither does it endorse the proposed reconfiguration as the best way to deliver the government’s objectives. It says that general practitioners should “be seen as generalists who draw on specialist knowledge when required, not as the ultimate arbiters of all commissioning decisions.”

No matter how many GP consortiums eventually emerge, their number will probably greatly exceed the 152 primary care trusts they are replacing, which brings a set of new challenges. Smaller populations increase the chances that a few very expensive patients will blow a hole in budgets. More consortiums mean that commissioning skills, already in short supply nationally, will be spread even more thinly. Denied economies of scale, smaller consortiums may be tempted to cut corners on high quality infrastructure and management, thereby endangering their

survival. These points emerge clearly from an examination of 20 years of US experience of handing the equivalent of commissioning budgets to groups of doctors. Some groups had severely underestimated the importance of high quality professional management support in their early days and gone bankrupt as a result.

Moving to consortiums will incur the costs of transition in addition to their recurring costs. On the basis of past National Audit Office data, Kieran Walshe has put the cost of the NHS reorganisation at £2-3bn, and the government's figure is at the lower end of this range. The white paper's key financial pledge was to reduce the NHS's management costs by more than 45%: GP consortiums would replace primary care trusts with administrative costs of over a billion pounds a year (for a population of 51 million)—and practice based commissioners. Since then, potential consortiums have learnt that their running costs will be capped at between £25 and £35 per head of population, not far off the primary care trust average management spend.

The government's recent "bonfire of the quangos" provides an instructive example of how a rush job doesn't necessarily guarantee the best outcome. Earlier this month, the parliamentary select committee on public administration criticised the axing of 192 public bodies and the merging of 118 more as poorly managed. It also said that this move would not deliver significant cost savings or better accountability—two of the government's key aims. The committee's chairman said that, "The whole process was rushed and poorly handled and should have been thought through a lot more."

Rationalising a few hundred arm's length bodies hardly compares with turning the NHS upside down, yet the proposed timescale for the health reforms is dizzying. The bill promises that all general practices will be part of consortiums by April 2012, yet it took six years for 56% of general practices to become fund-holders after the introduction of the internal market. Nearly seven years after the first NHS trust was granted foundation status, there are still more than half to go—within two years. And there's more. The replacement for the 10 strategic health authorities—the NHS Commissioning Board—needs to be fully operational by next April. By then, GP consortiums should have developed relationships with local authorities, which will assume ultimate responsibility for public health via their new health and wellbeing boards, working alongside Public Health England, a completely new entity.

The health secretary has made much of these changes being evolutionary rather than revolutionary. People “woefully overestimate the scale of the change,” he said. After all, practice based commissioning, choice of provider, an NHS price list, and foundation trusts already exist. True, but a week later came the revelation that hospitals would be allowed to undercut the NHS tariff to increase their business. Health economists queued up to say what a terrible idea this was, citing evidence that it would lead to a race to the bottom on price, which would threaten quality. Taken with the opening up of NHS contracts to European competition law, it was the last piece of evidence needed to convince critics that the government was unleashing a storm of creative destruction onto the NHS, with the imperative: compete or die.

Whatever the eventual outcome, such radical reorganisations adversely affect service performance. As Kieran Walshe wrote, they are “a huge distraction from the real mission of the NHS—to deliver and improve the quality of healthcare” that can absorb a massive amount of managerial and clinical time and effort. Even the earliest days of the transition have proved disruptive, with employees of the doomed primary care trusts and strategic health authorities choosing to jump ship rather than to go down with it.

With an estimated one billion pounds of redundancy money in their pockets, many of the survivors are likely to be employed by the new GP consortiums in much their same roles. It raises the question: if GP commissioning turns out to be simply primary care trust commissioning done by GPs, aren't there less disruptive routes to this destination?

Meanwhile, the need to begin making efficiency savings hasn't gone away. Although the impact assessment of the new bill calculates that savings will have covered the costs of transition by 2012-13, overall savings won't have contributed much to the £15-£20bn efficiency savings required from the NHS by 2014-15.

Given their scale, securing these efficiency savings should take priority over the massive upheaval proposed in the new bill. For the time being, we agree with the King's Fund that those GPs who are successfully involved in practice based commissioning should be given real rather than indicative budgets for some services and their performance monitored closely. All other proposals should be kept on hold, pending an evaluation of whether this iteration of GP commissioning can bear the responsibility that the new bill seeks to place on it. If it turns out that it can, then the full introduction of the government's ambitious health

reforms will have been delayed a few years. If it can't, then the country—and its government—will have got off lightly.

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