Analysis and comment

NHS reorganisation

Who's kicking who?

Nigel Hawkes

Are you clear what a primary care trust does or how payment by results works? To help, we asked a health journalist to explain the numerous changes in the English health service and their implications

Sometimes it helps to take a different point of view. Doctors puzzled by what is happening to the National Health Service in England do not have the time or the inclination to wade through the blizzard of documents that issue from the Department of Health. Doing so would not guarantee understanding, anyway.

What follows is an idiot's guide to the new look NHS in England, written from a different perspective. Lenin famously asked, "Who whom?" What he meant was, "Who has the power over whom? Who is the master, and who the servant?" Seen in this light, the English NHS reforms become more understandable. As they move the pieces about the chess board, ministers talk grandly about "strengthening the architecture of the NHS," but what really matters is who does the kicking and who is kicked.

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BMJ 2006;333:645–8

Power shift

Almost all the changes that have been introduced in recent years are driven by power, not architecture. Independent sector treatment centres did increase capacity as ministers claimed, though not by much,[1] but their real purpose was to undermine the power of surgeons to control waiting lists. Patient choice had the same motive. Payment by results aimed to exploit market power to squeeze high cost hospitals, while practice based commissioning was a counterbalance to prevent the low cost hospitals expanding their market so fast they ran away with all the cash. The idea was to give general practitioners incentives to produce alternative services that would treat patients more economically by allowing them to keep some of the savings.

Liberalising measures, including foundation trusts and plurality in primary care, were aimed at undermining union power and central bargaining. The unions quickly realised that, which is why they stamped so hard on former NHS chief executive Sir Nigel Crisp's order that primary care trusts should stop employing health visitors and community nurses and concentrate on commissioning care from others. This might have left some NHS staff with new employers in (heaven forbid) the private sector. Unions could see a kicking coming and forced the government to retreat.

The reorganisation of strategic health authorities and primary care trusts can be seen in the same light. As kickers, primary care trusts have been a serious disappointment, forever in thrall to the powerful acute trusts down the road and poor at pioneering new community based services. Primary care trusts have been "lamentable" at commissioning, admits Sir William Wells, chairman of the NHS Appointments Commission.[2] He should know: he appointed the chairs and non-executive directors of most of them.

Policy shifts

Health policy under Labour has had three distinct phases. First there were the Dobson years, when policy was driven by the belief that if the changes introduced by the Conservatives were reversed, all would be well. The internal market was scrapped, fundholding by general practitioners abolished, and Conservative appointees on health authorites and trusts removed. But all was not well.

Next came the NHS Plan in 2000, the high watermark of central kicking. Targets were set and imposed by managers who would not take no for an answer. Managers further down the line massaged the data so that they could say yes.[3] The NHS Plan's aspirations were excellent, and considerable progress has been made towards achieving them. But doctors and

managers grew weary of targets, and ministers cast about for a way of replacing them.

The third phase has therefore been the reinvention of the market mechanism. For the internal market, read patient choice; for freestanding acute trusts, read foundation trusts; for fundholding, read practice based commissioning. Even the architecture of the NHS is back where it started, with 10 strategic health authorities (they used to be called regional offices) and around 150 primary care trusts (they used to be district health authorities). Every step of this circle has been presented as if it were a consistent progress towards a predetermined goal. Cynics may prefer to see it as an awfully expensive way of educating Labour ministers.

Has it worked?

What matters now, though, is whether the right boots have been laced up and are ready to kick the right bottoms. Or, to put it less crudely, has NHS reform in England reached a moment of stillness, with all the right levers and pulleys in place to make sure every pound is wisely spent buying 100 pence worth of care? Given recent history that seems unlikely, but it is worth exploring.

The lurch into financial deficits in the NHS despite a doubling of the budget is a clear indication that the service lacks the capacity to use money well. Major advances have been made in cancer care, accident and emergency services, and reducing the number of patients waiting unconscionable times for operations,[4] to mention but three. But opinion polls show that the public verdict coincides with that of 10 Downing Street—that this is less than we had hoped for.[5]

The plan, therefore, is to save money by moving care out of hospitals and into general practices and other community based services. This is always presented by ministers as what patients want, and perhaps they do. But if what they wanted cost more, rather than less, you can be sure the NHS would not be falling over itself to provide it.

As an aside, the basic premise merits a brief examination. Let us assume for a moment a service in which, say, dermatology is provided from several local centres attached to general practices. To assure quality, care would need to be provided by consultants, or at least by doctors trained to the same level of expertise as consultants. Not all practices could provide such expertise, so "local" would be a relative term; users would have to travel quite a long way to get that suspect mole examined.

If we had such a system it would be easy to argue that services could be provided more cheaply by bringing all the dermatologists together in a single place, with shared overheads. We might call it, for the sake of example, a hospital. Economies of scale, shared equipment, and shared expertise would make such a service much more economical to provide, and of better clinical quality.

Any plan that can be turned on its head as easily as this is ripe for a kicking. Is local really better, or cheaper? In 2005 Salisbury and collegues showed that providing dermatology services through general practitioners with a special interest was actually more expensive than hospital care.[6] And we are not comparing like with like. General practitioners with special interests, with the best will in the world, are nowhere near as well trained as consultant dermatologists. It will only take a few of them missing malignant melanomas to make the whole idea seem a lot less appealing, especially to ministers.

Although it makes sense to think that keeping people out of hospital is a good thing, that is rather different from proving it. But if health reforms needed proving before they were tried, nothing would ever get done. We would bumble on as before, which is roughly what the devolved services in Scotland, Wales, and Northern Ireland have decided to do. They still have health boards (14 in Scotland, 22 in Wales, four in Northern Ireland) that commission primary and secondary care. None of the devolved governments has adopted payment by results, patient choice, practice based commissioning, foundation trusts, or independent sector treatment centres. The passion for constant reform is an exclusively English phenomenon.

Is commissioning the answer?

So is the system in England now fit for purpose? Primary care trusts proved too weak to force changes, so their number has been halved[7] in the belief that this will make them twice as strong. But the department

NHS reforms: the glossary

Primary care trusts—The bodies principally responsible for planning, commissioning, and paying for care. After the latest round of changes are complete, there will be 152 of them. They have chief executives, finance directors, and boards, with non-executive directors appointed by the NHS Appointments Commission. Each is now responsible for a population of around 300 000 people

Strategic health authorities—The next tier of authority, responsible for strategic planning and oversight of primary care and hospital trusts. They have recently been reduced in number from 28 to 10. Each region of England now has a single authority. Their catchment areas vary from 2.5 million people in the North East, to 7.4 million in London

Payment by results—A funding system that requires primary care trusts to pay service providers such as hospitals on the basis of a price list (the tariff) which lists every procedure and its cost. Efficient hospitals will be able to make a profit if they can work at less than the tariff; inefficient ones will lose money if their costs are higher than the tariff

Practice based commissioning—General practices that take part will have an indicative budget from which they can commission care for their patients. This is not an actual budget; trusts remain legally responsible for finances and contracts, and for the overall strategy. Practices that save money by reorganising services should get 70% of the savings but can use them only for purposes that meet national or primary care trust requirements

Patient choice—Since the beginning of 2006, patients in England have had the choice of four or more providers when referred by a general practitioner for hospital care

Foundation trusts—Hospitals liberated from central control, and given greater financial and clinical independence, managed under local governance procedures and regulated by a new body, Monitor. On 1 June 2006, there were 40 foundation trusts in England

realised this was not enough, and added practice based commissioning to the mix. This aims to give general practitioners a cash incentive to save money by innovative changes in services. But unlike fundholding, the room for initiative is small and careful reading of a recently published report, *Health reform in England*, suggests that most of the power remains with the trusts.[8]

In early July, ministers claimed that practice based commissioning was "surging ahead," on the back of figures showing that 3454 out of 8433 practices in England had taken it up.[9] This was misleading. What these practices have actually taken up is a 95 pence per patient inducement for making a commissioning plan, which can amount to very little. In the view of one general practitioner, a couple of sides of A4 is sufficient to get "your bag of gold."[10] More recent figures, released at the beginning of September, do show evidence of greater enthusiasm among general practitioners to get to at least this first stage, with 65% of practices taking up the incentive payment by the end of July.[11]

The next step in making commissioning work is to get data from the primary care trusts about the cost of services and suggest ways in which they can be delivered more cheaply. Of the savings made, 70% is supposed to go to the practice. By the middle of July only about 20% of practices had been provided with this "indicative budget," according to James Kingsland, chairman of the National Association of Primary Care.[12]

Unlike hospitals, general practices are allowed to undercut the tariff, the price list of procedures that forms the basis of payment by results. So while hospital A cannot increase its market share by undercutting hospital B, general practices can do exactly that. A good example is Tim Morton, a general practitioner in Beccles, Suffolk, who believes he can undercut the tariff for vasectomies by doing them for £250 a time, against the tariff of £350. Hospitals, he points out, charge extra for preoperative and postoperative care, doubling the tariff, whereas his price is all inclusive.[13]

But practices cannot simply choose to launch services such as this without approval from primary care trusts, because the trust still holds the funds. And as 70% of the savings go to the practice, trusts do not stand to gain hugely from any savings made. Trusts can also dictate how the savings are used. In some cases when trusts are in financial trouble, it has even been hinted that general practices will be asked to give back some of the 70% they are entitled to.[10]

These plans make it pretty clear that the trusts are still in the driving seat, can determine how fast the vehicle goes, and can also choose its direction. So policy remains in the hands of organisations already found wanting, and general practitioners seem to have been pushed aside once more. Is there really much incentive for them to take on commissioning? Perhaps not, and whatever the numbers, practice based commissioning seems unlikely to be the miracle ingredient that makes the reforms cohere.

Private involvement

The winners—as usual—are likely to be consultancy firms, which have enjoyed a huge boom under Labour.[14] The Department of Health recently advertised for private companies to provide specialised services for primary care trusts, such as actuarial and population risk assessments, data harvesting and analysis, social marketing, opinion surveys, service evaluation and redesign, and procurement. The department plans to negotiate central contracts from which trusts can "pick and mix" to acquire the expertise they need. Conflict of interest rules will cover situations in which a private company may be advising on commissioning a service that it might also be able to supply, the health secretary, Patricia Hewitt, said.

The private sector is a welcome partner, ministers now insist. The prime minister recently held a breakfast at Downing Street at which chief executives and finance directors from the UK's top 100 companies were urged to help foundation trusts. Mr Blair seemed unconscious of the irony that it was his government, during the first phase of Labour's health policy, that eradicated such people from NHS non-executive appointments in droves.

The policy of providing the jobs to Labour sympathisers was so biased that it led to the establishment of Sir William Wells' NHS Appointments Commission. But even now, under supposedly non-partisan selection, among those appointed who declare a political alliegance, there are four times as many Labour supporters as Conservatives.[15]

Pretty soon, if Sir Liam Donaldson has his way, Sir William will also be responsible for appointing new tribunals to rule on fitness to practice cases, removing medical self regulation from the General Medical Council after 150 years.[16] At the same time, through the policy called Modernising Medical Careers, the training of doctors has effectively been nationalised and brought under almost complete departmental control.

Far from the NHS being privatised, as critics of the government's reforms bitterly complain, it can just as plausibly be argued that medicine is becoming ever more a creature of the state. From inside the bunker, the policy may seem coherent and consistent, but from

NHS reforms: the timeline

1991. Conservatives introduce the internal market

1992. Fundholding gives general practitioners control over budgets

1996. Abolition of regional health authorities and creation of nine regional offices

1997. Labour elected with "24 hours to save the NHS"

1999. Abolition of fundholding

2000. The NHS Plan sets targets for improving care and cutting waiting lists

2001. Hospital league tables introduced

2002. Major funding increases announced

2002. Primary care trusts take over commissioning

2002. 100 health authorities replaced by 28 strategic health authorities

2004. First foundation trusts authorised

2005. Payment by results starts

2005. Practice based commissioning announced

2006. Primary care trusts cut from 302 to 152 and strategic health authorities from 28 to 10

2006. Hospital league tables abolished

outside it looks like a patchwork of mutually contradictory ideas struggling for dominance.

Contributors and sources: NH has been health editor of the *Times* since 2000 and a close follower of every twist and turn in NHS policy under four ministers. The information comes from briefings, published documents, and open literature sources but the judgments are his own.

Competing interests: None declared.

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doi 10.1136/bmj.38967.410428.68

Controversy

Race and mental health: there is more to race than racism

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Some minority ethnic groups in England and Wales have higher rates of admission for mental illness and more adverse pathways to care. Are the resulting accusations of institutional racism within psychiatry justified?

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BMJ 2006;333:648–51

> It occurred to me that there was no difference between men, in intelligence or race, so profound as the difference between the sick and the well.
> F Scott Fitzgerald. *The Great Gatsby.* 1925

The "Count me in" census for England and Wales showed higher rates of admission for mental illness and more adverse pathways to care for some black and minority ethnic groups and produced predictable accusations of institutional racism within psychiatry.[1] Lee Jasper, chair of African and Caribbean Mental Health, stated: "This census confirms once and for all that mental health services are institutionally racist and overwhelmingly discriminatory. They are more about criminalising our community than caring for it."[2] In fact, the census clearly states that it "highlights the differences between various black and minority ethnic groups and the need to avoid generalisations about these groups. It does not show a failure in the services" (page 7) and comments that "although many possible explanations have been put forward for these patterns, the evidence is inconclusive" (page 27). Not surprisingly it was the accusation of institutional racism, described as a "festering abscess within the NHS,"[2] that made the headlines. Mr Jasper is not alone in expressing such concerns. Several reports and inquiries have also alleged that psychiatry is institutionally racist.[3–6] What then, is the evidence that the census findings can be attributed to racism within psychiatry?

Rates of mental illness in minority groups

High rates of mental illness in migrant groups have been recognised and speculated on throughout the past century. A scientific approach to understanding the issue originated with Odegaard's observation of raised rates in Norwegian immigrants in Chicago,[7] and various theories have been proposed to explain this excess.[8] In the United Kingdom the argument is at its most intense around the enduring epidemiological finding of high rates of psychosis in second generation African-Caribbean patients.

IAN MILLOGRAM/REX FEATURES

Lee Jasper, chair of African and Caribbean Mental Health, says mental health services are institutionally racist

These higher rates have been proposed as evidence of racism on two main grounds. Firstly, that the diagnoses are mistaken, stemming from "Eurocentric" diagnostic practices; Western psychiatrists are proposed to be more likely to misinterpret behaviour and distress that is culturally alien to them as psychosis. It is unfamiliarity with culturally alien ideas and practices that leads psychiatrists to label some black and ethnic minority people's behaviour as "bizarre" or illogical (characteristics of psychotic psychopathology). In short, the patients neither have the illness nor the symptoms attributed to them but are simply misunder-