Reading Note: A GP is a "General Practitioner" (or family doctor). The GP is the first person with whom a patient has contact in the health system. Depending on the nature of the patient's illness, the GP either provides basic treatment, or else refers him or her to specialists.

Pros and cons of a delicate operation

By Nicholas Timmins
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Patients

What has been announced?

Patients will, in theory, have more choice and more information on which to base that choice. They will be able to register with any GP, choose a named consultant team and – as now – choose where to go for their outpatient appointments and operations.

What do critics say?

Some argue that patients do not care about choice, just good local services, and they fear that the competition will undermine local NHS hospitals. There is a tension between patient choice and the requirement that GP consortia set priorities and stay in budget. So, in some cases at least, the choice may be constrained by the contracts that consortia set up. It will be "choice within limitations, because GP consortia have a responsibility to manage their services within budget", said Andrew Lansley, health secretary.

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Commissioning

What has been announced?

GP consortia will take over the commissioning of perhaps £70bn of NHS care, overseen by a commissioning board that will buy in the remainder – for example, rarer high-tech care. The board will be set targets to improve the results the NHS achieves in cancer, mental illness and other conditions.

What do critics say?

All GPs – ready, willing, capable or not – will be required to take part, even if only passively by letting others do the job for them. There are undoubted enthusiasts for the idea. But questions remain over whether the capacity of GPs to undertake the job is sufficiently evenly spread across the country. Huge amounts of detail are still to be spelt out – for example, the extent to which consortia will be at personal financial risk for hitting or missing their budgets.

Greater involvement of clinicians in commissioning NHS care is an important step forward. Whether the wholesale change Mr Lansley plans was necessary to achieve that is more debatable.

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Hospitals/providers

What has been announced?

In one of the most radical changes, the half of hospitals known as NHS Trusts will cease to be directly managed by health authorities, and NHS Foundation Trusts will no longer be overseen by their own regulator.

What do critics say?

This is a really big change. Care will come from competing publicly, privately and voluntary owned providers who will stand or fall by their own efforts. The provision of NHS care will be much more like the operations of a regulated industry. A brand new economic regulator will set prices, promote competition and operate a failure regime to ensure continuity of essential – but only essential – services. It retains the name of the current foundation trust regulator, Monitor, but is an entirely new body: an 'Ofhealth' for NHS care.

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Public health

What has been announced?

Local authorities will take back the responsibility for public health that they enjoyed up to 1974. Existing bodies such as the Health Protection Agency will be absorbed into the health department. Local authorities also obtain oversight of GP consortia plans and powers to refer big hospital and other changes to the secretary of state.

What do critics say?

The creation of a separate public health service funded by £4bn ($6.4bn) of NHS money has been widely welcomed – though it will stop the NHS diverting public health cash to patient care when times are tight. The real nature of the new power relationship between GPs and councils over other services is less clear. New health and wellbeing boards in local authorities stand a real chance of improving the co-ordination of health and social care and could tie that in better with mental health care too.

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Overall

What has been announced?

The biggest shift of power and accountability in the NHS's 62-year history – along with a huge structural change as strategic health authorities and primary care trusts are abolished and all but a handful or two of hospitals are set to become entirely self-governing organisations.

What do critics say?

Opponents say that this shift to a much more market-based system in the provision of care will fragment it, to the detriment of patients. The health service unions are bitterly opposed to more competition, more choice and greater use of the private and voluntary sectors. Existing NHS hospitals will lose out to private providers who will cherry pick services. It is a mistake of "Titanic proportions", according to Unison, the biggest health union.

Cameron's NHS reform is no health revolution

Julian Le Grand
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Huge exaggeration characterises the debate over the coalition's health reforms, published on Wednesday. Many unwisely say they are the most radical in NHS history. In fact, they are evolutionary, not revolutionary: a logical, sensible extension of those put in place by Tony Blair, which in turn developed the internal market set up by John Major. The danger the reforms pose is different: the risk of introducing competition between hospitals based on price.

The commissioner-provider split, payment-by-results, and more choice and competition: all were developed under Mr Blair, and are now extended by the coalition. The evidence suggests they are working. Research by Zack Cooper at the London School of Economics, and (independently) Carol Propper at Bristol University, shows hospital competition improving quality of service. Hospitals in competitive areas reduce post-operative mortality faster, saving lives and promoting efficiency. The Nuffield Trust has shown higher productivity and lower waiting times in England than (unreformed) Scotland and Wales, despite the latter having more money per head. Even equity has improved: waiting times have fallen sharply for all, but more so for the less well off.

Indeed, the only area not working well is the area targeted by the new reforms: NHS commissioning. Many analysts have been critical here, especially of primary care trusts. Yet research shows that one of the predecessors of the coalition's proposed GP consortia, GP fund-holding, was relatively successful – controlling hospital referrals and prescription costs and introducing innovation. Fund-holders were also good at sticking to budgets.

Mr Blair failed in his attempt to reintroduce this approach, but the coalition has been bolder, giving GPs more power. We know GPs tend to commission wisely by virtue of knowing their patients' needs. If so, it makes sense to align the holding of a budget with decisions concerning the spending: GPs make referrals to hospital, so they should have responsibility for the costs of their decisions.

A potential problem lies in the consortia's sizes. Many will be large, while research into fund-holding suggests, counter-intuitively, that smaller groups work better. Larger groups find it difficult to change commissioning patterns without destabilising providers. Smaller groups can play the market more easily and are closer to patients. On the upside, existing systems of GP commissioning mean many of the consortia already exist: in fact there are more than 600, even if some still lack the full responsibilities the new system will provide.

The possible introduction of price competition between hospitals remains the reform's biggest risk. The coalition says explicitly that it wants to encourage competition on quality alone and not on price. Nonetheless, elements in the reforms' operating framework (actually dating from Gordon Brown's government) offer the possibility that price will play a role. Mr Blair considered this option, in place of a fixed tariff for each hospital procedure. He decided it would undermine trust between patients and GPs. The same is true today: if patients think their doctor is referring on cost grounds, this crucial relationship could be damaged. Evidence from the US, and from the UK's earlier internal market experiments, shows hospitals competing on price also often lower quality in the search for savings.

There will also be turbulence in the change-over period, and strategic health authorities and PCTs will lose staff and focus. But even this is exaggerated. Against the doomsayers, the NHS does not face an enormous resource crisis. It is well funded, and will remain so, with small increases projected. There are cost pressures – notably from staff pay increments – but these are not likely to be exceptional in coming years.

Most of the opposition to these reforms is the same standard NHS push-back that confronts any attempt at change. Public sector reform is always messy, but it does not help if commentators and others exaggerate the difficulties involved. There will undoubtedly be crises in specific areas, especially during the transition period; but these should not be used to discredit the reforms overall. These have the potential to make a good service great – provided they are not derailed by overblown predictions of mayhem and disaster.

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Questions for Discussion

1. In the new system, hospitals will compete with each other to attract patients. How might this increase overall patient welfare? What perverse outcomes might arise? How might regulation reduce the incidence of the latter?

2. In the new system, groups of GPs will receive the bulk of the NHS budget, and patients will be free to register with whichever GP they want. According to the article, the incentive system for GPs has yet to be decided. What do you believe the appropriate incentive scheme for GP consortia should be if the goal is to maximize patient welfare?

3. In the past, state-owned monopolies provided the UK's gas and electricity services. In the 1980's the Thatcher government privatized the monopolies and allowed competition in the utility market. Since then, productivity in the utility sector has increased, prices have generally fallen in real terms, and hardly any commentator argues that the UK is now worse off than before.

   Are there any differences between the electricity sector and health sector that might make competition in the latter less beneficial in the long run than in the former?