Consequently, many of the most important questions about the reforms remain unanswered. These include the balance that will be struck between competition and management, the relation between fundholding and health authority commissioning, and the number and configuration of NHS trusts. The reality is that the way in which these issues are resolved will depend as much on how the reforms develop locally as on the decisions of ministers. To this extent, the changes introduced by *Working for Patients* are out of control, with developments being driven from the bottom up not from the top down.

And yet. Despite the overwhelming evidence of confusion and inconsistency at the centre of the NHS, there are those who argue that the reforms are guided by a master plan, designed to unfreeze (or destabilise) established relationships and to undermine the very principles on which the NHS was established. This conspiracy theory holds that ministers are pursuing a hidden agenda which, through a series of incremental steps, will result in more private involvement in the financing and delivery of health services. The difficulty with this argument is that not only are politicians not that clever but also for any government to undermine the NHS, however surreptitiously, would be electoral suicide. In practice, health policy is more the result of cock up than conspiracy, and the time has now come to address some of the ambiguities that exist.

What should be done? Firstly, ministers should assess the founding principles of the NHS for their relevance today. This applies not only to the principles of access and equity, which have come under pressure as the NHS market has begun to bite, but also to the principle of comprehensiveness. The decision by the ombudsman that the NHS has an obligation to provide nursing care to patients who are seriously ill has thrown down a challenge to ministers and will intensify the debate about rationing.[7] This issue can no longer be avoided, and ministers should immediately initiate a debate about the scope of the NHS, following the example of their counterparts in Sweden,[8] the Netherlands,[9] and New Zealand.[10]

Alongside this debate, ministers should clarify where they see the current reforms taking the NHS in the longer term. This will not be possible in great detail, but at a minimum there should be greater clarity about the principles of market management, the nature of the purchasing function, and the development of NHS trusts. Four years into the implementation of the reforms there is sufficient experience to fill the gaps in *Working for Patients* and to spell out the direction of change in the next phase of development. This would enable the legitimate (as opposed to partisan) claims of the medical profession and other interests to be taken into account in a refinement of the reforms. In this respect, ministers should place the emphasis on contestability rather than competitive tendering of clinical services, build in stronger incentives for improved performance, and address the growing problem of morale in general practice.

The other priority is to articulate a vision of the future of health services themselves. This includes taking into account the impact of technological advances and demographic changes and ensuring that services develop in line with research evidence on the most appropriate and effective location of medical care. This may entail the politically uncomfortable acceptance that market principles won't guarantee the concentration of services in centres that produce the best results. These issues need to be addressed alongside issues to do with structure and management.

CHRIS HAM
Director

Health Services Management Centre,
University of Birmingham,
Birmingham B15 2RT

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An outsider's view of the NHS reforms

Enthusiasts at the OECD should not induce complacency

The recent report of the Organisation for Economic Cooperation and Development (OECD) on Britain's health care reforms[1] has been welcomed by the secretary of state for health as "the most authoritative assessment of the reforms produced so far."[2] The report is largely enthusiastic about the internal market reforms of the NHS. This is not surprising since the economists who wrote it are generally advocates of competition. There is, however, concern that the report and its conclusions appear to be based on inadequate evidence. The endorsement of the reforms by such a prominent body should therefore not induce complacency about the need for a better research base for health policy.

Health care reform has three main objectives: cost containment, equity, and efficiency (the relation between quality and cost). The OECD's report attributes the British health reforms to the belief of some policymakers "that an alternative system could be devised that retained the advantages of the NHS—universal coverage and cost control—while expanding consumer choice and reducing supply side inefficiencies."[1] It begins by comparing health spending and outcomes in Britain with those of other countries that are members of the OECD. In 1992 Britain spent 6.7% of its gross domestic product on health care, compared with an average of 8.2% in the OECD as a whole. Mortality and life expectancy, however, are close to the averages for the OECD. From this evidence the report concludes that the NHS "was, and is, a remarkably cost-effective institution."

Before the 1991 reforms, costs in the NHS were

contained by tight central control of cash limited budgets. This system was, however, inflexible, and towards the end of the 1980s, with increasing pressure on public spending on health, a desire for change emerged (partly to counter constant demands for increased funding): "the command-and-control system of the NHS lacked flexibility, incentives for efficiency, financial information (and hence accountability) and choice of providers of secondary care."[1] The NHS reforms have introduced more flexibility in some areas—for example, local pay bargaining.

The OECD's report notes large increases in expenditure since 1990 but underplays the potential trade off between flexibility and cost containment objectives. It acknowledges that the reforms have required higher spending, to define and monitor contracts and increase financial and other information. But it ignores the more important possible long term loss of cost control through the introduction of trust status and more flexible employment regulations. Salaries and wages make up around 80% of expenditure on hospital and community health services,[3] and expenditure on staff is the dominant factor contributing to overall NHS costs. Now that trusts may employ staff on locally determined contracts this may lead to cost inflation. Such inflationary effects might be increased if trusts were given access to private capital, which could enable competition on the basis of apparent "quality" rather than simply price—as in the United States.

The British system embodies "a much cherished principle—free access by all citizens to comprehensive medical care."[1] In some areas this principle of equity has been eroded, particularly in dental and optical care, prescription charges, and access to some services, such as infertility treatment.[4] The existence of general practitioner fundholders as a "separate (and more effective) group of purchasers"[1] has also raised concerns about an explicitly two tier service.[5] The report states that the answer to this potential inequity is to extend fundholding and general practitioner based purchasing to cover more patients, but the research evidence to support this unequivocal statement is not clear.

The report praises Britain's allocation of health budgets to regions by a weighted capitation formula as "one of the most sophisticated and effective methods of allocating health resources to areas of need."[1] It does not, however, address problems of subregional allocation or the fact that the formula applies only to hospital and community health services and not to primary and social care. Several authors have called for primary care budgets also to be allocated by formula[6-8]—to give "equal access to the gatekeeper."[6]

The final objective of health care reform is efficiency, and the OECD's report is enthusiastic in its belief that the internal market can increase efficiency. This, however, is a belief that is not as yet based on sound evidence.[9] The report points out that the government has not established a programme of research to evaluate the reforms, although various research projects have been undertaken.[10] Information remains partial in many areas—for example, comparisons of performance between trusts are inconclusive, and there is little information on the purchasing function of district health authorities, which remains underdeveloped. Indicators of "efficiency" released by the Department of Health invariably concentrate on activity. To what extent increases in activity are the product of the reforms or of recent increases in funding is unknown.[11] And there is little evidence about improvements in the effectiveness or cost effectiveness of this clinical activity.

The NHS reforms were an ideological experiment, introduced without information on the impact of markets or on their costs (the then secretary of state for health, Kenneth Clarke, in 1989 freely admitted that he had "no idea" how much the reforms would cost[12]). The OECD's economists, with a similar ideological background, are enthusiastic about the principles of the market but fail to produce convincing evidence of their beneficial effects in the NHS. To inform policy and practice in the NHS we need thorough research and evaluation. Assessments through rose tinted glasses are not enough.

KAREN BLOOR
Research fellow
ALAN MAYNARD
Director

Centre for Health Economics,
University of York,
York YO1 5DD

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Psychosocial factors and relapse of schizophrenia

Interventions with the families of schizophrenics can reduce relapse rates

Schizophrenia follows a relapsing course for life in most sufferers. In one study almost 80% of patients relapsed repeatedly, and at five years half showed persistent handicap.[1] Relapse takes a toll on patients and their families and imposes a financial burden on hospital and community services.[2]

Some patients relapse while taking maintenance medication,[3 4] and this stimulated a search for other contributory factors which has now led to an emerging consensus.[5-10] What are the psychosocial factors, how do they operate, and what interventions are effective?

The chance of relapse in patients with schizophrenia living at home depends heavily on the emotional environment provided by the family.[11] The concept of expressed emotion has evolved as an index of the quality of this environment.[11-13] Expressed emotion covers many of the emotional responses by a key relative, usually the spouse or parent, towards the patient. The key relative's level of