doctors enabling a more precise diagnosis and more accurate titration of treatment in the long term follow up of hypertension.

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Primary care trusts

Premature reorganisation, with mergers, may be harmful

Just over two years ago, in a reorganisation of the NHS in England, 303 primary care trusts were created, each with responsibility for providing primary health care, improving health, and commissioning secondary care services for a population of around 180 000. With about 80% of NHS funding flowing directly to primary care trusts on a capitation based formula, hopes were high that these new organisations would be powerful agents for change in a more devolved, clinically driven, and locally responsive NHS.[1]

Some in the NHS, however, believe that primary care trusts have failed to fulfil these expectations. There is a growing belief that many trusts are perhaps ineffective organisations—too weak to stand up to providers of acute care in tough negotiations on commissioning and too small to fulfil their public health responsibilities. Some would argue that they have so far been unable to establish strong and credible management teams.[2]

The unsurprising solution being mooted is a further reorganisation, in which widespread mergers of primary care trusts would reduce their number to 100-150 across England.[3] Coincidentally, that is roughly how many health authorities existed before they were abolished and primary care trusts were created to take on many of their responsibilities. Although a moratorium of sorts on wholesale organisational restructuring has been in place for the past two years in the Department of Health, some primary care trusts have already been merged in all but name. Strategic health authorities have organised them into "clusters" and appointed joint management teams.[4] In 2005—after the next election—we expect an epidemic of mergers of primary care trusts.

So what would these mergers achieve? We have no good evidence to show that a structural reorganisation of primary care trusts would bring benefit to patients. It would lead to a distraction from the real tasks at hand such as developing clinical governance and new forms of management for chronic disease; implementing new incentive structures, such as practice based commissioning, to improve coordination of services and deal with poor morale; and using new policies such as payment by results and choice for patients as a lever for developing services that are more responsive to local people.[5] Primary care trusts have so far made some progress, but they have important problems to tackle.[6 7] The growing and somewhat self fulfilling beliefs that they are not fit for their purpose in the longer term and that structural reorganisation would bring improvement deserve to be challenged.

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Firstly, primary care organisations do not have one right size and configuration. The advantages of being big for managing risk and exploiting economies of scale in management clash with the advantages of being small, close to primary care, and adaptable to local needs.[8] However, many primary care trusts already struggle to secure clinical engagement and support among general practitioners because of their size and the number of practices they cover. Larger primary care trusts would seem more remote and bureaucratic to clinicians. Securing clinical involvement and leadership are crucial to the success of primary care organisations as providers and commissioners and to developing practice based commissioning.[9 10]

Secondly, although primary care trusts have not yet had time to become effective negotiators in their commissioning relations with acute care providers or to develop their planning and purchasing capacity, we have no evidence to show that the old health authorities that were larger than current primary care trusts were any better at commissioning.[11] We know that flexible arrangements are needed to let commissioning take place at different population levels, depending on the nature of the service.[12]

Thirdly, although management teams of primary care trusts are still immature and inexperienced, this will resolve over time. The rush to reorganise and merge fails to recognise that many primary care trusts are already developing creative and flexible arrangements for the sharing of expertise and functions with neighbouring trusts.[13] Countywide or citywide networks for public health, commissioning arrangements, shared senior executive posts, and agencies to provide support services are examples of such innovation. These are happening in response to local need—not prescribed from above by strategic health authorities or the Department of Health.

Reorganisations are a clumsy reform tool, and research shows that they seldom deliver the promised benefits. Every reorganisation produces a transient drop in performance,[14] and it takes a new organisation at least two to three years to become established and start to perform as well as its predecessor. Yet the NHS is reorganised every two years or so, which probably means it sees all the costs of each reorganisation and few of the benefits. In a truly devolved NHS that is clinically driven and locally responsive, top down reorganisations should become outdated. To propose making major structural changes to primary care trusts is premature. What they need instead is the space to work on implementing current policy initiatives and seeing their effects, building relations in local healthcare communities, and securing much needed clinical engagement and improvement in service. The Department of Health and NHS managers should resist the temptation to reach for the old panacea of reorganisation.

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