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FEATURE

NHS REFORMS

NHS rethink: charade or cause for new hope?

We asked a range of commentators from clinicians to academics for their thoughts on the proposed changes to the NHS Health and Social Care Bill. Do the changes move us to a healthcare model we can be proud of or do they take us back to pre-1948 inequity and a “return to fear”?

Kate Arden, director of public health, Wigan

I’ve been a chief officer in the local authority for three years now. If you are a doctor who has “grown up” in the NHS don’t underestimate what a big culture change it is moving to local government. You will need to influence cabinet and understand how local authorities work. Public health professionals will be coming into local government at a time of huge cutbacks and will have to negotiate that change and continue doing their job. It is going to be a real leadership challenge to keep them motivated. But I do think public health’s proper home is in local government—the key thing is not to lose precious links with the NHS.

I’m glad that Public Health England is to be an executive agency. Public health has to be seen as independent—you sometimes have to give advice, even when people don’t want to hear it. Public trust in scientific advice really took a battering during the bovine spongiform encephalopathy (BSE) crisis of the 1990s, and later with the MMR vaccine scare. I remember Liam Donaldson saying that as chief medical officer you have to be trusted as a politician, have a good relationship with the profession, but also be trusted by the public as the nation’s doctor. That’s hard.

John Black, president of the Royal College of Surgeons

The government should take great credit for taking time to listen to concerns from healthcare professionals and patients over the detail of the health reforms. Amendments to formally include hospital doctors in commissioning will help ensure all patients are fully accounted for and prevent unintended destabilisation of hospital services. Commitments to prohibit cherry picking of cases and to maintain medical training are welcome.

But the best thing for the future of the NHS is to get on with making these plans a reality without delay. Our experience of past attempts to reform the health service is that open ended commitments are never fulfilled because there are too many confounding vested interests in the system. Removing the 2013 deadline would prove a mistake. Our concern is that this opens the door to a mixed economy of commissioning by new consortiums in addition to alternative commissioners creating wasteful duplication of how NHS money is spent. This could

lead to funds being spent on administration that could have gone on patient care at a time when public finances are at their most vulnerable.

Kambiz Boomla, chair of City and East London Local Medical Committee

This bill arose as the latest stage in a plot against the NHS, as enabling legislation to allow for its gradual dismemberment and piecemeal privatisation.

We have won concessions that might slow down the privatisation project. Yet most of the proposed amendments are neither as important nor as welcome as might first appear.^{1 2}

While the commitment to retain the responsibility on the secretary of state for a comprehensive health service is welcome, this duty is watered down into “securing” rather than “providing,” an important distinction as it allows further privatisations.

It’s good that clinical networks are retained and that commissioning groups must be responsible for whole borough based populations, and welcome too is the obligation for clinical commissioning groups to be more broadly based and that they and foundation trusts must meet in public. Yet commissioning managers, although now “more valued,” can still be drawn from the private sector.

Monitor’s main duty is no longer to promote competition, but instead “patient choice” has been chosen as the new battering ram the private sector will use to increase its NHS market share. Commissioners now have an obligation to “make markets,” if patients complain. “Supporting choice, competition, and integrated care” is not a change of direction, simply a slowing of pace.

There remains a relentless rush into foundation trusts and social enterprises, distancing them from ministerial responsibility and their staff from NHS terms and conditions of service.

Not removed is Andrew Lansley’s pledge that there will be “no toleration of financial failure.” As austerity cuts inevitably drive provider units into deficit, we still face the prospect of debt problems forcing hospital closures, with the only alternative on offer being private sector buy-out.

The BMA should retain its opposition to the bill. Greater clinical involvement in commissioning can be achieved without a bill at all.

Andy Haines, professor of public health and primary care, and Liam Smeeth, professor of epidemiology, London School of Hygiene and Tropical Medicine

While the recommendations by the NHS Future Forum deal with many concerns, there remains a stark lack of evidence to support the proposed reforms and no clear plan of evaluation. Vast sums of public money and the energy and commitment of thousands of talented people could be wasted implementing policies with little or no evidence base.

Elected governments rightly determine the resources allocated to and the overall priorities of health services. However, the means of achieving their objectives should be scrutinised by—and ideally developed in collaboration with—an independent body equipped with the necessary technical capacity. The Future Forum set a precedent, but it was convened as an afterthought in order to respond to a crisis in public and professional confidence and had neither the time nor the resources to examine the evidence base for the reforms. The proposed new independent body should be empowered to systematically review the evidence for the most cost effective strategies to meet the government's objectives and could work closely with the National Institute for Health and Clinical Excellence (NICE), which has many of the skills required. Major policies should be implemented on a trial basis with mandatory evaluation using the best available designs through a competitively commissioned research programme.³ The results of evaluative research would determine whether a policy was implemented nationally.

Recently the Department for International Development has moved to ensure that aid to low income countries is based on evidence of effectiveness and that its impact is rigorously evaluated. However, the government does not seem to be committed to implementing this approach for its domestic policies.

Just as it is imperative to show the safety and cost effectiveness of clinical interventions by well designed and ethically conducted research, so it should be essential to show that health service policies have the desired effect without causing unintended harms.

David J Hunter, professor of health policy and management, Durham University

The outcome of the “pause and listen” charade is a masterly lesson in wordsmithing worthy of the BBC political satires *Yes Minister* or *The Thick of It*. True, some cosmetic changes have been made to mollify critics of the odious Health and Social Care Bill. But on the more contentious and worrying aspects of the proposals, it's a case of smoke and mirrors. The media have largely been duped, and those Liberal Democrat MPs who rose up in anger back in March seem to have dutifully accepted the prescription of Steve Field and his Future Forum.¹ The giveaway lies in both prime minister David Cameron and deputy prime minister Nick Clegg claiming victory. Surely they can't both be right? But if little of substance has changed while pretending otherwise then they can both be right.

Take the Future Forum's report on choice and competition. Largely accepted by the government, it takes few hostages, arguing vigorously in favour of more pluralism and diversity in provision. The contested desire for choice and competition is swept aside in favour of an insistence, based on flimsy evidence, that both are essential. Make no mistake, the proposals

are virtually indistinguishable from those in the bill. Soothing words about slowing the pace of change and ensuring that nice cuddly mutuals take the strain rather than nasty for-profits (even if it is often hard to distinguish the two) amount to a clever attempt to deflect attention from the charge of privatisation. Monitor's modified remit is designed to reassure, but as long as those appointed to head up the original version remain then the reality is unlikely to match the new rhetoric. And there's the rub. As ever, the devil is in the detail, and most of that is not yet in place. When it is, it may be too late.

If there is a plot against the NHS, then the Field report and the government's response to it are another turn in the road New Labour set forth on and has yet to come to terms with. The broad direction of travel remains much as the beleaguered Andrew Lansley laid out in his white paper of a year ago. Only the good Lords can save the NHS now.

Stephen Lawrence, general practitioner with a special interest in diabetes, Kent

I'm glad Monitor's wings have been clipped and that nurses and doctors will be represented on commissioning groups. But they've watered down the 2013 deadline. This deferral is one of the greatest threats to these reforms. The government should have learnt from fundholding, where the early adopters did very well for patients but not so well by the third and fourth waves. They should have stuck to their guns and said 2013, that's it.

GPs have worked with the private sector for years. What is different now is there is going to be more emphasis on the private sector providing care. It's important to ensure a level playing field so that the health economy is not destabilised by companies picking the low hanging fruit, then claiming they have a good track record in providing NHS care and picking up lots of national contracts as a result. The problem is that GPs may get left with the more difficult high hanging fruit to be provided for hard to reach groups. This may give the perception that GPs are not being as successful as the private sector.

Judith Lindeck, general practitioner, Cambridgeshire

To this grass roots general practitioner, the revised health bill is as unclear as the original, while promising yet more bureaucracy.

I am pleased to see the removal of “promoting competition” from Monitor's role. Personally I feel abandoning the purchaser-provider split would save a huge amount of money; all parts of the NHS should work together to improve patient care. At present, it feels as though the main aim of secondary care is to squeeze as much money from primary care as it can. Often the local provider obstructs commissioning of new community based pathways lest it lose money. Our local secondary care trust is effectively a monopoly, hence has considerable power.

With these changes, primary care trusts and strategic health authorities could be swept away before all consortiums are up and running. How many good administrators will leave during this period of instability? Many have already gone; in our area, one commissioning group has already gone live and is sucking up resources, destabilising services needed by other practices. This effectively creates a two tier system, something the government said it aims to prevent.

The paper states that no GPs will be compelled to get involved in running consortiums. However, as all practices must be

involved, all will have to cover while a partner represents the practice at meetings. Everyone else will have to pick up the work, and my major concern—that with a more part time work force there won't be the capacity to do the work—is not addressed. It seems that if a consortium isn't ready the central NHS Commissioning Board takes charge. In this situation, could local needs really be taken into account?

Allyson M Pollock, professor of public health research and policy, Barts and The London School of Medicine and Dentistry

The NHS Future Forum report and the government response signal that the policy of switching to mixed funding and insurance pools and further privatisation of care is unabated.^{1 2}

Redistribution underpins the 1946 NHS Act and the secretary of state's duty to secure and provide comprehensive care. If redistribution had been central to the Future Forum's concerns it would have highlighted how the NHS and Social Care Bill will allow commissioners (purchasers of health care or insurers) to pick and choose patients and services, introduce user charges, and promote private health insurance by entering into joint ventures with private companies and equity investors. It would then have argued for the restoration of the 1946 duty to secure and provide comprehensive care and the mechanisms that this requires—namely, administrative tiers covering geographical populations; services integrated into the administrative structures; the abolition of billing, invoicing, and market transaction costs; and the denial of care by patient selection.

It did none of those. Instead Monitor, the health service regulator originally charged with promoting competition, is retained. Government assurances that market reforms do not change “the application” of EU law are unchallenged—the secretary of state was not required to publish his legal opinion on whether the NHS comes under the jurisdiction of the European Union, which sets the rules for markets.

And the forum is silent on how primary care trusts, in advance of their abolition in 2013, are closing NHS hospitals and services and drawing up lists of services that will no longer be provided by the NHS. It recommends that clinicians and nurses be given a new “right to provide” and start-up funds to try their hand at turning tax funds into profits. It proposes a right to challenge, which it describes as “new powers to help communities save local facilities and services threatened with closure, and gives communities the right to bid to take over local state-run services.” The report and the government's response heralds a return to pre-1948 arrangements of inequitable provision and funding and a return to fear.

Martin Roland, professor of health services research, University of Cambridge

I qualified 35 years ago. Maybe I was young and naive, but I remember being proud that we had the best healthcare system in the world. With the proposed changes to the NHS reforms, I think we are moving towards a model that we can again be proud of.

GPs will retain a large measure of control over commissioning. This will harness their enthusiasm and entrepreneurialism but

they will not be free agents. Commissioning groups will have at least one specialist and one nurse member on their board (not from local providers), and lay members will have an important voice. Commissioning boards will also have to listen to local “clinical senates” on which a wide range of disciplines will be represented. This all sounds like a good compromise.

The risk of a market producing fragmented care has been reduced. Clinical commissioning groups will have a “duty to promote integrated health and social care,” clinical senates will include experts “to support better integration of services,” and Monitor (previously solely an economic regulator) will be required to “support the delivery of integrated services” where this improves care or efficiency. So although there will still be an emphasis on patient choice, the risks of an unfettered market in healthcare have been reduced.

The speed of change will be slowed down, giving some prospect that the new model might get the five to 10 years that it will need to bed-in. Several important areas remain unclear. Proposed changes to medical education had few supporters and will be rethought. It is also unclear how public health will sit in the new NHS. However, overall, we now have an imaginative approach to organising healthcare that might just make the NHS the envy of the world once more.

Peter Watts, chief executive, The Practice (runs 60 general practices across England, employing 220 doctors)

There is massive scope for increased efficiency in the NHS. One example is outpatient clinics; you hear of patients making multiple visits to a hospital before they eventually get to see an appropriately trained senior specialist instead of a more junior clinician. It is nearly always more beneficial for a patient to be referred to a specialist who is appropriately experienced and for that person to be seen in a primary care setting, closer to a patient's home and outside of an acute environment. Not only is this more cost effective, it relieves pressure on hospitals and, more importantly, patients prefer it.

The NHS is an excellent model, but it is not a religion; there isn't just one way to provide healthcare.

I'd say to clinicians, don't try to do it all yourself. As professionals they need to do their day job and what they were trained to do; clinicians to do the medicine, not the information technology, European law, finance, etc.

GPs and all NHS providers should not be fearful of competition but embrace it in order to sustain the health ecosystem and drive standards. Integration is key to delivering 21st century healthcare—but integration and competition aren't mutually exclusive—they can and do sit successfully side by side. This is why data gathering, data interpretation, and data sharing is fundamental to the success of The Practice and future healthcare in the UK.

- 1 NHS Future Forum. Recommendations to government. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443
- 2 Department of Health. Government response to the NHS Future Forum report. London Department of Health 2011. Available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127578.pdf
- 3 Oxman A, Bjorndal A, Becerra-Posada F, Gibson M, Gonzalez Block M, Haines A, et al. A framework for mandatory impact evaluation to ensure well informed public policy decisions. *Lancet* 2010;375:427-31.

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