Health and Social Care Bill: what concerns remain?

- The White Paper ‘Equity and Excellence: Liberating the NHS’ was published on 12 July 2010.
- The Health and Social Care Bill was published on 19 January 2011.
- The proposed “reforms” to the NHS have drawn widespread criticism from doctors, nurses health service managers and academics.
- In March 2011 Liberal Democrat Conference clearly expressed disagreement with many of its provisions and likely effects.
- In May and June the government engaged in a ‘listening exercise’.
- Over 1,000 amendments have been made to the Bill.
- Widespread concerns remain.
- It is expected that more amendments will be suggested by the house of Lords.
- My view is that the most constructive way forward would be to withdraw the current bill and address afresh the issues of how best to deliver an effective, efficient and integrated healthcare system for the next twenty years.
- I have, nevertheless, prepared this paper in response to a request from our minister.

Charles West

Background.

The NHS is a large organisation and is responsible for spending a great deal of taxpayers money. By international comparators it delivers a high quality and responsive service and good value for money. Unlike many insurance-based health services, it provides care, free at the point of need and is a universal system, covering every citizen, irrespective of ability to pay.

The NHS was born in a time of austerity.

Andrew Lansley's proposals for the NHS like those of Blair's New Labour from which they are derived were born at a time of financial 'boom' and are based on unqualified faith in markets and their deregulation.

The events of 2008 have shown that markets are not infallible.

The original Bevan ideal was that

"The NHS was created not merely to provide services for the sick but to make a healthy nation, so that services would not depend on the financial resources of the individuals but rather pool the nation's resources to cover all kinds of care"

The NHS is also highly cherished by the people of this country. Some aspects of care in the NHS have improved in the last ten years, but there are undoubtedly areas where the NHS could improve both in efficiency and in eliminating areas of poor care. It behoves politicians of all sorts to consider how best the service can be delivered now and into the future.

PCTs have been criticised for taking on too many tasks, becoming over bureaucratic and ignoring local professional advice. Many PCTs have marginalised the Professional Executive Committee (PEC) such that this clearly no longer has any executive function, and some have removed the medical director from the main board of the PCT. PCTs have often failed to develop joint strategies, or joint working relationships with Local Authorities and local scrutiny arrangements have been less than satisfactory.

These issues could have been readily addressed with little disruption. The input of clinical professions, particularly GPs into the commissioning process could have been increased by giving the PEC increased authority, the PCTs could have been obliged to have a Medical Director on the main board, and a clearer role could have been set for the involvement of locally elected representatives.

Even now, although many changes have been implemented in advance of legislation it would in my view be perfectly practicable to abandon the current proposals and work up an alternative plan that would allow incremental change along the lines above. What the NHS does not need at this time is a major and disruptive change, more so now that we are entering serious financial crises. To undergo such organisational change of the systems and structures of the NHS at the same time as requiring £20 billion savings, could be considered foolhardy or even immoral – placing patients at risk. At a time when so

much attention is being paid to deficit reduction it is difficult to see how ministers can justify imposing radical and disruptive change on the NHS which is likely to cost £3bn and bring ongoing increases in the costs of delivering healthcare.

General practitioners have shown little enthusiasm for commissioning in the past (with for example only 50% of GPs embracing Fundholding in 5 years of operation, and few still engaging in GP commissioning, locality commissioning or practice based commissioning).

In the current atmosphere involving confusion and lack of trust, where repeated modifications of an already over-complex bill look likely to increase, rather than reduce, the layers of bureaucracy and where numerous issues risk being overlooked I believe that the most satisfactory outcome would be to abandon the current Health and Social Care Bill, instead focussing on making the current systems safe and allowing local areas to develop integrated, population based health services.

However, I have been asked by our Health Minister if I would summarise my remaining concerns, and if possible prioritise them.

I have chosen to adopt a different approach from that which has been employed by those of us who have sought to modify the Bill over the last five months. Instead of offering a 'shopping list' or a 'box of sticking plasters' in the form of specific amendments I have outlined my major areas of concern. These I have outlined in the five numbered sections that follow. For each area of concern I have also offered as bullet points some possible ways in which these concerns might be addressed. These are not meant to be exhaustive or prescriptive.

1. The duty of a doctor.

The GMC booklet 'Good Medical Practice' requires that a doctor "Must make the care of your patient your first concern". (see box p.6)

Most doctors, I believe do just that, and that is one of the reasons that the medical profession is so trusted.

However, at the margins almost everyone to some extent and some people to a major extent, will be motivated by other things including money. It makes sense to design a system so that there is the minimal risk of a conflict of interest for the doctor. One of the reasons that the NHS GP is both cost effective and well trusted is that there is no incentive to over-treat or over-investigate the patient.[1] In fee for service systems, such as are present in the majority of countries and is present in private consultations outside the NHS, there is an inbuilt incentive for the person providing the service to suggest further or prolonged treatment. A recent paper analysed the number of scanning investigations requested by US doctors who had a financial interest in a scanner. It found a marked increase in the number of scans requested by such doctors with no commensurate improvement in outcomes for patients.

There are risks for patients and for the NHS if there is any possibility of doctors being influenced in their commissioning decisions by personal financial gain. Despite suggested safeguards such as requiring the declaration of interest, and application of Nolan principles to the behaviour of Clinical Commissioning Groups (CCG) it will be impossible to eradicate this risk. It was claimed that the moneys given to Practices under the GP Fundholding scheme were held separately from money that was the legitimate income for the Practice. In fact this separation was not watertight, and GP fundholders were able to gain financially from fundholding funds.

Even more serious for protecting the interests of patients and maintaining patient trust is the risk of doctors coming under financial pressure to withhold treatment that the patient needs. The current proposal for implementing the Quality Premium is that Practices have 15% of Practice income withheld and they are able to recoup that lost income by meeting certain

Aesculapius *

quality targets set by the CCG. Despite claims that this will be paid on the basis of quality and outcomes, there is no robust method of doing this. Outcome measures such as survival in cancer or heart attack, or successful mobilisation and lack of complication after hip replacement may take years to measure and are potentially subject to multiple confounding factors. The CCG will need some in-year measure to justify returning the lost income to Practices. However, such considerations may become irrelevant, as the Quality Premium will not be paid if the CCG is not staying within its budget. As many PCTs are already subject to financial pressures, and as we know that the NHS is already going to be subject to severe financial constraints in the next ten or twenty years (demographic changes, above inflation rises in drug costs, new medical technology and techniques all exacerbated by the outgoing Labour government's £20bn savings target) it is likely that many CCGs will be threatening to withhold the Quality Premium, unless Practices reduce referral or treatment.

To a certain extent this is already happening – with GPs in some areas being forced to use Referral-management systems, such that a third party will have access to confidential

patient information and be able to refuse the referral. The model described being similar to those used by the American Health Maintenance Organisations

In these organisations quality is not improved, far from it.

"A series of perverse economic incentives were instituted from top to bottom so as to seriously compromise the independent clinical judgments of physicians and other health professionals and often to turn the pocket-book allegiance of the health care servers against the interests of their patients, as with gag rules, bonuses for not referring and the like.

"The HMO and its deepening swamp of commercialism over service, of profiteering over professionalism, of denial or rationing of care where such care is critically needed, of depersonalization of intensely personal kinds of relationships, are all accruing and spreading without sufficient disclosure, accountability and structurally responsibility before the damage to life and health is done." [2]

A cynic might suggest that this is in the interests of the Government, as it puts a downward pressure on NHS expenditure. I would hope that no thoughtful and conscientious government would genuinely believe that it is in the interests of the government, the country, the NHS or the patient deliberately to undermine the high quality treatment of patients.

It follows therefore, that it is generally not good practice, and is probably incompatible with the promotion of ethical medical practice to make practising doctors directly responsible for the budgets allocated for patient treatment. The most stark and clear example of why this is unethical is demonstrated by the way prison medical officers were paid in the 19th Century. Prison doctors were given a single allocation of finance which was intended to cover both the doctors own remuneration and the costs of all treatment for the prisoners. It will not come as a surprise that patients were frequently under-treated or completely neglected. The doctor who determines a patient's healthcare needs should not hold the purse used to buy that care.

Another of the duties of a doctor required by the GMC is to respect patients' right to confidentiality. The Chief Executive of the GMC recently emphasised the importance of this saying "Patient confidentiality is all."[3] However, paragraph 249 of the Health and Social Care Bill establishes a corporate body known as the Information Centre. Paragraph 255 (1) a) and b) then makes it law that doctors will have to reveal "any information" that this Information Centre requests of them. This will introduce a further unacceptable conflict of interests for GPs.

- In the current context, therefore, GPs should not be in charge of CCG budgets. CCGs or PCTs should be required to have a Professional Executive committee (PEC), a statutory obligation to take the advice of the PEC and have a medical director as a full member of the board.
- The Quality Premium should not be introduced. There are better ways of encouraging best practice among medical practitioners. Removing 15% of Practice income will simply produce resentment and allowing practices to earn it back under certain circumstances will encourage 'gaming'.
- Doctors should not be obliged by law to reveal confidential patient data to the Information Centre.

"..... the health of my patient will be my Number One consideration."
from Declaration of Geneva by the World Medical Association

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
    - Keep your professional knowledge and skills up to date
    - Recognise and work within the limits of your competence
    - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
    - Treat patients politely and considerately
    - Respect patients' right to confidentiality
- Work in partnership with patients
    - Listen to patients and respond to their concerns and preferences
    - Give patients the information they want or need in a way they can understand
    - Respect patients' right to reach decisions with you about their treatment and care
    - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
    - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
    - Never discriminate unfairly against patients or colleagues
    - Never abuse your patients' trust in you or the public's trust in the profession.

Duties of a Doctor: G.M.C.

Who then should commission?

GP generally do not have the time, skills or inclination to get deeply involved in the process of commissioning. The greater involvement of GPs in the health care planning process is to be welcomed, but for the reasons above it is neither likely nor desirable that GPs should be doing it all. Neither is it acceptable that private, for profit corporate companies or Consultancies should take over the commissioning function. The potential for conflict of interest and the lack of public accountability would make this unacceptable.

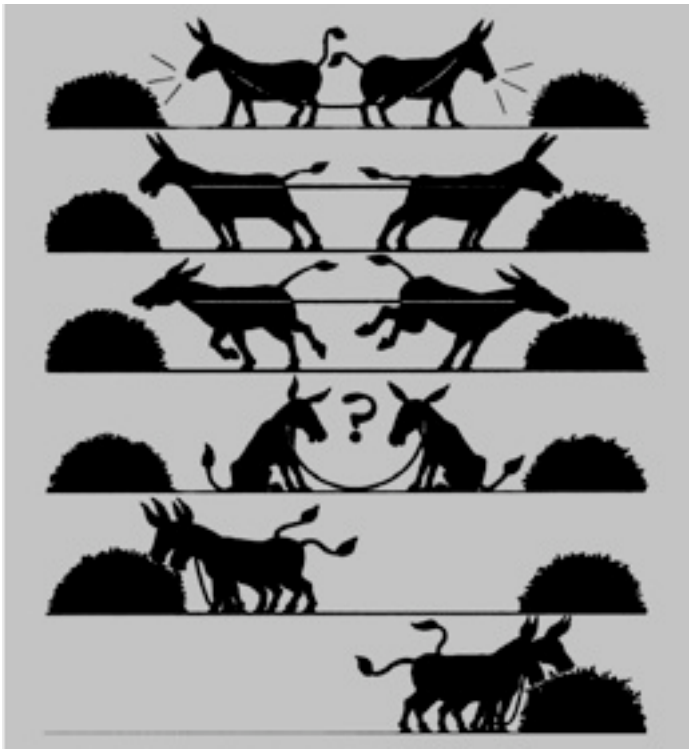
The body that does the commissioning should remain a public body.

The ideal solution would have been that PCTs, preferably slimmed down and with many functions removed, should continue the commissioning function subject to the oversight and input of a professional executive committee. It may be too late for such a solution to be based on the full complement of current PCTs, though many feel that the PCT clusters would be ideally placed to fulfil this role.

There remain concerns that commissioning may be subcontracted to private companies or consultancies. Ministers have sought to offer reassurance that this would not be permitted but unfortunately the use of the ambiguous word ‘responsible’ as in “CCGs as public bodies will remain responsible for commissioning decisions” has fed anxieties rather than giving reassurance. It is theoretically possible under such arrangements for the CCG to exert a purely nominal function, meeting from time to time to rubber stamp actions and decisions taken by a subcontractor that meets in private and is not open and accountable in the way that is the norm for public bodies.

- The commissioning function should remain explicitly a public function carried out by a public body.

2. Competition and Choice.



Cooperation is better than competition

Choice between NHS providers is not new. From the inception of the NHS until Kenneth Clarke introduced the 'Internal Market' under the Thatcher government, GPs could refer to any hospital in the country. I myself referred straight-forward surgery such as hernias or gall stones to a hospital in London[4] where one of my Partners in the Practice had a contact. I would also, from time to time refer a patient to a specialist in another part of the country either because the patient had relatives in that area, or because the specialist concerned was known to have special expertise in the condition. Note, that we only referred when we had some knowledge of the service to which we were referring.

The introduction of the Internal Market introduced constraints on referral, as GPs were generally only able to refer to those services where the PCT had a contract. If one wished to make a referral elsewhere that had to be negotiated separately as an "extra-contractual referral" and significant financial and administrative hurdles were set in the way.

"Choose and Book" was part of Tony Blair's naive idea that a National Programme for IT in the NHS could solve all the NHS's problems. It was not something that either GPs or hospitals were clamouring for, and is still used more in theory than practice. There are a number of practical problems around the IT, and the actual availability of appointments, but the fundamental problem remains that a GP cannot advise his or her patient about whether to get Mr 'X' or Mr 'Y' to do their operation if the GP has no knowledge of the surgeons concerned. The vast majority of patients still ask their doctor to refer them to the local hospital.

It has been claimed that competition between hospitals is associated with improved outcomes. However the studies often quoted are subject to confounding by a background increase in survival.[5] MINAP and the National Service Frameworks have been associated with a marked improvement in survival from myocardial infarction throughout the country, regardless of whether there is local competition or not. Even Simon Stevens, who has a strong vested interest in promoting a competitive market including private sector providers acknowledges that:

"Competition is not a silver bullet. Strong professionalism, greater performance transparency, sophisticated commissioning, and more rigourous independent regulation are also needed—as recent failures at care homes and at Mid-Staffordshire hospital graphically demonstrate." [6]

Other commentators have said:

"Like blood, health care is too precious, intimate and corruptible to entrust to the market" [7]

and:

"There is no health care no 'private, competitive market' of the form described in the economic text books, anywhere in the world. There never has been, and inherent characteristics of health and health care make it impossible that there ever could be……..

International experience over the past 40 years has demonstrated that greater reliance on the market is associated with inferior systems performance, inequity, inefficiency, higher cost and public dissatisfaction" [8]

Prof. Alan Maynard sums up the debate:

"*Competition is like medicine: if carefully regulated and evidence based it can be very beneficial. If poorly regulated and mere evidence free wheezes, a speciality of successive governments, it can undermine patient well being and inflate costs to taxpayers. The example of poor design and regulation of rail privatisation is a good example of how to inflate operating costs 30% higher than continental Europe and reduce quality!*

The crucial question is not whether competition in healthcare works, it does, but what is the relative cost effectiveness of competition policies such as QIPP, Foundation Trusts, Payment by Results and new contracts for GPs and consultants? All these policies aimed to enhance productivity by using comparative data and by getting providers to compete. Evaluation of the effectiveness of these policies is poor and evidence of cost effectiveness is absent."[9]

In contrast to the variable, weak or absent evidence of benefit from competition there are some inescapable facts.

Choice and competition are only possible where there are multiple providers of the same service. Duplication of provision increases costs due to the loss of economies of scale. In the less densely populated parts of the country it is impossible at any price. Economists have calculated that there must be at least 20% excess capacity to allow choice – a waste of resources as services and staff lie idle.

Choosing between multiple providers increases transaction costs, even if the choice of provider is not the subject to questioning, complaint or litigation.

The provision of choice or competition can be enabled by a managed market with providers competing for contracts which are awarded to a number of providers of each service, or by the concept of 'any willing provider' ('any qualified provider'). A managed market may limit the number of providers of a given service subject to there being enough different providers to ensure choice or competition. Using 'any willing provider' will potentially allow a number of providers to compete in the market, limited only by the ability of providers to make a profit.

In a market open to 'any willing provider' there will be more providers willing, able and qualified to perform simpler tasks, and fewer able to perform more complex tasks or care for complex patients.

Competition is the antithesis of, and incompatible with co-operation and collaboration. Co-operation brings significant benefits to the NHS and its patients. It facilitates the sharing of best practice and the acquisition of skills associated with the latest techniques. It encourages clinicians to hand on to colleagues cases for whom they are unable to provide the best possible care. It enables complex cases to be shared by a number of different clinicians who can each bring different skills to the overall care plan. This is well illustrated by the routine use of multidisciplinary teams in the care of cancer patients and is also necessary in rare and complex cases, but is increasingly necessary also in the care of our ageing population where multiple co-morbidity is becoming the norm rather than the exception. Co-operation also encourages the sharing of data and test results, saving the NHS money, and the patient both time, and the risks associated with exposure to multiple radiological investigations.

Co-operation has also been the hallmark of quality improvement programmes such as those in cardiological and cardiac surgical practice. Even though these programmes have an element of competition, it is competition based not on a desire to steal patients from a rival, but on a healthy rivalry between peers who wish to know that their own performance compares favourably with the best in class.

The question of co-operation leads on to the subject of clinical linkages.

The provision of high quality medical services requires that different specialties have close relationships. Some are more obvious than others, but some important links are indicated in the box on the next page.

Important links include:

Obstetrics and Gynaecology,
Obstetrics and paediatrics,
Gynaecology and General Surgery,
Paediatrics and Head and Neck surgery,
Head and Neck surgery and ITU
Head and Neck surgery and Radiotherapy,
Trauma and ITU,
Trauma and orthopaedics,
General Surgery and ITU,
Gynaecology and Radiotherapy.

In addition it is important for teaching that learners have access to all these specialties and others. The charging of a financial levy on providers who do not teach only goes part way to ensuring the provision of a teaching establishment. The teaching hospital must have an adequate caseload to provide suitable experience for the learner. This was starkly demonstrated by the removal of cataract surgery from Oxford's main NHS hospital when the contract for cataract surgery was given to an Independent Sector Treatment Centre. The Ophthalmology department in the NHS hospital was faced with the problem of how to teach the next generation of eye surgeons to remove a cataract when there were no such operations being performed in the hospital.

- Choice or competition should not be offered if doing so would jeopardise the provision of an integrated and coordinated service.
- Choice or competition should not be offered if doing so would jeopardise the provision of both funding and an environment for teaching.
- Choice or competition should not be offered in preference to the provision of a comprehensive service to all patients including the elderly, the less mobile, and those living in less densely populated parts of the country.
- Choice and Competition need to be managed in such a way as to ensure that services in any given area or sector do not become fragmented, and that one fully integrated and coordinated provider remains viable.
- Common standards of performing and recording laboratory and X-ray investigations should be required, and these and basic data including ICD 10, OPCS 4, or SnowmedCT codes for treatment episodes should be shared between providers either directly, or via an intermediary.

3. Privatisation.

The concerns about fragmentation and competition in the previous section apply whether the providers concerned are part of the mainstream NHS provision, or independent providers; and if independent providers, they apply whether those providers are charitable, third sector, not for profit companies, or private companies.

There are, however, some additional concerns that apply to the use of independent providers, and some that apply particularly to 'for profit' companies.

Many of those promoting the 'brave new world' of multiple competing providers fail to take adequate cognisance of the cultural heritage of the NHS. A whole generation has grown up since Margaret Thatcher's interview with Woman's Own when she famously said "There is no such thing as Society". A generation when the laudable aims of self-reliance and ambition have turned to self-centredness, acquisitiveness and materialism. Nevertheless, the NHS continues to be strongly served by a culture of public service and the vast majority of its staff are motivated by the aim to do a good job, to deliver the best possible service and to look after the patient. Those who assume that NHS staff are best motivated by bonuses and performance-related pay grossly misunderstand the culture of the NHS. Many of the comments about competition and collaboration in the previous section apply at the micro-level between individual workers in the NHS. It is possible for individual workers in an organisation to live by a culture of helping out a colleague who is under pressure, or conversely to concentrate only on their own work-load and ensuring that they only do work for which they will get the credit.

Many of the Labour Government's attempts to micro-manage the NHS with targets and performance payments have had a deleterious impact on the overall quality of care. If a chief executive knows that his future depends on the ability of his hospital to make sure that no-one stays on a trolley in the Accident and Emergency Department for more than fours hours, then he is likely to ensure that long trolley waits are eliminated, and this may well be achieved at the cost of delivering a poorer quality service, moving patients around, discharging patients before they are ready, failing to do necessary tests or even making incorrect diagnoses. The Stafford Hospital experience shows amongst other things what happens when a hospital focusses on the financial rigours of becoming Foundation Trust at the expense of providing good medical care.

After the Wall St crash

Some of these cultural arguments are difficult to define, though that does not make them trivial. What is certain, however, is that independent companies live or die by 'the bottom line'. Equally clear is that 'for-profit' companies must take money out of the business to pay shareholders. Focussing on the 'bottom line' and profitability of a company does not necessarily eliminate other values, but observers of the corporate world, can point to innumerable examples of activities that are at best irrelevant and typically diminish or damage the actual performance and value for money that is delivered by the organisation. These might include: mergers and de-mergers, the payment of high salaries and bonuses to executives, expenditure on lobbying and promotion, including the employment of politicians and ex-politicians as so-called consultants or directors, and 'clever' financial games such as sale and lease-back and asset stripping.

It is interesting that the single word 'privatisation' rings more alarm bells with the general public than any other aspect of the current proposals for the NHS. Much of this, I suspect is associated with a deep suspicion that the public have of both politicians and large corporate organisations. In recent years bankers have vied with politicians to be the group least trusted by the public. We talk of Nolan principles and attempting to limit the problems of commissioners or individual doctors with vested interests, how much more worrying is the string of politicians past and present who have close ties with, and have gained financially from an association with an organisations that serves or sells to the NHS. I shall not name individual politicians, but I shall mention one egregious example of a company whose behaviour is hardly inspiring of confidence. The American multinational United Health has been awarded contracts to the NHS. They are involved in both commissioning and providing, which raises an obvious conflict of interest. They pay $ millions on lobbying politicians, spent further millions to settle charges of defrauding health insurance organisations and took on Tony Blair's special adviser on health as a chief executive.

Given this background it is not surprising that the public are deeply suspicious of politicians who might be seen to be privatising the NHS.

Ministers have denied the intention to privatise, saying that the NHS will remain free at the point of use. This rather curious definition of privatisation is not recognised by the World Health Organisation. There are five more widely recognised features of privatisation, all present in the current proposals.[10]

The NHS has for decades, and arguably, since its inception been a mixed economy of direct provision services bought in from the private sector. There are a number of features of the present proposals that seem to separate it from previous behaviour. I clearly do not know what the long-term aspirations that Messrs Lansley and Cameron have for the NHS, but concerns include the altered duties of the Secretary of State, the removal of the private patient cap, and the ability to transfer assets including land to non-NHS providers.

Much has been said and written about the duties of the Secretary of State. You will know that these are referred to in schedule 1.1, 1.2, and 3.1 of the 2006 Act. The stubborn refusal of the DH negotiators to re-instate the previous wording, and the disingenuous attempt to

pretend that the wording had been restored when in fact only one of the three clauses had been restored was bound to feed suspicion. There is fear that one objective is for the NHS to cease to be a provider of healthcare and to become as Mark Britnell said an insurer. The removal of the duties of the Secretary of State, is compounded by the hands-off clause and the removal of his/her powers to delegate these powers to or direct NHS bodies to fulfil these duties suggests that in the future the Secretary of State may neither be obliged, to, nor indeed able to play any active part in guaranteeing a comprehensive health service to the people of England. This concern combined with the power of CCGs to determine what care is appropriate for their registered population suggest that another unstated objective of the Lansley proposals is to allow the NHS to withdraw certain services piecemeal and in different parts of the country, so that over time, the NHS becomes an insurer of last resort, and only offers to pay for basic services with an increasing requirement for

individuals to take out top-up insurance to pay for other medical care.

Given the previously mentioned financial pressures on health services in all developed countries, the fact that this re-organisation is likely to cost between £1bn and £3bn, and that ongoing transaction and administration costs are likely to be increased, the suspicion must remain that the only way that Lansley's proposals could help to control healthcare spending is by reducing the services provided or bought by the NHS.

The transfer of assets including land from the NHS to other providers and to sell land increase anxieties further. There are memories of previous governments 'selling off the family silver'. There are fears that we may be engaged in a one-way journey towards private or independent provision. There are anxieties that 'clever' providers could engage in sale and leaseback arrangements for land such as the one that caused Southern Cross much difficulty; after all in some ways the Private Finance initiative (PFI) could be seen as an expensive sale and leaseback arrangement. The assertion that only land surplus to requirements could be sold, does not reassure. It is easy for organisations to take an unfortunately short-term view and what is surplus to requirements today, might prove very useful tomorrow. There are already examples of land sales in one area being followed shortly afterwards by an inability of the local hospital to expand through lack of capital or land.

- The duties of the secretary of State should be restored to include the option of providing care, so "secure or provide".
- Clause 4, the 'hands off clause', should be removed.
- Any NHS assets made available for the use of independent providers should remain in the ownership of the NHS, and a rent or capital charge paid to the NHS for the use of those assets.
- Monitor should retain the power to limit the private patient income of any NHS hospital. This power could be a reserve power, and could be decided by monitor on a case by case basis.
- There should be a clear mechanisms for the establishment of a new service directly provided by the NHS, as and when that should be necessary to achieve a balanced, and coordinated service for all patients.
- Ministers should give an undertaking not to accept donations, gifts, inducements or offers of consultancy or employment from any company associated with healthcare provision while serving as a government minister and for a five year period after leaving government.

4. Democratic accountability.

The NHS is responsible for spending a great deal of public money. It needs to be accountable to democratically elected politicians. Both the Liberal Democrat manifesto and the coalition programme promised increased democratic accountability. The current proposals do not deliver democratic accountability. Health Overview and Scrutiny Committees tend to be somewhat limited in time and experience, but they do consist predominantly of elected representatives. It is unclear how Health and Well-being Boards will function. Patient representative groups have suffered even more than the NHS management structures by the constant reorganisations imposed on the NHS. 'Community Health Councils' were replaced by 'Patient and Public Involvement Forums' which in turn were replaced by 'Links'

and are now to be replaced by 'Healthwatch'. The remit, organisation and composition of each of these bodies has been different. It is known that NHS management suffers about three years of disruption, planning inertia and lost opportunities each time it is re-organised while senior managers look to their own futures, and either leave the NHS or shuffle around applying for jobs in the new structure. The members of patient representative bodies are predominantly volunteers and it seems to take even longer for them to develop a useful scrutiny function. Links groups are only now developing into their role.

For effective local accountability there needs to be a visible and comprehensible relationship between a local population and the organisations providing healthcare. The most straight forward way for this to be delivered is for CCGs to be coterminous with Local Authorities. There is a natural tension between this objective and the principle of allowing groups of general practices to cluster together to determine what they feel to be the needs of their patients. The present assumption that CCGs will indeed be coterminous with Local Authorities is welcome, but further consideration needs to be given to those situations where the local clinicians seek to have smaller CCGs. There is a risk that some members of the public, such as those without a permanent address, those not registered with a GP or those moving around the country for whatever reason may be denied treatment. There is a concern that a small CCG may attract or select certain groups or types of patient that are easier or cheaper to treat, thus destabilising the balance of service and funding. With the abolition of Practice boundaries it will be possible for Practices to 'cherry-pick' patients. If CCGs are only responsible for the patients registered with their constituent practices then in effect the CCG is also 'cherry-picking'. There has been experience of this happening in Holland.

- CCGs should generally be coterminous with Local Authorities.
- Where CCGs are not coterminous with Local Authorities more work is needed to ensure that everyone has fair access to a comprehensive healthcare service.
- CCGs must provide health care to a geographically defined population and not be allowed to develop piece meal.
- In the event of disagreement over commissioning decisions local elected representatives should have the right of appeal to the national democratic representative i.e. the Secretary of state. It is not satisfactory that the ultimate authority is the National Commissioning Board. That would be to risk having decisions made locally by unaccountable bodies, subsequently endorsed nationally by another unaccountable body.
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5. Public Health.

There is merit in moving Public Health back to Local Authorities.
However, the government proposes that Local Authorities will have responsibility for all three domains of public health: health: improvement, health protection and health
services. This proposal seems to overlook the need for good links between Public Health and healthcare deliverers. Much of Public Health is delivered through the NHS. Epidemic control and major incident planning cannot be delivered without good links to NHS healthcare deliverers. The response to a major incident will need to have access to a large number and wide range of medical facilities. This will be much more difficult if resources are spread across a number of different providers.
Directors of Public Health need proper authority and a guarantee of independence, as they may need to speak out on behalf of their populations at times and in ways that the Local Authority may not like.
Public Health England also needs to have clear independence and authority.

- Directors of Public Health should have formal accreditation.
- Directors of Public Health need to have a degree of authority and autonomy, either by being directly employed by Public Health England, or by giving them a status akin to that of the Section 151 officer.
- More consideration needs to be given to the links between the DPH and NHS providers.

Cadduceus photo by Jim Kuhn
Asklepios, from his sanctuary at Epidauros. Photo E. Brundige 2005.

[1] For many years GP remuneration consisted of approximately equal parts 'Basic Practice Allowance' a fee for being there, intended to cover some of the fixed costs of running a Practice and used as a way of controlling the supply of GPs across the country in line with population needs, 'capitation fees' based on the number of patients on a GP's list, and fee-for service payments for evidence based public health interventions (e.g. immunisations, cervical smears) More recently the fee for service element has been increased by payments made under the Quality and Outcomes Framework. These were initially based on evidence based measures that had well documented links to improved outcomes for patients. They have been adjusted year on year, and are at risk of becoming less relevant as new targets introduced which do not have a similarly robust evidence base.

[2] Ralph Nader in the foreword to "Making a Killing: HMOs and the threat to your health" by Jamie Court and Francis Smith 1999

[3] Niall Dickson speaking on the radio 16th September 2011

[4] London is 150 miles from my Practice.

[5] Cooper Z, Gibbons S, Jones S, McGuire A. Does hospital competition save lives? Evidence from the English NHS patient choice reforms. Econ J

[6] BMJ 2011; 343:d4136

[7] Woodhandler and Himmelstein 1999

[8] Robert Evans – health economist

[9] http://www.bmj.com/content/343/bmj.d4337/reply

[10] Clive Peedell, in BMJ 2011; 342:d2996
(a) Divestiture or outright sale of public sector assets in which the state divests itself of public assets to private owners
(b) Franchising or contracting out to private, for profit, or not for profit providers
(c) Self management, wherein providers are given autonomy to generate and spend resources
(d) Market liberalisation or deregulation to actively promote growth of the private health sector through various incentive mechanisms, and
(e) Withdrawal from state provision, wherein the private sector grows rapidly as a result of the failure on the part of the government to meet the healthcare demands of the people.