> We shouldn't simply use anecdotes as the basis for changing practice, leaving it to others to find actual evidence

NO HOLDS BARRED Margaret McCartney

Miracle diets aren't fair to anyone

In the world of nutrition, "low carb and high fat" diets are a growing trend. Big claims are made, including from doctors, that these can "save your life," "reverse type 2 diabetes," and, of course, help you lose weight. So, should GPs start recommending low carbohydrate diets to people who want to lose weight or who have type 2 diabetes?

Criticism of the status quo is reasonable. By its nature, diet research contains many uncertainties, with few long term randomised controlled trials. But doctors, researchers, and guideline committees can surely aspire to do better.

Many in the low carb lobby have been highly critical of current government dietary guidance. Some legitimately criticise conflicting or weak evidence underpinning some guidelines. But we should be just as critical of the evidence for low carb diets, which should include clear definitions. We must prove that such diets lead to the benefits their proponents claim. We shouldn't simply use anecdotes as the basis for changing practice, leaving it to others to find actual evidence.

For long term weight loss, a 2015 systematic review published in the *Lancet* found that low carb diets were no better than low fat diets. The difference between the two was statistically but surely not clinically significant—an average of 1.15 kg after a year. For type 2 diabetes, a 2011 systematic review found no consistent differences in weight and glycated haemoglobin (HbA_{1c}) between low fat and low carb diets.

Several randomised controlled trials have been reported since then. An Australian trial in 2015 compared low fat and low carb diets, containing the same number of calories, in obese people with type 2 diabetes. Participants were offered fortnightly individual meetings with a dietitian, exercise classes three times a week, and key foods or food vouchers. Both groups lost weight, marginally more in the low carb group, but the difference in HbA_{1c} between the groups did not reach significance.

A 2017 systematic review, meanwhile, found no long term difference between high and low carb diets in glycaemic control, weight, or low density lipoprotein cholesterol. The low carb diet did, however, allow for more people to use less medication: the average improvement was 0.34% lower HbA_{1c}.

None of this negates the experience of people who dedicate themselves to a major dietary change of the low carb type and are successful in the long term. It does mean, however, that there isn't one big, miracle diet fix. A 2013 systematic review found that low carb diets were as good as a Mediterranean diet. The authors concluded that "there may be a range of beneficial dietary options for people with type 2 diabetes."

Surely this is the offer we should make to patients. We need light, not heat. While it's long been known that bariatric surgery may effectively halt type 2 diabetes, the question is whether the same effect can be achieved with diet alone. A study of 11 patients who followed a very low calorie diet for eight weeks showed that fasting glucose returned to non-diabetic levels, but a longer term, larger study is yet to report. And the environment, poverty, inequality, and work all affect what (and how) we eat.

Promising an easy solution in the form of uncertain science isn't fair on anyone. And replacing one set of flawed guidelines with another is not progress.

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com
Follow Margaret on Twitter, @mgtmccartney

Cite this as: *BMJ* 2017;358:j4226

PERSONAL VIEW Matt Morgan

The ward round is broken; let's fix it

Doctors' way of working would not be accepted by businesses making decisions with far less impact

You are the director of a multi-million pound coffee business. The working lives of your employees, not to mention your customers, are dependent on your actions today. Today, you will visit 10 of the lowest performing branches in your business. You will need to decide what is wrong with each branch and, more importantly, what to do about it. You may even need to close a store if the causes of poor performance cannot be rectified.

The method you have chosen to conduct this process is novel. You decide to drive from store to store throughout one morning with little or no prior knowledge of their problems. When you arrive, you plunge into masses of unfiltered, unstructured data. You are shown complex financial reports going back over the past few years, followed by masses of customer comment cards. As you try to synthesise it all, you have frequent interruptions. You do all of this standing in front of all the shareholders, in the middle of the store. Then, 10 minutes later, you announce your decision to increase the strength of the coffee by 10% in all drinks as part of the treatment. You then move on to the next store. By the time you get to the tenth store you are tired, having made at least 200 decisions already that morning. This is known to be the limit of reasonable decision making. Then you do it all again the next day, and the day after, and the day after that.

When viewed through this lens, the way in which decisions are made in medicine seems crazy. First described by the Dutch physician Herman Boerhaave in the 1700s, the ward round was a great innovative concept at the time. With limited amounts of information to process and a small team to communicate with, it was just what patients needed. Today, however, I stand in a busy, noisy, critical care unit, presented with hundreds of pieces of data, surrounded by a multidisciplinary team of 10 people. This is not what patients need.

I stand in a busy, noisy, critical care unit, presented with hundreds of pieces of data. This is not what patients need

Many doctors, including myself and my colleagues, have recognised

ACUTE PERSPECTIVE David Oliver

Junior doctors' working conditions are an urgent priority

A health service is nothing without its clinical workforce. The biggest existential threat to the NHS is a failure to retain existing clinicians or attract enough new ones. This damages morale, burns out those who stay, and compromises care quality.

For junior doctors, the workforce crisis is becoming critical. We must act now to tackle it or reap the consequences for years. The length of training means that there's no reserve of ready replacements. Juniors are a precious human resource that we shouldn't casually alienate or squander. Their intellect, skills, and UK training are eminently exportable—right out of the NHS. Fewer trainees today means fewer GPs or consultants tomorrow, and we are already failing to fill many consultant posts in key specialties.

Junior doctors' intellect, skills, and UK training are eminently exportable—right out of the NHS

Junior doctors suffer from being a transient workforce—they are often only in one hospital or even town for a year at a time—and their concerns all too easy to brush aside. We need to wake up and take those concerns more seriously.

At the end of the foundation programme only a half of doctors are going straight into core or "run-through" training, including GP vocational training. Core training places in much needed specialty stems are increasingly unfilled. There's a knock-on effect of falling recruitment into higher specialist training.

Some doctors stepping out of training programmes may rejoin later and continue an NHS career. Plenty will not. Others will decide against joining the most hard pressed and short staffed specialties (often those the health service needs most) in favour of better training, work-life balance, and work intensity.

We know plenty about what current junior doctors think about their own working lives, the problems they encounter, and the solutions they'd like to see implemented—in their own words, in official reports and surveys, and from social media. In the wake of the 2015-16 dispute over the (ultimately imposed) junior doctor contract, there was a contractual commitment and multi-agency code of conduct to tackle a range of concerns about working conditions.

this. I often arrive early for work, sit down in a comfy chair, in a cool office, with a hot coffee. I review the history of patients using my two screen computer set-up, while writing notes for the ward round on another. I review blood results and contextualise them by speaking to colleagues personally, by phone, and from the confidentiality of my office. I review complex scans while sitting down, and examine them in detail. After this, I move to the ward, prepared and forewarned. We then conduct a multidisciplinary ward round, with the help of a cognitive checklist, and spend time speaking to patients, examining them when appropriate, and communicating with them, family members, and other members of the team. We have time to teach, time to reflect, and time to talk. We finish on time (mostly).

The old concept of the ward round is broken and needs to change. This fact needs to be recognised, researched, and taught. It is surprising that, although I attend a compulsory resuscitation update annually, I have never been taught how to conduct a better ward round. We need technology to support this shift, and spaces where we can sit and review the complexity of patient care. The timetable of the day may need to change to reflect this. Modes of communication need to support, not obstruct, contact. Overall, we need to recognise these issues and move to tackle them. Our way of working would not be accepted by businesses making decisions of far less impact than we, as healthcare professionals, make every day. The ward round is broken, let's fix it.

Matt Morgan is an intensive care consultant
mmorgan@bmj.com
Cite this as: *BMJ* 2017;358:j4390

Is it too much to ask for some potentially quick and low cost wins? NHS employers should be able to ensure adequate access to rest facilities and to food and drink outside daytime hours; give adequate notice of rotas and flexibility in booking leave; minimise long commutes within regions; and ensure that people know their pay rates, that those rates are accurate, and that people don't have to battle over these rates. They should also make reasonable efforts to fill rota gaps. This in turn means continuing to welcome and support overseas medical graduates, ensuring that doctors don't feel bullied into filling the gaps, reducing the burden of repeated mandatory training and induction, and getting IT and logistics working better, to cut down on administrative work. There is also potential to reduce the burden of documentation of competencies in educational e-portfolios and the process of annual review of competence progression.

Such actions rely on better human resources management, on listening to and valuing doctors, and on showing some basic concern for their welfare. With responsibility for crucial actions distributed among many national and regional bodies and employing organisations, it's easy for everyone to pass the buck or bury their heads.

Doing nothing is not an option. Nor is doing something but far too slowly. Without concerted, urgent action, we won't have enough doctors to run viable services.

David Oliver is a consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com
Follow David on Twitter, @mancunianmedic
Cite this as: *BMJ* 2017;358:j4407

BMJ OPINION Florence Wilcock

Helping women navigate uncertainty during pregnancy

Recent reporting of a study on alcohol consumption in pregnancy is typical of the changing instructions faced by women.

From the moment a pregnancy test is positive, a woman is besieged by advice: don't eat or drink this, do eat and drink that. Some of this advice may come from health professionals, but frequently friends, family, and even strangers have something to contribute. The NHS website's catalogue of foods to avoid is daunting. Suddenly, everything a woman consumes is subjected to what may feel like arbitrary rules.

The evolution of evidence means that advice may change between generations or even from one pregnancy to the next.

It is important to recognise that not all published evidence is the same. Most national guidance comments on the "level of evidence"—with an adequately powered randomised controlled trial being the gold standard. The better the quality of evidence, the more weight a study carries when drawing up recommendations.

The NHS website's catalogue of foods to avoid is daunting

Yet in today's world of social media and round the clock news, women access information faster than ever before, regardless of the level of quality. Rapid access to information can be positive—important health advice is disseminated more quickly—but in other instances media outlets can pick and choose headlines that distort findings. This can lead to increased anxiety and uncertainty for women.

Women may arrive at an appointment with questions about evidence before the health professional is even aware of it, making them feel unprepared to have a well informed discussion.

For many years, maternity care has focused on informed choice and tried to shift away from a paternalistic model of care. With the current climate of maternity transformation, and the national ambition for women to receive safe and personalised care, there is increasing emphasis on this approach. It is our responsibility as health professionals to educate women and to help them navigate and understand the impact of their choices. In doing so, we need to be careful to avoid unconscious bias and judgment.

We know that pregnancy is an opportunity. If we can facilitate and educate women, enabling them to take ownership and responsibility for their health and that of their baby, we will provide a valuable service whose benefits last way beyond the nine months of pregnancy.

Florence Wilcock is a consultant obstetrician at Kingston Hospital

ANTIDEPRESSANT CASE

Antidepressants and murder: justice denied

Adshead misses the point of the *Panorama* programme "A Prescription for Murder" (This Week, 5-12 August).

It did not attempt to prove that antidepressants cause homicide or whether sertraline caused Holmes to murder.

The focus was why Holmes's legal team didn't raise these matters. The answer is partly that the literature on selective serotonin reuptake inhibitors is almost entirely ghostwritten, and we don't have access to the data from randomised controlled trials. *The BMJ* and other journals play a part in this situation.

To acquit Holmes, a lawyer must persuade a jury that academics and journals are guilty of breaching the norms of science. Paraphrasing Lord Denning: "Wrongfully convicted prisoners should stay in jail rather than be freed and risk a loss of public confidence in the law."

We must find balance between raising alarms about a drug and ensuring that we do not compromise the right to a fair trial.

David Healy, professor of psychiatry, Bangor

Cite this as: *BMJ* 2017;358:j4196

BURNOUT AMONG DOCTORS

Focus on job related depression instead

The "burnout epidemic" is unsubstantiated (Editorial, 29 July). The prevalence of burnout cannot be estimated because diagnostic criteria do not exist. Estimates rely on categorisation criteria that are clinically and theoretically arbitrary.

Given the overlap of burnout with depression, we might save resources by focusing on job related depression instead. Depressive disorders are diagnosable, and their prevalence can be estimated. Methods for linking depressive symptoms and disorders to work stress are available.

Burnout has sometimes been used as a convenient euphemism for depression. But the (legitimate) concern for illness stigma should not lead researchers and clinicians to overlook the major problems affecting the concept of burnout and to cultivate practices that are methodologically invalid.

Focusing on job related depression might boost research and enable us to protect physicians' health more effectively in the future.

Renzo Bianchi, lecturer and researcher in psychology, Neuchâtel, Switzerland

Cite this as: *BMJ* 2017;358:j4389

LETTER OF THE WEEK

Is a rushed consultation better than none?

GPs are always running late (No Holds Barred, 2 September) because they think they can deal with patients' problems in 10 minutes. They cling to this belief despite years and even decades of experience telling them otherwise.

I struggled to run on time and knew GPs who always finished their surgeries 1-2 hours late. Even if the GP was comfortable with this, their GP partners and patients with later appointments are unlikely to have felt the same. Some loyal patients might put up with this by rationalising that the GP is late because they are willing to give them all the time they need. But for me, running late was only stressful.

I found that the average number of problems presented was 2.4. I became concerned that practising medicine this way was increasingly risky, not just to the patient presenting but to the patient who might be more seriously ill but can't get an appointment.

GPs face a dilemma. Modern complex care needs longer consulting times, but this will mean less availability. Perhaps a rushed consultation is better than none.

GPs who persistently run late should do what I did—start your surgeries 30 minutes early and book a 30 minute break in the middle. If running late, you can catch up. If not, you can have a cup of tea and sign some prescriptions.

Peter J O'Donnell, retired GP, Epsom

Cite this as: *BMJ* 2017;358:j4373

Value of debrief groups for peers

Recognising rising stress in our peers, we started a monthly debrief group for oncology registrars, facilitated by a medically qualified chaplain (SLH).

Topics have been wide ranging, reflecting all three dimensions of burnout—depersonalisation, exhaustion, and professional inefficacy. We have also reflected on the effects of patient complaints while exploring strategies for self care.

Group members completed the Oldenburg burnout inventory, and 80% had scores that were "high to very high." Exhaustion component scores were generally higher than disengagement component scores.

In contrast to Lemaire and Wallace's suggestion that juniors adopt seniors' maladaptive behaviours (Editorial, 29 July), the group has become embedded in our department, and now a consultants' group has been started, tackling challenges unique to this grade.

Peer debrief groups should be established across organisations and should be included in healthcare quality indicators.

Sara V Lightowlers, academic clinical fellow clinical oncology, Cambridge
Mareike K Thompson, academic clinical fellow clinical oncology, Cambridge
Susannah L Hunt, chaplain, Cambridge

Cite this as: *BMJ* 2017;358:j4377

LICENCE TO CHALLENGE

Committees wield too much power

Like Oliver, I'm uneasy with medical committees' assumption that all progress will come through consensus (Acute Perspective, 22 July). Consensus is a commendable way to stabilise established positions but no way to seek ideas.

During 25 years at the General Medical Council I noticed that members of committees that wield real power can sometimes become so engrossed in committee gaming that they lose touch with the purpose for which they were originally convened.

Maybe the honourable course is not to join them but to try to curb committee power.

A possible solution: create enough committees to accommodate the game players, reward them with honours rather than power, and feed them enough paperwork to keep them out of the hair of the unreasonable people whose ideas might lead us to greener pastures.

Michael O'Donnell, retired GP, Loxhill

Cite this as: *BMJ* 2017;358:j4206

OBITUARY

Herbert L Needleman

Identified the long term effects of lead in children

Herbert L Needleman (b 1927; q University of Pennsylvania Medical School 1952), died from pulmonary oedema on 17 July 2017

Herbert Needleman made his greatest contribution to medicine by playing the tooth fairy. His work demonstrating that early exposure to lead caused a lifelong reduction in intelligence and brain function was based on analysis of thousands of "baby teeth" from primary school children, gathered after they came loose.

Lead toxicity and poverty

The knowledge that lead can be toxic is almost as old as use of the metal itself. The focus of medicine had been on acute disease, treatment to lower blood concentrations of lead by reducing exposure, and chelation to draw out the poison. Meanwhile, the scope of unacknowledged subclinical disease increased in industrialised countries in the 20th century, owing to increased use of lead in products such as paint and gasoline.

Needleman saw the effects of acute lead poisoning when he served as chief resident at Children's Hospital of Philadelphia in the 1950s.

Over the years he began to wonder how many of the children who were coming to the low income community clinic were in fact a missed case of lead poisoning. Although concentrations of lead in the blood were not necessarily high, perhaps the damage had occurred earlier in life and then the poison cleared from the blood.

Needleman suspected that past exposure was an important piece of the equation and that signs of that exposure might be found in slow growing tissue. Hair and nails might offer a window to this past exposure, but they also could be contaminated by environmental contact. Bone biopsy would provide a cleaner sample, but that was invasive and difficult to obtain. He settled on sampling "baby teeth," which typically fall out during elementary school years.

The first publication was a brief letter in *Nature*, in 1972. It showed that "The tooth lead levels in the inner city kids were five times what they were in the suburban kids," said Needleman, who by then was teaching at Harvard Medical School. Other papers, more than 80 in all, built on these findings. The most controversial paper came in 1979, in the *New England Journal of Medicine*. It established a link between lead exposure as measured in the teeth, lower IQ, and hyperactivity in the classroom.

Throughout his career Needleman was not content to simply let the data speak for themselves, rather he took the next steps of pushing regulatory agencies to rein in exposure to lead by banning its use in gasoline, reducing environmental contamination in manufacturing processes, and requiring government to implement lead abatement strategies in housing stock it owned or subsidised.

Opposition

Then as now, vested interests that benefited from lead and the status quo employed a panoply of tactics in an attempt to discredit Needleman's findings and his integrity. Those efforts included a lengthy investigation by the University of Pittsburgh that found some minor quibbles with his methods that did not undercut the major findings of the research.

The experience "was absolutely horrible," Needleman said in the 2005 interview. "What I discovered is that not only did the university not come to defend me, but they wouldn't give me an even playing field." It led him to become active in the university tenure and academic freedom committee.

Needleman made his greatest contribution to medicine by playing the tooth fairy

Social justice

Needleman had a profound sense of social justice that manifested itself not only in his research but also in his volunteer work and community involvement. In 1966 he founded the Committee of Responsibility to Save War Burned and War Injured Vietnamese Children, to bring injured children to the US for medical care. He was arrested with fellow paediatrician Benjamin Spock at antiwar protests at the Pentagon in 1967.

He received the John Heinz Award for innovative contributions to the environment in 1996 and used the $250 000 prize to fund the Alliance to End Childhood Lead Poisoning. Other honours included were the Prince Mahidol Award (2003) and the Rachael Carson Award for Integrity (2004) from the Center for Science in the Public Interest.

Herbert L Needleman was born into an immigrant family of pickle makers in Philadelphia, Pennsylvania, on 13 December 1927. He practised medicine as a paediatrician in the US Army and private practice, and taught at Temple University, Harvard Medical School, and the University of Pittsburgh. He leaves his second wife of 54 years, the former Roberta Pizor; two children; seven grandchildren; and three great grandchildren.

Bob Roehr

Cite this as: *BMJ* 2017;358:j3684

ANALYSIS

Are radical changes to health and social care paving the way for fewer services?

Current reforms and radical redesign of the local government finance system may signal the end of the NHS and local government in England as we know them, argue **Allyson M Pollock and colleagues**

Seismic changes in the organisation, delivery, and funding of health and social care services have been under way throughout England since the introduction of the Health and Social Care Act 2012.

One of the act's major changes was to transfer public health responsibilities to local authorities—described as "one of the most significant extensions of local government powers and duties in a generation."[1] The Cities and Local Government Devolution Act 2016 allows further health functions to be devolved to local authorities.[2]

At the same time, NHS England is implementing sustainability and transformation partnerships (STPs) covering 44 geographical "footprints" in England.[3] These have been reported to be required to cut £26bn from health and social care costs over five years.[4] STPs are intended to pool the budgets of health bodies and local authorities for joint commissioning of health and social care services, creating new organisational forms and care models, such as newly proposed accountable care organisations.[5]

The devolution deals and STPs are being presented to the public and health professionals as a way of integrating health and local authority social care. But missing from the picture is their fundamentally different funding bases: social care is a local authority responsibility and subject to means testing and user charges, whereas NHS services are free at the point of delivery.

These changes are taking place while the NHS undergoes the largest sustained reduction in spending as a percentage of gross domestic product (GDP) since 1951,[6] NHS providers have recorded their highest ever deficit,[7] and there has been a 37% real terms reduction in local authority funding from central government grants from 2010 to 2016 (excluding public health and the Better Care Fund),[8] alongside the ongoing radical and regressive reform of local government finance.

How will these changes and reductions in funding affect access to care, equity, and already widening inequalities? Experience from the last major transfer of responsibilities from the NHS to local authorities suggests they are likely to lead to reduced services and entitlements, more private provision of publicly funded services and, potentially, the introduction of charges for health services.

KEY MESSAGES

- STPs, accountable care organisations, devolution deals, joint commissioning of health and social care services, and redesign of the local government finance system are radically changing the NHS and local government in England
- The effect on service provision of the fundamentally different funding bases for health (free at the point of delivery) and social care (means tested) services has been ignored
- People in poorer areas are likely to lose out as funding will depend more on the wealth of local areas and less on the principles of redistribution and need

Effects on services and entitlements

Long stay care was transferred from NHS to local authorities in 1990 under the NHS and Community Care Act. Over the following three decades NHS and local authority provision reduced, private provision increased, and there was a gradual switch to means tested and self funded care as falling government expenditure failed to meet needs.

Contracting out: the blurred distinction between health and social care could see some health services fall out of NHS funding altogether

Although the care in the community policy meant NHS funded beds for geriatric, mental illness, and learning disability care were closing before 1990, closures accelerated after the implementation of the act. NHS long stay beds decreased by 38% from 106 173 in 1992-93 to 65 764 beds in 2002-03 (fig 1). During the same period local government owned long stay beds decreased by 53% from 117 400 beds to 55 600 while the number of private long term care beds increased from 384 900 to 422 200 (see figure, p 492).

Before 1990, local authorities provided most residential care directly. In 1989-90 they supported 129 000 individuals in residential care, 84% of whom were placed in local authority owned residential homes and the remainder in privately owned (for profit and voluntary) homes (fig 2, see bmj.com). But in the 1990s policies that incentivised local authorities to outsource care saw a switch to private provision (fig 2, see bmj.com).[9-11]

Reductions in expenditure and the removal of ring fencing have also affected services and entitlements. Ring fencing of the main central government grant to fund social care expenditure (the Personal Social Service grant) ended in 2010 and since then local authority expenditure on adult social care has decreased in real terms from £18.5bn in 2010 to £17.5bn in 2014 (fig 3, see bmj.com)—these figures include the NHS funds transferred to local authorities for adults with learning difficulties from 2009. Over the same period spending on older people, adults with physical disabilities and mental health needs, and other adult services decreased by 13% from £13.6bn in 2008-09 to £11.9bn (fig 4, see bmj.com). The number of adults receiving non-residential adult social care services fell by 33% between 2008-09 and 2013-14, with the largest decrease for those receiving meals and day care services (fig 5, see bmj.com).

Reduction in expenditure and removal of ring fencing has been closely followed by reduction in services, often achieved by tightening eligibility criteria. For example, in 2005-06, 35% of local authorities funded moderate care needs compared with only 10.5% in 2013-14.[12] A shortfall in funding for adult social care is still predicted,[13] despite piecemeal government announcements in October 2015 and December 2016 to allow limited rises in council tax to pay for care and the March 2017 promise of an additional £2bn from central government up to 2019-20.[14-16]

The effects of reduced expenditure and services are now also being seen in public health services, which moved to local government under the 2012 act. Local authorities are reported to have spent the 2013-14 ring fenced central public health grant on a wide range of services that were previously paid for by council funds as well as public health.[17] The grant was scheduled to be reduced by 9.6% in cash terms over five years to 2020,[18] and the government has announced plans to end the ring fenced central grant and require local authorities to fund public health services though retained business rates.[19] A recent survey of the association of public health directors reported plans for many local authority public health services to be reduced and some decommissioned.[20]

From April 2013 to August 2014, a third of NHS contracts awarded went to the private sector

More private provision of publicly funded services

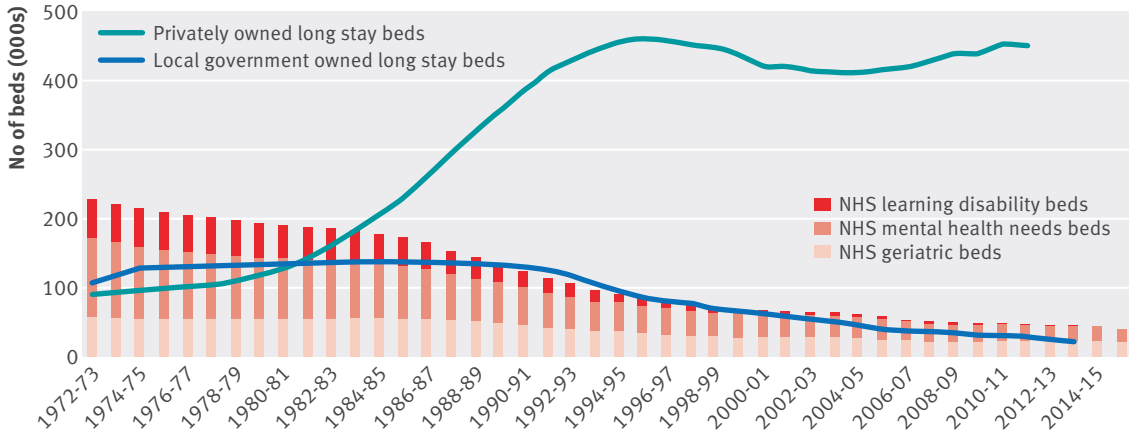
The legal basis for outsourcing health services, including to private providers, flows from abolition in the 2012 act of the secretary of state's duty "to provide throughout England [key health services] to such extent as he considers necessary to meet all reasonable requirements." That duty was replaced with a duty on each of the 207 CCGs to "arrange for provision" of these services for the populations for which they have responsibility. These changes mirror changes to section 2 of the 1948 National Assistance Act when the duty to provide residential accommodation was replaced by a power to arrange that provision. The legal shift from a "duty to provide" to a "duty to arrange provision" is standard legalese for outsourcing.

From April 2013 to August 2014, a third of NHS contracts awarded went to the private sector.[29] The majority (71.3%) of commissioners' spending on non-NHS providers went to private companies in 2015-16, which saw the fastest annual growth in NHS spending (15%) from 2013-14 to 2014-15 (compared with 11% and 6.7% for the voluntary sector and local authorities respectively).[32]

The private health companies' association, the NHS Partners Network, is helping to develop STPs,[33] and on the back of the government's encouragement of "long term partnerships between the NHS and the private sector," 17 private companies have been paid £2.7m to draw up STPs.[16 34]

Potential for user charges

A major concern with the reduction of NHS services is that people will be able to obtain them only if they can pay or have insurance. Financially strapped trusts, particularly in wealthier areas, are well placed to charge, and foundation trusts are allowed to make 49% of their income from outside the NHS. Well positioned trusts have already seen large increases in income generated through charging.[39]



Average daily number of NHS geriatric, mental health needs, and learning disability beds and number of available long term beds by provider, 1972-73 to 2015-16 (data from Health and Social Care Information Centre and LaingBuisson Care of older people UK market report, 27th ed)

The greater involvement of local authorities in health service provision also increases the risk of new charges for what were previously free NHS services. Under the 2012 act the health secretary can impose charges for Public Health England's services but is prohibited from exercising this power to charge individuals receiving those services. However, regulations can be made allowing local authorities to charge individuals for public health services.

At the moment, the regulations for mandatory local authority public health services, which include health checks, open access sexual health services, and child health surveillance, expressly prohibit charging individuals.[40] However, this is because the health secretary chose to impose the prohibition, not because parliament has prevented charging. As local authorities become increasingly squeezed financially, there is a risk that new regulations without the charging prohibition will be enacted.

Demonstrating the potential for charges, in 2013-14, local authorities earned £2.6bn from sales, fees, and charges in adult social care, accounting for 15% of gross social care expenditure.[41] Local authority revenue from fees and charges for social care for those aged 65 and over increased by 4.4% from 2009 to 2013 despite net spending being cut.[42] Since the Care Act 2014, local authorities have a legal duty to promote the efficient and effective operation of a market for care and support services.[43]

Making councils self sufficient

Funding of local authority expenditure in England, including social care and other council services, has traditionally come from four main sources: central government, business rates, council tax, and fees and charges. In 2010, central government grants accounted for almost 80% of local authority expenditure.[44] Between 2010-11 and 2015-16, government funding to local authorities (excluding the public health grant and Better Care Fund) fell by an estimated 37% in real terms.[8] Analysis by local authorities in the north east showed that the 10 most deprived areas in England saw an average decrease in spending power (a measures of core revenue funding available for local authority services) between 2014-15 and 2015-16 of 10.5% while the 10 least deprived areas saw an average increase in spending power of 1.1%.[45]

This disparity reflects changes to government funding, such that grants are no longer allocated based on annual assessments of needs and will not reflect changing relative needs and deprivation until they are reassessed in 2020.[42] Crucially by 2020, government plans to decrease and discontinue central grants, including the public health grant, will leave local authorities increasingly reliant on local business rates, which will no longer be pooled centrally and redistributed. These measures are part of the government's policy for local authorities to move towards self sufficiency and "away from dependence on central government," inevitably widening inequalities.[46]

Reduction in expenditure and removal of ring fencing has been closely followed by reduction in services

Need for transparency

The zeitgeist of integration and devolution obscures the fundamentally different funding bases for health and social care. As funding decreases, and with single contracts for both services, we expect the distinction between them to blur over time and some health services to fall out of commissioning, and out of NHS funding altogether. Private providers and local authorities—both accustomed to charging and privatisation—may also lobby for concessions to charge for services that were once free at the point of delivery and delivered through the NHS.

It is therefore essential that the public is given access to all the tender documents for joint commissioning and local authority commissioning of health services so that we can see how the distinction between NHS funded care and social care is made, what services are being tendered, how services are being defined, and how charging is dealt with. Most importantly, the evidence for and the effects of these seismic changes on access to care, equity, and widening inequalities must be disclosed and understood.

Shailen Sutaria, specialty registrar in public health medicine, Global Public Health Unit, Centre for Primary Care and Public Health, Queen Mary University of London, London, E1 2AB, UK

Peter Roderick, principal research associate

Allyson M Pollock, director, Institute of Health and Society, Newcastle University, Newcastle upon Tyne, UK
allyson.pollock@newcastle.ac.uk

Cite this as: *BMJ* 2017;358:j4279

HEAD TO HEAD, p 478