HEALTH AND SOCIAL CARE BILL

The new health bill—all 281 clauses of it—was introduced into parliament last week.But can the NHS roll out this ambitous vision in a climate of cuts and fiscal prudence?

Pace of reform

Lansley's insistence on a breakneck speed for his reforms could be his downfall, say critics. By April 2013, the 152 primary care trusts will be abolished and all general practitioners required to join a commissioning consortium. The pace is breathtaking. One scenario is that this wholesale transition won't be possible. Nuffield Trust director Jennifer Dixon believes that "in areas where there are the weakest consortia, PCTs will remain in existence for much longer than 2013."

Cost of reform

The upfront cost of putting reforms in place—to be largely incurred between this year and 2013—is estimated to be £1.4bn (€1.6bn, $2.2bn). This includes redundancy costs of £1bn. The remainder of the cost will be run up by transferring IT systems and staff from PCT to consortium premises, and start-up costs for consortiums. The Department of Health expects 50-70% of staff will transfer from PCTs/strategic health authorities to new structures, including consortiums. Lansley is hoping for a reduction of a third in administration spending. By 2014-5, the NHS in England (excluding the acute sector) is expected to be spending £1.7bn less than the current £5bn on administration.

But are these savings illusory? There are fears that many GPs are just too green to handle £80bn worth of public money. Can GP consortiums make the necessary savings and drive up quality? The £104bn NHS budget will increase by 0.4% over the next four years. But to achieve its reforms the NHS has to find £20bn in savings by 2014, and increase its productivity by 5% a year—a feat never before achieved.

What about GP commissioning?

Some of England's 30 000 GPs are champing at the bit—witness the first pilot wave of GP consortiums already up and covering 50% of the population.

Consortiums have to commission services from "any willing provider" and face scrutiny from the NHS's financial regulator, Monitor, if they act in an anti-competitive manner when awarding contracts for services. Payment by Results remains, but with key—some say alarming—differences. Monitor will be able set a "maximum price" for a service. This, say critics, including the BMA, can and will encourage a "race to the bottom" on price, with quality concerns forgotten.

There are other concerns. The bill makes provision for a downgrading of NICE, handing tricky rationing decisions to GPs. Commissioning decisions made by consortiums could also have the effect of putting ill favoured providers out of business. Historically the state has found it politically hard to let hospitals fail—will GPs be any different?

Local versus central—who wins?

The bill carves out huge powers for the NHS Commissioning board. Despite the new creed of localism, these reforms will be closely managed by this central board. One big clue is Sir David Nicholson's appointment as chief executive of the board. Nicholson's style is to exert an "iron grip" on the service, said one commentator. Nicholson would, for example, consider direct management of consortiums that failed to reach appropriate standards by April 2013, he told *HSJ* last week. He is also able to split a consortium up and reallocate practices to another consortium.

As well as holding GPs to account, the board will also allocate resources—high performing consortiums will get an (annual) quality premium. It will also set commissioning guidelines on the basis of NICE-approved quality standards.

Directors of public health will work in local authority health and wellbeing boards. They also be accountable to the secretary of state.

What's in this for the specialists?

Not much, if you read the responses from the royal colleges. Hospitals are left competing with private health companies for contracts awarded by their colleagues in primary care.

A big concern is GPs' ability to commission specialist care. Robert Lechler, executive director of King's Health Partners, says: "GPs know about local services and are sensibly placed to manage how needs are commissioned. But if you get pulmonary hypertension or rare conditions, for example, they have very little experience or knowledge and are less well placed to commission."

Speaking on BBC Radio 4's *PM* programme last week, Lansley was clear: "Highly specialised services will be commissioned by the NHS commissioning board." He said cancer services were best commissioned across a population of 1-1.5m patients.

Bigger role for private sector?

The government downplayed any advantage opened up for the private sector in a bid, perhaps, to calm the fears of the public and stakeholders. The main rock being thrown by the BMA and others is that this could spell the end of the NHS as we know it. But can the private sector even take advantage? Humana, the private commissioning group, is leaving the UK because the market is too small (see News, p 247). Lansley says: "For the private sector, the bill does make clear that competition rules will not be at the secretary of state's day-to-day political whim, but will be something stable, so there's a consistent, stable competition framework."

What's in it for patients?

As long as GPs can formulate and push through a vision of a primary care led NHS with better access for care in the community, then patients could see a positive difference. It could lead to more responsive doctors, for example, with GPs responding to patients by email and specialists carrying out outpatient clinics in local health centres. But if reforms don't go so well, we will see cuts, longer waiting times, and rationing.

What's the evidence for reform?

Lansley hasn't yet come up with a convincing narrative. We know public satisfaction with the NHS is high. Lansley's main justification is one of quality and his claims that England continues to lag behind other developed countries when it comes to outcomes in areas such as cancer and cardiovascular disease. However, Lansley's right in his instinct to give clinicians responsibility for budgets, says Jennifer Dixon. "Many developed countries are going that way."

What next?

The bill is due for its second reading in the House of Commons on 31 January, and the committee of MPs who will scrutinise the draft legislation will be appointed on 2 February.

Rebecca Coombes features editor, *BMJ*
rcoombes@bmjgroup.com
Competing interests: None declared.
Provenance and peer review: Commissioned, not externally peer reviewed.
Cite this as: *BMJ* 2011;342:d507

bmj.com/archive

For all the up to date information about the health bill visit bmj.com/nhsreforms

ANDREW LANSLEY AND HIS BIG EXPERIMENT

The Health Secretary is known as a free marketeer, friend of the Prime Minister, and a policy obsessive. But has he gambled everything on his radical health reforms, asks **Peter Davies**

UK health secretary Andrew Lansley was once prime minister David Cameron's boss—a little remarked fact that may partly account for the fearlessness with which Mr Lansley felt able to spring upon cabinet colleagues his controversial plans for the NHS. As head of the Conservative research department in the early 1990s, Mr Lansley gave Mr Cameron and George Osborne, now chancellor, their first jobs in politics.

"That explains why he and David Cameron have a good relationship and why Andrew is trusted on health," says Andrew Jones, formerly a Conservative policy adviser and now group medical director of Nuffield Health. Indeed Mr Lansley distinguished himself at the research department, playing a significant backroom role in the Tories' unexpected 1992 election victory, for which he was awarded the CBE.

So if he behaves like someone with credit in the bank, it may be with justification. Mr Cameron confirmed that Mr Lansley would be health secretary in a Tory government as long ago as 2008, a public guarantee extended to no other opposition frontbencher apart from Mr Osborne.[1] Before the election, he was able with impunity to initiate cross-party talks on social care without telling Mr Cameron.[2] He remains immune to the more swingeing budget cuts imposed on his colleagues.

He's not a good communicator of the ideas he's spent so long thinking through

Yet one sceptical policy expert thinks Mr Lansley would be well advised not to push his luck and made a serious political mistake in not ensuring that the prime minister was fully briefed on the radical nature of the NHS reorganisation. "History suggests that relying on the personal loyalty of politicians is a very quick way to the backbenches. It probably helped him make the sale. But you can only use it once, and he probably has used it now."

However, Mr Lansley is not trading solely on 20 year old friendships: during his six year apprenticeship as shadow health secretary, the public's view of whether it could trust the Conservatives with the NHS was transformed, despite Labour's massive investment in the service. "I consider that a major, major achievement," says Dr Jones, pointing out that health, often toxic for the Tories during election campaigns, was a neutral issue in 2010. During those long years in opposition Mr Lansley toured the NHS assiduously. "He was probably better prepared than any previous health secretary," says King's Fund chief executive Chris Ham.

He had taken an interest in health since becoming an MP in 1997, immediately joining the health select committee. He may have had strong personal motives for doing so. In 1992, though in apparent good health and aged 36, he suffered a stroke misdiagnosed by his GP as an ear infection.[3] His first wife (they divorced in 2001) was a doctor. His father worked in the NHS from 1948, running the pathology lab at East Ham Memorial Hospital for 30 years.

Mr Lansley's own career, after a politics degree at Exeter University, took him into the civil service. He was principal private secretary to Norman Tebbit for three years at the Department of Trade and Industry, where he worked on privatising British Telecom. Some claim this experience was crucial to his political outlook and personal style. Though now a Tory "moderniser" rather than a right-winger, he still believes in the free market.[3]

"He's a civil servant and policy wonk. He's not a politician, and I'm surprised by his lack of political dexterity," says one, citing Mr Lansley's inability to create a narrative to convince the public of the need for his reforms. "He has no constituency of support on the backbenches."

Another says: "He's not a good communicator of the ideas he's spent so long thinking through. He doesn't win hearts and minds. He often comes over as critical of people in the system, not realising you need them on board."

At times Mr Lansley can seem gaffe prone. His 2008 claim that "recession can be good for us" was swiftly retracted.[4] He accepted a £21 000 donation from Care UK for his personal office, apparently unaware of any potential for what the Liberal Democrats called "a staggering conflict of interest."[5] His directorship of marketing company Profero, whose clients included GlaxoSmithKline, Pizza Hut, and Pepsi, attracted similar criticism.[6] The agency helps mount government health drives, such as anti-drug campaigns. And he infuriated chef Jamie Oliver by suggesting his school meals initiative had made children's diets worse, later apologising.[7]

Others are more positive about Mr Lansley's civil service background. "He has a very good idea of how sound policy development should be done," says Dr Jones. "He went into the Department of Health with a very clear plan and he's exceeded expectations in getting a very positive response out of the DH. Everyone thought [NHS chief executive] David Nicholson wouldn't stay five minutes, but the reverse is true."

Professor Ham has doubts about that plan. "He developed a lot of these ideas when the NHS budget was still growing significantly. They would have been much easier to apply in 2007-8. If he's vulnerable to criticism, it's that he's not been flexible to change."

Some who have met Mr Lansley since he launched his reforms report him unsettled by the reaction. "He's had a long, dark night of the soul," says one. The result of the next election may decide whether his NHS reorganisation proves his biggest gaffe of all.

Peter Davies is a freelance journalist, London
petergdavies@ntlworld.com

Competing interests: None declared.
References are on bmj.com
Cite this as: *BMJ* 2011;342:d491

bmj.com/archive
- Independent review is needed to decide HFEA's fate (*BMJ* 2011;342:d379)
- HFEA investigates websites matching sperm donors to would be mothers (*BMJ* 2010;341:c5353)

New life for the fertility regulator?

The government has announced the disbanding of the Human Fertilisation and Embryology Authority, but as **Clare Dyer** reports, it is not going quietly

"It's a very Alice in Wonderland situation," muses Lisa Jardine. "I feel like the Cheshire cat. I'm smiling a Cheshire cat smile." The Cheshire cat's grin, of course, was all that was left after the rest of him disappeared. "Precisely," she laughs.

The organisation she chairs, the Human Fertilisation and Embryology Authority (HFEA), could go up in smoke in the UK government's bonfire of the quangos, the rationalisation exercise that will see some so called arm's length bodies abolished and the functions of others taken into government departments or spread among other, larger organisations. The Department of Health is proposing to hand over the authority's role in regulating fertility clinics to the Care Quality Commission, the general healthcare regulator, and to relocate its other main function, licensing embryo research, within a proposed new agency that will streamline the process of approval for medical research. Yet Jardine, professor of renaissance studies at Queen Mary, University of London, has just been reappointed as the HFEA's chair for a new three year term.

The authority, established in 1991 by the Human Fertilisation and Embryology Act, celebrated its 20th anniversary this month. The birth of the first test tube baby, Louise Brown, in 1978, and the speed at which the technologies of in vitro fertilisation and embryology were developing prompted the government to establish a committee under the philosopher Mary Warnock, now Baroness Warnock, to look at regulation. The 1984 Warnock report concluded that the special status of the human embryo should be enshrined in law but that in vitro fertilisation and research on embryos should be permissible, with appropriate safeguards, and the HFEA was born. The act stipulates that a licence can be granted for embryo research only if the use of embryos is necessary and the research is for one of several purposes laid down by parliament.

This is not an area where the average MP or civil servant should be asked to make decisions, let alone be in a position to make decisions

Some clinicians argue that, 20 years on, in vitro fertilisation is now so routine it no longer needs a special regulator but should be dealt with in the same way as other medical treatments. The HFEA has voiced fears that the embryo could lose its special status if the authority's functions are transferred elsewhere by the Public Bodies Bill, now in committee stage in the House of Lords. But the minister responsible for the bill, Earl Howe, has reassured Baroness Warnock in a letter: "There is no suggestion of changing the special status of the embryo, and we have no plans to re-examine those parts of the legislation that recognise that status." The establishment of the Care Quality Commission and the possibility of a new health research agency, he added, would enable "a joined-up system, which would streamline compliance and reduce the time and effort, and consequently cost, while continuing to offer the public reassurance."

Bid for survival

Nevertheless, some peers have put down an amendment to the bill to try to remove the HFEA from the list of bodies due to have their functions relocated to other organisations. The amendment is supported by the BMA, which says it is not against change but calls for a detailed review of the current regulatory mechanism for the areas covered by the HFEA, to be followed by specific legislation for any changes that require it.

Some contend that the issues dealt with by the authority are so sensitive and potentially controversial that they need to be handled by an expert and focused body to retain the confidence of public and parliament. One issue that caused huge controversy was the creation of animal-human hybrid embryos, which the last Labour government had originally intended to ban but got the go-ahead under legislation passed in 2008. The Human Fertilisation and Embryology Act 2008 also permitted the use of pre-implantation genetic diagnosis to screen embryos to produce a "saviour sibling" who could donate tissue to treat a sick brother or sister.

Public consultation by the HFEA informs the public and helps dispel the "yuck factor." Who, asked Robin Lovell-Badge at a Progress Educational Trust panel discussion on the authority's future at the Royal Society last week, would do these consultations if not the HFEA?

"At some stage," added Professor Lovell-Badge, head of stem cell biology and developmental genetics at the National Institute for Medical Research, "we will be able to derive gametes from pluripotent stem cells and the [Human Fertilisation and Embryology] Act will need to be changed. Who will tackle this?" A member of the HFEA's scientific and clinical advances advisory committee, he wondered "whether a large organisation will ever want to rock the boat." How would the important function of horizon scanning be done in a large organisation?

Both he and Sheila McLean, professor of law and ethics in medicine at Glasgow University and another member of the panel, argued that the HFEA was unique in having a duty to take account of the welfare of children who will be born as a result of in vitro fertilisation. "Other bodies do not have experience of considering the welfare of future children," noted Professor McLean.

But another speaker, Alison Murdoch, who heads the Fertility Centre at the Newcastle Centre for Life, supported the redistribution of the HFEA's functions and called for an independent review of the way the authority's regulatory process affects the outcomes of clinical practice. Professor Murdoch, who does both fertility treatment and embryo research, argued that the HFEA should have no role in policy decisions, insisting that these should be made by parliament.

The birth in 1978 of Louise Brown, the first test tube baby, was a headline-making event

JEREMY SUTTON HIBBERT/REX FEATURES

Baroness Warnock, whose 1984 report on regulation paved the way for the HFEA

Professor Lisa Jardine, chair of the HFEA, says life at 20 year old organisation is business as usual

ROD MINCHIN/PA

"I don't think there was any need to change the HFEA." Professor John Burn, Newcastle

Professor Jardine, who was in the packed hall at the Royal Society on Monday last week, stayed silent at the time. But she says now, "I couldn't disagree more with Alison Murdoch. This is not an area where the average MP or civil servant should be asked to make decisions, let alone be in a position to make decisions."

Time for change?

Some in the audience damned the authority as heavy handed and overly bureaucratic, or too prone to set moral guidelines, while others came to its defence. The message for Professor Jardine was that "there's a historic sense that the organisation used to be dysfunctional and that's unfortunate. I said to a senior Tory in the House of Commons, who'd asked me if I thought someone was briefing against us, 'no, no one's briefing against us.' But on Monday what I heard was that our history was briefing against us."

The government hopes to redistribute the HFEA's functions by the end of this parliament in 2015. But Professor Jardine insists: "There is no way we can be dismantled in under three years—and probably five." She expects the proposals for a new health research agency, put forward this month by a working group of the Academy of Medical Sciences led by Michael Rawlins,[1] to take at least three years to come to fruition.

Meanwhile, the HFEA is moving this summer from its current building in Bloomsbury to the offices occupied by the Care Quality Commission. So the authority's staff will be on the premises already if the government goes ahead with its plans to relocate its function of licensing and inspecting in vitro fertilisation services within the commission.

What is not yet clear is what will happen to the database the HFEA keeps on all fertility treatments over the past 20 years. The information is so sensitive that Professor Jardine says even she and the authority's chief executive have no access to it. Children conceived using donor gametes since 2005, when donor confidentiality was removed, will have the right to find out the name of their donor when they reach 18. The government suggests the database should be kept by the NHS Information Centre, but the centre handles only NHS information, and 80% of the services regulated by the HFEA are delivered privately.

Ministers claim the plans for rationalising quangos will cut bureaucracy and save more than £1bn (€1.2bn; $1.6bn). But the Commons public administration committee, in a damning report this month, concluded that the exercise had been poorly managed, resulting in badly drafted legislation that would not deliver savings or greater accountability. Little, if anything, is likely to be saved from dismantling the HFEA: its receives only £2m a year from central government, with the rest coming from clinics, and the government's plans envisage that its current functions will continue and its existing senior staff be transferred to the larger bodies.

Some clinicians, whether or not they support retention of the HFEA, suggest that after 20 years the time is ripe for a re-examination of the way its regulatory functions are exercised. Professor Jardine says the authority is already moving towards a lighter touch in regulation.

Mark Hamilton, consultant obstetrician and gynaecologist at Aberdeen University and former chair of the British Fertility Society, says: "It's premature to jump to the conclusion that the only solution is to disband the HFEA. I think a bit of debate is required. That's what is happening presently." He is "comfortable" with the HFEA's involvement in policy development. "I think the way they have gone about policy development has been rigorous and transparent."

John Burn, professor of clinical genetics at Newcastle University, was "surprised" when he heard the HFEA was to be disbanded. "I thought it was a retrograde step. Having a body which is seen to be full of sensible people who will take sensible decisions and not be told what to do by the government to my mind makes a lot of sense. I don't think there was any need to change the HFEA. I think it was one they could have left alone.

"I think if they're going to make it part of the new research agency, that is a less worrying development. There is probably some scope for rationalisation, and most of the sensitivities are now in the vicinity of the research applications. The health research agency is long overdue. If it's seen as an equivalent independent body, then consolidating the HFEA into it makes a lot of sense."

Sir Michael Rawlins explained at a briefing this month that he envisaged experts from the HFEA sitting on health research agency committees examining applications for embryo research. One of the new agency's functions would be "to interact with the public the same way that the HFEA interacts with the public," he added. "It is a very important part of its role."

While she waits to hear her organisation's fate, Professor Jardine says she will just carry on regulating, as the law requires. "I've spent my career turning around organisations and making them function in a gold standard way, and I'd like to think we're moving in that direction." She adds with a mischievous Cheshire cat grin: "I'm never happier than with something that's controversial."

Clare Dyer legal correspondent, *BMJ*, London WC1H 9JR, UK ClareDyer@aol.com

Competing interests: None declared.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 Dillner L. UK needs new health research agency to speed up approval process. *BMJ* 2011;342:d185.

Cite this as: *BMJ* 2011;342:d439