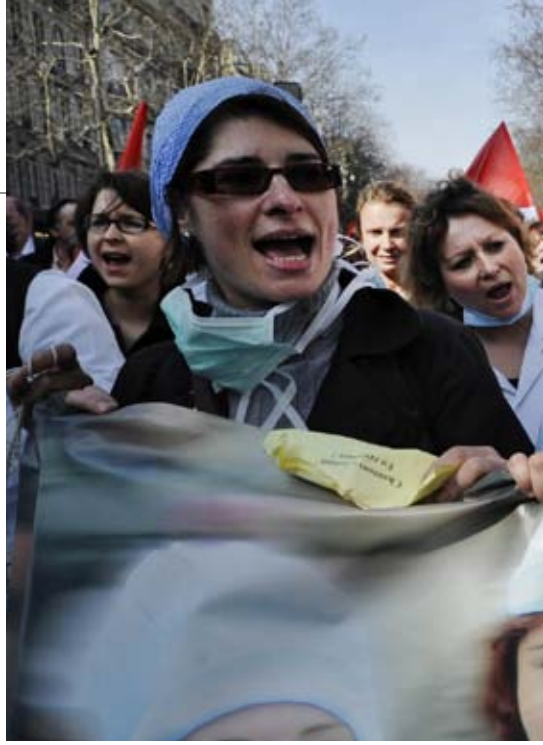
Calling time on the world's best healthcare system

The French health system is highly rated but paying for it is becoming increasingly difficult, **Sophie Arie** reports



VO TRUNG DUNG/SYGMA/CORBIS

The Georges Pompidou European Hospital is a gleaming example of a modern French university hospital. When you arrive it feels as though you have come to a plush shopping centre or an airport (it was designed by leading French architect Aymeric Zublena, who also co-designed the Stade de France football stadium). Beneath a high, modern glass and steel structure, there is a central "street" where patients, students, doctors, and the public mingle in a light, airy setting complete with palm tree, cacti, and a film centre. Off to one side there is a newsagent, a café, and a panoramic lift leading to spacious offices flooded with natural light. To the other side are the wards, where nurses push computers on trolleys down wide corridors with brushed steel hand rails and metal splash protectors along the walls. Ninety per cent of patients have their own room with en suite bathroom, and some have a sofa bed for relatives wishing to stay the night. There are large, well equipped operating theatres and a digitised drugs dispensing system that allows hospital staff to withdraw stock by tapping the name and quantity into a screen and automatically orders new stocks when supplies run low.

"France is running a health service that many treat like an open bar"

Built just over 10 years ago, it is a model of modern French hospital management. It replaced five old institutions and groups together three hospitals, coordinating the resources, facilities, and expertise of each to provide efficient, top quality care for the 600 000 residents of south western Paris. The hospital opened in 2000, the same year that the World Health Organization announced that France had the best health system in the world.[1]

The only problem is that the hospital overspends every year. The deficit was €25m (£22m; $35m) in 2009, the latest year for which figures are available.

Unchecked demand

Like this hospital, the entire French health system has a reputation for high standards of care and facilities. But today the state health insurance fund is €14.5bn in the red—and a climate that once tolerated living beyond your means has suddenly gone.

France is scrambling to get its public books in order to avoid having its credit rating downgraded. And health spending now accounts for more than half of the total social security overspend. But when it comes to health, public opinion is so strongly against any major changes, that all that Nicolas Sarkozy's government has been able to do is nibble at the edges of the deficit problem.

"I fear we are heading for a catastrophe. I am not optimistic," says Philippe Even, a medical adviser to the French health minister and president of Necker, a Paris health research institute.

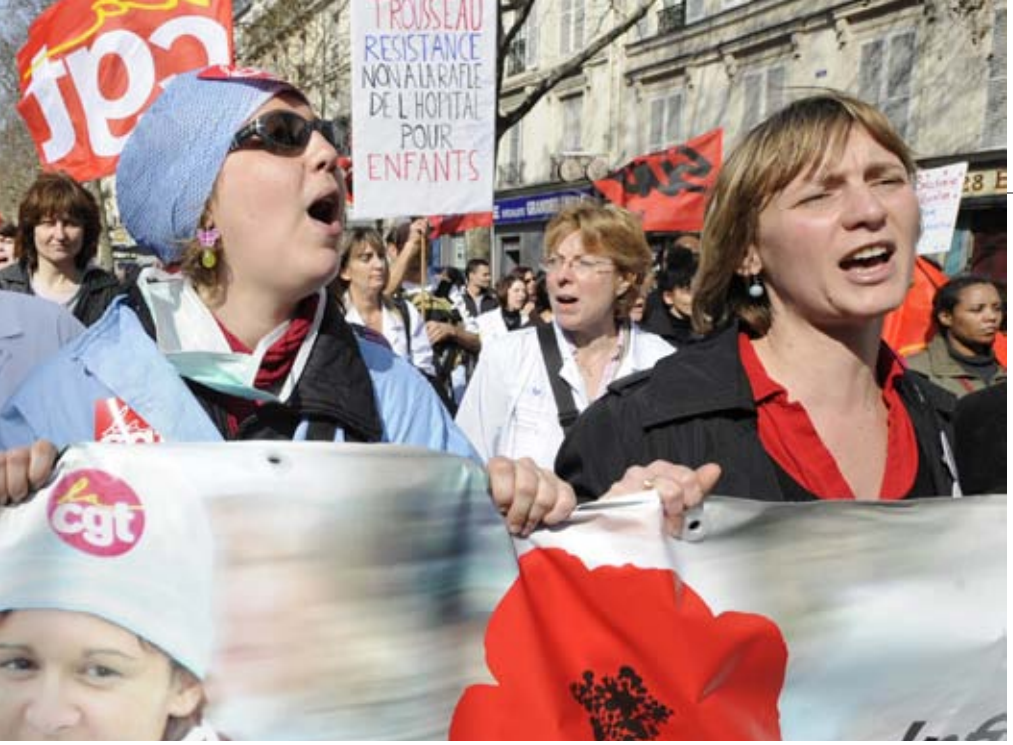
France faces similar problems to many industrialised countries in that it is trying to control health spending at a time when its population is ageing, there is a shortage of medical staff, and costs keep rising for sophisticated equipment and treatments.

The French case is particularly acute. French women are now living longer than any in Europe (84.4 years), and if they make it to 65, the French then live longer than any of their European counterparts (women 22.6 years, men 18.1 years).[2] And because of a cut back on medical training and the retirement of the babyboom generation, the number of general practitioners in France is expected to drop from 54 000 in 2010 to 27 000 in 2020, according to figures from MG France, the general practitioners' union.

The French system also has some idiosyncracies that add to the problem. Professor Even, like many others, points to a culture of waste and unnecessary use of health services. In the name of high standards of healthcare, he explains, French hospitals have got into the habit of carrying out unnecessary procedures, prescribing unnecessary drugs, and "ticking the boxes for all sorts of tests to be done" rather than targeting the most likely causes of complaints. Patients stay in hospital for longer than in many other countries (average length of stay in a French hospital is 13 days, compared with eight in the UK and five in Denmark[3]) and are often transported in ambulances when a taxi would suffice, he says.

"Hospitals act as if money doesn't matter," Professor Even tells me. "Staff spend without thinking about what they're spending."

The public has come to expect this level of care and attention and governments find it hard to trim anything back without facing public unrest. At present, France can be proud to be the country where you are least likely to die if you contract



GONZALO FUENTES/REUTERS

PASCAL DELOCHE/GODONG/CORBIS

Clockwise from top: healthcare workers protesting in Paris, March 2010; A pharmacist in Paris—France is one of the world's biggest consumers of drugs; the lobby of Georges Pompidou European Hospital, Paris

a preventable disease.[3] But at the same time, observers say, France is running a health service that many treat like an open bar. France is one of the world's biggest consumers of drugs (in 2008 it spent more on drugs than all other countries in the Organisation for Economic Cooperation and Development (OECD) except the United States, Canada, and Ireland and almost twice as much as the UK[4]). France consumes more antibiotics than any country in the OECD except Greece,[5] and of the 4000 drugs currently on the French market, Professor Even believes as many as half are not proved to have any medical value. Eliminating prescription of useless medicines and overuse of effective drugs and limiting access to the most expensive new cancer treatments would save up to €10bn a year, Professor Even estimates. That is a third of the total annual drug spend. Other estimates say the saving could be closer to €5bn, but there are no official government calculations.

Balancing act

The government has begun to tackle this and other kinds of waste. It is gradually withdrawing certain drugs from the list of those that the state will pay for. Decisions about which drugs should be withdrawn and reimbursement of new drugs are made by the Agence de Produits de Santé en France. When drugs are considered not really useful, it decides to reimburse a small percentage of its costs or none at all. Critics say it should be braver and just declare more of them useless or unfeasibly expensive. There have also been attempts to change public attitudes through government publicity campaigns reminding people that "antibiotics are not automatic." Ironically, it may ultimately be scandals over the health risks of some unsuitably prescribed drugs (like Servier's Mediator (benfluorex), which is thought to have caused between 500 and 2000 deaths after being widely used as a weight loss pill rather than for its licensed purpose) that may lead the French to be more cautious about popping so many pills.

Jann Bubien, counsellor to the health minister in charge of hospitals, care provision, and social relations, insists the government will tackle problems like unnecessary consultations and operations such as removing appendixes, which occur two to three times more often in France than elsewhere. But, he says, it's hard to define which procedures really are unnecessary.

Many see any attempt to reduce the number of operations, tests, or medicines provided as an attack on the quality of the service. And any substantial cuts aimed at greater efficiency and less waste would imply job losses in the health sector, which is one of the largest employers in France. The drug industry is also a leading employer and currently one of the few thriving sectors of the economy.

"There is no miracle method for resolving the deficit problem," says Mr Bubien. "There is no question of introducing drastic measures that would involve job losses. We have constantly to improve things bit by bit."

The government has given state hospitals five years (to the end of 2012) to balance their books, and hospitals are cutting back on everything from numbers of beds to quality of food. According to Mr Bubien, the total overspend has already dropped from €900m to €500m. He expects it to fall by at least another €100m this year.

A law was passed in 2009 aimed at improving efficiency in hospital management and consolidating resources. And a digital medical record system, on trial in several regions, has the potential to identify duplication of effort and help doctors make better informed decisions about patients.

But with general elections in April 2012, the government is unlikely to attempt any major health reforms before then.

"We can't say that we have made drastic savings," says Mr Bubien. "Nobody is asking us to. In France, health is sacred; the system is sacred. It's one of the hardest things to touch."

Population pressures

Whoever is elected next year faces a huge challenge as demands on the health service grow. France needs to keep increasing health spending to keep up with those demands, but it already spends a larger proportion of its gross domestic product (GDP) on health than any other country in Europe (11.2% compared with 8.6% in the UK and 10.5% in Germany).[4]

And now, as the global economic crisis has pushed unemployment up, social security contributions, which are calculated according to earnings, have dropped dramatically. The deficit of the national insurance fund for healthcare (known as Assurance Maladie) jumped to €14.5bn in 2010 from €4.5bn in 2008.[6]

That is more than half of the total social security deficit (covering pensions and social benefits as well as healthcare), which was €23bn in 2010. The government is under pressure to cut its public deficit from the current 6% of GDP to 3% by 2012 or risk being downgraded in international credit rankings.

Successive governments have recognised that the health system is in need of reform, but when they attempt to introduce major changes, public outcry forces them into retreat.

France's ultra-liberal health system, based on the principle that patients should have access to any doctor or specialist or hospital they want, means the public are very content. People can choose to see a specialist or a general practitioner as often as they feel necessary and whether to be treated in a state, private, or non-profit (usually run by religious orders) hospital (about 60% of hospitals are state run). All those earning more than the minimum wage pay contributions to the health fund and therefore feel entitled to the choice the system provides.

The universal coverage system means patients must pay up front for services and will then be reimbursed the majority of the costs (the proportion varies depending on the service) by the state health system. Over 90% of the population has a top-up insurance policy that covers the remainder or almost all of it. For fundamental services such as maternity care or treatment for acute and long term illnesses the state covers all costs.

At present, the average time a woman spends in hospital after giving birth is four to five days. The pulse of the baby is monitored electronically throughout the birth and epidurals are the norm. Mothers receive thorough training in child care before going home. The state will cover the full cost for a stay in a room shared with one other person. The only thing the woman has to pay for out of her own pocket is the use of a telephone and television while in hospital (€10 a day). She can choose to pay a supplement of €53 a day for a single room, which her top-up insurance policy may cover. Many women choose to give birth in a private clinic to be guaranteed a single room (often with a spare bed for the father). The total cost can be around €1000 for the full stay and the Assurance Maladie and a top-up insurance policy combined will cover about 85% of the cost.

VARIO IMAGES GMBH & CO KG/ALAMY

French women are now living longer than any in Europe

As the pressure has grown on finances, the government has begun to pass some costs on to the public or insurers. A law passed in 2004 attempted to establish a general practitioner gatekeeper system, much like that in the UK. Patients who go directly to a specialist without being referred by a general practitioner are reimbursed a little less by the state. The government has also introduced patient charges of €1 for each consultation. New health conditions have been added to the list of those not covered or covered at a lower percentage by the health insurance fund.

Many of the top-up insurance policies are picking up these costs, with the result that premiums—though still modest—are rising. And this has led to concerns that the French system is losing its fundamental principle of solidarity.

"Increasingly health is paid for by the sick rather than by general contributions," Zeynep Or, a researcher at the Institut de Recherche et Documentation en Economie de la Santé (an independent health research institute), concluded in a review of the 2011 health budget.[6]

"The budget project falls short of addressing any of the major efficiency issues and does not propose any useful measures for altering healthcare provision and consumption patterns," Or says.

Role of general practice

Many health professionals believe that deeper restructuring and reorganising of the French system is the only thing that can alter the trend of overspending. The general practitioners believe shifting the emphasis away from state hospital care (which is reimbursed at close to 90%) to primary care (which is currently reimbursed at closer to 50% by the state) is the answer. Others think that the answer is to impose limits on the way all health providers work.

Under the current system, general practitioners and specialists working outside hospitals are self employed. They can work anywhere they choose in the country. When the government has attempted to set limits in an attempt to gain a better distribution nationwide, health professionals have been up in arms.

Cities tend to be full of doctors of all sorts and small towns and rural areas very under served. And there are roughly as many specialists operating independently (and competing with each other for patients) as there are general practitioners.

Although the gatekeeper system has begun to show savings, MG France, the general practitioners' union, says that it has not significantly changed attitudes.

"All that happens is that patients demand signed referrals [from us] and we have to fill out more forms," says Jacques Battistoni, general secretary of MG France.

General practitioners are among the least well paid in Europe and are allowed to charge a set fee of only €23 per consultation. After covering their office running costs and paying social security this leaves them with €7 take-home pay per consultation, according to the union. The result is that many cannot afford to risk losing a patient by refusing them the prescription or the referral that they want.

The union believes that the fact that general practitioner services are so cheap may eventually lead the government to make more use of primary care. "As long as the choice is not structured to a minimum, we will not get out of this [situation]," said Francois Wilthien, vice president of the union and a practising general practitioner for 35 years.

However, in coming years there will be fewer and fewer doctors per capita as a post war generation goes into retirement and quotas set years back mean that there are now not enough new doctors qualifying. Many fear that there will be a crisis in the next few years.

"In concrete terms, patients are going to have to travel further to get care. Small towns may not have many GPs or other types of care. There will be uprisings in the regions over health," says Dr Wilthien.

If the government does not tackle the need to reorganise the system, he believes, "the fabric of French health will disintegrate." After the 2012 elections, whoever is in government will need to make difficult decisions. There will be brutal closing down of all sorts of services. "We will no longer be the champions of the world in terms of access to services."

Jean Yves Fagon, a professor of medicine at the University of Paris Descartes and former director of medical affairs and strategy for Paris hospitals (Assistance Publique, Hopitaux de Paris), believes that the incremental cuts being made in hospitals mean that France has already lost that status. "The quality of services are being gradually degraded to cut deficits now," he says. "But there is no long term strategy."

"We needed to reorganise the whole system of healthcare provision. We didn't do it when we had plenty of money. And now it will be much harder to do."

Sophie Arie is a freelance journalist, London, UK
ariesophie@yahoo.co.uk

Competing interests: None declared.

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

References can be found on bmj.com.

Cite this as: *BMJ* 2011;342:d1524

CLINICAL LEADERSHIP

Finding the leader of 2011

Helen Morant and **Cath McDermott** introduce the shortlisted 2011 award candidates

"Big improvements in care and quality of life do not always come from fancy drugs, professors, academic institutions, or, dare I say it, high profile surgeons but from simple commitment to patients and staff, and the ability to use the evidence that is already out there," says Sam Everington, general practitioner in east London and a member of our judging panel.

The art of clinical leadership has never been in more demand. In the United Kingdom and worldwide, government and healthcare systems are looking to doctors to tell them how to organise and deliver healthcare. It is no longer enough to just lead a small clinical team; clinicians are now taking responsibility for whole patient pathways and the budgets that follow them.

And there are plenty of clinicians stepping up to meet the challenge. Many of the submissions combined leadership with managing limited resources, overcoming organisational and personal barriers, and meeting really tough targets. We read inspirational stories from the front line of patient care across the world, from Ukraine to Chester.

Our first shortlisted nominee is Brian Bradley, respiratory consultant physician at the Royal Bolton Hospital. His respiratory service had been facing large workloads on the wards for both junior medical and nursing staff. The staff team was demotivated, clinical management plans were taking time to be implemented, and investigations were being missed or delayed.

Dr Bradley used the lean method to change things, as part of the Bolton Improving Care System. Work started with changing the ways that the two inpatient wards operated, and the interventions were simple. Clear and agreed ways of working, with all team members knowing their own (and each other's) roles and responsibilities, led to shorter stays for patients and a decrease in mortality. The role of specialist respiratory nurses was reviewed and changed to better meet the needs of patients. Outpatient pathways are being redesigned, as is vital collaborative work with general practitioners.

Brian Bradley

Mauricio Rueda-Acevedo

Ian Dufton

This year, for the first time, we had strong entries from around the world, and we were really pleased to shortlist someone from a middle income country. Mauricio Rueda-Acevedo started working in the Instituto Neurologico de Antioquia centre in Medellin, Colombia, in 2007. The institute offers services for patients with stroke, epilepsy, movement disorders, pain, dementia, and headache.

Dr Rueda-Acevedo built up a service for patients with movement disorders from a small start. By developing strong treatment, assessment, research, and education teams, he has established a sustainable service with enthusiastic staff and grateful patients (one of whom subsequently became a major donor to the centre). He introduced the use of clinical protocols and offered an emergency telephone system. Patients felt supported, and this encouraged confidence in the services and further attendance. The service pioneered multidisciplinary working in movement disorders in Colombia and now provides a model for other services.

Very different challenges faced Ian Dufton when he started to lead the Bolton Child and Adolescent Mental Health Service. The service had lost large numbers of key staff in the preceding two years and was serving one of the most deprived areas of the UK.

Dr Dufton re-established the lead clinician team (comprising a psychiatrist, psychologists, and nursing staff) and created multidisciplinary, cross professional groups to harness the team's creativity and push forward the service. Monthly drop-in surgeries and personal development and job plans for all staff were established as the norm.

The team developed a five year vision and strategy that directed the rebuilding of the service to ensure sustainable investment and quality recruitment and retention of staff. They used the lean method of the Bolton Improving Care Scheme to make this happen, and the results were impressive. Measuring achievement in mental health services is known to be difficult, and we were impressed by the clear benchmarking and goals that were set, as well as the achievements of the service against them.

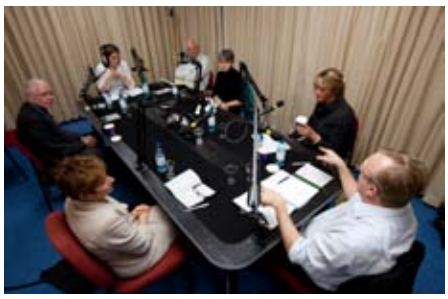
So our shortlist is now finalised. And now it's down to the judges—Julie Andrews, director of infection prevention and control at the Whittington Hospital, London; Mark Kinirons, clinical lead, patient and drug safety, at Guy's and St Thomas' Hospital, London (last year's runner-up); Pam Garside, fellow in health management at Judge Business School, University of Cambridge (last year's winner); and Sam Everington—to choose a winner. They will be looking for a clinician who has shown leadership that goes beyond the expectations of their appointment.

Helen Morant is editor, online learning, BMJ Learning, London WC1H 9JR, UK
hmorant@bmjgroup.com
Cath McDermott is development editor, BMJ Learning, London WC1H 9JR, UK

Cite this as: *BMJ* 2011;342:d1583

Last week the *BMJ* brought together a group of influential clinicians and thinkers in UK healthcare to discuss the radical changes afoot in the English NHS. **Rebecca Coombes** summarises the key points.

"WE NEED TO 'SHAKE' THE BILL TO MAKE SURE IT WORKS FOR PATIENTS"



Listen to the roundtable debate on this week's podcast at bmj.com/podcast

"There is a risk of it all being provider dominated" John Black, president, Royal College of Surgeons

"Shouldn't we accept that there is a lot that the third sector and potentially the private sector can bring?" Anna Dixon, King's Fund

Major changes to the English NHS, as set out in the Health and Social Care Bill 2011, are currently under scrutiny by parliament. A complete middle tier of NHS management is being swept away—primary care trusts, currently a major commissioner of services, and strategic health authorities will be gone by 2013. Instead consortiums of general practitioners are to receive 80% of the healthcare budget—around £80bn (€95bn; $130bn) with a remit to tender services to "any willing provider" that can offer the best quality service locally.

The *BMJ* brought together a panel to discuss the health service view of these changes. The panel was made up of Michelle Drage, chief executive of BMA London-wide local medical committee and a general practitioner; Clare Gerada, chair of the Royal College of General Practitioners; John Black, president of the Royal College of Surgeons; Anna Dixon, director of policy at the King's Fund, a health thinktank; and Nigel Edwards, acting chief executive of the NHS Confederation, which represent managers.

Around the table, talk was about how GPs still feared domination by provider hospitals and anxieties about how doctors would be able to judge which services to buy based on clinical quality, when outcomes are notoriously difficult to measure. There was agreement that although the reform programme was designed on the basis that "small is beautiful," actually some health services, such as for cancer, clearly worked best on a macro level. But would any of these changes tackle the widening inequalities in health in England? Panellists also mulled over the future of medical training in a health service dominated by a multiplicity of providers. And would the changes lead to a federated health service, handing too much control to profit hungry private companies, or was this simply shroud waving? Finally, would reform fall flat as money is rapidly taken out of the system over the next five years.

What is the greatest weakness in the NHS reforms?

Clare Gerada: We welcome putting clinicians in the centre of planning health services for their local population. But we do have concerns about the "any willing provider" issue. There should be a requirement to do an impact assessment on what any willing providers mean to the whole system, including what it means to education and training.

Another major issue is around [the removal of] practice boundaries. I'm not sure who sees the need to be able to register with any GP. We feel this will widen health inequalities. It will actually make planning health services very difficult. How do you look after a patient who may be living 200 or 300 miles away from where they are registered? We know that patients who don't live in the area where their general practice is are much more likely to use emergency services—accident and emergency—when they fall ill. And that will actually increase costs.

John Black: We feel there is a big gap that is being vacated by the regions because many services of a medium size—not the rare diseases that have to be commissioned nationally, not the relatively common diseases that the general practice consortiums can cope with—are best commissioned on a basis of about five million people—for example cardiac and paediatric surgery. And commissioning should be done on some level between national and the consortiums.

We're also concerned that whole services should be commissioned—we wouldn't just want to see cherry picking. It is particularly important that any service should be commissioned on quality including teaching, training, research, audit, measurement of outcomes, and provision of a complete emergency service.

Nigel Edwards: I would allow for much more experimentation. I would be allowing people to play a different game in the way that the

"There are no rules, and that is a recipe for inappropriate entrepreneurialism" Michelle Drage

"Our admission rates for things where GPs ought to make a difference are not as good as they should be" Nigel Edwards

"How do you look after a patient who may be living 200 miles away from where they are registered?" Clare Gerada

MARK THOMAS

Obama legislation allows for demonstration projects to drive more integration between primary and secondary care. I think we may not actually get to implement this bill because we'll be too busy fire fighting some of the financial issues that we face at this current point. We've missed an opportunity, I think, of getting social care commissioning more aligned with general practice commissioning, which would have been something that would have been worth doing.

Michelle Drage: What we see is a shell. We have to imagine [how the health service] is going to operate. There are no rules, and that is a recipe for inappropriate entrepreneurialism and also a fairly microscopic look. There needs to be commissioning above the level of consortiums, and the thrust of the bill does not facilitate that. It facilitates "small is beautiful." And I'm normally a small is beautiful person. But when you're talking about commissioning services for broad swathes of the population, you need to have a bigger profile.

There is nothing [in the bill] about how to commission better supply side from our providers. And one of the biggest bugbears for GPs who have been involved in practice based commissioning is their inability to get into the nitty gritty of the data and the behaviours of our very powerful and often predatory foundation trusts and teaching hospitals. And coding inspectorates would be a good thing in my view. It wouldn't take much money.

Anna Dixon: And I think the concern that we have is that potentially it will be—and perhaps it's the policy intention— the hand of the market that will actually shape the configuration of the provider service. And we have a concern that that may not in the end really deliver high quality, high value services. We know we have to get a grip on the situation very quickly because of the productivity challenge that the NHS faces. I think the system as a whole potentially lacks strength in how it will really focus on patients. The rhetoric is putting patients at the centre.

Will GPs have the necessary tools to commission only high quality services?

NE: Part of the bet of this set of reforms is that much more data availability will drive improvement. Andrew Lansley has massively underestimated how difficult it is to get outcomes data that will actually achieve that. Just look at the difficulty we've had agreeing on a method for calculating a hospital standardised mortality rate—which you would have thought, as a binary variable, might be one that we could agree on.

JB: In surgery there is plenty of evidence that if you measure outcomes and feed those outcomes back to the providers, results do improve. And the classic example is, of course, cardiac surgery. For 10 years every cardiac surgeon in the country has been collecting his or her results, and as a result we now have outstanding results by European and world standards. Doctors want to know their results and they want to get better. And if the commissioning process was to include compulsory measurement of outcomes, I'm sure that would put standards up. The trouble is it's easy in certain areas—surgery with a mortality is the classic—but it's very difficult in other areas."

CG: Of course, that raises the question, how do you measure outcomes other than in very specific areas? And we've heard even measuring death as an outcome is very difficult.

JB: There is also the fact that certain services have to be commissioned on a certain population basis because of a lack of expertise in any smaller unit. Take breast cancer, GPs don't see enough of these patients to have any real experience. In hospital practice, I saw these patients all the time.

Does GP led commissioning lead to closer working between primary and secondary care?

JB: Speaking as a secondary clinician I'm sure most of my colleagues would say they'd much rather talk to GPs than to primary care trusts. And one of the things that has been lost over the past 20 years is personal GP-clinician contact. And if the commissioning process can bring that in somehow, so that things are done on a more personal basis, we'd all love that to happen.

MD: I think you're absolutely right, but I worry it's very complicated, commissioning. People haven't done it right. Even very clever people haven't done it right. So can we expect that GPs, who are trained to deliver care to patients, are going to get this right? My sense is— and I hope I'm not right in this— that GPs will focus on what they know well. They'll focus on diabetes, chronic obstructive pulmonary disease, heart failure. And in terms of being truly innovative and truly looking at how we can deliver things differently, I think that will probably go on the backburner for a few years.

I think at the moment one should steer well clear of being a commissioner and a provider, which may mean you're actually going to be in a position where the best people aren't going to be on the commissioning board because they're standing back worried that they're going to be caught up in the purchaser-provider conflict.

Does the health bill hand too much advantage to independent healthcare providers?

AD: But shouldn't we accept that we already have a diversity of providers and there is a lot that the third sector and potentially the private sector can bring? We must be careful that we don't use the example of independent sector treatment centres (ISTCs) and say "what a disaster" and therefore we shouldn't be commissioning from diverse providers. The problem with ISTCs was poor commissioning. The information we needed to benchmark the quality was not set in the contracts. The other thing was poor pricing. We didn't require

ISTCs to take financial responsibility for those patients they had to transfer into the NHS.

We want to see commissioners who competitively tender for services in a way that may generate some very innovative partnerships between NHS providers, the voluntary sector, and possibly even the private sector.

MD: But therein is the problem. What you've described is the potential fragmentation of the holistic generalist care market. Currently commissioning is done on territorial lines against provider instigated priorities. And if you turn that around and you look at what GP initiated priorities are, they are the exact antithesis of that. They are whole patient commissioning: the physical, the social, and the psychological and economic components of an individual's problems. If you immediately take the care pathway approach you throw that out of the window—and it risks becoming provider dominated because that is where the so called expertise is and where pathways have always been led from.

JB: There is a risk of it all being provider dominated, and I think we still hear hangovers from the Darzi days that the whole health service will be run by 32 Imperial College lookalikes.

CG: I go up and down the country and I hear so many commissioning consortiums, or embryonic ones, saying right, we're going to move musculoskeletal services or another disease service. My worry is that, again, it's talking about people as if they just have one single problem. If [instead] we invested in general practice—that is, used some of the commissioning leverage to invest in general practice—we could have more time with our patients than 10 minutes. We know that where you have strong general practice you have better health outcomes, and you get value for money."

NE: The general practice on its own without specialist input?

CG: Of course we need specialist input.

NE: We're very stuck in this country in the division between secondary and primary care. We've raised what is really a charging structure that pre-dates the NHS into a nostrum of policy and it's not one recognised in other countries. It's highly contested and people are worried about these data. We don't do very well on a number of conditions that are amenable to ambulatory care interventions. Our admission rates for things where GPs ought to make a difference are not as good as they should be. There is some evidence, coming shortly, that gatekeeper systems are pretty poor at the care of complex children, for example.

MD: I think the worse case scenario is that we divert all the GPs' attention into commissioning process, tendering and setting up all these challenges. Actually we need experts to do it but directed and conducted by a GP view of the world.

How will an increased number of healthcare providers affect medical training?

CG: How are we going to be training the next generation of whatever if we have a multiplicity of providers? Look at addiction— a vast number of third sector organisations have got contracts for addiction services, but that actually means there isn't any education and training. And what that means is now we are destabilising NHS providers. And you can imagine a situation where in a few years' time we've gone from batting way above our weight in addictions and being a world leader, to a service that is just fragmented and higgledy-piggledy.

MD: We share your view, particularly on GP training. I think the simplest analogy is to look at what has happened to the quality of bus driving since the government deregulated bus driver training. The same fears arise in my mind that if you leave it to provider organisations you don't get the levels of quality that you intended at the beginning. I think the current trend to split commissioning of education from provision in preparation for hiving it off to providers is a worry.

AD: But do we not need to modernise workforce and education to recognise that there may be other settings in which people need to be trained?

NE: Well, certainly other European countries manage to train professions with diverse provider sites.

Are doctors going to face a conflict of interest as both commissioners and providers of care? Will their popularity suffer as a result?

AD: We know that there are going to be some very difficult decisions ahead and services will be closing. And if those cases can be made to local people by their trusted GPs then there's a much greater chance they will be palatable than if they are made by primary care trusts or remote bureaucrats.

CG: I'm not sure it will be easier for a group of GPs to close a hospital than it would be for a group of MPs unless the argument is clearly well made.

MD: The minute you try to even mention the relocation of a service out of a teaching hospital, or even worse, a district general hospital, the world falls apart and the placards come up and the braziers start getting going. It's really tricky territory.

NE: Let's just be clear here. There aren't going to be many hospitals that absolutely, completely close, OK? And many of the decisions to change hospitals will be taken by hospitals in response to the changes in the flow of funding and the way GP commissioners make decisions. The secretary of state will probably still get the blame. The local MP will probably lose his or her seat. But their actual ability to do very much about it will be significantly altered.

JB: Do you really believe that there will be far less political control of the NHS?

NE: Well, that's the way the bill is written. The reality may be very different.

As health services become more localised, do we risk the break up of a national health service? How does this affect the health of the nation?

CG: I worry that there is not going to be central planning determining the health needs of our population and this is going to be up to groups of GPs of various sizes who don't even have a responsibility for a geographical area.

NE: How do you get general practice consortiums to take a population health [needs] view. Andrew Lansley's assumption is that population health is a sum of seeing 70% of your patients each year, which it isn't. It's too big an intellectual leap, and anyway there is a science to doing it. It is obvious that consortiums will want to buy that public health expertise back.

CG: Last week, we saw the lowest teenage pregnancy rate for 30 years. I think that is testament to public health and joined up thinking across health and social care. I worry in the new scheme of things we won't be able to do that. The same with young people and sexually transmitted diseases. If we leave it to local consortiums or even local health and wellbeing boards [in local authorities] there won't be enough buy-in.

AD: And the incentives for local authorities in regard to reducing health inequalities are looking very weak.

CG: I do understand that we are quite a small country and we've had a national health service since 1948 that's worked reasonably well. I think we have to "shake" the bill to make sure it works for patients and for the NHS because it sounds so complicated, and it just reinforces to me how complex the NHS is.

Rebecca Coombes is features editor, *BMJ*, London WC1H 9JR rcoombes@bmjgroup.com

Have your say on any of the issues raised here on doc2doc or through rapid responses.

Cite this as: *BMJ* 2011;342:d1637