



bmj.com

More articles about the NHS reforms in England at bmj.com/nhsreforms

How the secretary of state for health proposes to abolish the NHS in England

Allyson Pollock and **David Price** examine the proposed statutory changes to the NHS and raise concerns that the government's role could be reduced to that of payer

The coalition government's Health and Social Care Bill 2010-11 heralds the most controversial reform in the history of the NHS in England.¹⁻³ The government plans to replace the NHS system of public funding and mainly public provision and public administration with a competitive market of corporate providers in which government finances but does not provide healthcare.⁴

Primary care trusts and strategic health authorities are to be abolished and replaced by general practice commissioning consortiums, which all practices must join. As incorporated bodies, consortiums will not be directly controlled by the secretary of state for health and may enter into commercial contracts with "any willing provider" for all health services and will set terms and conditions of staff. They will have extraordinary discretionary powers to define entitlement to NHS provision and charge patients. Direct management and control of NHS providers will cease as foundation trust status becomes mandatory for all trusts. Provider regulation will be overseen by a market regulator, Monitor.

Since 1948 the government has had a duty to provide comprehensive healthcare free at the point of delivery. This duty is underpinned by structures, systems, and mechanisms that promote fairness and efficiency in resource allocation and facilitate planning of services according to geographical healthcare needs through risk pooling and service integration. These mechanisms have been eroded by a succession of major regulatory changes, including revision of funding and responsibility for provision of long term care; creation of an internal market; introduction of private providers and capital through the private finance initiative, independent treatment centres, foundation trusts, and the 2004 general practice contract; and creation of a tariff system of payment for providers.⁵ We examine the proposed statutory protections of the duty to promote and provide comprehensive care in the bill.

Box 1 | Regulating providers through commercial contracts

The government proposes to regulate providers through commercial contracts:

"The Government's approach is that where specific control mechanisms are needed for providers, these should in general take effect through regulatory licensing and clinically-led contracting, rather than hierarchical management by regions or the centre."¹⁸

Most economists agree health services cannot be sufficiently controlled through market regulation because the complexity and unpredictability of treatment makes it impossible to set out all eventualities in a contract.

This problem of incomplete contracts was first described by the founding father of health economics and Nobel laureate, Kenneth Arrow.³¹ He argued in 1963 that producers of healthcare services will always have more information than purchasers, who will never be able fully to evaluate the likely consequences of different services and so will never be completely certain that they have chosen the best provider or that the outcome is optimal.

When market contracts are used to regulate providers and commissioners, managers have an incentive to exploit the information deficit on the part of patients and government by reducing service quality in order to maximise profits.

According to Arrow, incomplete contracts can explain why "the association of profit-making with the supply of medical services arouses antagonism and suspicion on the part of patients and referring physicians."

Duty to provide a comprehensive public service

Although the bill retains the secretary of state's duty to promote a comprehensive service, the duty to provide a comprehensive health service in England is abolished.⁴ It is replaced with a duty to "act with a view to securing" comprehensive services. The health secretary's general

powers of direction over NHS bodies and providers are also abolished, and the focus of his or her role will shift to public health functions, which become the responsibility of local authorities.

Section 9 abolishes the duty on the health secretary to "provide [certain health services] throughout England, to such extent as he considers necessary to meet all reasonable requirements." Commissioning consortiums will "arrange for" the services necessary "to meet all reasonable requirements" and determine which services are "appropriate as parts of the health service" (section 9, 2a).⁴ A consortium does not have a duty to provide a comprehensive range of services but only "such services or facilities as it considers appropriate" (section 10, 1). In making these arrangements, commissioning consortiums must ensure that their annual expenditure does not exceed their aggregate financial allocation (section 22, 223I-K). Consortiums may join together to form a single commissioning group for England (section 21, 14Q, 2b),⁴ but they are not required to cover all persons or provide comprehensive healthcare when doing so.

The NHS Commissioning Board must "ensure that . . . commissioning consortia—(a) together cover the whole of England, and (b) do not coincide or overlap" (section 21, 14A, 2) but the board will not have a power of general direction over the health services for which consortiums contract or patients' entitlements. The secretary of state's influence is indirect, exercised through an annual "mandate" that will set out the objectives of the independent NHS Commissioning Board (section 19). The economic regulator, Monitor, also has no duty to ensure provision for all residents. Its main duty will be to "protect and promote the interests of people who use health services . . . by promoting competition."

The commissioning consortiums' duty to arrange for health service provision applies to their enrolled population. In contrast to primary care trusts, the populations of consortiums will

be drawn from the patient lists of member general practices rather than all residents living within a defined geographical area (section 9, 3, 1A). Practice boundaries may be abolished as part of patient choice, which means that

“practices can accept patients regardless of where they live, effectively allowing patients to choose their commissioner,”⁶ or commissioners to choose their patients. If this happens, practices and consortiums will be able to compete (and advertise)

for patients from across the whole country just as private healthcare corporations and health insurers do now.

The bill makes consortiums responsible for services such as emergency care with respect to “persons who have a prescribed connection with the consortium’s area” (section 9, 3, 1B) and requires that they must specify their “area” in their constitutions (schedule 2, section 2), but responsibilities and services for people who are not enrolled with them are not defined. Pooled funds will provide a mechanism for compensating commissioners and providers for these unspecified responsibilities with respect to the unenrolled populations.

The secretary of state’s duty to provide free services that are “part of the health service in England” ... is undermined

Provider of last resort

Because the secretary of state will no longer be able to ensure comprehensive, universal cover to all residents in geographically defined areas, the legislators have drafted a safety net

whereby local authorities can be required to undertake NHS functions. Under section 8 (2B, 3c) of the bill, the health secretary can require councils to provide “services or facilities for the prevention, diagnosis or treatment of illness.” Local

authorities alone have a duty to provide for geographical populations. Healthcare services that consortiums and market providers deem will threaten their financial viability can therefore be trans-

ferred out of the NHS in much the same way as long term care and continuing care responsibilities were transferred out in 1996. Patients who cannot get access to general practices or services of commissioning consortiums may have to default to local authorities, which would become the provider of last resort, and the core functions of the health secretary will shift to the chargeable local authority sector.⁷

Equity of access

The secretary of state has no duty to promote equity of access apart from a vague duty to “have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service” (section 3). The NHS Commissioning Board will not have a general power of direction over consortiums or be under a duty

to ensure equal access for equal need to health services. A vague and unenforceable equity duty also applies to consortiums, which will be required to



“have regard to the need to reduce inequalities between patients” (sections 19 and 22). Equality of access is not a required outcome of consortiums’ duty to secure “continuous improvement” from the provision of services (section 22, 14L, 3); nor is it part of annual “commissioning plans” that consortiums will be required to prepare (section 22, 14Y). These will cover only continuous improvement and the financial duty to break even.

Duty to provide services free of charge

There are new mechanisms to introduce charges and privately funded healthcare. The secretary of state’s duty to provide free services that are “part of the health service in England,” except where charges are expressly allowed (section 1, 4), is undermined because the power under the Health and Medicines Act 1988 to impose charges is transferred from the secretary of state to consortiums (section 22). Consortiums will determine which services are part of the health service and which are chargeable (section 9), and they have been given a general power to charge (section 7, 2h).

The cap on foundation trusts’ generation of income from private care will be abolished (section 150). They will be able to charge for hospital accommodation⁷ and, without reference to Monitor, amend their primary purpose of providing services to the NHS (section 146). The government has signalled elsewhere that the introduction of personal health budgets is “a high priority,”⁸ and pilots show they are linked to top-up charges.⁹

Mechanisms for allocating resources

The funds allocated to primary care trusts are determined by using formulas adjusted for area based population and needs. However, the budgets of consortiums will be allocated on the basis of aggregated general practice lists rather than geographical population.⁸

To mitigate the risks of adverse selection (risks that some consortiums will attract sicker and more expensive patients) the bill proposes a risk equalisation mechanism in which consortiums can establish a pooled fund to off-set costs in consortiums that have different proportions of high and low risk patients.¹⁰ However, the absence of individual risk data and robust resource allocation methods is problematic,^{11 12} as are the high transaction costs associated with risk equalisation funds.

Commissioning budgets based on membership resemble European sickness funds, in which members share costs among themselves rather than across the whole society.¹³ Sickness funds are associated with unequal risk bearing among pools, risk selection, patient charges, and supplementary insurance. Compensatory

Box 2 | Freedoms created under the new bill

Investor-run commissioners and providers will be free to

- Invest in and form companies
- Use commercial contracts to bring in commercial providers
- Define the range of services to be provided and patient entitlements under the NHS
- Charge for some elements that are currently NHS services and for health services they determine are no longer covered by the NHS
- Generate and distribute surpluses to shareholders, investors, and employees by underspending the patient care budget
- Use competition law to challenge public policies that impair their profitability and freedom to operate
- Contract out all NHS services to a range of private providers
- Select patients and services
- Determine staff terms and conditions

Box 3 | Amendments to ensure continuation of NHS comprehensive healthcare

- Restore the duty of the secretary of state for health to provide or secure the provision of comprehensive healthcare throughout England to such extent as he or she considers necessary to meet all reasonable requirements
- Impose a duty on general practice commissioning consortiums to provide comprehensive healthcare for all residents in geographically defined areas and fund them accordingly and on the basis of need
- Impose a duty on the NHS Commissioning Board to retain and further develop a system of resource allocation based on the healthcare needs of all residents of geographically coterminous areas
- Withdraw the power granted to commissioners to charge for healthcare services and reserve the power to the health secretary
- Remove health services from jurisdiction of competition law
- Require the health secretary to ensure continuity of patient care through administrative and financial integration of provider services under the jurisdiction of geographically defined consortiums (as in Scotland and Wales)
- Impose a duty on the health secretary to protect professional autonomy and increase direct public accountability
- Impose a duty on the health secretary to abolish financial incentives to create and distribute surpluses by underspending patient care budgets

risk equalisation mechanisms are inefficient, expensive,¹⁴ and increase risk selection because funds avoid high risk patients on financial grounds.¹⁵

Abolition of direct control over NHS provision

Greater corporate involvement in primary care
Although the NHS Commissioning Board will have a duty to “secure the provision of primary medical services throughout England” (schedule 4, part 5) “to the extent that it considers necessary” (schedule 4, part 4), consortiums will become budget holders and determine which primary services they contract, from whom, and at what cost. Patients may therefore be exposed to a plurality of primary care contractors for different services. All general practices will be required to join a commissioning consortium. Various bodies can apply to become a commissioning consortium, including foundation trusts and for-profit organisations that run general practices.

Increasingly, general practice and commissioning functions will be operated and managed by for-profit companies, 23 of which (including Virgin, Care UK, and Chilvers McCrae) reportedly already run 227 general practices.¹⁶ Professional autonomy will be eroded if, for example, referral management centres run by corporate providers are used to ensure referral and prescribing practices conform to corporate budgets (schedule 12, 1) and the needs of shareholders. These centres are currently rejecting one in eight general practitioner referrals¹⁷ and seem to operate along the lines of “prior authorisation” arrangements in the United States, whereby doctors are required to obtain approval from a higher authority before making a referral for treatment or investigation. Some of the centres, such as UnitedHealth UK’s recently established “referral facilitation service” in Hounslow, London, are run by subsidiaries of US multinationals.

Abolition of NHS trusts

From 1 April 2014, all NHS hospital and community trusts are required to become foundation trusts. Foundation trusts may enter into joint ventures with and distribute surpluses to for-profit companies and raise commercial loans without restriction. The NHS Commissioning Board and general practice consortiums will also have powers to form and invest in commercial companies (schedule 4, part 10).

Provider regulation will be overseen by Monitor, whose primary duty will be to promote competition. Controversially, regulation by Monitor and the Quality Care Commission will be chiefly through commercial licensing and contracting (box 1, p 800)¹⁸ and limited by a duty of “maximising the autonomy of individual

commissioners and providers and minimising the obligations placed upon them.”⁸ Regulators are required not to impose “unnecessary burdens” and regulation can be dispensed with as more providers enter the market place.⁷ The “necessity” of public regulation can be challenged by corporations in the courts. Proposals by the European Commission to introduce such tests to health services created Europe-wide controversy in 2004 and had to be withdrawn because they were deemed to conflict with public health policies such as controls over market access.¹⁹ However, conflict between competition policy and the health secretary’s duty to promote a comprehensive service will be resolved not by parliament but by Monitor, “in the manner it considers best” (section 55).

Section 52 of the bill proposes new competition duties that will allow remaining public controls over health services to be challenged by multinational companies and investors anywhere in the world.²⁰ Trade rules outlaw public policies that prevent, restrict, or distort competition in trade within the UK or the European Union such as setting prices, public subsidies for teaching and research, and controls designed to ensure fair distribution of resources. Rules on free movement of capital could undermine powers that the government proposes to reserve for protection of service continuity.²¹ One company, Circle, the first to take over a foundation trust, is already using competition rules to challenge a primary care trust’s decision to restrict the volume and range of services under the commercial contracts for NHS elective surgery.²²

Freedom to create surpluses from care budget

The bill explicitly authorises the creation of surpluses from the patient care budget and their distribution to staff and shareholders as part of financial incentive or bonus schemes (section 23). Surpluses can be generated by selecting patients or services, denial of care, or reductions in staff terms and conditions, responsibility for which will be transferred to corporate bodies. The secretary of state cannot be held to account for diversion of NHS funds from patient care to staff or investors.

The end of the NHS?

The government proposes a commercial system in which the NHS is reduced to the role of government payer, equivalent to Medicare and Medicaid schemes in the US. However, government belief that cost efficiency, improved quality, and greater equity flow from competition in healthcare markets²² is not supported by evidence, the Office of Fair Trading, the government’s impact assessment, or its experience of independent treatment centres and private

finance initiatives.²³⁻³¹

In order to create a commercial market the government has repealed the health secretary’s duty to provide or secure the provision of comprehensive care and has abolished the structures and mechanisms that follow from this duty. It has granted new powers and financial incentives to corporate commissioners and investors to redefine eligibility and entitlement for NHS funded care, select out profitable patients and services, and introduce regressive funding through patient charges and private healthcare (box 2).

In box 3 we list some key amend-

ments to ensure continuation of NHS comprehensive healthcare throughout England. The stark alternative is exposure of NHS funds and provision to international competition laws that will further limit the ways in which governments can intervene in markets to off-set unwanted effects for public health. Unless the amendments are made, the bill as drafted amounts to the abolition of the English NHS as a universal, comprehensive, publicly accountable, tax funded service, free at the point of delivery.

Allyson M Pollock is professor

David Price is senior research fellow, Centre for Health Sciences, Barts and The London School of Medicine and Dentistry, Queen Mary’s College, University of London, London E1 2AT, UK

Correspondence to: A M Pollock allyson.pollock@gmail.com

Accepted: 9 March 2011

Contributors and sources: AMP and DP have studied, taught, and reported widely on health system reform in the UK and abroad. This article follows extensive research into government policy and on private sector participation in the NHS over two decades.

Competing interests: None declared.

Provenance and peer review: Not commissioned; externally peer reviewed.



The bill as drafted amounts to the abolition of the English NHS as a universal, comprehensive, publicly accountable, tax funded service, free at the point of delivery

- 1 Department of Health. *Equity and excellence: liberating the NHS*. Cm7881. Stationery Office, 2010.
- 2 White paper challenging timetable. *Health Adviser* 2010;3:5.
- 3 Campbell D. Opponent of NHS reform driven by grim memory of 60s. *Guardian* 2010 Nov 19. www.guardian.co.uk/society/2010/nov/19/nhs-gp-leader-clare-gerada.
- 4 House of Commons. *Health and social care bill 2010-2011*. Stationery Office, 2011.
- 5 Pollock AM, Leys C, Price D, Rowland D, Gnani S. *NHS plc: the privatisation of our health care*. 2nd ed. Verso, 2005.
- 6 House of Commons Health Committee. *Commissioning. Third report of session 2010-2011*. Stationery Office, 2011.
- 7 House of Commons. *Health and social care bill 2010-11. Explanatory notes*. Stationery Office, 2011. <http://services.parliament.uk/bills/2010-11/healthandsocialcare/documents.html>.
- 8 Department of Health. *Liberating the NHS: legislative framework and next steps. A consultation on proposals*. DH, 2010.
- 9 House of Commons Health Committee. *Top-up fees. Written evidence*. Stationery Office, 2009. www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/194i/194i.pdf.
- 10 Department of Health. *Commissioning for patients*. Stationery Office, 2010.
- 11 Person Based Resource Allocation Team. *Developing a person-based resource allocation formula for allocations to general practices in England*. Nuffield Trust, 2009.
- 12 Department of Health. *Advisory Committee on Resource Allocation summary of recommendations*. 2010. www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/index.htm.
- 13 Mossialos E, Dixon A, Figueras J, Kutzin J, eds. *Funding health care: options for Europe*. Open University Press, 2002.
- 14 Van de Ven WP, Beck K, Buchner F, Chemichovsky D, Gardiol L, Holly A, et al. Risk adjustment and risk selection on the sickness fund insurance market in five European countries. *Health Policy* 2003;65:75-98.
- 15 Van de Ven WP. Risk adjustment and risk equalization: what needs to be done? *Health Econ Policy Law* 2011;6:147-56.
- 16 More than 200 GP surgeries now run by private companies. *Circle News* 2010 Jul 15. www.circlehealth.co.uk/news/2010-july/more-than-200-gp-surgeries-now-run-by-private-companies.
- 17 Quinn I. GP ‘referrals clampdown’ in breach of competition rules. *Pulse* 2011 Feb 24. www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4128650&c=2.
- 18 Department of Health. *Liberating the NHS: regulating healthcare providers. A consultation on proposals*. DH, 2010.
- 19 Rowland D, Price D, Pollock AM. The implications of the draft EU directive for health care. *Lancet* 2004;364:1200-2.
- 20 Bemasconi-Osterwalder N. European parliament hearing on foreign direct investment. International Institute for Sustainable Development, 2010. www.iisd.org/publications/pub.aspx?pno=1365.
- 21 Dawson D, Mountford L. Health care services and the single European market. OHE Briefing. Office of Health Economics, 2008.
- 22 Laja S. Healthcare partnership refers NHS trusts to competition panel. *Guardian* 2011 Feb 23. www.guardian.co.uk/healthcare-network/2011/feb/23/circle-bath-wiltshire-pct-competition-referral.
- 23 Department of Health. *Health and social bill 2011. Impact assessments*. DH, 2011.
- 24 Melhado E. Economic theory, economists, and the formulation of health policy. *J Health Politics, Policy Law* 2000;25:233-56.
- 25 Morris S, Devlin N, Parkin D. *Economic analysis in health care*. Wiley, 2007.
- 26 Department of Health. *Health and social bill 2011. Equity impact assessments*. DH, 2011.
- 27 Office of Fair Trading. *Choice and competition in public services. A guide for policy makers*. Office of Fair Trading, 2010.
- 28 Anderson F. Health spending in the United States and the rest of the industrialized world. *Health Aff* 2005;24:903-14.
- 29 Himmelstein D, Woolhandler S, Hellander I. *Bleeding the patient: the consequences of corporate health care*. Common Courage Press, 2001.
- 30 Marini G, Street A. A transaction costs analysis of changing contractual relations in the English NHS. *Health Policy* 2007;83:17-26.
- 31 Arrow KA. Uncertainty and the welfare economics of medical care. *Am Econ Rev* 1963;53:941-73.

Cite this as: *BMJ* 2011;342:d1695

See ANALYSIS, p 804

Can the government's proposals for NHS reform be made to work?

The new health bill is contentious, and growing professional opposition to some aspects could undermine the reforms. **Kieran Walshe** and **Chris Ham** suggest some changes that may help the government to make its reforms work

Since the publication of the coalition government's white paper in July 2010,¹ the political, professional, media, and public response to the proposed National Health Service reforms has shifted from incomprehension, through scepticism, towards increasing opposition.² Many important stakeholders whose support will be essential, such as general practitioners, NHS managers, patient groups, and local authorities, do not accept the need for these reforms³ and fear their potential risks and costs for the NHS at a time of huge financial challenge.⁴ But preparations for their implementation have proceeded apace, in advance of legislation, and their reversal would now be very difficult.

The two main stated aims of the reforms—improving quality and outcomes for patients, and making health services more patient centred—unsurprisingly command universal support. So do some of the mechanisms for achieving those aims, such as greater localism—creating an NHS that is effectively managed and organised by and for the communities it serves, is responsive to the needs and concerns of patients both individually and collectively, and in which there is both less cause and less opportunity for the Department of Health to micromanage the NHS from a distance and to intervene with central directives. The emphasis on creating an NHS in which clinical professionals work collaboratively to provide consistently high quality, effective and efficient healthcare, and where clinicians take the lead in designing care pathways and take responsibility for the use of resources is also widely endorsed.

The main area of contention concerns the development of competition among providers, the increased role of the private sector, and the wider use of other market mechanisms.⁵ We suggest some changes to the bill that would secure greater support from stakeholders and reduce the risks associated with its implementation, focusing on three main areas: general practice commissioning consortiums and primary care, competition and choice, and system governance and accountability.

Commissioning consortiums and primary care

At the heart of the proposals is the intention to create general practice consortiums that will com-

mission health services for the populations they serve. The government is determined that these consortiums will be different from the primary care trusts they replace—more autonomous and clinically led, and more effective at commissioning from powerful secondary care providers. The experience of commissioning in the NHS and elsewhere suggests important modifications to the reforms would make them more likely to succeed.⁶

Firstly, although some consortiums may be able to take on a full set of responsibilities in 2013, many will need much more time to evolve and mature.⁷ A graduated approach to authorising consortiums should be adopted in which they take on functions of increasing complexity as they are able to show that they are capable of doing so. This would not be dissimilar to the process for authorising NHS foundation trusts, where it has taken several years (and often more than one attempt) for NHS trusts to satisfy the regulatory agency Monitor that they are capable of holding foundation status.⁸

Secondly, the consortiums must be able to take responsibility for the quality and nature of primary care provision if they are to be effective in commissioning secondary care because the two are so interdependent. The government envisages that the NHS Commissioning Board will be responsible for commissioning primary care, but it should do so in partnership with commissioning consortiums. Consortiums will have the knowledge of primary care provision in their areas and credibility with general practitioners that are essential to improve standards of provision.

Thirdly, consortiums have to be able to take sensible “make or buy” decisions—whether to provide services through their constituent practices or commission them from elsewhere—but this must be done in a way that is completely transparent and accountable and ensures that potential or actual conflicts of interest for general practitioners in particular are dealt with robustly.

Fourthly, the commissioning function should be essentially a public responsibility that cannot be devolved or fully outsourced. Consortiums might seek support and advice on commissioning from private entities,⁹ but they must remain publicly accountable for all commissioning decisions and resources, and information about commission-

ing and provision must be in the public domain. Finally, consortiums need effective governance arrangements that embrace relevant patient, professional, and population interests. The bill says little about consortiums' constitutions and governance. It should do more to ensure that primary care clinicians other than GPs, secondary care clinicians, patients, users, and local authorities are properly represented and involved, that consortiums' business is open to public scrutiny, and that formal safeguards of financial probity such as having an audit committee, a qualified financial director, and independent external audit are all in place. The new health and wellbeing boards led by local government should be given a bigger role in governance of consortiums, including the opportunity not just to comment on but to influence their commissioning priorities and plans.

Choice and competition

A large part of the health bill is concerned with establishing the mechanisms for competition between providers in the NHS—for example, the new economic regulator, the rules and regulations for competition, and the setting of service tariffs. It restates the freedom of patients to choose where they are treated and suggests that they will be able to turn for treatment to “any willing provider,” not just those with whom their general practice commissioning consortium may have agreed contracts.

Competition is not an end in itself but a means to achieve improved performance.^{10 11} But both international and NHS experience suggest that competitive markets in healthcare are often imperfect—the effects of information asymmetry, natural monopoly, vertical service integration, service co-dependencies, costs of market entry, and so on can make it difficult to realise the benefits of competition and can instead produce a range of adverse and unintended consequences such as patient selection by providers, overtreatment, and lower clinical quality.¹² The introduction of greater competition needs to be phased and evaluated to ensure it is delivering improved performance.

The bill needs to create ways to allow commissioning consortiums to use competition and contestability to improve performance rather than stipulate competition in all circumstances

regardless of the likely effects on performance and expose consortiums to legal challenges if they do not put services out to tender. Existing guidance¹³ on the principles and rules for cooperation and competition should be revised to set out more explicitly the circumstances in which competitive tendering is required—primarily where existing services are poorly performing, expensive, or do not meet patients' needs, or where there are credible alternative providers that can offer better value for money. If consortiums do not use these opportunities to drive improvement, Monitor could use its powers to promote competition in areas where it is likely to improve performance.

The government should also be clearer about the intended scope and purpose of “any willing provider” arrangements in the bill. Currently it seems that once a provider is approved by the NHS Commissioning Board it would be able to offer services to patients of any commissioning consortium, and no consortium could refuse to use them without good cause. Similar arrangements have been in place in planned and elective care since 2006 (at least in theory, though uptake has been limited).¹⁴ The impact of these experiments should be evaluated before “any willing provider” is extended to other services.

The bill should also do more to enable commissioning consortiums to plan and deliver integrated systems of care, especially for patients whose healthcare needs are complex and intensive. That implies some restriction of patient choice of provider, since planned and integrated systems or pathways for care require a closely coordinated network of providers. This does not rule out contestability among providers for roles within that network; nor should it prohibit competition between organisations to be the lead providers within networks for a defined period. The way in which competition is implemented in the NHS needs to be sensitive to the requirements of different services and to allow for competition between clinically integrated systems when this will benefit patients.¹⁵ The bill needs explicitly to allow commissioning consortiums to balance their duty to the individual patient to offer free choice against their duties to the wider patient population to plan and provide effective and efficient health services through integrated networks that offer advantages for the community.

System governance and accountability

For many decades, the NHS in England has been managed through a hierarchy of organisations with the Department of Health at its apex. Legislation has given the secretary of state huge decision making discretion and extensive powers of direction over the whole system. The Health and Social Care Bill abolishes much of that hierarchy, explicitly reduces the powers and duties of the secretary of state in ways designed to prevent the Department

Proposed modifications to the NHS reforms in England

Commissioning consortiums and primary care

- Create a graduated and phased approach to authorising consortiums, in which they take on increasing functions as they become capable of doing so
- Enable consortiums to be directly involved in managing primary care and influencing clinical standards and processes, working with the NHS Commissioning Board
- Allow consortiums to take sensible “make or buy” decisions without rules which require competition by default but with robust arrangements to deal with conflicts of interest
- Ensure that commissioning remains a public responsibility that consortiums cannot wholly outsource, and ensure information remains in the public domain
- Put in place strong governance arrangements for consortiums

Choice and competition

- Allow consortiums to use competition and contestability only where it is likely to improve performance and define those circumstances more clearly
- Assess the impact of “any willing provider” arrangements in areas where it is currently used (eg, elective care) before future expansion
- Allow consortiums to plan and deliver integrated care through provider networks (that is, allow them to constrain individual choice in the interests of collective benefits for efficiency and quality of care)

System governance and accountability

- Define more clearly the circumstances in which the secretary of state's reserve powers over the NHS Commissioning Board and other bodies might be used to avoid inappropriate intervention
- Define more clearly the governance arrangements and ways of working of five key national bodies—the NHS Commissioning Board, Care Quality Commission, Monitor, NICE and the Department of Health
- Create strong governance arrangements for consortiums that ensure they look first to the communities they serve rather than upwards to the NHS Commissioning Board when setting priorities
- Give consortiums meaningful autonomy and accountability and reserve the NHS Commissioning Board's powers of intervention for cases of serious financial or clinical concern
- Plan for primary care trusts clusters to become collectively owned federations of consortiums providing shared and specialist services such as commissioning and service reconfiguration



of Health from continuing to manage the NHS, and creates two national quangos—the NHS Commissioning Board and Monitor—to take on many of the health department's current powers.

But the bill retains extensive reserve powers of intervention for the secretary of state, and it is likely that the political dynamics nationally and locally will be so strong that the Department of Health will be drawn in to intervene—for example, at times of financial or clinical crisis. At a national level, it is difficult to see who, if anyone, will be in charge of the NHS. There will be five key national bodies: the Department of Health, the National Institute for Health and Clinical Excellence, the Care Quality Commission, the NHS Commissioning Board, and the economic regulator Monitor. Although the remit of each is set out in legislation, it is not clear how these national bodies will interact or how they will provide coordinated and consistent governance of the NHS. Experience suggests there is a substantial risk of conflict, and if this happens the Department of Health will be drawn in to direct and manage the NHS more extensively than envisaged.

The bill should therefore define more clearly the circumstances in which the reserve powers of the secretary of state might be used, and formal guidance should be developed to avoid inappropriate

intervention. The governance relationships, ways of working, and accountabilities of the national bodies also need to be defined and described—for example, through a jointly developed and published agreement among those bodies.

The abolition of strategic health authorities may seem like a good way to reduce NHS management costs, but it will leave a substantial organisational distance between the NHS Commissioning Board and general practice commissioning consortiums. This creates a risk that strategic health authorities are simply reinvented as outposts or offices of the NHS Commissioning Board, and that could produce greater centralism not localism. Three modifications to the reforms are needed to deal with this. Firstly, the creation of strong systems for local governance for commissioning consortiums, which we discussed above, will ensure that they look locally, to the communities they serve, rather than upwards to the NHS Commissioning Board. Secondly, guidance is needed on the intended relationship between the NHS Commissioning Board and consortiums. This should give the consortiums meaningful autonomy and accountability and reserve the NHS Commissioning Board's substantial powers of intervention for cases of serious financial or clinical concern. Thirdly, the primary care trust (PCT) clusters now being formed—groups

of trusts that have been merged in all but name, partly to save on management costs—should not be seen as purely transitional arrangements but should have a longer term role.¹⁶ In the short to medium term these PCT clusters will need to support general practice consortiums and undertake some functions and responsibilities that consortiums are not yet capable of assuming full responsibility for. But in the longer term, we suggest that PCT clusters should become federations or collectives of commissioning consortiums, led and managed by the consortiums themselves, and existing to provide shared and specialist services that no individual consortium might provide for itself. One essential function would be to plan and coordinate redesign and reconfiguration of services across a health economy, which will often require a high level of collaboration and shared decision making across multiple consortiums.¹⁷ In time, much of the responsibility for specialised commissioning, which the bill proposes centralising in the NHS Commissioning Board, could be transferred to these federations.

Conclusion

The parliamentary arithmetic suggests that the Health and Social Care Bill will, perhaps in modified form, become legislation later this year. But making that legislation produce improved per-

formance in the NHS, better value for money for the taxpayer, and better clinical outcomes for patients requires the support and engagement of many stakeholders.¹⁸ The current disengagement evident across key groups like healthcare professionals and managers represents a serious challenge to the reforms. It would be a mistake to assume that these groups will simply come to accept the reforms in time, and there is a real risk of the reforms failing at considerable political cost to the government. Modifications of the kind we have set out would be compatible with the core aims of the government's policies, would minimise the risks involved in taking them forward, and would make the reforms more likely to command the support of those who are needed to make them work.

Kieran Walshe is professor of health policy and management, Manchester Business School, Manchester, M15 6PB, UK

Chris Ham is chief executive, King's Fund, London W1G 0AN, UK

Correspondence to: K Walshe kieran.walshe@mbs.ac.uk

We thank Jennifer Dixon, Naomi Chambers, Nigel Edwards, and Martin McKee for their comments.

Contributors and sources: KW and CH have studied, reported, and advised on health reform and health policy in the UK and elsewhere. This paper is based on an analysis of publications on the current health reforms in England, and draws on our discussions with many people working in and with the NHS.

Competing interests: None declared.

Provenance and peer review: Commissioned; externally peer reviewed.

- 1 Department of Health. Equity and excellence: liberating the NHS. DH, 2010.
- 2 Delamothe T, Godlee F. Dr Lansley's monster: too soon to let it out of the lab. *BMJ* 2011;342:d408.
- 3 Nuffield Trust. Snapshot survey of health leaders on the government's NHS reforms. Nuffield Trust, 2011.
- 4 NHS Confederation. Liberating the NHS: what might happen? NHS Confederation, 2011.
- 5 Ham C. Competition in the NHS in England. *BMJ* 2011;342:d1035.
- 6 Nuffield Trust. Giving GPs budgets for commissioning: what needs to be done? Nuffield Trust, 2010.
- 7 Thorlby R, Rosen R, Smith J. GP commissioning: insights from medical groups in the United States. Nuffield Trust, 2011.
- 8 Monitor. Annual report and accounts 2009-10. Monitor, 2010.
- 9 Naylor C, Goodwin N. Building high quality commissioning: what role can external organisations play? King's Fund, 2010.
- 10 Gaynor, M. Competition and quality in health care markets: what do we know, what don't we know? Department of Public Policy, Carnegie Mellon University, 2004.
- 11 Porter M, Olmstead E. Redefining healthcare: creating value based competition on results. Harvard Business Press, 2006.
- 12 Smith P. Market mechanisms and the use of health care resources. In: Achieving better value for money in health care. Directorate for Employment, Labour and Social Affairs, Health Division, 2009:53-77.
- 13 Department of Health. Principles and rules for cooperation and competition. DH, 2010.
- 14 Cooperation and Competition Panel. Review of the operation of "any willing provider" for the provision of routine elective care: interim assessment. CCP, 2011.
- 15 Ham C, Dixon J, Chantler C. Clinically integrated systems: the future of NHS reform in England? *BMJ* 2011;342:d905.
- 16 Smith J, Charlesworth A. Managing the transition. Nuffield Trust, 2011.
- 17 Palmer K. Reconfiguring hospital services: lessons from south east London. King's Fund, 2011.
- 18 Health Select Committee. HC513-II. Third report—commissioning. Stationery Office, 2011.

Cite this as: *BMJ* 2011;342:d2038

See ANALYSIS, p 800

COMMENTARY

Fixing the policy may not sort out the politics

There has been growing disquiet about the NHS Health and Social Care Bill and how the reforms will work in practice. Walshe and Ham's long list of proposals covers many of these.¹ Others remain, including changes to the public health system and the Health Protection Agency, concerns about workforce planning and education, and unanswered questions about organisations that will not be able to become foundation trusts. All these points will need to be addressed, but fixing the technical issues is only part of the problem. Fixing the politics, telling the story, and containing the anxiety that has been created may be much harder.

Major reforms require a strong narrative about why the inevitable upheaval they involve will be worthwhile. This is missing, and when the story has been told it has often seemed either highly complex and technocratic or vague. Reducing bureaucracy is a popular idea, but it is not strong enough to justify the policy. The argument that the NHS has poor outcomes has often unravelled, with ministers being rapidly and authoritatively contradicted.² This has left an uncomfortable feeling that this justification was hastily cobbled together. This impression is heightened by the Department of Health providing negative comments about the NHS to counter positive stories³ and having to be pressured to

publish favourable opinion polling.⁴ Even if the case for change is strong, the government has not made the case that this particular set of reforms is the answer.

This confusion is a concern because it makes the change management task inside the NHS much harder. Furthermore, without a government narrative, others will supply alternatives—and in the absence of evidence to the contrary these other narratives will often attribute sinister motives.⁵ The fact that the reform programme departs from the manifestos and coalition agreement in creating not one but two top-down reorganisations (the NHS and public health) further weakens the ability of government to respond to these alternative stories.

The bill only creates a framework; it is how it will operate in practice that matters, and here too the narrative is missing. The area that concerns many parliamentarians is accountability. What recourse is there if a hospital closes a department? Or a general practice consortium refuses to fund a high cost drug? The current accountability arrangements are poor, but the removal of the secretary of state from day to day decision making and the complexity of the new system may not be an improvement. This is a huge change from 60 years of expectation that governments are accountable and secretaries of

state intervene. Adding local politicians to general practice consortiums is not likely to solve the problem, and it is strange to depoliticise the NHS at national level only to reintroduce politics locally. Crucially, parliament and the public still expect national accountability.

The complexity of the changes, the failure to explain or make a strong case for them against the background of positive polling and widespread suspicion may mean that more than just technical changes will be required.

Nigel Edwards is acting chief executive, NHS Confederation, London SW1E 5DD, UK nigel.edwards@nhsconfed.org

Competing interests: None declared.

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

- 1 Walshe K, Ham CJ. NHS reform: can the government's proposals be made to work? *BMJ* 2011;342:d2038.
- 2 Goldacre B. Don't cherry pick NHS findings minister. *Guardian* 2011 Feb 12. www.guardian.co.uk/commentisfree/2011/feb/12/bad-science-ben-goldacre-nhs.
- 3 Roberts M. England healthier than US. *BBC News* 2011 Mar 9. www.bbc.co.uk/news/health-12674976.
- 4 Helm T. Andrew Lansley accused of burying poll showing record satisfaction with NHS. *Guardian* 2011 Mar 19. www.guardian.co.uk/society/2011/mar/19/nhs-andrew-lansley-healthcare-reform?CMP=tw_t_fd.
- 5 Pollock AM, Price D. How the secretary of state for health proposes to abolish the NHS in England. *BMJ* 2011;342:d1695.

Cite this as: *BMJ* 2011;342:d2039