EDITOR'S CHOICE

NHS reconfiguration: coming ready or not

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Under the Hoover presidency, American voters were promised a chicken in every pot and a car in every garage. English voters behave as if in a similarly far off time they were promised a fully equipped hospital no further than a bus ride away. Woe betide any politician who attempts to renege on this imagined promise.

The brutal truth, however, is that some services will have to close—whether as the result of central planning or the dead hand of the market. Two news stories this week tell us why. Caroline White reports the latest audit of the proportion of patients receiving primary angioplasty for myocardial infarction, which ranges from 5% to 93% in England's 28 cardiac networks (doi:10.1136/bmj.d5508). As the patient representative on the audit project says: "The safest and most effective treatment for heart attack is at the specialised and centralised heart attack centre," and not every local hospital can provide such a service. Yet politicians continue to fight shy of endorsing service closures in public, says Roger Boyle, until recently the national director for heart disease and stroke.

The second news story discusses the review by the think tank Civitas of London's HIV services (doi:10.1136/bmj.d5661). It counted 23 hospital trusts delivering HIV outpatient services in the city. "Encouraging specialisation and excellence in specific areas is more likely to find real savings than the government's broad brush commissioning reform," concluded James Gubb, one of the report's co-authors.

In his feature on the politics of NHS reconfiguration, Sam Lister describes the battles that follow any suggestion for service closures, no matter how justified they may seem on objective analysis (doi:10.1136/bmj.d5311). Presumably, today's politicians are spooked by the success of Dr Richard Taylor,

who ousted the sitting Labour MP in the 2001 general election on the single issue of reopening Kidderminster's accident and emergency department. It's why before the last election all three political parties pledged to keep my very own district general hospital open—none could risk losing votes over the issue.

In its report this week, the King's Fund says that reconfiguration of hospital services is a necessity, not an option, and too often politicians are the barrier to change (doi:10.1136/bmj.d5669). It argues that these fraught decisions should be depoliticised: the Independent Reconfiguration Panel, rather than the secretary of state, should have the final say, and an independent commission should have a mandate to drive through change.

No doubt politicians would always like to do the very best for their country, but sometimes their need to get re-elected can conflict with their nobler aims. Conflicts of interest were the topic of a recent editor's choice by Fiona Godlee (*BMJ* 2011;343:d5147). She asked whether the *BMJ* should ban editorials and clinical reviews from authors with ties to industry. So far two dozen people have responded, and this week we devote two pages of Letters to their responses (p 493). As expected, there's a wide range of opinions and rationales. I was particularly interested in the results of a survey of drug bulletins, which we regard as the squeakiest of the squeaky clean. All 28 bulletins responding to the survey endorsed the importance of disclosure of conflicts of interest, but only four limit authorship to those known to lack conflicts. We'll let you know what the *BMJ* decides.

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