NHSCA

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PATIENT POWER, DEMOCRATIC ACCOUNTABILITY AND THE MARKET

'Patient power' is a much used and frequently abused term. In the context of the NHS, it has clear rhetorical value and constitutes the theme of many a political, consciousness raising message. It slots rather well into the consumerist view of the patient as the ultimate 'customer' in the new, market-shaped configuration into which the English NHS is being driven. Some health economists influencing the evolution of central NHS policy argue that the patient, appropriately empowered, will by the exercise of choice drive down price and drive up quality. In today's NHS healthcare is a commodity and the clinical encounter is a trading transaction, a concept readily grasped by those coming in from the commercial world to manage the 'new NHS'.

Apart from the fact that an effective market requires clear understanding of the nature and relative values of the competing products and an excess of supply over demand, the acolytes of Adam Smith fail to recognise that, as the late and great Douglas Black reminded us, medicine as well as a number of other of society's activities, were excluded from this blind process. One of the moves to facilitate the operation of the 'invisible hand' of the market in a post-Bevanite NHS is the proposal in the recent Health Bill to introduce individual health budgets later this year. This further contribution to patient choice, which will include cash payments will, it is supposed, provide a further fillip to the NHS market.

Health Budgets

The evidence base for the introduction of health budgets is very slender, drawn from experience reported from the selective piloting of individual budgets in social care provision (Evaluation of the Individual Budgets Pilot Programme www.kcl.ac.uk/research/groups/healthsoc/scwru.html). The main advantage claimed was 'psychological'. Patients felt more in command of their care. However, this benefit was bought at the price of new and increased operational complexities. These included deciding on the appropriate individual budget quantum, hearing appeals, assessing allowable and non-allowable choices, negotiating legal and commercial barriers and satisfying a new range of accountancy procedures. The public has meanwhile been regaled with anecdotal spin offs - e.g. funding of the purchase of a football season ticket for a friend to describe the games to a partially sighted beneficiary and a lady with chronic respiratory disease who installed air conditioning instead of seeking hospital admission.

Individual health care budgets drawn on the NHS account will be even more difficult to set and run. What proportion of the 80% of the total NHS budget now controlled by Primary Care Trusts (PCTs) will be allocated to individual patient budgets? For long term conditions like diabetes, for instance, it seems that the patient will be free to decide whether to buy their care from the GP or the hospital specialist team, perhaps preferring to try homeopathy or Chinese traditional medicine instead. What's to be done if the budget has been misspent and runs out or in the face of some sudden complication. Care on tick? How much active marketing will be allowed to competing providers? Cut price lines, two for one offers? Will the judicious use of top ups by those who can afford them ensure the availability of, or more rapid access to, scarce NHS items, skills or services. It will presumably be the responsibility of the health care professional to set out the alternatives (presumably with prices) and to assist the patient in making the choice free of any conflict of interests. Discussing and advising on alternative treatments differs little from today's practice except that cash will enter the care equation. Each PCT may develop its own list of approved diseases and/or treatments which it is prepared to fund via the patient budget. What is on and what is off that list is likely to vary from PCT to PCT and from time to time, depending on the funds available. Will it require something like the ill-fated Oregon citizen juries to compile and review the lists? It seems highly questionable whether the outcome justifies the inevitably increased bureaucratic costs and the predictable outcry about postcode lotteries in the NHS.

Democratic Accountability

Of broader concern in the future of the NHS is the general question of democratic accountability. The social ascendancy of economic neoliberalism and the free market philosophy during the Thatcher years spread the worship of hard-nosed business managerialism and the expulsion of the public voice well beyond the industrial and service industries and into social enterprise. Those years saw the progressive replacement of the democratic impulse and input with powerful, target-conscious, career-orientated management, responsible only to a directorial board and shareholders or to appointed quangos. NHS hospitals finally fell victim when the trust structure of market orientated management and operation was imposed by the 1990 National Health Service and Community Care Act.

It is an arrant distortion of history to claim that those Thatcher/Clarke 'reforms' (the apostrophes remain irresistible) freed the NHS from a prior tyrannical 'command and control', Soviet-style structure. In many ways the reverse is true. There was a remarkable degree of autonomy, with hospital policies being set locally, much influenced by local staff and local authority. Many operational decisions were devolved well down the management structure and much accountability was to colleagues and patients.

Progressive NHS underfunding highlighted and aggravated the many systemic shortcomings and frozen postures of the NHS and made the need for true reform painfully apparent. It was a swashbuckling Ken Clarke who, as Health Secretary, installed a centrally directed management structure operating to Whitehall instruction throughout the NHS hospital service. It was Thatcher, not Stalin, who determined to smash the power of the professionals and replace it with 'branch managers'.

The Resource Management Initiative of the late 1980s was an interesting and informative pilot study of institutional self-regulation. It was restricted to a few hospitals, however, with little relevance to primary care and, though showing many promising features, ran directly counter to the Downing Street drive to professional disempowerment. It was subsequently been ignored as the tsunami of internal market management structure was imposed on the hospital service.

Democratic accountability was not restored to the NHS in any real sense after the 1997 change of Government, contrary to the hopes and expectations of many. Not only was there failure to honour an explicit election pledge to abolish the internal market but in many respects, in England, the competitive market has been further developed. The long-awaited return of democratic accountability has failed to materialise and has been represented by a succession of well-meaning but toothless user groups. The prompt winding up and dissolution of Barbara Castle's Community Health Councils which held at least some hospital managements to account was an indicator of distaste for the occasionally strident encounters with public opinion.

NHS policy making and implementation along competitive market lines has been virtually continuous since 1990 with some change of nomenclature since 1997 but intensification of processes. The deliberate stimulation of private sector involvement in the NHS, seen first in the private finance initiative (PFI), then in more general private public partnership (PPP) deals is being extended into the heart of clinical NHS activity, both in hospital and primary care. Democratic accountability has been a major casualty of the commercial ethos with its balance sheet accountability. An example of a glaring absence of the public voice has been in the ongoing reorganisation of primary care. In the early 2000s, this huge clinical area of the NHS, with which every citizen is familiar and has a stake, was scheduled for the biggest change in its organisation and operation in NHS history. In the event, this was undertaken with the most trivial of public consultation and with derisory public representation or accountability in the Primary Care Organisations now entrusted with control of the vast majority of the NHS budget and responsible for the provision and expansion of health care.

Rating the NHS

There can be no doubt that in response to the great increase in national funding the NHS is now performing better than ever. One can only speculate – the clinical trial can never be performed – on how much better it could have been had the 1997 election pledge been honoured, the market abandoned and all its costly paraphernalia of commercial consultations, institutional intercharging, marketing and outsourcing and long-term indebtedness been avoided. On the international scene, a WHO international comparison made in 2000 gave the UK NHS performance a startlingly low ranking – 24th (later elevated to 18th) in a rating which placed Oman and Malta ahead of the UK and the US 72nd. The more recent (2007) methodologically sounder US Commonwealth Fund performance analysis gave the UK overall first place, placing it ahead of all competitors in equity, coordinated care and efficiency.

Despite a seemingly unending chorus of complaint, the NHS is held in generally high esteem by the British public, particularly by those who have had relatively recent experience of its services. Maintaining and improving the NHS, even the agreement to tax increases for it, has long received public support. By many, the NHS is nominated as the top priority need for our society. Whatever the level of general satisfaction, surveys give little or no indication of how the public view the involvement of the profit-seeking commercial sector in the clinical activities of the NHS. It is argued that 'the public doesn't care about such matters so long as treatment is free at the time of need' but there is no real basis for that assertion. Many of those in the ranks of NHS management are reported by the Office for Public Management (2008) as expressing grave doubts about the waste of time and public money in outsourcing NHS services to private companies. The response of the public to a direct question about the role of the for-profit, private sector in the provision of clinical services in the NHS is very likely to be negative but is highly dependent on the terms in which the question is asked.

Honour the Pledge

On one issue, it is highly likely we would find wide agreement. The encounter between the sick person and the health care provider is not the setting to test the assertion that a financial transaction clarifies the relationship between purchaser and provider. That assertion is inherent in the retention of the purchaser/provider split in the NHS. It is time to honour the pledge and abolish the market.

HARRY KEEN
Guest Editor

THE RICHARDS REPORT and "TOP UP FEES"

This difficult and controversial matter was discussed at both NHSCA Executive and the KONP Steering Committee, to clarify our position and with a view to responding to the Consultation, although regrettably that was largely aimed at Chief Executives and other managerial staff and stated that the only matter actually out for consultation was the technicalities involved in implementing the recommendations.

Fortunately Dr Jacky Davis, Co-Chair of NHSCA and a member of KONP Steering Group, had been invited to appear before the Health Select Committee, which gave opportunity to address the wider issues.

We are grateful to those members of NHSCA working in Oncology who responded to the request to send us their views. The common thread running through these responses was the difficulties foreseen in attempting to implement the Richards recommendations.

The following written evidence was submitted on behalf of both organisations.

ENQUIRY INTO THE PURCHASE OF ADDITIONAL DRUGS BY NHS PATIENTS

1. Introduction

I am a consultant radiologist at the Whittington Hospital in London. I am a member of the BMA Council, Co Chair of the NHS Consultants Association and I am a founder member of the campaign to Keep our NHS Public. I believe the NHS functions best as a publicly funded and delivered service and that the introduction of top up payments has the potential to undermine the founding principles of the NHS, creating a two tier service.

- I welcome the following points in the report
- the recommendation that the option of NHS top ups should be rejected
- a recognition of the dangers to the principles of the NHS in introducing top ups
- the unequivocal statement that no solution should lead to an insurance based system
- the wish to keep the number of patients involved in treatment outside the NHS to a minimum
- the belief that this can largely be dealt with by improved drug access within the NHS through improving NICE and working with the drug companies
- the acknowledgement that the extent of problem is unknown

2. The extent of the problem

The extent of the problem is unknown and may have been exaggerated by those who believe that the NHS should move towards an insurance based system. Their hope is that the introduction of top ups will precipitate a move in that direction.

http://www.bmj.com/cgi/content/full/336/7656/1265?maxtoshow=

(for role of Doctors for Reform)

The report states that requests for exceptional funding number 15000 cases a year (P 15, 2.4). Most of these are for drugs waiting for NICE approval (P 16).

Average cost/patient varied between £8,000 and £20,000 (unfunded cancer treatment) 65 – 75% were approved (P 18, 2.12)

The number of patients is thus relatively small, as are the sums of money involved compared with the overall drugs budget. Patient charges are currently only 1.3% of current NHS spending (P 27, 3.22) and thus peripheral to the core function of the NHS. The solution to this problem does not require a change in the basic principles of the NHS, but rather improvements in the function of NICE and better liaison with the pharmaceutical industry.

3. The road to an insurance based system

While Professor Richards states that he does not want any solution to precipitate a move towards an insurance based system, the insurance companies themselves see great potential in any change.

http://news.bbc.co.uk/1/hi/health/7714039.stm

"The potential for this (insurance) market is phenomenal"

"One firm said it could be bigger than the private medical insurance market, while analysts predicted the top-up ruling could mark a "pivotal point".

4. Stakeholder opinions

While many different groups contributed to this report, the voice which is almost always lacking in this debate is that of those who will not be able to afford the top ups or even the relevant insurance– most often the elderly, the poor, the chronically sick and the inarticulate. The tension in the debate is between personal autonomy and principles of equity and inevitably the consumer has thus far spoken louder than the citizen.

The welcome inclusion of the letter (P 34) is indicative of how this group – likely to significantly outnumber those who would benefit from a change of practice – might feel.

The funding of patients groups by the pharmaceutical industry is also of note in this context.
http://blogs.independent.co.uk
openhouse/2008/10/why-nice-gets-b.html

5. Loss of equity

The statement is frequently made that no solution should be to the detriment of those NHS patients who cannot pay for additional unfunded treatments or insurance. Little is known however about the effects upon this group of the availability of treatments which they cannot afford. They are likely to significantly outnumber those who benefit from top up arrangements. Research is needed about the effects – clinical and psychological – on those are, or will perceive themselves to be, second class citizens with the health service.

The poorest members of society tend to be the least healthy and will thus have the most difficulty in either paying for additional treatments or obtaining insurance to cover them, especially should the range of unfunded treatments and interventions increase. Any move in the direction of top ups within the NHS will increase health inequalities, which are already a continuing source of concern.

There has been some work on the adverse effects of the introduction of co-payments, for example

http://www.rand.org/pubs/research_briefs/RB9169/index1.html

http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/815/815ii.pdf.
(ev 49, ref 22)

6. Principle of 'separatedness'

While the principle is a good place to start it is difficult to see from a clinical perspective how it will always be maintained in practice.

Medical care, particularly cancer care, requires a multidisciplinary approach and team work which may be undermined by 'separatedness'. Some treatments may not be able to be separated physically, and local expertise may mean that they have to be given by the same clinician.

Local considerations may mean that treatments have to be given in the same establishment, leading inevitable to a two tier service within the NHS. Having a treatment down the corridor as an NHS patient will not appear very 'separate' to another patient on the ward who cannot afford it.

It may not be easy to separate complications arising from NHS v privately purchased drugs.
It thus seems inevitable that NHS patients will on occasion end up having different treatments in the same establishment, based on ability (or inability) to pay.

7. Safeguards for those who can't afford to pay

As mentioned above, insurance is already available for those who can't afford to pay out of pocket. The government might wish to provide cover for those who can't afford the insurance (we have no idea what percentage of the population this would be) but this is likely to prove difficult to administer and possibly more expensive than providing the treatment on the NHS in the first place.

P 70 of the report states that:

'patients should only be able to supplement their NHS care with additional private care where a clinician agrees that this is clinically appropriate'.

It would be better to aim to have all clinically appropriate care available for all patients in the NHS.

8. Other difficulties

The NHS Confederation has identified a list of practical difficulties, mostly centering on the financial administration of such an arrangement (P 35, 4.26). No answers to these difficult questions are contained within the report.

9. Effects of proposals on healthcare workers

Much of the burden of applying the recommendations appears to fall on frontline workers. For instance (recommendation 12) doctors' communication skills are to be improved so they can discuss all options, funded and unfunded, with patients. The problem (for clinician and patient) of fully discussing unfunded options with those who cannot afford them is not addressed. The report recognizes that there will be increased communication problems for the clinicians (P.37, 4.34)
There is also an inherent contradiction, as doctors are expressly forbidden to discuss private treatment with patients (paragraph 2.9 of the Code of Conduct for Private practice).

"In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf."

The requirement that clinicians 'exhaust all reasonable avenues to secure NHS funding' will also be time consuming, taking skilled workers away from clinical work.

Managers will need to put in place arrangements for separate facilities for delivering private treatment, and governance arrangements to ensure continuity of care. The cost of this extra activity is unclear. Would it be greater than the money saved by not funding the small range of drugs in question?

Conclusion

The need for this report has arisen because not all clinically appropriate drugs are available on the NHS. It is frequently said that the NHS can no longer afford to be comprehensive. The observation is traditionally made by those who would like to dismantle the NHS and replace it with another system. It is however a dangerous starting point for this debate, and needs challenging. It is worth asking as part of this exercise whether the NHS could in fact offer all clinically appropriate drugs to patients and thus avoid the problem of top ups altogether.

The report identifies ways of working with the pharmaceutical industry and NICE to increase the number of drugs available. In addition the DoH has identified savings elsewhere in the system ('Better care, better value indicators') which could be used in this context. Is it possible that through these mechanisms we could offer all clinically appropriate drugs to NHS patients, thus avoiding the inevitable two tier system which will result from even Professor Richards thoughtful approach.

The reality of 'separate care' is apparent on P 51, 'option appraisals for separate care' steps will have to be taken to ensure continuity of care as patients will be receiving different care from the NHS and the private provider (although this will often be in the NHS)

The NHS is a vital act of social solidarity and equity lies at the heart of it. We must not move towards a two tier system. The only solution which avoids a two tier system and which remains fair to the

minority of patients who need clinically appropriate drugs not currently available is to work towards making all clinically appropriate drugs available to NHS patients. Mechanisms have been identified and may indeed cost less than the (uncosted) alternatives proposed.

This evidence clearly aroused interest in the Select Committee as Dr Davis was asked to submit a supplementary paper as follows, developing further the alternative proposals.

Suggestion for funding for additional cancer drugs

While listening to the evidence at the HSC on Jan 29th several facts emerged

- The problem of top ups is 'not a big issue' and 'not a real issue'.
- For the patients' representative the problem is equitable access for patients to clinically effective drugs which are currently not available – either because they have not yet been assessed by NICE or are too expensive by NICE criteria.
- The number of patients involved in buying top ups is likely to be small 'because of the expense', and the true number is unclear.
- The cost of setting up a parallel system (as recommended by Professor Richards) has not been assessed and is likely to be high.
- There will be many practical difficulties in setting up this system which have not yet been resolved. The many questions raised by the NHS Confederation, particularly around the financial aspects, have not been answered.
- Exceptional funding reviews are expensive and time consuming for PCTs. There is a wide variation between PCTs which may approve between 0% and 100% of requests. This leads to delay and anxiety for patients and unfairness in regard to access to additional drugs
- Cancer drugs, even when approved, take a large and unpredictable slice from PCT budgets.

Proposed Solution

A central funding mechanism for additional cancer drugs should be established. This would include drugs which are either in the NICE pipeline, and/ or are clinically effective (and considered [clinically beneficial] by the patient's clinician) but judged by NICE to be too expensive by current criteria.

The money for this central fund could come from several sources

- Top slicing the PCT budgets to the tune of the amount that is spent now by exceptional funding reviews, plus the money spent on administering the reviews themselves.
- Additional money could be provided centrally to reflect the potential cost of administering the parallel system proposed by the Richards report.
- Money could be used from the NHS surplus (£1.7 billion last year).

Advantages of a Central Fund

- Cancer patients would have access to all cancer drugs considered sufficiently likely to be clinically effective in their particular case by their treating doctor. There would be no 'two tier' system for NHS patients.
- Patients being treated would remain within the NHS, thus avoiding all the clinical and personal difficulties of transferring between clinical teams.
- Clinicians and patients would not have to spend time – 'exhausting all avenues' to access these drugs.
- PCTs would not have the responsibility for exceptional funding reviews. This would save them time and money.
- The unpredictable and high costs of granting exceptional funding would be removed from PCTs.
- Patients being treated with new drugs would remain with the NHS, thus allowing better monitoring of these drugs.
- Better 'bargaining powers' about the cost of new drugs if they remain within the NHS rather than being paid for by individuals.

- It is possible that this method would cost less than administering the system proposed in the Richards report, while removing the contentious aspects of running a parallel system.
- It is understood that there is already a similar system in place for the funding of 'orphan drugs'.

This is of necessity a brief and broad outline.
The proposals in it are supported by the

The NHS Consultants Association
The NHS Support Federation
Keep Our NHS Public

JACKY DAVIS

It is of interest that within a very short period reports have begun to appear in, for instance, the Health Service Journal raising further concern about increasing bureaucracy, inappropriate pressures on PCTs and threats of legal action.

BMA WESTMINSTER POLITICAL LECTURES

The BMA held a series of political lectures addressed by the leading health spokespersons of all three main parties. Each lecture was chaired by Hamish Meldrum. After an initial talk, answers were given to selected questions invited in advance from participants, finishing with free questions from the floor, time permitting. There were lively to and froms. The full proceedings can be viewed on the BMA website at
http://www.bma.public-i.tv/site/webcasts.php?l=en_GB

Norman Lamb MP for the Liberal Democrats

The first session, on Tuesday 20th January was addressed by Norman Lamb MP Liberal Democrat Shadow Secretary of State for Health since December 2006 who outlined his priorities for healthcare. Allowing the huge increase in NHS spending, he questioned whether it had been wisely spent. Even though now well paid, he found doctors' morale low. He would like to see local decision making with local accountability and would ensure that members of PCTs were elected rather than appointed. They would seek to remedy inadequacies in psychiatric care with its long waiting lists for cognitive behaviour therapy. Social enterprise schemes were good examples of integration of social and medical care which they would build on.

The Lib Dems would scrap the costly central IT scheme, widely perceived to be failing, in favour of more local projects. They would redress the funding gaps in preventive medicine and public health. He felt that QOF targets had contributed to disease prevention.

My question was put to him. "Would you consider replacing the current market system of healthcare which is divisive, hugely costly to administer, and militates against integrated care with a return to healthcare planned by a health authority ?"

As a Liberal, he said, he was against state monopolies and favoured plurality of service provision while accepting the high costs of a market approach.

However, undoing the market structure would be difficult and result in further de-stabilising reorganization. Much could be learnt from the integrated care approach of the Kaiser Permanente organization in the USA. But, he was reminded, our market system divided primary from secondary care: its financial constraints inhibited GPs from referring to consultants, and the huge costs of the contracting process required by the purchaser provider split robbed patient care of major resources.

All in all I got the impression that the Liberal Democrats would do little more than tinker at the edges of the NHS. Their policies would do little to improve the delivery of health care, to clarify current confusions of policy, or to improve morale of clinical staff.

Andrew Lansley for the Conservatives

Andrew Lansley, the Tory Shadow Shadow Secretary of State for Health since 2003 addressed the second meeting Tuesday 27th January. Labour, he argued, had promised healthcare at least as good as any country in the world but despite a huge increase in spending, had failed to deliver. Our healthcare was still not up to the standard of many other European countries.

Equitable access to healthcare was his main objective and Tory health policy would turn to public health to achieve this with new focus on population outcomes. Our public health spending was currently one third below the OECD average. He would register this new emphasis by renaming his department the Department of Public Health.

The quality of commissioning required major improvement with local accountability replacing central diktats. Patients should be urged to exercise real choice advised by their GPs who would be at the centre of commissioning. Government should set objectives but performance targets should be set and engineered locally by the professionals. Greater local freedoms could be given to professionals and patients, for instance through Foundation Trusts Four hour trolley wait targets were

an insult to professionals. Central control led to loss of professionalism and morale. Clinicians felt they were on a production line. Devolution was key.

Jacky Davis questioned the value of the market approach to health care and asked for the evidence base. Andrew Lansley declared his firm belief, now he said supported by all the political parties, that competitive market principles and the purchaser provider split were the best way to ensure value for money. In response to Harry Keen's question on Tory plans for the future role of the private sector in NHS clinical services, Mr Lansley dismissed old slogans like 'public sector bad, private sector good' or vice versa as old fashioned. He believed in allowing a market to find its own level but espoused 'better regulation'. Present government policy just to create more capacity by buying in more operations was unfair to the NHS, and inefficient.

The European Working Time Directive provoked lively exchanges. The problems of a 48 hour working week had been pointed out to Mr Lansley by the Royal Colleges and he felt that the government should seek a derogation until proper arrangement could be made to accommodate this. From the floor, the BMA junior doctors leader strongly advocated full implementation of the 48 hour week. Mr Lansley felt huge amounts of money had been wasted on the poorly thought out central IT scheme but it would be difficult to cancel contracts already in place.

Alan Johnson for Labour

Alan Johnson, Labour Secretary of State for Health since 2007, wound up the series on Thursday Feb 5th. Commenting on the USA where 47 million people have no health insurance and where General Motors spends more on health insurance than on steel, he claimed that Labour's record on health was good. Annual spending on health was now £1600 per head and had increased from 6.8% to 8.5% of GDP. Labour had greatly decreased A&E and outpatient waiting times, shortening them to 18 weeks for general referrals and, 2 weeks for cancer. Lord Darzi's reviews with their numerous patient and professional consultations, and centred on improving the quality of care would be implemented in a 10 year plan. Among current new initiatives he highlighted Dementia strategy and successful price renegotiation between NICE and the pharmaceutical industry for the provision of new and expensive drugs. The new emphasis on disease prevention will include vascular checks, an obesity programme, vaccination for cervical cancer and ultrasound detection of aortic aneurysm. The NHS would be secured by the new Constitution and Alan Johnson foresaw no major new changes in NHS structure. He found nothing to commend the Conservative and Lib Dem proposal for an independent health board to run the NHS which would deprive ministers of an ultimate parliamentary accountability which was integral to the NHS.

Responding to questions, he understood the serious concerns about the effects of the EWTD on training. Government had asked for a derogation to 52 hours but he was not enthusiastic about avoiding full implementation. He felt that any general relaxation was unlikely but that individual opt out would remain. He vigorously rebutted the suggestion in a question sent in by Harry Keen that Labour had abandoned its 1997 election manifesto pledge "to restore the NHS as a public service working cooperatively for patients, not a commercial business driven by competition". Labour had involved the private sector only to increase capacity. Chillingly he repeated almost verbatim his rejection of the 'public sector good, private sector bad' mantra. People were not concerned who provided the service as long as the service was free at the point of use. In answer to a further question from Robert Elkeles he also dismissed the idea of abandonment of the purchaser/provider split and a return to planned health care as in Scotland and Wales. Labour accepted MORI public opinion polls which he said showed record high ratings for the NHS. There was no need to change the system. He failed to address the question of the divisive effect of the market – primary care versus secondary, hospital versus hospital, professionals versus management etc. Defending the new NHS IT system he accepted that it was delayed but claimed that all the financial losses incurred had been borne by the contractors. In the end it would be a very valuable project.

Alan Johnson gave a polished performance. He appeared genuinely committed to the NHS though he fashioned his answers to questions as do all accomplished politicians.

The BMA did well to host these political lectures. There were no big differences between the parties in their approach to the NHS. On the positive side all parties seem committed to an emphasis on public health and disease prevention All parties, however, appear committed to maintaining the purchaser provider split and a competitive market configuration for the NHS. Smaller waiting lists, shortened waiting times and better public polls are advanced as evidence of its success but without any critical scrutiny of costs and benefits or value for money. It ignores any idea that it has caused the problems which we in the NHSCA see. No speaker has fully grasped the threats to continuity of patient care and the quality of training posed by the EWTD, an attitude apparently shared by the BMA junior doctors (who in my experience are not representative of most doctors in training).

No politician likes to admit to mistakes. To abandon the purchaser provider split would cost huge loss of face. Another radical change in the system could destabilise it to destruction, they plead. We must continue to take our arguments to the widest possible audience and to present an attractive alternative, if possible, one which avoids too much loss of face!

ROBERT ELKELES
Physician, London

POLYCLINICS – A PERSONAL VIEW

History

From 1921 until 1945 there was much discussion about the potential organisation of medical services. With regard to primary care, reorganisation of general practices into "health centres" was recommended initially by the Dawson Committee in 1920 (1). The Socialist Medical Association proposed the most radical reform in 1933 - group practice in health centres, staffed by full-time, salaried practitioners and managed by reconstituted local authorities. In 1944 the BMA submitted a questionnaire to members, who voted by a large majority in favour of group practice in health centres (1). In the 1946 NHS Act, local authorities were enjoined to build health centres in which doctors would practice not only in partnership with one another but also with other professionals (eg dentists) and ancillary medical and social services. However, for reasons which the historian Eckstein [(1)], despite interviewing Aneurin Bevan, could not satisfactorily elucidate, the government went cold on the proposal and in 1948 the Ministry of Health issued a circular absolving local authorities from formulating proposals for health centres.

Meanwhile in countries of the Soviet bloc primary care was largely provided by polyclinics, which provided outpatient care for populations in a specified district and employed general physicians and some specialists [(2)]. The system has persisted in Russia, but in the former European satellite countries and in Cuba has been largely abandoned in favour of systems more akin to our own.

Health Centres, Polyclinics – What's in a Name?

The "health centres" envisaged in the 1946 Act were, ideally, purpose built, or specially adapted buildings, housing integrated services - medical, dental, ophthalmological, paramedical and social, which seems a *priori* a good idea. Of course proceeding from a good idea to its implementation is fraught with problems, not least cost and the need for a complete change in the accustomed ways of the several professional groups involved. Which may well be the reasons for Bevan's retreat.

Sixty years on, Lord Darzi has come up with similar proposals, though using the word "polyclinic" and presenting them in the 'NHS market' setting. This reappearance has met with a largely hostile response, not least from the BMA. Part of this negative reaction is political - lack of trust - arising in part from its uncompromising presentation and introduction to a market mood music background by the Department of Health and in part from its perceived Trojan Horse role to inject privatisation into NHS primary care. Thus, the final Darzi report was to be published in June 2008 and was supposed then to be open to consultation. However, in December 2007 the DOH had already leant on strategic health authorities to implement the given "policy" on polyclinics.

Suspicion has been further raised by the insistence of the DOH that, in the bidding for polyclinics, PCTs should use a type of contract called Alternative Provider Medical Services (APMS), which clearly favours commercial organisations against GPs or GP consortia. Private contractors, it is alleged, are more likely to employ salaried doctors, who would be more likely to be transients and less likely to be independent. In my own patch, NHS London carried out a consultation including a questionnaire which did not seek an opinion about the desirability of polyclinics, only what kind of services should be included in them! Yet NHS London subsequently claimed a majority in favour of polyclinics!

This general disregard for and positive abuse of the consultation process has been recently highlighted by an NHS Support Federation survey [(3)]. Despite clear instruction, only 9 of 40 PCTs explicitly mentioned that private sector bidders could compete with GPs.

Fit for Purpose?

Apart from the political *"sturm und drang"*, there is room for rational debate about the nature of polyclinics, in terms of size, frequency, siting, extent of services, relationship with hospitals (eg would PFI hospitals be willing to relinquish specialist services?), and, not least, cost effectiveness. The King's Fund has published a major analysis of polyclinics [(4)], which should be required reading for anyone engaging in the debate and twice read by members of PCTs. A brief quote: "For some health communities the development of polyclinic type facilities could offer great opportunities to establish more integrated care that delivers real benefits to patients. But these benefits will only be realised if the focus is on changing the way we deliver care, not just changing where care is delivered" [(5)]. And from reference (2) a more sceptical quote: "There is a strong case for piloting the proposed new model, to allow enough time to learn. Unfortunately, as the past two decades have shown, that is not how things work here."

Time moves on and the term "polyclinics" is so 2008! My local PCT is consulting on what are now called "GP-led health centres", presumably considered a more palatable term. As it would appear that NHS London has decreed that each PCT should have at least one such centre, the consultation questionnaire does not offer the opportunity to question either the need for or the merits of the proposed model, it does not clearly present the alternatives of an 'in-house' NHS-run Centre versus a 'privatised' polyclinic, asking only where it might be and what services one would like to see included. The notion of democratic accountability in the NHS still has some way to go! It would be saddening if the prospect of a long-delayed, potentially valuable development in the provision of health and social services to the public were to be destroyed by the ineptness of its introduction.

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References:

(1) Eckstein H. 1964 The English Health Service. Harvard University Press, Cambridge Mass

(2) Rechel B, McKee M. Lessons from polyclinics in Central and Eastern Europe. BMJ 2008; 337:a952

(3) Is the public shaping the future of their NHS? 2009 An NHS Support Federation Report Available from Paul Evans email info@nhscampaign.org

(4) The King's Fund. ISBN 9781 1 857 17 569 1

(5) www.kingsfund.org.uk/media/kings_fund_101.html

WHAT KIND OF HEALTH SERVICE DO WE WANT?
A DISCUSSION DOCUMENT

I INTRODUCTION

This discussion document is based on an analysis of the ideas and observations of participants in the national Keep Our NHS Public Workshop, held in Leicester in November 2008, entitled 'What kind of health service do we want?'. The workshop was underpinned by the belief that, although much health service campaigning is characterised by fairly defensive approaches designed to combat privatisation and the extension of market principles, an effective campaign requires a positive vision of what is being campaigned for. The workshop offered campaigners the opportunity to discuss and develop ideas about the kind of health service we should be trying to build and attempted to establish whether there was a consensus or 'common sense' among campaigners as to the kind of positive policy agenda we should be developing. The report provides a summary and organisation of the ideas expressed in small group discussions and some suggestions for further work. The boxes identify notable areas of agreement and contain recommendations/views of two or more groups without dissent from other groups.

The views and ideas recorded here are not a statement of Keep Our NHS Public policy but are presented as a basis for further discussion among those who care passionately about the future of our health service.

II SUMMARY POINTS

The workshop established some of the key pillars of a reformed health service. It should

- Be democratically accountable
- Be integrated and based on cooperation and planning
- Devolve much greater decision making to a local level
- Be available on the basis envisaged by Bevan: universally and according to need alone
-
- Be publicly provided and funded
- Work closely alongside social care services
- Build in staff representation locally
- Be more responsive to the community

The workshop also revealed a vision of a much more holistic, social and integrated approach to health policy which should:

- Place a greater emphasis on prevention of illness and health promotion,

including through population level interventions

- Adopt social policy measures which create a more egalitarian and less consumerist society
- Ensure that the bringing up of children is a highly valued and protected activity
- Inform all other areas of policy making through greater integration of some form of health impact assessment
- Toughen the regulation of business practices of relevance to health

III CORE PRICIPLES

The following core principles were established prior to the workshop and no dissent was expressed. The service should be:

Universally available and on the basis of need alone
Publicly owned and publicly provided
Planned, integrated and rational
Democratically accountable

This additional principle emerged from the workshop:
The healthy society should be a key organising principle across all public policies.

The Alma Ata Declaration also offers guiding principles, specifically the following:
"…health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity, is a fundamental human right"

and

"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (Declaration of Alma Ata, 1978: Points I and IV).

IV THE REFORMED HEALTH SERVICE

Broad structure

The market in health care and the purchaser-provider split should be abolished, along with competition. In its place, an integrated, planned and co-ordinated service should be established. Health and social care should work in partnership or even be merged.

Serious consideration should be given to the merger of the NHS and social care into a Health and Social Care Service.

The abolition of the market will require a new financial system for channelling funds through the organisation. An examination of the current system in Scotland and the previous system in England (prior to both the market reforms of New Labour and the internal market reforms of the Conservatives) should be undertaken to see how these systems could be improved in our reformed service.

Democratic Accountability

Democratic accountability is essential and should form one of the fundamental tenets of the service. Democratic accountability should entail both representative and participative approaches and the principle of subsidiarity should apply – that is, decisions should be taken at the level closest to those affected consistent with the principles of good governance. This represents a shift of power to the local level. Broadly, a national-regional-local structure is envisaged. Elected local boards managing and planning local services should be the principal bodies through which health services are organised and through which they are held to account. These, and institution-level boards, should include representatives of the public and representatives of local health service workers.

Consideration should be given to the following structure:

- Institution level boards
- Local - City-region boards (e.g. Leicester and Leicestershire)
- Regional - Joint local bodies (e.g. Midlands or E Midlands)
- National

Here, the principal power rests with the local bodies which collaborate to form the regional structure where services need to be planned and organised on a regional basis. Local bodies should be composed of democratically elected members and should include representation of both local public (on an areas basis) and local staff. The precise composition of local bodies, as well as effective forms of consultation, should be considered in more detail and it may be worth considering models from elsewhere.

The precise remit and powers of each level have yet to be worked out. The national level should include the establishment of minimum standards.

Institution level bodies should include representation from the public and staff.

Thought needs to be given to how community power is represented and articulated both in the democratic participation of running the local institutions and the local boards and in engaging with health care staff around the implementation of particular aspects of patient care. Consideration should be given to patient participation groups in which 'expert patients' develop a growing body of knowledge which can be used both to influence the planning of services and in the development and implementation of particular service programmes. A body similar to the Community Health Council (but avoiding the CHC's weaknesses) should be established to correspond with local boards and regional bodies. The CHC could serve both monitoring and user-representation functions. Other mechanisms for representing user perspectives should be considered.

Rationing and Resource Allocation

Funding should be allocated through a needs-based approach, not an activity-based approach. NICE's remit should be retained in some form as rationing decisions are unavoidable. NICE should be extended to other areas of activity.

NICE – or some similar body – should be retained but the advantages and disadvantages of separating assessment of clinical effectiveness from assessment of cost effectiveness and making rationing decisions should be reviewed. Decisions taken by NICE should be implemented at the local level so that all those in need of and prescribe approved treatments can receive them. The body should operate at a national level but mechanisms for increasing its accountability to the public need to be considered. A similar body should be established to assess the effectiveness of public health or preventative measures. Another similar body could be established as a source of expertise on other sorts of evaluation matters such as the configuration of services, since service planning and configuration should be evidence-based.

Local resources will vary according to needs assessment and local services will vary according to health needs. Resources should be used in ways which are effective and accountable.

Delivery of health services

All health care workers, including professionals, should be salaried employees. There should be a greater emphasis on interventions at the population level rather than at the level of the individual.

Parts of the health service should be connected through an IT system which would also allow patients to access their records. A list-based GP system should be maintained. The relationship between the community and the health care system needs to be strengthened.

Services should be organised around care pathways and clinical networks should develop to support this. Managers and clinicians should work in equal partnership to strike a balance between individual patient care and cost effective use of resources. Innovation and service development should be the norm.

Not all health services can be delivered in the 'community'; some will be delivered in hospital or other buildings and the configuration and location of services should be evidence based. This could include polyclinics where the clustering of services is evidence based and appropriate to local health care needs. Non-invasive ways of reaching out to patients who are infrequent users of health services should be explored and this may involve non-clinically trained personnel working alongside GPs. Health care buildings should be healthy buildings with healthy employment policies and healthy food policies.

Overall, services should be more prevention orientated and mental health should receive a greater share of available resources.

Pay bargaining should be national even where services are locally managed and planned.

Charges should be abolished.

The concept of choice needs to be reclaimed and redefined in a way which is consistent with the principle of equity and which addresses health needs more effectively. Choice will not be offered or expressed in a competitive environment and the aim will be to have excellent services locally. More information should be made available to patients about how to lead healthier lives as well as to enable them to assess whether they wish to have treatment at all and, if so, which treatment they wish to have.

Choice can mean little where patients and doctors have limited relevant information. In addition, choice has the potential to exacerbate health inequalities and other inequalities so it needs to be defined and expressed in a reformed service in a way which avoids these pitfalls. Among common conditions, best practice should be instituted and the routine evidence based management of care and

treatment will be more important than choice. The expectation is that most routine health care will be accessed locally. This requires up to date information, adequate resources and time and the right facilities. Choices can be influenced by media reporting which exaggerates the benefits of particular treatments and patients need to be better informed, especially about alternatives in end of life care.

The guiding and advising role of the GP will be important in the exercise of choice.

Partnership in the delivery of health care and the promotion of good health

Further discussion is required to establish the best way of organising services vis a vis the need for local authority and health service collaboration. One aspect of this is the relationship of health and social care and consideration should be given to a possible merger of health and social care.

A second aspect of this relationship concerns the planning and delivery of health promotion and public health measures. There is a need to vigorously assess the relative clinical effectiveness and cost effectiveness of social (public health) interventions and medical (primary healthcare) interventions for illness prevention and health promotion. The increasing trend to medicalise and medicate risk-factors for ill health (including stress, obesity, inactivity, cholesterol) should be challenged since this results in the creation of disease as a consequence of the chosen medical/pharmacological solution. Whilst primary care has a responsibility to promote and support healthy lifestyles, it should focus on managing illness, whilst public health should have the main responsibility for promoting health.

V A SOCIAL APPROACH TO HEALTH

Creating a healthy society and making health central to all policy making

An holistic approach (that is, one that recognises that impact of social factors on health) is required both to tackle ill-health and to promote more healthy living. This entails a cultural shift which includes a move away from competition and consumerism and towards cooperation and citizenship. Institutions central to healthy living include the family and the school.

Health is a social as well as individual phenomenon to be addressed, promoted, safeguarded and sustained through a wide range of social policies and social interventions. Health is shaped at least as much by environmental policy, housing and transport policy and redistribution through the tax and benefits system and so forth as it is through health service interventions. Consequently, there is the need to subject all policies to some form of health impact assessment so that all policies are pro-health. Some policy areas could be more integrated.

Health considerations should be part of policy making across the board. This includes consideration of the health impacts of specific policy areas such as transport, food policy, housing, employment, education and leisure at both national and local levels. A portion of the budgets in these policy areas should be used to address health impacts. Greater consideration should be given to the healthy cities initiative. Tougher regulation of business should be introduced in relation to advertising, the labelling and contents of food and the availability of cheap alcohol.

Consideration should be given to the appointment of a minister for Public Health at a Cabinet level who is charged with ensuring increased health promotion and a healthier society. S/he would require access to all departments of state and would be able to influence them all at a national level – including environment, (waste disposal, pollution, DEFRA, food), health transport, housing etc. At local level, a parallel system could develop with Local Authorities appointing local Directors of Public Health who have the same level of access to and influence in all departments.

Health and healthy living can only be produced and sustained in a much more egalitarian society. Reduction in inequalities in both income and wealth is essential prerequisite to a healthy and cohesive society. Thus, significant redistribution is required through a much reformed tax and benefits system.

Non EU citizens should be allowed free health care when in the UK.

The family is central to maintaining physical and mental health and to passing on knowledge about healthy living. Parenting and caring should be recognised as critically important roles.

Parents should be offered financial support to make staying at home to look after children a feasible and realistic option. The policy bias towards encouraging participation by parents in the labour market needs to be redressed although where parents want to work, this should be facilitated. The 'long hours culture' should be challenged and a debate should

be initiated regarding the benefits and disadvantages of the 24/7 culture.

Community sources of support for parents, the isolated and those suffering health problems should be developed, for instance via expert patient groups which lead to knowledgeable citizens.

The centrality of schools to a health promotion/ illness prevention strategy should be recognised. Schools should be places where children learn self-care and healthy behaviours and where they are able to take exercise.

Schools are central institutions for developing healthy behaviours – they are places where children can be taught good self care, healthy eating, including food production and cooking, exercise, good dental care and care of the environment. Every school should have good fitness facilities and local playing fields should be retained. Sport and health need to be embedded in all education policies and should be reflected in the curriculum. Sporting activities should be enjoyable and allow all to take part and do well; local playing fields and leisure centres should be retained. Educational targets should be more holistic, preparing children for life. Education should become less exam driven and less stressful for children and young people.

Consideration could be given to linking vaccination systems to school entry and screening should be expanded. A proper awareness of public hygiene should be restored, including through simple posters with simple messages.

VI NEXT STEPS: SOME AREAS FOR FURTHER WORK

The Keep Our NHS Public workshop is one of a number of recent attempts by a range of organisations to deliberate alternatives to the current paradigm in health policy. There is a need now to circulate for further debate the ideas and principles which have emerged. Where appropriate, this should be done taking into consideration (although not be constrained by) relevant concepts and ideas being discussed and developed elsewhere.

Further deliberation by Keep Our NHS Public is required on:

- The precise structures to be established to secure democratic accountability. This deliberation should take into account developments in Wales and Scotland as well as the structures used in selected EU countries. The work of Democratic Health Network, NHS Alliance & Socialist Health Association on accountability should also be taken into consideration.

- The arguments for and against a merger between health and social care to create some kind of local health and social care service.

- The reintegration of the health service and abolition of the market structure should not simply assume a return to the status quo ante but should examine how the previous system can be improved upon. Studying the Scottish health service could help here.

- Reforms to the tax and benefits system which will bring about a more egalitarian society. The work of the Compass Tax Group, Richard Wilkinson and the new Equality Trust should be taken into consideration.

- Developing stronger community mechanisms to support patients and citizens likely to benefit and to engage with both the implementation of specific health policies and the shaping of overall policy (i.e. at the system and programme levels).

- Specific approaches to building health considerations into other areas of policy. This would take into consideration the work on health impact assessment currently undertaken, for instance in Liverpool.

The dissemination of ideas is an essential part of attempts to shape the policy agenda. Keep Our NHS Public should consider ways of disseminating the broad ideas reported here and drawing others into discussing them. The superiority of a publicly funded and publicly provided health care system should not be assumed but should be explicitly articulated and disseminated.

The workshop has attempted to draw grassroots campaigners into a process of bottom-up policy deliberation. The further development and firming up of policy proposals should continue to build in democratic process.

SALLY RUANE,
Leicester KONP

"A LOCAL HOSPITAL MODEL FOR LONDON"

This is a 62 page document from Healthcare for London (HfL), which specialises in promoting the Darzi DoH reforms for the capital. It was published on 28th November with no publicity and is written in the usual code.

1. The Local Hospital (LH) model is based on the premise that there will be only six models of care in London;

- home,
- polyclinic,
- local hospital,
- elective centre
- acute major hospital
- specialist hospitals.
  (A Framework for Action technical doc p.15)

2. The report proposes taking the following out of the DGH

a) all the elective services
- outpatients to polyclinics
- elective surgery to elective centres.
- minor injuries and illnesses to urgent care centres

b) acute / complex medicine removed to an acute major

c) acute / complex surgery removed to an acute major

d) inpatient paediatrics

e) ITU

f) full path lab

The " minimum core services Local Hospital" would contain, medical inpatient beds, intermediate care beds, "A&E", satellite path lab, obstetric unit, HDU, acute assessment unit (AAU), paediatric assessment unit (PAU), daytime emergency surgery, imaging.

This was the proposal in " A framework for Action" HfL Darzi July 07 .
The report discusses the financial effects of removing all of these services and finds that the " minimum core services LH" or base case, would operate at a huge loss, so it then goes on to discuss adding back various of the above, such as a 4 bedded ITU.
Then it says that the polyclinic and the elective surgery centre would be "discrete entities" separately managed, so the money they would generate would not come back to the LH, and it would be financially unviable any way and could not become a "viable business" foundation trust.

3. The report advocates a huge attack on staff and private ownership as solutions.

a) changes to work practices, change in skill mix, getting nurses to do doctors work, a great reduction in junior doctors to comply with EWT, the hospital at night team to cover the whole hospital at night from AMU, consultant paediatricians and surgeons on networks.

b) selling off land and assets to reduce fixed costs. (the PFI payments are immutable fixed costs and cannot be touched.)

c) becoming part of public/ private organisations variously labelled "partnerships", "joint ventures", networks, or a host landlord for other services.

d) becoming part of an "integrated care organisation" (ICO). These would integrate primary and secondary care. This is the idea behind putting a polyclinic in the grounds of a hospital. It would form an integrated foundation trust business. (Still part of a publicly owned NHS to start with, it would prepare the ground for a shift to a privately owned Health Maintenance Organisation, when the government felt like tendering it out.)

4. A&E sign over half a hospital
Patients would see the A&E sign and think it was a DGH as before, only to find the only doctors in the hospital were A&E doctors, physicians and obstetricians. There would not be a surgical team as part of that hospital and no emergency surgery at night. For children there would be a consultant paediatrician working from a Paediatric Assessment Unit (PAU) in A&E during the day.

5. The assessment process of emergency patients smacks of a certain desperation to discharge patients as quickly as possible. They would enter a AAU, having been seen by an interchangeable A&E or acute physicians during the day, but maybe not at night. 50% of patients would be discharged within 48 hours. Any patient requiring admission would go to a " general pool of medical beds".

6. "A general pool of medical beds"
There is no mention of coronary care, respiratory, gastro intestinal units, or renal units, haematology or oncology or care of the elderly. Would the medical specialties or specialised consultant physicians exist there? Anyway there would only be a satellite lab. Would these beds be largely taken up with geriatric patients with multiple co-morbidities? (oops no, see next section.)

7. There are repeated calls to prevent patient with longterm conditions being admitted to hospital. They are to be cared for in the community, meaning polyclinic or home. Home care is to be provided by "clinical staff given a high degree of autonomy". There is no mention of care by the GP, but then the plan is to abolish the GP surgery. (The only mention of GPs in the whole report is as manning the urgent care centre at the front door of the hospital, together with nurse practitioners and emergency care practitioners.)

Patients with complications of COPD, CCF, heart attacks, diabetes, hypertension,etc , are not to darken the door of a hospital. The acute physicians would be working in the polyclinic to make sure this did not happen.

8. Obstetric units would continue without in patient paediatrics, begging the question who would resuscitate the sick newborn.

9. ITU would either not be present, or with 4 beds, necessitating the use of respiratory physicians as well as anaesthetists and nurse practitioners to maintain HDU +/- ITU.

10. More transfers
The report anticipates the increased need to identify sick patients and nurses would be trained to do this. Staff would need to be trained to stabilise, intubate and ventilate ready for transfer to the acute major.

Conclusion

It has to be obvious that any hospital with an A&E sign written over the front door which did not have 24 hour surgical cover and ITU and was taking an undifferentiated take of patients, would be a death trap.

Patients with acute conditions could be diagnosed late could face life threatening trips across the capital.

This is all being proposed and instituted in the interests of shifting elective care to commercial polyclinics and ISTCs on an increasingly large scale and preparing the ground for private corporate owned hospitals.

It is to accelerate the advent of "joint venture" ICOs (say a publicly owned LH and commercial owned polyclinic and ISTC) which could in the next stage be converted into American style for profit Health Maintenance Organisations (HMO s).

This rump LH has to be thrown out. The BMA has to lead an all out fight to defend our DGHs with all the main specialties on site alongside its campaign to save our GP's surgeries. Please contact your division or your MSC, regional council or branch practice rep and push to get this campaign going. BMA Council is discussing campaigns next week.

ANNA ATHOW
Surgeon. London
(Article submitted earlier this year to Doctors net)

FOUNDATION TRUST STATUS

Time is running out - but who's for Governor?

What a hard readership you are to stimulate! Not a squeak from anyone!

Here was I, adrenaline flowing freely in the December Newsletter, thinking that I had left you also in a state of arousal.

My cooperative FT manager, Carla. was about to reveal the long-awaited secrets of her post-consultation Document for me to explore and hopefully approve, and Jemma at Monitor was about to tease me, yet again with tit-bits of information about the secret world of her employer from the depths of its Consultation and Application Department.

And you may recall that there was a poignant personal touch to all this-----Should I go for it and sacrifice my beloved golf and garden for the doubtful joys of becoming a Foundation Trust Governor-----?

I'm going to try again for a response --- if only to try and help those of you facing a similar dilemma.

You'll have realised by now that my approach to the subject is essentially a practical one, based upon a stage-by-stage examination of the FT process, with suggestions of how to challenge and delay the

inevitable, rather than an invitation to debate the philosophy behind this government's determination to proceed with its commercial and competitive model for the NHS. Some of you, indeed, may well see the model as sound, and long-overdue encouraging local initiative and independence as it does, and be able to prove this from personal experience -- even on the Governorship issue which is engaging some of us.

So what is there to report after all this brow-beating frothy introduction you may well ask?

Well, referring to the December Newsletter article, which I trust you keep permanently by your bedside, for reference during sleepless nights whether on call or with bladder disturbance, I can report the following---:

The Post-Consultation Document is frankly a bit of a let-down after what I was led to believe from Carla. Granted it comprises the completed pro-formas Appendices 2 and 6 but the Trust's interpretation of the robustness of the Consultation is only required by Monitor to be couched in such language as "Broadly----" and "In general---" which doesn't leave room for comment by signed-up Members or Public alike, assuming that comment is invited, which it isn't.

So the answer to my question--- "Can the report be challenged on grounds of inaccuracy irregularity in consultation etc"? is a clear NO!

Extracting data from the relatively few "hard" facts made available, it appears that the 13 Public Meetings attracted 91attenders i.e. a mean of 7 per meeting with 30 attending one meeting but with many meetings having single figure attendances. Major stakeholder attendances, not surprisingly, were better and the main topics attracting critical comment are summarised, unlike comments from the Public Meetings, which were not but instead are incorporated into the Trust's "Comments about the general tone of responses received", summarised as:--Broadly in favour 175; Broadly Neutral 0; Broadly opposed 5. How do they define such nebulous concepts?

The major stakeholder comment which appears to have been responded to is a request for more patient Governor numbers, although a request that the starting age for Membership should be higher than the proposed age of 16 (32 written requests) was rejected. There was a minority view of stakeholders (3 written requests) that the age should be lower.

As an aside, one can't help wondering why the Oxford Radcliffe Trust, in our President's patch, is chasing up 12 year olds for membership. Let's accept that some Regions are more promiscuous than others but what's it all about? Perhaps it's all the fault of Oxfordshire's elderly who are too wise to vote?

What else is there to say about our local document which is printable?
The IBP (Independent Business Plan) is with our SHA for "development" before being approved by the Board of Directors. I can see no reference to Staff Meetings or Staff side involvement in the Consultation Process, beyond an issue raised by the local JNCC about the role of Staff Governor and how staff will be better engaged in a foundation Trust. This is not discussed further in the Document.

Monitor's role

I can now answer some of the questions posed in my first article, thanks to Jemma's, and my, persistence-

- Does Monitor hold meetings with members of the public regarding the Consultation Process and in particular regarding any concerns about any perceived irregularities? NO, but the assessment process includes interviews with key stakeholders.

- Does Monitor advise Trusts on "innovative membership recruitment schemes"? NO, but it does advise that legal advice might need to be sought.

- Has it turned down any recruitment scheme to date? NO. So the staff incentive scheme of Worcestershire Acute NHS Trust offering £1000 prize money to staff recruiting the highest number of Members is acceptable to Monitor(see Ref 4 in earlier article), as is the child abduction scheme of 12 year olds in Oxfordshire.

So what are Monitor's concerns as the independent Regulator?

- Well a hint of what these are is given in Wm. Moyes interview in the Guardian of 17/12/08. As Chairman he is proud that Monitor has passed the half-way point towards all Trusts being FT's and predicts that at a rate of 40 authorisations per year, by 2011/2012 "ministerial control of all Trusts will have been lost", with up

to 20 Trusts having gone to the wall on Managerial criteria, having been merged with viable Trusts. He champions the right of FT's to expect freedom from Departmental control of finances and ways of meeting Clinical targets such as infection rates. He makes no mention of how services might be affected or local pay structures influenced.

However, to return to more immediate practical issues.

There are well-defined rules covering Governance and elections but with the major anomaly that the Electoral Register has no relevance and for example, those wanting to delay signing up to membership in order to vote must do so 28 days before the poll closes.

Finally, what is known about the crucial issue driving this article, namely the inter-relationship between Directors Governors and Members?

Well, not a great deal has been published of any depth or worth and I remain hopeful that a picture will eventually emerge based upon the experiences of NHSCA colleagues as Medical Directors, Governors or Members whether Public or Staff.

The forthcoming NHSCA Policy Meeting in York on 25 April will probably give our Association the opportunity to define it's official stance on FT's, at the same time giving us the chance to share experiences.

With this in mind, attached as an Appendix is an up to date list of Trusts awaiting either approval or application. Please keep it handy for reference and to remind you of your own Trust's status and bring it along to the York Meeting along with my two FT articles for easy reference and to avoid having to print handouts.

If you can't get to the York Meeting then please don't hesitate to e-mail me with any information or comments, especially about Governor experience.
e-mail:geoffreymtchll@googlemail.com

GEOFF MITCHELL
Psychiatrist, Beverley

Trust Applications with Monitor:

Calderstones NHS Trust
Dartford and Gravesham NHS Trust
Ealing Hospital NHS Trust
East Kent Hospitals University NHS Trust
East Lancashire Hospitals NHS Trust
Hampshire Partnership NHS Trust
Liverpool Heart and Chest Hospital NHS Trust
(formerly known asThe Cardiothoracic Centre)
Northamptonshire Healthcare NHS Trust
Plymouth Hospitals NHS Trust
Portsmouth Hospitals NHS Trust
Royal Brompton and Harefield NHS Trust
Royal Free Hampstead NHS Trust
Sandwell Mental Health NHS and Social Care Trust
South Tees Hospitals NHS Trust
South Warwickshire Acute
South West Yorkshire Mental Health NHS Trust
Southampton University Hospital NHS Trust
The Hillingdon Hospitals NHS Trust
Walton Centre for Neurology and Neurosurgery NHS Trust
West Suffolk NHS Trust
Whittington NHS Trust

Trusts yet to apply to Monitor:

Airedale NHS Trust
Ashford and St Peters NHS Trust
Avon & Wiltshire Mental Health Partnership NHS Trust
Barking Havering and Redbridge Hospitals NHS Trust
Barnet and Chase Farm NHS Trust
Barnet Enfield and Haringey Mental Health NHS Trust
Barts and The London Hospitals NHS Trust
Bedford Hospitals NHS Trust
Bedfordshire and Luton Mental Health NHS Trust
Bradford Care Trust
Brighton and Sussex University Hospitals NHS Trust
Bromley Hospital NHS Trust
Buckinghamshire Hospitals NHS Trust
Cornwall Partnership NHS Trust
Coventry and Warwickshire Partnership NHS Trust
Derbyshire Mental Health NHS Trust
Devon Partnership NHS Trust
Dudley and Walsall Mental Health Partnership NHS Trust
East and North Hertfordshire NHS Trust
East Cheshire NHS Trust
East Sussex Hospitals NHS Trust
Epsom and St Helier University Hospitals NHS Trust
George Eliot Hospitals NHS Trust
Great Ormond Street Hospital for Children NHS Trust
Hereford Hospitals NHS Trust
Hinchingbrooke Healthcare NHS Trust
Hull and East Yorkshire NHS Trust
Humber Mental Health NHS Trust
Imperial Healthcare NHS Trust
Ipswich Hospital NHS Trust
Kent and Medway Social Care Partnership NHS Trust

Kingston NHS Trust
Leicester Partnership NHS Trust
Maidstone and Tunbridge Wells NHS Trust
Manchester Mental Health and Social Care Trust
Mayday NHS Trust
Mid Essex Hospital NHS Trust
Mid Yorkshire NHS Trust
Newham Hospitals NHS Trust
North Bristol NHS Trust (incl NHSP)
North Cumbria Acute Hospitals NHS Trust
North Middlesex NHS Trust
North Staffordshire Combined Heathcare NHS Trust
North West London Hospitals NHS Trust
Northampton General Hospital NHS Trust
Northern Devon Healthcare NHS Trust
Northumberland Tyne and Wear Mental NHS Trust
Nottingham University Hospitals NHS Trust
Nuffield Orthopaedic Centre
Oxford Learning Disabilities Mental Health NHS Trust
Oxford Radcliffe NHS Trust
Pennine Acute Hospitals NHS Trust
Princess Alexandra Hospitals (Harlow) NHS Trust
Queen Elizabeth Hospital NHS Trust
Queen Elizabeth Hospitals (Kings Lynn) NHS Trust
Queen Mary's Sidcup NHS Trust
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust
Royal Cornwall Hospitals NHS Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Royal National Orthopaedic Hospitals NHS Trust
Royal Surrey County Hospital NHS Trust
Royal United Bath Hospital NHS Trust
Sandwell and West Birmingham Hospitals NHS Trust
Scarborough and North East Yorkshire NHS Trust
Shrewsbury and Telford Hospitals NHS Trust
South West London and St Georges Mental Health NHS Trust
Southport and Ormskirk Hospital NHS Trust
St George's Acute Hospitals NHS Trust
St Helens and Knowsley Hospitals NHS Trust
Suffolk Mental Health Partnership NHS Trust
Surrey and Sussex Healthcare NHS Trust
The Leeds Teaching Hospitals NHS Trust
The Lewisham Hospital NHS Trust
The Royal West Sussex NHS Trust
The Royal Wolverhampton Hospital NHS Trust
Trafford Healthcare NHS Trust
University Hospital Leicester NHS Trust
University Hospital of North Staffordshire NHS Trust
University Hospitals Coventry and Warwickshire
University Hospitals Lincoln NHS Trust
University Hospitals of Morecambe Bay NHS Trust
Walsall Hospitals NHS Trust
West Hertfordshire Hospitals NHS Trust
West Middlesex Hospital NHS Trust
Weston Area Health NHS Trust
Whipps Cross Hospital NHS Trust
Winchester and Eastleigh NHS Trust
Worcestershire Acute Hospitals
Worcestershire Mental Health Partnership NHS Trust
Worthing and Southlands Hospitals NHS Trust

RUNNING THE NHS – THE DEMOCRATIC VOICE

According to the government the driving force in the new health service is the patient. This can be engaged, we are told, by introducing market forces into the NHS in England, by creating 'purchasers' and 'providers' competing for NHS contracts and patients who can supposedly shop around for their care. This transactional choice, it is argued, will mean GPs, hospitals and health workers will raise their game and become more responsive to people's needs and wants. The health service will be remoulded around patients' priorities.

Patient & public power

In reality of course, patient-power is very limited. The key spending decisions are taken well above their heads - by ministers in Whitehall, by PCTs outsourcing services or by lawyers in the drafting of contracts. Many decisions have been made and millions of pounds spent, before the patient is presented with a limited choice of "providers" in which to receive their treatment or care. In the process of running the NHS house, the public have the right to choose the colour of the door.

Government will claim that patients' views influence the planning of care. There is indeed a new industry of public engagement which allows the public and NHS staff into the decision making process. But it is late in the day for this to influence operational decisions in the NHS. It is no match for the central diktats from the Department of Health. As last year's headline-grabbing plan to install a 'GP-led health centre' in every area shows, too often the government uses the command and control culture of the NHS to force through change, overriding both local management and the views of local people.

The reality is that, faced with ever more NHS outsourcing and a determined, centrally driven policy to commercialise, the citizen's role and influence is diminishing. Increasingly, to hear the democratic voice we will need local NHS staff and an informed public to respond to defend their services. So how can we help?

Create local networks

The NHS Support Federation is promoting a local cooperation between many of the staff bodies, trade unions and patient groups that already exist. General awareness has developed, so that many of them now share common concerns about commercialisation, but at present they seldom communicate or organise together. We are aiming to get these key local groups to set up their own networks. Even at a basic level this will mean that more groups are aware of what's going on and are organising to get their views across.

Too often the public only discover that services are being outsourced when the new provider is reported in the local media. Contracts have been signed and all the legal avenues for objecting are effectively closed. Early detection and intervention are therefore crucial. By working with trade unions and other bodies with national networks, we are trying to set up an early warning system that can quickly spread information around key groups. This should enable a wider response at an earlier stage when PCT plans are less concrete and more easily influenced.

Know your rights and how the system works

Recently the Federation performed a study of how PCTs are consulting the public. It was clear that standards vary greatly and that in many areas the public are deprived of adequate information and involvement. We have since been lobbying Parliament to improve and enforce standards, but knowledge of the basic right to information and consultation can be implemented to good effect at the local level too. We are working with legal advisors to brief local organisations. Pressure can be applied by an informed public using the legal obligations on PCTs to involve them, but first the public must know its rights and how to use them.

LINks

Amongst the key local groups we are working with is the new patient involvement body, Local Involvement Networks (LINks), a year-old national organisation given statutory powers to independently scrutinise the local health and social care services. It is made up of volunteers with limited funding from government so it has a tough but vital job. The Federation has set up a charitable organisation, Healthcare Concern, to develop training and information to support their work. In a sort of succession to Community Health Councils, LINks will be the first line of public involvement. Unlike CHCs, LINks will have access to NHS bodies in primary care and will be a prime responsibility of Primary Care Trusts. Fuller information may be obtained online from: http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/dh_076366#_1

Citizen Seminars

The proper functioning of LINks requires that information, education and training about the nature of the health problems the country faces, how the NHS works and how to influence it should be available to any concerned local citizen. Any hope that the over-ambitious, ill-starred NHS University might take on this role has long since disappeared. Healthcare Concern is therefore proposing a limited programme of seminars, starting with pilots in Brighton and London. It is hoped in due course to make these self-supporting and available to individual LINks, charities, patients groups, pensioners or anyone with the ambition and opportunity to play a more active role in support of their NHS. Local people, properly prepared with sound information can make real contributions to local NHS decision-making. It takes organisation, but there are plenty of examples of groups of local people attending board meetings, organising public meetings and talking to their local politicians and the media can have a big impact. Healthcare Concern will look hopefully to the distinguished and highly qualified membership of the NHS Consultants' Association to contribute to a superb faculty willing to conduct a session.

The defence of the NHS is an unremitting task. The service provides great benefits but will always need to explain itself and to seek and deserve the support of the society that brought it into existence. It is hoped that this Health Concern initiative, cautiously introduced and expanded, will give real substance to the partnership between professionals and an active and knowledgeable public, so necessary to sustain and enrich our National Health Service.

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Health care, marketising reforms and the media

A CONFERENCE called by the International Association of Health Policy in Europe (IAHPE) with the support of Coventry University's School of Art and Design and Faculty of Health and Life Sciences.

Also supported by the People's Health Movement, the International Journal of Health Services, the Politics of Health Group, the NHS Consultants Association, and Keep Our NHS Public

IAHPE

Coventry University

Wednesday - Saturday
June 17-20, 2009
Coventry University, UK

Invited speakers include

- Professor DAVID HUNTER, University of Durham
- Professor ALLYSON POLLOCK, Centre for International Public Health Policy, University of Edinburgh
- Dr JULIAN TUDOR HART (author of *The political economy of health care*)
- Professor HANS ULRICH DEPPE, Frankfurt
- Professor ALEXIS BENOS, Aristotle University, Thessaloniki (IAHPE President)
- Dr JOHN LISTER, Coventry University
- Physicians for a National Health Program (USA)

Conference Invitation and Call for Papers

It's our pleasure to invite you to submit a paper and attend the XVth conference of the International Association of Health Policy in Europe (IAHPE), to be held in Coventry University, June 17-20 2009.

We welcome abstracts for research papers case studies and posters relating the current situation and policy reforms in the health care sector, and the way these are reported in the print and broadcast media. The conference will address six main themes.

- THE IMPACT OF THE CREDIT CRUNCH
- PRIMARY CARE
- ACUTE HOSPITAL CARE
- PUBLIC HEALTH
- MEDIA COVERAGE OF HEALTH AND HEALTH POLICY, AND THE PUBLIC RIGHT TO KNOW
- ELDERLY CARE & MENTAL HEALTH: MARKETS v EQUITY

Above is the first page of a flyer about a Conference supported by a number of organisations including NHSCA and KONP.

Key details follow and the whole 4 page flyer is available electronically from the NHSCA office.

REGISTRATION: what's included

Registration fee includes conference admission and conference pack, lunches on Thursday and Friday, with refreshments morning and afternoon and a Friday night conference dinner. Hotel accommodation is NOT included but delegates may claim a special discounted rate at the nearby Ramada hotel info@ramadacoventry.co.uk/
Tel 0870 890 3722

Conference Fees £120 (register before April 1st), £150 (late registration)

Pay registration online at www.healthp.org, or by cheque (payable to Public Services Insight) posted to: John Lister, c/o Media & Communication, Coventry University, Priory St, Coventry CV1 5FB

RATIONING IS NOT RATIONAL IF NOT RELATIONAL

It would appear that hard times are not so much around the corner as staring us in the face. Sadly the government policy regarding its dogmatic approach towards a commissioner provider divide remains despite no realistic likelihood that such an approach can or ever will be an economically sound mechanism. Whilst I would probably agree with many who do not believe the above mechanism will ever be efficient I do think a more salient concern for a practising clinician such as myself is that it will also be ineffective. Why do I hold such a pessimistic outlook regarding this matter? In my own case it is simply related to my actual clinical experience of the above process being placed into operation. In this brief article I will outline this experience and I hope examine at least superficially some of the flawed rationale that the commissioner provider strategy is based upon. I will also attempt to link this with other areas of existing activity within the social health welfare sector that I hope others will similarly consider as evidence of a flawed market economy approach currently being implemented.

I was up until September 2008 a full time NHS child and adolescent psychiatrist working in Halifax in West Yorkshire. I had the pleasure to work for this organization for 3 years and whilst many differences emerged between myself and the Trust management regarding service operation, I always felt that my managers were frankly trying to resolve impossible demands with inadequate resources. Overall I have no criticism of any individuals I had dealings with either within my "provider trust" or with the actual commissioners of these services. Rather it was within the system and process employed to structure and manage our services that I had most concerns.

The Child and Adolescent Mental Health Service (CAMHS) service I worked within was at the time of my appointment fairly representative in terms of activity of CAMHS services across the country. The most immediate complaints related to its lack of out of hours provision and complete lack of immediate access to inpatient resources for the small number of under 18 year old requiring such intensive and or emergency treatment. This state of affairs was clearly unacceptable and this state of "crisis" had been in existence for nearly 20 years without any reported deaths or obvious preventable injuries. The crisis had been managed by cooperation between adult and child services in covering the gaps whereby unavoidable admission to adult wards was agreed for the youngsters who could not wait for adolescent inpatient treatment. Less significant out of hour crisis was managed using the disastrous process called common sense until the next working day when such crisis was largely dealt with by solely community based interventions. Frequently such crisis did not really represent health but social care issues but that is a separate story given the current climate of divide and redirection of referral. The matter really came to a head when it was "realised" that child admission to adult wards was perceived as being "illegal" by adult service managers and South West Yorkshire Mental Health Trust (SWYMHT) took a unilateral decision that their service would no longer bestow any service to under 18 year old human beings. That such a world view is in clear breach of the rights of a child in this country awaits a married and litigious 17 year old potential law student in ill health being refused his or her perceived rights. It is also my experience that the combination of child rights and access to achieve them is never in this country amenable to meaning. This created some immediate tensions as of course no alternatives were in place. This resulted in immediate civil war between child services located within the acute trust and the separate adult mental health trust. The was a compromise solution that I understand still stands to this day, whereby the adult trust does have a mechanism to admit 16 to 18 year old in dire emergency but it is my experience that there are never any beds to access and I have certainly never been able to experience the previous cooperation between CAMHS and SWYMHT. An unfortunate and in the longer term disastrous consequence of this first round of civil war has been the cessation of junior doctor training within Halifax as the decision not to allow them ever to see under 18's out of hours means that placements in Calderdale CAMHS cannot really meet the training needs required by the Royal College of Psychiatrists, whereas previously over the years of their training on call supplemented their brief experience when they where placed in Calderdale CAMHS. I would suggest this outcome will not foster links to repair distrust between respective organizations.

However the above developments did foster a determination to create inpatient access for young people as the consultant group flatly refused to undertake out of hours on call duties without this and a first on call tier, which resulted in a block contract being awarded to Affinity Healthcare. This is a private venture capital firm that has recently launched a variety of inpatient services for young people. That this organization had no track record of providing such services and was inconveniently located for the young people and families who were to use it does not really explain why such a contract was ever arranged

without consultation with the CAMHS services who were to work with it. The plain truth of the matter was that it was the only provider on the block and the 20 year crisis needed resolving at all costs; which is precisely what will be achieved. It is not fair to say that this new provider is good or bad as governance arrangements and case comparison costs have and probably will never be made available. That a single provider can with one unit provide all inpatient specialist care for all complex cases of youngsters with severe and frequently enduring mental health problems can be seen as a failure of commissioners to understand the problem. As of course they never spoke to the clinicians undertaking the work with the specialist training to know the range and type of services actually required. This investment was led by crisis thinking in my view rather than actual crisis.

The above development led to an establishment of an on call service for under 18 year olds. This development has never had any clear funding allocation and really has been tagged on to the demands of the existing service. This has caused much resentment and resulted in pretty much 50% of senior psychiatric and psychology staff leaving the service including myself. It has also created a perception of the trust management being felt as driving through change regardless to employees sense of fairness. The existing on call arrangement at the time of my own personal departure was rather fragile and potentially compromised by an arrangement that was not sustainable without staff voluntarily opting/ being bribed to participate. That this arrangement may contravene EWTD legislation is a moot point. Certainly when the fiscal incentives are removed so will opting in. This eventuality is in hand as the departure of experienced staff has been taken as an opportunity to find less experienced and cheaper staff who within their new contract must perform such on call duties. I fully expect that there will be much need for crisis intervention out of hours as of course the quality and capacity of the within office hours service will be affected by such changes.

However the above events are really small beer in the scheme of things. What directly led to my own resignation and maybe others was the arrival of fresh finance to develop an early intervention service for 14 to 24 year olds. This service had been undertaken for all under 18 year olds by my CAMHS team for 20 years without any specific funding and we had developed a small effective and highly trained workforce to manage this. The fresh funding was awarded solely to the adult psychiatric service (SWYMHT) who had no staff trained to perform this role including even a psychiatrist. SWYMHT managed to recruit non medical staff from CAMHS to perform this role which they agreed to provide solely in working hours, outside this it fell again upon a now depleted CAMHS service who of course now do not have such staff as they are located in the new service which is not available out of hours. A further lamentable experience is that SWYMHT are unable (at time of writing) to recruit the single consultant psychiatrist to run this EIP service and in the interim the existing CAMHS consultants are being paid to do this. A clear case of double payment in that previously they did this work within their pre existing duties. Even if SWYMHT eventually recruit a consultant one can only imagine how a service with a single consultant can be sustainable unless they never get unwell, attend training or go on vacation. How it must demotivate people to be carved out of existing roles and then expecting them to perform them again only at times of crisis, out of hours with cases they have no familiarity with can only be speculated upon ..... so I resigned and the best of luck to them.

The final piece of the jigsaw is frankly pretty squalid. The trust I worked for has embraced public private partnership and the hospital was built within such an arrangement. In fact SWYMHT (yes the adult psychiatric service) has rented a building from the acute trust which is now surplus to requirements and at great cost lying fallow. I understand the longer term hope is that Affinity Healthcare will take on this building to expand child and adolescent based services. I wonder if the financial arrangements will ever be made public? Anyhow the good people of Halifax and Huddersfield can hope to have inpatient services for their adolescent population with mental health problems when of course SWYMHT are given foundation status allowing them the fiscal freedom to presumably sublet this building. The entire experience demonstrates a spectacular waste of time, effort, resource and has in my view resulted in fractured services with less qualified poorer paid staff being provided by a more costly and bloated managerial arrangement. The issue of costs and profiteering in my mind is less central than the qualitative implications and the increased likelihood of creating multiple transitions and boundary arguments between already tense providers playing by different rules and by differing standards of probity. It is clearly nonsense to think such organizations will cooperatively collaborate given the past history of buck passing, competing for finite staff resources and funding. The commissioners are sadly far removed and ill equipped to manage such services, not in any small part by the necessary tools to measure and consider such decisions as being unavailable or unknown.

The above health model directly mirrors examples such as social care for the elderly, foster agencies and even therapeutic services for looked after children. Later examples are deliberately chosen as this has rarely been considered as a significant cause of child protection failure in this country, whereby resources are squandered on ill fitting parts, the least attractive and usually most demanding aspects of services are not tendered for but provided by existing ruminants of past services. Usually by persons either training or looking to move further up the food chain within and without the agencies employing them. The greatest peril from the market force model is not that services will not be cost effective it is that they will be ineffective not only because less costs more but by poor coordination and cooperation they are simply less effective. The argument that a free economy allows investment in success seems very lame when the customer via tax has no choice on his expenditure and when certain products have to simply be provided even if there is little scope for profiteering. A simple example being a supermarket recognising certain products are not really worth the hassle of stocking them but not to do so makes the entire store less attractive if such essentials are not available.

There are emerging academic interests within management theory regarding the factorising of relational aspects of business and service and certainly within the health field directly related to commissioning process. The current crop of commissioners are sadly at huge disadvantage in that they are usually addressing a limited horizon of activity. Whilst I still strongly suspect that I am against the commissioning provider division, the need for commissioning and service structure organization will obviously remain. My major gripe is not with commissioners themselves, it is the very poor level of direction and actual need to employ recognised commissioning cycle processes that address not only quantitative and qualitative aspects but relational aspects as well. It is impossible in the current climate to see how the swarming bee hive of tiny disconnected PCTs can undertake these at times strategic and not to mention multiagency decisions with extremely long lead times in terms of outcome. That failure lies squarely at the government door. They financed a commissioning system with no idea how it would operate and without any recognizable process to establish its effectiveness. It has increasingly been my experience across many policy fields that the problem is central policy aspiration and expected devolved local implementation with no actual local structure to be allowed the authority to actually coordinate such local implementation. Mr Brown and his government face a tough year but like the banks simply giving health cash doesn't create output that meets hoped for outcome in policy. I would argue that the economic argument in these times of recession will hurt the government but for practitioners it is poor service that is the real concern. It will be important not to let the political elite get away with convincing the public that universal healthcare for all is better off in the private sector by making people increasingly aware not of a failed philosophy but a government although generous failing to govern.

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