

The Health and Social Care Bill is now law, but its implementation will be fraught with challenges

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The real impact of the Health Care reforms depends not on their design but on their implementation. Anna Dixon argues that the government has largely failed to win the support of the medical profession for the Act – as it now is – and yet without their support it is difficult to see how they can make this work.



After many long nights spent debating the hundreds of amendments laid before them, members of the House of Lords will have breathed a huge sigh of relief that the [Health and Social Care Bill](#) has finally been granted Royal Assent. Secretary of State for Health Andrew Lansley will be equally relieved but for other reasons. His grand plans to redesign the NHS, developed during six years in opposition, have had a very difficult passage and, after much amendment, the final results are very different from the original.

Lansley's original aims were to liberate the NHS by giving patients more choice, clinicians more control and organisations greater freedom from central control and political interference. To realise this, the Bill was originally designed to do several things: establish a powerful regulator to promote choice and competition (the new [Monitor](#)), hand over [commissioning](#) budgets to groups of GPs, abolish layers of regional and local NHS 'bureaucracy,' and hand over responsibility to more powerful independent bodies including the [NHS Commissioning Board](#) and [Public Health England](#).

The reality is quite different. Monitor will tackle anti-competitive behaviour where this is not in the interests of patients and the public, but its more interventionist powers have been removed. Commissioning groups have more governance requirements and population responsibilities, need to be subject to more scrutiny by local authorities through [health and wellbeing boards](#) and have more stringent requirements on the handling of conflicts of interest. The Department of Health is in the process of downsizing and handing over responsibilities to various arm's length bodies, and the abolition of primary care trusts and strategic health authorities is well under way. However, the new structure of the NHS Commissioning Board suggests it will try to fill the gaps left behind with regional and local offices.

We know from [our analysis of previous reforms](#) that the real impact depends not on their design but on implementation. The task of implementation lies in the hands of others beyond government who may not share in the vision, may have their own priorities and interests, and may be influenced by other more powerful pressures. Whether these reforms deliver on the government's vision and have the desired impact of improving outcomes will depend on the actions of the newly created national and local organisations. Here I set out briefly the three priorities that face the implementers.

A new approach to commissioning: at national level the NHS Commissioning Board needs to set out a clear vision for commissioning that focuses on securing improvements in health and providing the best health care for local populations with the resources available. It needs to provide the tools for local commissioners to contract for services (not with organisations), to specify the standards and outcomes (not the means of delivering them) and currencies which transfer risk to providers with incentives to innovate and change to more effective models of care (not rewarding activity). At local level, clinical commissioning groups need to work closely with local authorities to ensure their focus is on outcomes for their local population. This sounds very complex – what it really means is they need to focus on transforming services locally, not on transactions and performance management of providers.

Establishing clinical and financially sustainable providers: at national level the NHS Trust

Development Authority, which has been set up to oversee the transition of all NHS trusts to become foundation trusts, needs to be given the freedom to restructure trusts that are not sustainable (rather than having to force mergers, which evidence has shown often result in poorer performance). Monitor will also need to act early to find solutions for foundation trusts that are no longer clinically and financially sustainable rather than waiting until providers are failing. Locally, the leaders of provider organisations need to recognise and make difficult strategic choices about their future sustainability. They need to be allowed to stop providing some services themselves and to develop innovative partnerships with other public, private and third sector organisations.

Balancing the benefits of choice and integrated care for patients: at national level Monitor will need to carefully balance the benefits of integrated care for patients with complex needs and the potential benefits of greater choice and competition. It needs to send a strong signal to local commissioners and providers about the importance of integrating care and explain how they can do this without breaching competition rules. Locally, commissioners will need to think carefully about the feasibility and desirability of applying competition to different types of services. They will need to offer a degree of choice and contestability but recognise that the majority of users have complex needs that span health and social care and physical and mental health.

In the face of these challenges, the real risk is inertia – that leaders in the system resist the reforms but in so doing resist change. The government has largely failed to win the support of the medical profession for the Act – as it now is – and yet without their support it is difficult to see how they can make this work. The political debate about the Act may be over but the political repercussions if the health and social care system does not change to meet the unprecedented challenges it faces will be great. Any failure to do so will firmly land at the government's door.

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Note: This article gives the views of the author, and not the position of the British Politics and Policy blog, nor of the London School of Economics.

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