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NEWS

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69 Scholarly pursuits denied



PICTURE OF THE WEEK

An open access button that counts the number of times journal readers hit an article paywall was one of three winners at the *BMJ* inaugural hack day, held in London at the weekend. Readers submit details on an online form, and their data are used to populate a “map of frustration” aimed at persuading publishers to embrace open access.

● **OBSERVATION**, p 27

RESPONSE OF THE WEEK

The start of science was arguably Descartes' formulation of systematic doubt. Yet today the sceptic sometimes seems under-represented on expert committees.

My wife and colleague Jenny du Toit had a powerful idea to reduce overmedicalisation. Exclude subspecialist expert authors from guidance committees. Insist instead on generalist authors, appropriately advised by expert subspecialists. The expert is rather rarely a therapeutic or diagnostic sceptic. The “SIF” (single issue fanatic) sees their specialist condition everywhere. Research grants and recognition are proportional to the perceived importance of the condition. But their unmodified enthusiasm risks medicalising the world. Descartes had it right. The sceptic needs a voice.

Kevin Barraclough, GP, Painswick, UK, in response to “Too much medicine; too little care” (*BMJ* 2013;347:f4247)

MOST SHARED

Bicycle helmets and the law

Put your ties back on: scruffy doctors damage our reputation and indicate a decline in hygiene

Too much medicine; too little care

A&E doctor is suspended for nine months after series of incidents that alarmed colleagues

England's national programme for IT

BMJ.COM POLL

Last week's poll asked: “Are hospitals justified in refusing to hire smokers?”

54% voted no
(total 951 votes cast)

► *BMJ* 2013;347:f4294

This week's poll asks:

“Are clinical trial data shared sufficiently today?”

► Yes *BMJ* 2013;347:f1880

► No *BMJ* 2013;347:f1881

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EDITOR'S CHOICE

Cut to the core

The NHS is still one of the most cost efficient health services in the world. Why would the government want to dismantle it?

The costs and quality of hospital care are under scrutiny as never before. How should we decide which types of secondary care represent value for money, how should we pay for them, and which treatments should be included in a tax funded service, free at the point of care (as the NHS still purports to be)?

In the first of a two part *BMJ* investigation, Gareth Iacobucci lifts the lid on England's clinical commissioning groups (CCGs) as they take control of the purse strings for hospital care (p 3). Through freedom of information requests, he finds that CCGs are taking a range of different approaches to managing the money. Many have tightened existing restrictions on referrals for elective surgery; some have introduced new "gateways" and triage services to limit referrals and admissions to hospital; some have not implemented recent NICE guidance that would increase cost—for example, provision of IVF to older women and single sex couples. But a few have taken a very different route. Instead of tightening restrictions they have removed them, relying instead on improved dialogue between clinicians in primary and secondary care to deliver efficiencies.

Of course, such variation in local decision making is key to the government's plan. Given time and good data we will be able to see which approach is better. And the government wants doctors, rather than politicians and managers, to decide which treatments to provide. Despite doctors' concerns, NHS England is unapologetic about the idea that good clinical practice must encompass effective use of resources.

So should we mind the inevitable return of postcode prescribing, with patients being "at the mercy of CCG

finances"? Or should the government, in the form of NHS England, draw up a list of core services for the NHS so that individual doctors are not asked to decide between their responsibilities to their patient and the need to help their CCG stay within budget?

In their replies to Iacobucci's investigation, all the CCGs said that their decisions were being driven by clinical evidence rather than cost. But unlike their predecessors, the primary care trusts, CCGs have a legal duty to break even. In the words of one GP who recently stepped down as a CCG clinical director, "CCGs can run out of services but they cannot run out of money."

These pressures will only get worse as the finances tighten. Jon Ford, head of the BMA's Health Policy and Economic Research Unit, concludes that the NHS is being required to create efficiency savings equal to a quarter of its budget by 2016, something he believes to be "totally unrealistic" (p 26). It can only be achieved, he says, by slashing pay and staffing levels, which would make the service unviable. Yet by most accounts the NHS is still one of the most cost efficient health services in the world. Why would the government want to dismantle it?

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