

NHS Long Term Plan Legislation

Please tell us the organisation's name:

Federation of Ophthalmic and Dispensing Opticians (FODO)

Should the law be changed to prioritise integration and collaboration in the NHS through the changes we recommend?

(Required)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:			x		

Would you like to continue to the optional questions and feedback?

(Required)	Yes	No (this will take you to the end of the survey)
Please select:	x	

Promoting collaboration

Do you agree with our proposals to remove the Competition and Markets Authority's functions to review mergers involving NHS foundation trusts?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:				x	

Do you agree with our proposals to remove NHS Improvement's powers to enforce competition?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:		x			

Do you agree with our proposals to remove the need for contested National Tariff provisions or licence conditions to be referred to the CMA?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:			x		

Getting better value for the NHS

Do you agree with our proposals to free up procurement rules including revoking section 75 of the Health and Social Care Act 2012 and giving NHS commissioners more freedom to determine when a procurement process is needed, subject to a new best value test?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:			x		

Increasing the flexibility of national payment systems

Do you agree with our proposals to increase the flexibility of the national NHS payments system?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:				x	

Integrating care provision

Do you agree that it should be possible to establish new NHS trusts to deliver integrated care?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:			x		

Managing the NHS's resources better

Do you agree that there should be targeted powers to direct mergers or acquisitions involving NHS foundation trusts in specific circumstances where there is clear patient benefit?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:				x	

Do you agree that it should be possible to set annual capital spending limits for NHS foundation trusts?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:				x	

Every part of the NHS working together

Do you agree that CCGs and NHS providers should be able to create joint decision-making committees to support integrated care systems (ICSs)?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:			x		

Do you agree that the nurse and secondary care doctor on CCG governing bodies be able to come from local providers?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:				x	

Do you agree that there should be greater flexibility for CCGs and NHS providers to make joint appointments?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:		x			

Shared responsibility for the NHS

Do you agree that NHS commissioners and providers should have a shared duty to promote the 'triple aim' of better health for everyone, better care for all patients and to use NHS resources efficiently?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:				x	

Planning our services together

Do you agree that it should be easier for NHS England and CCGs to work together to commission care?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:			x		

Joined-up national leadership

Which of these options to join up national leadership do you prefer?

- a) ~~combine NHS England and NHS Improvement~~
- b) provide flexibility for NHS England and NHS Improvement to work more closely together
- c) ~~neither of the above~~

Do you agree that the Secretary of State should have power to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs, with appropriate safeguards?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Please select:				x	

Would you like to provide further feedback?

(Required)

Yes

No (this will take you to the end of the survey)

Please select:

x

The additional boxes below are optional and are provided if you want to add any additional detail on the specific questions from the previous page. You can submit the application now by scrolling to the bottom of the page and clicking continue.

Promoting collaboration

This includes the following proposals:

- Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts.
- Remove NHS Improvement's competition powers and its general duty to prevent anti-competitive behaviour.
- Remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA.

We recognise the importance of promoting collaboration and support regulatory change to facilitate this, provided that it benefits patients and offers sufficient safeguards for taxpayers. On this basis

- we support removing the CMA's function to review mergers involving NHS Foundation Trusts. However, as the CMA has made clear in its evidence to the Health Select Committee, this would most likely involve changing the status of Foundation Trusts¹. As a result this proposal might require a more detailed public consultation
- we, like the CMA¹, also have no objection to removing the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA.

FODO supports the goals set out in the NHS Long Term Plan and in that context agrees that it is important to review NHS Improvement's competition powers. However, in our view, NHS Improvement's existing powers can also be used to encourage/facilitate collaboration and certainly be used to challenge anti-collaborative behaviours.

We therefore strongly support not removing existing powers, but instead refreshing them to focus more on enforcement in cases where providers or commissioners demonstrate anti-collaborative behaviour where collaboration would benefit patients and provide the best value for money.

The most pragmatic way to achieve this might be to follow advice given by the CMA to the Health Select Committee in March 2019. This would involve the CMA and NHS Improvement working collaboratively via a MoU and other processes to ensure that the right balance is struck with regard to regulating commissioners and providers in the public interest, at the same time as accepting that competition does not work in health care as it works in other sectors but that targeted oversight of health care provision still has benefits¹.

In our view the above proposal would help address concerns about accountability that have been raised by the Health Select Committee and other health policy experts.

References:

1. CMA, 2019, Health Select Committee response, submission by the Competition and Markets Authority,
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/795915/health_and_social_care_response.pdf

Getting better value for the NHS

This includes the following proposals:

- Revoke regulations made under section 75 of the Health and Social Care Act 2012 and repeal powers in primary legislation under which they are made, subject to a new best value test.
- Remove arrangements between NHS commissioners and NHS providers from the scope of the Public Contracts Regulations, subject to a new best value test.

The “new best value test”

It is regrettable that the definition of ‘best value’ and draft statutory guidance have not been included in this consultation. Consulting on these after new legislation is passed, will mean that Parliament will have to agree wide-ranging legislative change without having the full information before it. In our view it will be important for the new ‘best value’ test (and draft statutory guidance) to be defined and consulted on before Parliament is asked agree to legislative change.

Here we also agree with the Health Select Committee that it is vitally important to clarify what is meant by ‘best value’, including what the accompanying statutory guidance contains, as this will be key to how the NHS Long Term Plan benefits patients, the public and high quality providers.

This issue goes to the heart of the NHS Long Term Plan as the ‘best value’ test will also be the benchmark against which NHS commissioners or Integrated Care Providers (which may have joint staff and operations) use their discretion to seek to expand capacity from or to transfer services to healthcare providers outside the NHS.

Revoking section 75 of the Health and Social Care Act 2012 and modifying the scope of Public Contracts Regulations

We are agnostic on section 75 of the Health and Social Care Act 2012 as the NHS has not enforced it for some time, even when this has been to the detriment of patient care and sustainability of services, and at a significant cost to the taxpayer.

Our main concern is about how best to safeguard patients’ interests against both anti-collaborative and competitive behaviours and to encourage working constructively in the public interest and driving the efficiencies and innovation required to deliver the Long Term Plan. We would have more confidence in NHS England and NHS Improvement being able to manage commissioners and providers if the evidence supported this. Regrettably the evidence base and history do not encourage such confidence, and the evidence base for such high risk reforms

without sufficient safeguards is weak and partial. We have seen first-hand how 'hands-off approaches' by both NHS England and NHS Improvement have hampered service development and value for the benefit of patients and favoured the interests of institutions instead. It is doubtful whether the new incentives in the NHS Long Term Plan - which we support - will be strong enough to counteract this.

If however the goal is to provide the NHS (England and NHS Improvement) with the ability to instruct local commissioners and providers to act in the public interest and make difficult but evidence based decisions which will help shift services out of acute hospitals and into primary and community care settings, then this might deliver significant benefits – for example millions of hospital visits for eye and hearing related problems can be managed safely and effectively in primary care, but to date the existing NHS set-up has acted as a barrier to much needed change here.

We would strongly support maintaining backup powers as safeguards – which may need never to be used of course – until the system has proved that it is working as intended. Removing them too soon is not sound public policy.

Strengthening patient choice

We see there is merit in streamlining procurement rules where this can reduce costs, provided there are sufficient safeguards in place for patients and the taxpayer, and especially in ending “overly rigid procurement requirements and their replacement by a new best value and stronger protection for patient choice”.

Patient choice is a central tenet of the NHS Constitution (this goes far wider than personal budgets which evidence has shown are not suitable for all patients). We therefore welcome the commitments that “choice will still exist for elective care and money will need to continue to follow the patient accordingly” (18).

We support the proposal that the requirements on commissioners and providers in relation to patient choice will be preserved under separate regulations and that the power to set standing rules for commissioners be explicitly amended to include patient choice rights (13) and that “the preservation of patient choice” will inform decisions on service changes following NHS Trust acquisitions and mergers (36).

We also welcome evidence given by NHS leadership to the Health Select Committee on 2 April which suggests in some cases patient choice might be extended to achieve goals set out in the NHS Long Term Plan.

Here we would call on the NHS in England to review the weight of its own evidence and extend the right to patient choice to

1. non-consultant led ophthalmology services, most of which are ambulatory, so that patients can access care closer to home without the need to go to hospital for routine eye care and follow-ups, helping reduce millions of visits per year to hospital. This is particularly important for chronic eye conditions such as glaucoma, with an estimated 1 million and growing outpatient visits per year and routine pre and post-operative care for cataract surgery, which alone would help shift millions of patient visits out of hospital and into primary and community care settings over the next five years

2. audiology (adult hearing services) for which there is overwhelming evidence on the benefits (including from NICE, NHS Improvement and NHS England). This could help shift more than 2 million outpatient appointments each year into primary and community care settings – including 2 million audiology appointments and 300,000 ENT visits.

This will help the NHS deliver on goals set out in the NHS Long Term Plan, including prevention, supporting the population to age well and transforming outpatient models of care by reducing the need for hospital appointments.

We stand ready to support the NHS deliver the Long Term Plan and help ensure patients are put at the heart of the NHS and taxpayer investment in the NHS maximised in terms of patient outcomes.

Increasing the flexibility of national NHS payment systems

This includes the following proposals:

- Remove the power to apply to NHS Improvement to make local modifications to tariff prices, once ICSs are fully developed.
- Enable the national tariff to include prices for 'section 7A' public health services.
- Enable national prices to be set as a formula rather than a fixed value, so prices can reflect local factors.
- Enable national prices to be applied only in specified circumstances.
- Enable selected adjustments to tariff provisions to be made within a tariff period (subject to consultation).

We see the merits of reviewing the NHS payment system - e.g. amending the tariff - so that new reimbursement models can be developed to incentivise high quality care for long-term conditions (e.g. glaucoma) which are growing due to our ageing population, provided NHS pricing principles, which safeguard quality of care, are maintained.

Done well, it should help achieve the NHS Long Term Plan goal of transforming outpatient care which NHS leaders describe as “outdated and unsustainable”, shifting millions of annual and avoidable hospital visits into primary and community care settings at the same time as improving quality of care and controlling the rate of growth in NHS expenditure.

We have offered to support NHS England and NHS Improvement with expertise on the pricing of packages of care for long term conditions so that the NHS can ensure money still follows the patient whilst incentivising quality and coordinated care, and dis-incentivising solely activity based reimbursement models.

Integrating care provision

Enable the Secretary of State to set up new NHS trusts to provide integrated care.

We have stated above that we are neutral on this proposal because the consultation document does not include sufficient information to support the proposal – e.g. it is not clear what the consultation and decision making process will be.

If there were sufficient checks and balances in place, then yes it is sensible for the Secretary of State have powers to establish new NHS trusts to deliver integrated care services across a given area, provided the NHS Constitution is adhered to and patients, not institutions, are put at the heart of the NHS.

However, we do have concerns about accountability and the potential consequences of 'too big to fail' organisations. Without necessary back-up powers at NHS England/Improvement or DHSC it is difficult to see how the Secretary of State will be able properly to discharge his/her NHS duties to the public either indirectly through NHS England/Improvement or directly.

New trusts will no doubt also be established on the grounds of 'patient benefit' but it is not clear how this will be defined, who will decide what that is, who can challenge it and how it should operate in an age where services are to be shaped around individuals. Similarly there will no doubt be a duty to "involve the local community" but there is no clarity about what rights the community will have or how it will be decided that this duty has been fulfilled. This will be even more problematic as commissioner and providers operate increasingly as one.

We have also already identified the lack of a definition of 'best value' and sight of the draft accompanying statutory guidance as problematic issues (see our response to "Getting better value for the NHS" above and in "other comments" below).

Managing the NHS's resources better

This includes the following proposals:

- Give NHS Improvement targeted powers to direct mergers involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits
- Give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts

We agree that NHS improvement directing some foundation trusts to merge might be in the public interest but with the same caveats noted in our response to other questions – i.e. where there are sufficient safeguards and doing so will benefit patients.

We also agree that NHS Improvement having powers to set annual capital spending limits might be sensible on grounds of fairness to local populations and making the best use of NHS capital resources. However the NHS has traditionally been poor at exploiting the totality of resources in a given locality, and therefore NHS Improvement should consult on its criteria for approving capital spend limits to address this. For instance community eye health practices have over 5000 well-equipped NHS premises at their disposal which could take on a large amount of routine non-medical ophthalmology care from hospitals without the need for significant capital investment.

This would allow more money to be invested in capital expenditure where there are no suitable alternatives.

In summary, we strongly support better oversight of NHS resources. In our experience the NHS has been slow to respond to its own evidence on how to improve services and value for money and transform out of hospital care by ensuring capital expenditure is carefully directed. Ensuring providers are held to account, should help ensure that the NHS can transform what the Long Term Plan now accepts is an “outdated and unsustainable” model of outpatient care.

Every part of the NHS working together

This includes the following proposals:

- Enable CCGs and NHS providers to create joint committees.
- Give NHS England powers to set guidance on the formation and governance of joint committees and the decisions that could appropriately be delegated to them.
- Allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers.
- Enable CCGs and NHS providers to make joint appointments.

We of course welcome greater collaboration across the NHS that works in the public interest and puts patients at the heart of the NHS. However, it is not clear how the proposed structures will achieve this.

The consultation document for example does not explain how genuine accountability can operate between commissioners (who under the NHS Long Term Plan are to be “streamlined and become leaner, more strategic organisations”) and providers (which will have “overall responsibility for deciding how to use resources to improve quality of care and health outcomes for a defined population”). This becomes even less clear when an Integrated Care Provider (ICP):

- may have “a single contact and combined budget” (24)
- may subcontract uncontestedly and at discretion (11)
- may have joint committees (45) and joint appointments (53, 57) with the commissioner
- may include GP services (66)
- may include social care (49) despite the intention for local authorities to retain their powers independently to challenge local NHS plans through Overview and Scrutiny Committees (69)
- is likely to be many times larger and more powerful than the new primary care networks of 30-50,000 registered population.

We welcome the reassurance that joint committees between commissioners and NHS providers will not “do away with existing responsibilities of CCGs and NHS providers”(45) and will not be able to exercise decisions on purchasing services (47) although it is difficult to see how these distinctions can be safeguarded in reality, especially in the light of joint appointments.

On the other hand we agree that it is no longer a sensible or wise use of NHS resources to pit one NHS Trust against another. We therefore support the proposals to permit joint committees of NHS providers (and others) in order to set up, for example, clinical services or IT networks – just as CCGs can.

The aims “to change the NHS for the better and improve services for everyone working in them and using them” and for “local NHS bodies to be free to work together with partners including

local authorities, to plan and provide care around patients, not services or institutions” are incontestable. We would however propose that 'amongst partners' who can be included should be the NHS contractor professions and independent sector partners, without whose participation the NHS will not be able to meet population need or achieve its wider goals.

Similarly we would make the same point about “other partners” in terms of Integrated Care System (ICS) partnership boards (43) (subject to the same safeguards against conflicts of interest as GPs and others).

The rationale for this is because, in forward planning, ICSs need to take account of all available local capacity, not just that in acute hospitals, to meet population need and their wider goals. For example, without this system-wide approach, the NHS will risk wasting scarce resources on building or training new capacity when existing capacity exists. This would not only be a poor use of NHS resources but would also unnecessarily delay care and result in less good outcomes for patients and population health overall.

Shared responsibility for the NHS

Create a new shared duty for all NHS organisations to promote the ‘triple aim’ of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS.

Whilst the principle of “the ‘triple aim’ of better health for everyone, better care for all patients and efficient use of NHS resources, both for their local system and for the wider NHS” (60) is unexceptionable, it would be good to know which will become more important when the three aims conflict or in times of financial constraint.

The principle of “the ‘triple aim’ of better health for everyone, better care for all patients and efficient use of NHS resources, both for their local system and for the wider NHS” (60) is so broad and lacking in detail as to be unexceptionable. However it would be good to know which will become more important when the three aims conflict or in times of financial constraint.

Historically, as the Five Year Forward View recognised, prevention and better health for everyone has very much taken third place in this triangle, whilst care has taken second and finance (in recent years) primacy over everything else (even when that has meant patients not getting the treatment they need in time).

Traditionally the NHS has striven towards allocating NHS resources to be spent on a given population weighted for age, deprivation, market forces etc on the principle that this was that population’s ‘fair share’ (even though that has never quite been achieved). However, when local system priorities and ‘wider NHS’ financial priorities conflict it is not clear how this will be resolved by the new shared ‘triple aim’ duty, how this can be challenged by stakeholders or who will arbitrate.

It is also unclear how this new duty will be more effective than the existing “statutory duties [on the NHS bodies and local authorities] to cooperate with one another when performing their functions” (59) and “the extensive freedoms [they already have] to work together jointly, including joint commissioning and budget pooling where this is locally agreed” (69).

The review of metrics and targets may help but it may also lead to an increased risk of hidden rationing which always falls on the weakest in society.

We strongly urge the DHSC and NHS England therefore to build safeguards against these risks into the legislation.

Planning our services together

This includes the following proposals:

- Enable groups of CCGs to collaborate to arrange services for their combined populations.
- Allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'.
- Enable groups of CCGs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions.
- Enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement, or to delegate the commissioning of these services to groups of CCGs.
- Enable NHS England to enter into formal joint commissioning arrangements with CCGs for specialised services and for the wider NHS.

We support the principle of permitting NHS England and one or more CCGs to commission 'section 7A' services jointly to avoid unlawful 'double delegation (even though these will cover geographical foot-prints far larger than primary care networks of 30-50,000 population).

However, whilst this may just be loose drafting, joint commissioning is not at all the same thing as, as the consultation document suggests, permitting CCGs to commission those services as "if they were their own" (67, 73).

It is not clear how this would be consistent with enabling NHS England to "keep overall responsibility for these functions" (68) or how the fact of NHS England consulting on plans to delegate functions to CCGs and pool budgets would offer any protection to patients or the public, especially if financial pressures were the driver (68).

It would be helpful if these difficulties, and how they might be overcome, were set out clearly for comment before Parliament is asked to legislate.

Joined up national leadership

This includes the following proposals:

- Bring NHS England and NHS Improvement together more closely, either by combining the organisations or providing more flexibility for them to work closely together.
- Enable wider collaboration between ALBs.

We can see the benefit of joining up national leadership to achieve value for the taxpayer provided, as the consultation document asserts, there are appropriate safeguards.

Given that such reforms are normally in one direction only – to create larger organisations – we very much hope one of the safeguards will be transparency about the evidence base for change and rigorous test about whether bigger is always best for the public and NHS patients/service users. As a sector that has suffered significantly from the debacle of Capita involvement in primary care for example, we know only too well how the NHS and government can seriously underestimate the scale of tasks to be delivered, the timescales necessary to effect change and the realistic long-term costs. Simply cost shifting is not 'saving' in any meaningful public value sense.

Beyond what you've outlined above, are there any aspects of this engagement document you feel have an impact on equality considerations?

Yes.

We are concerned that unless there is a concerted effort to shift more eye care out of hospital for chronic conditions like glaucoma that warrant ongoing monitoring more than medical attention, the eye care service will become ever more unsustainable and the cases of preventable blindness will continue to increase further worsening inequalities due to variation in access to care.

We are also concerned that the proposals might have an adverse impact on older people with a hearing disability. We therefore feel that age related hearing loss also warrants special consideration.

Other comments?

As we have noted elsewhere, the evidence base presented for such wide-ranging legislative change is not strong.

The consultation proposals are “based on what [NHS England has] heard from patients, clinicians, NHS leaders and partner organisations, as well as national professional and representative bodies” (Introduction). However the substance and detail of this evidence, how it was analysed and weighted, is not presented - not even on the NHS England or DHSC websites as would normally be expected for independent scrutiny.

It is reported that “some local health systems have expressed interest in.....bringing some services together under the responsibility of a single provider organisation, supported by a single contract and combined budget” (24). Given the magnitude of this proposal and the historical experience of District Health Authorities which were deemed not to have served patients well, it is surprising that this consultation does not provide evidence of which health systems these are, what proportion of all health systems they represent, whether the expressions of interest were unanimous or contested, and what other views (if any) have emerged which might not have been so positively considered.

The consultation also reports that

- “in recent years it has become increasingly common for NHS provider organisations to come together, through mergers and acquisitions, so that a single organisation can plan and deliver service better across multiple sites. This can allow the NHS to manage its resources – its workforce, its buildings and other capital assets, its knowledge and insights – better, for instance by developing standardised approaches to service design and continuous quality

improvement, improving approaches to recruiting, retaining and developing staff and sharing back office and clinical support services” (31).

While much of this is undoubtedly true – especially in respect of workforce planning, recruitment and management where it was absurd for the NHS to be competing against itself for staff groups in short supply – the main success criteria identified are managerial and inward-looking and it would have been helpful if the consultation had provided links to hard evidence of examples where mergers and acquisitions have resulted in better care, outcomes and value, as we understand this has not universally been the case in other industries in either the public and independent sectors. Also, the three examples cited date only from 2017 (Manchester University NHS Foundation Trust) and 2018 (University Hospitals Birmingham NHS Foundation Trust and East Suffolk and North Essex NHS Foundation Trust) and so are unlikely yet to provide solid evidence on which to base national policy on this scale.

Given the importance of the new ‘best value’ test in future commissioning arrangements (8), it would have been helpful for NHS England to have published evidence about how well the ‘best value’ test has worked for clients in social care since its introduction in that sector, and whether and if so how NHS England’s thinking differs from or builds on this.

Finally – and perhaps understandably in a consultation about NHS primary legislation - there is not a great deal about local authorities or social care. This is regrettable as NHS legislation intermeshes with local authorities’ legislation. Local authorities, and their public health and social care roles will also be central to the success of the NHS Long Term Plan and potentially have much to teach the NHS.

As noted above, no evidence is presented about the benefits or otherwise of the introduction of 'best value' in social care. It is also not clear whether the NHS 'best value' test will be the same as local authorities' 'best value' test under the 'triple aim'.

The proposal to permit local authorities to be part of joint NHS provider committees to develop integrated pathways etc across health and social care where this is agreed by all parties, is sensible. Nevertheless it does risk undermining the power of local authorities (which it is clearly intended they retain) independently to challenge local health systems through Overview and Scrutiny Committees and to refer a matter to the Secretary of State for Health where the Committee feels that a proposal substantially to vary local health services has not been adequately consulted upon (69).

Only passing reference is made to this but it is hard to see how local authorities can fulfil this role if they are part of the same decision-making process and may have shared staff. It may be that these roles have been proven or judged to be ineffective or impossible to operate in a more integrated world. In either case greater explanation would be helpful as it may assist Parliament in deciding how NHS legislation should be changed.

In our view therefore the evidence to support the far-reaching proposals put forward in this consultation should be published before Parliament is asked approve changes to primary legislation so that informed decisions can be made.