

## MEDACT BACKGROUND DOCUMENT ON THE NHS WHITE PAPER

### 1. Underlying principles and concepts the WP ignores

#### ***Health as an individual and collective right***

This was recognised when the NHS was founded – health care was paid for out of the communal purse, by everyone according to their ability to pay (by taxation) and to everyone according to their need. It was a great force for equality because there was no direct relationship between what you put in and what you took out. A national organisation organised on national lines means that everyone's risks are pooled and everyone takes care of everyone else. Risk pooling is essential for equality in health – the WP mentions it only once.

#### ***Privatising health systems leads to inefficient use of resources and inequity.***

The WP mentions opening '*the NHS social market up to competition*' and applying '*competition law*'. They will '*move as soon as possible to an "any willing provider" approach for community services, reducing barriers to entry by new suppliers.*' This opens the way for private companies to provide services and make profits for themselves, from those who pay.

The WP say they are going to consult on '*abolishing the arbitrary cap on the amount of income foundation trusts may earn from other sources to reinvest in their services*' - providing a strong incentive for private practice.

There is also no guarantee that funds generated by private providers will be reinvested into health care improvements rather than being turned into profits for shareholders.

#### ***Ignoring evidence of the negative effects of privatisation***

The privatisation of health services is growing globally and the US system is a prime example despite recent attempts to reform that system. The evidence from the US is that private provision an inefficient way to use resources and causes inequity. The drive for privatisation is clearly driven by global capital seeking new markets. Health services are very attractive to global capital as everyone needs them and the NHS is particularly attractive as it has the guarantee of public money. The WP tries to fudge this as it knows it would be unpopular with the public.

#### ***An emphasis on the individual will increase inequity***

Health is a public good. It belongs to everyone and if I have it it in no way limits you having it, in fact it will often make it easier for you to have it (in the case of communicable diseases for example). The WP outlines a system that will erodes that idea and creates a consumer /business relationship between the patient and carer.

Those who are poor, old and vulnerable won't be able to afford the best services and those who can will buy them.

Many decisions re the use of public resources have to be made for the public good and according to public health principles. The WP emphasises the decision making power of the individual patient, but it will be difficult for them to have the overview and professional knowledge to make decisions on the system as a whole. It may also result in the most articulate and loudest voices being heard and these are unlikely to be the ones with the greatest need.

The WP emphasises 'personalised care' some aspects of which are fine, but in the context of competition (GPs competing for patients, providers for contracts, patients for the 'best' GPs) this will mean that the better off and more influential individuals will be able to prioritise their needs within a limited budget, increasing inequality.

### ***The misuse of 'choice'***

The WP talks about '*the right choice of hospital or clinical department*' - the question is who gets the wrong choice and what 'choice' do they have? The use of choice implies that everyone (with or without a car, funds to travel, time to read up about all the possibilities) will have an equal choice and never addresses the issue of who gets the 'wrong' choice and whether everyone has the same opportunities in making that choice. The emphasis on choice is also about a transfer of responsibility as the WP says '*patients should accept responsibility for the choices they make*'.

### ***Ignoring the importance of a clinical relationship***

The WP clearly states that '*It [commissioning] will bring together responsibility for clinical decision and for the financial consequences of these decisions.*' This puts the potential conflicts of interests, and unhealthy changes to the patient / doctor relationship, in a nutshell. A doctor can of course fight for more resources for his patients, but that is very different from making day to day and patient by patient financial decisions – a process similar to selling his or her services.

### ***The problems of payment by results***

The WP says '*Payment should reflect outcomes, not just activity, and provide an incentive for better quality*'. What happens to those patients whose consortia – for whatever reason - receive less resources because they do not have good outcomes, is unclear. There will be implications for their patients if they are left with fewer resources to deal with a more difficult situation.

*'We will create an environment where staff and organisations enjoy greater freedom and clearer incentives to flourish, but also know the consequences of failing the patient they*

*serve and the taxpayers who fund them*'. The consequences (withdrawal of funds) will be as much for the patients as for the staff. The patients will be punished for the perceived shortcomings of the professional, and these shortcomings may be in financial management rather than professional care.

## **2. Practical problems with policy problems/future scenarios**

The GP consortia will create smaller commissioning areas than at present potentially increasing inequity in service provision as commissioners have a narrower field of view. Variation between different practice areas has the potential to increase inequity in the services patients receive.

GP boundaries are being removed, and so in principal patients will be able to register at any practice. Whilst this promotes choice for mobile and empowered patients with the necessary time and resources, over two-thirds of people want quality local services and do not want to travel (Kings Fund. 2010. Patient choice: How patients choose and how providers respond).

Home visits to housebound patients will be made difficult, if not impossible, as scattered patient populations and travel times will make home visits from your own GP practice impractical for some patients. Even if out of hours arrangements make sure scattered patients receive home calls, the possibility of continuity of carer - particularly for the elderly and housebound – is likely to be severely disrupted.

The proposed GP commissioning bodies (consortia) will receive 80% of tax payers' money allocated for the NHS via an NHS Commissioning Board. These consortia will assess the needs of their local populations and pay for services to meet these needs, be they community or hospital based. PCTs will be abolished. GPs will have to find the skills and the time to do this work on top of their clinical commitments, and this is not an appropriate and cost-effective use of a trained clinician's time. It is likely that GPs will be forced to contract outside bodies to do financial, management and research tasks from companies who will have the opportunity to make considerable profits from GP budgets. GP budget funds will thus provide profits for private companies rather than being reinvested into health care.

However GPs won't have a choice about it and it has been clearly specified that failing GP consortia, particularly those that fail financially, will not be bailed out (WP '*We are very clear that there will be no bail-outs for organisations which overspend public budgets.*') It has not been specified what will happen to their patients in this situation, and financial rather than clinical skills appear to be prioritised.

Secondary care doctors also need to have a say in the allocation of resources and planning but it is unclear how they will be able to.

In urban areas it may be possible for practices with similar demographics to combine into consortia, but this is likely to be difficult for rural practices. They are likely to have to combine with consortia with different needs and may find they have reduced bargaining power for services appropriate for their patients and less ability to advocate for their patients needs.

Political agendas may affect GPs' independence. Locally elected NHS Boards will be introduced, and GPs may be lobbied and influenced by elected members.

Hospitals will have to deal with a larger number of commissioning consortia, and different care plans commissioned for the same condition. They will have to tailor services depending on which consortia the patient belongs to with clear implications for cost-effective use of resources.

As with all reorganisations, the proposed changes will be expensive, and are expected to cost between £2-3bn (BMJ 2010;341:c3843). Civitas (July 2010) suggest that the reforms will lead to a one-year dip in performance in absolute terms, and a three-year set back in potential achievement when compared to the status quo.

### **3. Tactics the WP is using**

The British public would never agree to the dismantling of the NHS, and the language of the WP is careful to avoid this impression. However fundamental changes to the way the NHS is organised are breaking it up, and these reforms will mean it is gradually abolished.

(This gradual transformation started some time ago: the Private Finance Initiative allowed business to fund buildings and some NHS services up front; they would then be paid back for many years at high rates of interest from the NHS budget; the introduction of Independent Treatment Centres meant the NHS was forced to contract out routine, easier surgery to private for-profit companies).

The WP claims the reforms are evidence-based but there is no clear evidence base provided, despite it being requested. There is also considerable evidence to show that privatisation is harmful for equity and efficient use of resources. Given the lack of supportive evidence this does make the reforms seem based on the "*arbitrary political meddling*" that the WP says it will avoid.

The WP emphasises outcome indicators (improving cancer, stroke survival rates) at the expense of '*bureaucratic process targets*'. While some process targets may need reconsideration, suggesting they can just be replaced by outcome indicators shows a lack of practical knowledge. Most outcome indicators need long timeframes to show trends, and are subject to multiple influences that need to be taken into account.

#### **4. Possible opportunities**

No explicit role for the involvement of public (that is employers, public and patients and also those in the supply chain) has been defined and this could be a potential opportunity which could facilitate opposition and damage limitation.

It needs to be pointed out that some positive things mentioned in the WP do not need, and could potentially be damaged by the reforms. For example the WP mentions working with the Carbon Trust and similar bodies on carbon reduction programmes. There are already positive examples that demonstrate how energy can be saved in the present system that need to be replicated / scaled up; these are not dependent on the reforms they are proposing which could potentially disrupt progress to date.

#### **5. Specific details and contradictions within the WP**

Healthcare records: '*We will make it simple for a patient to download their record and pass it, in a standard format, to any organisation of their choice*' anticipates that patients will be handing out their health information to third parties such as insurers. The record of private health insurance is that will try to sign up clients who have lower health risks and this can be highly damaging for those with long term and chronic conditions and for equity.

Information: '*In addition to NHS Choices, a range of third parties will be encouraged to provide information to support patient choice*'. It is unclear who these third parties would be and how it would be ensured that the information they gave out would enhance health and equity.

Choice: the 'evidence' that patients want choice in healthcare is based on the 2009 British Social Attitudes Survey which 'shows that over 95% of people think that there should be at least some choice over which hospital a patient attends and what kind of treatment they receive.'

The WP expect 'local pressure' to bring about improvement in 'unacceptable services'; at other times it says people should vote with their feet and seek out the services they want; in this case they won't be around to apply local pressure.

Drugs: the WP says: '*We will pay drug companies according to the value of new medicines, to promote innovation, ensure better access for patients to effective drugs and improve value for money. As an interim measure, we are creating a new Cancer Drug Fund, which will operate from April 2011; this fund will support patients to get the drugs their doctors recommend.*'

Cancer is an emotive subject and funds for it are likely to be popular; it already has £185 per sufferer per year spent on it whereas diabetes is £3. Diabetes is mentioned once in the whitepaper, in a sentence saying that UK has '*high rates of acute diabetes*'

from CMO report 2009

<b>Table 1: Funding for research, and numbers affected, for various conditions in the United Kingdom Disease</b>	<b>Number of affected individuals</b>	<b>Research funding (2008/09)</b>	<b>Approximate spend per person affected</b>
Cancer	2,000,000	£370,087,680	£185
Heart disease	2,600,000	£75,200,599	£29
Alzheimer's dementia	420,000	£5,221,278	£12
Diabetes	2,600,000	£7,073,613	£3
Rare diseases	3,500,000	£3,595,880	£1

The WP mentions '*Freedom to use professional judgement*': how does this sit with control of finance and the potential conflicts of interests this presents in the context of a finite budget?

No cost appears to be attributed to '*research, analysis and evaluation*' - which can be extremely costly. For example the present trial to decide whether or not to introduce routine screening for ovarian cancer involves 200,000 women who were recruited over 3 years and continues until 2014.

The WP talks about removing '*bureaucratic process targets*' but it is unclear exactly what they mean by these; there are many process indicators listed under the WPs 'robust information' (Box p15).

There is very little information on the new maternity care 'provider networks'.

At least 6 major consultations are mentioned in the WP as being planned on key aspects of the WP; 'national outcome goals' are not yet decided; there seems an element of cart before the horse.

The WP has multiple references to 'payment by results'; at the same time it says the NHS Commissioning Board will allocate '*NHS revenue resources to GP consortia on the basis of seeking to secure equivalent access to NHS services relative to the burden of disease and disability*' (which is encouraging but unclear how the two fit together).

In the UK GP fund holding (1991) was similar to the proposed consortia of GPs but on a smaller scale and had many problems.