

Response to White Paper: *Equity and Excellence: Liberating the NHS from*
Medact
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Medact is an organisation of healthcare professionals committed to challenging barriers to healthcare. We welcome this opportunity to comment on the White Paper; our submission has been written by Medact members who all have direct experience of the NHS – both as professionals and patients.

For more detail on the principles that underpin this response, and concerns about the consultation process, please see the end of our submission.

1. Commissioning Health Care – GP Consortia

1.0 The White Paper clearly states that *'It [commissioning] will bring together responsibility for clinical decision and for the financial consequences of these decisions.'*

We are deeply concerned about potential conflicts of interests, and unhealthy changes to the patient-doctor relationship. 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.

1.2 All GPs will have to find the skills and the time to input to varying degrees into GP Commissioning Consortia, this work coming on top of their clinical commitments. This is not an appropriate and cost-effective use of a trained clinician's time. It is likely (and expected) that GPs will be forced to contract outside bodies to undertake financial, managerial and research tasks. Consultants and the private sector will have the opportunity to make considerable profits from GP and consortia budgets which could otherwise be reinvested in health care. GPs will be subjected to conflicts of interest – their professional/clinical interests versus the commercial interests of the consortium they are part of.

1.3 However, GPs will have no choice about commissioning and it has been clearly specified that GP consortia failing financially will not be bailed out (*'We are very clear that there will be no bail-outs for organisations which overspend public budgets.'*) Thus GPs (through consortia) will have absorbed all the financial risks of providing a health service, previously held by the NHS and government at more central levels.

It has not been specified what would happen to their patients were consortia to run into difficulties. This is one of the unacceptable ways that patients who were unable to travel, or who were unaware that a better service was being provided elsewhere, would be the ones to suffer as a result of this attempt to introduce free market economics to the NHS.

1.4 The current proposals have much in common with earlier experiments in GP Fund Holding. Fund holding had many problems, including the creation of a two tier service. Consortia pose precisely the same problem, as they will each take autonomous decisions as to

which health services to commission, so that patients in one area could be provided with very different quality of services to those in another.

1.5 The argument for abolishing PCTs in favour of GP Commissioning Consortia is that the latter will be more in touch with local needs. However this ignores the evidence from the history of the development of PCTs. In the 1990s, 99 Health Authorities became many smaller primary care groups, renamed Primary Care Trusts and then all 302 of them were reduced to 152. Reasons given were: the smaller groups had high overheads, did not have enough management expertise between them and their boundaries were not coterminous with local authorities. Now there will be 500 plus GP consortia – and all in the context of aiming to reduce overall management costs!

1.6 The Commons Select Committee on Health says that currently the NHS is spending 14% of its budgets on the transactional costs of the internal market, compared to 8% in 1991, and the number of senior managers has increased by 91% since 1995 (Commons Health Committee 2010). The lower 1991 costs were associated with a much simpler and fairer system of cooperation and needs-based planning and service delivery.

1.7 Because GP consortia will create these smaller commissioning areas, there is more likely to be inequity in service provision as commissioners have a narrower field of view, and there are bound to be differences in the size and power of different consortia and this factor will compound the problem.

To give an example, 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.

2.0 Patient choice

2.1 Providing patient choice is fundamental to the concept of GP commissioning. However the White Paper doesn't clearly distinguish the concept of individual patient choice and the choice of patients as a collective. Decisions made by GP Consortia will need to be informed by the local population they serve and the use of public resources have to be made for the public good and according to public health principles. However, it will be difficult for patients to have an overview and sufficient professional knowledge to make public health decisions that relate to the greater good. Public consultation may result in the most articulate and loudest voices being heard and these are unlikely to represent individuals with the greatest need. Only an expert community development approach to this kind of participation would provide genuinely democratic input and this is not mentioned in the Paper.

2.2 With its emphasis on choice, this document risks repeating the mistakes by the last Government. Whilst the overall performance of the NHS undoubtedly improved from 1997

onwards, the Labour government's major failing was that it did not reverse rising health inequality (Thorlby and Maybin, 2010)

Whilst factors outside the health service, such as income inequality, will have played a role in this, Labour's assertion that choice, through systems such as *Choose and Book*, can play a role in reducing inequalities in health must surely be called in to question.

2.3 On an individual patient level, the White Paper talks about '*the right choice of hospital or clinical department.*' 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.

We know that health related behaviours, such smoking, are stratified by income. As has been argued elsewhere...

'...the existence of systematic differences in health-related choices between groups implies imperfect freedom of choice for the individuals within these groups. People may have different views on how to live their lives, but why should these individuals be grouped in a non-random way into particular geographic or social groups? Similarly, we would argue that offering choice to all patients does not resolve concerns about equity if there are systematic differences in the uptake of this choice.' (Barr et al, 2008)

2.4 The emphasis on choice is also about a transfer of responsibility as the White Paper says '*patients should accept responsibility for the choices they make*'. This is clearly not true. Moreover some patients, such as those with chronic illnesses and cancer may not recognise the importance of continuity of care and the need for long-term follow-up which, when provided by distant hospitals, brings many problems both for the team providing the care and for patients. In general those with complex needs may not be willing or able to either make choices or accept responsibility for them.

What happens to patients who make the 'wrong' choice is not addressed. Who picks up the tabs for investigations and treatment initiated? How will transfer of care be affected?

2.5 GP boundaries are being removed, and so in principal patients will be able to register at any practice. Again, 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).

Home visits to housebound patients will be made difficult, if not impossible, as scattered patient populations and travel times will make home visits from one's 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.

2.6 It is far from clear how this aspect of patient choice - choice of GP - squares with the White Paper's assertion that '*GP consortia will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services*'

Also, once the consortium (including local people at some level) have commissioned services - what opportunity would any individual patient have to choices which are outside of the contracts agreed? The point made above about the size of, and decisions made by, different consortia is also relevant to individual choice.

2.7 The White Paper expects '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. The likely outcome is that empowered and mobile patients will leave failing services to those less able to travel or advocate local change.

2.8 To sum up the issue of choice in the context of GP Commissioning Consortia:

- individual choice of health services is inconsistent with the collective choice integral to the democratic decisions made in a local area about health services
- there is a conflict between individual autonomy and choices about a common good
- this illustrates the fundamental move in the White Paper away from the values of the NHS in favour of a privatised market for health care
- Moreover, there is no evidence (from research from many countries) that choice enhances equity of acquisition of health services - one of the main goals of the White Paper ('*Equity and Excellence*').

3.0 The problems of payment by outcomes

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

3.2 '*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.

3.3 The White Paper emphasises outcome indicators (improving cancer and stroke survival rates) at the expense of '*bureaucratic process targets*'. While some process targets may need reconsideration, suggesting that 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. Moreover it is unclear

exactly what is meant by 'bureaucratic process targets'; there are many process indicators listed under the White Paper's 'robust information' (Box p15).

3.4 The White Paper makes multiple references to '*payment by results*' related to '*improvement in health outcomes*'; it also 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*'. Successful outcomes in terms of some disease and much disability are difficult to measure, and are often about relieving symptoms and enhancing quality of life by good basic nursing and social care. There is no indication in the White Paper as to how this will be taken into account in legislation relating to '*improvement of health outcomes*'.

4.0 Abolishing the NHS Trust model and reforming the Foundation Trust model

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

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.

4.2 Foundation Trusts will be expected to compete for patients, threatening the sharing of good practice and prospects for collaboration in research and development. This will also negatively influence the ability of the public to obtain the information they need to be fully informed and involved in decisions about their care. We suggest that this will not increase '*transparency in their functions*'.

4.3 Those Foundation Trusts which do well will be rewarded but those that fail will not be bailed out and it is unclear how Monitor (the economic regulator) will help their patients – or those of failing GP consortia – who will undoubtedly suffer.

A recent example from London: when hospital and community trusts in one area had deficits approximately equal to the surpluses made by two nearby foundation trusts the latter did not – and were not required to – help them out. Again this illustrates the way the proposed new structures for health services are mean-spirited and against the ethos of the NHS.

4.4 It is recommended that Foundation Trusts adopt the social enterprise model. However there is little evidence that staff wish to transfer from their NHS work, pay, pensions and conditions to those of an autonomous business. Whenever staff have actually been balloted about joining a health social enterprise in the past, 80 – 90% have been against it (Lister 2010).

5.0 In conclusion

As with all reorganisations, the proposed changes will be expensive, and are expected to cost £2-3bn (Walshe, 2010). Civitas (Gubb, 2010) suggests 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. We suggest that the proposed changes are not a good use of public resources at a time of massive cuts in public spending and we hope that we have demonstrated some reasons why the primary legislation necessary for them should not be passed. These proposals are both very expensive and unworkable.

6.0 Principles underpinning this submission

6.1 Medact subscribes to the underlying principle behind the NHS that health is an individual and also a collective human right. Despite the White Paper's assertion in Point 1 of the 'Executive Summary' we do not believe that the radical changes proposed will uphold 'the values and principles of the NHS, of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay'. We see this Paper as a landmark en route to privatising the NHS.

The British public would never agree to the dismantling of the NHS, and the language of the White Paper is careful to avoid this impression. However the proposed fundamental changes to the way the NHS is organised would break it up and result in creeping privatisation.

6.2 This 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 saw the NHS contracting out routine, easier surgery to private for-profit companies, to the detriment of both surgical training and cost effectiveness (Pollock and Kirkwood, 2009).

6.3 The current White Paper mentions opening '*the NHS social market up to competition*' and applying '*competition law*'. It 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 the public purse.

In law there is little to stop any organisation holding an NHS contract (for example a social enterprise or community interest company) changing its nature or selling itself to profit-making organisations. US evidence shows that in highly competitive environments, non-profit organisations behave very much like profit-making ones (Landsberg 2004).

6.4 The White Paper also says there will be consultation on '*abolishing the arbitrary cap on the amount of income foundation trusts may earn from other sources to reinvest in their services*' removing an important brake on privatisation.

6.5 The growing privatisation of health services is a global phenomenon and the US system is a prime example of where this can lead (despite recent attempts at reform). This drive for privatisation is clearly motivated 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.

However, there is considerable evidence, especially from the USA, to show that privatisation is harmful to equity and the efficient use of resources (CSDH, 2008; Pollock and Kirkwood, 2009). The lack of evidence to support these radical reforms (as indicated in the above) lays the Government open to claims that these reforms are a result of the “*arbitrary political meddling*” it says it will avoid.

6.6 The White Paper claims its reforms are evidence-based but there is no clear evidence base provided, despite it being requested (Maynard, 2010). If we were to behave in such a manner as clinicians, our conduct would be felt to be lacking.

7.0 The consultation process

7.1 The consultation appears to be about *how* rather than *whether* the White Paper changes should be implemented. We understand that this is subject to a judicial review because:

- the changes seem to be going ahead before the primary legislation required for them has come before parliament,
- under the NHS Constitution, and the Partnership Agreement, this consultation may be inadequate*
- Under Section 242 of the NHS Act this lack of consultation may be unlawful.

* The NHS Constitution states ‘you have a right to be involved...in the planning of health care services, the development and considerations of proposals for changes in the way those services are provided’ .

7.2 It is unfortunate that process is being considered before there has been a proper opportunity for discussion about strategy and evidence.

Be that as it may, our response has focused on the process of implementation by looking at why we believe that these changes *cannot* be implemented successfully. As suggested we have concentrated on the changes that will require primary legislation and on those about which we have expertise amongst our membership.

7.3 We note that at least 6 other major consultations (closing 11 October) are mentioned as important in the context of this one. We note that ‘national outcome goals’ are not yet decided. There seems therefore to be an element of putting cart before horse. Also noteworthy is that these other consultations are aimed at health and social care professionals only and are on very specific, quite technical implementation issues. It would seem that the more general nature of the consultation on this main document is disingenuous in its request for responses, which seem unlikely to be given any weight.

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