



NHS Support Federation response to the consultation on the White Paper 'Equity and Excellence: Liberating the NHS'

1. The NHS Support Federation is an independent voluntary organisation founded in 1989 which campaigns for the right of every citizen to comprehensive healthcare regardless of their financial means.

2. We believe the White Paper 'Equity and excellence: Liberating the NHS' represents the biggest change to the NHS since its foundation in 1948. It constitutes a move to an entirely different model of healthcare that carries additional risks for patients

A flawed vision

3. The white paper is a well-structured document that outlines a single vision of a market system. Unfortunately, in its consultation exercise the Government has attempted to divide responses into separate themes relating to aspects of the white paper. It has sought views on the best ways to implement the broad vision, but not views on the vision itself. We feel this is wrong and betrays the fact that there is a significant shift in the direction of the NHS strongly outlined within the white paper. The key question is whether the move to a system based on an alternative philosophy of healthcare is sensible, given the cost and potential consequences outlined below.

4. Combined, the proposals form a theoretical model of a market health system. Each element is outlined in the white paper in turn:

First, the patient is cast as a consumer with a responsibility to choose, or effectively buy, his or her healthcare.

Second, targets are removed and replaced by the market as the mechanism for improvement. To achieve this the system of performance related pay is expanded.

Third, control over 80% of the NHS budget is delegated to GPs, who are then encouraged to outsource it to private companies or professional managers. The NHS in-house management arms, SHAs and PCTs, are abolished.

Fourth, because the only true consumer using its own resources in this market is the state, a new controlling quango is needed in the form of the NHS Commissioning Board.

Fifth, every hospital and community health service is transformed into a foundation trust, an independent organisation forced to compete for business.

Sixth, the vast majority of health service staff, including doctors and nurses, are transferred from being employees of the NHS to being employees of their particular institutions, effectively ending national pay deals and terms, and putting pressure on wages.

Seventh, because the nature of a health service makes a functional free market impossible, Monitor is required to be the economic regulator and enforcer of competition.

Eighth, separately the NHS is required to make £20 billion of efficiency savings, resulting in closures that bring new market opportunities and job losses that create a pool of unemployed healthcare workers for the new flexible labour market.

5. While the white paper enunciates this theoretical social market model (Equity and Excellence, paragraph 4.26), in practice a market is not an appropriate way to deliver healthcare for a number of reasons: a patient does not know as much as a doctor meaning the consumer is not sovereign; price signals do not work because the patient lacks sufficient information to make the best choices; contracts are hard to draft and enforce because of the complexity of healthcare; regulating private providers is costly and complicated.

6. As the market model is laid out so fully in the white paper and in such a logical sequence, we ask why it did not appear in either the Conservative or Liberal Democrat manifestos at the general election, or even in the coalition's Programme for Government of May 2010. Further, the Conservatives made an explicit promise not to reorganise the NHS. We therefore believe there is no democratic mandate for the vision in the white paper and that its implementation will erode trust in the political system.

Practical problems

7. Impact on patients. The white paper states, there will be no bail-outs for organisations which overspend public budgets. This is asserted with no discussion of its potential consequences. What assessment has been made of how this will affect patients? We call on the Department of Health to spell out what would happen to patients in the event of a GP consortium going over-budget. Will patients be asked to wait until the new financial year before their treatment can be funded? Similarly, if a foundation trust hospital becomes unviable and closes due to a local private competitor, what would happen to the patient who relies on specialist services that the private facility does not offer?

In a competitive market system every provider will have an incentive to drop unprofitable treatments. What safeguards will the Department of Health put in place to ensure that the NHS continues to be a comprehensive service?

8. Erosion of trust in GPs. The trust between patients and their GP is a precious and delicate resource. It cannot be measured in economic terms. The move to GP commissioning, an integral part of the broader market vision, will erode that trust. In a context of £20 billion efficiency savings, the public will see GPs as culpable for service cuts caused by commissioning decisions. The suspicion of conflicts of interest in referrals is inevitable. Rather than feeling empowered by a range of choices, patients are likely to feel their options are narrowed by the financial interest of their GP, as may well be the case if each commissioning consortia is to have individual contracts with providers.

The white paper is explicit that a consortium can choose to buy in support from external organisations (paragraph 4.6) for commissioning, and we know that companies such as UnitedHealth and Humana are preparing themselves for this role. These companies hold shareholders as their top priority, not patients.

Private companies will also play a greatly expanded role in providing GP services themselves. One of the strengths of the NHS is the continuity of care between a GP and a patient. We have already seen this relationship suffer where GPs have become salaried employees of a company and when fewer doctors have been employed to cut costs.

British general practice is admired around the world for the gatekeeper role that GPs play, but these proposals will put considerable strain on that model. GPs are doctors, not accountants. All their energies should be focused on caring for patients, not managing a budget.

9. Impact on equity. We believe that a central social purpose of the NHS is to offer equal access to care for all and in particular to the most vulnerable and demanding patients and those with complex conditions. These are generally not profitable patients to treat. How will the NHS avoid perverse market outcomes. Profit-seeking providers are notorious for cherry-picking, going for the least demanding and most cash-bearing patients first. Will the new GP budget-holders prioritise relatively healthy patients in order to achieve maximal profitability at minimum cost? That is good business practice. Will there be conflict between financial incomes and health outcomes?

The white paper is explicit that the cap on the income that foundation trusts can earn from private patients will be removed (paragraph 4.22). As all hospitals are to be foundation trusts forced to compete with each other and the private sector, inevitably trusts will seek to maximise their income by exploiting this change. We believe this will lead to priority being given to paying customers, resulting in longer waits for the less well off. This will cause a greater disparity between those who can afford to pay and those who cannot - the opposite of health equity. Given the Government's concern for the independence of foundation trusts, it is not clear what mechanisms the Department of Health could use to counter this, or even if it would see it as a problem.

10. Loss of accountability. The white paper makes great play of the claim that ministers will have less control over the health service, but ministers represent the public and the public pays over a hundred-billion pounds a year for the NHS. Whereas currently PCTs and SHAs are public bodies, the new commissioning consortia will be groups of GPs - independent contractors. We believe this proposal represents the privatisation of the NHS's commissioning function, taking over £80bn of taxpayers' money out of public control. In the scenario outlined above of a patient being asked by a GP to wait until the new financial year for treatment, to whom could the patient take his or her grievance?

With hospital and community services being transformed into independent foundation trusts the public will feel further distance from the decisions affecting their healthcare, such as whether a hospital closes a particular department or a community social enterprise ceases a specific service. The market's alternative to democratic oversight is the regulator, but the white paper is clear that Monitor's primary role will be to promote competition (paragraph 4.27), not advocate for patients.

The coalition's Programme for Government of May 2010 included a proposal for an elected element on PCT boards, which we support. By the July publication of the white paper this idea, along with PCTs themselves, had been ditched. There is not enough detail in the white paper on how the new HealthWatch will have any greater powers than its failed predecessors, leaving an accountability gap.

11. Fragmentation of the health service. The policy of 'any willing provider' is central to the white paper vision (paragraph 4.21). Every hospital and community health service will cease to be part of the NHS proper, but will become a foundation trust, an individual 'willing provider' competing against all the rest. For the first time since 1948, private companies will have the same status as all these former NHS bodies. The role of Monitor will be to 'help open the NHS social market up to competition'. This includes the power to 'require monopoly providers to grant access to their facilities to third parties'. How can this not put the NHS at a disadvantage? Taxpayers have built up the NHS resources over decades, only for it to be required to make them available to others who have not made similar investments. Monitor will also stop commissioners 'failing to tender services or discriminating in favour of incumbent providers'. Aside from the cost involved in such extensive tendering, will the Department of Health clarify whether this will bring the whole of the health service under EU competition law?

The NHS was designed to embrace the largest and most efficient risk-pool - everybody pays in, and resources are distributed according to need. With fragmentation the risk-pool is diminished.

12. Impact on staff. The white paper states clearly, 'the NHS will employ fewer staff at the end of this Parliament' (paragraph 1.21). Since a health service is its staff, we worry about the affect on patient care. It is in the interests of patients to be treated by staff with good morale, fairly rewarded for their work. In the fragmented NHS of the white paper, national pay deals, terms and conditions and pensions are threatened as staff will no longer be employed by the NHS but by their particular institutions which will be 'responsible for leading negotiations on new employment contracts' (paragraph 4.36).

13. Cost of reorganisation. Reshaping the health service will cost billions at a time when the country can least afford it. £1.7 billion has been allocated to the purpose for this year alone. The final cost will be much higher due to redundancy payments for PCT and SHA staff, the costs of recruitment to the new bodies, and the enormous administrative costs of the new commissioning consortia that will each have to draft fresh contracts and launch new tenders across the board.

The white paper claims that this expense will be partly offset by a 45% cut in the cost of NHS management (paragraphs 1.21, 5.3). This claim is misleading and unacceptable. The 45% figure refers to the management costs of PCTs and SHAs, but excludes the management costs of every hospital in the country. Of further concern is the decision of the Department of Health under the last government not to publish the management costs or accounts of foundation trusts. With every hospital and community service forced to become a foundation trust, and with PCTs and SHAs abolished, the whole cost of management in the health service will effectively be moved off-balance-sheet, yet the taxpayer will still be funding it.

14. Cost of the market. International evidence shows that involving markets in healthcare raises costs. Our experience in the UK tallies with this. According to research commissioned by the Department of Health but suppressed until referred to in the Health Select Committee's report on commissioning (of 30 March 2010), the cost of management and administration in the health service is at least 14% of the budget, or a staggering £15bn. The unpublished report compares this figure unfavourably with the 6% that management and administration cost before 1991, when market reforms commenced. This reflects the additional costs of contracts, billing, tendering etc over allocated budgets. We call on the Department of Health to produce annual credible figures for the cost of management, administration and transactions in the health service so the impact of the white paper proposals can be assessed.

According to the white paper: Providers will be paid according to their performance. Payment should reflect outcomes, not just activity (executive summary, section 5m). Why has the Department of Health not given an estimate of how much this payment system will cost to implement, given the complexity of collecting and tallying data on health outcomes?

15. Inefficiency. The white paper talks of increasing efficiency in the health service, but many of the proposals will result in the opposite. We cannot see how the duplication inherent in having as many as 500 commissioning consortia, effectively mini-PCTs, will be more efficient than the current 152 PCTs. Each consortium will need to be staffed with commissioning experts. We think it likely that many of these will be the very same managers made redundant in the abolition of PCTs and SHAs. The white paper encourages consortia to utilise private sector support, which experience suggests is very expensive (as found by the Health Select Committee in its report on commissioning).

16. Lack of an evidence base. The white paper says: The Department is committed to evidence-based policy-making and a culture of evaluation and learning . We applaud this commitment, but wonder why it comes in a document that outlines the biggest untested, un-piloted gamble with the NHS and with taxpayer s money in 60 years.

If the proposals in the white paper are implemented in full, we believe there will no longer be an organisation called the NHS. There will just be a brand, a blue logo, and a budget to buy treatments with. The taxpayer will still be funding health care, but there will be no unified health service.