The NHS White Paper

This is a summary of the contentious issues in the NHS White Paper.

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NHS Funding

"NHS services will continue to be funded by the taxpayer." (5.14)

*"We are very clear that there will be **no bail-outs** for organisations which overspend public budgets."* (1.22)

*"Existing providers will be set free and will be in charge of their own destiny, without central or regional management or support. [...] **Hidden bail-outs will end.**"* (5.12)

*"The Department will also refine the basis of current tariffs. We will rapidly accelerate the development of best-practice tariffs, introducing an increasing number each year, so that providers are **paid according to the costs of excellent care, rather than average price.**"* (3.19)

*"Prices will be calculated on the basis of the **most efficient**, high quality services **rather than average cost**."* (5.12)

"abolishing the arbitrary cap on the amount of income foundation trusts may earn from other sources" (4.22)

"Dorrell says govt is looking at future co-payment model; have to look at funds and also at achievable levels of private funding compatible with principles of equity." Health Select Committee on the 20 July 2010[1]

The change from the *average price* to the *most efficient* (a euphemism for the *cheapest*) means that no hospital will be able to generate a surplus from providing services, and most will generate deficits. This means that almost all hospitals will generate deficits by doing NHS work. Paragraph 1.22 says that the government who will have engineered this situation will not help to ease the problem. The suggestion from Stephen Dorrell that the government is looking at co-pay suggests that the patient will be asked to provide a top-up to pay for their care.

Reducing Costs

"The Government has guaranteed that health spending will increase in real terms in every year of this Parliament." (5.1)

"Large cuts in administrative costs ... the NHS will employ fewer staff at the end of this Parliament" (1.21)

"Over the next four years we will reduce the NHS's management costs by more than 45%." (5.2)

[1] http://www.healthpolicyinsight.com/?q=node/643

The first year of this government has a *decreased* budget because it was set by the last government. The government has chosen not to correct this anomaly. Large cuts in administration costs will come at a time when the government will introduce 150 "quality standards" (each based on 5-10 "quality statements"[2]). Cutting management costs by 45% also seems unobtainable. Currently managers make up 4% of the NHS[3] whereas the ONS says that the proportion of managers in the whole of the workforce in the UK is 16%[4].

Information

*"Our aim is that people **should be able to share their records with third parties**"* (2.12)

*"We are also clear that increasing patient choice is not a one-way street. In return for greater choice and control, **patients should accept responsibility for the choices they make**, concordance with treatment programmes and the implications for their lifestyle."* (2.18)

Patients already have complete access to their hospital notes under the Data Protection Act 1998[5] so no new policy is required for patients to have access to their own records. The worry is the policy will allow third parties like insurance companies and employers to have access.

It is concerning that patients who make decisions when they are ill will be made responsible for those decisions.

GP Commissioning

"In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning services to local consortia of GP practices." (4.2)

"a reserve power for the NHS Commissioning Board to be able to assign practices to consortia if necessary" (4.6)

*"GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities [...] they may choose to buy in support from external organisations, including local authorities, **private** and voluntary sector bodies."* (4.6)

"the Government will not bail out commissioners who fail" (5.14)

Statement 4.2 seems to contradict the statements about the NHS Commissioning Board which will take over about one third of the commissioning currently carried out by PCTs. The GP Commissioning Board will also commission the GPs and provide guidelines on commissioning. Statement 4.6 implies that most commissioning will be performed by private companies. Indeed, HealthInvestor reckon this will be a £1bn market for outsourcing companies[6]. Statement 5.14 is

[2] See Whitepaper sections 3.12, 3.13
[3] http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1999--2009-overview
[4] http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=14248
[5] http://www.nhs.uk/chq/pages/1309.aspx?categoryid=68&subcategoryid=160
[6] http://tinyurl.com/383c699

worrying because patients want financial stability in their healthcare providers and do not want the possibility of their GP going bankrupt.

*"It will **bring together responsibility for clinical decisions and for the financial consequences** of these decisions."* (4.4)

*"GP consortia will **align clinical decisions** in general practice **with the financial consequences** of those decisions."* (5.12)

Statements 4.4 and 5.12 indicate that as a patient you will always be a financial liability to a GP. GPs should only make clinical decisions.

NHS Commissioning Board

"The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia." (4.6)

"[GPs] will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services, although consortia will have influence and involvement." (4.6)

"[NHS Commissioning Board will host] some clinical commissioning networks, for example for rarer cancers and transplant services, to pool specialist expertise" (4.11)

"[NHS Commissioning Board will commission] GP, dentistry, community pharmacy and primary ophthalmic services; national specialised services and regional specialised services set out in the Specialised Services National Definitions Set; and maternity services." (4.11)

The NHS Commissioning Board will *centralise* decision making, a clear contradiction to statement 4.2. At the moment dentistry, community pharmacy and primary ophthalmic services, maternity and the commissioning of GPs are all carried out locally by PCTs. The NHS Commissioning Board will centralise these functions into one body in Whitehall.

Hospital Governance

"Our ambition is to create the largest and most vibrant social enterprise sector in the world." (4.21)

*"As all NHS trusts become foundation trusts, staff will have an opportunity to transform their organisations into **employee-led social enterprises** that they themselves control, freeing them to use their front-line experience to structure services around what works best for patients."* (4.21)

*"we envisage that some foundation trusts will be **led only by employees**; others will have wider memberships"* (4.21)

*"Reforming the foundation trust model, removing restrictions and enabling **new governance arrangements**, increasing transparency in their functions, **repealing foundation trust deauthorisation** and enabling the abolition of the NHS trust model;"* (6.7)

The government indicates that it will remove public governor representation in some Foundation Trusts. Deauthorisation is needed to maintain standards, repealing this ability means that Foundation Trust status will no longer be a mark of excellence. Social enterprises are private businesses, 4.21 means that NHS hospitals will no longer be publicly owned.

Any Willing Provider

"We will give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices." The Coalition Agreement

"Commissioners will be free to buy services from ***any willing provider****; and* ***providers will compete*** *to provide services. Providers who wish to provide NHS-funded services must be licensed by Monitor, who will assess financial viability."* (5.14)

Although the Coalition Agreement says that the private sector will be paid *"within NHS prices"* the white paper says **nothing** about this. The private sector cannot provide services to the current national tariff (the *average price*) and are not happy with statements 3.19 and 5.12 which says that NHS rates will be the cheapest rate of the entire NHS. In this context, Dorrell's announcement about co-pay becomes very significant. In the future hospitals will compete on cost, on the level of co-pay they charge.

"Monitor and the NHS Commissioning Board will ensure that commissioning decisions are fair and transparent, and will promote ***competition****."* (4.6)

"[The role of Monitor is] Promoting competition, to ensure that competition works effectively in the interests of patients and taxpayers. Like other sectoral regulators, such as OFCOM and OFGEM, Monitor will have concurrent powers with the Office of Fair Trading ***to apply competition law*** *to prevent anti-competitive behaviour;"* (4.27)

"Monitor should have proactive, "ex ante" powers to protect essential services and help ***open the NHS social market up to competition****"* (4.28)

"[Monitor will be able to] require monopoly providers ***to grant access to their facilities to third parties;****"* (4.28)

"Patient choice will reward the most efficient, high quality services, reducing expenditure on less efficient care." (5.12)

These policies will result in many bitter local battles where Monitor and OFT close services at NHS hospitals in the name of "competition". Statement 4.28 indicates that private health providers will have access to NHS premises and equipment and it raises the question of who will get priority: NHS patients or private patients.

Hospital Standards

"Information will improve accountability: in future, it will be far easier for the public to see where unacceptable services are being provided and to exert local pressure for them to be improved." (2.9)

"In future, performance will be driven by patient choice and commissioning; as a result, there will be no excuse or hiding place for deteriorating standards and our proposals will drive improving standards." (3.2)

These statements indicate that the responsibility for raising standards will be put on patients. The private service sector is littered with examples where "customer choice" has not lead to better standards, customer choice has lead merely to cheaper services.

*"Progress on outcomes will be supported by quality standards. ... Within the next five years, NICE expects to produce **150 standards**."* (3.12)

"Each standard is a set of 5-10 specific, concise quality statements and associated measures." (3.13)

The 10 or so performance related targets (and 50 or so additional targets) will be replaced with 150 "quality standards" at a time when administration costs have to be reduced by 30%.