



Keep our NHS public
19 Vincent Terrace, London N1 8HN
Tele: 020 7837 7635 Email: wdsavage@doctors.org.uk
Web: www.keepournhspublic.com

**Statement, January 2008
in response to the Reviews of the NHS by Lord Ara Darzi:**

“Our NHS Our Future — NHS Next Stage Review”

“Healthcare for London: A Framework for Action”

“In the proposals, there is both promise and threat for the future of the NHS. The threat — of transactional fragmentation and commercial distortion of care — could be notably reduced by recognition by government that involvement of market mechanisms including the private sector in any such development plans is totally incompatible with the conditions of mutual support, trust and cooperation that are necessary to attain these new levels of NHS performance and achievement. Without this the promise in Darzi’s plans — the release of the creative enthusiasm and the mutually supportive drivers that established the NHS — cannot be fulfilled.”

Statement by Keep Our NHS Public in response to the Reviews of the NHS by Lord Darzi

Consultation with “Stakeholders” on England Review

1. Following the publication of the Darzi “Healthcare for London: A Framework for Action” in July 2007, an interim Report “Our NHS Our Future — NHS Next Stage Review” appeared in October 2007. The interim Report is designed to assess the performance of the NHS in England and to indicate the way forward. It affirms “. . . *no major service change should happen except on the basis of need and sound clinical evidence*”. The Review will examine the barriers preventing sound practice. It seeks to identify what is needed to achieve major improvements in clinical outcomes for patients. It is therefore concerned with looking at clinician engagement, improvements to patient care and better access. At the first of the consultation meetings Darzi spoke about achieving a local vision supported by national principles, standards and support. He emphasised the importance of innovation and said quality of care is more important than simply measurement of activity.

2. The Review will examine a number of clinical areas. There are eight to be covered; maternity and new born care, children’s health, planned care, staying healthy, long-term conditions, acute care, mental health and end-of-life care. The Review will look at inequalities, outcomes, variation in quality, patient access, expectations and the changes and pressures affecting diagnosis, treatment and prevention. The themes particularly suggested for examination are quality, innovation, education/training/workforce and constitution. On the latter he is looking at the NHS mission, what citizens want and expect, and public accountability.

3. The Review places repeated emphasis on increased involvement of the private sector in delivering primary care and argues strongly in support of the inevitably costly use of private companies to deliver non-complex elective care through independent sector treatment centres. Lord Darzi’s final report is expected in June 2008 to coincide with the 60th anniversary of the NHS.

Concerns identified by Keep Our NHS Public

4. There is much in the report to be welcomed. However, Darzi states that the current set of

market-oriented NHS reforms should be seen through to their conclusion. His Report does not make any specific mention, let alone offer any analysis, of the market innovations introduced by the Blair governments. As we indicate below, these new market mechanisms have created financial drivers which dangerously undermine the cooperative approach which Darzi claims to espouse and which seriously compromise the aim to provide appropriate clinical care to meet patient needs. On top of this, these measures have inflicted a heavy and wasteful transactional burden on the NHS current account, a cost burden which has not been adequately quantified and made transparent. The reality is that, for these and other key reasons outlined below, the Blair market reforms are incompatible with the approach set out by Darzi.

5. Some of Darzi’s positive proposals are clearly worthy of measured consideration. However, they require an integrated healthcare system which runs on the basis of cooperation and collaboration. Incongruously, Darzi calls for more private sector involvement and fails to consider the damaging consequences of commercial competition between trusts and other NHS organisations driven primarily by financial rather than clinical considerations.

6. The interim report gives no consideration to the potentially destabilising effects and inadequacies of the co-called Payment by Results system or the whole question of the commissioner/provider structure including Practice Based Commissioning. The Review is clearly incomplete without consideration of the impact of these market mechanisms on clinical care, preferably based upon sound evidence. Due attention should be paid to them within the final Report.

7. It appears highly unlikely that the government will support the high yearly revenue costs faced by trusts that have undertaken a major Private Finance Initiative (PFI) commitment. These revenue costs are not covered centrally, are already having a damaging impact on patient services and would interfere with the implementation of Darzi’s plan. A recent Parliamentary MPs report, based on Treasury figures, estimates that at least £91bn and perhaps as much as £170bn in today’s values will have to be paid back by 2032 to cover all existing

PFI schemes. Urgent financial intervention by the Department of Health or Treasury to address the indebtedness which has resulted from inadequately thought-through government policy is required. Now that the major rebuilding programme has taken place, further projects for new build or other capital improvements should be funded and contracted for through the traditional direct funding system, supported if necessary by the issue of NHS bonds.

8. The use of private providers contracted for routine elective procedures raises concerns of equity because of their selective approach to patients. They are generally averse to accepting patients who also suffer from other conditions. Should their procedures fail or complications arise, they return patients to NHS care. They typically carry no training or teaching responsibilities. Despite this, these providers are significantly more costly than their NHS counterparts and they under-perform against contract. Fragmentation of provision reduces the ability to sustain a universal and equitable health service by undermining the basic principles of risk pooling and cross-subsidy. This system should be discontinued.

9. The split between purchasers (or “commissioners”) and providers of care was a necessary step to allow the establishment of a health-care market. Markets are not known as a means to remedy inequalities in health-care or to match resources to social need. An economic structure which sets health-care organisations in competition one with another cannot be reconciled with Darzi’s integrationist approach. This crucially requires mutual support, planning and cooperation between primary and secondary care, between different specialities, between hospitals and between colleagues.

10. The re-establishment of national, regional and local planning and development systems in the NHS would ensure that — unlike commissioners negotiating price and service at one remove from the operational end of health care — the planners, managers and clinical staff could work together to achieve shared purposes and agreed outcomes. Darzi recognises that it is through collaborative effort that sound outcomes can be achieved. He states “. . . *the most successful action happens when different agencies work together.*”

11. The introduction of Practice Based Commissioning takes the market approach further.

It fragments the process of care and exacerbates competition within the system. It diverts general practice from its prime function and may introduce perverse incentives into patient care decision making.

12. Payment by Results also challenges the key requirement to ensure that treatment is appropriate to clinical need. Many senior clinicians report difficulties with the system. Pressure to release beds — either before completion of diagnosis in complex cases or before full recovery from an operation — occurs too readily, causing further costs on readmission. Referrals to other specialities within an institution may now require reference back to the General Practitioner (GP) or Primary Care Trust (PCT) for re-referral to claim extra income, wasting time and resource and delaying treatment. Darzi’s aim to enhance patient access and to facilitate patient movement within the service is clearly incompatible with such bureaucratic hindrances and finance-driven distortions.

13. Darzi exposes very effectively the need to improve the present complicated arrangements for patient access to the various branches and departments of the health service. However, he fails to analyse in similar detail the potential hindrances to free patient movement within a system where access is “regulated” by a business contract culture. A harbinger of such hindrance is the introduction of so-called Referral Management Centres which have powers to divert or refuse a patient’s referral contrary to the agreed wishes of the GP and the patient. This flouts the GP’s authority to recommend, in consultation with the patient, the treatment and care pathway they consider appropriate.

The London Plan

14. Lord Darzi has already produced a detailed plan designed to address some long-standing inequalities and important weaknesses in health and healthcare in London. It deserves to be taken seriously in proposing some radical changes and seeking genuine modernisation to deliver improved health and social care in Greater London. Some of its proposals merit careful consideration; others much less so.

15. His proposal to develop 150 polyclinics to provide a mix of primary care, urgent care, ambulatory care and outpatient treatment may have some merits, but remains controversial even

among Darzi's own team of advisors and NHS London. There are serious questions over the proposed size, cost-effectiveness and user-friendliness of single site, multipurpose services for such large catchment populations. Important concerns that polyclinics may attract further encroachment by private sector providers have been underlined by recent statements from Health Secretary Alan Johnson promoting the increased role of private sector provision in primary care. The possibility has even been raised that "healthcare silos" and provider trusts will become the ready victims of corporate buy-outs and be operated as fiscal entities like US Health Maintenance Organisations. The polyclinic model, as yet in embryo, has to date attracted opposition from organizations representing many of London's GPs. Without their involvement the scheme is unworkable.

16. Darzi proclaims the end of the era of district general hospitals and yet the evidence for hospital reconfiguration is based upon computer modeling and remains highly contested. Darzi's general ideas cannot be endorsed until specific and detailed proposals are put forward for consideration by staff and patients as well as planners. Similarly, proposals for large-scale investment in reconfigured specialist services must be evidence-based and Lord Darzi must explicitly identify the evidence base used. His Report has been published at a time when many hospitals and other units are facing controversial cash-driven cuts in services. This raises understandable fears that the upgrading of a few acute centres would run alongside the downgrading of busy local hospitals. Darzi accepts that no existing facilities must be lost until at least equally effective alternative provision is up and running.

17. These fears are amplified by the refusal of NHS London to insist on a moratorium on hospital cuts and closures while the debate on Darzi takes place, including the fact that services in, for example, Enfield (Chase Farm), Redbridge (King George's Hospital), Brent (Central Middlesex Hospital), South West London (Epsom and St. Helier) and South East London (Queen Mary's Hospital) are currently under threat, out to consultation or already being run down in

response to cash shortfalls and long-term financial pressures. Indeed, the crisis quadrant of South East London has accumulated debts of £180m.

18. With no credible route map for its implementation, there are real fears that the positive elements of this Darzi Report may be used as a smokescreen to divert attention from unpopular policies which threaten to undermine local access to care and which increasingly open up an ever-widening and deepening role for private sector providers at the heart of the NHS.

Conclusion

19. The Darzi Review for England may, despite the principled concerns set out above, have a genuinely valuable effect on the quality of care provided within the NHS. The approach he takes for England as a whole will clearly differ in a number of important respects from his London Plan which concentrates on reconfiguration of hospitals and proposes the setting up of polyclinics in primary care.

20. In the Darzi proposals, there is both promise and threat for the future of the NHS. The threat — of transactional fragmentation and commercial distortion of care — could be notably reduced by recognition by government that involvement of market mechanisms including the private sector in any such development plans is totally incompatible with the conditions of mutual support, trust and cooperation that are necessary to attain these new levels of NHS performance and achievement. Without this, the promise in Darzi's plans — the release of the creative enthusiasm and the mutually supportive drivers that established the NHS — cannot be fulfilled.

21. As a pre-condition for further effective progress with the Darzi proposals, Keep Our NHS Public calls upon government to reverse the market structure and processes that have been imposed on the NHS and to declare a moratorium on further involvement of the private sector in the provision of NHS services. Adequate resources and facilities should be provided without delay to commence pilot trials within the NHS of some of the innovative and exciting service proposals outlined in the Darzi Reports.