Letters

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The White Paper: a framework for survival?

In his editorial in the September issue,[1] Roger Jones asks:

'Why do we not look to and learn from more successful health systems in which a mix of private and public provision — including insurance schemes, means testing, payments for hospital and doctor visits, and co-payments for drug treatments — lead to better patient health outcomes and greater patient satisfaction? ... this, of course, is the heart of the matter: through no fault of its own, the NHS has become unaffordable ...'

There is no 'of course' about it. If this is indeed the 'heart of the matter', then it deserves some evidence to support all these assertions. I don't know, nor do I think Roger knows, any country anywhere where public service medical care has had media approval over the last decade of transitional promotion for marketed care. Falsehoods about NHS cancer outcomes comparable to backward and broken services in Bulgaria and Romania have been exposed as statistical nonsense by experts in this Journal.[2] They depend not on better care abroad, but grossly inferior data collection in, for example, Germany, and almost none at all in the eastern Balkan republics.

Lobbying against free public services, funded from income tax, has everywhere been very well funded and very effective. It has told governments serving transnational corporate business, rather than their own electorates, just what they want to hear. Opposition to it has not even a small fraction of that funding, nor support from the leaders of any of our political parties in serious contention. Mass opposition will eventually develop, as it always does when people are seriously hurt, but for the time being most simply cannot believe that so many people who claim to be saving the NHS are actually selling it off to the strongest commercial bidder.

What we can afford is surely a matter of opinion and choice. In 1948, Nye Bevan had to push his proposals for a free national health service, funded from income tax, past not only professional opposition, but a sceptical majority of his cabinet colleagues — mainly because the UK was then virtually bankrupt. He succeeded because the government was swept in with mass support, which would not take no for an answer. There was political will. Nobody today can deny that we are richer now than we were then. Yes, I know the NHS costs more today. Of course, because it can do more. But everything else costs more too. For example, if Spitfires had cost in 1940 what Eurofighters do today, the entire RAF would possess a few dozen at most. If we can afford Trident missiles, for which even Tony Blair now sees no rational purpose (other than to assert power we no longer possess), we can afford the NHS as a public service, a gift economy, and almost our only hope for some more truly civilised and sustainable society in the future.[3]

Roger says '... western societies now have to find alternative ways to pay for health care.' What better way is there, than income tax? In 1762 Adam Smith, founder of economics, wrote:

'The subjects of every state ought to contribute towards the support of the government, as nearly as possible, in proportion to their respective abilities; that is, in proportion to the revenue which they respectively enjoy under the protection of the state.'[4]

Those who have much depend on the state to protect them from those who have little. Differences in personal wealth are now greater than at any time over the past century. I look at the bankers, the corporate executives, the playboys, and playgirls of our increasingly decadent society, and ask why they can't afford the rising costs of a rising civilisation. Doctors must occasionally help patients to see what is in their own vital interests. This is one of those occasions.

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Your editorial 'The White Paper' highlights the futility of past and present reforms.[1] The urgent need to get it right cannot be understated. There are common themes to the past and present failures from which all should learn. If clinicians are permitted to concentrate on clinical work, productivity, and quality, then morale

would rocket upwards.

The NHS exists to ameliorate the fear of illness, injury, suffering, and death; the preventative and public health elements are subsumed within this. It does not have to do everything for everyone all the time.

Taking the consultation as the starting point, proper assessment and advice about anything, any time, anywhere, for free — in person, by phone, by email/SMS, by Skype, or whatever — is the first requirement. People access health care because they do not have the answer to a concern. The access points must be immediate, effortless, ubiquitous, and 24/7. It has been my experience that when patients know that an immediate response is a button press away, they are apt to relax and use the system to best effect of their own accord.

Consider the 'pyramid of care'. There is a vast stratum of minor and self-limiting conditions for which, after proper assessment, no treatment or self treatment is appropriate. The NHS should not bear the cost of any of this treatment. In time, the high street pharmacy would become the first port of call for much of this morbidity, thus freeing primary care to focus further up the pyramid. The savings in prescriptions would be vast and the funds released can percolate up the pyramid, easing the pressure on funding high tech, high cost treatments. With the high street pharmacy shouldering the greater part of minor and self-limiting morbidity, that part of pharmacy which is of the greatest direct value to primary care should be fully integrated with it. All primary care teams should have a resident pharmacist and dispensary that can optimise all aspects of therapeutic usage in real time and on site.

Further up the pyramid are those common non-red-flag conditions, for which treatment can be more appropriate, but which may lack objective confirmation of significant pathology. In the absence of this confirmation, treatment should rely on self treatment, private prescription, and/or lifestyle change. Where there is objective confirmation of significant pathology then the NHS should start to pay for treatment.

Malignancy is subject to populist political exploitation (2-week waits and cancer funds, for example); this must stop. We need to move away from any wait at all for those with confirmed or suspected malignancy. Faced with the possibility or reality of life-shortening illness, most people would be prepared to drop everything immediately and travel from Lands' End to John O'Groats within the hour if it would help — and who is to say it wouldn't?

Every county should have an immediate, same hour, referral service for all suspected or confirmed new cases of malignancy. In such a unit, all protocols would be fully up to date and instantly initiated with physical, psychological, and social support given. Appropriate baseline investigations would be performed at first attendance, including all imaging modalities, biopsies, and endoscopic assessment. Follow-up appointments or admissions would be organised. Why not?

The pernicious impulse to eliminate variability must be recast as a determination to promote properly exercised clinical autonomy while eliminating feckless eclecticism. The tabloid mania over postcode lottery treatment must be deflected by permitting variation in service by area when it has the informed consent of the affected population.

The bottom line is that unless all the involved professions assert themselves decisively and coherently, the NHS is lost. You asked for a bolder and more imaginative approach — this is my offering in outline.

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Competing interest

In 2008, at the age of 55, I retired from general practice, primarily to register the withdrawal of my consent from what has been and is being done to the NHS. I stood as an Independent in the 2010 general election, with health as one of the main elements of my campaign: I got 1974 votes, coming 28th in the UK among Independent candidates.

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Professor Jones believes that the White Paper ignores the 'funding crisis'.[1] Nothing could be further from the truth. The White Paper proposes that GP consortia will hold a budget for purchasing care for the population covered by the consortia. If a consortium fails to meet its responsibility to break even, its commissioning responsibilities will be taken over by the NHS Commissioning Board or assigned to a third party. This provides a powerful incentive to focus on the cost of services being provided or purchased. GPs are responsible for the vast majority of decisions relating to this expenditure, and they will now be directly accountable for these decisions.

The White Paper, therefore, proposes a powerful incentive to manage financial costs that has not existed since GP fundholding. The level of funding required to deliver a service with high quality outcomes can only be addressed once the incentives to achieve the desired outcomes are in place. The case that funding from general taxation is both fair and efficient has been comprehensively made by Wanless.[2] This is and still should be the policy of the Royal College of General Practitioners.

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