

# Debate & Analysis

## Crystal therapy for all?

*'Doctor, I've decided to spend my personal health budget on crystal therapy this year. What do you think?'*  
*'Umm ... well, umm ... I'm not sure really ...'*

In England, personal health budgets (PHBs) are being rolled out from April 2013, initially for patients eligible for NHS Continuing Healthcare,<sup>1</sup> and the government has committed to give all those eligible the right to ask for a PHB by April 2014.

### WHAT IS A PERSONAL HEALTH BUDGET?

A PHB is an amount of money allocated to a patient that allows them more choice, flexibility, and control over the care they receive. The budget will cover an individual's health needs to achieve agreed health outcomes through an agreed care plan.

*'Well, if you think that crystal therapy won't help, can I spend it on a cat instead or ... how about a scooter? It would at least get me out of the house.'*

Under the current regulations, a patient can choose to spend their PHB on any activity or non-traditional treatment, providing it is not hazardous to their health. As a professional, the GP has the responsibility to inform the patient if an activity is hazardous, but under the current General Medical Council guidelines,<sup>2</sup> has to support the patient to make an informed decision.

### Benefits

PHBs are one of the tools through which, for some patients at least, the benefits of personalisation may be realised. In particular, they do have the potential to:<sup>3</sup>

- act as a stimulus for increased care planning, with its focus on outcomes and its emphasis on shared decision making;
- enable patients to access different types of care better tailored to their needs, for example, non-traditional treatments and services provided by the voluntary sector;
- give patients greater control and flexibility over who provides their care and when, for example by employing their own personal carers; and
- allow greater integration of care across the boundary between health and social care, by facilitating a dialogue using the

process of agreeing a care plan for a PHB, especially for patients with complex and multiple conditions.

It must be stressed that, at present, evidence on the benefits of the introduction of PHBs remains limited, including that derived from other healthcare systems such as the US or from the social care field. In particular, while there is reasonable evidence that PHBs are associated with increased patient satisfaction, the evidence for a direct positive impact on health outcomes is currently sparse.

### IS THIS PERSONALISATION OF CARE?

PHBs are being rolled out as part of the government's personalisation agenda, with initiatives ranging from 'No decision about me, without me' through shared decision making,<sup>4</sup> to co-creating health.<sup>5</sup> PHBs are part of the ideology of free market health care,<sup>6,7</sup> where patients are empowered to choose not only where and by whom their treatment is provided, but also the type of treatment they receive. They can allow patients to access treatments not traditionally provided by the NHS, without the need for proven clinical effectiveness. Does this 'de-professionalise' healthcare practitioners such as GPs?

Personalised care is one of the key dimensions of the quality of care, strongly associated with better patient outcomes.<sup>8</sup> It is claimed that PHBs are rooted in the same values of 'holism' and patient centeredness as general practice.<sup>9</sup> This, in our view, is disingenuous and misses the point about the free market ideology that underpins PHBs. The language of patient empowerment, patient enablement, and informed consumers of health care is being used to justify the introduction of PHBs; so much so, the original decision to implement them from October 2012 was taken long before the final results of the pilot studies had been evaluated.

### Challenges for general practice: knowledge, skills, and culture

PHBs are one of the many challenges facing us: for example, our knowledge of PHBs ('hands up' those who already know the process of a PHB?). Do we have the necessary skills to negotiate with care brokers who draw up PHB care plans? However, perhaps the biggest challenge that we may face is the 'cultural challenge': we already think we're empowering patients, but, patients say we're not<sup>10</sup> despite patient satisfaction with their GPs remaining very high.<sup>11</sup> In addition the supporting role a GP plays for patients who have chosen non-evidence based treatments remains to be clarified.

### Robbing Peter to pay Paul?

One significant unknown is the impact that PHBs will have on overall levels of demand. PHBs are to be provided using existing resources and are taken from NHS budgets. The Netherlands experienced a tenfold increase in the demand for PHBs, from 13 000 to 130 000 between 2002 and 2010 and this led to temporary closure of the scheme to new applicants and restrictions on eligibility.<sup>12</sup> Although the scheme in England is about spending money on health care in a different way, if patients who previously were not in receipt of NHS funded services take up the offer of a PHB, increased demand could still occur. Individuals who previously relied on informal carers for support or who paid privately for certain treatments, could opt to meet these needs through a PHB instead.

The evidence from social care suggests that the use of PHBs can be expected to lead to additional administrative and support costs, associated with the need for more detailed care planning, brokerage, and monitoring. In its preliminary impact assessment for the PHB pilots in England, the government expressed a hope that these costs would be offset by savings from the optimisation of care facilitated by the

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introduction of PHBs, for example due to a shift in resource towards prevention, and lower levels of hospitalisation. However, at this stage, these predicted savings remain highly uncertain, and may have to be realised elsewhere in the healthcare system. In addition, the care planning aspect of PHBs will give rise to an upfront increase in GP workload; for example, in signing off care plans, although this may be offset over time if the process results in better self management and a less frequent need for GP visits.

#### **Should taxpayers fund non-evidence based treatment?**

It has been claimed that certain treatments traditionally prescribed by the NHS do not work for some individuals, and conversely, some treatments not traditionally prescribed by the NHS may be effective in improving health outcomes in certain cases: a case in point would be acupuncture for pain relief.<sup>13</sup>

There is a risk that PHBs will be spent in ways that do not improve health. At worst, and without proper safeguards, this could lead to patients discontinuing their current treatment, experiencing poorer health outcomes, or indeed suffering actual harm. In an environment where the NHS is under considerable financial pressure, can we justify using a finite pot of money on a cat simply because a patient says it would improve their health?

Such a move away from traditional NHS services towards a greater multiplicity of providers may have the effect of creating additional costs, both for individual budget holders and for the NHS as a whole. This could be the result of:

- double running costs, due to commissioners being unable to release money from existing long-term contracts;
- reduced scope for providers to drive down costs by realising economies of scale; and
- less power in the market, as the procurement of services is fragmented between multiple purchasers.

#### **IS ACUPUNCTURE BETTER THAN AROMATHERAPY?**

GPs and commissioners cannot guarantee the quality of services provided through PHBs and patients may not have the knowledge to judge good from poor quality services. Although some service providers may be Care Quality Commission (CQC) registered, where a person uses an individual budget to arrange their own personal or nursing care without agency involvement, this service is exempt from the requirements for CQC registration. In addition, most complementary and alternative therapies are outside the scope of CQC regulation.

There is also a risk that the move away from planned provision towards a free market-led approach may jeopardise the continued survival of certain services if too many users switch away. Most vulnerable to this are specialist services that rely on minimum numbers of patients, such as services for motor neurone disease.

#### **WILL PHBs INCREASE INEQUALITY?**

Alongside increased choice and empowerment, PHBs also have the effect of shifting responsibility and risk away from the NHS and onto the individual. Without appropriate support, there is a danger that some groups of patients may prove less able than others to cope with this, potentially leading to increased inequalities. This is particularly likely to be an issue for older people, those that are more vulnerable, and for patients with PHB payments paid directly into their bank accounts.

The introduction of PHBs may also lead to increased scope for the emergence of 'postcode lotteries' between different areas. This could arise, for example, as a result of differences in the budget setting methodologies adopted, or in decisions taken regarding what treatments and services PHBs can be used to purchase. Patients could also be disadvantaged if their budget runs out prior to the end of its allocated span, for instance because their needs have changed, or simply because of the inherent difficulties of establishing a budget formula that accurately reflects

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need. This risk is likely to be greatest for patients who are least inclined or able to argue the case for their budget to be increased.

#### **SO, WILL IT BE POSSIBLE TO SPEND A PHB ON CRYSTAL THERAPY, A SCOOTER, OR A CAT?**

The answer in principle is yes. However, one of the most critical questions concerning PHBs that remains unanswered is how the amount of the budget is set. Different approaches are being evaluated as part of the PHB pilots in England, but at the time of writing the government is yet to announce how it intends to proceed with implementation.

Since April 2009, the government has funded PHB pilots across 64 sites in England, covering NHS continuing care, stroke, mental ill health, and care for long-term conditions such as COPD and diabetes. This has, hopefully, improved health outcomes and of course, we're all in favour of this (who wouldn't be?). However, little is known yet about the impact of PHBs on the workload, their acceptability to primary healthcare teams, and the likelihood of engagement of GPs in implementing PHB. To date, there is limited evidence of patient benefit from the introduction of PHBs and in our view, the case for PHBs has not yet been proved. A drug would never be introduced into the NHS with limited evidence of benefit, so should such major innovations in health care be introduced with such a limited evidence base?

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**Provenance**

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