

Making Sense of the NHS

Tim Ambler
Senior Fellow, Adam Smith Institute

Executive Summary

Exactly how much the Treasury should provide the NHS is a political decision, based on the state of the UK economy, international comparatives, the coherence of NHS strategy and the competing demands for support. But there is wide agreement that exactly how those funds should be allocated should not be a political decision.

The cross-party convention proposed by Norman Lamb, or the Royal Commission proposed by Lord Saatchi, could help create this division of responsibilities. They should consider five major NHS structural changes to realise its potential:

- NHS England is too big to manage. It needs to be split into six autonomous NHS Regions—run as independent public corporations like the Bank of England or BBC, not by a vast central Whitehall staff.
- The limits of NHS provision—at present open-ended—must be identified. Only then can resources be focused on their most urgent uses.
- Patient co-payments, common in almost every other healthcare system (and already current in NHS dentistry and prescriptions), needs to be extended, with care, to reduce marginal and unnecessary demand on NHS services.
- Our ageing population means that the number of GPs and geriatricians must be increased, particularly geriatricians, whose numbers are outstripped by demand.
- The 12% of the UK population with mental health issues need greater prioritisation and specialist resource.

The benefits of this clearer, more manageable strategy include:

- Improved morale, recruitment and retention of a workforce that feels more valued and able to achieve identified aims, rather than having to deal with continual crisis.
- Localised autonomy to innovate, reduce waste and learn from others.
- Better balance of NHS resources with demand, which is outstripping supply because (a) they are free, (b) an older population needs more geriatrician care, (c) mental health needs more specialists and (d) a wealthier population demands more healthcare in general.
- Improving the quality of healthcare and balancing the books by focusing money, personnel and equipment on their most cost-effective uses. More skills need to be pushed down the line: consultants to primary care, GPs to nurses and pharmacists.

Strategic priorities for the NHS

The NHS is highly politicized—which creates most of its problems, as Chris Ham, Chief Executive of the King’s Fund, explains: *“The real NHS crisis is political. It is the result of short term thinking geared around election cycles and an unwillingness to deal with long term challenges that are not amenable to incremental policy changes. A preference for adversarial point scoring rather than crossparty consensus is an insurmountable obstacle to the kind of political leadership that is desperately needed.”*¹

Opposition politicians highlight deficiencies, not successes, and governments fail to make crucial decisions for fear of public and political criticism. Lobby groups, meanwhile, pressure ministers into sub-optimal decisions (such as preserving redundant facilities or offering new services that are poor value for money or unaffordable).

Setting the total budget inevitably has to be a matter for the government of the day but that does not require Whitehall trying to micro-manage one of the biggest and most complex organizations in the world. Others seem to think the same: former health minister Norman Lamb has created a cross-party initiative to create a nonpartisan convention on the NHS (his petition collected over 85,000 signatures when the 2017 election intervened); and in similar veins, Lord Saatchi has called for a Royal Commission and the Lords’ Select Committee on the Long-term Sustainability of the NHS recommended the establishment of an Office for Health and Care Sustainability to provide independent strategic advice.² Such initiatives should focus on the major, achievable strategic changes such as these five.

Depoliticized structure. A plausible model by which to depoliticize NHS provision is to make it a public corporation (like the BBC or Bank of England), where the Secretary of State agrees, annually, a five-year plan. A step in this direction was made in 2013 with NHS England taking on full statutory responsibilities from the Department of Health, strategic health authorities and primary care trusts.³ Public corporations have their imperfections but imagine what the BBC would be like if it was part of a government department, and that is what we have in the NHS.

Manageable size. NHS England is too big to be managed. If (as many agree) NHS Wales and NHS Scotland are roughly right-sized, then NHS England should be split into roughly six autonomous Regions. That would end the Service’s London-centric focus, and would need only a much slimmer Whitehall staff (and far fewer ministers)⁴ to allocate resources against acceptable Regional business plans. It would also promote cooperation between local NHS facilities, saving duplication.⁵ Regionalization was recommended in the 2014 Dalton Review.⁶

¹ BMJ 2017;356:j218

² “The Long-term Sustainability of the NHS and Adult Social Care” 5th April 2017.

³ Nigel Edwards and Jacob West documented haphazard movements in this direction in their October 2016 paper “No hospital is an island: new models of acute collaboration in the NHS”
<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx>

⁴ The DH, with only about 2,000 staff, currently has five ministers and four special advisors.

⁵ <https://www.england.nhs.uk/blog/nigel-edwards-2/>

⁶ See “The Dalton Review, Summary for NHS Confederation members, 5th December 2015”.

Regionalization will, of course, lead to complaints about a ‘postcode lottery’. But then each part of the country should expect the NHS to match its service to local needs. Healthcare needs vary between different areas, so a different set of services is needed in order to maximize value for money: one size does not fit all. And for improvement to happen, providers have to try out different things—impossible if services are standardized.

Deciding what the NHS is for. If resources are to be used cost-effectively, they must be targeted on the most essential and valued purposes. That means setting out the boundaries of what the NHS should try to do. This is difficult, but other state-funded healthcare systems manage it. The core purpose of any state-funded healthcare system in a developed country is fundamentally to focus on treatable needs, on preventing conditions (such as diabetes) from leading to further complications, on managing pain, on maternity and certain other definable needs. Specialist geriatric treatment is a difficult borderline problem: while long-term care (for the elderly, infirm and those with long-term mental issues) is not only vital but needs better integration with health care, it is not clear that the NHS, already too big, should perform that function. Can GPs also take on the management of social care programmes? Indeed, the National Audit Office investigated the integration of NHS and social care and concluded that no benefit resulted.⁷

Managing demand. On the one hand our ageing population requires more GPs and geriatricians, particularly geriatricians. The 12% of the UK population with mental health issues also need greater prioritisation and specialist resource. With increasing science and technology the NHS **can** do more and more, albeit at escalating cost. So, as noted above, limits need to be set in the national interest, i.e. not by any single political party. Patient co-payments, common in almost every other healthcare system (and already current in NHS dentistry and prescriptions), need to be extended, with care, to reduce marginal and unnecessary demand on NHS services. Demand can also be managed by pushing more skills down the line: consultants to primary care, GPs to nurses and pharmacists. Much of the demand for A&E can and should be pushed back to primary care.⁸

How should a de-politicised NHS better manage itself?

Cost-effective spending. Overall, the UK spends about 10% of GDP on patient healthcare (8% NHS, 2% private), which is above the OECD average—and more than Italy but slightly less than France or Germany (11%).⁹

Despite talk of cuts, NHS England’s budget continues to rise. The government is committed to increasing NHS England funding by a real-terms £10bn in 2020/21, compared to 2014/15. The King’s Fund tracking shows smaller but steady annual real-terms increases from £111.7 billion in

⁷ National Audit Office. Department of Health, Department for Communities and Local Government and NHS England: Health and social care integration. 8 Feb 2017. <https://www.nao.org.uk/report/health-and-social-care-integration/>.

⁸ Only “26 per cent of patients attending a major accident and emergency (A&E) department were then admitted to hospital in 2012-13” NAO Report: Emergency admissions to hospital: managing the demand, 25 October 2013.

Snooks HA, Dale J, Hartley-Sharpe C, *et al* “On-scene alternatives for emergency ambulance crews attending patients who do not need to travel to the accident and emergency department: a review of the literature,” *Emergency Medicine Journal* 2004;21:212-215.

⁹ <http://visual.ons.gov.uk/how-does-uk-healthcare-spending-compare-internationally/>

2009/10, to £122.6 billion in 2016/17 and (projected) £126.5 billion in 2020/21.¹⁰ So the budget is rising, even if demand is rising faster.

However, it is remarkably difficult to identify how this spending is divided between the main primary and secondary cost areas. A rough breakdown is as follows:

¹⁰ <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget> King's Fund sources: Department of Health annual report and accounts 2015/16 Central government supply estimates 2016-17, supplementary estimates and new estimates – Feb 2017; HM Treasury GDP deflators at market prices, and money GDP March 2017; (Quarterly national accounts, March 2017)

NHS England Breakdown of costs	£ bn	Percent
Acute hospitals @ about \$0.5 bn. Each	67.5	60.9
Primary (mostly GP surgeries) @ £141 ¹¹ per patient p.a. + Cahill formula + rural + health care (in some cases)	10	9.0
Dentistry and prescriptions (net)	11.7	10.6
NHS England research, contribution to adults social care and other costs	12.4 ¹²	11.2
Health education	5.4	4.9
DH and any number of quangos ¹³	3.8	3.4
Total	110.8	100

Source: Department of Health Annual Report 2014/5 p.103.

Only a small amount of cost is recovered from patients:

2013/4	Income £M	Cost £M	Net Cost £M
Dentistry	684	2,740	2,056
Prescriptions	471	10,115	9,644
Other fees and services	259	292	34
Total	1,413	13,149	11,734

Though crude, the figures above show that primary care, secondary care, dentistry and prescriptions receive little more than four-fifths of total NHS England funding—the rest going mainly on education, research, social care and quangos. In terms of fulfilling its core function and maximizing value for money, there is plenty of scope to move the £25 bn. or so (20%) which is not spent on curing the sick, surgery, mending limbs, medical treatment and maternity back to doing so. Furthermore, Professor Briggs and others have pointed to the considerable wastage, perhaps another 10%, within today’s NHS¹⁴.

¹¹

<http://www.pulsetoday.co.uk/your-practice/practice-topics/pay/average-gp-practice-receives-136-per-patient-annually-less-than-a-sky-tv-subscription/20009191.article>

<http://www.telegraph.co.uk/news/2017/01/27/no-146-per-patient-not-enough-time-gps-charge-fees/>

¹² “NHS England net expenditure” £15.5 bn. + “NHS England expenditure financed by NI Contributions” £17.5 bn. – contribution to primary care, say, £20.6 bn.

¹³ DH Annual Report 2014/15, Figure 2: The Department of Health’s Arm’s Length Bodies & Delivery Partners shows 16 quangos but Note 21 to the 2016/17 DH Accounts shows 47 quangos. Another DH listing (<https://www.gov.uk/government/organisations>) shows 27.

¹⁴ “Hospitals can save £1.4 billion by competing with private clinics, Tim Briggs tells NHS”, **Chris Smyth, Health Editor, The Times 5th August 2017.**

“Millions of needless NHS referrals”, **Chris Smith, The Times, 30th June 2017.**

Structural questions

Clinical Commissioning Groups. CCGs comprise disparate groups of GPs as well as lay people and managers drawn from other walks of life. They decide how the money allocated to their area should best be spent, e.g. on hospitals which are funded by tariffs—managed prices—for each type of work they carry out for their “customers” in the primary sector. This system has been widely discredited for the amount of GP distraction from their patients and the little benefit it brings to the allocation of resources. The King’s Fund, however, is more positive but points to the improvements CCGs need to make.¹⁵ The question though is whether we need them at all.

The DH has a computer model designed to share, as fairly as one can, the total available sum between the CCGs, accounting for population, age, deprivation and other factors. It should be possible to take this model one level down to hospitals, other secondary care units and GP practices.

Research. Much medical research is conducted in hospitals. More than £1bn of research costs¹⁶ are passed up to The National Institute for Health Research, which is part of NHS England. Why should NHS England bear the cost when we already have the Medical Research Council—the public agency responsible for coordinating and funding all medical research in the UK? Better value would be achieved by one, not two, funding quangos.

Quangos. The DH has some number between 16 and 47 quangos (see footnote 12 above) but, excluding NHS England itself, 26 is probably the most reliable number. Six of those should clearly be independent of NHS England but five are “helping” the NHS England CEO to do his job and, to the extent they are necessary at all, should be part of his responsibility. The “bonfire of the quangos” in incoming government promised us in 2010 seems not yet to have reached the DH. At least half of the remaining 15 should go.¹⁷

Making better use of IT. The NHS requires GP practices each to choose one of four IT systems: TPP SystemOne, EMIS Web, InPS Vision and Microtest Evolution.¹⁸ But the four are mutually incompatible so records for patients who move have to be re-entered by hand and a locum used to one system is unemployable by a practice using a different one.

GP services. It is hard to see substantive gains from further changes to GP services save simplifying their funding and paperwork. They work, broadly, four 10 hour days a week but many work more than that to keep up with paperwork and education: “*Bureaucracy takes up 3-4 hours, of which maybe 50% is of any clinical value*” according to one experienced GP practice head.

The 10 minutes allowed for each patient interview is difficult for both sides and would expand if more time were available through reducing bureaucracy and discouraging or filtering out those who do not need to see a doctor. It would be more productive for the GP if expert systems were used to refine the reason for the visit beforehand and help write the notes thereafter. Such expert systems have been resisted too long.

¹⁵ Clinical commissioning: GPs in charge?, 12 July 2016.

¹⁶ NIHR Annual Report 2014/15, pp. 85-87.

¹⁷ Department of Health: An Overview of its Quangos, Adam Smith Institute Blog, Tim Ambler, 26 July 2017.

¹⁸ <https://digital.nhs.uk/GP-Systems-of-Choice>

The Better Care Fund. The government seeks to integrate cure and care with the new £5bn-per-annum BCF. But the National Audit Office found that: “The Better Care Fund has not achieved the expected value for money, in terms of savings, outcomes for patients or hospital activity.” The BCF theory is that the individuals will be able to seamlessly manage their own cure and care. The reality is that they are overwhelmed with Kafkaesque confusion. We have been round this loop before¹⁹ The NHS is already unmanageably large and merging it with adult social services could only worsen that.²⁰ The £5 billion BCF funding should be put towards more doctors and nurses.

Acute hospitals. The usually quoted cost of hospital bed, at £400 per night,²¹ can be misleading: with increasing provision for out-patients, the cost of an acute hospital would not be reduced greatly if it had no overnight beds at all. The secondary sector sees itself as dealing with the more sophisticated and expensive treatments, and the belief that primary care is more cost effective drives the call to move treatment from the secondary to the primary sector, including ‘cottage’ hospitals and convalescence homes.²²

The last 30 years have seen a movement to fewer, larger hospitals driven largely by ever-increasing specialisation. The extent to which the trend should and can be reversed probably needs to be driven by both GPs and acute hospitals to save money without damaging patient care.

Maternity services. Maternity may be such an area. The second half of the 20th century saw provision switch from nursing/maternity homes, often run by local councils, to acute hospitals—not altogether happily, as Angela Davis put it: “*Throughout the period, some women felt they received excellent medical care, but criticised their treatment by hospital staff: medical professionals they perceived as self-important, who believed that they, rather than their ‘patients’, knew best.*”²³”

Hospital stays were shortened both to save money and to suit mothers who want to get home as soon as possible. There was much greater use of the knife and birth days were more determined by doctors than nature. The fact remains, however, that mortality has reduced to near zero. All this area remains much debated: Angela Davis concludes “*...current, controversial moves to reconfigure maternity services, closing smaller units and consolidating provision into a smaller number of large centres, is unlikely either to meet mothers’ needs, promote safety or prove cost effective.*” Perhaps it is time to revisit midwife driven maternity homes closely linked to acute hospitals to cover emergencies.

Cromer eye hospital provides a good example of specialists being available locally in lower cost facilities: if there is enough work in the local facility to occupy a specialist for a day or two a month, then it may be better for the specialist to travel to the patients than vice versa.

The pros and cons of specialisation. Greater specialisation means greater complexity; but often in the NHS it can seem as if no one is in charge. NHS consultants increased in number by 22% in the

¹⁹ 2017-19 Integration and Better Care Fund, Policy Framework, Departments of Health and Communities and Local Government, March 2017 Figure 2: Key integration initiatives and enabling legislation.

²⁰ <https://www.publications.parliament.uk/pa/cm201617/cmselect/cmcomloc/1103/110306.htm>.

²¹ <https://data.gov.uk/data-request/nhs-hospital-stay>

²² See for example, Sue Brown’s winning essay:

<https://www.kingsfund.org.uk/reports/thenhsif/what-if-the-nhs-moved-most-care-out-of-hospitals/>

²³ Angela Davis, “Choice, policy and practice in maternity care since 1948”, History & Policy, 30 May 2013.

six years to 2016 but their productivity declined.²⁴ Surgeons grumble that they spend more time in the canteen than in the operating theatre. If the £4 bn.²⁵ spent on agency staff were spent on salaries, productivity might well increase. And smaller, regional, NHS corporations would make pay levels more flexible.

To quote from Rivett's National Health Service History: "*The development of the NHS has created new problems, while not always solving old ones. One difficulty concerns the organisation of clinical staff in a way that is efficient and conducive to the provision of good treatment. In primary health care the developments have been largely beneficial and coherent, with the emergence of well-housed group practices. The same has not been the case in the acute hospitals. The NHS inherited a firm system, in which each patient was the responsibility of a single consultant, who usually held beds on two wards, male and female. Consultant-led teams were the rule, and each covered its own emergencies. The consultant had a small and well-defined team of juniors and close relationships with the nursing staff. Now, the firm system has largely gone and no effective alternative has as yet emerged. More patients are admitted and they spend less time in hospital. Patients, nurses and doctors have less time to get to know each other. Beds are seldom allocated to specific specialties and each ward may contain a continually changing mixture of cases. Junior doctors find that their patients distributed widely around the hospital, and receive less support than they did in the past from experienced ward sisters. Juniors who, in 1948, had almost no time off for the six months of their job, now cover for each other and see patients previously unknown. Lacking support of resident seniors or consultants is not only stressful but dangerous for patients, and European Working Time directives make matters worse*".²⁶

Unquestionably, specialisation has helped the speed and quality of treatment—once the patient gets to see the consultant. Against that, the complexity and size of hospitals has taken them further away from most patients and raised costs, and may be working against best care for the elderly. Consultants are notoriously slow to change and resistant to management—which can lead to long waits, lack of prioritization, unnecessary operations²⁷ or excessive medication. Should consultants, and especially surgeons, be paid on a piecework basis, as they are in their private practices, rather than by the day as they are in the NHS? That might raise the productivity and the quality of treatment but might also incentivise unnecessary interventions. There is plenty of room here for hospitals (and independent Regions) to experiment and learn how best to use these specialists' time.

Setting the priorities

Public health and longevity. "The patient will be at the heart of everything the NHS does,"²⁸ says its Constitution: but 'the patient' [singular] is not the same as society as a whole, and the current politicization of the NHS has also politicized public health policy.

Should average longevity, for example, be a target for the NHS? There are already plenty of lobby groups telling us how to live more healthily. In world terms, UK life expectancy is roughly 20th out

²⁴ "Under pressure: not enough support for consultants?" Sarah Lafond, Senior Economics Analyst, The Health Foundation, 27 Mar 2017

²⁵ <http://www.telegraph.co.uk/news/2016/05/09/nhs-agency-staff-spending/>

²⁶ Geoffrey Rivett, *National Health Service History*, Chapter 8, Envoi, nhshistory.net.

²⁷ Oliver Moody, "Patients' lives put at risk by pointless operations," *The Times*, 12 June 2017, p.1.

²⁸ Principle 4.

of 183 countries. NHS spending in Scotland is 10% higher than in England, but life expectancy is two years shorter. But longevity seems to be increasing on its own: does the NHS achieve anything by promoting it?

Later years. A person's final, post-HALE (Healthy Average Life Expectancy) years are particularly expensive for the NHS.²⁹ A typical 65 year old costs the NHS 2.5 times more than someone half that age and an 85 year old costs over five times as much.³⁰ If the goal were simply to reduce cost, the NHS would seek to extend HALE and, at the same time, minimize the post-HALE dependency on the NHS. But how can issues of humanity and morality be balanced against financial sustainability? A mature public debate is needed.

Geriatrics. There is no cure for old age, but people's quality of life can be enormously enhanced by treatment from professional geriatricians. As researchers pointed out in *Clinical Medicine*:

The NHS must meet the needs of an ageing population in a challenging social and economic climate. To do so successfully, we must make prudent use of teams specialising in geriatric medicine. Already geriatric medicine departments are stretched. This is partly because of an overall increase in NHS clinical activity. But equally important is the widening scope of their work as the beneficial impact of specialist medical skills in hospital and community healthcare is recognised.

Older People in the Modern NHS

- People aged 65+ are ~ 17 % of the population, and use 65% of acute hospital bed-days
 - People aged 65+ comprise more than 50% of surgical patients, more for major surgery
 - People aged 65+ use nearly half the NHS and over half of social services' budgets
 - Failures of safety, quality and patients' experience mainly concern older people
- Older people are the NHS' core activity.*³¹

Unfortunately, as the need for geriatricians increases, supply has been falling: the specialism is not seen as glamorous or rewarding. The UK has about 0.8 physicians per 1,000 population³² yet the very people who need doctors most are the least well served (geriatricians 0.1 per 1,000 over 65).

The NHS would save a great deal of money by employing more geriatricians relative to the number of other specialists and thereby provide better treatment for the elderly. Geriatricians lose out in the battle for resources. There are few to speak for them and, at the national level, the British Geriatrics Society does not have the clout of the BMA or the Royal Colleges. This conspires hopelessly against the best use of NHS resources. A retired head of a GP practice commented "GPs do most of the geriatrics and their skill in this is acknowledged by geriatricians. We had link schemes with the latter at [a local hospital] whereby they would do occasional ward rounds and share their skills with GPs who were looking after the patients day to day. That worked until they were sucked back by the city lights and more exciting stuff."

Elderly patients typically have many co-morbidities and the conventional view is that they need the attention of as many specialists. Yet one geriatrician can typically do more good for an elderly

²⁹ See, for example, Institute of Economic Affairs Discussion Paper No.80: Obesity and the Public Purse, Weighing up the true cost to the taxpayer, 2017.

³⁰ Max Pemberton, *The Spectator*, p.19, 20 May 2017.

³¹ James M Fisher, Mark Garside, Kelly Hunt and Nelson Lo, "Geriatric medicine workforce planning: a giant geriatric problem or has the tide turned?" *Clinical Medicine*, 2014 Vol 14, No 2: 102–6, 102.

³² 2014 World Health Organization's Global Health Workforce Statistics, OECD, supplemented by country data

patient than several specialists from other branches,³³ as the Royal College of Physicians points out.³⁴ Of course there are no certainties in this area: how can one balance, for an aged person, an unhappy time with a possible, but unlikely cure, versus a happy time with no medical intervention? Of course, the patient should choose; and geriatricians would be better placed to help them.

Mental health. Drawing the treatment boundary for mental health has similar problems: rapid growth in demand on the one hand and a shortage of professionals on the other, partly because it is less attractive than other branches of medicine. Nevertheless the number of consultant psychiatrists, for example, rose from 2,679 in 2011 to 4,793 in 2015, not including the 50.6% unfilled posts in 2015.³⁵

According to the Care Quality Commission: “Mental health problems account for almost a quarter of the total burden of illness in this country—more than either cancer or heart disease—and one in four of us will experience at least one such condition in our lives. Amongst the most common mental health conditions people seek treatment for are depression, anxiety disorders, phobias, obsessive compulsive disorder (OCD) and panic attacks.”³⁶ About half of those, i.e. 12%, had the problem(s) in the last 12 months which is regarded as “currently”.³⁷

Interestingly, such problems are particularly acute amongst GPs. In July 2015 David Millett reported in *gponline* “More than eight out of 10 UK doctors have experienced mental health issues during their career, with the vast majority reporting heavy workload and long working hours as key contributing factors.”³⁸ The British Medical Journal four years earlier claimed that “Nearly a third of doctors have some kind of mental disorder”³⁹, that is one third at any one time. Stress is the biggest contributor to that. More doctors and less bureaucracy would undoubtedly help.

Mental health problems can be serious and require medical treatment. But there are also less serious conditions that either do not require the services of doctors, or for which co-payment might be appropriate. Somehow, demand and the availability of services have to be matched. A tiered response is needed to focus NHS treatment where is most needed. Other demand can still be met from the private sector for those that can afford it. This would require some tilting of the tiers because, at present, the more deprived sections of the community get less than their share of mental health treatment.⁴⁰

³³ This is extensively documented in a book by a US surgeon: Atul Gawande, *Being Mortal: Illness, Medicine and What Matters in the End*, Profile Books, London 2014.

³⁴ Royal College of Physicians, *Referring Wisely*, 6 June 2017, p.11: “For geriatricians, the greater problem is that other specialists do not always recognise the potential benefits to their older patient of comprehensive geriatric assessment and don’t refer, rather than over-refer. Many older patients attend several separate outpatient clinics (such as cardiology, renal, diabetes) for their many long-term conditions, when they could more appropriately be seen in a medical older care clinic and have a coordinated, consistent approach, unless they have a high level of complexity in a specific condition.”

³⁵ The Royal College of Psychiatrists census of psychiatric staffing 2011 and 2015.

³⁶ <http://www.cqc.org.uk/what-we-do/services-we-regulate/mental-health>

³⁷ HSE 2014: Vol 1 | Ch 2: MENTAL HEALTH PROBLEMS, Figure 2F

³⁸ <http://www.gponline.com/eight-10-doctors-experience-mental-health-issues-during-career/mental-health/article/1356309>

³⁹ careers.bmj.com/careers/advice/view-article.html?id=20002383

⁴⁰ *Fundamental Facts about Mental Health 2016*, Mental Health Foundation.

Partnership with patients and the public sector

Co-payments. In various parts of the NHS, pricing may curb demand without significantly changing the Service from being free at the point of delivery. This is a delicate balance: as dentistry shows, pricing can deter those who really need treatment without deterring those who do not. New Zealand has a similar health system to the UK but people pay to visit their GPs: doctors set their own fees; children and some people who need to visit their doctor often can get free or subsidised visits;⁴¹ GPs do not charge those who cannot afford the fees. Such ideas work in other countries too. Is it not time to debate them here too?

The private sector. The NHS is much criticized for reducing waiting times by sending NHS patients to private hospitals. But if they have the money but not the capability, and tough mandatory waiting time performance metrics, what else should they do—especially if outsourcing costs them less than doing it themselves? Conversely, when the NHS treats patients covered by private insurance, should they not send the bill to the insurers?

Clearly the NHS has much to learn from private practice. Why for example can the same surgeons perform three operations on their daily private list but only one similar one on their NHS list? Kaiser Permanente in California and neighbouring states has attracted much interest among health policy specialists. Like the NHS it offers a comprehensive package and is big, albeit not so big: in 2015 it employed 18,652 physicians and 186,497 others. It too has had IT disasters but today the integrated system works well.⁴² Patients each carry a data file with much the same information as a UK GP would have on the patient's record. Whether such a 'membership' system actually provides a better model than the NHS has been challenged,⁴³ but again, is it not time to debate it here?

The benefits these proposals could bring

The potential benefits from these proposals fall into four groups:

- Improved morale, recruitment and retention of a workforce that feels more valued and able to achieve identified aims, rather than having to deal with continual crisis.
- Localised autonomy to innovate, reduce waste and learn from others.
- Better balance of NHS resources with demand, which is outstripping supply because (a) they are free, (b) an older population needs more geriatrician care, (c) mental health needs more specialists and (d) a wealthier population demands more healthcare in general.
- Improving the quality of healthcare and balancing the books by focusing money, personnel and equipment on their most cost-effective uses. More skills need to be pushed down the line: consultants to primary care, GPs to nurses and pharmacists.

Is it not time we had a mature public debate on these important strategic questions?

⁴¹ <https://www.govt.nz/browse/health-system/gps-and-prescriptions/paying-for-doctors-visits/>

⁴² https://en.wikipedia.org/wiki/Kaiser_Permanente

⁴³ Talbot-Smith, Alison, Gnani, Shamini, Pollock, Allyson M and Pereira Gray, Denis (2004) "Questioning the claims from Kaiser," *The British Journal of General Practice*. 54 (503): 415–21