Overview

The BMA is highly critical of the recent and proposed further marketisation of the NHS, pointing to evidence that marketisation has not improved outcomes for patients. It questions whether the proposed NHS restructuring will provide value for money at a time when huge efficiency savings are being demanded. It also expresses concerns that, despite the White Paper’s expressed intention to facilitate greater integration of health and social care, the proposed new commissioning structures, universal foundation trust status and a greater role for the private sector may not support this objective.

The BMA's response raises a number of issues of particular interest to local government, including some views and questions about how the proposed public health function and the role of Directors of Public Health may develop. It refers only very briefly to the proposed local health and wellbeing boards, which may add to local authorities' misgivings about how effective these boards are likely to be.

Briefing in full

The British Medical Association (BMA) is the representative body for doctors and medical students from all branches of medicine in the UK. Its response is to the White Paper’s proposals for the NHS in England only.

In general, the BMA remains “profoundly critical” of the direction of the NHS in recent years towards increased involvement of commercial interests and a market approach, which is continued by the White Paper’s proposals. It cites evidence that increased commercialisation has not been beneficial for the NHS or for patients. It claims that the frequently expressed wish to improve patients’ experience and provide more seamless, integrated care, seems at odds with many of the policies which will, it claims, “inevitably widen the purchaser-provider split”. It believes that the payment by results system discourages the collaboration that is needed to develop integrated services. It does not support Monitor’s proposed role as promoter of competition in healthcare and believes its time would be “better spent ensuring quality”. It expresses alarm at the clear suggestion in the White Paper that competition in healthcare should resemble that in the telecoms or energy industries.

The BMA is particularly concerned about the White Paper’s proposal of the choice of "any willing provider" for patients, believing that the NHS should remain the principal provider for primary and secondary care. It believes that this policy could undermine local health economies and threaten more integrated services by replacing existing multi-service natural monopolies with numerous smaller units providing a more limited range of services. This, it believes, would radically affect both the efficiency and value for money of the NHS. The BMA supports meaningful choices for patients, free from political targets, but does not believe the patient choice agenda of recent years, which is continued in the White Paper, has improved clinical outcomes or offers patients the choices they actually want. It suggests that most of all, patients want a high quality provider close to where they live and to receive timely, competent diagnoses and treatment and ongoing support when necessary. It believes that too much choice can lead to confusion and inaction due to uncertainty.
The proposals for increased patent autonomy and involvement in individual decisions about healthcare are welcomed, but the BMA notes that this will require better information for patients and longer consultations with GPs. It seeks greater protection for whistleblowers as well as assurances about patient confidentiality, patients’ access to their health records and accuracy of data.

The BMA also expresses concern about the proposed intention, expressed in the White Paper, that all NHS trusts should become, or become part of, foundation trusts. It claims that further moves towards the development of corporate entities would consolidate existing threats to the character and ethos of NHS provision and would threaten the stability of the NHS, the security of its employees and their terms and conditions of service. The BMA believes the abolition of the cap on the amount of income foundation trusts can earn from other sources has the potential to act as an incentive for foundation trusts to undertake more non-NHS activity at the expense of NHS provision. If unfettered, it believes that this could lead to a two-tier health service, as foundation trusts invest more resources in non-NHS facilities.

Noting that there are attempts to release £15-£20 billion of efficiency savings over the next four years, the BMA questions the value for money of the proposed changes and asks whether a less disruptive, more cost-effective process could achieve similar aims of reducing bureaucracy and empowering clinicians.

In addition to these general concerns, the BMA discusses a number of issues in some detail. The list below summarises those that are likely to be of most interest and concern to local authorities.

**GP consortia**

Concern is expressed about the transition from PCTs to GP commissioning consortia, with the danger that PCTs will “implode” as staff leave. It is suggested that PCTs should be retained until consortia are fully operational, and that greater clarity is required about which of their functions will cease and which will be passed over to consortia and local authorities. The BMA believes that, to be successful, consortia should include colleagues from secondary care and public health, as well as other medical and social care professionals. It acknowledges that the operation of consortia could create conflicts of interest for clinicians who will be competing for the work.

In a discussion about the geographical boundaries of consortia, the BMA suggests that GP practices could be required to join a consortium within their local authority boundary area, or in cases where a practice is near a local authority boundary, to join a consortium within the boundary of a neighbouring local authority, even if this does not necessarily fit neatly with a pre-existing natural health economy. Consortia may wish to consider acting coterminously with the local authority, to enable easier joint working with the public health services and the Director of Public Health. While believing that patients should be able to choose which GP practice is best for them, the BMA points out that removing practice boundaries will increase the cost of providing care, complicate resource allocation, make home visiting impractical and damage continuity of care. It may also widen health inequalities and make it difficult to commission care for patients who do not live locally.

**Cuts to local authority funding**

The BMA has “significant concern” about this year’s 20 per cent reduction in local authority funding, noting that budget cuts will make it more difficult to commission integrated care pathways and services, despite the White Paper’s proposals for closer working between health services and local authorities. It expresses concerns that local authorities “may need to use health funding to meet the costs of a significant amount of social care provision, long before the expected benefits of a new approach to the public saving for their social care will be realised”.

**Public Health Service and the role of the Director of Public Health**

It supports some of the proposals for a new Public Health Service (PHS) as potentially
contributing to reducing health inequalities and improving public health, and says that its focus should include the health needs of minority groups with an emphasis on early identification and prevention. However, it is concerned that the centralisation of skills and expertise into the PHS might be at the expense of public health delivery at a local level. The BMA believes that there must be continued public health input into commissioning and GP input into public health strategies.

The BMA would like the office of Director of Public Health (DPH) to be a statutory appointment, as an independent advocate for the health of a defined population, having a separate legal existence from the local authority or the Public Health Service. In its view, this is necessary because DsPH should have the power to advocate on behalf of the community without needing the authorisation of others. Furthermore, the BMA believes the DPH should be an executive appointment reporting directly to the chief executive of the local authority. The DPH should also be a statutory consultee in a number of areas, including planning, transport and environmental issues. Some concern is expressed about how DsPH could continue to play a part in "local medical leadership", as an important element of the public health contribution to the health and wellbeing process. It suggests that medically qualified Directors of Public Health could be given honorary consultant contracts (which seems to confirm that they would continue to be NHS employees, rather than being employed by local authorities).

The BMA requests that the government make explicit what is included within the public health funding stream, what part of the public health budget will be ring-fenced and that funding should come from local authorities as well as the NHS. It strongly recommends that there should be a wider policy review on the social determinants of health (in addition to the recent Marmot review) which would underpin a more coherent policy on prevention and public health.

Social care
The BMA believes reform of the "chronically under-funded and complex" social care service is needed. It urges the government to provide a clear definition of social care. This, it believes, would enable better joint commissioning, help GP-led consortia to see the value of investment in preventative services and clarify which services people “might need to save to pay for”. It supports greater integration between health and social care, with the development of new care pathways. It notes the establishment of the commission on the funding of long-term care and the forthcoming social care White Paper and states its intention to comment on these. It flags up its concern about the establishment of an insurance scheme and states its preference for a funding model based on a partnership of state and individual funding, ensuring that premia were related to ability to pay.

Mental health
The BMA cautiously welcomes the introduction of choice of treatment and provider in some mental health services from April 2011. However, it notes the low standard of mental health services in many areas and says that it must be improved before the introduction of choice, which also brings potential ethical issues. It would prefer to see this choice offer piloted and evaluated before being implemented more widely.

Performance and regulation
Although it welcomes a reduction in top-down targets, the BMA does not support the wholesale replacement of 'process targets and indicators' with clinical and patient reported outcomes measures, since there is evidence that valid process measures can be an effective tool for judging and rewarding quality. It broadly supports the continued role for the National Institute for Health and Clinical Excellence (NICE) and the introduction of quality standards in health and social care.

The BMA accepts the White Paper's proposal for the Secretary of State's continued statutory role of arbiter of last resort, but seeks clarification as to whether this will apply only to disputes between NHS commissioners and local authorities, or if it will also extend to other disputes such as those involving GPs and commissioning consortia.
Accountability and joint working

In principle, the BMA welcomes the aim of increasing local democracy in health and notes the proposed creation of local health and wellbeing boards to join up the commissioning of local NHS services, social care and health improvement. It expresses the hope that the boards will allow local authorities to take a strategic approach and promote integration across health and care services, including safeguarding. It supports the “necessary simplification and extension” of powers that enable joint working between the NHS and local authorities and hopes these arrangements will give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care. However, it would be “concerned if health issues became the subjects of local politicisation and distortion by local politicians as a result of these changes”. The BMA expresses particular concerns about the need for better accountability and strong leadership on equality and diversity.

Comment

This comprehensive response by the BMA to the NHS White Paper provides considerable food for thought for local authorities, not only in exploring in some detail concerns that are likely to be shared by local authorities, but also in shedding light on the BMA's own thinking about the relationships between health and social care on the one hand, and public health and the role of local authorities on the other. The BMA's concern about co-terminosity issues in relation to GP commissioning consortia is likely to be welcomed by local authorities, who will have similar but perhaps even more urgent concerns. Local authorities will also be interested in the BMA's strong views about how the direction of travel for the NHS outlined in the White Paper may adversely affect the greater integration of health and social care which the White Paper also advocates.

Some of the points made by the BMA about the role of Directors of Public Health will be of particular interest to local authorities. The response indicates, for example, that although the public health function is, in some senses, to be transferred to local government, the BMA still expects that DsPH will be employed by the NHS. How this will work in relation to their accountability to local authorities is not at all clear.

It may be a matter of concern to local authorities that the BMA gives very little space to discussing the proposed local health and wellbeing boards, although it does say that they should have a strategic role and should lead to mutual influencing between the NHS, public health and social care. It is not clear how the proposed new NHS commissioning structures would leave room for such influencing. The BMA's somewhat dismissive attitude to the proposed boards may give added urgency to local government's attempts to clarify their role, resources and decision-making powers and to councils' efforts to develop good relationships with local GPs and shadow commissioning consortia.

External links

- [BMA response to the Health White Paper](https://member.lgiu.org.uk/briefings/2010/Pages/201000741.asp)

Downloads

Related briefings

- [Equity and Excellence: Liberating the NHS (White Paper)]
- [Liberating the NHS - consultations: Transparency in outcomes: a framework for the NHS, and Regulating healthcare providers]
- [Consultation on local democratic legitimacy in health DH and CLG]
Department of Health and Communities and Local Government consultation on commissioning for patients

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