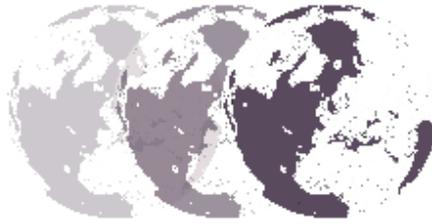


**The Centre for
International
Public Health Policy**



**Response to the Scottish Government's consultation on
arrangements for NHS patients receiving private healthcare**

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The Centre for International Public Health Policy makes the following submission under the Scottish Government's consultation on arrangements for NHS patients receiving private healthcare.

On 12 December 2008, the Scottish government published draft guidance on Arrangements for NHS Patients Receiving Private Healthcare (2008) for consultation, with comments to be returned by 12 January 2009. The guidance replaces CMO(2007)3 and the Code of Conduct for Private Practice, which restricted patients being treated as both an NHS and a private patient for the same condition during a single visit to an NHS organisation (DoH, 2004).

The key change in the draft guidance is that patients will be allowed to mix private and publicly funded care during the same NHS treatment episode:

Where, as part of their care a patient wishes to include elements of NHS care and private healthcare in combination and where this does not compromise patient safety; clinical accountability; probity; and existing treatment arrangements, NHS Boards should have arrangements in place to enable this to happen and in doing so should keep NHS and private care elements clearly separate

(Healthcare Policy and Strategy Directorate, 2008)

The guidance provides special directions for the processes to be followed where patients choose to fund some of the health care privately. It states that its provisions should be used on an exceptional basis for drug prescribing. The guidance leaves open the question of whether the principle of allowing patients to top up publicly funded NHS care with private funding will be extended to other services.

BACKGROUND

Scotland

In June 2008, the Scottish Public Petitions Committee reported on its inquiry into the appropriateness, effectiveness and availability of cancer treatment drugs within the NHS. At the heart of the enquiry was to question whether patients could self-fund cancer drugs which are not available on the NHS as part of their NHS care. Currently, patients wishing to obtain drugs that are not approved by the SRC for NHS use in Scotland, and who are refused an exceptional prescription, can purchase these drugs from the private sector, but in doing so must also purchase the rest of their care for that treatment episode from private providers. In September 2008, the Scottish Health Secretary Nicola Sturgeon announced her intention to revise guidance to NHS Boards on this issue; the current draft guidance is the result of that revision.

England

The Scottish guidance takes into account English draft guidance: *Guidance on NHS patients who wish to pay for additional private care – A consultation*, Department of Health (DoH) 4 November 2008, closing on 27 January 2009 (DoH, 2008). This guidance constitutes part of the government's response to the report by Professor Mike Richards, the UK's National Cancer Director, *Improving access to medicines for NHS patients*, published in June 2008 (Richards, 2008).

ISSUES RAISED BY THE DRAFT GUIDANCE

1 Adherence to the principles of the NHS

(i) Comprehensive service with access based on need

The guidance acknowledges that equity is foremost in the NHS. It states that "the NHS is meant to provide a comprehensive service available to all, with access based on clinical need rather than an individual's ability to pay" (Healthcare Policy and Strategy Directorate, 2008).

Combining public and private funding of treatment creates a two-tiered system of care, where patients who can afford it may top up publicly funded NHS care. This position is endorsed by witnesses to the Public Petitions Committee who included Deputy First Minister and Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon; Professor Peter Johnson, chief clinician of Cancer Research UK; MSP Rhoda Grant; and Professor Alan Rodger, medical director of the Beatson Oncology Unit (Public Petitions Committee, 2008a and 2008b).

As stated by NHS Grampian (2008)

It seems neither ethically nor morally appropriate that patients should self-fund in a national health service that espouses to be free at the point of delivery. An anomaly is created between those who can afford to pay potentially being advantaged over those who cannot.

(ii) Cost-sharing and its impact on the poor

The NHS Plan 2000 for England states:

Charges are inequitable in two important respects. First, new charges increase the proportion of funding from the unhealthy, old and poor compared with the healthy, young and wealthy. In particular, high charges risk worsening access to healthcare by the poor. As the World Health Organisation report – which assessed the United Kingdom as having one of the fairest systems in the world for funding healthcare – concludes: ‘Fairness of financial risk protection requires the highest possible degree of separation between contributions and utilisation’. Second, exempting low income families from user charges can create inequities for those just above the threshold. High user charges with exemptions can create disincentives to earning and working through the imposition of high marginal tax rates (DoH, 2000: p. 37)

In their 2005-2006 report *NHS Charges*, the Health Select Committee’s view was that private health funding is regressive and acts as a barrier to treatment. The report cites a UK survey conducted in 2001 which indicated that 28% of individuals liable for the prescription charge did not have all of their medications dispensed in full. Further, a survey of people in England and Wales estimated that each year 750,000 people did not have their prescriptions dispensed due to the cost of the co-payment. They also stated that UK evidence indicates that single parent households and individuals with long-term conditions face stronger barriers due to the costs of prescriptions (Health Committee, 2006). Further, the Committee’s document on NHS Charges states that there are no comprehensible underlying principles guiding charges in the NHS and that the system has many anomalies (Health Committee, 2006).

In the US, cost-sharing and co-payments are associated with risks of catastrophic health costs. In the United States, half of American families that filed for bankruptcy in 2001 cited medical costs, with 47.6% of those families listing drug costs as a contributor to these. Further, prescription medications were listed as the biggest contributor to medical expenses by 22% of those who filed for bankruptcy due to medical costs, and by almost all those with Medicare coverage (Himmelstein et al., 2005).

2 The separation of responsibility for public and private provision

The Scottish government’s guidance states that “where, as part of their care a patient wishes to include elements of NHS care and private healthcare in combination ... NHS Boards should have arrangements in place to enable this to happen and in doing so should keep NHS and private care elements clearly separate” (Healthcare Policy and Strategy Directorate, 2008). The document does not specify what mechanisms can be put in place to ensure that NHS and private care remain distinct.

The guidance states that:

- in all cases, it must be clearly understood by all parties involved whether an individual procedure or treatment is privately funded or NHS funded.
- the NHS should never subsidise private care with public money, which would breach core NHS principles.

However, the guidance does not show how these requirements can be fulfilled. NHS Grampian's statement to the Public Petitions Committee was that "it is not practically possible to make the separation in the way the health department letter suggests – we have difficulty with this because it places us in the difficult position of having to make judgments on a case-by-case basis". Further, the Public Petitions Committee (2008c) acknowledge in their report "that it is simply not possible to split pro rata a patient's treatment costs between that received privately and that on the NHS".

3 Conflicts of interest – both public and commercial

NHS staff could find themselves compromised by advising on privately funded care within the same NHS treatment episode, especially where they have private practice interests. Clinicians with a pecuniary interest may find their own judgement is clouded (Harding, 2006; Pitches et al., 2003; Yates, 1995).

4 Clinical accountability

The guidance states that "there should be clear separation of legal status, liability and accountability between NHS care and any private care that a patient receives". However, it does not provide further clarification of how separation will be achieved.

For example, if a patient is prescribed a drug privately and subsequently experiences a serious adverse reaction which requires treatment, is the NHS responsible to pay for the services required by the patient, or should they be charged to the private provider? Who will be responsible for monitoring these situations to ensure that the appropriate provider bears the risks costs? How will the patients and physicians deal with allocation of risk and responsibility for combined therapies, such as cancer treatments?

Nicola Sturgeon raised these concerns in her testimony to the Public Petitions Committee (2008b), stating that "if treatment is divided between the NHS and the independent sector, the lines of clinical accountability become blurred, which can have serious implications". Ms. Sturgeon made it clear that this possibility presents 'real dangers' for patients (Public Petitions Committee, 2008b).

Professor Rodger expresses this issue as one of clinical governance:

Someone might get three drugs through the NHS and one through the private sector. They might all have to go in through an intravenous line. That costs money. The NHS would put in the line. If it got infected, would it be the NHS's responsibility or the private sector's responsibility? If the patient becomes severely ill as a result of the combination of drugs, would they go into the private sector because it was the expensive, non-approved drug that caused the trouble? It might not have been the expensive drug that caused the trouble. How do you work that out? I can tell you that, in such circumstances, the patient would come straight back into the NHS under 'unscheduled care.

(Public Petitions Committee, 2008c).

5 Legal liability

It is unclear how legal liability will be determined when treatment is mixed between public and private. As Dr. Jean Turner of the Scotland Patients Association stated, “I can see the difficulties with mixing NHS and private care, which include difficulties with insurance and risk. If treatment takes place wholly within the NHS, the NHS carries all the risk. When treatment is part private, that is difficult”. (Public Petition Committee, 2008a). How will patients determine which sector is liable if and when things go wrong? How will they navigate the complaints and litigation processes?

6 Transaction costs

According to the guidance, “NHS providers are responsible for recovering all appropriate charges from private patients.” Administrative costs will be incurred as a result of new billing arrangements, as well as the costs of monitoring and regulation. How will these costs be met and how will they be budgeted for?

7 Parallel system of funding and delivery

If the core principles of the NHS are ceded, as is being done in England, the implications for broader NHS services are that the provision of privately funded drugs will require a privately funded delivery system, leading to the creation of a parallel healthcare system. In England, Europe’s largest pharmaceutical distribution and retail company, Celesio, has launched a service company, Evolution Homecare, that not only delivers privately funded drugs to patients’ doors, but will organise privately funded nurse visits to guide patients through their treatment (Evolution Homecare).

8 Erosion of entitlements to NHS care

This guidance could set a precedent, leading to the extension of this policy to other treatment areas. The loss of entitlements through delisting could lead to broader cost-sharing for the public, a policy that is regressive and has had demonstrable negative effects around the world. The practice of delisting or removal of entitlements to NHS care is best exemplified in the NHS in long-term care and dentistry, where increasingly the risk and the responsibility for funding is devolved to individuals and where there are widening inequalities in access to care (Ben-Shlomo and Chaturvedi, 1995; Drugan et al., 2007; Gilthorpe and Bedi, 1997; Landes et al., 2004; Maunder et al., 2006; Moles et al., 2001; Royal Commission on Long Term Care, 1999; Walls and Steele, 2001).

In the US, where the policy of mixing funding originates, co-payments are used by HMOs to reduce service costs. The ability to charge inevitably results in delisting, limiting eligibility and entitlement to public services or the introduction of private insurance policies. The US has a large body of evidence showing the way in which HMOs engage in fraud and denial of care when the option is open to restrict eligibility (Simonet, 2005).

CONCLUSIONS / RECOMMENDATIONS

The evidence supports the testimony of the Cabinet Secretary for Health and Wellbeing, Ms. Sturgeon, to the Public Petitions Committee report (2008b), in which she stated:

The NHS provides health care free at the point of need, and equity of access is the fundamental principle of the NHS. A system that in effect allows people to top up the care that they get on the NHS by paying privately for part of their care raises the danger of a two-tier system in which people who can afford to pay for bits of their care privately do so and people who cannot afford such care are denied it.

Recommendations

- This draft guidance should not be implemented as it is not compatible with the core principles of the NHS.
- If treatments are deemed to be effective then they should be available free at the point of delivery on the NHS.
- If the issue is the cost of pharmaceuticals then government should investigate the price and costs of drugs. Mike Rawlins, the Chairman of NICE, has stated that the drugs industry overprices vital new medicines in order to boost profits (Hinsliff, 2008).
- The government needs to review current price control mechanisms, particularly value-based pricing, as mentioned in the Public Petitions Committee's reports (2008a and 2008b) by Dr. Peter Johnson and MSP Nicola Sturgeon (for further details, see Jayadev and Stiglitz, 2008).
- As stated by NHS Grampian (2008) "Certainly questions should be asked of the medicine manufacturers as to why many oncology medicines remain so expensive relative to other medicines."

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