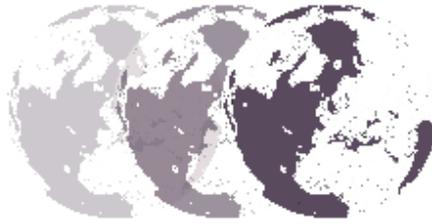


**The Centre for
International
Public Health Policy**



**Response to the Department of Health's consultation on
guidance for NHS patients who wish to pay for additional
private healthcare**

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Conclusion

- **This policy and the guidance is contrary to the goals of the NHS and the principles of universality, equity, and service provision on the basis of need rather than ability to pay, and should be withdrawn.**
- **The guidance claims that it is possible to separate public and private funding and delivery and put in place mechanisms and safeguards for this. All the evidence shows that it is not.**

Recommendations

- Treatments and services that are deemed to be effective should be available free at the point of delivery on the NHS. This founding principle of the NHS is inviolable.
- In the light of comments by the chairman of the National Institute for Healthcare & Clinical Excellence (NICE) on excessive prices of pharmaceuticals and the Office of Fair Trading (OFT) inquiry into the Pharmaceutical Price Regulation Scheme (PPRS)^{1,2}, the government should investigate the price and costs of drugs and seek to control NHS drugs expenditure by more efficient price regulation, not by opening up new funding mechanisms. It should explore the potential of the revised Pharmaceutical Price Regulation Scheme, in effect since 1 January 2009, to lower prices on oncology drugs.
- The government should also explore other measures for the control of prescription costs, such as the use of generics and the restriction of the pharmaceutical industry's attempts to influence GPs' prescribing patterns, as highlighted by the National Audit Office³.

What is being consulted on

England

On 4 November 2008, the Department of Health published its *Guidance on NHS patients who wish to pay for additional private care – a consultation*⁴, closing on 27 January 2009. 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*⁵, published in June 2008.

The key policy change addressed by the guidance is that patients will be allowed to mix private and publicly funded care during the same NHS treatment episode: "Patients may pay for additional private healthcare while continuing to receive care from the NHS."⁴

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 after all reasonable avenues for securing NHS funding have been exhausted. The guidance will allow patients to top up publicly funded NHS care with private funding for services other than drug prescribing.

Scotland

In June 2008, the Scottish Public Petitions Committee (PPC) reported on its inquiry into the appropriateness, effectiveness, and availability of cancer treatment drugs within the NHS⁶. At the heart of the enquiry was the question as to 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 Scottish Medicines Consortium 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.

On 12 December 2008, the Scottish government published draft guidance on *Arrangements for NHS patients receiving private healthcare* for consultation, with comments to be returned by 12 January 2009⁷. 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.

Unlike Scotland, where the consultation addresses the substantive issue of the principles and values of the NHS, the DH England appears to have departed from the NHS principles and is looking to establish a parallel privately funded and delivered system that can be implemented alongside the NHS.

Issues raised by the DH English guidance

1 Adherence to the principles of the NHS

(i) Comprehensive service with access based on need

The guidance undermines the principles of the NHS that “the NHS provides a comprehensive service, available to all” and that “access to NHS services is based on clinical need, not an individual’s ability to pay”⁴.

This policy also undermines Prof Mike Richards’ report, which states that a system of NHS top-ups whereby patients would pay a user charge to receive additional drugs “presents significant challenges and is inequitable for those NHS patients who could not afford to top up.”⁵

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 Scottish PPC who included Deputy First Minister and Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon; Prof Peter Johnson, chief clinician of Cancer Research UK; MSP Rhoda Grant; and Prof Alan Rodger, medical director of the Beatson Oncology Unit^{8,9}.

As stated by NHS Grampian¹⁰

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) The evidence behind 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.¹¹

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 that 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. 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 anomalies¹².

In the US, cost-sharing and co-payments are associated with risks of catastrophic health costs. Half the families that filed for bankruptcy in 2001 cited medical costs, with 47% 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 coverage¹³.

2 *The separation of responsibility for public and private provision*

The guidance states that

- the NHS should never subsidise private care with public money, which would breach core NHS principles; and therefore
- it should always be clear whether an individual procedure or treatment is privately funded or NHS funded

However, the document does not provide specific guidance on how trusts shall maintain the distinction between public and private care, nor does it explain how this will be monitored. NHS Grampian advised the Scottish PPC 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 basis¹⁰.

Further, the PPC 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.”⁶

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 clouded¹⁴⁻¹⁶. The guidance includes a cursory call for NHS clinicians who carry out private care to avoid any actual or perceived conflict of interest. It does not, however, describe how this will be monitored and regulated.

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.”⁴ 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 and costs? How will the patients and physicians deal with allocation of risk and responsibility for combined therapies, such as cancer treatments, where some drugs are provided by the NHS and others through the private sector?

Nicola Sturgeon raised these concerns in her testimony to the PPC, 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 patients⁹

Prof 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’.⁶

The guidance states that the NHS should not be expected to meet any predictable costs from the private element of care, yet it should continue to treat patients in an emergency. This means that the public sector’s tax-funded budgets will be expected to absorb the costs of treating side effects of privately-provided drugs, which may indeed be the rationale for the failure of NICE to approve certain drugs.

5 *Legal liability*

It is unclear how legal liability will be determined when treatment is mixed between public and private. The guidance states that “it should always be clear which clinician and which organisation are responsible for the assessment of the patient, the delivery of any care and the management of any complications”, but does not explain precisely how this can be done.

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.⁸

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, “the patient should bear the full costs of any private services.”⁴ Administrative costs will be incurred for the public sector 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 *Erosion of entitlements to NHS care will lead to a parallel private healthcare system*

This guidance sets a precedent, leading to the extension of this policy to other treatment areas and the loss of entitlements across the NHS. The loss of entitlements, known as delisting, could lead to more patient charges 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 care¹⁷⁻²³.

In the US, where the policy of mixing funding originates, co-payments are used by health maintenance organizations (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 eligibility²⁴.

The implications for the NHS are that enabling private funding of treatments and services will result in the creation of a parallel private 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 treatment²⁵.

8 *Cost control in the NHS*

This policy has primarily emerged out of the controversy and criticism surrounding the rationing of pharmaceuticals by NICE. Mike Rawlins, the chairman of NICE, has stated that the drugs industry overprices vital new medicines in order to boost profits¹. The OFT report on the PPRS² criticised the failure of the PPRS to achieve its objectives with respect to clinical value

We recommend that government reform the PPRS, replacing current profit and price controls with a value-based approach to pricing, which would ensure the price of drugs reflect their clinical and therapeutic value to patients and the broader NHS.

Conclusions

The evidence supports the testimony of Nicola Sturgeon to the PPC report⁹, 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.

- This policy and the guidance is contrary to the goals of the NHS and the principles of universality, equity, and service provision on the basis of need rather than ability to pay, and should be withdrawn.
- The guidance claims that it is possible to separate public and private funding and delivery and put in place mechanisms and safeguards for this. All the evidence shows that it is not.

Recommendations

- Treatments and services that are deemed to be effective should be available free at the point of delivery on the NHS. This founding principle of the NHS is inviolable.
- In the light of comments by the Chairman of NICE on excessive prices of pharmaceuticals and the OFT inquiry into the PPRS^{1,2}, the government should investigate the price and costs of drugs and seek to control NHS drugs expenditure by more efficient price regulation, not by opening up new funding mechanisms. It should explore the potential of the revised Pharmaceutical Price Regulation Scheme, in effect since 1 January 2009, to lower prices on oncology drugs.
- The government should also explore other measures for the control of prescription costs, such as the use of generics and the restriction of the pharmaceutical industry's attempts to influence GPs prescribing patterns, as highlighted by the National Audit Office³.

Sources

- 1 Hinsliff G. Health chief attacks drug giants over huge profits. *The Observer* 17 August 2008.
- 2 Office of Fair Trading. *The pharmaceutical price regulation scheme*. London: OFT 2007.
- 3 National Audit Office. *Prescribing costs in primary care*. London: The Stationery Office 2007.
- 4 Department of Health. *Guidance on NHS patients who wish to pay for additional private care – a consultation*. Department of Health 04 November 2008.
- 5 Richards M. *Improving access to medicines for NHS patients: A report for the Secretary of State for Health*. Department of Health November 2008.
- 6 Scottish Parliament Public Petitions Committee. *Availability on the NHS of cancer treatment drugs*. SP Paper 133. 3rd Report: 2008.
- 7 Healthcare Policy and Strategy Directorate. *Arrangements for NHS patients receiving healthcare. Proposed revised guidance to NHS boards – For consultation*. 12 December 2008.
- 8 Scottish Parliament Public Petitions Committee. *Cancer treatment drugs inquiry. Public Petitions Committee Official Report* 29 April 2008.
- 9 Scottish Parliament Public Petitions Committee. *Cancer treatment drugs inquiry. Public Petitions Committee Official Report* 13 May 2008.
- 10 NHS Grampian, Office of Chief Executive. *Public Petitions Committee inquiry into availability on NHS of cancer treatment drugs* 07 April 2008.
- 11 Department of Health. *The NHS Plan: a plan for investment, a plan for reform*. London: The Stationery Office 2000.
- 12 Health Committee, House of Commons. *NHS charges, third report of session 2005-2006, vol 1*. London: The Stationery Office 2006.
- 13 Himmelstein DU, Warren E, Thorne D, Woolhandler S. Illness and injury as contributors to bankruptcy. *Health Affairs* 2005 Feb; web exclusive: w63-w73.
<http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1> Accessed 27 January 2009
- 14 Harding M. Payment by results wide open to fraud, say commissioners. *Health Services Journal* 23 Feb 2006, p10.
- 15 Pitches D, Burls A Fry-Smith A. Snakes, ladders and spin: how to make a silk purse from a sow's ear – a comprehensive review of strategies to optimise data for corrupt managers and incompetent clinicians. *British Medical Journal* 2003; 327: 1436-9.
- 16 Yates J. *Private eye, heart and hip: surgical consultants, the NHS and private medicine*. London: Churchill Livingstone 1995.
- 17 Drugan CS, Hamilton S, Nagvi H and Boyles JR. Inequality in uptake of orthodontic services. *British Dental Journal* 2007; 202(6): E15.
- 18 Gilthorpe MS and Bedi R. An exploratory study combining hospital episode statistics with socio-demographic variables, to examine the access and utilisation of hospital oral surgery services. *Community Dental Health* 1997; 14(4): 209-13.
- 19 Landes DP, Adams GC, Whiston S. Distribution of NHS resources for children's dental care in general dental practice in England. *Community Dental Health* 2004; 21(2): 149-54.
- 20 Maunder P, Landes DP and Steen N. The equity of access to primary dental care for children in the North East of England. *Community Dental Health* 2006; 23(2): 116-9.
- 21 Moles DR, Frost C and Grundy C. Inequalities in availability of National Health Service general dental practitioners in England and Wales. *British Dental Journal* 2001; 190(10): 548-53.
- 22 Royal Commission on Long-Term Care for the Elderly. *With respect to old age long term care - rights and responsibilities*. London: HMSO 1999.
- 23 Walls AW, Steele JG. Geriatric oral health issues in the United Kingdom. *International Dental Journal* 2001; 51(3 suppl): 183-7.
- 24 Simonet D. Where does the US experience of managed care currently stand? *International Journal of Health Planning and Management* 2005; 20: 137-57.
- 25 Evolution Homecare. <http://www.evolutionhomecare.co.uk/Pages/About-Evolution.aspx>. Accessed 5 January 2009.