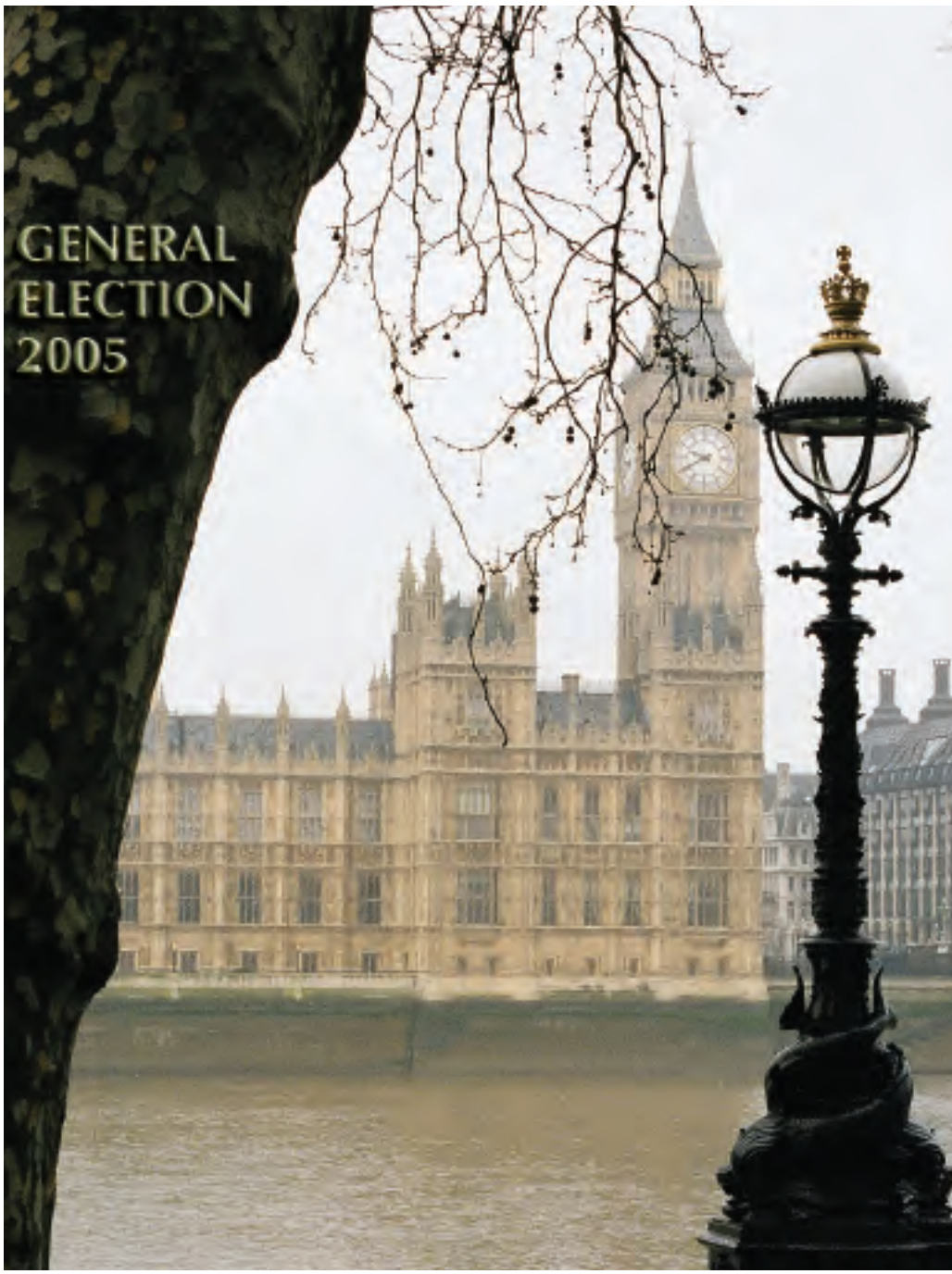
A vote to improve health

March 2005



improving | health

BMA

Doctors in all branches of medicine play a vital role in improving people's health and the quality of healthcare. They are committed to a health service that is properly resourced, comprehensive, free at the point of delivery and provides equal access for all.

The NHS is not as good as it could be and doctors share many of the political parties' stated aims to improve it – making care more patient-centred, improving information to underpin their choices, shortening waiting times, reducing bureaucracy and devolving decision-making to front-line clinicians in a health system that is based on clear standards and pathways of care. But a number of challenges need to be faced if these aims are to be made a reality and visibly improve the NHS.

The BMA challenges all political parties to say how they will...

...improve public health, helping people to lead healthier lives

Gross health inequalities continue to exist within the UK and immediate action is necessary to redress these. There are intolerable differences in health status between groups, and the infrastructure to tackle these problems, both within and outside the NHS, is weak. The incoming government must make public health policy more coherent and a clear national priority. People have to make their own choices, but the government has a responsibility to inform these fully, to encourage healthy choices and to ensure that the choices of some do not damage the health of others.

...make patient choice meaningful and relevant to patients

All political parties talk about improving patient choice and doctors strongly support greater choice for patients. But choices have to be genuine and meaningful. They cannot be delivered simply by buying more private provision or introducing a market where providers compete for referrals. Choices are needed in relation to treatment options and different pathways of care. Choice depends on strengthening the patient-doctor relationship. GPs have a crucial role to play in supporting and developing choices, and coordinating care.

...recognise limits to the role the private sector can play, and strengthen the NHS

There are limits to the role of the market in healthcare and the NHS should remain the principal driver of healthcare improvement. The private sector does not provide a comprehensive 24-hour emergency service or medical training. It avoids patients with chronic or multiple problems. Diverting investment from the NHS to the private sector will do little to solve the problems of the NHS and in the long term may worsen them by damaging mainstream healthcare. As services move to the private sector, NHS departments come under pressure to close. There is a danger that, as currently constructed, policies are relocating capacity instead of adding to it. The private sector must be employed to serve the strategic aims of the NHS, not the other way around.

...involve doctors, patients and the public in the formulation of policy and reform initiatives

Policies are too often developed without the involvement of doctors' representatives, patients and the public. The result is that they are sometimes impractical to implement or miss some vital aspect of patients' interests. Doctors should be involved at an early stage of all health policy development so that policies are workable in practice and, as a result, are more likely to be welcomed and implemented effectively by doctors.

...invest in doctors to enable them to lead improvement across the NHS

Doctors are at the core of improving the NHS, educating future professionals, transferring new knowledge into service improvements and redesigning care in a more patient-centred way. There must be investment in the medical profession, which must be expanded so doctors can work effectively with others to improve care across the NHS.

The new government must improve public health, helping people to lead healthier lives

It is widely accepted that the health of an individual depends on lots of factors, not all of which are within the control of the health departments. Income, diet, access to sports facilities, quality of housing and family relationships are all key influences.

Securing good health for the whole population will mean coordinating policy across different government departments to ensure policy in one area does not undermine it in another. Achieving coordinated working between health, education, social services and transport policy is a central challenge that will require sustained cross-departmental collaboration and on-the-ground policy. Public health policy must be more coherent and have a clearer national policy.

Government should provide support so people can make informed choices.

- The government should follow the leadership shown in Scotland and introduce, before the end of 2005, an end to smoking in all enclosed workplaces. Second-hand smoke kills and every year of delay results in more than 600 preventable deaths in the workplace. Smokefree laws are workable and enforceable and must be introduced to protect the health of **all** staff.

- Sexual health services must receive sufficient resources to reduce waiting times for assessment and treatment. This is crucial to stem the increasing incidence of sexually transmitted infections.

- Alcohol causes huge social and physical damage. Binge drinking, particularly among young people, causes both acute and chronic health problems. The action needed includes promoting sensible drinking, labelling drinks with their units of alcohol, more intensive public education and tighter regulation of drink promotion and the licensing of premises.

- Tackling MRSA is everyone's responsibility. Resources must be in place to ensure that doctors and nurses can clean their hands before and after contact with patients. Hospitals should give health professionals with expertise in infection control a greater say in management issues, and cleaning staff should be valued properly. NHS Trusts should be assessed on the effectiveness of their infection control measures.

- Proposals to manage long-term conditions better should be further developed. Careful consideration is needed about exactly how community matrons will integrate with general practices and the ways in which local systems can be developed to identify and support patients at risk of needing a hospital admission.

The new government must make patient choice meaningful and relevant to patients

Placing patients at the centre of the healthcare system is a vital reform and doctors strongly support this aim.

Patients and doctors wish to see choice that is meaningful and involves patients bringing their preferences to bear on the way their care is managed. Choices are needed in relation to different pathways of care between which patients can choose. Evidence shows that most patients would choose good quality services close to their home.

Developing and sustaining patient choice depends on maintaining and strengthening the patient-doctor relationship, particularly the GP-patient relationship. There is still a lot of work to be done before the IT systems to allow patients and GPs to book referral appointments electronically can work effectively. The IT system is still being developed and GPs are unclear how it will affect consultations. There are concerns the system will not protect patient confidentiality.

Doctors worry that patient choice will favour the more articulate and informed. If information – and therefore choice – about healthcare is only available to these people, the patients who most need to be empowered will be

disadvantaged. The most vulnerable people within our society also need access to choices.

Making choice meaningful is a long-term agenda and will involve improving information about conditions and illnesses, and how this is conveyed to different groups. It will mean developing a better understanding about what different groups want from the healthcare system as the very nature of individual choice means preferences will vary. How best to increase capacity in the service to support longer patient-doctor consultations that will be necessary if choice is to be developed properly will need to be examined.

Patient choice should not be dependent on a market or competition, neither should it be skewed by spurious targets relating to the level of private-provider use. It does, however, depend on spare capacity, which currently does not exist. The UK is still very short of the doctors, nurses and health professionals needed to run a high quality 21st century health service.

Until the first internal market was introduced, GPs could refer patients to any hospital in the country if this is what they and the patient agreed. This level of choice should be re-established. A GP's freedom to refer would provide true choice for patients rather than the limited options proposed. It would also help GP practices to commission services (practice-based commissioning).

Doctors worry that choice appears to be little more than a euphemism for increased private involvement in healthcare and competition between institutions that provide care. Doctors fear that patient choice is becoming a hollow phrase more centred on creating incentives for hospitals to compete rather than offering patients genuine options.

The new government must recognise limits to the role the private sector can play, and strengthen the NHS

It is clear that there is a fundamental shift in the balance between public and private provision in the health service. The BMA believes that the market in healthcare should have clear limits.

The private sector should be employed in pursuit of NHS aims and not the other way round. The private sector has a role in clearing waiting lists and in providing services to underserved communities. But while there may be a place for strategic employment of the private sector in some areas, the health system should be predicated on the mainstream NHS as the dominant provider of healthcare.

There are lots of ways in which the NHS could lead reform. For example, more efficient use could be made of expensive equipment by making funding available to extend their use during evenings and weekends.

The BMA acknowledges the potential role for treatment centres to cut waiting times in the short term and therefore to benefit patients whose quality of life is being seriously impaired while they wait for medical treatment. However, they should not be allowed to destabilise NHS hospitals' economies. Treatment centres must add to NHS capacity and not replace, or even worse, undermine it.

Current policy in England is predicated on a new financial system called payment-by-results. The aim is that each treatment has a cost (tariff) associated with it and a whole range of providers, both public and private, will compete for patients and the money that goes with them.

Unfortunately, this new competitive market, as currently configured, works against the NHS. While NHS institutions have to compete for patients (and income) the contracts for independent treatment centres offer a guaranteed flow of income and they do not have to compete.

At a time when many NHS Trusts are experiencing significant financial difficulties, primary care trusts in England have

been ordered to spend up to 15% of their elective budget with private providers to build capacity for competition. This does not take into account patient choice and whether local patients want this or will benefit from it.

It is right that money should follow patients, but financing healthcare through payment-by-results can only work equitably if all parties are treated equally and if the system is not skewed in favour of private sector providers. Payment should cover a whole pathway of care whereas at the moment it is predicated on secondary care. Tariffs must be fair and accurate and not incentivise unnecessary investigations or treatment.

The loss of even a small part of Trusts' income to the private sector could have very serious consequences on patient services because of the high fixed costs of most NHS healthcare.

The payment-by-results regime needs to be robust to prevent financial distortion and 'cherry picking' of services by private sector providers. Already, the guaranteed volume for independent sector treatment centres is leading to pressures on certain NHS services to close, thereby threatening the other, less commercially attractive services these providers offer.

There is a serious threat to training and the future medical workforce if certain treatments are moved outside the NHS No department or hospital should close without a strategic review of its role in the local health economy.

The new government must involve doctors, patients and the public in the formulation of policy and reform initiatives

To ensure that NHS facilities are not destabilised or fragmented, efforts must be made to involve doctors at the earliest possible opportunity in decisions about the planning and design of services, and when making decisions on how new money for the NHS should be spent.

Too often, policies are developed without the involvement of doctors' representatives, patients and the public with the result that they are sometimes impractical to implement, miss out some vital aspect of patients' interests or are not supported by doctors. A good example of this failure lies within the National Programme for IT.

Patients must be treated according to their clinical need with an effective new standards regime replacing the current targets that distort clinical decisions. All NHS providers – public, private and, in the case of foundation trusts those that are somewhere between the two – must have the quality of their service gauged on exactly the same basis with clinical standards paramount in the process of assessment.

The patient's journey must be improved by developing more integrated services across health and social care that are patient-focussed.

There is a danger that uncontrolled competition, plurality and payment-by-results will result in a greater fragmentation of care.

The incoming government must look at health services from the perspective of the patient and the pathway of care they embark on. As much focus should be placed on the potential gaps between services as the care received within particular institutions. Components of health services that should be taken into account include services provided in the patient's home, the community they live in, care centres, the emergency department, hospital areas other than A&E and intermediate care.

The incoming government must invest in doctors to enable them to lead improvement across the NHS

Doctors are at the core of treating patients, improving patient care, educating future professionals, transferring new knowledge into service improvements and redesigning care in a more patient-centred way. The medical profession must be valued, further invested in, and freed from political interference to work with other professionals and managers to improve care across the NHS.

The UK has first class doctors but the supply does not match the demand. Providing proper working conditions and reward are essential for the delivery of high quality healthcare to the population. The steady haemorrhage of qualified doctors from the NHS should be a matter for national concern and every effort made to improve conditions of service so they are made sufficiently attractive to keep qualified doctors in post and attract new recruits.

- **The developed world should be working towards achieving self-sufficiency in doctors and nurses over the next decade.** The NHS owes an enormous debt to its internationally qualified staff and the government should ensure that they are made welcome and their contribution valued. While doctors have the right to choose to migrate for training and development purposes, it seems iniquitous that wealthy, developed, English-speaking nations like the UK and the USA should be draining poorer countries of scarce medical manpower.

- **There should be open access to enter medical courses for those with the desire and merit regardless of class, disability or gender.** Access to medicine should be made more available to students from low-income families, and students should be chosen for aptitude rather than pure academic excellence. The BMA is striving to ensure that the medical profession reflects the population it serves.

- **Investment in academic medicine, with supporting organisational performance measures for teaching and research activities, should be a key concern for an incoming government.** Medical academics train the future generation of doctors, innovate through medical and health services research, and provide leadership and high quality patient care in the NHS. At a time when medical student numbers are increasing, there has been a decline in the numbers of medical teaching staff because of some universally acknowledged disincentives to this career, including a heavy workload, lack of career stability, insufficient recognition of the value of teaching by universities, and an under-valuing of medical research by the Research Assessment Exercise.

- **Urgent action is essential to ensure that plans for junior doctor training will be feasible in practice.** The first phase of the Department of Health's plans for reform of the postgraduate medical education and training of junior doctors – modernising medical careers (MMC) – will be implemented for new medical graduates as soon as August 2005. Adequate funding for training is essential, the collection of full and accurate medical workforce data is currently seriously inadequate and time and resources must be allocated to consultants and trainers for new methods of training and assessment.

- **The NHS should lead the way in breaking traditional thinking about childcare.** Doctors, medical students and other NHS staff work shifts that cover the full 24 hours each day so childcare has to be available to support them if the NHS is to get full value from the available workforce.

- **The provision of flexible employment opportunities is important to aid recruitment and retention, particularly in rural areas.**

- **Agreed contracts for consultants, GPs and others must be implemented and funded properly throughout the UK.** This is to ensure that doctors are treated equitably in all four countries and that all doctors have equality of opportunity.

- **Improving the working conditions of staff and associate specialist doctors is essential to the modernisation of the NHS and the improvement of patient care.** This group of doctors has direct contact with patients in hospitals and provides crucial services to those patients. Morale is very low because their contribution to the NHS has gone unrecognised for too long. Their skills, experience and hard work must be properly rewarded. The new contract about to be negotiated must provide improved opportunities for training, career progression and better pay and terms of service. A successful contract must be a priority for any new ministerial health team.

- **GPs must be placed at the centre of a modern, efficient, and high quality care service.** The government must recognise and value list-based, holistic care provided by GPs and their primary healthcare teams. GP practices should be the centre for development in the future. Properly funded, staffed and equipped, services delivered by the GP surgery will be cost-effective and best for patients. The quality and outcomes framework in the new GP contract (QOF) demonstrates that GPs are delivering high quality chronic disease management to patients.

- **The support GPs give to community hospitals should be acknowledged and adequately rewarded.** There should be a new deal for GPs working in community hospitals. A start would be to enter into meaningful UK-wide negotiations on the contractual arrangements for such GPs. Community hospitals relieve pressure on the secondary sector and ensure that high technical facilities in hospitals are freed for those patients who require them. GPs serving in community hospitals are undervalued and unrewarded. They bring experience, skills, commitment and clinical responsibility to this area of their work.

- **NHS Trusts should ensure that members of interview panels and selection committees receive equal opportunities awareness training.** Trusts should run training sessions on diversity and equality as part of their induction programmes for newly appointed doctors. Such training would help to increase awareness of equality and diversity issues, and provide doctors with contact details of individuals and organisations that could advise them if they felt they were being treated unfairly.

- **There should be a fully comprehensive NHS occupational health service for all doctors, including GPs and medical students.** This should be an unarguable commitment for any state employer. Specialists who are experienced in dealing with the needs of people with disabilities should be available to provide advice for doctors and students.

- **The NHS Pension Schemes should not be reduced in value.** They should be funded properly and designed to encourage the recruitment and retention of doctors to the workforce, rewarding those who wish and are able to stay in the NHS. It is unacceptable to renege on contractual expectations for those already in NHS employment. Penalties should not be imposed if doctors are unable or unwilling to continue beyond the normal pension age of 60 (55 for mental health officers).

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