

UK must hold its nerve on NHS reform

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Radical change is needed in the British healthcare system but some long-term thinking is required first, argues Helen Disney

Britain's coalition government is developing a reputation as a group of radical reformers. Love them or hate them, one thing this government cannot be accused of is timidity. Almost every area of policy is up for grabs - including prominent reforms to most aspects of the United Kingdom's healthcare system.

Not a huge amount was said by the Conservative Party about healthcare reform before the last election, aside from some high-profile comments about public health. Seen as the party's Achilles heel, most of the discussion revolved around reassuring the public of David Cameron's personal commitment to the NHS. But over the last year, a series of proposals and white papers have been launched - which suggest that the Tory commitment to the NHS is to save it by reforming it, rather than by simply throwing more money at the same set of problems. This is not least because, in the aftermath of the financial crisis, more spending is no longer a viable option.

Three key areas of reform are currently being proposed, all of which have attracted the inevitable controversy which surrounds any attempt to meddle with this most sacred cow of British politics. On the provider side, the coalition plans to abolish the existing Primary Care Trusts and move towards commissioning carried out directly by general practitioners. In terms of access to medicines, the government plans to bring in a new value-based pricing system for reimbursing the pharmaceutical industry for new medicines. Meanwhile, the new Public Health White Paper focuses mainly on the issue of tackling health inequalities.

Of these three changes, the most high-profile and contentious issue is the change to the way primary care is provided. So what are the issues and what impact will these changes have on patients and on the long-term future of the NHS? The Health and Social Care Bill aims to achieve huge improvements for patients. At its heart is the principle of local decision-making. General practitioners or family doctors, who tend to know their patients best, will in future be empowered to seek out and commission the best treatment.

But, in a report published early in April, the British think-tank Policy Exchange recommended that the 2013 deadline for all GPs to form consortiums should be relaxed. They believe a longer timeframe for change to take effect will make the reforms deeper and better. Research conducted with GPs in Cumbria, where the new system has been trialled, shows that many prefer it. But others need to have hard evidence that the system will bring real benefits. New providers from all sectors - public, private and voluntary - need more detail on how they will fit into the system.

Without it, there is a risk that these organisations will lack the confidence to implement the reforms over the longer-term. As Policy Exchange director Neil O'Brien has pointed out, rushing into reform could mean greater timidity - leaving a system that looks a great deal like the current one, with PCTs simply surviving under a different name. Andrew Lansley's new "listening exercise", therefore, needs to restore that sense of confidence - which is now on rather shaky ground after media scaremongering about the role of commercial firms and the spectre of "privatisation".

Meanwhile, when it comes to new medicines, it is not quite clear yet how the new value-based pricing mechanism will work out and whether it will indeed be an improvement on the decisions formerly made by the National Institute for Health and Clinical Excellence. Ideally, the system would allow for a more nuanced approach to access to medicines, working closely with GPs to understand where exceptions may be warranted and continuing to explore the use of patient access schemes, which can help widen access to the more expensive new treatments.

But can VBP really guarantee greater patient access when it continues to use cost thresholds, above which the NHS refuses to reimburse a particular treatment? And will this pricing system simply reinforce the one-size-fits-all approach to healthcare in the NHS, which concentrates on the value of drugs to all patients and not the individual patient that needs them? Significant doubts remain about the effect of VBP and some may not become clear until it is fully implemented, by which time it could be too late. Health policy experts now need to keep watching carefully and continue loudly asking the right questions to make sure that radical reform does, indeed, turn out to be the saviour of the NHS and not merely the cause of more ill-health.

Helen Disney is chief executive of the Stockholm Network