

Gesundheit!

Stockholm Network Health and Welfare Newsletter

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Commentary - Free Radicals?

Helen Disney, chief executive of the Stockholm Network

The UK's coalition government is developing a reputation as a group of radical reformers. Love them or hate them (and the latest round of student protests show that they are by no means universally popular), one thing this government cannot be accused of is timidity. Almost every area of policy is up for grabs from schools and universities, through to the police, welfare reform and healthcare.

Except for some comments about public health, not a huge amount was said by the Conservative Party about healthcare reform before the last election. Seen as the party's Achilles heel, most of the discussion revolved around reassuring the public of David Cameron's commitment to the NHS.

But since May 2010, a series of proposals and white papers have been launched which suggest the Conservatives' commitment to the NHS is to save it by reforming it, rather than by simply throwing more money at the same set of problems. Not least because in the aftermath of the financial crisis, more spending is no longer a viable option.

In this issue of *Gesundheit*, we take a closer look at three key areas of NHS reform, all of which have attracted the inevitable controversy which surrounds any attempt to

meddle with this most sacred cow of British politics.

James Gubb of Civitas takes a critical look at plans to abolish Primary Care Trusts (PCTs) and move towards GP commissioning, wondering if it will actually save any more money than it costs to implement.

Paul Healy provides some warnings and some advice on the road to a value-based pricing system for reimbursing the pharmaceutical industry for new medicines.

And Dr John Middleton examines the new public health white paper and gives it a cautious welcome for its focus on tackling health inequalities.

Of course, free radicals can also cause damage, and big questions remain over some important areas of policy – how much will the food industry be allowed to influence public health decisions, what is really going to happen once NICE loses the power to decide which medicines are funded on the NHS, can GPs really cope with all the extra responsibilities being put upon them, and will any of this actually improve the experience of the NHS for patients?

Health policy experts need to watch carefully and keep on loudly asking the right questions to make sure that reform does turn out to be the saviour of the NHS and not merely the cause of more ill-health.

NHS Commissioning: A Better Way Forward

James Gubb, director of the Civitas Health Unit

The NHS *White Paper* has garnered no end of controversy, not least its plans to transfer responsibility for commissioning health care from PCTs to 'consortia' of GPs by 2013. The aims are laudable: to push decision-making closer to patients and local communities; to ensure commissioning is underpinned by clinical insight; and to enable primary and secondary care to work more effectively together. Many PCTs, as things stand, are not delivering. However, there are valid reasons to question whether the restructuring is really a good idea.

First, while the evidence that exists on GP-led commissioning in the NHS shows there may well be some benefits – GP fundholding in the 1990s delivered improvements in speed, access and responsiveness of secondary care; reductions in waiting times; slight reductions in referral rates and costs; and widening the range of available services – it is by no means a certainty that these will be greater than what could have been delivered by PCTs. Importantly for the current financial climate, GP fundholders, for example, failed to reduce costs as much as expected or to improve patient experience.

The evidence that exists on GP-led commissioning also comes from a different

context to that proposed: one where GPs could volunteer to take on hard commissioning budgets for a sub-set of care (GP fundholding and total purchasing pilots in the 1990s), very different to now where every general practice must be part of a consortium and hold budgets, and the risk, for the vast majority of health care. In the United States, where the latter has been tried, only one in 10 associations succeeded both financially and in terms of improving patient care, according to the Nuffield Trust.

Second, while the *White Paper* rightly places a keen emphasis on increasing choice for patients and stimulating competition between providers to drive standards, it is unclear that GPs will have the clout or skills to deliver this through effective commissioning. As yet, the coalition government has not enunciated its vision for commissioning clearly enough.

The term still means different things to different people: 1) The management of existing contracts through defining cost and volume, 2) buying the services that will provide the best value (in terms of quality and cost) for the patient, 3) the management of clinical decision-making and how this commits resources. GP consortia will be well-placed, and probably better placed than PCTs, to do the latter. However, whether or not consortia can perform the more fundamental second function effectively is an open question. This requires bringing in alternative providers as a competitive challenge to acute trusts to 'up their game', breaking up

secondary care monopolies, and shifting patterns of care. With modest commissioning skills and (probably) smaller size in terms of population capture than existing PCTs, this may be beyond the majority.

Third, one cannot and should not ignore the possible impact of such fundamental restructuring of commissioning at a time when the NHS faces its greatest ever productivity challenge: around 4-5% per annum over this parliament according to the King's Fund/Institute for Fiscal Studies. Ironing out inefficiencies within organisations may well achieve this in the first one or two years, but, moving on from that, radically new models of care will be needed across the board – not least those that transverse the primary/secondary care 'divide'. This will require strong commissioning. Yet it is highly questionable whether this can be achieved in an organisation naturally inclined towards the status quo, while attention is diverted to creating new structures and dismantling old ones. It is certainly beyond what the NHS (-0.4% average productivity), and much of the private sector (+2.3%), has achieved in recent times. In 2006, when 203 PCTs were merged, performance on finance and quality of care dropped the following year; it took on average three years for their performance to catch up with the relative performance of those that weren't merged.

Fourth, the underlying assumption of the White Paper reforms is that, in acting as commissioners, the interests of GPs will

necessarily align with the interests of patients. This may or may not be the case: acting in the true spirit of the professional, they may well do, but it is easy to imagine a situation where GPs may be captured (consciously or unconsciously) by self- or provider-interest – as happened in PCTs with provider arms. Why, for example, do GPs over-populate more affluent areas and under-populate poorer ones? Why are there still such significant variations in clinical practice?

Related uncertainties include the following: what system of risk/reward will be implemented for GP consortia to 1) motivate involvement and 2) provide proper incentives for them to stay within budget and focus on improving outcomes for patients? Will commissioning budgets be separate from practice budgets and, if they are, does this provide the necessary incentives to commission effectively? How will consortia be able to influence primary care if contracts are to be held by the NHS Commissioning Board? How much freedom will the commissioning board allow GP consortia, particularly given the risks in transition are significant? What happens, also, if a consortium does not meet the perquisites to be authorised?

There may, in fact, be a better way: a way in which we might achieve the benefits of improved performance and increased localism and clinical input, without another round of top-down restructuring. First, the shackles should be taken off PCTs. They should be

freed of interference from Strategic Health Authorities (which the *White Paper* is right to abolish); and assessed by the outcomes they achieve not the processes they follow. Second, to increase clinical input, GPs should be given increased statutory influence over PCTs and be able to take them over, following a rules-based procedure. Third, there should be a rules-based failure regime: a 90-day notice period where other PCTs or entrepreneurial groups of GPs have the option of taking over a commissioning organisation that is failing. Fourth, PCTs should be free to change organisational form and governance structures: to merge and de-

merge and, more radically, to form as mutuals or cooperatives.

The coalition government spends much time talking of the 'Big Society' and localism. True localism would permit a series of locally-initiated experiments in commissioning that could be learnt from, rather than more of the centrally-initiated engineering that has failed the NHS throughout its history.

James Gubb is the director of the health unit at Civitas, an independent social policy think tank. Civitas' publications on the White Paper can be found at: www.civitas.org.uk/nhs.

Drug Pricing Reforms: A Switch to Value-Based Pricing

Paul Healy, senior research of Stockholm Network

As part of the coalition government's plans to reform the NHS, a change is being planned in how new branded pharmaceuticals (i.e. medicines protected by intellectual property rights) are reimbursed by the government. Branded pharmaceuticals account for 80% of the NHS's pharmaceutical expenditure, which in turn accounts for around 12% of total government spending on healthcare. This puts the figure currently spent by the government on branded pharmaceuticals at around £10 billion.

Free Pricing

The system as it currently stands in the NHS is that new branded pharmaceuticals are priced by their manufacturers. This differs from many other European countries where maximum prices are set by the government, often considering the price of the drug in other countries or the price of "similar" drugs. In theory, this suggests that the UK has a free pharmaceutical pricing system, like that of the United States for example. Yet in truth the UK government regulates drug prices through a mechanism called the Pharmaceutical Price Regulation System (PPRS).

The PPRS

The PPRS is a voluntary agreement negotiated regularly since 1957 by the UK department of health (DH) and the Association of the British Pharmaceutical Industry (ABPI). Through this agreement, maximum levels are set for the profits manufacturers are able to make on the sales of their pharmaceuticals to the NHS.

The current PPRS agreement, which is set to end in 2013, sets a return on capital target of 21%, with marketing expenses and information expenses restricted to 4% of turnover and research and development allowances up to 28%. There are also upper and lower "margins of tolerance" that allow greater profits to be retained, on the basis of innovation, efficiency and competitiveness, as well as price rises to be considered, if profits fall below a certain level.

Inevitably, the PPRS is designed to generate lower pharmaceutical prices, in addition to the across-the-board price cuts that are usually agreed as part of the negotiations. Yet, the coalition government believes that the freedom of pricing for new drugs has put the NHS in the position of paying high prices - that in the government's view are not always justified - or else of having to restrict access. It also argues that the arrangement does not promote innovation, stability or transparency. As a result, it proposes to scrap the PPRS when it expires in 2013 and to replace it with a value-based pricing (VBP) system that would price all new innovative medicines from 2014.

Value-based pricing

In theory, VBP works by establishing a stronger link between the price of a pharmaceutical and the value that the medicine delivers. In practice, this will be achieved by establishing maximum prices that the NHS is willing to pay for a particular drug, expressed in cost per quality-adjusted life year (QALY) and established by a technical appraisal. Once set, this basic threshold can then be increased on the basis of “burden of illness”, “greater therapeutic innovation” and “wider societal benefits”.

It is important to note that the VBP system would only be used to price new branded pharmaceuticals from 2014 and that the price of existing branded medicines would be agreed through a successor to the PPRS. In addition, transitional arrangements, such as the temporary Cancer Drugs Fund and Patient Access Schemes, are anticipated as not being needed post-2014, despite much pre-election trumpeting of such schemes.

The coalition government maintains that a move towards VBP will achieve five key objectives:

1. Improved outcomes for patients through better access to effective medicines;
2. The stimulation of innovation and development of high value treatments;
3. Improved transparency and predictability of timely decision-making;

4. Inclusion of a wider remit for assessments, including assessment of benefit for patients and society; and
5. Ensuring value for money for the NHS.

Conclusion

The likelihood of achieving such objectives through VBP continues to be debated, as the DH consultation period carries on until March. Certainly, there are a number of important questions about the reforms that need to be examined.

On innovation: is it plausible to suppose that the pharmaceutical industry is going to redesign its research and development priorities on the basis of a pricing constraint imposed today in one healthcare market, which accounts for only 3% of the global pharmaceutical market?

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 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?

Therefore, 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.

New Public Health White Paper for England: Lessons for National Public Health Systems, or Things to Avoid?

Dr John Middleton, vice-president of UK Faculty of Public Health

The English public health system is set to undergo a radical overhaul for the first time in nearly forty years. The government's new public health strategy white paper for England, *Healthy Living, Healthy Lives*, commits the coalition government to tackling health inequalities. In the current recession, austerity measures are already falling disproportionately on the poor so inequalities in health are likely to increase. The strategy adopts the 'life course' approach to reducing health inequalities advocated by Sir Michael Marmot's UK report, although ignoring the key recommendation to reduce inequalities in income across the social gradient.

What are these dramatic changes that the strategy outlines? It calls for an engaged, integrated, evidence-based approach, in which the NHS, the national and local government, schools, charities, industry and so on, all play a part. It accepts that there is a place for government leadership but is light on government intervention, despite the fact that major improvements in health have been brought about through legislation such as compulsory seat belts in cars and the ban on smoking in public places, and through fiscal means like alcohol and tobacco taxation. Its line is very much about shifting responsibility

and action to local communities and to individuals. Engaging different government departments is a clear objective - a cabinet sub-committee has been created to do that.

A new service, Public Health England, to be created within DH, will pull together functions such as the Health Protection Agency, the National (Drugs) Treatment Agency, and the regional public health teams and observatories. Top tier local authorities will be given increased powers and responsibilities for health strategy, for public involvement - through the 'Health Watch' - and for public health improvement. Directors of Public Health (DsPH) and their teams will be appointed and accountable both to the local authority and, through Public Health England, to the Secretary of State for Health. The teams will deliver health needs analysis, health protection and health improvement programmes, managed either by the team or commissioned from a range of voluntary and community providers and other agencies.

Local authorities will hold a ring-fenced public health budget and this will need to be deployed to achieve a series of public health outcomes. A health premium will be available for areas with the toughest tasks and greatest health inequalities, and with rewards and penalties for achievement and otherwise. Health and Wellbeing Boards will be set up to review local needs, based on the independent annual report by their DsPH.

The Faculty of Public Health (FPH) is the body responsible for standard setting and higher professional training in public health in the UK. We welcome the government's increased focus on population health, as we do the commitment to the Marmot review findings on health inequalities, and the evidence-based, professional approach to tackle them. FPH also thinks the approach to outcomes, evidence and expertise and transparency and to new resources for national public health research ought to be welcomed. It remains to be seen, of course, which 'evidence base' will be politically acceptable. Many observers outside the UK will be incredulous at the UK government's involvement of the fast food industry in responsibility deals to reduce obesity.

The UK lags behind other northern European countries in its recognition of the relationship between built environment, transport and improving mental and physical public health and in implementing effective measures to promote health through the public realm. So it is also welcome to see that the white paper makes a reference to public mental health and to sustainable development and green environments.

The return of public health to English local authorities is a return to where we came from. This aspect of the reforms brings us back in line with where most European public health departments are based. For instance, the European Healthy Cities movement has been based on city government action

budgets, agreements and partnerships. Only the UK Healthy Cities have had to make additional partnerships because of the primacy of the National Health Service in public health, until now that is.

But the forty year history of public health in the NHS has brought other benefits to the UK. The UK public health system has evolved with critical appraisal skills in epidemiology residing at local level, able to inform local health needs, advocate effective intervention and monitor outcomes. It has led the drive for preventive services to complement clinical care for instance, in stop smoking services, health trainers, community development and food and fitness workers. It has led critical analysis of the affordability and effectiveness of high-cost clinical interventions at local level. And it has led to critical recognition of the inverse care law - people in poor areas get poor services.

Even good health service interventions are delivered unequally to the population that could benefit. The major population health services screening and immunisation have also benefited massively from the leadership of public health specialists within the health service. For these reasons, FPH along with the Medical Royal Colleges and the new GP commissioners of health services want to see the practice of 'healthcare public health' protected.

The last few decades of public health in the UK have also seen the recognition of the

failure of technological medicine, the rise of new infectious diseases and growth of the new public health movement. Most countries and health systems grapple with the notion that public health is everybody's business and that very often this comes to mean nobody's business.

The specialist public health professional role is crucial in providing leadership and is recognised in the new public health white paper. The scale of the challenge to improve the health of the population, and at the same time to reduce inequalities in health, is substantial and will require a significant strengthening of the existing public health workforce as well as engaging wider professional, voluntary, and commercial forces.

In the UK, specialist public health is now a competence-based profession. Information scientists, nurses, health promotion specialists, and environmental health officers can gain accreditation as well as doctors. The defining skill is in management - enabling the successful professional to implement the best evidence of what is effective. This is different from public health practice in many parts of Europe where it remains a medical preserve. We believe this multidisciplinary approach creates a great strength in the UK public health system and potentially delivers a workforce fit for the purpose of the new public health service in local authorities and Public Health England.

The white paper expresses the desire to protect the public health workforce through this period of change. This echoes the sentiment of both the Secretary of State for Health, Andrew Lansley, and the interim Chief Medical officer, Dame Sally Davies, who observe that in all previous health service reorganisations public health expertise has been lost.

The immediate period of change is not going to be easy. The changes come at a time of immense turmoil in all aspects of public sector life. The budgets of local authorities are being cut by nearly one third. The modus operandi of local authorities is changing from big civic service delivery to smaller democratically accountable intelligent bodies able to commission services from a range of public, community and private providers. They crave the localism and the public health budget that the government proposes but do not want to be told what professionals to employ or what to spend the money on.

The terms and conditions of NHS-employed public health teams seem to be more favourable than in local government so the risk of wastage and loss is a reality unless the national Department of Health comes up with a legally binding solution. It seems ironic perhaps that local authorities, who have been claiming to be so vital to improving the public health, should, when pushed, seem so reluctant to embrace it vigorously and unreservedly, but that is a reflection of the political reality of the UK at present. We will

all have to exercise patient negotiation if we are to protect and improve the health of the people we serve, and if we are to tackle the persisting health inequalities gap.

The UK Faculty of Public Health will be delighted to continue the dialogue with other European observers of health and healthcare

to ensure we all learn from the best of our experiences.

Dr John Middleton is the vice-president of the UK Faculty of Public Health, a standard setting body for specialists in public health in the United Kingdom. For more information on the UK Faculty of Public Health can be found at www.fph.org.uk.

Stockholm Network Publications

Sharing the Burden: Could risk-sharing change the way we pay for healthcare?

Risk-sharing is a relatively new concept in the field of healthcare policy. As such, it is subject to confusion and misunderstanding, not only in terms of terminology but also in terms of substance. Different countries adopt and apply different forms of risk-sharing models and mechanisms. It is because of this confusion that the Stockholm Network is now seeking to demystify the concept of risk-sharing and to explore it in a more systematic way.

Accordingly, this paper examines and compares risk-sharing schemes in the following five countries: Australia, Germany, Italy, the United Kingdom, and the United States.

It concludes that there is, as yet, no gold standard for risk-sharing agreements, nor is there ever likely to be one. Risk-sharing

agreements should reflect a true commitment to serve the needs of patients, to allow for greater individual choice, while securing the most effective methods of treatments. This means that the risk may be at the expense of payers, or manufacturers or both - but never at the expense of patients.

The paper was launched at an opportune time in the UK, as the coalition government confirmed that the role of NICE would be reformed in favour of a value-based pricing system, with more use of patient access schemes.

As a result, the paper was able to achieve some significant coverage that further communicated the findings of the study, including *the Guardian*, *British Medical Journal*, *PharmaTimes*, *Healthcare Republic*, *InPharm*, *Public Finance* and *the Pharmaletter*.

Sharing the Burden: Could risk-sharing change the way we pay for healthcare? can be downloaded at:

<http://tinyurl.com/SharingtheBurden>

Stockholm Network Events

Patient Safety and Comfort: The challenges of switching medicines

At this roundtable event, the Stockholm Network launched a new report as part of its ongoing series on patient safety - *Patient Safety and Comfort: the Challenges of Switching Medicines*.

Whether switching of medicines takes place as part of a formal protocol or based on the discretion of a physician, it entails both benefits and risks. Sometimes it may help to identify more effective or cost-effective treatments, improving the quality of life for patients dealing with chronic conditions. But switching may also result in undue medical risks and jeopardise the independence and preference of patients, if it is not done

cautiously and with the appropriate information. This is especially the case for risky patients and those who are already stabilised on a treatment regime.

The paper was launched in Brussels at a roundtable seminar which was opened by Dr Jorgo Chatzimarkakis MEP, and was followed by presentations from three expert speakers: Dr Alexandra Wyke, founder and managing director of PatientView; Dr Alphonse Crespo, orthopaedic surgeon and director of Mecedine and Liberty (MedLib); and Dr Meir Pugatch, director of research of the Stockholm Network.

Patient Safety and Comfort: The challenges of switching medicines can be downloaded at:

<http://tinyurl.com/SwitchingMedicines>