

***CIVITAS: Response to 'Healthcare for London: A Framework for Action',
Professor Sir Ara Darzi
23 July 2007***

Few can argue with the premise of Sir Ara's argument, detailed in the report, that all is not well with the NHS in London. According to IPSOS Mori, 27% of Londoners are dissatisfied with the service compared with 18% nationally. The system is inequitable: more is actually spent on patients in boroughs where need is the least; PCTs with the highest QOF (quality) scores are those in the richest areas. And it is, in large parts, grossly inefficient; doctors in a large acute hospital in London typically see 24% less patients than elsewhere in England and in if all London hospitals had achieved the English average for lengths of stay last year, they would have saved 800,000 bed days or £200m. London also has by far and away the highest rates of A&E admissions in the country and 65% of doctors report problems of care not being adequately coordinated.

The five common principles his working group set out as their guiding lights are also, in general, valid means by which to reach a solution. Services focused on individual need and choice is number one; the others are the importance of integrated care, that prevention is better than care, a focus on health inequalities and the maxim 'localise where possible, centralise where necessary'. The latter rings alarm bells – centralisation, and the micromanagement that goes with it, has wreaked havoc in the NHS in recent years - but Sir Ara seems to use it in the sense of removing care where necessary from the immediate locality of the patient – i.e. to his specialist hospitals – rather than structural centralisation.

And there are real positives in his conclusions. The rationale for specialist hospitals to treat patients with cancer, heart attacks, serious trauma, and emergency stroke care is sound. A detailed review of stroke services by the Royal College of Physicians found that to treat stroke care, dedicated, high-quality, specialist stroke units saved lives. And there is also much international evidence concerning the other medical specialities. The Texas Heart Institute provides both better health outcomes (survival rates are 10% higher than the US average) and for much less cost (\$27,000 as apposed to \$48,000) than non-specialised hospitals dealing with heart conditions. Much of the superior performance of the French in cancer care is down to the work done by 20 specialist cancer hospitals. This all makes sense. As the report details: specialist teams need enough volume and variety of a medical condition to create a centre of excellence and technology is driving centralisation of specialist services in any case. 'The day of the district general hospital seeking to provide all services to a high enough standard are over'.

The polyclinic idea is more controversial. On one level it seems like the perfect solution. Economies of scale would suggest that it is much more efficient to have larger concentrations of GP surgeries than many individual practices. Indeed a BMA survey cited by the report found that almost 60% of London GP practices felt their premises were not even suitable for their present needs. It would also seem like a great way to ensure integrated care pathways – by having much of it under one roof and forcing a real crossover between primary and secondary care (both in terms of services and staff). Polyclinics also serve as a local setting, with more of the care pathway closer to the patient and, with a bit of luck, healthcare more tailored to patient need. For all this, Sir Ara also claims that the polyclinic model could save the NHS £1.5bn – largely because they are able to provide services more cheaply than under the existing tariff. (Though he does, somehow, claim that no local hospitals would be closed as a result of this revolution – which surely cannot be the case without massive inefficiency.) The polyclinic to local hospital/elective care/specialist hospital route could also help the NHS to use competition drive up standards, according to Porter and Teisberg's seminal study '*Redefining Healthcare*'. This argues that for competition to be effective it must be focused on value, rather than on (for example) activity, which tends to just encourage cost-shifting. Increasingly, they argue, healthcare should be aligned around care pathways for a particular

disease/condition, hospitals will increasingly specialise, and PCTs should be able to measure value across the complete pathway to commission effectively.

So is this the perfect solution? Not quite. As Nick Bosanquet has written in an open letter to Sir Ara: 'The report is an enticing vision that might be relevant if we were starting with a clean sheet of paper'. For a start, he quite rightly takes issue with the financial estimates the report provides – to say polyclinics could save the NHS £1.5bn without supporting estimates of income and expenditure, and without any real examples of polyclinics' performance even internationally, is surely folly.

But the real issue is how any service transformation is to take place. Despite presenting evidence of the effectiveness of patient choice and going so far as to say 'the choices that patients make about their healthcare will increasingly drive change and improvement in the system', the report, overall, only pays lip-service to patient choice and the role of competition. It instead tends to read as though it is the role of NHS London to impose changes. But the fact is that competition (even nominal, as it is at the moment) is already driving the most adept providers - for example Guy's and St. Thomas' and UCLH Foundation Trusts - to specialise. UCLH does not try to provide everything now, but rather try to do a few things incredibly well: heart conditions, obstetrics, tropical diseases, neurology/neurosurgery and homeopathy in particular. And GP practices are already taking advantage of incentives provided under the QOF and new GP contracts to provide other services. For example, the recently opened Heart of Hounslow Centre for Health includes – on top of three GP practices – a range of community care services including improved outpatient facilities, social care outreach, services for children and care for people with learning disabilities, as well as a health information centre and new therapy gym to aid rehabilitation.

Yes, of course, 'sophisticated commissioners are needed to encourage the development of providers' (in both primary and secondary care), but the danger is that Sir Ara's report will cause NHS London – or the Department of Health – to plant all Sir Ara's solutions on London's current NHS organisations. To do so would be to ignore the market incentives that have been put in place in the NHS – however haphazardly or half-heartedly – by commissioning, payment-by-results and a more liberalised supply side. Recent experience teaches us this would be disastrous. Reform efforts in the NHS have largely concentrated on telling NHS organisations they have to provide a good service, setting targets for that service and lecturing them when they fail. The DH have in effect attempted to guesstimate patient need and demands, and then allocate the supply of healthcare accordingly - an approach which has proved massively ineffective, with large proportions of the extra money provided in the NHS over the past seven years squandered. Most poignantly the majority of the large hospital-build programmes have, thus far at least, not been justified by income received under payment-by-results, resulting in significant financial deficits.

In sum, while this report serves as a useful incite for commissioners as to the direction they might wish to go in (and in the case of secondary care probably should go in), it should serve as exactly that, a useful incite, and not be used as a concrete blueprint for the imposition of a new healthcare system for London from above. Commissioners should be left to do their job - commission services based on clinical evidence and patient needs - and let these factors determine exactly how London's NHS develops.

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