BMA's historic mistake on White Paper

An Open letter to Dr Hamish Meldrum, Chair of the BMA Council, in response to his letter to BMA members, available at:

http://web2.bma.org.uk/pressrel.nsf/wlu/SGOY-87UCEG?OpenDocument

Dear Hamish Meldrum

As **a** campaigner who recently had the pleasure of working as a researcher supporting the BMA's Look After Your NHS campaign, it was with great sadness that I read your letter to BMA members explaining your organisation's decision not to join the widespread and growing opposition to the government's White Paper on the NHS, but instead to "critically engage with the consultation process".

This decision will certainly delight the Health Secretary, and those who share his declared objective of turning the NHS from a public service, largely publicly provided, into a "social market" in which 'in most sectors of care, any willing provider can provide services" (White Paper page 37).

By contrast it will dismay the many BMA members, members of the public and other health workers who, like me, were pleased to support the BMA's Look After Our NHS campaign, and the eight principles it endorsed, and who will see the decision to go along with the White Paper in this way as a retreat from these principles.

It is surely also quite extraordinary that your discussion of the issues which concern the BMA in what you describe as a "curate's egg" of a White Paper makes no mention at all of the colossal and quite unprecedented £20 billion spending cuts ("efficiency savings") which are quite explicitly written into the proposals, to be achieved by 2014 (Page 5). To discuss the White Paper without mentioning this crucial factor is rather like discussing a zoo as a space for empowering animals – without mentioning the existence of cages.

It is clear that, far from being empowered to improve services for patients as they might wish, if the White Paper is implemented GPs will, for the next few years at least, find themselves being used repeatedly to wield the axe on a range of popular services, take public responsibility for the closure of local hospitals and facilities and the rationing of care on financial grounds, and be blamed for large scale job losses – including consultants and other medical staff.

With no PCT bureaucrats or SHAs to carry the can for unpopular decisions, GPs will find themselves exposed time and again to hostile public opinion and even tabloid press coverage: their very motives in undertaking this role will also be widely called into question, especially when it is such a reversal from the previous, popular BMA stance.

Perhaps you maybe concerned that if the BMA did not get involved, the private sector might simply step in and take charge. But this is clearly not the case: Mr Lansley desperately needs the fig-leaf of BMA (and especially GP) involvement to lend any degree of credibility to his highly controversial proposals. As private consultancy Tribal have pointed out:

> "The success or failure of this initiative depends on whether GP support for the proposals can be secured. The first test is whether GPs will be willing to form consortia without excessive financial incentives, given the significant responsibilities associated with managing tax-payers money."[1]

It is also important to recognise that as a formula for a new, competitive health market, ALL of the White Paper proposals fit together as an interconnected whole, and ALL are therefore important to the government. This makes it almost impossible to imagine that ministers will be willing to make any serious concessions, let alone the level of compromises which might, as your letter suggests, enable the BMA to "mould these proposals into a set of solutions that can benefit our patients and the working lives of doctors".

Your letter gives no idea of what the BMA might do if it fails to achieve any of its (as yet undefined] objectives in "moulding" the White Paper, and finds the end result unacceptable. What credibility will it have with other health unions or the wider public if it is forced to make yet another abrupt U-turn after it has so seriously undermined the opposition at the outset?

And where in the White Paper does it give any grounds for the BMA to believe that the government might agree with you that "for commissioning to be successful, there must be the fullest engagement with secondary care colleagues..."? In fact the strengthened powers for Monitor and repeated reference to the Competition Commission in the White Paper make it clear that any such engagement is to be ruled out in the new, even tougher competitive market framework, which would pit GPs as commissioners on one side of the divide, and their professional colleagues in provider organisations on the other.

It is not at all clear how if the BMA had taken a hard line of opposition through the brief consultation period it would, as you claim, "greatly increase the risk of bringing about the adverse outcomes that many of you fear".

There is no sign so far of compromise from Mr Lansley. On the contrary the prospect of pulling the BMA in behind the proposals and splitting the ranks of health workers has strengthened the government's hand, giving ministers confidence to stand firm, making it more likely that they will discount other opposition from health unions as 'self-interested'.

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[1] Again, later in the full document, Tribal note that: "This problem will become acute if the GPs fail to respond with enthusiasm to Mr Lansley's invitation. Even with the power to direct, achieving both the timetable and the desired impact requires the positive engagement of a majority of GPs. There will doubtless be enthusiasts but will they constitute a majority, will they provide sufficient apostles to lead 500 consortia?"

(Tribal 2010: *'Liberating the NHS' . The next turn in the corkscrew?,* page 10)

In fact it is far from clear that a majority even of GPs are convinced that the White Paper offers them any positive way forward. The wafer thin vote in favour of commissioning at the LMC conference, and the 68% poll against it on DNUK suggest that a firm lead from the BMA, explaining the issues and reaffirming its principles, could easily carry a majority for demanding Mr Lansley think again. And this kind of solid front could make it very difficult for ministers to press through with reforms that only a few right wing think tanks, neoliberal academics and self-interested private sector employers can be seen to endorse[2].

There are signs that you and your colleagues are aware of the contradictory position you have now put yourselves in, by "engaging" with policies that only months ago you were correctly campaigning against. *BMA News* reports that the same BMA National Council which took this unfortunate decision also reaffirmed its support for the Look After Our NHS campaign. You, too, insist in your letter that you are not deserting these values:

> "Quite the reverse. We believe it is only by responding critically to the challenges and the potential consequences of the government's proposals that we can defend the founding principles of the NHS and the principles underpinning our campaign."

I am sure you and others are sincere in believing that it is possible both to "engage critically" with Mr Lansley and uphold your principles. But this is simply not the case: even a passing glance at the eight principles[3] shows immediately that they are all quite incompatible with Mr Lansley's vision for the NHS.

Principle 1 argues correctly that "Comprehensive and universal services can only be ensured by public sector services delivering treatment on the basis of clinical need, not ability to pay": yet the White Paper makes clear that existing NHS Trusts will be compelled to become Foundation Trusts, while Foundation Trusts (together with their assets currently valued at £15.8 billion) will in turn, if Mr Lansley has his way, be removed from the NHS balance sheet - ceasing to be public sector organisations.

The White Paper states clearly that in future Foundation Trusts "will be regulated in the same way as any other providers, whether from the private or voluntary sector" (page 36). The removal of Foundation Trusts from the NHS has

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[2] Criticism has spread well beyond the 'usual suspects" of opposition parties, the left and the TUC health unions. Both the Lancet and the BMJ have carried major and convincing critiques of the proposals: Sir David Nicholson has made it clear that he doubts the timescale and the viability of the proposals, although he is now committed to driving them through. The NHS Confederation has published a general critique of such sweeping reforms in the last ten years, pointing to the swift succession of organisational changes and the flimsy evidence of success; Civitas and others have been critical and warned of the likely implementation costs of the White paper proposals. Even Chris Ham of the King's Fund has been reluctant to lend more than minimal support to the Lansley plan.

[3] The principles are expanded in more detail in the BMA pamphlet *NHS Reforms are damaging our health service*, available at: http://lookafterournhs.org.uk/wp-content/uploads/doctor-final-270110.pdf

potentially serious consequences for their staff, including consultants and hospital doctors, who would no longer be NHS employees, and new members of staff who would as a consequence be outside NHS pay scales and review bodies, pensions and other important terms and conditions.

But privatisation of health care on this scale has never occurred in any health service anywhere in the world, so nobody knows the possible consequences for the future of patient care.

It is most surprising that the BMA should vote in favour of participating in an experimental change that has so little evidence to support it, and which poses such a long-term threat to a large section of its own members.

Principle 2 of the BMA's campaign for a public NHS argues for an NHS which is "publicly funded through central taxes, publicly provided and publicly accountable": but of course the White Paper does not even guarantee the first of these. It conspicuously avoids the issue of tax funding, while it also makes clear that few, if any NHS services will remain publicly provided after 2013, when NHS Trusts will be officially wound up. And it gives no clear mechanism by which the service will be publicly accountable.

The early signs on accountability are not promising: none of the sweeping changes being brought forward now by Mr Lansley and the ConDem coalition government have been subject to any prior public debate, let alone put forward clearly to the electorate: and if previous governments are any indication, the extent to which the public will be given any opportunity to shape the changes in advance of far-reaching top-down legislation is likely to be minimal. The best opportunity to force ministers to take note of public opinion and that of health care professionals and others would have been for the BMA to work with those who are challenging the proposals, rather than to allow itself to be tied in – however "critically" - with the plans themselves.

Principle 3 of the BMA's campaign calls for a significant reduction in commercial involvement in the provision of health care, and **principle 4** looks for public money to be used for "quality healthcare, not profits for shareholders".

However that is not the position of the White Paper, which explicitly rolls back the (belated, but welcome) commitment by Andy Burnham last autumn that the NHS should be the "preferred provider" of services.

Lansley's White Paper repeatedly argues instead for the use of "any willing provider" - an open invitation to for-profit private providers to bid for services. We have already seen (and campaigned against) the negative consequences of such bids, in the money wasted on Independent Sector Treatment Centres, primary care, and other sectors of the NHS. In each case, the costs are higher or quality of service lower than NHS provision.

To make matters even worse, the White Paper's organisational changes will effectively close off the option of NHS providers continuing in England after 2013, in what Kingsley Manning of Tribal has called a "revolutionary" denationalisation.

To make the direction of travel quite clear, the White Paper also explicitly proposes to abolish the "arbitrary cap on the amount of income Foundation Trusts may earn from other sources" - i.e. private, commercial medicine. Especially in the context of the frozen or declining revenue budgets for NHS and Foundation Trusts over the next five years, this too opens the way for a downsizing of public sector activity and an increase in "commercial involvement".

BMA Principle 5 restates the value of "co-operation, not competition", emphasising the risks to patient care, and calling for greater integration and collaboration. Again, no objective reading of the White Paper can find anything in it which is consistent with this approach.

The key principles embraced by Mr Lansley centre from start to finish on the creation of a competitive market, in which the power is put in the hands of commissioners, and providers are obliged to compete with each other.

Principle 6 calls for the NHS to be "led by medical professionals working in partnership with patients and the public". But it's clear that the scope within the White Paper for such partnerships will be extremely limited: GPs will have restricted managerial resources to assist and advise them in the allocation of large commissioning budgets [4], and limited time and capacity to conduct their own interaction with any wider public alongside their own clinical work.

If rumours that there will be around 500 consortia in England are correct, the average size for a consortium will be around 80 GPs, or 3-4 per existing PCT area: this leaves ample scope for widely different local pressures and issues between different GP practices in different areas within consortia. Nor is it clear how GPs can really be accountable to their own patients, when they will also be under pressure from GP colleagues to press through decisions that balance the books for the whole consortium, in the context of £20 billion of cuts.

To add to the potential confusion, the White Paper makes no reference to neighbouring consortia having any obligation to cooperate with *each other* – for instance over the resourcing of services from a shared local hospital – after the mechanisms for wider planning of services (SHAs and PCTs are to be abolished. There is a real danger of a new parochialism, and a new postcode lottery on availability of treatment, with widening inequalities even within PCT areas – and contradictory decisions on the future of local provider services. Do GPs really want to carry responsibility for the unpredictable consequences of this potentially anarchic situation?

Principle 7 seeks value for money, "but puts the care of patients before financial targets". With the overriding obligation on GPs as commissioners to carry

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[4] (the *Health Service Journal* suggests that the consortia management budgets could be as little as one third of the present management spend by PCTs (Ju1y22:7)

through £20 billion of cuts by 2014, the White Paper makes it difficult to ensure that this principle could be consistently upheld in any area.

Principle 8 sounds an important warning over the need to commit to "training future generations of medical professionals". But the SHAs which currently plan medical and professional training are to be abolished. Thousands of training places are already set to disappear for both doctors and for nursing staff, with University staff posts also at risk.

The fragmentation of the NHS, especially once Foundations are "off balance sheet" and obliged to run as businesses outside of any guaranteed framework of funding or government support, also throws the long term future of training and education of professionals into serious doubt.

By 2013 the NHS Commissioning Board would be the only, drastically reduced, surviving element of today's NHS: can we be certain that this will be able to ensure that self-managing Foundation Trusts concerned with their own balance sheets and financial pressures – let alone the panoply of "any willing providers" – will invest sufficiently in training and development of staff?

Conclusion

In summary, it is clear that the BMA decision represents a very serious mistake, and is clearly incompatible with the previously declared principles and campaigning profile of the BMA.

It runs the risk of putting GP members as commissioners into conflict with members working in hospitals and other providers, dividing the organisation itself, while also splitting the BMA from the broad body of opinion of health trade unions and professionals.

It is most unlikely that this stance will be viewed with much respect by health ministers, who will simply regard it as a strengthening of their position – and an indication that if they keep the pressure on they can get their way with the BMA.

And it seems that there is no fall-back position to be adopted if the gamble of "critical engagement" falls flat, and the government presses on with those aspects of the White Paper that the BMA regards as unacceptable.

It is also worrying that you have not identified any "red line" issues where you are determined changes must be made as a condition of involvement, or bottom line objectives to enable the BMA to determine the success or failure of your "critical engagement". This vague approach seems more likely to lock the BMA into the process regardless of the outcome of its engagement with ministers.

The BMA is to be applauded for having taken a firm and principled position for the last few years in challenging New Labour's market-style policies and upholding the principles of the NHS. It is unfortunate that the change of government appears to have brought a retreat from this position, and concessions to policies which are far more extreme in their scale and implications that any previous NHS reforms.

I'm sure I don't need to remind you that in 1946 the BMA chose badly and wound up on the wrong side of the debate in opposing the launch of the NHS in 1948. The last to come round at that time - long after consultants and hospital staff had been persuaded of the advantages of a national career structure, training and standards - were the GPs, many of whom did not change their position until after the NHS had been formed and almost the entire population had immediately signed up for it.

You will be aware that for many decades this error haunted the BMA's links with other organisations. But it seemed that this had finally been overcome with the BMA's vigorous defence of NHS values against New Labour's proposals. Indeed it was remarkable that earlier this year the BMA contingent on the national demonstration in defence of public services, in which you took part, was bigger and more vigorous than some of the TUC health unions with larger membership.

Sadly it seems that the current stance of the BMA could result in the GPs again lining up on the wrong side of the debate, as the current government contemplates the definitive reversal of Bevan's nationalisation of the hospital network, which laid the groundwork for the NHS.

I very much hope that the BMA will take immediate steps to strengthen the very limited critique which seems to inform the current policy, and will soon recognise the need for a shift of direction. If not, the organisation will again be discredited - for effectively abandoning its key principles in the vain hope of future influence over a government that does not share them, and is firmly set on an opposite course, to the detriment of doctors, health workers and patients.

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