The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

Javid's 'new' ideas short on funding

Sajid Javid's lengthy (8,600 word, 16-page) speech was laden with waffle, two feeble jokes, and centred on half a dozen rehashed old ideas – but gave not a single clue as to where the money is supposed to come from to make any of them deliver improved services.

The enhanced "right to choose" already exists in the NHS Constitution: but it's cold comfort to older patients losing their mobility on the country's longest waiting lists in Birmingham, for example, to be given the chance to compete with millions of others facing long delays for the chance of securing a quicker operation in Guy's and St Thomas's in London, where the delays are shorter.

Patients want timely access to good quality care where they are, not a system that requires them to spend weeks trawling the internet, join a bunfight with other desperate patients to get on another list – and then trek a hundred miles or more to, and back from, a distant operating theatre.

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That's not choice: that's a nightmare – and without the massive additional spending called for by SOSNHS, it does nothing to expand capacity.

Javid also wants to expand the number of people benefitting from "personalised care" – but without additional staff and services, this just amounts to more online "do it yourself" manuals in the form of apps and websites that leave millions of digitally excluded people on the outside looking in.

Limited budgets

Javid calls for more people to be given "personal health budgets": this was the big idea of Simon Stevens' Five Year Forward View eight years ago. He 2014 suggested "north of five million" such personal budgets might be operational by 2018, sharing £5 billion between them.

This would have meant average payments of just £20 per week – nowhere near enough to secure any meaningful care package – even if the services required were available, and the patient/client was confident enough and able to sort out their own care. But almost nobody really wants these budgets: by 2021 the number of people receiving them had only risen to 100,000.

Javid wants more use of the NHS App "to help people manage their health," but while apps might be good at monitoring, it needs health professionals to advise and prescribe the necessary treatment. He demands electronic patient records are rolled out to 90% of trusts by December 2023 and 80% of social care providers by March 2024 – but with many trusts facing hefty urgent backlog maintenance bills, it's obvious there is nowhere near enough money in the system for this.

Like fostering, but for adults?

Javid also drew attention to the 'Shared Lives' scheme, "'… where people in need of care go to live with carers and become like any other member of the family – think of it like fostering but for adults."

Again this lacks all of the necessary ingredients: carers, management and coordination, and resources: it is yet another attempt to substitute for the gaping holes that should be social care and community health services.

These "reforms" recycle old ideas that are discredited, or impractical, or both. In the midst of 15 years of brutal austerity funding they are a poor substitute for investment in health and social care.

Offered the choice between 'reforms' and more money, the NHS has to demand the money.

John Lister

One in ten on NHS waiting list in the Midlands

Labour MPs got no useful answers when they challenged ministers to explain how they would cut massive waiting lists in the Midlands, with NHS data showing Birmingham with the worst waiting lists in the country.

Shadow Health Minister Andrew Gwynne highlighted the disastrous performance of the University Hospitals Birmingham NHS Trust (UHB), running major hospitals across Birmingham, Solihull and Sutton Coldfield, where the latest figures show 183,000 patients were waiting for treatment in December, of whom only 38% had been waiting less than 18 weeks.

Health minister Maria Caulfield claimed that Covid was to blame, and that the Government had committed funding for elective recovery.

However NHS England's recent Delivery Plan, constrained by the limits of last autumn's spending review, accepts that waiting lists will continue to go up until 2024 – perhaps as high as nine million – and numbers waiting over a year will not be reduced until 2025.

More than a million people – around one in ten of the population – are waiting for care in the Midlands, the highest number in any region, and four other major hospital trusts (University Hospitals North Midlands, United Hospitals Lincolnshire, University Hospitals Leicester, and Worcestershire Acute Hospitals) have less than 60% of their total list waiting fewer than 18 weeks (University Hospital Coventry & Warwickshire has not published full figures).

However UHB's performance is by far the worst. A staggering 31,000 UHB patients had waited over a year, 17% of the total waiting, compared with 15,877 in Leicester (14.5% of the total of 108,365). By contrast in Barts Health in London, with 103,000 waiting, 8,244 (8%) were waiting over a year.

Pressures on midlands hospitals have been worsened by high levels of unfilled vacancies, with almost 15,000 vacant posts in acute hospitals, a third of them for nurses, leaving one in ten acute nursing posts unfilled, along with almost one in six mental health nursing posts.

The latest government call for NHS pay to rise by just 2-3% in 2022 will do nothing to fill the gaps in staffing, or reduce waiting lists that were headed upwards before the pandemic even began.

John Lister

Unions win fight for staff to move back in-house

Almost 1,800 staff at the Barts Health NHS Trust are to benefit from NHS pay, terms and conditions after a successful campaign by trade unions and their members. The cleaners, porters, security guards and domestic staff, grouped together as "soft facilities management", at the trust's hospitals are currently employed by Serco, but from 1 May 2023 they will be transferred across to join the existing 17,000 Barts Health staff as NHS employees under Agenda for Change (AfC) conditions.

Serco won the contract in a competitive tender in 2017, but has served notice that it will terminate early, at the end of April 2023. Following this announcement, the trust and trade unions explored alternative options to outsourcing. The Board agreed to pursue one that was both "financially advantageous but would also improve the quality of service, be flexible in response to demand, and maximise engagement with staff."

UNISON regional organiser Pam Okuns-Edokpayi said: "This is a fantastic result for a group of staff who fully deserve to be fully part of the NHS again. UNISON is proud of the deal we negotiated, but it wouldn't have been possible without the support of our members at Barts. Thanks to them, we're the largest and most effective union in the NHS.

Unite General Secretary Sharon Graham said:

"Unite has struck a landmark agreement with one of the UK's largest NHS trusts to end the two-tier workforce. Unite members and their representatives have shown impressive determination and resilience to reach this negotiated settlement. The workers are exposed to the same risks as NHS-employed staff, so it's only right for them to be treated equally and brought back into NHS employment."

Barts is not the first to bring such services back in house. In June 2021, Epsom and St Helier University Hospitals Trust brought cleaning, catering and portering staff back in house, rather than retain its outsourced contract with Mitie.

And in January 2020, Imperial College Healthcare Trust decided to bring almost 1,000 catering and cleaning staff back onto the NHS payroll from an outsourced contract with Sodexo. Imperial increased the staffs' pay after they came back in-house. The decision to bring staff back in-house followed industrial action by staff.

The three other London hospital trusts where these services are provided in-house are Whittington Health Trust, Hillingdon Hospitals Foundation Trust and Guy's and St Thomas' Foundation Trust.

Javid pushes ahead with changes to primary care

Sajid Javid has announced plans for big changes in primary care, based on a report from the thinktank Policy Exchange.

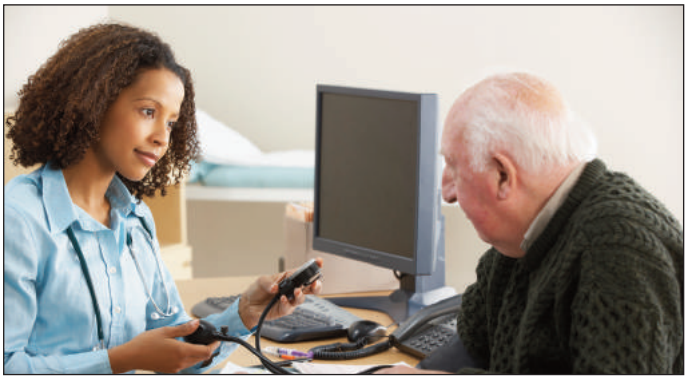
The 98-page report was written by two academics and a private sector oncologist, advised by a motley array of 38 individuals including a gamut of private sector interests such as askmyGP, eConsult, Livi, Assura, Babylon Health, Modality Partnership, Palantir … and Mark Warman, Tory MP and former Technology Editor of the Daily Telegraph.

Interestingly the report argues GPs "want their voices heard in the design and organisation of integrated care" – but the authors don't seem bothered to allow any GP views to be heard on primary care. Just four GPs were included in the long list: and it's not clear how they were chosen or whether any of their comments were included. If it's primary care this gang are proposing, then it's not as we know it.

The report wants the restructured primary care to work in a completely different way, with a new online 'NHS Gateway' "evolving" to become "a 'smart' triage tool for primary care."

"This would include using machine learning and AI (Artificial Intelligence) to direct consumers to services (including those delivered beyond the neighbourhood) based upon real-time service activity information and patient data."

Any notion of recruiting sufficient GPs and staff to run services locally appears to have been abandoned. Instead services would be increasingly structured around apps and remote consultations – so remote that it even discusses "opportunities to enable NHS-trained GPs who have left the country to deliver remote sessions from overseas." It explains: "Remote consultation represents a possibility for GPs trained in the NHS but have since emigrated to deliver sessions from abroad."



As expected, the report, which was endorsed by a Foreword from Sajid Javid, seeks to phase out the existing system of general practice, and move over ten years to a model in which GPs become salaried employees, probably working for NHS trusts.

And after years of failure to make the promised investment in primary care, it suggests a £6bn 'rescue package' – to "gradually buy-out the GP owned estate" and "fund the transition to scaled models over the remainder of the decade."

Some socialist GPs have long campaigned for salaried status in place of the traditional arrangement in which 'partnerships' work to a contract with the NHS, which was conceded as a compromise by Nye Bevan in 1948 to get reluctant GPs on board as the NHS was launched. But any steps to replace the current arrangements while GPs are still under such stress has to be discussed and negotiated with GPs themselves, not imposed upon them by politicians and a bunch of self-interested outsiders.

Nuffield Trust chief executive Nigel Edwards said general practice is "the bedrock of the NHS," and warned Javid his reform will fail if it undermines the work of GPs and prevents them from co-ordinating care for patients.

The BMA warns "taking a sledgehammer to the partnership model will not fix general practice," and Royal College of General Practitioners chair Professor Martin Marshall said the College 'agrees' that a 'comprehensive rescue package is urgently needed for general practice,' but said:

"We would advise caution against implementing wholescale changes to the way GP care and services are delivered and how patients access them, without properly piloting and evaluating such initiatives in terms of efficiency, patient safety and how they impact on the long-standing trusted relationships between family doctors and their patients."

But with so many private companies baying at the heels of Javid and his policy wonks it seems caution is the last thing on their minds. The Policy Exchange document makes a token reference to the many millions of digitally excluded:

"… patients for whom remote consultation is less suitable: the very unwell or those with high-risk conditions; those who have difficulty communicating; have complex health; want or need a physical examination; need supervised check-ups, or do not own, or wish to use a smartphone to access services."

But these concerns are likely to be brushed easily aside in the dash for easy profits. This issue is likely to run and run – attracting more comment and making more waves than the Health and Care Bill.

John Lister

The true extent of A&E delays to be reported

The Royal College of Emergency Medicine is celebrating a breakthrough in its fight to fully reveal the extent of delays in hospital emergency departments affecting those in most serious clinical need.

Until now NHS England has insisted on reporting only 12 hour-plus delays after the decision has been taken to admit a patient – by which time they could already have been in the hospital for many hours. Now the NHS Standard Contract 2022/23 will measure data from point of arrival in A&E to discharge, admission or transfer, rather than from the decision to admit.

The RCEM now expects NHS England to publish this data in full on a monthly basis from the start of the new financial year. The information is already collected by trusts, but until now it has not been made public in the same way as the four-hour target data, and the current figures on 12-hour "trolley waits" for a bed after decision to admit.

The change will lead to a significant increase in the number of reported waits over 12 hours – although the actual number of incidents will remain the same, with the smokescreen of the less accurate measure removed. The new contract also better reflects reality by changing NHS England's stance from 'zero tolerance' for 12-hour waits to seeking to cap numbers, at a maximum of 2 per cent of patients, although it seems even this lesser target is out of reach.

RCEM Dr Katherine Henderson said: "We know that long stays in Emergency Departments harm patients and long stays (usually due to lack of an available bed) have consequences for other patients; ambulances cannot transfer patients into the department, and then cannot go back into the community, thereby putting further lives at risk.

"When published, together with NHS England and the Department of Health and Social Care, we will be able to assess in full the state of Urgent and Emergency Care and both bring about and implement the changes that staff and patients urgently need."

In the most recent RCEM Winter Flow survey, which covers a sample of 50 hospitals across the UK, 12-hour stays from arrival in A&E exceeded 6,000 in every single week of February, and between January and February, 12-hour stays increased to over 9% of attendances. With five weeks still left to run 12-hour stays in winter 2021/22 (121,003) exceeded the total set during the whole of Winter Flow 2019/20 (119,281).

Twelve hour waits from decision to admit have become increasingly common: House of Commons Library figures show between 2011-2014 there were a total of 915 12-hour waits: but in January 2022 there were an average of 534 per DAY (16,558 in the month).

Four hour waits have also increased from an average of 5.2% of patients attending a major hospital (Type 1) A&E in 2011/12 to 24.7% in 2019/20. In January 2015 8.7% of patients waited over 4 hours: in January 2022 it was a staggering 37.7%.

Delays arise from shortage of beds: an RCEM survey last November showed over half of Emergency Departments had provided care to patients in non-designated areas such as corridors every day in the previous week, heightening safety risks.

Mental health: underfunding and outsourcing policies fail patients

As the most vulnerable NHS mental health patients face growing waits for treatment, and ministers signal they want to talk about a new mental health strategy, it is time to recognise that partnerships with the private sector are no easy route to easing the NHS waiting lists.

Private health companies have a strong foothold in the NHS, established over decades, and market analysts Laing & Buisson estimate that over 30% of NHS mental health hospital capacity is now supplied by the private sector. These firms provide over half the NHS inpatient beds for children and teenagers with mental health problems, and almost all of the secure beds for adults.

The revenue that these companies accrue from NHS contracts has risen steadily in recent years and the biggest providers are now highly dependent upon NHS work as it makes up around 90% of the total market value, with self-pay and private medical insurance fees only accounting for 10%.

Prior to the pandemic the both the NHS and the private sector had failed to respond adequately to rising demand. Within the NHS, inpatient mental health beds have fallen from 18,750 to 18,232 over the last five years. This shortage of hospital beds across the country means that vulnerable patients are being treated out of their local area, away from families, causing distress and slowing their recovery. Alternatively patients are being treated in the community with greater risk.

It's all about the numbers

The NHS regularly searches countrywide for mental health bed space for patients and has little option but to lean heavily on private providers. A recent study found that 99% of Out of Area placements for patients with personality disorders were provided by the private sector.

Although private providers are taking up more NHS work they too are facing difficulties in recruiting qualified staff which has caused them to cut the number of beds they can provide. A report in the FT notes that they have reduced beds for children

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Mental health: is private in-store support the future?

Boots brought private health a little closer to the high street last week with the launch of a subscription-based, on-demand service for customers suffering from depression and anxiety.

A press release supporting the move cites the current crisis in free mental healthcare provision in the NHS – and appears to link it with a claimed rise in in-store demand for psychiatric support – to explain why Boots is launching the paid-for service.

The retailer, owned by US pharmacy giant Walgreen, already offers a pay-as-you-go online doctor service for minor ailments, at £15 per virtual visit, and last autumn it unveiled an in-person version of that service at its 2,200-plus sites, in a move marketed as offering "immediate diagnosis, treatment and medication for the price of a Nando's".

The new depression and anxiety service costs £65 per month, a sum that covers GP consultations and medication but not, we understand, talking therapies – the latter will be available separately from Boots, along with mood and symptom checkers.

Clearly designed to target 'time poor, cash rich' clients with psychiatric symptoms that aren't likely to require inpatient care, this expansion into mental health services by a commercial operator aligns well with various political initiatives introduced in recent months, all seemingly designed to bolster the role of retail pharmacies within the public sector.

In October health secretary Sajid Javid insisted that primary care networks used the NHS Community Pharmacist Consultation Service, overseen by the independent Pharmaceutical Services Negotiating Committee (PSNC), and he also mooted the idea of a national version of the Pharmacy First marketing programme, currently being piloted by local CCGs across England.

Meanwhile, the PSNC has itself been lobbying for pharmacy representation on the NHS' new Integrated Care Boards, and last September the All-Party Parliamentary Pharmacy Group launched an inquiry, supported by the PSNC, into the future of pharmacy in the wake of the pandemic, seeking views from the pharmacy sector on a range of issues, including "how pharmacy can be better integrated into NHS care pathways".

But it's unlikely any of these initiatives will have much of an impact on the provision of mental health services in the public sector, and neither will Boots' latest 'product offering', despite the retailer's chief pharmacist claiming that it will "[help] relieve pressure on… services already available through the NHS".

The Lowdown has reported extensively in recent months on the extent of the crisis in mental health care, but it's simply worth noting here that there are now 1.4m people on the waiting list for care in the sector, with an additional 8m who would benefit from care but do not meet current criteria. And also that mental health bed numbers fell from 23,208 in September 2011 to 18,493 in September 2021.

Last month the NHS Confederation and the Royal College of Psychiatrists jointly warned of a "second pandemic" of depression, anxiety, psychosis and eating disorders, with a 52 per cent rise in emergency referrals since early 2020. They claimed that 10m people in England are now predicted to need new or additional mental health support over the next five years, and called for an expansion of NHS estates for specialist mental health care, along with a major recruitment drive – one in ten consultant psychiatrist posts are currently unfilled.

While there is obviously a huge unaddressed demand for mental health services, that's down to the pandemic and a decade of public sector underinvestment – not a lack of participation by US-owned retail chains. Which rather begs the question: does Boots' latest initiative represent anything more than low-level fear-based marketing?

Martin Shelley

Insourcing – private companies working in the heart of NHS hospitals

With elective care waiting lists at a record high of over 6 million, hospitals are working flat out to make a meaningful impact, with hospital trusts having to find ways of getting more work out of a workforce exhausted from the pandemic. The situation has given private companies a way into the heart of the NHS – its hospitals – in the form of insourcing.

Insourcing – inviting a private business to carry out work on the trust's premises – is now a rapidly growing way for private healthcare to generate revenue from the NHS.

In the past the word 'insourcing' has been used to describe taking back in-house a service that has been outsourced, however NHS England, NHS Improvement, and the Department of Health and Social Care describe insourcing as:

"where an NHS organisation subcontracts medical services/procedures. It differs to locum supply in that the full end to end service is provided, not just staff. The supplier uses the NHS organisation's premises and equipment to deliver these services, however remote consultations are also available."

The idea is that these companies conduct medical procedures, such as surgery and diagnostics, in NHS premises in downtimes, primarily the weekend, when the NHS is not using the premises. The staff they employ are generally full-time NHS employees who work on their rest days.

A national framework agreement is in place with NHS Shared Business Services listing 18 companies. These companies have already gone through a competitive tendering procedure to be put on the list and can be used by trusts without additional contract tendering.

The framework began back in 2018 and runs until September 2022. However, trusts are also using companies that are not listed on this framework.

The popularity of this approach has increased over the past few years and with any extra money for the NHS being funnelled into reducing the elective care waiting list, it is likely to keep on increasing.

The healthcare market analysts Mansfield Advisors have noted that the NHS insourcing market is one of the fastest growing markets in private healthcare, in the 2019 financial year it was worth £44m, by FY2021 it had reached £95m, and is predicted to rise to £139m in FY2022 and £295m in FY2024.

Companies active in the area and listed on the NHS SBS framework include Totally Healthcare, Eden Clinical Services, Gutcare, The Endoscopy Group, Medinet, and Alliance Health. Services being carried out by these companies include dermatology, general surgery, endoscopy, radiology, and a range of diagnostics for neurology and cardiology.

The companies perform services for less than the NHS tariff, often at 20% less. The reason they can is that the private companies don't have the fixed costs of their own hospital. This makes the process of insourcing highly attractive to the trusts, which are desperately trying to get more done within budget constraints.

The popularity of insourcing with trusts also relates to how insourcing falls outside existing mechanisms for regulating staff labour. There is a cap on how much trusts can spend on agency workers and rates can only be increased beyond the cap to fill a shift if there is a patient safety issue, and it may be difficult to show there is an issue for routine elective care procedures.

Trusts can employ bank staff as they are not subject to a price cap, but this could be expensive for the trusts as they may find themselves paying significantly more, particularly for nurses and allied health professionals.

It begs the question, if staffing is such an issue within the NHS, where do the insourcing companies find their staff. The companies recruit full time NHS employees who work for the insourcing companies on their rest days, often Saturday and Sunday. The companies recruit from a larger pool of staff across a number of trusts – a team working for an insourcing company at one trust is likely to consist of employees of several different trusts.

Pension benefits?

The attraction for consultants of working for an insourcing company on rest days is that the pension tax threshold is not an issue. Consultants may not be willing to work extra bank shifts however much they may be paid as earning money from bank shifts increases the likelihood of both breaching the pension tax threshold and increasing the amount of tax payable by making automatic pension contributions.

Unfortunately, until changes are made to the pension situation this will limit the number of consultants willing to work overtime within the NHS with the knock on effect of increasing the

popularity of insourcing companies as the only way to get extra procedures carried out.

Are things likely to change any time soon? Speaking at the Nuffield Trust's virtual annual conference 2022 Amanda Pritchard, CEO of NHS England, said that NHSE leaders were actively "working with government" on making pension arrangements more attractive in a bid to support the NHS workforce.

There have been calls for changes in the pension situation for some time. But in February 2021 the government announced it was going to ignore proposals in a 2019 consultation designed to make it easier for consultants to work extra shifts in the NHS, as it felt the changes it had made in the March 2020 Budget had resolved the issue of clinicians being discouraged to take extra shifts.

But the pension issue has not been resolved and consultants do not want to do extra NHS hours. So for now, private companies will continue to find lucrative work within hospital trusts as they attempt to reduce their waiting lists.

There are already signs that private companies are trying to cheat the system leading to issues with workforce availability. In January 2022, NHS England and NHS Improvement had to send out guidance after it became aware that several staffing agencies were approaching NHS trusts offering insourcing solutions that were just providing staff at an escalated rate of pay.

These insourcing solutions have included "the provision of individuals or teams of clinical and medical staff who are paid at an escalated rate above the NHS England and NHS Improvement price caps" and who are engaged through a staffing agency not on the insourcing framework.

The use of escalated pay rates attracts workers from elsewhere in the NHS, which in turn reduces the supply of agency workers available to fill shifts in the trust and wider health system. It also has "a ripple effect on general agency rates, as it raises the pay expectations of agency workers, and forces other departments and trusts to increase their rates to attract their workers back."

It would be good to think that if the NHS pension issue is sorted out, then there would be no need for insourcing. If the companies can find NHS staff to run an operating theatre or carry out diagnostics on a weekend, then the NHS should be able to do this as well. If the companies can recruit staff from across trusts to get a team together, then the NHS should be able to do this as well. This would remove yet another opportunity for private companies to profit from the NHS.

Charges loom large in NHS recovery plan

Although the Department of Health & Social Care (DHSC) has yet to make a formal decision on ending free prescriptions in England for most 60- to 66-year olds, an announcement is widely expected next month, when the provision of free lateral-flow covid test kits for everyone bar the extremely vulnerable will also be withdrawn.

Coming just a month after a leading thinktank suggested people should pay for GP appointments, the combination of these moves hints at a new government approach to stem rising NHS costs: charging for items and services that are currently provided to patients for free.

With the over-60s accounting for almost 63 per cent of all prescribed items that are dispensed free of charge, the government risks alienating its traditional electoral constituency if it restricts the provision of free prescriptions. Nevertheless, it put the proposal out to public consultation last year, accompanied by DHSC guidance that detailed its potentially negative financial and health impacts.

This guidance noted that the proposal would mean patients reaching the age of 60 would need to pay charges for six more years than they do now, disproportionately affecting disabled people who are more likely to have long-term health conditions. It pointed out that extra charges could lead to people not taking their prescribed medicines, potentially leading to additional costs in social care in later years. And it recognised that people may stop using medicines as frequently, leading to increased hospital admissions and GP appointments.

The DHSC's guidance still failed to fully reflect evidence from earlier research on the downside of prescription charges, some of which contradicts the government line on the prescriptions proposal that "an increase to the upper age exemption could generate additional revenue for NHS frontline services".

In 2000, a review by York University's Theodore Hitiris concluded, "Prescription charges have an inverse effect on the demand for drugs by patients liable to pay the charge. Increases in charges are associated with a significant reduction in utilisation of prescribed drugs among non-exempt patients."

He added, "There is also evidence that the short-term target of using charges to raise revenue is pursued at the expense of the long-term health of persons, and this may cost more to the NHS than the increase in revenue. Therefore, the introduction of [charges] is not an efficient policy."

To offset the financial impact of the prescription proposal, the DHSC last year mooted the introduction of a £108 "prescription prepayment certificate", but Age UK has dismissed this idea as a stealth tax, describing it an opportunity to extract more cash each year from the estimated 2.4m people aged over 60 who previously didn't have to pay anything at all.

Charges for lateral flow tests...

Meanwhile, the scrapping of free lateral-flow covid test kits from 1 April has already led to these items being sold over the counter in high street pharmacies. Boots is now selling kits online at £5.99 each or four for £17 (and £12 for a pack of five if bought in-store). Superdrug has followed suit, and has set its prices even lower, at £1.99 for a single test and £9.79 for a pack of five bought in-store.

These prices are thought to be broadly equivalent to those charged in Europe, and lower than in the US. But the kits are still not free, and the public health implications of charging for them have been an issue ever since the possibility was first discussed back in January. That same month Liverpool University's Iain Buchan warned of the associated dangers, notably telling Reuters that, "Viruses move quicker than free market economics."

... and for GP appointments?

The suggestion that GPs should charge for appointments to ease pressures on the NHS is certainly radical, and one not – so far – backed by health secretary Sajid Javid. But it's an idea being promoted by Whitehall thinktank the Institute for Government.

Speaking at a Resolution Foundation event last month, the institute's chief economist Gemma Tetlow told attendees, "The UK is really unusual in not charging for GP appointments. I know it's utterly beyond the pale to suggest that here, but it's extraordinarily common [elsewhere]. And if you think about the incentives for utilisation of healthcare, having some kind of private cost so that someone [thinks], 'Do I actually really need to go and see the GP?', could have lots of benefits."

But despite such free-marketeer enthusiasm, there is scant evidence to justify imposing GP appointment charges. In fact, back in 2005 the King's Fund thinktank concluded that, to the contrary, there was substantial international evidence of the detrimental health effects of charging, in addition to evidence in the UK that charging actually reduced utilisation of non-exempt services.

And more recently, the Nuffield Trust's chief economist John Appleby analysed the potential impact of charging £10 per GP visit. Taking as a starting point a 2007 Ipsos MORI poll on access to NHS dental treatment, which had found that 4 per cent of

those surveyed mentioned cost as a major factor in not seeking care, Appleby suggested that any cash-raising dividend for the NHS – possibly around £4bn – would therefore be significantly reduced, due to the number of exemptions needed to prevent around 1.7m patients from being deterred from seeking help.

Negative impact on maternity services

The experience of pregnant migrant women accessing maternity care in the NHS also offers a sobering perspective on the real-world impact of healthcare charging.

Last week the charity Maternity Action – which helps hundreds of women each year to navigate the health service's existing, albeit limited, charging system – told the Guardian that one trust asked a migrant woman for a £5,000 deposit for her birth, while another trust demanded monthly repayments of £800 from a woman who could not afford to pay, and then referred her to a debt collection agency while she was still pregnant.

A spokesperson for the charity added that NHS trusts had wrongly assessed charging regulations "many, many times", and the Royal College of Midwives has now called on the government to scrap the "punitive" NHS charging of pregnant migrant women completely.

It's not even clear that charging will significantly add to NHS revenue. Research by healthcare pressure group Docs Not Cops in 2015 found that a third of all NHS trusts in England spent more on the staffing and administration costs of implementing charging than they actually recouped, despite the fact that migrants at that time were charged 150 per cent of standard fees to compensate for such costs.

A 'return on investment' review of the public health sector, published five years ago in the Journal of Epidemiology & Community Health, also undermined arguments for the introduction of charging across the NHS. The review found that for every £1 invested in public health, £14 is subsequently returned to the wider health and social care sector, and that cuts to public health services therefore represent a false economy.

A follow-up analysis in the journal BMJ Global Health again appeared to undermine the case for increased charging, concluding that, "The published evidence to date suggests that reducing user charges is likely to have beneficial effects on health outcomes."

And the 2005 policy paper from the King's Fund thinktank policy paper mentioned earlier also offered compelling evidence that taxation, not charging, was the fairest and most effective way to pay for the health service generally.

It also emphasised that charging was "inimical to the basic principle of the NHS [which was] founded principally on breaking the link between healthcare consumption and ability to pay, in order to promote the socially desirable goal of equity of access to healthcare".

Martin Shelley

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and teenagers in England by 325 over the past five years, which leaves just 1,321.

The Priory, the UK's largest private mental healthcare provider, told the FT that the closures of beds were "the result of having to address a sector-wide shortage of specialist child and adolescent clinical staff". It reminds us too that the independent sector leaves the NHS to invest billions in the training of health specialists to secure future staff.

Supply and demand

The weakness in NHS workforce planning, disabled for many years by underfunding, has left NHS providers to watch in dismay while the gap between supply and demand widens. In the 3 years before the pandemic patient demand for NHS mental health services rose by 21%. No wonder then that the increase of under 5% in NHS mental health nurses over the same period was simply not enough to cope. And the stark reality is that the current nursing workforce in mental health (38,897) is still lower than the number working in the NHS 12 years ago (40,602 – NHS Digital Oct 2021).

Shortages in mental health doctors have also been consistently highlighted by the health professions who point to the fact that the NHS has only 1 consultant psychiatrist for every 12,567 people in the country and 10% of posts are not filled.

In a survey by the mental health charity Stem4 published back in December 2019, 43% of UK family doctors were already telling the parents of children who were struggling with anxiety, depression, self-harm or eating disorders to seek treatment privately, a self-pay market which is rising sharply since the pandemic. Waiting times for assessments for conditions like ADHD are driving patients towards the private sector to such an extent that delays are evident there too.

Patients are getting sicker while they wait. Two-fifths of patients end up seeking treatment from emergency or crisis services, with one-in-nine (11%) ending up in A&E, research by the Royal College of Psychiatrists has found.

And the problem is going to get worse. Unsurprisingly since the pandemic the number of people asking for help has soared. In the 3 months from April to September 2021 there was an 81% increase in referrals for children and young people's mental health services alone.

The need for a long term strategy to raise NHS capacity has never been stronger. And yet the health secretary has confirmed in his most recent speech that new NHS staff will have to be found from existing budgets.

And so the NHS will continue to be undermined by its limited capacity and heavily reliant on the private sector to treat its patients even though there are widespread problems in accessing care through this approach – all evident even before the pandemic.

Unfortunately the government is still to learn that the policy of underfunding the NHS and shifting more patients into the private sector is no guarantee for the quantity or quality of services that NHS patients need.

Paul Evans

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If you've enjoyed reading this issue of The Lowdown please help support our campaigning journalism to protect healthcare for all.

Our goal is to inform people, hold our politicians to account and help to build change through evidence-based ideas. Everyone should have access to comprehensive healthcare, but our NHS needs support.

You can help us to continue to counter bad policy, battle neglect of the NHS and correct dangerous mis-information. Supporters of the NHS are crucial in sustaining our health service and with your help we will be able to engage more people in securing its future.

We know many readers are willing to make a contribution, but have not yet done so. With many of the committees and meetings that might have voted us a donation now suspended because of the virus, we are now asking those who can to give as much as you can afford.

We suggest £5 per month or £50 per year for individuals, and hopefully at least £20 per month or £200 per year for organisations. If you can give us more, please do.

Please send your donation by BACS (54006610 / 60-83-01), or by cheque made out to NHS Support Federation and posted to us at Community Base, 113 Queens Road, Brighton BN1 3XG.