BMA CAMPAIGN **Hamish Meldrum**

Stop this wasteful commercialisation of the NHS

The drive to introduce private sector initiatives into the health service has led to inefficiency

In February the BMA launched to the general public its "Look after our NHS" campaign, which aims to stop the increasing commercialisation of our health service (*BMJ* 2010;340:c884). This does not mean we believe that the private sector doesn't have a role to play, but it should be used only in cooperation with existing NHS services and in circumstances where the NHS cannot fulfil a key requirement for patients. Unfortunately the NHS at the moment is being submitted to a programme of reckless commercialisation that threatens to undermine the principles on which it was founded.

The response to our campaign from Civitas and other pro-market groups was predictably hostile. Accompanying the vitriolic attacks on the BMA was a rosy picture of a healthcare system where the NHS and private providers compete on an equal footing for the custom of patients—with the tacit implication that this arrangement allows the private sector to deliver a whole host of benefits and innovations that the sluggish public sector cannot.

At the centre of this argument is the championing of the two great benefits of deep involvement of the private sector in the NHS: increased quality and reduced costs, thus leading to greater productivity and streamlined efficiency. Repeated constantly by ministers and profit seeking companies, this is the deafening mantra used to sell the commercialisation of our health service to the public.

Yet while those involved in the market experiment spin this line with great enthusiasm, the evidence for such benefits is hard to find, and the drive to introduce private sector reforms has resulted in a staggering catalogue of wasteful, inefficient spending. A good starting point when approaching this topic is that much maligned group who often have a hand in embedding market reforms, management consultants. They are a group of professionals who can be a force for positive change; however, in recent years they have been a substantial drain on precious NHS resources, often in relation to tasks of questionable value. Last year, for example, Hull primary care trust spent at least £75 000 (€83 000; $114 000) on private sector consultants to advise on how it should privatise its provider arm. Remember, this figure does not include the practical costs of privatisation—including altering the tax and pensions status of employees and making sure that every bit of stationery has the new logo printed prominently—it covers only the gathering of advice on how to make these changes.

In total the Department of Health spent £125m in 2008-9 on management consultants and well over £400m in the three previous years—most of this on how to manage the sort of market reforms being driven through in Hull, without public consultation.

Even the government has realised that money has been thrown away needlessly and has pledged to scale back its use of these consultants. But the policies they were brought in to deliver remain in place and continue to be startlingly expensive, and there is ample evidence that the private sector has often been given a costly advantage in the terms of its contracts with the NHS, primarily to induce them into the health sector. Importantly, there is little tangible evidence that this expensive move provides real benefits to patients.

Again, we are spoilt for choice in terms of figures and examples that demonstrate these points. In secondary care the first wave of independent sector treatment centres delivered just 85% of what was paid for—suggesting a shortfall of £220m on the £1.47bn worth of contracts. Every eight cases diverted to an independent sector treatment centre costs the taxpayer the equivalent of almost 10 cases dealt with by the NHS, owing to the overgenerous contracts. In primary care the much vaunted new GP led health centres have enjoyed, on average, three times the funding per patient of regular general practices. To meet the commercial demands the NHS often contorts itself into maddening examples of bureaucratic perversion. In a recent report Derby City primary care trust admitted to using a "package of measures" to boost the number of orthopaedic treatments at the new Barlborough treatment centre, including "a financial return to GPs when patients attended."

"Every eight cases diverted to an independent sector treatment centre costs the taxpayer the equivalent of almost 10 cases dealt with by the NHS"

I could go on at length with more examples, but ultimately pure market theories have simply not delivered an acceptable level of return for the billions that have been spent erecting a system that the public didn't ask for or want. A recent survey by the Economist Intelligence Unit found that less than a quarter of the UK population believes the NHS would be improved by a greater role for private providers, an indication that, thankfully, patients are not being taken in by the spin from the pro-market lobby.

In a tight fiscal environment that is likely to continue for many years, we cannot afford to waste resources, time, and effort on a commercialisation project that has not delivered. A key reason for doctors and other healthcare staff entering medicine is an ethos of cooperation and equality, the original tenets of the NHS when it was founded. Our campaign has grown directly out of our members' desire to protect these important values—and it is now time for policy makers to stop wasting money and get back to helping staff deliver the best service for patients.

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YANKEE DOODLING **Douglas Kamerow**

Is hypertension really a neglected disease?

If the US Institute of Medicine says so, it must be true

Quick, what do you think of when you hear the term "neglected disease"? Kala-azar, perhaps, or schistosomiasis? Me, too. In fact, Wikipedia, the source of all knowledge these days (sorry, *BMJ*), says that the neglected diseases are "a group of tropical infections which are especially endemic in low-income populations in developing regions of Africa, Asia, and the Americas." So I was a little surprised to read a new US Institute of Medicine report that says that hypertension should be added to the list of neglected diseases (*BMJ* 2010;340:c1074).

Everyone knows the IOM. Usually termed the "prestigious Institute of Medicine," it is the most junior branch of the US National Academies, "advisers to the Nation on science, engineering, and medicine" (as their tagline has it). IOM, chartered in 1970, includes about 1200 distinguished medical doctors and scientists. They serve on various committees and issue reports on all manner of health related topics at the request of the government and foundations.

The Centers for Disease Control and Prevention (CDC), specifically its division for heart disease and stroke prevention, commissioned this report. The CDC asked IOM for guidance on what its role should be in reducing and controlling high blood pressure. A committee was assembled, they and IOM staff worked on it for a year, and they have just issued their findings and recommendations.

Interestingly, just about their first conclusion was that—wait for it—given the burden of disease represented by hypertension, CDC's programme is "dramatically underfunded." This is pretty standard stuff in IOM reports. Agency asks (and pays) for guidance, IOM looks into it, and two findings emerge: the problem is really big and important, and the requesting agency needs more funds to fight it. CDC has always been a poor sister to the National Institutes of Health. The National Heart, Lung, and Blood Institute gets a cool $3bn (£2bn; €2.2bn) a year, compared with a paltry $54m for CDC's heart disease prevention division. Are you listening, Congress?

To be fair, there is a lot more to the report.

It begins by laying out the magnitude of the problem. Hypertension is common, affecting almost a third of all American adults. After decreasing from about 1970 to 1990, the prevalence of hypertension has risen in the past two decades. It is one of the leading causes of death, accounting for about 45% of all cardiovascular deaths. And it is expensive, with direct and indirect costs estimated to exceed $73bn a year in the United States. Hypertension is highly treatable, often with inexpensive, generic drugs, together with weight loss, proper diet, and exercise. It is even, in many cases, preventable, through the same hygienic measures.

Despite the relative ease of treatment and the wide attention it has had through such initiatives as the National High Blood Pressure Education Program, hypertension is not well controlled in many patients. Although more than 70% of people with hypertension are aware of their condition, only 61% are treated, and only 35% are under good control.

The reasons for this are not well understood. Some of it is due to access and economic factors, some is patients' attitude and knowledge, and some is lack of proper treatment by doctors. Long discredited ideas, such as the benign nature of isolated systolic hypertension, still have a hold on many doctors. Some doctors won't treat "mildly" elevated blood pressure or will allow elderly patients "10 points per decade" over 60 before they consider treatment. This is where the neglect comes in, I guess. Patients know they are hypertensive. Doctors know they are hypertensive. Too little gets done about it.

"Just for fun we pulled some patients' charts at random. A surprising number had blood pressures above 140/90 mm Hg, despite being "under treatment"

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The report recommends that, given CDC's limited resources, public health interventions will deliver more bang for the buck than one on one clinical treatment. The problems with the public health approach, however, are obvious. Firstly, interventions are easy to list but hard to implement. How does a government agency spend money wisely to decrease a population's obesity, increase physical activity, and encourage heart healthy diets? Secondly, with one exception, there is nothing unique to hypertension about these interventions. They are the same ones recommended for preventing obesity, diabetes, arthritis, and almost everything else that ails us. Only sodium reduction is particular to high blood pressure. That might be one of the public health take-home messages from this report, if we can figure out population strategies to decrease salt consumption.

Even though the report focuses on population based policies and system changes, I am still drawn to the clinical challenge. The day the report came out I asked some family medicine residents if they thought hypertension was a "neglected" disease. They looked at me as though I was daft. "We spend all day every day treating high blood pressure." That's what I thought, too, but just for fun we pulled some patients' charts at random. A surprising number had blood pressures above 140/90 mm Hg, despite being "under treatment."

So maybe my cynicism was uncalled for. Maybe hypertension is indeed a neglected disease. Maybe I should add it to my shortlist of things we doctors have to be good at in order to be members of the Good Doctors' Club. And maybe this IOM report is an important one after all.

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FROM BMJ BLOGS **Domhnall Macauley**

Goodbye health visiting

Baby clinic was always the happiest and busiest afternoon of the week. After routine medical checks, there was a chance to share the excitement of the new baby and build on a relationship for the future. Our practice has had an open access baby clinic, where mums can see both the doctor and health visitor at one visit, for many years. But with patients drawn from two health districts, health visitors based in the other area had to cross an arbitrary boundary to see our patients who lived in their patch. Every so often a new manager would change the structure of the service, introduce new ideas like first parent visiting or geographical allocation but we tried hard to maintain the personal relationship with a named health visitor. It worked very well and, over the years, we worked closely to sort out some very complex problems and supported our health visitor colleagues when there were difficulties. At one stage, when they felt threatened by the erosion of their professional role, they asked if they could immunise our patients at the baby clinic in order to maintain their skills. It was great working as a team.

> **Once health visiting dissociates itself from direct first line patient care, I cannot see it surviving as an independent profession. Health visitors will, most likely, become a form of hybrid social worker**

Today we received a letter from their manager (director of primary care, older people and executive director of nursing), saying that her health visitors would no longer cross the boundary to provide a service in our practice. No consultation, no negotiation, no discussion.

For a practice that has always been a strong advocate of interprofessional collaboration and interdisciplinary learning (we set up the first nurse practitioner course with the RCN), this was disappointing. In the past, we would have arranged another meeting and tried, yet again, to point out the benefits of working together. But, in today's climate, it is increasingly difficult. The media image of general practitioners is such that no one believes we could possibly be thinking first about our patients and their care and how working as a team in one centre might make life easier for young mums. And our nursing colleagues seem increasingly determined to go their own way. They argue that they provide a clinic elsewhere. Mums, however, will still come to our baby clinic, worry about feeding and weight gain, ask about problems with breast feeding and changing formula, and bring sick babies and their siblings. For some, their own health visitor will not be there.

It is sad to see health visitors making themselves increasingly irrelevant. We enjoyed working with them. There were some wonderful women, outstanding professionals, and they taught us a lot. Once health visiting dissociates itself from direct first line patient care, I cannot see it surviving as an independent profession. Health visitors will, most likely, become a form of hybrid social worker. Give it five to 10 years, perhaps less. We will miss them.

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Members of doc2doc, BMJ Group's online global community, are discussing doctors' handwriting

Analuisavidigal: "Mine is terrible, and because of this I prefer to type. Sometimes I can't even read my notes or my supermarket list."

csm@csm: "A kid in a primary school was advised to improve her handwriting. The kid replied, "I am going to become a doctor and that's why I'm preparing for that…"

Martin Young: "My hanwiting is grate but it is mi speling dat is atroshus!"

petrel: "The all important thing is the pressure of work. If you see 10 people a day, your records can be works of art. If you see 50, the writing resembles hens' scratchings."

Hanlmp: "I have learnt to write clearly but quickly, for accurate communication, from an alternative career requirement, now I'm going into medicine should I mess up my handwriting?"

Eva Marie: "At primary school my handwriting was a disaster. Everybody prophesised I'd become a doctor."

Odysseus: "An arrogant barrister (tautology ?) once quizzed me in court about my hand-written notes. I retorted that they were not Hansard but my own personal *aide mémoire*. He desisted from further interrogation on that point."
"I once had a medical registrar whose writing was so illegible we had to stop him prescribing and sent him to a hand writing course before allowing him back on duty."

Imran Qureshi: "I am fortunate enough to have been tied to handwriting books as a child and throughout my formative years was encouraged that good penmanship was as important as learning how to spell or memorising your times tables."

Artemis: "Not sure that handwriting lessons help - I had plenty over the years, along with jokes that only pharmacists could read my youthful letters. Having to write fast and sign loads of stuff only makes things worse. Not sure why so many doctors fit the stereotype, but thank god for computers and typing!"

jamilhussain: "A urologist (defendant in a law suit) could not read his own hand writing in the court. This is indeed a major dilemma. One in four physicians in the US is a foreign medical graduate (not necessarily well versed in English language) and sometimes write what they do not mean in the hospital charts."

How bad is your handwriting?
Have your say at http://tinyurl.com/yjmb6b7