How unpopular healthcare legislation can be dealt with

New Zealand has shown that repeal of competition based health law resulted in a better, more integrated care system

It is now hard to find anyone in England who believes that the 2012 Health and Social Care Act was a good idea, with one senior Conservative politician branding it the greatest mistake of this parliament.\(^1\) There is, however, less agreement about what to do about it. The BMA has voted for its repeal, and Labour and Green MPs have introduced an NHS Reinstatement Act to repeal it.\(^3\) Others are more cautious, arguing that, although changes are needed, they should build on rather than tear up the existing legislation.\(^6\) They contend, firstly, that no one wants another major reorganisation and, secondly, that it is simply impossible to return to what went before.

**Failure of the market model**
The first argument has already been disproved, and major legislative change now seems inevitable. The complexities and contradictions of the competition elements of the Health and Social Care Act are seen as unworkable by many. From the outset, general practitioners, seen as leading the new clinical commissioning groups, failed to engage with them.\(^5\) The large corporations, envisaged as new providers of NHS services, are withdrawing as they realise they cannot make profits without incurring reputational damage.\(^4\)

But what about the second argument? Can the act be repealed?
The experience of New Zealand shows what’s possible. In 1993 the National (conservative) government had implemented an “internal market” that went far beyond what was then being espoused by the Thatcher government in Britain. It was based on the belief that market forces, with competition from commercial providers, would enhance effectiveness and efficiency.\(^8\) Many of the features would be familiar to contemporary observers of the NHS. In theory there was to be no preference between public and private providers. In practice, though, there was a predisposition towards the private sector. Previously public services were contracted out, and public hospitals were run by state owned companies governed by the Commerce and Companies Acts, with many of the features of NHS foundation trusts.

As the 1990s progressed it became clear the new model was failing. It led to contradictory and perverse incentives, neglect of workforce development and planning (the legacies of which still plague the system), fiscal irresponsibility, and excessive transaction costs. Nor did it reduce government spending. In 1992-93 health expenditure was $NZ24.88bn, but by 1999-2000 it had risen by a third to $NZ26.5bn. In the same period, real terms government health spending per capita rose by 23% from $NZ1373 to $NZ1690.\(^10\)

The election of a new Labour led coalition government in late 1999 marked a major break with the prevailing market forces ideology.\(^11\) The existing legislation was repealed and replaced by the New Zealand Public Health and Disability Act 2000. The decision to repeal and replace rather than amend it was an explicit decision to signify its fundamentally different policy objectives.

The state owned companies were replaced by district health boards responsible for the provision of a comprehensive range of health services for a defined population, with objectives such as improving, promoting, and protecting the health of all people and communities, integration of health services (especially primary and secondary), and reduction of health disparities. The boards were not subject to the Commerce and Companies Acts, and their scope was extended from tertiary and secondary services to include primary and community services.

The clear success of the Public Health and Disability Act generated broad political support. When the National Party returned to power in 2008, leading a coalition government, it strengthened the act, attracting support across the parties. By 2011 an independent analysis concluded that the act had succeeded in integrating planning and funding functions and “assisted in focusing attention on the roles that an enhanced primary care service might play in better supporting integrated care.”\(^12\)

New Zealand has shown that health legislation that focuses on competition and market forces is unsuccessful and unpopular and that “careful crafting of governance, contracting, funding and information sharing” can achieve important benefits by avoiding competition and fragmentation.\(^14\) However, even more importantly it has shown how it is possible to repeal in its entirety a flawed piece of market based legislation, rather than simply amend it, replacing it with something that can actually deliver integrated care.

Crucially, this new model has proved highly resilient, both to a change of government and, in its greatest test, to the February 2010 earthquake that hit Christchurch. There is widespread agreement in New Zealand that the local model of integrated care was critical to mounting a successful response in the face of widespread devastation but that the system in place in the 1990s would have struggled to respond. In England the risk register leaked in 2012 explicitly warned that the Health and Social Care Act could make it more difficult for the NHS to respond to emergencies,\(^15\) a concern accentuated by experience of the challenge of ascertaining who is responsible for anything.\(^16\)

In 1938 New Zealand’s prime minister, Michael Savage, created a national health system, coining the term “from cradle to grave,” showing the British government what was possible. Maybe New Zealand is once again offering lessons for England.

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NO HOLDS BARRED Margaret McCartney

Can doctors fix cold homes?

Cold homes are bad for health—and also for the outcome of a society that doesn’t care enough about the people at the bottom. The social inequality that poor living conditions reflect is real and leads to people dying younger than they should.

The UK government axed the Warm Homes Healthy People fund in 2012 despite it having been “universally popular” in helping 200 000 people a year who needed emergency boiler repairs and hot food. The National Institute for Health and Care Excellence (NICE) has now made recommendations including the creation of a single point of contact for vulnerable people who need help with housing conditions.

This may be useful, but where is the money to help people who have poor living environments but no cash to improve their heating or insulation?

NICE has told GPs that they should “at least once a year, assess the heating needs of people who use their services, whether during a home visit or elsewhere.” But should cold homes be seen as a medical problem rather than a political and social deficit?

During routine work doctors come across all kinds of problems that are not medical. Holistic care is not merely about physical and psychological harms but also environmental ones. Truly preventive medicine concerns social equality, employment, living wages, and clean water, and it extends far into political territory. But GPs cannot take responsibility for the effects of poor housing stock without the power and resources—heating engineers and social workers, for example—to deal with it.

And what of the potential harm in opportunity costs? Our patients are getting older, accumulating more diagnoses, and GPs are dealing with the resultant complexity and polypharmacy, all with fewer hospital beds available. What gets squeezed out to make way for this new work?

In response to concerns about workload, NICE says that improving homes may lead to less work for GPs in the long term. This is nebulous. I remember NICE accepting expert opinion that noted “insufficient capacity within existing primary care resources to meet the increase in demand” when it lowered the recommended threshold for prescribing statins. But it went ahead anyway.

Improving housing conditions is a moral responsibility of society. For one doctor to discuss heating for three minutes with each patient in a practice of 5000 would take five weeks. As GPs we do not have capes or wear our knickers outside our trousers. To fit this in, then, NICE, what can we stop doing instead?

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IF I RULED THE NHS Ann Smallridge

Allow GPs and consultants to speak to each other again

I qualified in 1981 and have been a GP since 1986, spending most of the time in inner city practices in Manchester. Last year I was burnt out and decided to take a gap year, so I left my job and went to work as a GP in Cairns, Queensland. It was a joy to just be a good, old fashioned GP, managing people holistically without the tyranny of the Quality and Outcomes Framework and targets, medicines management, spreadsheets, and referral gateways.

I am now back doing locum shifts in Britain. If I ruled the NHS I would restore practice based community teams. I would encourage informal networking and trust the vast majority of NHS workers to behave professionally and with the best interests of patients foremost in their minds, without constant monitoring and checking what they do. Overmanagement and fear destroy professionalism and weaken the quality of care and carers’ sense of duty for and accountability to the patient.

I would allow GPs and consultants to speak to each other again. We should be making space for the meetings we used to have where GPs could get to know their local consultants and their special interests. The current system blocks sensible dialogue and appropriate referrals. I would allow consultants to book patients into their clinics. I would get rid of the referral management systems and gateways, which don’t offer real choice to the patient and cause delays. Many referrals and hours of time were saved by picking up the phone and discussing a case with a colleague who could give advice or see someone quickly.

We should allow GPs wider access to investigations such as magnetic resonance imaging and computed tomography and facilitate more contact with consultants to discuss cases. A named accountable consultant should be available to answer queries about test results, often passed to GPs to chase.

I would improve the interface between GPs and hospitals to tackle the problem of patients who do not attend. We should text, email, or ring patients to tell them about their appointments. The post is unreliable. Make sure they opt in, remind them, and then fine them if they don’t attend. Don’t cancel or rearrange appointments at the last minute then discharge patients from the system if they don’t attend.

Lastly, I would focus on learning from errors. All doctors now have to include audits of complaints and significant events in their appraisal documentation. Responsible officers should collect these, anonymise them, and look for trends. They should also liaise with local hospitals and look through all their significant event audits. These should be collated and circulated every quarter to all the relevant GPs.

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PERSONAL VIEW

thebmj.com
• Practice: Acute kidney injury: summary of NICE guidance (BMJ 2013;347:f4930)
• Editorial: Statins in acute kidney injury; friend or foe? (BMJ 2013;346:f1531)
• ABC of Kidney Disease: Dialysis (BMJ 2014;348:g2)

Automated alerts for acute kidney injury warrant caution

Moves to improve identification of acute kidney injury are to be welcomed, writes Simon Sawhney, but the diagnostic criteria are vague, he says, and caution is needed in interpreting test results.

As an academic renal trainee and apprentice of acute kidney injury (AKI), I have had the privilege of learning my art in parallel with a paradigm shift in diagnosis. In a decade the new term AKI has transformed our awareness of a serious condition that can happen anywhere in the NHS.1 2

AKI is defined by changes in serum creatinine from a previous baseline over a short period (28 μmol/L in 48 hours, or 50% in one week), and it is measured in three stages of severity depending on the magnitude of change. Even small changes in vulnerable patients can signal increased mortality.1 A national inquiry, Adding Insult to Injury, reminds us that late intervention can lead to preventable death, and we could all do better in our efforts to provide prompt and safe care.4 But our desire to recognise and treat patients early must be balanced with the harms of overdiagnosis and overtreatment.

A promising new development is the imminent mandated introduction to all hospitals in England of an automatic system to detect AKI.1 Using an algorithm modified from international criteria,3 a warning that AKI is suspected can appear automatically with a serum creatinine result. This may prompt early reassessment, close monitoring, or hospital admission. It may also be linked with clinical guidance and a national AKI registry. This could improve decision making and early management in a condition where most patients are cared for by non-specialists. But a new gadget should be stress tested for unintended effects and should come with a disclaimer against incorrect use.

An umbrella of pathophysiological states
AKI is not a single condition but rather an umbrella of pathophysiological states and circumstances that have led a person to cross a threshold and acquire new labels. Just as one extra grain of sand does not make a heap, logically one extra micromole of creatinine in each litre of serum does not make an AKI.4

Nevertheless, some creatinine changes will in time lead to some patients being judged as lying uncomfortably on the wrong side of a cut-off. This betrayal, without discernment, may risk misinterpretation or may be coupled with a diverging road in clinical decision making and unintended consequences. To add a further challenge, it is not even possible to apply the AKI diagnostic rules to a change in creatinine without some knowledge of the previous baseline, yet this is often unknown and assumed. The result is an abundance of definitions for AKI in clinical research, stemming from attempts to traverse a void of missing data.

So, we know in broad terms that patients with AKI have poor health, but we remain uncertain about how to identify those patients in whom the diagnosis matters most and where the prognostic influence is the greatest or most modifiable. We also remain unclear about the patients in whom we might be liable to overdiagnose disease and those whose disease we might underdiagnose, by using different definitions.

Just as one extra grain of sand does not make a heap, logically one extra micromole of creatinine in each litre of serum does not make an AKI.4

In the Grampian region of Scotland (population 530 000) our renal research group has tested variations of the intended NHS England algorithm for automated detection in a one year extract from our biochemistry database. Just a small change in the baseline definition—comparing creatinine concentration with the lowest rather than the median result from the past year (both are common definitions in AKI clinical research5)—increased the number of patients we labelled as having AKI to 5758 from 2546. We are left to speculate who the extra 3212 patients are and what the implications could have been of sending an automated alert or including them in a clinical research study.

Modicum of uncertainty
The widespread and successful implementation of an automated AKI detection system represents a great opportunity to improve further the early recognition and communication of AKI throughout the NHS. New tools, however, can come with unforeseen harms, and we must be careful to lay down clear boundaries as to how a new label of AKI is interpreted by specialists, non-specialists, patients, policy makers, and researchers. For instance, when I carry the on-call renal pager I will try to be proactive and to act early when called about the next patient with AKI—but with a modicum of uncertainty over what the diagnosis really is. Also, I will not reassure myself just because a patient’s results have not yet crossed the diagnostic threshold.

What is the diagnosis? AKI is what we choose to define it as, but we still have a responsibility to understand what it is that we are testing, whether we are focusing on the right people, and whether it is always clinically relevant.

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