

Power to the people?

Do personal budgets represent privatisation by the back door? Or could they provide a genuine opportunity for empowering patients and transforming the relationship between the state and the individual? Mike Foster reports from Westminster

PERSONAL health budgets are a bit like Marmite: you either love them or hate them. That was how Birmingham professor of health and social care Jon Glasby, co-director of the university's Health Services Management Centre, described attitudes towards an initiative that aims to give patients more control over their care.

Professor Glasby claimed momentum was growing in support of PBs (personal budgets) in health, following a period of 'policy hostility'.

However, the BMA has strong reservations about them. It has warned that they could undermine the fundamental principles it is supporting through its calls to 'Look After Our NHS'.

Personalised care

At the Westminster briefing event *The Health Bill 2009: Examining the Future of the NHS and Patient Care*, which was hosted by *The House* magazine last month, BMA council chairman Hamish Meldrum explained that doctors were in favour of providing personalised care in partnership with their patients.

But he said he was worried that PBs could become overly bureaucratic, adding transaction costs and creating a 'huge new industry'. He also expressed fears that they would reinforce the concept of an NHS market and a view of healthcare as a 'commodity'.

However, he added that, although he 'remained unconvinced' by PBs, he looked forward to the findings from provisional pilots of the concept announced by the Department of Health last month.

The 68 provisional pilots across 75 PCTs will examine how PBs could work in the context of long-term conditions, stroke, continuing healthcare, mental health, end of

life, substance misuse, learning disabilities and physical disabilities.

At the end of this year, these provisional pilots will be assessed, and some will go forward for full three-year pilots.

There are three models for PBs:

- A notional budget held by the commissioner. No money would change hands, but the patient would know what the costs of healthcare options were and the financial implications of the different ways of spending money. The NHS would be in charge of contracting and service coordination

- A real budget held by an NHS intermediary such as a GP, care manager or advocate who would help the patient decide what he or she needed; the patient and intermediary would then purchase care together

- Patients would be given a cash entitlement to buy the services and treatments that they thought best suited their needs.

The NHS already has the powers to implement the first two models. But the direct payment model depends upon the enactment of the Health Bill 2009, which is due for its second Commons reading on June 8, following debate in the Lords.

And it is this model, expected to be piloted from next summer, about which the BMA is particularly concerned.

Equity at risk

What would be the impact of putting a cash value on care? Will patients feel that they are burdens on the NHS and society, and seek to restrict their treatment? What happens if a budget runs out? Who is responsible? What if patients spend less than their budgets allow? Will they be encouraged to give surplus money back to the NHS or to spend all the money available?

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These are just some of the questions raised by the BMA. Doctors leaders fear equity could be at risk if some patients are allowed to buy services not normally available on the NHS. Also, NHS resources could be wasted if PBs were used for services and treatments that were not proven to be clinically sound or cost-effective.

Dr Meldrum cited the example of complementary therapies, saying many people wanted them but there was not a lot of clinical evidence to suggest that they worked.

'Are you going to allow patients to buy complementary therapies when they do not cut the mustard in the NHS?' he asked at the briefing.

Dr Meldrum also described the BMA's concerns about the scope and allocation of PBs. Will they be set nationally or locally? Will they include all aspects of care or just some of it? How will they be priced? Will budgets be calculated differently between PCTs or patients or between NHS and private providers? How will pricing be done for services in community care that currently do not have payment by results tariffs in the same way as secondary care?

Professor Glasby said there were more than 70,000 people receiving direct payments in social care, following their introduction in 1997. The government has said that within three years all adult social care will be provided through independent budgets and self-directed support.

The professor agreed that there was very little evidence about how PBs would work in healthcare and it could be difficult to decide where the boundary was between health and social care. However, he said

the experience in social care was that improved clarity about available funding and giving carers and service users more control over how money was spent gave people a sense of empowerment.

He said: 'If you explain this badly, it can look like privatisation by the back door. But I think it is about citizenship, changing the nature of the relationship between the state and the individual.'

Missing information

Rita Brewis, lead of the Staying in Control project of social enterprise In Control, which seeks to extend self-directed support into health, said those calling for PBs were not saying that patients always knew what was best for them. And she acknowledged that healthcare was very different from social care.

Ms Brewis said: 'Work in health is just beginning. We don't have the answers, and we are working through some of the things. We fully support an NHS being free at the point of delivery. This is not all about money. It allows for good planning and can be a lever for improving relationships.'

Staying in Control, a 'learning community' of 37 PCTs and local authorities, has been examining how personalised models tested in social care can best be amended and tested in the NHS. On July 1, it plans to unveil a model for the personalisation of healthcare, based on real-life situations.

The BMA will keep a watchful eye on developments. As Dr Meldrum said at the Westminster briefing, experience has shown that some pilots can be more like slow roll-outs of policies that are never properly evaluated. Then the NHS is stuck with them.

Doctors also want any decision about PBs to be preceded by a national debate that would take place alongside the pilots and continue after their results have been evaluated.

- BMA members can view a BMA briefing on PBs (personal budgets) and direct payments by logging in to www.bma.org.uk/healthcare_policy/Healthbill_policy.jsp

A full list of PB provisional pilots is at www.dhcarenetworks.org.uk/PHBLN/

To find out more about In Control, visit www.in-control.org.uk



HUMAN TOUCH: a session at the Tower Hamlets Exercise and Nutrition Programme. The programme has been set up as a result of Tower Hamlets Primary Care Trust's participation in the Staying in Control 'learning community', which is exploring the potential for personalised models of care to be used in the NHS

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