Consultation response

The King's Fund response to the Department of Health's draft guidance on NHS patients who wish to pay for additional private care

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The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

This paper is a formal response to the Department of Health's draft guidance on NHS patients who wish to pay for additional private care. The King's Fund previously responded to the Department of Health's review, led by Professor Mike Richards, into the consequences of additional private drugs for NHS care. This response is available at: www.kingsfund.org.uk/document.rm?id=7996

In addition, The King's Fund also produced a briefing on top-up payments, which includes background information on the processes by which drugs are granted NHS funding; clarifies how top-up payments are distinct from other charges in the NHS; and outlines the relevant existing legislation and guidance in this area. The briefing is available at: www.kingsfund.org.uk/publications/briefings/index.html

Is the principle of separateness clear?
The Department of Health has decided to define separateness in physical terms. As we have pointed out in our evidence to the Health Select Committee, this is only one of a number of ways of drawing a line between what the NHS will pay for and what individuals must pay for.

In the case studies set out on page six, it would be easy enough to estimate the additional cost of the multi-focal lens and to charge patients for that incremental cost. That would ensure that the NHS was not subsidising care it did not wish to pay for itself and that the patient did not lose the right to free NHS care if he/she chose this form of lens.

Given the choice of a physical criterion, the guidance is as clear as is feasible given the variety of situations in which care is provided. What is less clear, however, is on what broader principle the guidance is based. The principles set out in 3.3 and 5.1 do not rule out 'picking and mixing' private and NHS treatment within a single care pathway provided that the private element – ie, the element the NHS does not consider worth funding – is fully paid for by the patient or their insurer.

We support the 'no subsidy' principle and that the NHS should, generally, be free at the point of delivery. But it seems unwise to insist on the second principle in 3.3 that patients should never be charged for their NHS care given that the NHS does do so in some circumstances – for example, in the case of prescription charges.

Both the title of the consultation and the proposed dividing line between what is and what is not allowed in terms of extra privately funded care are based on the difference between one medical technology (a drug) that can be administered separately and another (such as a superior lens) that cannot be.

It is not clear though what moral distinction is being applied between the two cases. Is the refusal to allow the alternative lens based on the fact that patients would thereby be able to buy a better version of what is essentially the same treatment rather than a different treatment? Or is this not a moral distinction at all, just a practical one which in effect reduces to a minimum the number of instances where patients will seek to 'add-on' to their NHS care? More clarity on this would be helpful.

From the government's viewpoint the danger is that the contradiction between allowing top-ups when a patient can go to another place (possibly within the same ward or clinic) while refusing them in other circumstances will become hard to justify as the guidance is applied in practice. The guidance also suggests that private care should be provided at a different time – there is a danger here in making the guidance too prescriptive but it would be helpful to spell out what this might mean in practice.

The present form of guidance may provide a 'breathing space' while the other measures the government is proposing and which we support, such as negotiating new pricing schemes with the pharmaceutical industry, come into effect. It may be that these measures will reduce the problem to negligible proportions. But even if they do, it is not clear that the guidance will provide a lasting solution given the likelihood of challenge to the principle of physical separation from NHS users who will not benefit from it.

Are sufficient safeguards in place?
The draft guidance says that NHS clinicians should 'make all care options available to patients' (presumably this means 'explain all care options'), but then goes on to say that they should not initiate discussions about providing private services. These statements appear to be in contradiction. If a patient asks 'what are the options?', is that to be taken as 'asking about options not funded by the NHS' or just those provided by the NHS? If the latter, the current wording implies that it is for patients to research into non-funded treatments, but how are they to know what is or is not funded before the discussion takes place? We believe patients should have all their options explained, including if appropriate the option of paying for care the NHS does not fund.

We believe the guidance could be more helpful by giving more detail about how the costs of private treatment should be calculated. A definition of full costs, including how the time of NHS staff and overheads should be calculated, will be needed to ensure patients are treated fairly and that the NHS does not subsidise private treatment.

The wording of the 2004 Code is not precise on this and of course it was not written with the current situation in mind.

Should there be more assurance mechanisms in place to ensure the guidance is followed and does not lead to any unintended consequences?
Assurance appears to be left to strategic health authorities but no procedure is specified. It would not be sensible to specify a detailed procedure before the numbers of patients concerned and the circumstances of their treatment are known. The best approach may therefore be to set up some form of informal monitoring at this stage and then devise a formal procedure when the nature and scale of the issue is better understood.

In particular, it will be important to ensure that consultants are in a position to explain the financial as well as the clinical implications of paying for a 'top-up' drug. We also recommend that a payment limit should be introduced in the event that a drug does prove successful with that patient.