
BLOATED NHS FAILS IN FINANCE, TREATMENT, PATIENTS AND ETHICS

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The British NHS has changed for the worse. Patients are dying every day because the designers of the new NHS made some fundamental design flaws. The next government will no doubt put right some of these failures. However, some changes could be made now, with relatively little effort, and a high probability of success. Lives would be saved but it needs people in powerful positions with considerable influence to get things moving. Help is needed to overcome the inertia of the largest organisation in the country, the NHS. Do you have influence or know anyone who has influence?

The original 1948 NHS motto was "to each according to their needs". A more appropriate motto for the present would be "equality for all". Unfortunately "equality" does not equate with "fairness". So how has this come about?

As a patient with an incurable cancer I have seen the changes over nearly 14 years. During this time the doctors have managed to keep me remarkably fit, so much so that my family and I have been able to build our own house. Now the house will have to be sold to pay for the drug needed to give me some more years of life. My battle with the NHS is causing my family and I a vast amount of anguish. Yet it is all so unnecessary.

So what is to be done about it. It is probably an under-statement to say that the NHS finance systems are a shambles. Funding for new and experimental treatments tends to be refused on the grounds of cost by the same civil servants in the Primary Care Trusts who control routine medicines. In the political rush to put patients first, the doctors have been pushed aside. In particular the doctors' ethic of "saving life" has been replaced with the civil servants' ethic of "cost effectiveness".

These problems are going to effect the family and friends of every person in this country. The "post code lottery" is here to stay, unless we all try to do something to overcome it. The NHS is very sick and clearly writhing in financial pain. Can you help to change it?

Do you have the power and influence to arrange for hospital departments to be equipped with some decent microcomputer software to give the medical staff and supervisors sound operational and financial control?

Do you have the power and influence to get the NHS to spend some R & D money on experimental treatments for individual patients?

Do you have the power and influence to ensure patients really come first once again?

Do you have the power and influence to give doctors back the authority to authorise medication, which has been usurped by untrained civil servants in the Primary Care Trusts?

So what is wrong with the Finance System

The government poured billions of pounds into the NHS. It paid for an army of civil servants to man the Primary Care and other Trusts, and paid hush money to operational staff. The weak financial control disintegrated under the onslaught of this new money and changing structures. The rest of the money was overspent in a myriad new projects, and as publicised vast sums have been spent on computer systems of dubious value. It was often forgotten that current spending implies future upkeep.

The Audit Commission have produced at least one damning report dealing with finance from the top down. Let us hope some of you have the power and influence to get those recommendations implemented.

Budgetary control needs tackling from the bottom up. The first elements are already in place in a few hospitals. Nurses use hand held devices with touch screen and bar code readers to check patients receive the intended medication. It is fast, efficient and forms the basis of the raw data input that should allow supervisors to monitor the daily work of the department. Add appropriate data from Personnel, Stock Control, and Finance and the supervisor gets full financial control over expenditure. If we let the departments look after the pennies, then the organisation will achieve financial stability and control, and the pounds will look after themselves. Upload the summaries to the managers, and PCT staff will get what they crave, real time costs providing sound forecasts on which to base future budgets.

By sharing these programs over the networks we could follow the lead of successful computer companies like Microsoft. Teams of programmers could transform the control of NHS hospitals in a year or two, at a small fraction of the money spent every year over this past decade and we might even make a profit.

We must get the finances under control, so that the NHS can again hold up its head and demonstrate it leads the world, rather than trailing along like a third world country able to afford only the least expensive medication, so that patients die for lack of drugs.

Is there anyone with the power and influence to persuade NHS officials to urgently start building such cheap and simple (by their standards) financial systems?

Experimental Treatments

Funding of new drugs should be under the central NHS Research and Development. They already control drug trials, but at the moment they do not control the use of new drugs on individual patients. This is left with the Primary Care Trusts which control expenditure on all individual treatments from one pot of money. New drugs are inevitably more expensive than standard drugs, so new drugs are the first to be dropped during any period of financial stringency. The current brain washing of officials becomes apparent when you talk to them. When I struggled to explain to a PCT Commissioner that I was dying from lack of this drug and was therefore a special case, she responded that each and every patient was special, and had to be treated equally. It was not fair to give one patient a more expensive drug. How can you get through to people like that?

I tried the tack that doctors must try these new drugs to learn about how they work in practice. The response was negative. I was told PCT staff must control what experimental work can be supported within the money available. The PCTs are stretched to the limit with high profile projects, local to the PCT region. What this means of course is that the PCT can be seen to support influential local groups. The result is that country wide projects are starved of funds, so individual patients cannot receive new drugs and they die. The only option to these patients is to buy the drugs privately, if they can afford it.

I would visualise it administered by groups of doctors specialising in each disease, such as the Myeloma Forum for those patients with Multiple Myeloma. Such a system would provide an ideal repository for specialist patient data, suitable for researchers. This information should not be part of some grand database for the whole nation. Changes are needed in 12 months, not 12 years.

Is there anyone with the power and influence to persuade the NHS R & D to set aside a sum of money to spend on individual patients?

Patients First

The Health Minister repeats her mantra that in the new organisation patients come first. This is patently untrue. Before this new NHS was created by the present government, doctors decided what treatment was required, and the patient received that treatment. All patients received the treatment they needed, and none died for lack of medication in the UK.

Today, the doctor submits a request for a particular drug, and the PCT staff decide whether to approve or deny it. But the process is not as simple as that. The doctor has to allow for the fact that the administrative process takes weeks, or months.

Unfortunately the human body is rather fickle, and sometimes the doctor can only make the decision with hours to spare. Hard luck, that patient dies!

Take my own case. On 15th June 2006, my remission came to an end. The Myeloma paraprotein was seen to be accumulating in my bone marrow, so the doctor applied for Velcade. The refusal letter arrived on the 25th July 2006. We had forced them to move like greased lightning, and they had brought forward their committee meeting to accommodate this urgent request for drugs. It only took them 40 days before I knew!

The objection took another month, and the formal appeal yet another month. They are still prevaricating and might make a final decision in November. I have had to face up to the fact they have no intention of giving me the drug, and will find reasons to delay until I am dead. A doctor would be struck off for doing what the PCT staff are doing. Doctor Shipman was convicted of multiple murder for achieving the same result.

At the beginning of October I am receiving blood transfusions to keep me alive. I am spending my savings to pay for six weeks treatment. A loan will pay for further treatment, and the house sold to repay the loan. The reason the cost is astronomically high is that the Treasury takes 17.5% VAT because I am forced to become a private patient; the Hospital adds 10% for their overheads and every blood test and cup of tea is charged for, because the civil servants refuse to allow me to be treated within the NHS while I am a private patient, even though it is an NHS hospital. This is what their manuals tell them to do. The civil servants have it tied up in all ways.

This is NOT putting patients first. Doctors must be given back the responsibility and the means for obtaining the funds they need for saving life. Control of the patient's life has been passed to civil servants and committees working at a distance and making third hand judgments on matters with which they have little knowledge. The nation's choice is between paying for civil servants or paying for medical staff and drugs. The nation cannot afford both.

The patient has no comeback. The Police and the Health Ombudsman both advised me to go to law and they admitted they have no jurisdiction over civil service actions. I can assure you this option is only available to the very rich. I have tried and had to back down, because the choice was between "going to law" or "buying the drug". I could go to law later and probably win, which would be good for the nation, but not for my purse. The small portion of unredeemable costs would still exceed what I am paying for the drug.

Please, can someone find a way to fund all patients for the medications prescribed by doctors?

Civil Servant Ethic

The Department of Health has this army of civil servants in Primary Care Trusts and other unfathomable names, that reorganise themselves every few months. They have set up an uncountable number of committees, some with 20 members or more. They all hide behind their rule books. Doctors are “below stairs”. They are now the servants of the civil servants! As such doctors are scarcely mentioned in the rule books. These civil servants are the people given responsibility for the well being of the nations’ health.

They have adopted an ethic of “cost effectiveness” and, as beholds any civil servant, this ethic is surrounded with means to calculate “life expectancy” and patient “comfort”. They only need these because they never actually see a patient, except when granting a special audience. Statistics will allow them to determine how to treat the population; to decide what drugs are good and what drugs are bad?

As this empire has expanded it has become necessary to save money. They have the answer! It is not cost effective to treat patients who may have only a few months to live, particularly if there is no immediate cure. Let the rich buy the expensive drugs if they think their life is worth prolonging or quality of life improving. As for the rest of us, treatments of average cost are okay, but anything more is not “equality” and it exceeds the civil service limits!

Can you hear them say: “But that patient wants a drug costing 10 times the norm!”? The answer of course is that all new developments cost much more than the norm. Doctors have always tried these drugs out on patients with most to gain and least to lose: the terminal patients who are delighted to take the opportunity of another year or two of life. As I have done several times, turning an 18 month life expectancy into nearly 14 years to-date. For this I am most grateful, and I assume the doctors are too, for what they have learnt. As experience is gained, the costs come down, and the treatment is gradually accepted as the norm.

Can someone please find a way to give the doctors, arguably the most intelligent and able group of people in the NHS, the authority to ensure patients are treated according to need?