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# EQUIPOISE



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The  
Policy  
Issue



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***“Medicine is a social science, and politics is nothing more than medicine on a large scale.”***

**—Rudolf Virchow**

**H**ealth and wellbeing are deeply political issues and politicians of all parties do their best to assure us that they will promote the nation's health and protect our National Health Service. But despite much optimistic political rhetoric, we live in a society marred by persistent and intractable inequalities in health, with a healthcare system straining to cope with reduced funding, an ageing population and increasingly expensive medical treatments. And it's not just through the NHS budget that politics shapes our wellbeing – almost everything that politicians do affects population health, from spending on transport, education or the environment, to regulating pollution levels or the financial sector. Politics, power and ideologies shape the public policies that influence people's health.

For this issue, we asked leading researchers in the Department of Health Sciences, University of York, to look at the consequences for health and healthcare of the new UK government's policies. So here you will find new *Equipoise* Editor, Tim Doran, writing about the seven day NHS and Professor of Primary Care, Ian Watt, discussing the government's plans to train more GPs. Researchers from our Mental Health and Addiction research group, Ian Hamilton and Jaime Delgado, examine government policy on conditional welfare benefits for people with drug and alcohol problems and the provision of psychological services in deprived areas, respectively. Research fellow Jennifer Sumner asks whether the government's health strategy will support people with long term conditions, and Jo Taylor and

Anne Phillips examine the prospects for the NHS Diabetes Prevention Programme. Finally, renowned health economist and policy expert, Professor Alan Maynard, looks at NHS spending plans with a highly critical eye; and I discuss the implications for public health of the government's announcement of a national living wage.

The May 2015 election might seem quite a long time ago now, and things move fast in politics. Since May, we've seen the unfolding of the refugee crisis in the Mediterranean, dramatic headlines about the pollution caused by diesel engines, a call from health leaders for the government to increase taxes to cut sugar consumption, and strike action by junior doctors. Politicians are always doing 'medicine on a large scale' and at the University of York we'll continue to provide an evidence base for their policy choices and a critique of their actions and consequences, whichever party is currently in power. We hope you enjoy the Policy Issue.

This is also my last editorial for *Equipoise* as I've been appointed as the university's Research Theme Champion for Justice and Equality and will be giving much of my time to fostering research collaborations across the university's different faculties and departments. Our new editor, Tim Doran, will continue to highlight Health Sciences' research for our readers, and we hope you continue to enjoy reading about it.

**Kate Pickett**

**J'arrive...**

**Tim Doran**



# SEVEN — DAY — NHS SERVICES



## Why the need for seven-day services?

The National Health Service (NHS) was founded on fundamentally equitable principles, with the intention that everyone – regardless of circumstance – would have access to the same high standard of care, based purely on their clinical need.

Patients, therefore, have a legitimate expectation that the NHS will provide high quality care on an equitable basis. However, patients admitted to hospital at night and at weekends, when staffing levels are lower and some services are not available, are at greater risk of adverse outcomes – including death – than patients admitted when the hospital is fully operational.

Most attention has focused on what has become known as the ‘weekend effect’: the persistent finding of higher death rates for patients admitted on Saturdays and Sundays. This ‘weekend effect’ varies by condition, from a 37% increased risk of death for patients with renal failure to no apparent increased risk for patients with pneumonia.<sup>1</sup>

Overall, there are around 5,000 excess weekend deaths in England every year, which at first glance suggests the NHS is failing to meet one of its most fundamental obligations – to treat all patients equally. Instead, it appears that the chances of surviving a hospital admission depend on arriving at hospital at the right time – when the most experienced staff are on duty and the full range of diagnostic services are available.

## The government’s response

The coalition government recognised the existence of the ‘weekend effect’ during the last parliament and started to respond. The Department of Health funded a research programme into the phenomenon and marshalled the medical professional bodies, starting a debate on the causes and possible solutions.

The Academy of Medical Colleges was quick to conclude that improving quality and equity of care would require senior clinicians to adopt seven-day working, including supervising junior doctors and reviewing patients at weekends.<sup>2</sup> The Conservative party seized on this in its manifesto, pledging to provide seven-day access to GPs and “properly staffed” hospitals by 2020, to ensure that “quality of care is the same every day of the week”.<sup>3</sup>

Jeremy Hunt, Secretary of State for Health, has pushed this agenda hard since the election, although his rhetoric has relied on broad brush strokes and it is still not clear exactly what a seven-day NHS would look like. Initially, the government’s focus was on emergency care and supporting diagnostic services, but increasingly routine care is being included in the offer to the public.

## Will it work?

The move towards seven-day services is already being made by several hospitals, as part of a wider drive to make better use of resources, such as operating theatre capacity, round the clock. In addition to these local initiatives, there are wider national trends, including moves towards longer nursing shifts and extended contracts for community pharmacies.

The costs and benefits of these initiatives are largely unknown. Extending normal hours of operation could be cost-effective if it leads to improved access and better patient outcomes, particularly if these improvements benefit groups that are traditionally under-served and suffer worse health as a result. More deprived populations tend to make greater use of unplanned services and less use of planned services, and it is therefore feasible that extending opening hours could disproportionately benefit poorer groups and contribute towards reducing health inequalities.

### *There are around 5,000 excess weekend deaths in England every year*

However, it is unlikely that simply extending normal hours of operation will eliminate the 'weekend effect'. Unless there is substantial investment in training and recruitment, increasing the level of consultant cover during the weekends will require a redistribution of the existing workforce, diverting cover away from weekdays.

It is not even clear that the 'weekend effect' is due to poorer care. Fewer emergency patients are admitted to hospitals at weekends, which suggests that patients are more likely to delay presenting to services at the weekend or that assessing physicians have a higher threshold for admission. As a result, patients admitted at weekends are likely to be sicker, on average, than patients admitted during the week, and therefore more likely to have poor outcomes.

The costs of introducing seven-day services in hospitals are also unclear. The best guess of the NHS Seven Days a Week Forum is that it would cost the NHS over a billion pounds a year.<sup>4</sup> Even assuming that a fully seven-day service could eliminate the mortality gap between

weekdays and weekends, it would not be a cost-effective intervention, and there would be cheaper ways for the NHS to save 5,000 lives.<sup>5</sup> A more nuanced approach, extending services for key specialties rather than across the whole NHS, might prove more effective.

However, the issue of weekend deaths could just be a McGuffin. Tellingly, the Conservative manifesto commitment to seven-day services appears under the heading "We will make the NHS more convenient for you", with the emphasis on consumerism rather than safety.<sup>3</sup> But the government will have greater leverage against the medical professions when negotiating contracts with extended hours if the stated purpose is to save lives rather than to simply increase convenience.

None of this is lost on the professions' leaders, who are manning the barricades, with the president of the Royal College of Physicians dismissing the dream of a seven-day NHS as "utopian" and doomed to failure.<sup>6</sup> Rank and file juniors are also up in arms, finding barbs about inadequate out-of-hours care hard to swallow during the small hours of a weekend shift, and general practitioners, without whom a fully seven-day service cannot function, have added the requirement to provide weekend surgeries to their growing list of grievances (see this issue's article on primary care by Ian Watt, Page 8).

The government therefore has an enormous task on its hands in convincing the professions that a fundamental change in practice is required and in providing the necessary resources to support it. Evidence on the costs and benefits of seven-day services is slowly emerging, but the government has set itself a tight deadline for delivery, and that evidence could get lost during what is likely to be a rancorous debate.

**Tim Doran is a Professor of Health Policy in the Department of Health Sciences, University of York**

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# What are the problems facing UK primary care?

Primary care, and general practice in particular, are facing a crisis. Ian Watt, Professor of Primary and Community Care, examines some of the causes of the current challenges and government initiatives being considered to deal with the problems.

The world's most successful healthcare systems are based on high quality primary care providing patients with a first point of contact with health professionals and acting as a gatekeeper to hospital and specialised services.

For many years, general practice, a cornerstone of UK primary care provision, has been frequently referred to as “the Jewel in the Crown” of the NHS. But now, primary care, and general practice in particular, are facing a crisis with all the major political parties proffering solutions in their manifestos at the last election.

The crisis reflects both general issues facing the whole of the NHS and concerns specific to primary care. The general challenges are well rehearsed and include pressure from a growing and ageing population at a time of economic constraints.

The specific issues relate to rising demand for primary care services with increasing numbers of consultations now being seen each year; the increasing complexity of the patients who do consult as more people develop multiple long term conditions; a need for increased time with patients to support shared decision making and self-management; and the movement of significant elements of care from hospital to the community.

We are also starting to see more expressions of dissatisfaction with the quality of primary care, calls for better access to general practice and frustration with poor coordination of services between hospital and community care and between the NHS and social services.

Perhaps the most significant concern for policy makers is how to provide and maintain a primary care workforce that is able to meet future challenges. Despite increasing

expectations, investment in primary care has fallen behind investment in hospitals. Whilst the number of hospital consultants increased by 48% between 2003 and 2013, GP numbers only increased by 14% and the number of GPs per head has actually declined since 2009.

A similar picture exists for nurses and between 2001 and 2011 the number of community nurses fell by 38% and of nurses employed in general practice 64% are over 50 with only 3% under 40. Only in pharmacy does there appear to be an adequate supply of newly trained graduates.

The GP workforce is particularly problematic with difficulties in both recruitment and retention. Some 8% of GP places and 12% of GP training places remained unfilled in 2013/14 and fewer than 20% of foundation doctors say that general practice is their first choice of career. Within this pattern there is significant geographical variation with, for example, only 51% training places filled in the North East, compared to 100% in the Kent, Surrey, and Sussex training region.

To compound the problems posed by difficulties in recruitment, recent surveys report falling job satisfaction and morale amongst GPs. A poll of 15,560 GPs by the British Medical Association (BMA) has found that 34% intend to stop working by 2020, with many others going part-time, moving abroad or even abandoning medicine altogether. Most of the GPs who said they would retire were over the age of 50. There are currently 9,000 GPs in training, although 14,000 doctors – about four in ten – are over the age of 50. The BMA stated that a significant number of those quitting will be taking early retirement because they are disillusioned and worn down.

## What is the Government's proposed solution?

With respect to primary care, the eye-catching initiative in the Conservative 2015 general election manifesto was a commitment to train and retain 5,000 more GPs by 2020. It was expected that this would facilitate another manifesto pledge—to provide patients with GP access seven days a week by 2020. In his first speech after the election, Prime Minister David Cameron said his vision was ‘a modern NHS working for you seven days a week’ adding that it ‘begins with a transformation of primary care’.



**INVESTING  
£10m**

**RECRUITING  
10,000**

**FURTHER  
1 YEAR  
TRAINING**

**£750m  
PREMISES FUNDING**

In June 2015, the Secretary of State for Health, Jeremy Hunt, provided more detail on the manifesto commitments when he announced a “new deal” for GPs. The main elements of the policy were:

- Investing £10 million in a turn-around programme to support struggling practices, led by NHS England and NHS Clinical Commissioners.
- Recruiting at least 10,000 extra primary care staff – including 5,000 GPs as well as practice nurses, district nurses, physician associates and pharmacists.
- Using new data from NHS England on staffing levels to focus recruitment on the most under-doctored areas.
- Exploring the idea of targeted financial incentives to attract doctors into areas of greatest need as part of a plan being developed by NHS England and Health Education England in conjunction with GP leaders.
- Offering trainees a further year of training in a clinical specialty relevant to primary care, such as paediatrics, psychiatry and emergency medicine.
- Recommitting the Government to £750m of new premises funding for GPs over the next three years.
- Rolling out a national marketing campaign, led by the Royal College of General Practitioners (RCGP) and the British Medical Association, to encourage medical students to choose general practice, highlighting that it will be the biggest growth area of the NHS in coming years.
- Implementing new flexibilities for GPs who wish to work part time, as well as more support for those who wish to return to the profession.

**Source: Department of Health**

*The government's new deal for GPs.*

continued overleaf →

# Building the workforce— the new deal for general practice



There was also an expectation that, as their part of the deal, GPs should be prepared to open seven days a week. The new deal actually had little that was new, building as it did on work undertaken prior to the election by NHS England. In January 2015, NHS England (together with Health Education England, RCGP and the BMA) published a strategy – “Building the workforce – the new deal for general practice” together with £10 million funding. This had a 10 point plan to help recruit, retain and return GPs into practice.

**1**

A marketing campaign for general practice careers, including a letter to all newly qualified doctors.

**2**

An additional year of training to study a special interest in medicine or business for GP trainees.

**3**

‘Training hubs’ for GP practice staff to extend their skills.

**4**

‘Golden hello’ incentives for GP trainees committing to work in an under-doctored area for at least three years.

**5**

A review of retainer schemes and investment in a new national scheme.

**6**

New premises funding for training practices.

**7**

Incentives for experienced GPs to remain in practice, such as a funded mentorship scheme or portfolio careers.

**8**

Pilots of new support staff to take the workload off GPs, such as physician associates, medical assistants, clinical pharmacists and advanced practitioners.

**9**

Clearer induction and returner scheme for those who have worked overseas or taken a career break.

**10**

Financial incentives for returners opting to work in under-doctored areas and reviewing the value of the performers list.

*10 point plan to help recruit, retain and return GPs into practice.*

*Source: NHS England, January 2015 - Building the workforce – the new deal for general practice.*

# A significant number of those quitting will be taking early retirement because they are disillusioned and worn down

## Will the policy work?

It remains to be seen whether the initiatives announced will have any impact on the challenges facing primary care. This depends in part on the extent to which the proposals can be implemented and adequately funded. Good intentions are often not enough. In 2012 for example the then Secretary of State for Health, Andrew Lansley's pledges to increase GP trainees by 2015 have yet to materialise. So it is perhaps no surprise that following his announcement of the "new deal," Jeremy Hunt made a speech later in June where he appeared to soften one his central commitments stating that 5,000 new GPs was the "maximum" that was achievable and that the government would have to be "flexible" about its 5,000 GPs pledge.

In addition to increases in GP numbers, the government has also pledged 5,000 new non-medical primary care staff including pharmacists, physician associates (1,000 new physician associates working in general practice by 2020), and district nurses. Physician associates are relatively new in UK primary care and their effectiveness and acceptability in this setting are currently uncertain. The details of how the various professional groups will work together and their respective roles and responsibilities in providing accessible, effective and efficient primary care have yet to be worked through.

The role of the GP, which has already changed significantly over the past 50 years, is likely to develop further. Working with a greater array of non-medical health professionals will require GPs to act in a more consultative way, providing oversight

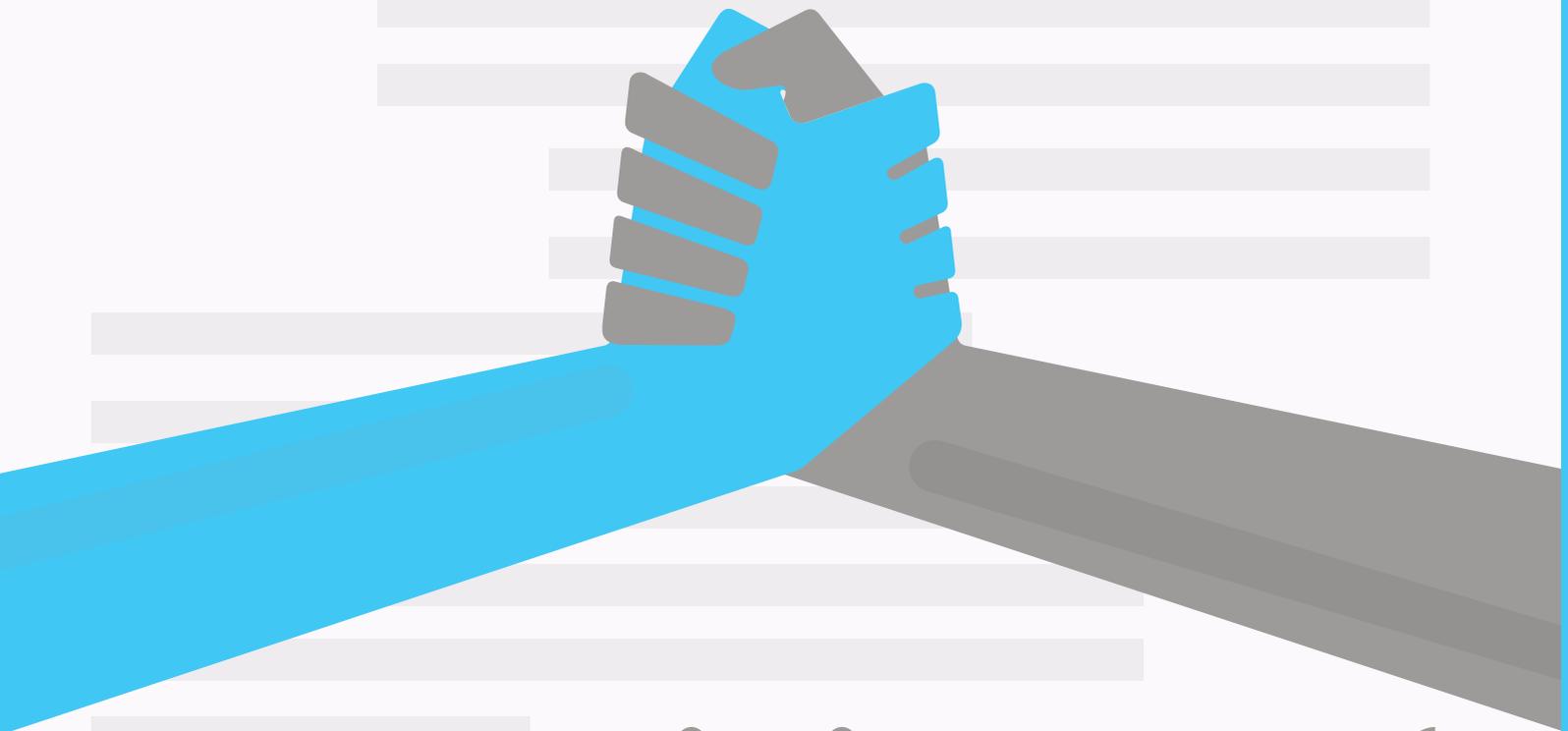
and support to the decisions of the other professional groups who will be seeing patients. GPs will also see their consultations change as their clinical work becomes increasingly focused on patients with multi-morbidity and complex health problems that can't be addressed by their non-medical colleagues. Such changes will have important implications for the selection, training and retention of GPs.

### *"Pledges to increase GP trainees by 2015 have yet to materialise"*

Is there anything else that could be done? Well, other than recruiting more staff and spending more money, one option might be to dismantle the NHS commissioning infrastructure. Currently Clinical Commissioning Groups (CCGs), as the major commissioners of healthcare for their local populations, require significant GP time, taking them away from direct patient care. Whilst one of the original aims of CCGs was to better utilise GP knowledge of their local communities to inform commissioning decisions, it is arguable whether this is the most effective use of GP time and skills given the current workforce problems. However, this was not a suggestion in the Conservative manifesto.

**Ian Watt** is Professor of Primary and Community Care in the Department of Health Sciences and the Hull York Medical School (HYMS).

Supporting people  
with long term  
conditions,



is it part of  
the Conservative  
manifesto?

## What is the problem?

Long term conditions; incurable but controllable conditions, are an ever increasing problem faced by the NHS. An estimated 15 million people in England have a long term condition, a figure which is set to grow dramatically with an increasingly ageing population.<sup>1</sup>

The growing burden of long term conditions such as diabetes, depression, or high blood pressure, along with pressures from austerity measures, requires a reconfiguration of services to maintain a sustainable and effective NHS. With approximately 70% of the total NHS spend<sup>2</sup> used for long term conditions, it is crucial that changes to improve efficiency are centred around these heavy users of the health service.

In 2015 the conservatives released their manifesto detailing their vision for the future of the NHS.<sup>3</sup> Various challenges are laid out alongside ambitious plans for a 21st century health service but how will these be achieved and how will they affect care of long term conditions?

## What is the proposed solution?

As part of the Conservatives' commitment to the NHS, an additional £8 billion a year by 2020 was pledged during the election campaign. This offering, although welcome, was quoted by Simon Stevens (chief executive NHS England) as the bare minimum needed to plug a funding gap alongside a huge £22 billion in efficiency savings by the end of the decade. Many have asked where will this money come from and how will such large savings be achieved? The current government has yet to make this clear, despite promising numerous improvements to the health service.

A key strategy to providing a sustainable and effective health service for patients with long term conditions is the promotion of self-management.<sup>2,5</sup> One proposed enhancement – telehealth and telecare – may be able to facilitate the self-management approach. Telehealth/telecare technologies allow doctors to monitor a patient's condition remotely or allows a patient to self-monitor and manage accordingly. An investigation by the Department of Health found large reductions in death rates, A&E visits and emergency hospital admissions could be achieved through telehealth and telecare use.<sup>4</sup> It will come as no surprise then that commissioners are being supported to implement this technology. However, despite the

Conservative vision for a 'modern' NHS (i.e. increased healthcare access), technology investment and the health and social care service merger, question marks around funding such strategies remain.

## Will it work?

Overall the general lack of transparent plans has certainly led to scepticism and criticism of the Conservatives' pledge to the NHS. Promises to provide extra funding are clearly essential for the continuation of NHS services; a commitment of £8 billion provides this, but falls short of providing anything for other initiatives or improvements, which will impact care of long term conditions.

Elements of the manifesto around improving care coordination, increased access to healthcare professionals and use of technology, would all support the self-management approach, but should more caution have been shown before jumping on the technology wagon? Indeed the main supporting study for telehealth and telecare use demonstrated positive results but only over 12 months, providing no evidence for long-term benefits<sup>5</sup>. There are some which even go on to state there may be unknown consequences of delivering on the aforementioned pledges. For example, would extended access to healthcare professionals (same day GP appointments and seven-day service) reduce the overall quality of care by overstressing an already overburdened service? Evidence already exists that doctors are unhappy with existing extended working hours.

## What are the alternatives?

Unsurprisingly, funding continues to be a key issue when it comes to the NHS. The Conservative party remains confident that with a strong economy large investments in the NHS are achievable, a promise that many other politicians did not make during the election campaign. It is clear that failure to meet the minimum £8 billion investment required to sustain the NHS could alone be catastrophic. The proposed initiatives, which have great promise in terms of supporting self-management, also appear infeasible without initial investment and further outsourcing. With this in mind the spectre of privatisation is yet again looming.

**Jennifer Sumner is a Research Fellow in the Department of Health Sciences, University of York**

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# When is a living wage not a living wage?

In the government's summer budget, Chancellor of the Exchequer George Osborne promised to introduce a new "national living wage" of £9 per hour by 2020.

The stated intention was to create a "higher wage, lower tax, lower welfare country", which is the sort of motherhood and apple pie vision that nobody could disagree with. And challenging the low pay culture that exists in many UK sectors right now, including health and social care, is surely right. Yet in 2015 the Living Wage, established through a respected process by respected authorities, is £7.85 outside London and already £9.15 in London. So the 2020 'national living wage' doesn't offer any prospect of increased pay for London workers and less than one might have expected in the rest of the country.

How this is expected to deliver a "higher wage" economy is a bit of a mystery, sitting as it does alongside a restriction on pay rises of more than 1% per year in the public sector and cuts to tax credits. The Institute for Fiscal Studies analysed the budget and concluded that 3 million families would be £1,000 a year worse off as a result of the cuts to tax credits, with low-income workers hardest hit.

There are many links between the Living Wage and health and wellbeing.<sup>1</sup> We have an abundance of evidence that low incomes are linked to morbidity and mortality, and being poorly paid is a risk factor for long term limiting illness and mental health problems, including depression and anxiety.

It is shocking that in the UK there is at least one person in work in the majority of poor households; clearly many peoples' incomes are insufficient to lift them out of poverty and all the stresses that come with it.<sup>2</sup> To date more than 15 local authorities have established Fairness Commissions to look at how they can reduce income inequalities locally, and all have supported the adoption of the Living Wage.<sup>3</sup> York City Council has gone even further – since April 2015, it has

required that the companies with whom it contracts and procures also pay their staff the Living Wage. There are other good Yorkshire examples: The Joseph Rowntree Housing Trust is a Living Wage employer, one of the first employers in the social care sector to become certified as such, as is insurance company Aviva, headquartered in York and an important local employer.

Researchers at Queen Mary University have shown that when employers adopt the Living Wage, employees have improved psychological wellbeing<sup>2</sup> – it's important to all of us to feel that our work is respected and fairly rewarded. The independent Living Wage Commission also found that there were economic, social and moral benefits from the Living Wage. To that we must add a public health case; income is an important aspect of people's wellbeing, and the Living Wage Commission proposed a level that would allow people to participate in society as well as meet their most basic needs. Unfortunately, the Government's proposed 'national living wage' will not be set by the same careful consideration of needs and functions, but will simply be pegged to the median income in the UK. It should more properly be seen as a raise in the national minimum wage rather than a Living Wage as most people would define it.

Public health advocates should be thinking about how to encourage their politicians, and indeed their own employers, to adopt a real, meaningful Living Wage to promote population health and wellbeing for the lowest paid.

**Kate Pickett is Professor of Epidemiology at the Department of Health Sciences. She is also the University of York's Research Champion for Justice and Equality.**

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# The inverse care law in psychological services



Despite a £400 million investment by the Government in Improving Access to Psychological Therapies, patients from poorer areas still show less chance of recovering from mental health symptoms. In this article, Visiting Research Fellow Jaime Delgado explores why this might be the case.

The chances are that you know someone suffering with depression or anxiety problems, or may have experienced these problems yourself. These mental health issues are common, affecting about one in six people in the UK at some point in their lives.<sup>1</sup>

In particular, depression is a major source of burden and suffering across the world, and is expected to become the second most common source of disability by 2020.<sup>2</sup> Without treatment, depression and anxiety symptoms tend to become chronic for at least one in two sufferers, and they can accelerate the chances of death from all causes, including associated physical illnesses and suicide.<sup>3</sup>

In line with the scale and impact of mental disorders, the government has invested over £400 million since 2008 in the development of a national Improving Access to Psychological Therapies Programme (IAPT), which offers treatment to people with depression and anxiety problems. To some extent, this development has been predicated on the grounds that investing in psychological care would eventually pay for itself, as people recovering from mental health problems would return to work and would be less reliant on benefits.<sup>4</sup>

According to a recent study conducted by a group of researchers from the University of York<sup>5</sup> psychological services are no exception to the 'inverse care law' (the principle that the availability of good medical or social care tends to vary inversely

with the need of the population served—so a poorer community with greater need will tend to have fewer high-quality resources). Investigating almost 300,000 patients referred to IAPT programmes, they found that in poorer areas more people were referred to services but fewer went on to complete treatment.

*Mental ill health affects about one in six people in the UK at some point in their lives.*

Furthermore, a significantly lower percentage of patients from poorer areas recovered from mental ill health symptoms after therapy. This might indicate that poverty hampers service use even after being referred for care, or that there are insufficient healthcare resources in deprived areas.

Although there is mounting evidence of the detrimental influence of poverty on mental health, IAPT psychological services are working in the absence of effective policy and practice guidelines to minimise this source of inequality. Perhaps a good start might be to ask: are psychological services in deprived areas under-resourced.

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## What is the problem?

Some 3.3 million people in the UK have diabetes, with a further estimated 600,000 believed to be undiagnosed.<sup>1</sup> These numbers are expected to increase because of changing demographics, with a predicted one in 10 people developing Type 2 diabetes by 2035. Type 2 diabetes accounts for 90% of all cases, and is caused by a combination of genetic, lifestyle and socio-economic risk factors.

The annual cost of diabetes to the NHS is currently £10 billion, and much of this is due to treating preventable complications which impact on quality of life and can result in premature death. Diabetes is also linked to depression, with nearly half of those living with diabetes experiencing high levels of distress.<sup>2</sup>

Lowering body weight, glucose levels, blood pressure and cholesterol through lifestyle initiatives (improving diet and increasing physical activity) can significantly reduce the risk of developing complications for patients with the disease, and can also reduce the risk of developing the condition in the first place. To date, little has been done to help the 5 million people in England estimated to be at high risk of developing diabetes.<sup>3</sup> Without the right support, lifestyle changes can be difficult to sustain, and many individuals lack the motivation and skills to manage their own health.

## What is the proposed solution?

Earlier this year, Public Health England, NHS England and Diabetes UK announced a joint plan to prevent or delay the onset of Type 2 diabetes in people who have high blood glucose levels and are at risk of developing the condition. The NHS Diabetes Prevention Programme (NDPP) will be rolled out nationally by 2020, following an initial pilot of the programme in seven 'demonstrator' sites across England, targeting up to 10,000 people.<sup>4</sup> The programme focuses on weight loss, physical activity, nutrition, and health engagement using evidence-based behaviour change techniques. Participants will first be identified by practice nurses who are already using NHS health checks and electronic patient records to screen for high-risk individuals, and then will receive intensive support and monitoring of risk factors in group sessions supplemented with individual support.

## Will it work?

The NDPP has been translated from similar successful programmes operating in other countries, including China, Finland, India, Japan, and the US.<sup>5</sup> A pilot programme in the north of England, adapted from The European Diabetes Prevention trial, has also reported promising results at 12 months follow-up.<sup>6</sup> However, England will be the first country to roll out a national programme, and there are concerns about the feasibility of translating small-scale programmes to a whole country, where participants are more diverse, and barriers to engagement may be difficult to overcome. Many eligible participants are likely to experience barriers to attending regular group sessions. NHS England has allowed for local flexibility while still maintaining an evidence-based approach and this may help to address local barriers to implementation and target those most at risk.

Identifying and targeting high risk patients in this way has the potential to reduce the burden of diabetes on health services, but not everyone at high risk will develop diabetes, and many people at low risk—who will be missed by this programme – will nevertheless go on to develop diabetes. This raises important questions about deploying a single intervention for such a diverse population.

## What are the alternatives?

Weight loss medications such as metformin can help to reduce the risk of developing Type 2 diabetes, either in isolation or in combination with lifestyle interventions.<sup>7</sup> Although there may be resistance to using drugs to address what is primarily a lifestyle problem, these low cost medications offer potential to use for individuals who do not benefit from the proposed prevention programme, which places responsibility on the individual to make significant life changes.

To redress the balance between individual and societal responsibility, the government has introduced requirements for improved nutritional labelling of foods, and there have been calls for government to tax calorie dense products and impose new regulations on the food industry so that they too will play a role.<sup>8</sup> However, paternalism is not a popular policy choice, and while the NDPP may not be the only solution, it has the potential to ease the burden on health services by delaying onset of diabetes in high risk individuals, and encouraging healthier lifestyles which may also have benefits for family members.

If we are to address the growing epidemic of diabetes, a broader approach that addresses societal risk factors (such as rising levels of physical inactivity and obesity), mental health illnesses, and socio-economic inequalities is urgently required.

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NHS Workforce Policy:

# Confusion *or* Conspiracy?

## Government policy for reform of the NHS includes many un-costed pledges. Emeritus Professor Alan Maynard looks at the fragmented and contradictory policies and asks whether they are a recipe for disaster.

The Conservative manifesto pledges for healthcare are ambitious. In addition to promises of seven day care, from 8am to 8pm, by 2020, the Conservatives promise to “root out poor care” and ensure that mental health is taken “as seriously as physical health”.

In addition to these worthy and un-costed pledges, the Conservatives promise to employ 9,500 additional doctors and 6,900 more nurses by 2020.

### The supply of doctors

Difficulties in modelling and data quality make doctor workforce forecasting problematic. Immediately after the Second World War, the Goodenough Committee recommended a modest increase in medical school intake, which the government translated into a significant increase. By 1957 the Willink Committee was forecasting a surplus and recommending cuts. Less than a decade later the Todd Royal Commission identified a shortage and recommend an increase.

This “hog cycle” of shortage and surplus continues. The Third Report of the Medical Workforce Standing Committee recommended an increase “of about 1,000 places as soon as possible”, and 1,129 places were allocated in 1999. Subsequently, the NHS Plan (2000) recommended an increase of an additional 1,000 new medical students and the creation of new medical schools in Sussex, Hull and York, Plymouth and Exeter. These investments led to significant increases in medical school intake in 2005–6. Current medical school intake is around 7,300.

The National Plan increases ensured that ratios of patients to both hospital consultants and to GPs marginally improved despite a significant increase in the English population, although ratios for GPs have slipped back since 2009. However, the composition of the doctor workforce has changed. The number of female practitioners has increased significantly: the percentage of female consultants grew from 25% to 33% in the 10 years to 2014. The percentage of female GPs in the same period grew from 39% to nearly 50% in the same period. In addition to women being more likely to work part-time and take career breaks, it is possible that the practice style of female doctors differs from that of men. For example, Bloor et al (2008) showed that the activity rates of female consultants are significantly less than that of men,<sup>1</sup> and Jefferson et al (2015) found gender differences in various aspects of the working lives of hospital consultants.<sup>2</sup>

A 2012 review of the doctors’ workforce concluded that there was an increased demand for primary care GPs and that “the over-supply of hospital doctors...falls outside reasonable affordability projections.”<sup>3</sup> This was based on ranges of assumptions. For instance it was assumed that “real health spending per head would grow in line with real incomes” and productivity would grow in a range of 0.8 to 2.7%.

The modelling of 2012 now has to be confronted by continuing economic austerity aimed at narrowing the public sector deficit. The public sector has shrunk to around 35% of Gross Domestic Product (GDP).

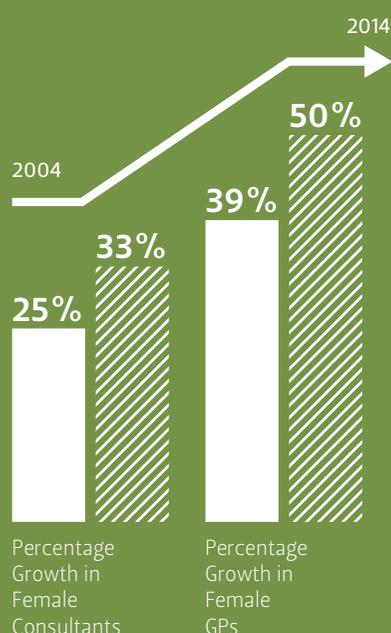
The Conservatives promise to employ an additional

**9500**

doctors

**6900**

nurses by 2020



Additional productivity savings of

**£22bn**

are required to meet increased patient demand

## Current workforce dilemmas

### Money

NHS hospitals declared a deficit in excess of £900 million for the first three months of the 2015-16 financial year. It is forecast that the annual deficit at March 2016 will exceed £2 billion.

The government increased NHS spending in the 2014 budget by £2 billion, and there is a manifesto pledge to increase it by a further £8 billion in the period up to 2020. The timing of these additional funds is still unclear.

The Five Year Forward View of NHS England (2014) estimates that additional “productivity” savings of £22 billion are required to meet increased patient demand. NHS England has implemented an innovation agenda, the “Vanguard” projects, aimed at greater productivity. The time frame to evaluate these projects and ensure cost effective implementation is ambitious.

### Political largesse

The Conservative manifesto advocates 24/7 service provision in the NHS as a result of concerns about access and care at weekends in particular. It is asserted that avoidable mortality is considerable but there is little specificity about which specialisms are particularly problematic, whether such problems also occur at night when out-of-hours cover is less and how adverse outcomes can be avoided. Meacock et al (2015) have shown that 24/7 for hospital care is not cost effective and that its provision would cost an additional £1 billion.<sup>4</sup>

The Conservatives have to find funding for long needed improvements in mental healthcare and for the Care Quality Commission and other regulatory efforts aimed at reducing patient risk. Investments in the latter are rarely evaluated in terms of cost effectiveness.

This proposed largesse by the government will add financial pressures to an increasingly bankrupt NHS. The Thatcher-Cameron rhetoric of the NHS being safe in their hands is being challenged.

### The medical minefield

As ministers have discovered over the life of the NHS, attack the medical profession and your future will be endangered. Over the last decade GPs have done well financially but are now in a state of revolt. As a result of the generous pay settlement in 2003-4, average weekly working hours of GPs is reported to have fallen from 46 to 41 hours and is currently around 42 hours. The burden of administration has fallen.

Despite these findings GPs are less satisfied about hours of work, remuneration, recognition of good work, and freedom to choose their own method of working, amongst other issues. In recent surveys, nearly 24% reported a high likelihood of

quitting direct patient care in the next five years. Some 35% of GPs reported an intention to reduce their hours (Gibson et al, 2015<sup>5</sup>).

This survey indicates that primary care is in severe distress. Government initiatives such as £50 million for GP 24/7 projects have added to cynicism when it is reported that GPs and surgeries are not used effectively.

Hospital consultants do not fare better in terms of continued, un-evidenced change predicated on the rhetoric of “patient safety”. Furthermore, attempts to challenge existing contracts, for instance for junior doctors, and plans to cut pensions are creating significant opposition. Some might regard these government attempts to cut practitioner income and mitigate the effects of austerity as equitable but the effects are hardly efficient. These moves, and the Secretary of State referring to the Mid-Staffs chaos 16 times in a recent Select Committee hearing, epitomise the undermining of trust in political rhetoric. As Confucius argued ‘without trust we cannot stand’.

*The government increased NHS spending in the 2014 budget by £2 billion, and there is a manifesto pledge to increase it by a further £8 billion in the period up to 2020.*

Despite the “over-supply” of hospital doctors reported by the 2012 review (Higher Education Funding Council for England (HEFCE) and Department of Health, 2012<sup>6</sup>) hospital recruitment remains problematic, especially in specialties such as emergency medicine. As a consequence there is considerable employment of locums. These short term appointments are expensive and potentially undermine continuity of care and safety.

It is recognised that unwarranted clinical practice variations create avoidable waste. However, policy makers know little about how to recoup these wasted resources cost effectively. They seek to do this with voluminous regulations – with high opportunity costs – which increase cynicism and fear amongst doctors. It is asserted that NHS managers and clinicians face over 300 “quality” regulations. This costly regulatory mountain is of uncertain effectiveness and cost effectiveness. For example the Pennsylvania–New York cardiac mortality score cards appear to increase mortality as surgeons chose safety rather than intervening on marginal patients, many of whom might survive (Rosenbaum, 2015<sup>7</sup>).

## Nursing issues

The problems in the nursing workforce reinforce those of the doctors. There are contradictions between the government’s rhetoric on the need for quality improvement and 24/7 service provision and the reality of fragmented and often contradictory policy making.

Nurse training was funded by bursaries. As with the junior doctor dispute which involved reduced postgraduate training proposals, the government is seeking to reform nurse funding. The proposed changes are contentious and aimed in part at reducing NHS Education spending.

Having applied a strict incomes policy to public sector pay, there have been inevitable supply problems. This has led to nurses joining agencies which sell their services to the NHS at higher prices than those paid to NHS workers. Agency nursing costs exceeded £1 billion last year. The government response is typically short sighted: expenditure caps. How are hospitals to meet CQC staffing targets if they cannot recruit nurses on NHS contracts or from agencies?

An alternative policy would be to require those publically trained nurses working for agencies to repay the cost of their training. Additionally those employed by agencies should not be able to pay NHS funds into schemes that enable them to pay tax as a corporation rather than income tax.

Recruitment of nurses from outside the European Union is essential, with 35% of the NHS labour force foreign born. Current rules mean that nurses who are not earning in excess of £34,000 after six years in the UK can be deported. This is because nursing is not decreed to be a shortage specialty, whilst being a ballerina is. Such nonsense needs urgent reform.

## Overview

NHS funding is inadequate. Productivity increases remain elusive. Government policy of continually under-funding the NHS is disabling the existing workforce. Yet the government wants to recruit more doctors and nurses.

Government policy is fragmented and contradictory. It imposes avoidable costs on the NHS and compounds the difficulties of austerity. Workforce policy requires the coordination of high quality data modelling with integrated incentive systems. Current workforce policies compound the difficulties of the Five Year Forward Plan (2014)<sup>8</sup> and are a recipe for disaster.

**Alan Maynard is Emeritus Professor at the Department of Health Sciences, University of York.**

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# STATE SPONSORED COERCION?

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**The proposed support from welfare benefits into employment comes in the form of an ultimatum – accept treatment for your problem or lose your right to benefits.**

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**Ian Hamilton** is a lecturer in mental health at the Department of Health Sciences, University of York.

Supporting people with drug and alcohol problems into employment and off welfare benefits seems like a good idea. Moving from benefits to employment can, after all, improve not just your finances but your health.<sup>1</sup> This idea was advanced in the Conservative party manifesto and has now emerged as a proposal put forward by the Department for Work and Pensions.<sup>2</sup>

However, this proposed ‘support’ comes in the form of an ultimatum – accept treatment for your problem or lose your right to welfare benefits.

This proposal contravenes the NHS Constitution which is clear that any treatment must be entered into voluntarily and without coercion. If people know that refusing treatment will lead to benefit sanctions, they are being forced. This is also at odds with the central tenant of treatment providers and therapists who rely on nurturing trust and acting as advocates to deliver psycho-social interventions. In effect, treatment staff need to decide if they are willing to participate in state-sponsored coercion.

This initiative, led by Dame Professor Carol Black, will have its supporters. The government has

pledged to reduce the country’s deficit. When tax-payers’ money is given to people who will inevitably spend some of it on the substances they are reliant on, many people despair. The idea of sanctioning people with drug and alcohol problems will resonate broadly with the public who often view such problems as self-inflicted in the first place. But that is not the full story – and to cut through these emotionally charged arguments we need to consider the context.

The first thing to consider is how many people who have drug and alcohol problems claim welfare benefits – something that, unfortunately, we don’t know. Even the government’s own calculations of those in treatment and claiming benefit are three years out of date. If we don’t know how many people are claiming benefits and are not in contact with treatment services, it is difficult to see how the government’s spending review was based on anything other than guesswork. This was not the finest hour for the new era of evidence-based policy.

Compounding this missing data is the lack of evidence supporting such an initiative. There is already clear evidence from other parts of the



world that coercive treatment does not produce the desired benefits. One of the main findings of a report commissioned by the Department for Work and Pensions was that such benefit sanctions actually increased levels of drug related crime, as those who were sanctioned engaged in acquisitive crime to fund their drug use.<sup>3</sup>

Services have become increasingly specialised and resistant to accepting people who don't meet their strict criteria. Navigating such complex pathways into and around treatment would challenge the most cognitively able.

Treatment can take time and, for most people, will require more than one attempt to recover from

proposal could also make it more difficult for those who are ready for treatment to access services. Increasing demand without resources to match will delay entry into treatment for such people.

If the moral arguments for treatment fail to seduce politicians and taxpayers perhaps the clear economic case might be persuasive. For every £1 invested in treatment there is a conservative estimate that £9 is saved by reducing crime and other health related costs.<sup>5</sup>

In economically austere times, led by a government that believes it has a mandate to cut public costs, we need to be realistic about what form drug and alcohol support takes, ask whether there's evidence to justify it and think carefully about the unintended consequences.

***This proposal could also make it more difficult for those who are ready for treatment to access services.***

It would be naive to assume that people only have problems with drugs and alcohol. Most will have a range of complex and interrelated issues in which their physical and mental health is also compromised.<sup>4</sup> This complexity is not matched by a sophisticated treatment response.

addiction. So if drug treatment becomes compulsory, the capacity of treatment services will need attention. Particularly if funding for drug treatment continues to be cut, then the ability of these services to accept the increasing number of referrals will be compromised. This



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