# this week

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STEPHEN CHUNG / ALAMY

## Two doctors to approve assisted death

Terminally ill adults in England and Wales who are expected to die within six months would be able to get help to end their lives if their applications were approved by two doctors and a High Court judge, under proposed new legislation.

Labour MP Kim Leadbeater, who proposed the bill, said it provided the "strictest safeguards anywhere in the world." The law would apply only to people who have full mental capacity and are terminally ill. Mental illness and disability are both excluded as eligibility criteria, and a person would need to declare twice in writing that they wanted to be helped to die.

A person who wished to end their life would administer the medication themselves. It will remain illegal for a doctor or anybody else to end a person's life. Doctors will not be obliged to participate in the process.

The bill would also make it illegal to coerce, pressure, or induce anyone into dying—with a sentence of up to 14 years in prison for anyone found guilty.

Leadbeater said she had consulted widely with doctors, legal experts, the palliative care and hospice sectors, and disability rights activists and faith leaders and had heard that the current law was "not fit for purpose."

She said, "I have looked closely at the evidence from other jurisdictions, and I believe this bill not only offers protections to people nearing the end of their lives that they don't have at present but also provides for the strictest safeguards anywhere in the world.

"I believe it is our duty as parliamentarians to give these proposals careful scrutiny, and I hope MPs will agree with me that we can offer the safest choice to those who want it at the end of their lives, while at the same time working to make our already excellent palliative care provision even better and protecting the rights of people with disabilities, mental illness, and other challenges to have all the support and care they need throughout their lives."

The bill states that the two independent doctors who authorise an assisted death must be satisfied the person is eligible and must, if necessary, consult a specialist in the person's condition and receive an assessment from an expert in mental capacity.

Both doctors must also be satisfied the person has made their decision voluntarily and must also ensure the person is making an informed choice, including being made aware of their other treatment options, such as palliative and hospice care.

When applications go to a High Court, the

*(Continued on page 172)*

**Labour MP Kim Leadbeater (centre), who introduced the private member's bill, with supporters outside parliament last month**

### LATEST ONLINE

- UK sex and gender research framework hopes to improve health outcomes
- Women with suspected endometriosis should be offered ultrasound scan
- Generic varenicline pill for smoking cessation to be rolled out in England

# SEVEN DAYS IN

## Streeting "actively looking" at lowering prostate cancer "screening" age

TOM SHAW/GETTY/SIX DAY LONDON

**The health and social care secretary, Wes Streeting, has asked the NHS to "look at the case for lowering the screening age on prostate cancer," particularly for people with a family history of the disease, after comments made by the Olympic cyclist Chris Hoy.**

**Hoy, who revealed last month he has terminal cancer, has called for the PSA test to be available to younger men. He told the BBC, "If you've got family history of it like I have, if you're over the age of 45, go and ask your doctor . . . To me it seems a no brainer. Reduce the age; allow more men to just go in and get a blood test."**

**The UK National Screening Committee (NSC) does not recommend screening for prostate cancer because the benefits do not outweigh the harms, but men over 50 can request a PSA test. Charities also encourage men aged 45 or over who are deemed to be at higher risk to ask for the test. Only two countries, Kazakhstan and Lithuania, have a population based prostate cancer screening programme. The main barrier is the test's poor predictive value.**

**Experts have told *The BMJ* that the UK situation of "informed choice," in which men without symptoms can get a PSA test by request, is the worst of both worlds and has led to overdiagnosis and unnecessary testing. Others have also expressed frustration that government campaigning to encourage these requests goes against the NSC's recommendations and places a huge burden on already overstretched GP services.**

Elisabeth Mahase, *The BMJ* **Cite this as: *BMJ* 2024;387:q2446**

### Wales

**GP leaders in Wales reject contract offer**

BMA Cymru Wales's GP committee has rejected the Welsh government's general medical services (GMS) contract offer for 2024-25, saying that it "fails to provide a credible and sustainable future" for general practice. GPs in Wales will now vote on whether to accept or reject the contract in a referendum that opens later this month. The BMA said that it was unable to disclose details of the offer and was liaising with the Welsh government on what details it could share ahead of the referendum.

### RSV

**Marked rise in cases of the virus in under 5s**

Respiratory syncytial virus is now circulating above baseline levels overall, with more pronounced rises seen in children aged under 5 years, showed data from the UK Health Security Agency. Laboratory surveillance from week 44 showed RSV positivity of 7.1%, up from 5.2% the previous week. The overall weekly hospital admission rate for RSV rose from 0.88 to 1.26 per 100 000 population. Pregnant women and people aged 75-79 are eligible for a free NHS vaccine against RSV.

### Mental health

**New bill gives patients more autonomy**

Long awaited reforms to outdated mental health laws in England and Wales have been introduced in the UK parliament. Under the Mental Health Bill people being detained for mental health reasons will no longer be allowed to be held in police or prison cells. There will be a limit on the length of time people with autism or learning disabilities can be detained unless they have a co-occurring mental health condition. Patients will have care and treatment plans tailored to their individual needs, and doctors will be required to consult the people close to patients when making decisions about their care.

### Air pollution

**Government agrees compensation**

Rosamund Adoo-Kissi-Debrah (right), the mother of a 9 year old girl who became the first person in the UK to have air pollution cited on their death certificate, will receive an undisclosed settlement from the government. The Department for Environment, Food and Rural Affairs, the Department for Transport, and the Department for Health and Social Care issued a statement expressing sincere condolences to the family of Ella, who died in 2013. She developed severe asthma just before her 7th birthday and was admitted to hospital 30 times. An inquest in 2020 concluded that excessive air pollution had made a "material contribution to Ella's death."

### Opioids

**Million pills are seized in London drug haul**

Three people were sentenced in relation to drug charges on 25 October after an international police investigation found that they had conspired to import unregulated drugs into the UK from India and had then repackaged them for internal and overseas distribution. More than 730 kg of drugs were seized during the operation, including more than a million individual tablets. Drugs identified in the haul included pharmaceutical

grade opioids, such as tramadol and tapentadol, and anti-anxiety medicines and sedatives such as zopiclone, etizolam, alprazolam, nitrazepam, zolpidem, and pregabalin.

### Surgery

**Jailed breast surgeon did not seek consent**

The rogue breast surgeon Ian Paterson has told a coroner's court that he did not seek specific consent for the cleavage sparing mastectomies he carried out because the operation was merely an "adaptation" of the standard procedure and did not need separate consent. Giving evidence at an inquest into the death of Elaine Turbill, Paterson told Birmingham and Solihull Coroner's Court that he had adapted the traditional mastectomy to allow more subcutaneous fatty tissue to remain. Paterson was jailed for 20 years in 2017.

# MEDICINE

## Cancer

### Targeted lung checks help early diagnosis

More than 5000 people in England have had lung cancer diagnosed early through the NHS Targeted Lung Health Check programme, which uses mobile scanning trucks to visit areas with high rates of lung cancer. In-depth lung checks are carried out on current and past smokers from trucks that visit sites such as supermarket car parks and town centres. Figures show that 5037 lung cancers have been found through the programme since its launch in 2019—76% at the earliest stages of I and II, when the cancer is potentially curable.

**Mobile scanning trucks have found 5037 lung cancers in current and former smokers since 2019**

### Device to rule out throat cancer is piloted

NHS England is piloting a device that can be attached to a smartphone to enable nurses to capture live throat endoscopy examinations, as part of plans to rule out suspected throat cancer more quickly. The adaptor aligns an iPhone camera with a 32 mm conventional endoscope eyepiece. The high definition footage can be instantly shared with specialists, who can look for signs of cancer and report directly back to the patient. The device, developed by Endoscope-i, is one of 14 projects to receive a share of £25m as part of an "innovation open call" by the NHS cancer programme.

## Stroke

### NHS campaign urges people to call 999

NHS England launched a campaign emphasising the importance of dialling 999 as soon as stroke symptoms occur. This follows an analysis of data from 2023-24 showing that the average time between the first sign of symptoms and a 999 call being made was 88 minutes, in 41 327 patients with a recorded time of stroke symptom onset. The Act FAST (face, arms, speech, time) campaign urges people to call 999 immediately if one of three symptoms occurs: struggling to smile, struggling to raise an arm, or slurring words.


## Training

### Disciplinary procedures "need better training"

The Medical Protection Society has called for all NHS trust staff who deal with disciplinary investigations to have specialised training to ensure doctors are treated fairly and compassionately. It sent freedom of information requests to 145 trusts and found that, of 74 that answered, 35% did not mandate training for staff handling disciplinaries. A quarter said they did not regularly submit disciplinary data to trust boards.

## Patient satisfaction

### Most GP patients in England are satisfied

ONS data on experiences of NHS services in England show most patients contacted their GP on the day of trying or the next day, and 70% found it easy. Ruth Rankine, NHS Confederation primary care director, said, "These results show that despite the ongoing crisis, GPs and their teams still manage to keep the majority of patients happy."

Cite this as: *BMJ* 2024;387:q2487

## OBESITY

On leaving primary school **28.9%** of children who live in England's most deprived areas are obese, which compares with 14.7% of children in the least deprived areas

*[Institute for Public Policy Research]*

# SIXTY SECONDS ON . . . SPELLING ERRORS

**DOCTOR, I'VE BEEN READING ABOUT PUBIC HEALTH AND I'M WORRIED**
You mean public health?

**WHAT HAPPENED THERE?**
You're in the error strewn world of academia.

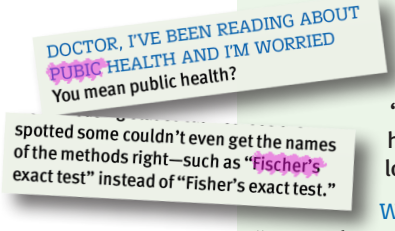
**BUT STANDARDS ARE RISING, SURELY?**
Not according to analysis of over 32 million research abstracts published over the past 50 years. Eleven of 15 common spelling errors have increased over time. The total error rate has jumped from 0.1 per 10 000 abstracts in 1970 to 8.7 in 2023.

**HOW DO WE KNOW?**
The analysis was carried out by Adrian Barnett and Nicole White, from Queensland University of Technology, Australia, who'd noticed researchers misusing statistical methods, then spotted that some couldn't even get the method names right—such as "Fischer's exact test" instead of "Fisher's."

**HOW BAD IS IT?**
It's clearly less serious than other bad research writing practices, such as plagiarism and spin. However, the "rise in errors is a symptom of growing sloppy practice," Barnett told *The BMJ*. "It's not just spelling errors that get published but also mistakes in the data and results."

**WHAT'S THE CAUSE?**
It's a symptom of researchers prioritising quantity over quality and further evidence of the "publish or perish" ethos in competitive medical publishing, said the authors. It might also be harder to find proofreaders and to justify their expense.

**WHAT OTHER ERRORS ARE THERE?**
Casual inference, confident interval, and odd ratio—to name a few. Barnett said, "I did like this one: 'Demographers have long held that prosperity brings lower birth and death rats.'"




**WHAT SHOULD HAPPEN?**
"Researchers need to slow down and thoroughly check every stage of the research process," said Barnett. "Teams should also act as their own proofreaders."

**WILL AI MAKE THINGS BETTER?**
AI tools could make writing faster, with fewer spelling errors, but not better—and they risk introducing other problems, such as vague and derivative text.

Matthew Limb, London

Cite this as: *BMJ* 2024;387:q2414

(Continued from page 169)

judge must hear from at least one of the doctors and may hear from and question the person making the application and anybody else they consider appropriate.

There must be at least a seven day gap between the doctors' assessments and a further 14 days after a judge has made a ruling, unless the person is expected to die imminently.

The chief medical officers in England and Wales and the health and social care secretary will be required to monitor and report on the operation of the law.

MPs will vote on the bill after a second reading debate in the Commons on 29 November. If it passes, it will be subject to further

**This is a critical opportunity to bring about real change for dying people**
Sarah Wootton

scrutiny by an MPs' committee and both houses of parliament, during which time it can be amended. It will become law if both chambers support it in votes next year.

Sarah Wootton, chief executive of Dignity in Dying, which supports a law change, said that there was "inarguable evidence the status quo is not working," referring to opinion polls showing that the majority of the public backs changes. "This is a critical opportunity to bring about real change for dying people and their families—MPs must grasp it with both hands," she said.

But Gordon Macdonald, chief executive of Care Not Killing, which opposes the changes, said, "This bill is being rushed with indecent haste and ignores the deep seated problems in the UK's broken and patchy palliative care system and the crisis in social care. It also ignores data from around the world that shows changing the law would put pressure on vulnerable people to end their lives."

Since 2021 the BMA has held a position of neutrality on assisted dying, including physician assisted dying.

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2024;387:q2500

# What will the national insurance hike mean for general practice?

**What is changing?**
In her budget chancellor Rachel Reeves announced an increase in national insurance contributions paid by employers to 15% on salaries above £5000 from April next year, up from 13.8% on salaries above £9100. The NHS and the rest of the public sector are exempt from the increase, but social care and GP surgeries are not.

The Treasury chief secretary, Darren Jones, justified this on BBC's *Question Time* on 31 October by saying, "GPs are privately owned partnerships, they're not part of the public sector" and that "they will therefore have to pay."

**How have doctors' leaders reacted?**
The Royal College of General Practitioners and BMA have demanded urgent assurances that practices will be given the same protection as the rest of the NHS and public sector. Without extra funding to cover the additional costs some practices will be forced to close, they warn.

In a letter to Jones, Katie Bramall-Stainer, chair of the BMA's General Practitioners Committee for England, said previous governments had followed the principle that increases to general practices' employment expenses, including NI, were fully funded.

**How has the government responded?**
The Treasury has reiterated that its approach to exemptions to NI increases did not include support for the private sector, including private sector firms contracted out—with GPs generally operating as independent businesses. But there are hints that funding options were still being considered as the changes do not take effect until next April. "We will set out further details on allocation of funding for next year in due course," said a Treasury spokesperson.

**How are GPs' staff employment expenses funded?**
GP contract funding through the "global sum" (the guaranteed payment per weighted number of patients) includes an element intended to meet the full salary costs of staff employed in the practice.

James Gransby, vice chairman of the Association of Independent Specialist Medical Accountants,

# Target to reduce preterm births to 6% in England "will not be met without action"

A House of Lords committee has called on the government and NHS England to act to reduce preterm births and provide greater support for the parents of babies born before 37 weeks.

The peers' report said evidence was "unequivocal" that the target to reduce the proportion of preterm births in England to 6% by 2025 will not be met. The target was introduced in 2017, when the rate was 8%, but 7.9% of babies were born preterm in 2022.

The committee took evidence from parents, charities, academics, health professionals, NHS England, and the Department of Health and Social Care. Many witnesses expressed concern at the disparities in preterm birth rates and outcomes between socioeconomic and ethnic groups. The report called on ministers to set out how they will revise maternity safety targets to focus on decreasing preterm birth rates across all groups.


MARK THOMAS/SPL

The committee said helping parents to be involved closely in their babies' care while in neonatal units was essential to improving outcomes. But the availability of parental accommodation on units was "inadequate in most cases, despite the promise of investment in the NHS long term plan."

NHS England has produced a toolkit of evidence based interventions to help reduce perinatal mortality, but the guidance is applied inconsistently across the country, the report said. It pointed out that maternity and neonatal services continued to be affected by staff shortages.

Community health workers were often poorly equipped to provide the informed care and support parents need after hospital discharge, the report said. It also called for more research into preterm birth to identify which women were at greatest risk and more effectively target preventive treatments. Optimising women's health before pregnancy was important in preventing preterm birth, it said. This includes tackling social deprivation and potential risk factors such as smoking, drug misuse, obesity, and mental ill health.

Jacqui Wise, Kent
Cite this as: *BMJ* 2024;387:q2488

explained that this includes gross salary, the employer's pension contributions, and the employer's NI contributions. "Therefore, the global sum should be uplifted to compensate for the increase in employer's NICs [national insurance contributions] announced in the budget," he said.

Gransby noted that the staffing expenses element of the GP contract was calculated by NHS England as 44% of the total. "However, this calculation has always been a blunt instrument, and practices have been consistently underfunded on staff costs for many years," he said. "Also, the 44% staff cost calculation doesn't account for changes in the way GP practices now operate. They provide many other services that aren't funded through the global sum—for example, extended hours appointments—and staff costs have risen consistently as a result."

### What will the change mean for practices?

The reduction in the threshold means practices will have to pay employer NI contributions for more employees. For example, previously a practice would not need to pay contributions for an employee earning £9100; it will now have to pay £615. And as the contribution rate is also increasing it means an employee earning £30 000 a year will cost a practice an extra £866.

Although Rachel Reeves (below) has increased the employment allowance for small businesses, this does not apply to general practices. Gransby said he did not expect the employment allowance rules to be changed, because the government would be reluctant to make an exception for practices.

"Even if they were changed, this would not remove all the costs, since the increase to the employment allowance would be insufficient to cover the uplifted cost in a majority of practices," he added.

### Could the government U turn?

There may be some signs of movement. Responding to a question in the House of Commons on 5 November, Streeting said he was "well aware of the pressures" on GPs, hospices, and other parts of the health and care system that will be affected by the NI contribution changes. "We haven't made allocations for the year ahead, and I will take those representations seriously."

The BMA is lobbying the Treasury and the Department of Health and Social Care hard on the issue and emphasised that the cost rise could simply be covered through increased practice income. A BMA spokesperson said, "The Treasury has given the NHS an extra £22bn over two years in the autumn budget. The secretary of state can use that NHS funding boost to cover this cost increase to NHS GPs."

Pressure is also being put on the UK government by the other home nations. The Welsh Assembly has pledged to discuss support for GPs affected by tax rises. Scotland's finance secretary, Shona Robison, told BBC radio's *Good Morning Scotland* that the tax rise could cost the Scottish government up to £500m. "Because the Scottish public sector is larger, we need to see that fully covered," she added. "We will be seeking urgent clarity on that."

The Labour government has pledged to increase the proportion of NHS funds going to general practice and "fix the front door to the NHS," so it is difficult to square that with taking money away from general practice. So watch this space.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;387:q2482

# Former GPCE chair wins right to unfair dismissal tribunal

An employment judge has cleared the way for Farah Jameel, a former chair of the BMA's General Practitioners Committee for England (GPCE), to go ahead with claims of discrimination and unfair dismissal against the association over her removal from the post during maternity leave.

Jameel, who was elected the first female chair in November 2021, was put on temporary suspension in 2022 after complaints made against her by BMA staff. The BMA told her in August 2023 that her contract was being terminated.

The contract described her as a contractor providing consultancy services rather than an employee. But in a preliminary ruling the judge Natasha Joffe has held that Jameel was in reality an office holder and an employee, opening the way for a full hearing by an employment tribunal.

The GPCE passed a vote of no confidence in Jameel in July 2023, as a means of electing a new chair, noting that the committee was "deeply concerned at the lack of clarity surrounding the status of the alleged suspension" of Jameel.

A petition calling for the withdrawal of the vote of no confidence, on the basis that Jameel had been treated unfairly, drew over 800 signatures.

### "No choice"

The BMA argued at the preliminary employment tribunal hearing that Jameel had accepted the agreement that described her as a self-employed contractor, but her lawyer said that she had thought she had no choice.

The judge said a number of features indicated that Jameel was an employee, including that she was required to work a certain number of hours and attend meetings, could be disciplined, earned a "very substantial salary," and was paid through PAYE. The judge added, "I did not hear sufficient evidence to reach any conclusions as to the nature of the claimant's dismissal in this case, ie whether that involved some decision making by the respondent after the vote of no confidence had occurred. That will be a matter for the full merits hearing."

A BMA spokesperson said, "We are surprised the tribunal has come to this judgment on employment status given this was an elected position and Dr Jameel was removed from her post as a result of a vote of no confidence by the GPCE.

"We will now take time to examine the findings carefully."

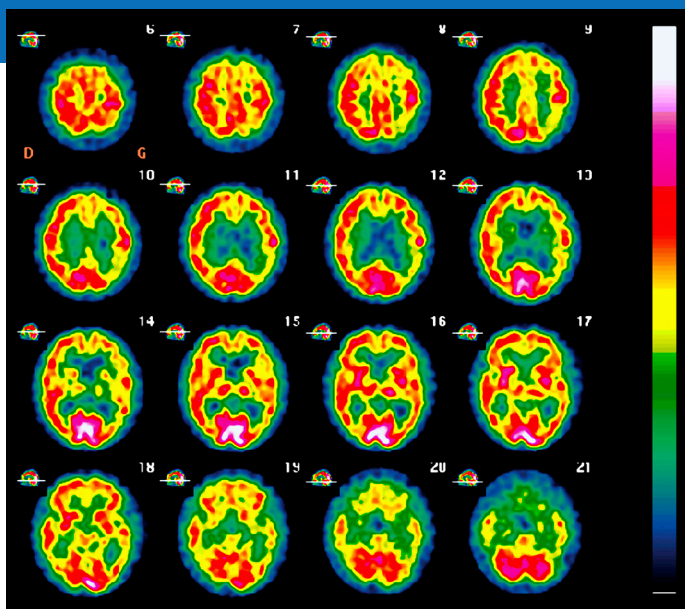
Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2024;387:q2495

**Farah Jameel, the first female chair of the General Practitioners Committee for England, was suspended and then removed after a vote of no confidence**

# ALZHEIMER'S DISEASE
# What treatments could the NHS roll out?

NICE expects to evaluate dozens of potential dementia drugs over the next few years. **Elisabeth Mahase** looks at what we know about the candidates



### Which drugs have been evaluated this year?

NICE rejected two new drugs for Alzheimer's disease, lecanemab and donanemab, earlier this year, arguing that the small benefit they may provide does not outweigh the large cost of providing them. This cost is partly due to the need to monitor patients intensively for side effects such as brain swelling and bleeding.

Both drugs work by targeting β amyloid proteins in the brain that are thought to cause the disease.

Although the drugs can be provided through private healthcare providers, as they have been authorised by the drug regulator the MHRA, the approximate price tag of £20 000 a year means few people will be likely to be able to get them. However, their approval has sparked hope that new and effective drugs for Alzheimer's disease are on the horizon.

David Thomas, head of policy and public affairs at Alzheimer's Research UK, said, "Though far from perfect, these drugs open the door for the development of safer, more effective treatments that will slow, stop, and reverse all forms of dementia."

He added, "This means developing therapies that can remove harmful proteins in the brain, protect brain cells by making them more resilient, and restore damage. In the future, people may be prescribed a combination of treatments, depending on what type of dementia they have and the stage of disease, as is the approach with other diseases, such as cancer."

**Though far from perfect, lecanemab and donanemab open the door for the development of safer, more effective treatments** David Thomas

### Which drugs are in the pipeline?

**• Trontinemab**

Developed by Roche, trontinemab also targets amyloid proteins. The company said interim results from its phase 1b/2a study involving 160 patients showed the drug led to "rapid and robust amyloid plaque depletion" after 12-28 weeks. These data are yet to be peer reviewed. But, presenting to investors at the end of October, Roche suggested the drug could be launched between 2025 and 2028 if it continued to produce positive results.

**• Remternetug**

Another monoclonal antibody in the pipeline that targets amyloid is remternetug, developed by Eli Lilly, which also makes donanemab. Remternetug works in a similar way to donanemab but is delivered through injection rather than intravenously, potentially cutting costs. A phase III trial of remternetug called Trailrunner-ALZ1 began in 2022 and is expected to finish next October.

**• ALZ-801**

A drug known as tramiprosate has been in the pipeline for almost two decades after first being found to inhibit amyloid aggregation (Aβ42) in 2007. Although tramiprosate previously failed to perform in phase 3 testing, a subgroup analysis of trial data indicated it could be effective in people who have two copies of the ApoE4 gene, a strong genetic risk factor for Alzheimer's disease. This led to the US company Alzheon deciding to give the drug another go, this time through ALZ-801—a prodrug of tramiprosate that converts to tramiprosate in the body. A phase 3 trial is under way.

**There is now hope that new and effective drugs for Alzheimer's disease are on the horizon**

**• BIIB080**

Also known as MAPTRx, BIIB080 is an antisense oligonucleotide that works by lowering the production of tau proteins, which can become misfolded and accumulate in the nerve cells of people with Alzheimer's disease.

A phase 1 trial of the drug, with 46 patients, was carried out between 2017 and 2020, with the results published in *Nature Medicine* last year. These showed that BIIB080 led to a dose dependent reduction in total tau concentration, with a "greater than 50% mean reduction from baseline at 24 weeks post-last dose" in the highest dose group.

Mild or moderate adverse events were common in the treatment group (94%) and the placebo group (75%). A phase 2 trial is under way in more than 700 people with mild cognitive impairment or mild dementia and is expected to finish in December 2026.

**• Blarcamesine**

Blarcamesine is a drug delivered through an oral capsule that works by activating sigmar1, a protein that enables the removal of protein aggregates. Results of a phase 2b/3 study involving 508 patients with mild dementia or mild cognitive impairment from Alzheimer's disease presented at a conference showed that the drug significantly slowed cognitive decline but did not significantly affect scores on the activities of daily living scale (ADCS-ADL).

**• Hydromethylthionine mesylate**

This drug is currently being reviewed by both the MHRA and NICE. The oral tablet works by inhibiting tau

aggregation. Not much information is available, but reports indicate that the drug failed to reach its primary co-endpoints in phase 3 testing.

**• AR1001**
A selective inhibitor of phosphodiesterase 5 (PDE5), AR1001 was first developed as an erectile dysfunction treatment in South Korea and is still undergoing phase 3 testing.

**• Semaglutide**
The antidiabetes and obesity treatment semaglutide is also being investigated as a potential Alzheimer's treatment, with researchers suggesting that the drug may be able to protect against neurodegeneration and neuroinflammation. The glucagon-like peptide-1 receptor agonist (GLP-1 RA) is being trialled in amyloid positive people with mild cognitive impairment from Alzheimer's disease through two phase 3 trials: evoke and evoke+. Early results are expected in 2025.

**? Is the NHS ready to roll out a new Alzheimer's disease treatment?**
Although drugs in the pipeline may hold promise, work still needs to be done to ensure the health service is ready to roll out any successful candidates.

Richard Oakley, associate director of research and innovation at the charity the Alzheimer's Society, said "significant government investment" would be crucial in bringing about "radical change, so that everyone with dementia in the UK can get an early and accurate diagnosis."

Thomas emphasised the importance of finding affordable ways to deliver new treatments, given the high cost of administering drugs such as donanemab. "Clinical trials are currently evaluating at-home injections as an alternative to IV infusions, which would help expand access to new treatments and relieve the pressure on hospitals," he said.

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2024;387:q2477

**Significant investment is crucial so everyone with dementia in the UK can get an early and accurate diagnosis** Richard Oakley

M O HABERT, PITIE-SALPETRIERE, ISM/ SPL

# UK must maximise benefits to society from "rich" health data, says Sudlow review

Access to the UK's rich and vast banks of health data should be streamlined and simplified, to capitalise on the unique opportunity they offer to boost biomedical research and improve lives, a major review has recommended.

The independent review led by neurologist Cathie Sudlow was commissioned by England's chief medical officer to examine how to overcome barriers and inefficiencies in the secure use of health data across the four UK nations, with a focus on England.

The UK has one of the world's largest and deepest health databases, stretching back decades. The report points out that, besides being used for patient care, the data are also used to support the delivery of equitable health and care, as well as research and innovation.

THE UK HAS ONE OF THE WORLD'S LARGEST AND DEEPEST HEALTH DATABASES, STRETCHING BACK DECADES

Data relevant to health also come from sources beyond the NHS. The review argues that, to fulfil the potential of health data to improve lives, governments should collate data on social care, housing, education, and pollution, which are often isolated from one another, with more direct health data.

The review makes five key recommendations to overcome barriers, streamline and simplify systems, and enable safe and secure data use for patients, providers, and researchers:

- Agree a coordinated joint strategy to make England's health data a critical national infrastructure
- Establish a national health data service for England, with accountable senior leadership
- Produce a strategy for ongoing and coordinated engagement with patients, the public, health professionals, and policymakers and politicians, overseen and commissioned by the Department of Health and Social Care
- The four UK nations should set a UK-wide approach for data access processes, with proportionate data governance
- National organisations in the four nations should develop a UK-wide system for standards and accreditation of secure data environments (SDEs) holding data from the health and care system.

**Prioritise GP data**
A key priority of any national health data service should be to establish a system for organising data from general practice, as these patient interactions are often the first port of call for patients and the broader NHS, the review says, and access to them would bring immediate benefits.

It notes that surveys over the past 15-20 years have consistently shown that people in the UK overwhelmingly support the use of their health data, provided that this comes with appropriate safeguards, to benefit themselves and others.

Sudlow said, "We are simply not maximising the benefits to society from the rich abundance of health data in the UK. For example, research about health conditions affecting millions of people across the UK is far too often prevented or delayed by the complexity of our systems for managing and accessing data. We are letting patients and their families down as a result. This review shows that getting this right holds a great prize, for our own care and for an effective healthcare system for everyone."

Brian Kennedy, London Cite this as: *BMJ* 2024;387:q2475

**The complexity of managing and accessing data is preventing and delaying research** Cathie Sudlow

## PRICE TAG of £20 000
a year for lecanemab and donanemab means few people will be likely to be able to get them

Red Cross volunteers check in with residents in the Paiporta area of Valencia 12 days after the first flood surge

THE BIG PICTURE

# Spain takes stock of flood damage

**The devastating power and impact of the flash floods that swept through eastern Spain from 29 October is captured in this image from the city of Valencia.**

**More than 200 people are known to have been killed—and around 100 are still missing—in floods caused by rivers and normally dry canals bursting their banks after torrential rain across the region.**

**Medical sites have been severely hit, with several towns setting up temporary clinics in sports centres for essential services. A local GP told Medscape Network that because many roads were closed it was difficult for people to reach these makeshift facilities.**

**In an effort to combat this the Valencia region's ministry of health has established a register of volunteer health professionals available to help in affected areas. It has also launched a public health campaign warning of the spread of infectious diseases made possible by damage to the sanitation infrastructure, including leptospirosis, tetanus, and hepatitis A.**

Alison Shepherd Cite this as: *BMJ* 2024;387:q2490

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EDITORIAL

# Budget funding for the NHS

Increases will be tempered by low productivity growth

The government announced £41bn of tax rises in the October budget, taking tax as a share of national income to a post-war record high.[1] Post-pandemic, the UK is moving towards a level of taxation closer to that in other high income countries,[2] but it remains to be seen if this can improve the quality of public services sufficiently.

NHS England's funding will increase by an average of 3% a year in real terms between 2023-24 and 2025-26 after pension policy changes are taken into account. This is significantly higher than the 2.1% a year increases in the five years before the pandemic. In 2025-26 public service spending will be 17% higher than in 2018-19, but NHS spending is up by 30%.

Satisfaction with the NHS is at an all-time low,[3] however, and a stronger economy and a stronger NHS are far from guaranteed. Analysis of the autumn budget by the Institute for Fiscal Studies shows that, without higher productivity and therefore economic growth, public services in the UK are likely to suffer and cuts to departmental budgets may be required in the spring spending review.[5]

Since the pandemic, the NHS has more staff, but care delivered has not increased in step.[6] The budget repeats the previous government's stipulation that the NHS must deliver annual productivity increases of 2% a year[7]—higher than productivity growth across the economy as a whole. However, NHS England analysis finds that acute sector productivity was 11% lower in 2023-24 than before the pandemic.[9] Barriers to improving productivity include lack of capital investment, high staff turnover, more inexperienced staff, low staff morale, and problems with hospital management and incentives.[10]

## Where will the money go?

The budget has earmarked a bigger increase in funding for capital than day-to-day running costs. The NHS capital budget will rise to over £13bn next year, 80% more than in 2018-19. How the government targets the capital investment will be critical. Some £1.5bn has been earmarked for surgical hubs and diagnostic scanners and £2bn for NHS technology, and there is evidence that surgical hubs, in particular, can substantially increase treatment volumes and improve efficiency, helping to reduce the elective care waiting list.[11]

**The budget has earmarked a bigger increase in funding for capital than day-to-day running costs**

The resident doctors strike has been settled, but big workforce challenges remain. The Office for Budget Responsibility expects average earnings across the economy will rise by 3.6% in 2025, equivalent to a 1.2% increase in real terms.[2] NHS earnings need to be competitive, especially if the health service is to be able to attract and retain the increased number of staff implied in the long term workforce plan.[7] Over the past decade, NHS earnings have fallen behind inflation and those of other sectors. As a result there will be pressure for pay to rise faster than average earnings over the parliament.[12] The Treasury has signalled concern about affordability. But retaining more experienced staff and avoiding further industrial action is critical to delivering sustained productivity improvements.

Big questions and challenges remain for the 10 year plan and next year's spending review. The health secretary, Wes Streeting, signalled three shifts at the heart of the government's reform agenda: analogue to digital, acute to community, and treatment to prevention. These ambitions have been a consistent feature of health policy for many years but progress has been limited. One of the challenges is that the productivity gains from shifting modes of care often take time to realise, and so require a period of "double running." However, the budget arithmetic doesn't allow for long periods of double running costs.

## Prevention, social care

Since 2016-17, spending on prevention, community services, and primary care has fallen as a share of the total health budget.[13] If the government is serious about prevention and community based services, it must reverse those trends.

Relatively larger increases in spending on these priority areas will be possible only if spending on acute hospitals increases at a slower rate. That would imply that hospitals need to deliver greater increases in productivity than the (demanding) 2% a year that's already factored in. Realising quickly the potential benefits of a shift from analogue to digital will be critical.

Some of the current challenges are exacerbated by problems in social care. The budget provided some funding to social care but there is still a large gap in government policy on reforming that sector. The Labour manifesto included an aim to establish a National Care Service but there is still no clear process to develop a firm alternative plan for social care.

The NHS was the clear relative winner from the Labour government's first budget. However, while funding is increasing, the pressures on the health service budget are also rising. Increasing productivity and modernising services are essential, but whether these can be delivered on the scale needed is uncertain.

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EDITORIAL

# Declaration of Helsinki puts global justice up front

Update revises language and focuses on fairness in research

Anybody who has undertaken research involving human participants knows that research ethics has to square some challenging circles.

Medical research can be dangerous, even deadly. Improperly conducted it can be disastrous—the thalidomide tragedy ushered in the UK Committee on the Safety of Drugs and the 1968 Medicines Act. We must protect participants. But we must also facilitate essential medical research. Covid-19 vaccines are one of many examples of the benefits that rapid research can bring.

Getting the balance right between protection and facilitation is not easy. Bureaucracy and what some perceive to be excessive regulation are often cited as impediments to essential research.[1] And there is always a danger that a proper alertness to ethical issues throughout the research cycle decays into regulatory compliance and the ticking of boxes.

The Declaration of Helsinki is one of the jewels in the World Medical Association's (WMA) ethical crown. First developed in 1964, partly to address revelations about Nazi research, it is among the most authoritative global statements of the ethical responsibilities of researchers. Although not a legal document, its principles are embedded worldwide in statute and regulations. After 30 months of work, involving participants from 19 countries, the WMA has issued the first update since 2013.[2]

The updated declaration is finely balanced between brevity and comprehensiveness. Research is increasingly complex and ever evolving. Different ethical and regulatory histories and approaches among different jurisdictions may bring different emphases.

High level principles have far greater purchase globally than legal minutiae, and drafters of the declaration have rightly resisted any pressures to expand it.


**The new declaration makes some vital first gestures towards climate change**

Julian Sheather, ethics consultant, London
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## Promoting fairness

Language matters. As social mores change, language shifts to accommodate new insights, interests, and priorities. It is good to see the declaration swap "human subjects" for "human participants." "Subjects" now suggests a dehumanising passivity rather than alertness to the richness of human subjectivity. "Participants" gestures towards choice and parity, another step away from the ossified medical hierarchies of previous generations.

One essential change aims to better incorporate questions of global justice and fairness in research. As someone who helped draft several ethical statements, I understand the impulse to try to separate the ethical from the political. But it is impossible to ignore the injustices that structure global research, or to dismiss them as "political."

We still see extractive research, with perverse flows of value away from some of the most resource poor settings in the world.[3] Parachute research still exists: communities subjected to research that does not speak to their key interests and perspectives.[4] It is good to see the declaration introduce obligations to ensure that research is properly participatory, stating that: "Meaningful engagement with potential and enrolled participants and their communities should occur before, during, and following medical research."

The updated declaration includes a more enriched understanding of the structural and dynamic nature of vulnerability in the context of research and draws out the complex interplay of obligations. The harms of excluding vulnerable people, it states, "must be considered and weighed against the harms of inclusion [and vulnerable participants] should receive specifically considered support and protections."

Is anything missing? The declaration does not mention use of artificial intelligence. AI represents such a paradigm shift, and ushers in a suite of ethical challenges—including the possibility that algorithms amplify background biases—but it may be too early to tell if new principles are required, or just a deft application of those we already have.

The new declaration makes some vital first gestures towards climate change. Research should be "designed and conducted in a manner that avoids or minimises harm to the environment and strives for environmental sustainability." More is required here. At the very least, that "should" ought to be a "must."

This is a welcome revision of the Helsinki declaration. It acknowledges environmental obligations, dusts off some linguistic cobwebs, makes clear that the principles are for all researchers—not just physicians—and binds-in obligations to acknowledge the challenges of global justice in research. Many of these changes are belated. Ten years between revisions is too long.

Regulators must now incorporate these new obligations to ensure the protections it calls for become reality.

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US ELECTION

# Abortion dominant, but health sidelined: the road to Trump's win

The Republican was re-elected after an ill tempered campaign that saw reproductive rights dominate on the Democratic side of the debate, but healthcare was a minor part of the overall discourse. **Joanne Silberner** reports on the medical issues that were debated—and what this may bode for the president elect's agenda for the next four years


ANDREA RENAULT/AP/ALAMY

The route to the White House this election season was a wild ride, marked by a relatively last minute change of candidates on the Democratic side, from incumbent president Joe Biden to his deputy Kamala Harris, and disinformation, misdirection, and odd statements by former president—now president elect—Donald Trump, the Republican candidate.

Three weeks before voting day, Drew Altman, chief executive of the health policy research foundation KFF, wrote that this was not a "healthcare election." Indeed, throughout the months long campaigning the only health topic that made it into the top tier for the presidential candidates was reproductive rights.

Beyond that, the high price of prescription drugs and the limits of the health insurance system got occasional mentions. The candidates made promises about reform of Medicare, the healthcare insurance scheme for over 65s and disabled people. And only the Democrats talked about Medicaid, the scheme for people on low incomes.

However, Altman noted, healthcare costs formed a big part of worries about the economy. And a Harvard Youth Poll of 18 to 29 year olds in March found that healthcare was a key issue, rating higher than inflation, housing, gun violence, and jobs.

## Convention season

Trump announced his plan to run again for the presidency in November 2022. His hour long speech mentioned healthcare once, in promising to "systematically" bring it back to "the American middle class and to America itself." By July 2024, at the Republican National Convention, where Trump became the official nominee of the party, health policy was, in the words of Kaiser Health News, "missing in action." The 28 page convention platform statement didn't even mention the Affordable Care Act, also known as "Obamacare," the health insurance reform instituted by Barack Obama.

In his convention speech Trump also promised that, unlike Joe Biden, who in 2021 succeeded him as president, "We're going to get to the cure for cancer and Alzheimer's and so many other things."

**The Democrats placed healthcare, abortion, and Medicare front and centre of their campaign**

The word abortion appeared only once in the Republican platform statement—a contrast to Trump's 2016 presidential campaign, where Obamacare and abortion were major issues. In one of 20 promises the statement said funding for Medicare would not be cut (with a proposal to clamp down on "illegal immigrants" who enrol in the programme). It also mentioned keeping men out of women's sports.

The Democrats went the polar opposite, placing healthcare, abortion, and Medicare front and centre of their campaign. Abortion and reproductive rights were a rallying cry for the party throughout the campaign and a key issue for women under 30—and one that has engulfed the country since 2022, when the Republican controlled Supreme Court overturned the longstanding Roe *v* Wade ruling that made the right to abortion available throughout the US.

In a survey of young women in late spring, 20% said abortion was their most important

voting issue; in a poll in late September and early October nearly 40% named abortion. By the time of the Democrats' nominating convention three weeks later, a KFF poll showed that a majority of all voters (53%) trusted Harris on abortion (34% for Trump), and 61% preferred a federal guarantee to the right to abortion.

Still, how much the issue of abortion actually affected voting choices is questionable. The same KFF poll found that abortion was the most important healthcare issue for only 7% of voters, and only 14% of Democrats and Democratic leaning voters said that among healthcare issues abortion was what they most wanted to hear Harris talk about during the convention. For context, 42% wanted to hear about healthcare costs. And they did, at least occasionally—specifically, the high cost of prescription drugs even for people with health insurance.

## Presidential debates

By the time of the first and only presidential candidate debate between Trump and Harris, on 10 September, the healthcare issues were abortion, the covid pandemic, and Obamacare. Abortion, as headlines had it, took centre stage at the debate: about 10 minutes of the 90 minute time slot. While Trump falsely claimed that the Democrats "have abortion in the ninth month," Harris said she strongly supported the reinstitution of abortion rights and would proudly sign a bill to protect access to abortion.

And with in vitro fertilisation caught up in the abortion debate because of the issue of unused embryos, Trump said that he had been a "leader on IVF" and opened himself up to mockery from the Democrats in early October when he claimed at an all women town hall event that he was the "father of IVF."

In the September debate Trump highlighted how six of the nine Supreme Court justices, three of whom he appointed while president between 2016 and 2020, had overturned Roe *v* Wade. Leaving decisions to the individual states was the way to go, he reiterated. Harris said she'd protect abortion access up until the stage of fetal viability.

Harris accused Trump of failing to handle the covid pandemic as it played out, dumping the situation on Biden.

### What about the health of the president?

Joe Biden was forced to abandon his campaign for re-election after a disastrous television debate that stoked worries over his health and fitness to lead. Yet despite calls for Donald Trump, who is 78 years old and obese, to make public his medical reports, he has yet to do so, even though he had promised this.

The White House did release a medical report on Kamala Harris, revealing that the 59 year old vice president had seasonal allergies and mild nearsightedness but was otherwise in "excellent health."

Trump countered by saying that the US had supplied ventilators to the world. (Critics said that the government had sent out ventilators but probably not to places where they were needed.)

On Obamacare, Harris criticised Trump for not having a plan and for trying to repeal the Affordable Care Act during his previous presidency. Trump, who had promised a replacement healthcare plan several times during his first term but never delivered, retorted by saying that he had the "concepts of a plan" but offered no details.

After the September debate healthcare made an occasional appearance. In the first week of October Harris took to a daytime television talk show to promise to provide home care, a revolution for Medicare, which currently covers people only in the days or weeks after hospital treatment, and the same day she promised other new benefits: hearing aids, eyeglasses, and hearing and vision exams. The Republican platform promised to "shift resources back to at-home senior care" but offered no specific details or new or expanded benefits.

## Access to healthcare—or lack of it

Medicaid did not come up at either the Republicans' summer convention or the presidential debate, though some political watchers believe that a Republican administration is likely to cut it.

The Democratic National Convention platform mentioned it 26 times, with promises to support and strengthen the programme, and repeatedly castigated Trump and the Republican party for working to weaken it.

**Americans pay the highest prices for drugs in the world, and insulin prices have become a focus of the problem**

Americans pay the highest prices for drugs in the world, and insulin prices have become a focus of the problem. In various speeches throughout the campaign both Trump and Harris took credit for lowering the price of insulin to $35 (£27) a month. Fact checkers at media outlets across the country were quick to point out that Trump simply allowed Medicare drug plans, which are optional in the first place, to charge less than $35, and many did not.

Biden signed a law requiring all Medicare drug insurance policies to do so, and the Democratic platform promised to extend the $35 cap to everyone else. Harris also vowed to expand an endeavour that would have the government negotiating lower drug prices within Medicare for 10 popular drugs this year to 50 drugs a year.

Of greater concern, throughout the election season health related rumblings were heard from Robert F Kennedy Jr, a one time third party candidate and nephew of former president John F Kennedy. Health researchers were "in a state of panic," reported the journal *Science*, after Trump announced in late October that he'd allow Kennedy, a long time vaccine sceptic who has tweeted criticism of the FDA for suppressing "psychedelics, peptides, stem cells, raw milk, hyperbaric therapies, chelating compounds, ivermectin, hydroxychloroquine, vitamins" and more, to "go wild on health." And on the weekend before the election Kennedy said that one of his first acts in a new Trump administration would be to advise US water systems to remove fluoride from water supplies.

Whether any new laws or regulations will appear is now up to Trump. Whatever gets done is likely to take some doing. Obamacare, seen as one of Obama's major achievements, came only after major campaign promises and a tight focus on the goal. Campaign rhetoric from both sides has not suggested any likely revamps of the US healthcare system, the most expensive in the world but far from the most effective.


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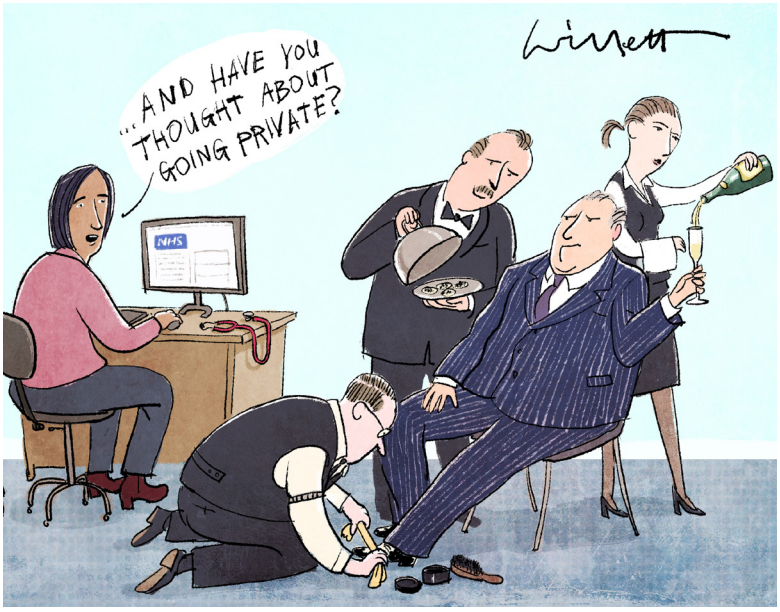
PRIVATE PRACTICE

# Should GPs be allowed to offer private services to their patients?

Some GPs think people should have the freedom to choose how they access care, others believe that offering private appointments would lead to a two tier system, further entrenching social inequality. **Ingrid Torjesen** reports




At the start of 2024, a GP practice in Northern Ireland began offering private appointments during the evening to people who weren't on its NHS list. The decision was forced on the GP partners at Abbey Medical, in Derry (Londonderry), because the practice was in financial crisis.

"We were knee deep in debt," says Tom Black, one of the partners. "It was obvious that we were about six months from bankruptcy and that was because of underfunding.

"Over the previous 12 months we'd tried to maximise our income by working harder, and we'd tried to minimise our costs by making cuts, but it wasn't working, it was just getting worse and worse."

"Political incompetence was going to close down a practice which had been running for 100 years," says Black who has been a GP for more than 35 years.

"It made me angry and frustrated, and I decided to embarrass myself by contravening all my Bevanite principles—universal, free at the point of delivery, funded by taxation—and open a parallel practice offering private appointments at a fee of £75 to those who aren't NHS patients," says Black, who was chair of BMA Northern Ireland Council at the time.

The five doctors at the practice do not get paid or receive time in lieu for seeing private patients. All the money from the private clinic goes towards clearing the practice's overdraft.

**Political incompetence was going to close down a practice which had been running for 100 years**
Tom Black

Patients requesting private appointments are also triaged. "We try only to see people who are sick and need to be seen," Black says.

## Contractual barriers

Increasingly practices across the UK are finding it difficult to balance their books. General practice funding has not kept pace with the rising costs of running a practice, and workload has grown because of increased patient demand from record hospital waiting lists.

In England the BMA balloted GPs on collective action after NHS England imposed 2024-25 General Medical Services (GMS) contract changes which offered only a 1.9% uplift from April—GMS contract remuneration has fallen by 6.6% in real terms since 2018-19.

A BMA survey of 10% of practices in England found that almost two thirds (375 of 588, 64%) reported concerns over short and long term viability. More than half (323 of 567, 57%) reported cashflow problems in the past 12 months.

In light of this funding shortfall the 2024 BMA conference of UK local medical committees (LMCs) included a motion requesting the BMA's General Practitioners Committees (GPCs) to negotiate a change in contract rules to allow practices to offer private primary medical services to their own NHS patients (box).

While consultants, pharmacists, and dentists can provide private services to NHS patients, UK GPs are currently precluded from doing so. The motion was passed in full.

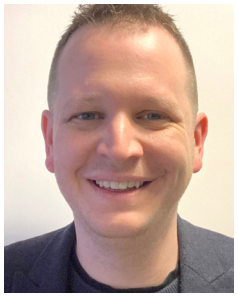
Proposing the motion on behalf of Gloucestershire LMC, GP Ben Lees asked why some health professionals were allowed to provide private services to their NHS patients while GPs were not.

As funding for general practice has not kept up with rises in patient demand, the GMS contract has become "a barrier to providing high quality, timely care to our patients" so many were turning to private healthcare, he said.

"Patients choosing to spend some of their income on privately

**Motion passed by BMA conference of local medical committees in May**

- That conference regrets that the NHS is underfunding general practice to such an extent that patients are increasingly looking to access care privately and:
- Insists that GPs should have the ability to treat patients privately in the same way that other appropriately trained clinicians can
- Requests that GP committees in the four nations ensure there are no contractual restrictions on practices seeing private patients, subject to appropriate fair systems in place
- That practices are not unfairly penalised financially by seeing private patients in NHS facilities



**Clockwise from above left: Tom Black, Ben Lees, Jacob Lant, and John Puntis**

funded GP appointments have to do so outside their regular practice. They're often seen by corporate owned remote clinics, which cannot match the care of traditional general practice."

The proposed changes would allow patients to have private appointments with their trusted family doctor in their own practice, which might be more timely, more convenient, or longer, Lees said. They "would bolster the stability of our practices, and the additional revenue could be reinvested in NHS services, enhancing care for all patients."

Removing contractual barriers to enable GPs to offer additional appointments where NHS funding fails to meet patient needs is "not about abandoning a commitment to care that's free at the point of delivery," Lees emphasised. "It's about finding solutions to system failures, and allowing people the freedom to choose how they access their GP."

## A two tier service

Allowing private work would generate more revenue for practices, enabling them to employ more people, Lees told *The BMJ*. "We would be adding capacity to our practice."

But charities representing patients fear that allowing NHS patients to pay their GPs for private consultations would reduce the number of NHS appointments available and create a "two tier" GP service.

**Effort should be put into restoring the NHS rather than promoting a two tier system**
John Puntis

Jacob Lant, chief executive of National Voices, the leading coalition of health and social care charities in England, says, "We should be working to reduce health inequalities across England and the proposal to allow doctors in primary care to take on private work threatens to reduce NHS capacity further and worsen the gap in life expectancy between those who can afford to pay and those who cannot.

"We would need further detail to understand how the plan to ensure 'appropriate fair systems' would adequately mitigate our concerns about the creation of a two tier GP service."

John Puntis, co-chair of Keep Our NHS Public and a retired consultant paediatrician, says the growth in private care is a consequence of government policy.

"Proper planning and increased investment in general practice would greatly weaken the call for GPs to be allowed to see those patients who can afford to pay. Effort should be put into restoring the NHS rather than promoting a two tier system that can only increase health inequality and ultimately weaken NHS provision."

Following the passing of the motion at the LMC conference, it will be up to BMA representatives in each UK nation to decide whether to take the proposals forward.

**The additional revenue could be reinvested in NHS services, enhancing care for all patients**
Ben Lees

Alan Stout and Andrew Buist, co-chairs of the BMA's UK GPC, told *The BMJ* that if governments fail to invest properly in publicly funded healthcare "it is only to be expected that some may want to consider other ways of providing patient care to help ensure the viability of their practices and meet the needs of patients."

They add, "By definition GPs are innovative and enterprising."

## UK variation

Six months on from when it started offering private appointments Abbey Medical is back in the black. "We're financially viable for the moment," says Black. "Goodness knows what this winter will bring, so we're keeping the private clinic running at a low level because we might need it again."

He says his NHS registered patients are appreciative and supportive of the efforts that the practice has made to keep afloat financially. "First of all, you have to give your own patients a good service, and there is an element of trust going on here. I haven't let them down before," he says.

The practice is able to provide private appointments to non-registered patients under a clause in the original General Medical Services—Premises Costs (England) Directions 2004 which allowed practices to earn up to 10% of their income from private services.

"I've been very clear with the Northern Ireland GPC that this is an existential right that we need to hold on to," Black says.

Amendments to contract regulations in some other UK nations have restricted GPs' ability to offer private services. In England GPs are forbidden from hosting or using their premises to provide private consultations that fall within

**Clockwise from above: Andrew Buist, Azeem Majeed, and Alan Stout**

the scope of NHS funded primary medical services even to patients not on their NHS list, and from advertising any private services using the same written or electronic means the practice uses to advertise NHS funded primary medical services.

In Scotland GPs can still earn up to 10% of their income from private services before their NHS contract is subject to abatement, and GPs in Wales are allowed to offer private services to patients not on their list but they cannot advertise them alongside NHS services.

Without more government funding for general practice, a move to a mixed funding model, such as has happened with dentistry, seems inevitable, Black warns.

Rebecca Rosen, a senior fellow at the Nuffield Trust, agrees, "The nature of the NHS GP contract means that there is no immediate financial reward for extra NHS work most of the time. Allowing private consultations could send general practice down a similar route to NHS dentistry, where years of drift have depleted the NHS workforce, and patients are squeezed into paying for private care."

She adds, "In theory it might be possible to limit GP time spent on seeing patients privately and preserve access to NHS care. But with integrated care board primary care commissioning hollowed out and limited capacity for contract monitoring, this would be difficult to achieve."

Azeem Majeed, professor of primary care and public health at Imperial College London, says it is unlikely that the government would allow a change to the GP contract that would enable GPs to see their own patients privately.

"The arguments in favour of this change are that patients would be better able to access timely and potentially more convenient primary care services. It would also increase the funding of general practices and reduce the reliance on public funding," he says.

"This change would, however, create a two tier public-private system in which those people who can afford to pay receive faster or better primary care services, undermining the principle of equal access to healthcare based on clinical need."

He adds that implementing and overseeing the provision of private medical services by GPs would require robust regulatory frameworks and safeguards. "In the end, this change would be a political decision and I can't see the current government allowing such a change to be made to the NHS GP contract."

**Private consultations could send general practice down a similar route to dentistry, where years of drift have depleted the NHS workforce**
Rebecca Rosen

**I can't see the government allowing such a change to be made to the GP contract**
Azeem Majeed

## New government

Lees argues that if the Labour government doesn't fund primary care properly "then people will need to use private funds to access higher quality general practice consultations."

Ahead of the general election on 4 July, Labour said that if they came to power they would increase primary care's proportion of the NHS budget and tackle upstream pressures on general practice, such as secondary care waiting lists, community mental health provision, and social care.

In a statement less than a week into the job, Secretary of State for Health and Social Care Wes Streeting suggested that the government wanted well supported primary care funded by the state. He said it was committed to "fixing the front door to the NHS" by ensuring general practice gets a larger slice of funding.

"Patients can't get through the front door of the NHS, so they aren't getting the timely care they need. That's no surprise when GPs and primary care have been receiving a smaller proportion of NHS resources. I'm committed to reversing that."

Streeting has also expressed his opposition to a two tier system. At the Future of Britain Conference 2024, hosted online by the Tony Blair Institute for Global Change on 9 July, Streeting was asked about an Australian style healthcare system where patients pay to "top up" their healthcare.

He said that the current UK system, with its emphasis on free at the point of use, was about fairness and equity. He said he was committed to defending "a system that means when you fall ill you do not have to worry about the bill." He added, "That is an equitable principle that is worth fighting for."

Streeting asked, "Why should those without means wait longer while those who have means are seen faster? That's an affront to my left wing principles."

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