BODY POLITIC **Nigel Hawkes**

Time to face up to “scandal” of funding formula

The government is in denial about the effects of funding inequities on primary care trust deficits

Sometimes it is the unasked political questions that are the most interesting. If a political party stood up before an election and said: “We intend to give some areas of the country twice as much money to run their health services as others,” questions might well be raised.

The obvious one would be: “How on earth do you justify that?” It would be quickly followed by demanding whether this lopsided generosity produced the desired results. Voters in unfavoured areas where services were being cut, referrals to consultants stymied, or waiting times artificially lengthened would be enraged.

Yet that is what actually happens, largely behind the electorate’s back. In 2004-5, for example, Islington Primary Care Trust received £1566 (€2326; \$3054) per head to run its health services, while Wokingham PCT in Berkshire got £752 per head.

It is likely that inner city Islington has greater health needs than leafy Wokingham, but it is difficult to believe that it is more than twice as needy. Both areas need general practitioners, access to hospital services, community care, and all the other services that PCTs are charged with providing.

Can it really cost more than twice as much to deliver these services in Islington as in Wokingham? The cash amounts involved are not simply tinkering at the margin: they are huge. If all PCTs had got as much as Islington, the extra cost to the NHS in 2004-5 would have been more than £20bn.

Deficits have dragged this submerged issue to the surface. At the end of last year the House of Commons Health Select Committee took evidence on the deficits, but its report rather glossed over the effects of the funding formula on the financial performance of PCTs. The official view is, and remains, that there is no correlation between allocations and deficits. It is all down to the competence of the local managers, not to the cash they are given to run

their services. This seems barely plausible.

Actually, the hearings did produce a small hole in the dyke of official reassurance, though Professor Barry McCormick, chief economic adviser to the Department of Health, rushed to push his finger into it. In 2004-5, he admitted, the figures did show “a slight tendency” for deficits to cluster in less well funded areas, but he put that down to profligate spending, not lower income.

Why did the relationship appear only in 2004-5? Professor Sheena Asthana of Plymouth University, a critic of the NHS funding formula, has no doubts. She blames the end of brokering, the old system in which cash was shipped around the NHS to resolve local deficits. In effect, she is saying that brokering was how the NHS compensated for a defective funding formula: end brokering and the flaws are revealed.

Her own figures show a strong link between funding and deficits. In 2004-5, only four of the 60 most generously funded PCTs were in deficit, compared with 36 of the 60 least generously funded. The former group got an average of £1166 per head; the latter, only £860 per head. “Poor financial or clinical management is a highly unlikely explanation for the financial difficulties experienced by PCTs,” she said.

The funding formula is designed to secure equal opportunities of access to health care for people at equal risk. That is unexceptionable. The question is whether it works.

The demand for health care is determined by morbidity and demography. Morbidity—the burden of disease—is measured by the existing use of health care, but that is largely determined by its availability. The more doctors, the more illness; the more hospitals, the more admissions. So the formula tends to perpetuate existing patterns by confusing provision with need. Age is taken into account, too, but in a way that underestimates its

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true impact, critics complain. Rural areas with older populations are disadvantaged.

A government dedicated to reducing health inequalities, and with most of its MPs elected from areas favoured by the formula, has brushed these criticisms aside. It believes that the apparent inequities of funding are justified by the need to narrow gaps in health between rich and poor. But the problem is that greater spending on health care does little to narrow the gaps. They are caused by a multitude of life choices that need to be addressed in other ways—through education, social support, and community action, for example. By the time a patient sees a doctor, the damage is done.

If it were the case that the better funded PCTs ran ambitious local public health and education programmes with their extra money, then the discrepancies in funding might be justified. But they do not. As the chief medical officer has acknowledged, funds intended to address health inequalities have been swallowed up to bail out the acute sector.

What happens is that well funded areas build more capacity, creating more demand, and because this is then taken to demonstrate need, it ensures that they continue to get the lion’s share of resources. Giving evidence to the select committee, Professor Mervyn Stone of University College London said that the present formula was “a national scandal which the Department of Health does not face up to.”

Perhaps it is about to. Despite being in denial over the link between funding and deficits, the department last year announced that it was planning to review the “need formula” for resource allocation, and invited expressions of interest from academics keen to do the work. They have until 8 March to make their bids, and a final decision on who gets the job is due by the end of March. **Nigel Hawkes is health editor at the Times** nigel.hawkes@thetimes.co.uk

MEDICINE AND THE MEDIA

Having the last laugh at big pharma

How campaigners are creating humorous videos to hit back at the drug industry

Satire is becoming the latest weapon of campaigners against the influence of drug companies. A series of wickedly clever parodies has been posted in recent months on internet sites such as YouTube (www.youtube.com) and has quickly proved successful in communicating an anti-“big pharma” message to a wide audience.

The most popular spoofs in circulation target direct to consumer drug advertising, which was legalised in the

United States in 1997 and is now a mainstay of the country’s television advertising. The object of the lampooning is the way in which drug companies, it is suggested, turn ordinary ailments into medical problems. The new breed of satirists claim that prescription drug advertisements are now so powerful that they can convince well people that they are sick and need the advertised drug.

The current buzz is around a mock advertising campaign for

“Havidol” (as in “Have it all”), a sharply observed parody that promises to treat a mock illness, dysphoric social attention consumption deficit anxiety disorder (DSACDAD).

Feel empty after a full day of shopping? Enjoy new things more than used ones? Does life seem better when you have more than others? Then, claims Havidol’s website (www.havidol.com), you may have the newly identified disorder. Future PHARM, the drug’s

manufacturer, claims that more than 50% of people over the age of 18 may have the disorder and that Havidol (slogan: “when more is not enough”) is the “first and only” treatment. You don’t have to stop drinking; in fact, the safety information warns that Havidol is not for you if you have abruptly stopped using alcohol or sedatives. Yet read on and you find that the side effects may include “inter-species communication, dermal gloss, excessive salivation, and terminal smile.”

Look carefully and it’s obvious that Havidol is nothing but a glorious hoax. The fake marketing campaign started life as a New York exhibition by the Australian artist Justine Cooper. The artist has painstakingly recreated the entire drug marketing process—from the invention of a new disorder to creating a magic bullet drug. The drug has a generic name, a brand name, a logo design, a promotional website, and even merchandise.

The campaign is so clever that some people have been duped into believing that the fake drug and illness are for real and have contacted the gallery for prescription information.

Daneyal Mahmood, owner of the gallery exhibiting Cooper’s work, told *Reuters*: “People didn’t get the fact that this was a parody or satire. The thing that amazes me is that it has been folded into real websites for panic and anxiety disorder. It’s been folded into a website for depression.”

In the first few days after the website went up it had 5000 hits. The number has now reached a quarter of a million.

Cooper says that she gave

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IMPORTANT SAFETY INFORMATION
Problems can be avoided if you take HAVIDOL only when you are able to immediately benefit from its effects. To fully benefit from HAVIDOL patients are encouraged to engage in activities requiring exceptional mental, motor, and consumptive coordination. HAVIDOL is not for you if you have abruptly stopped using alcohol or sedatives. Havidol should be taken indefinitely. Side effects may include mood changes, muscle strain, extraordinary thinking, dermal gloss, impulsively induced consumption, excessive salivation, hair growth, markedly delayed sexual climax, inter-species communication, taste perversion, terminal smile, and oral infomulation. Very rarely users may experience a need to change physicians. Talk to your doctor about HAVIDOL.

Did you know...?
DSACDAD is one of the most screened disorders out there, but it's the least talked about.

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the campaign an authentic edge to highlight how people could be seduced by advertising into wanting a drug they did not need. "The drug ads themselves are sometimes so comedic. I couldn't be outrageously spoofy, so I really wanted it to be a more subtle kind of parody that draws you in, makes you want this thing, and then makes you wonder why you want it and maybe where you can get it," she told Reuters.

Other slick parodies lampoon a culture of "disease mongering," whereby drug companies sponsor diseases and promote them to prescribers and consumers. One YouTube video describes an epidemic called motivational deficiency disorder (first "announced" in the 1 April 2006 edition of the *BMJ* (2006;332:745)). "In its mild form, persons can't get off the beach," says the spoof film. Patients become "unmotivated to breath, and die."

The "sufferer" Roy Moynihan complains, "All my life people have called me lazy. But now I know I was sick." The disorder's champion, the neuroscientist Leth Argos, of Hypnos Torpor Medical School, celebrates the success of early clinical trials of the new drug indolebant, made by the drug company HealthTech. Professor Argos tells how a patient's wife, in tears of joy, telephoned him: "After using indolebant her husband had mowed the lawn, repaired the gutter, and paid an electricity bill—all in one week."

The *BMJ* columnist Iona Heath makes an appearance to sound a note of caution. Dr Heath said, "I find it truly terrifying how easy it is to create a new disease, and it shows just how very little effort it takes to generate a whole new area of anxiety and possibility for people to convince themselves that they are ill."

Commentators say they are not surprised by how easy it is to dupe people. Vera Hassner Sharav, who runs Veracare,

an email news alert service on medical research ethics and abuses, said: "That people are taken in by these parodies is a testament to how the drug industry has insinuated non-diseases into the culture."

The power of YouTube, which claims 40 million plays of its

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videos a day, has not been lost on other campaigners.

For example, several original clips ridicule attention deficit hyperactivity disorder. One video is dedicated to "all those kids who got a prescription instead of understanding."

A number of videos with a harder campaigning edge concern antidepressants, including a frank interview with an intense former pharmaceutical sales representative caught up in the current furore over the antipsychotic drug olanzapine (Zyprexa). Documents passed to the *New York Times* allegedly suggest that the drug's manufacturer, Eli Lilly, did not disclose company data showing that 16% of people who took olanzapine for a year gained more than 30 kg (*BMJ* 2007;334:171).

Also shown on YouTube was a series of investigative reports by Nanci Wilson of KeyTV, part of the CBS media group, about the use of selective serotonin reuptake inhibitors in children and adolescents.

Sites such as YouTube make it easy to publish and play video clips, and it grants free access to a potential audience of millions. Unless the drug companies fight back successfully the chorus of campaigning voices is only likely to swell.

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WHAT'S ON THE WEB

24/7 surgery to cut NHS waiting lists

PHOTOS.COM

"Even in the more efficient trusts, it is rare to find operating theatres in use on Friday afternoons, let alone at the weekends. There are some good, practical reasons for this. Operating theatres require deep cleaning on a regular basis if methicillin resistant *Staphylococcus aureus* is not to become even more prevalent than at present. And staffing up for such round the clock surgery would add enormously to the NHS's already gargantuan wage bill.

"On a more prosaic note, who among us would want to undergo a tricky surgical procedure at three in the morning, when even the most skilled surgeons may not be quite up to snuff?

"Does Mr Blair spell out how this exciting new vision of round-the-clock surgery is to be delivered? Only by invoking his old friends 'change and innovation'—the same change and innovation that were supposed to accompany the record levels of NHS spending under New Labour, but that have been palpably absent throughout."

<http://aboutsalt.blogspot.com/index.html>

"Round-the-clock surgery could be introduced in England to help cut NHS waiting times to a maximum of 18 weeks, Tony Blair is to say. He will suggest the idea of keeping operating theatres open 'out of hours' during a visit to a London hospital.

"Anyone with the remotest knowledge of how to run a business efficiently, someone in private industry for example, would hardly be unaware that exploiting a resource from nine till five that costs in excess of £0.8 million to build and equip is a guarantee of bankruptcy. And after 10 years in government, Tony Blair has finally noticed that the NHS could double the return on one of its biggest capital investments by utilising it round the clock. Wow, if only the New Labour health secretaries since 1997, Frank Dobson, Alan Milburn, John Reid, or Patricia Hewitt had thought of this, then the NHS might be a shining example of efficiency today."

<http://johnechoices.blogspot.com/index.html>

"I have to say I was a bit perplexed to read that Tony Blair was promising to get theatres working around the clock to make waiting for procedures a thing of the past.

"Having watched the BBC programme *Can Gerry Robinson save the NHS?* I had to laugh. After all, why get them working 24 hours a day when you can't get them working on Friday afternoons. Tony Blair is making a pledge to cut waiting times from a GP deciding to send you off to a consultant to surgery to 18 weeks or less.

"I have to say I am sceptical. The reason why this does not happen at the moment is not that hospitals can't cope, though some no doubt can't, but so many primary care trusts have run out of money to fund the operations so they just don't get done."

<http://aconservatives.blogspot.com/index.html>

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