

ASSOCIATION · OF

# **COMMUNITY HEALTH COUNCILS**

FOR · ENGLAND · & · WALES

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# NHS FUNDING 1991/2: THE IMPACT ON PATIENT SERVICES

# A SURVEY OF COMMUNITY HEALTH COUNCILS

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### INTRODUCTION

For the current financial year the NHS budget officially received a 4% real terms increase on the previous year, a cash increase of about £3 billion more than in 1990/91 taking the total budget to about £32 billion. However, organisations such as the Chartered Institute of Public Finance and Accountancy pointed out that this growth in expenditure was probably not sufficient to allow a real increase in expenditure on health services. Most of the increase would be necessary, it was argued, to finance increased costs in the health service, for example, health service staff pay awards, the cost of implementing the NHS reforms, costs of new medical technology and settlements for medical negligence. The official 4% figure for growth did not take account of the fact that health service inflation is normally several points higher than the Government estimate; 8.6% this year as opposed to the Government estimate of 6%. This has a significant effect on the "real terms" budget increase, bringing it down to probably less than 28.

The Government has pledged an increase of 5% in real terms for the hospital and community health services budget for 1992/3 although, taking into account interim spending such as pay award funding and using NHS managers' estimates of health service inflation, the real increase may be nearer 2%. Health economists estimate that a real terms increase of 1.4% - 1.7% will be necessary simply to take account of the UK's ageing population and the increasing cost of medical technology, so it is unlikely that there will be a great deal of room for expansion although further cuts may be avoided.

Health expenditure as a proportion of the UK's Gross Domestic Product has risen indisputably over the last decade from 4.77% in 1979 to 5.22% in 1990 although the UK still spends far less than comparable European countries on health care such as France, Germany and Sweden which all devote more than 8% of their GDP to health. Much more substantial increases in NHS funding would be necessary to allow significant growth in the Health Service and to bring the UK closer to our European counterparts in terms of health spending.

# Survey of community health councils

In December 1991 ACHCEW conducted a survey of community health councils to examine NHS funding in health districts around the country. The aim of the survey was to identify any areas where there was a shortfall in funding and if this was impacting on patient care. The survey looked at the basic financial position of health authorities, directly-managed provider units, NHS Trusts and GP fund-holders. 77 of the 211 community health councils in England & Wales responded to the survey, covering 76 district health authorities.

Very little financial information about NHS trusts was available to CHCs and because of this it is difficult to

draw any conclusions about the financial position of trust units. The same applies to GP fund-holders. This highlights the very real problem of public accountability of NHS trusts and fund-holders which ACHCEW has drawn attention to since the inception of the reforms. Some information regarding changes to trusts' services and GP fund-holders has been collected and this is discussed later in this report.

The purchaser/provider split in the NHS means that health authorities are responsible only for purchasing services while hospitals and other providers are responsible for operational management. The structure of the new system puts the responsibility of managing hospital and other NHS activity within the available resources very much at the door of the provider units rather than the purchasers and it is in this area that most financial problems have emerged during this first year of the reforms. If health authorities are underfunded as has been the case in previous years then one would expect the difficulties to be largely passed on to the provider units.

Over this financial year it has become clear that many providers have come under financial pressure and that services to patients have been affected. In many instances providers have claimed that activity levels have been higher than expected and than was contracted for and that this has led to budgetary problems. However, the contract system in the NHS generates an inbuilt incentive for providers to overestimate activity because this may affect their income and statistics now available suggest that the increase in number of patients treated this year is largely in line with the longstanding trend. Therefore, it seems that the budget deficits that are emerging in various units around the country reflect an inadequate level of funding for the Health Service rather than a substantial increase in NHS activity.

Providers that have run into deficits must now attempt to balance their budgets by restricting expenditure, in many cases impacting directly on patient care and services. This survey shows that financial restrictions are having serious effects on direct patient services and that the problem of end-of-year cuts and bed closures continues much as in previous years.

#### PROVIDERS - "DIRECTLY MANAGED UNITS"

58% of CHCs responding reported that one or more provider units in their district was currently overspent at the end of December. The majority of these CHCs, 36% of all respondents, reported significant effects on patient care and services as a result of financial restrictions. The extent of these reductions in services is set out in the table on the following page. No distinction has been made between temporary and permanent closures.

# Extent of cuts and closures

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% of CHCs reporting -	2 or more ward closures	12%
-	l ward closure	5%
-	Significant no. of bed closures	8%
-	Other restrictions on services	11%
Total % CHCs repo	rting cuts or closures	36%

The table shows that more than 1 in 3 CHCs responding reports service cuts or closures and a significant proportion of these reductions in services are very substantial. Approximately 1 in 8 CHCs report that a unit in their district has closed 2 or more wards and 1 in 4 report at least some significant bed closures. The following quotes are from 5 of the CHCs reporting cuts:

"Closed: I medical ward with loss of medical and elderly beds, I female ward with loss of gynaecology, general surgery and trauma & orthopaedic beds, I children's surgical ward"

"In order to make £1.4 million savings, the health authority regretted having to close a 95-bed elderly and elderly mentally infirm hospital, being replaced by only 50 beds at other sites. Some patients have been moved into private nursing homes and others have returned home."

"Beds are shut for a few weeks all the time"

"The bed shortage is so acute that emergency patients are travelling miles by ambulance to be found a bed"

"The health authority proposed to cut 52 continuing care beds for the elderly in favour of private sector provision...opposed by the CHC - cut reduced to 18"

The National Association of Health Authorities and Trusts autumn financial survey found that 65% of providers expected to have to restrict activity in some way in order to achieve a balanced budget by April 1992. The ACHCEW survey reinforces the NAHAT survey findings and demonstrates that considerable bed closures are now occurring in order to reduce budget deficits. From the responses from CHCs it is clear that direct patient services are suffering in many districts and that the end-of-year financial crisis that has afflicted the NHS for many years is now biting once again despite the structural changes of the NHS reforms.

One in five CHCs commented that "temporary closures" from the previous financial year have continued through the 1991/92

financial year and that deficits have only been held in check by this continued action.

# Waiting lists

As a result of these cuts and closures some CHCs report some waiting lists worsening although special additional "waiting list monies" have helped to reduce waiting lists in many areas, particularly for those patients waiting over two years. The overall waiting list figures for in-patient and day-case treatment fell slightly by 20,000 from 948,000 between April and November 1991.

However, this may also be related to the record number of people removed from the waiting lists for reasons other than for treatment, that is "weeding-out" of waiting lists. 168,000 people were taken off waiting lists for reasons other than treatment in the six months up to April 1991, an increase of 30,000 over the previous period. This makes administrative sense where waiting lists are simply out-of-date. But there have been some instances where people who have waited a long time but are considered "low-priority" have then been told that they will not be treated. This is far from satisfactory. The increase in "weeding-out" suggests that reductions in overall waiting list figures are reductions on paper only. Further, the reports that some patients are not being put onto waiting lists or that this is being delayed raises concerns that the waiting list statistics are unreliable.

Where provider units impose cuts and closures this is likely to lengthen waiting lists. This has very considerable implications for the Government's target in the Patient's Charter to eliminate all waiting times of over two years. Between April and November 1991 there was a reduction of 35% of those waiting over 2 years from 51,000 to 34,000 but waiting lists would have to be cleared at three times this rate to meet the target. However, this comes at a time when it seems likely that a significant minority of provider units will be restricting services and making bed closures to balance their budgets. At the time of writing, the number of people waiting more than two years stands at about 28,000.

The drive to implement the Patient's Charter two-year maximum waiting time also seems to be having some other very undesirable effects on shorter waiting times. A number of CHCs commented that the lists of people waiting over two years was being reduced but the numbers of people waiting less than one year and between one and two years were increasing. Other commentators have claimed that the resources now available for treating people waiting over 2 years are interfering with clinical priorities. Patients in more urgent need of treatment, it has been said, who would otherwise have been treated earlier, may be passed over in order to satisfy the Patient's Charter waiting list target although this would be extremely difficult to prove.

In Mersey region, CHCs are extremely concerned that "waiting list" money has been made available to reduce certain cosmetic

surgery waiting lists of over 2 years when there are patients waiting for more urgent medical treatment. In this case clinical priorities for NHS spending seem to have been dispensed with.

# Services and specialties affected

Cuts and closures were made across a variety of specialties and services. The worst affected service areas were continuing care beds for elderly people, provision for elderly mentally infirm patients and other services for elderly people. These services were reduced in 9% of districts. General medical beds were also reduced in 9% of districts. Other services that have been affected in a number of districts are mental health services and paediatrics. The table below shows the areas where cuts have been made:

# Specialties/services affected

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% of CHCs reporting bed closures/ cuts in		Continuing care beds/ ESMI beds/ other services for elderly	9%
	-	General medical beds	9%
	-	Mental health services	5%
	-	Paediatrics	5%
	-	Gynaecology & female wards	4%
	-	Orthopaedics	3%
	_	ENT	3%
	<b>-</b> ,	Other specialty/ specialty not known	17%

The cuts in continuing care beds and other elderly services are causing great distress to patients and carers in a number of districts. Many health authorities have a policy of moving elderly patients into private nursing homes and NHS continuing care of the elderly is effectively not available in a number of areas. ACHCEW is particularly concerned about the standards of care in private nursing homes and the financial costs to patients and their families of meeting the fees for private nursing homes. Also, ACHCEW found in a recent study that many elderly patients in NHS wards are moved without being given a choice and, in some cases, by consultants who have a financial interest in the nursing home.

## Reductions in staff

In many of those units where cuts in services were reported, cuts in staff or a freeze on recruitment had also been made. 33% of CHCs reported that there were cuts in staff, posts were being frozen, or recruitment was being delayed. The worst affected area was paramedical posts such as occupational therapists and physiotherapists which are often regarded as optional extras rather than core services. However, such staff provide a vital part of patients' rehabilitation back to normal life and can assist the cost-effectiveness of the service by reducing the need for further costly in-patient stays.

Agency nurses were being used for financial reasons in many areas in preference to permanent staff which is not a welcome trend from patients' point of view or for the nursing profession. Insufficient staff was also singled as a reason for failure to deal with lengthening waiting lists.

# Cancelled operations

Just over 1 in 10 CHCs reported that the cancellation of operations was increasing as a result of financial restrictions. In most of these cases the prime causes were pressure on beds allowing fewer elective cases to be treated. Staff shortages were also cited as a cause of cancellations. In some areas where cancellations had risen this was related to unpredictable increases in emergency admissions. Increased cancellations may also possibly be related to priority being given in some cases to deal with patients waiting over two years.

"surgery is practically all emergencies on 5-day and 7-day wards"

"non-emergency admissions were banned until a month ago"

# Discharge from hospital.

A similar proportion of CHCs reported concern at inappropriate early discharge of some patients from local units. Very early discharge from hospital can have implications for patients' recovery and for the control of post-operative complications. Many CHCs have been warning for some time that the trend towards the faster turnover of beds is not in patients' best interests. Several CHCs in the survey reported frustration from community health services at the increased workload borne by community staff as more patients are discharged at an earlier stage. In some cases early discharge can be counter-productive by resulting in a further in-patient admission as well as being against the best interests of the patient. CHCs commented as follows -

"pressure on staff in community - elderly people only bathed once a fortnight"

"discharge is chaotic and early"

"always pressure to vacate beds"

#### NHS trusts

So little financial information was available to CHCs from trust units that it was not possible to assess their financial position. The CHCs surveyed covered 20 trust hospitals, approximately 1 in 3 of those established in 1991. Of these CHCs, 5 reported that their local trust was reducing some patient services, freezing medical and nursing posts or had not restored "temporary closures" made in the previous financial year. The proportion of trusts making cuts is lower but comparable with the level of cuts in directly managed units.

As with DMUs, some CHCs reported improvements to waiting lists where additional money has been made available, although waiting lists remain a problem in many units. Also, patients' and carers' complaints about inappropriate early discharge are equally widespread. None of the CHCs surveyed reported improved patient services as a result of trust status.

#### PURCHASERS - DISTRICT HEALTH AUTHORITIES

26% of CHCs reported that their district health authority was currently overspent and had had to make significant adjustments to its budget during the present financial year. All authorities with deficits were taking action to achieve balanced budgets as near as possible by the end of the financial year. Some of these health authorities running a relatively small deficit may possibly have expected to balance their budgets by the end of the financial year.

A hard-core of 6% of authorities had a deficit of over £500,000. This corresponds closely with the survey of health authority finance carried out by the National Association of Health Authorities and Trusts autumn financial survey which found that 8% of DHAs believed their allocations were insufficient to meet contractual obligations.

# Rationing of services

One of the measures taken by a number of authorities to stay within budgets has been to restrict the range of services available and not provide "low-priority" services such as varicose vein treatment and infertility treatment. The table shows the percentage of CHCs reporting non-provision of these and other services:

# Rationing "low priority" services

% of CHCs reporting services not purchased		
	In-vitro fertility treatment	10%
-	Sterilisation reversal	6%
-	Removal of "lumps and bumps"	5%
- ,	Tattoo removal	5%
-	Varicose vein treatment	4%
-	Cosmetic surgery	4%
-	Sterilisations	3%
-	Non-infected wisdom teeth	1%

There are clearly a minority of health authorities that have taken explicit decisions not to purchase such "non-essential" services as fertility treatment and sterilisations. In a sense this is nothing new because in many districts waiting lists for some of these treatments are so long that they are virtually unavailable. However, some districts have specifically chosen not to make these treatments available. North East Thames RHA for example, advises its districts not to provide most of the above services.

IVF fertility treatment is a special case because it has never been a mainstream NHS service but has been paid for from research funds. Where it is available patients are often seen as private patients and have to pay for or contribute to the costs.

## Inadequate contracts

In a small number of cases CHCs have reported that rather than failing to provide a service, the contracts for particular services have been inadequate for the district population's needs. A small number of CHCs reported that contracts for continuing care beds were insufficient or non-existent. This tallies with the policy in many districts to move most patients in continuing care into private nursing homes. Two CHCs also reported that contracts for orthopaedic services were clearly not sufficient for district residents, creating longer waiting lists. One CHC reported that contracts for mental illness services were inadequate for established levels of demand, the result of this being that patients must now be more acutely ill to be admitted to hospital.

#### **ECRs**

A further area where some health authorities have attempted to make savings is in the area of extra-contractual referrals. 8% of health authorities in this survey were reported as making considerable restrictions on ECRs which are one of the few outlets for patient choice in the reformed NHS. In several cases CHCs complained that the scrutiny of ECRs had delayed treatment and that considerable proportion of referrals were being refused. In a number of districts there now exists a waiting list for ECRs which cannot be paid for until the new financial year. The following quotes exemplify some of the problems CHCs have encountered with extra-contractual referrals:

"A man referred to a pain clinic found that the hospital was not prepared to treat him because they did not consider the treatment part of the contract with his health authority. The dispute over payment lasted more than three weeks and it was only after the community health council intervened on the patient's behalf that the man was eventually accepted for treatment."

"A child was referred for specialist treatment in this DHA but the home DHA refused to pay for it and demanded a 'cost-benefit analysis' of the treatment. Work was eventually carried out due to the dedication of medical staff without any assurance that it would be paid for."

#### Specialist services threatened?

Several CHCs also report that some specialist services that rely heavily on extra-contractual referrals for their income are becoming financially unviable because referrals from other districts are being restricted. For example, in one district a 29 bed therapeutic community mental health unit has had considerable difficulties maintaining income and in another district the health authority has refused to underwrite the basic costs of a drug and alcohol dependency unit and will only purchase services on a one-off basis. It seems very unlikely to survive on ECRs alone. The NHS internal market may make bankrupt some specialist services which are regarded as 'peripheral' by health authorities although they may provide high-quality services and there are people who could benefit from them.

#### GP FUND-HOLDING

51 of the 77 CHCs in the sample had one or more GP fund-holders in their district. Of these, none were able to obtain any financial information relating to them. 11 CHCs did, however, report various developments and complaints related to GP fund-holders:

\* fund-holders had attempted or been able to secure preferential waiting times with local providers.

- \* some CHCs had received increased complaints from patients who had been removed from GP fund-holders' lists, particularly people with high levels of medical need or those who might be considered "expensive patients".
- \* complaints had also been received from patients relating to restrictions on prescribing made by their GP.
- \* one CHC reported that referrals to outpatients' departments from GP fund-holders were dramatically reduced across all specialties.

The results indicate a number of problem areas which have been identified since the publication of the 1989 NHS White Paper as likely effects of the fund-holding scheme. ACHCEW detailed some of these concerns in a briefing paper published in April 1991 and continues to ask the Government to look more critically at some of the negative effects of GP fund-holding on patients. There are particular problems with their accountability to the public. CHCs have no remit to monitor their activity although they could soon control a considerable proportion of NHS resources. One specific problem is that a large number of CHCs have been unable to obtain fund-holders' contracts with providers despite them being public documents.

#### CONCLUSION

The main findings of this survey, that more than 1 district in 3 has a provider unit making significant cuts in services and 1 district in 8 has a unit with a closure of 2 or more wards, shows that the NHS continues to endure problems of inadequate levels of resources.

Despite the NHS reforms which have changed the structure of the Health Service the problem of insufficient funding has resurfaced although this time at the door of the provider units (rather than health authorities), some of whom are struggling to operate within available resources. Many of the cuts and closures made in previous financial years have not been restored and consequently waiting lists have been hard to shift.

It will be difficult to meet the Patient's Charter target to clear all two-year waiting lists as providers attempt to balance their budgets by April although in some cases this is being carried out at the expense of increasing shorter waits and at the risk of distorting clinical priorities. The question also has to be asked as to how much this exercise is costing and why has this money become available on a one-off basis? If this level of funding were available to the NHS budget on an on-going basis many of the human and capital resources currently lying idle could be brought into use.

The effects of cutbacks and closures on patient care are considerable. Care for the elderly is one area particularly badly hit and is associated with a growing trend in the NHS not

to provide some services, for example, continuing nursing care for elderly patients.

In acute services the cancellation of operations has worsened in some areas because of pressure on bed spaces. Bed shortages have contributed also to acute anxieties in many CHCs about inappropriate early discharging of patients from hospital. Speedier treatment and day-case treatment can be a boon to patients in the right circumstances but early discharges because of severe pressure on beds are bound to cut the margins of safety.

District health authorities are also increasingly taking decisions not to provide or to ration "non-essential" services such as infertility treatment and cosmetic surgery. Many such treatments will increasingly only be available privately. In many cases there has been no public consultation as to whether these services should be available on the NHS or whether the health authority should only provide services that are medically necessary.

There are strong arguments on both sides of the "rationing" question and there needs to be public debate on the issue in order to give health authorities a mandate to ration health services paid for by the taxpayer.