HEALTH NEWS Briefing

ASSOCIATION · OF

COMMUNITY HEALTH COUNCILS

FOR · ENGLAND · & · WALES

30 DRAYTON PARK · LONDON N5 1PB
TEL: 01-609 8405
FAX: 01-700 1152

# THE PROVISION OF CORE SERVICES IN THE NHS

CONTENTS



**********

# THE PROVISION OF CORE SERVICES IN THE NHS

## Introduction

One of the most fundamental changes proposed in the White Paper Working for Patients is the provision for Hospital and Community Health Services to be funded by contract between purchasers and providers of care. In future both District Health Authorities and budget-holding general practices will be purchasers of services. The providers may be units within a District, whether self-governing or directly managed, units outside the District or private sector facilities.

It is intended this proposal should, amongst other things, facilitate the flow of patients across District boundaries. It will give DHAs and budget-holding general practices greater freedom to choose between different sources of provision, some of which are likely to be outside the District. This greater freedom for the purchasers will need to be matched by a greater latitude for the providers in the range and level of services offered. The main centres of provision in this case are District General Hospitals, and if they want to be more responsive to the demands of the newly created purchasers, they will opt for self-governing status. This, at least, is the theory.

Greater freedom to choose sources of provision could confer two sorts of benefit on those in need of care:

(1) It could improve access to hospital services by shortening waiting times for certain kinds of in-patient treatment, day-case treatment, out-patient consultation and diagnostic investigation.

(2) It could also offer patients access to more appropriate or better quality care. (This will depend largely on the flow of relevant information from providers to purchasers).

Corresponding to these potential benefits, there are potential losses of benefit:

(1) Access to care could be diminished, as some patients may find themselves having to travel farther than previously.

(2) It is also possible that some patients will receive less appropriate or worse care. (This could happen if the costs of care became the overriding factor in the choice of provider and if providers cut corners in order to reduce their costs).

Accessibility and quality are two aspects of health care provision which must be seen to improve if the White Paper proposals are to be judged a success. Diminished access and deteriorating quality are precisely what many people fear will be the consequences of subjecting providers to the pressures of

competition and purchasers to the exigencies of cash limits. This is why the White Paper proposes the establishment of regulatory mechanisms to "control" both accessibility and quality. The important questions to ask are: how will they work and will they be adequate for the purpose?

## Accessibility: the limits to choice

Decisions made by providers about the range and level of services to offer and the purchasers' choice of providers are intended (presumably) to have a significant and beneficial impact on the accessibility of services. The White Paper does however place limits on the freedom of choice that is to be allowed to both providers and purchasers. These limits reflect the view that such considerations apply only to some services or forms of clinical activity, not all.

General Practitioners:

Budget-holding GPs will be able to purchase three categories of hospital service: out-patient services, including associated diagnostic and treatment costs; a defined group of in-patient and day case treatments, "for which there may be some choice over the time and place of treatment"; diagnostic tests which are undertaken by hospitals at the direct request of GPs.

District Health Authorities:

DHAs will guarantee local access to "core" services. The White Paper divides these into five categories: A & E departments; immediate admissions from A & E departments; other immediate admissions, e.g. most general medicine, and many geriatric and psychiatric services; out-patient and other support services needed to back up the first three categories; services which need to be provided on a local basis, either as a matter of policy or on grounds of practicality e.g. services for the mentally ill or district nursing.

A recent Department of Health leaflet has stated that DHAs will continue to have a duty to see that their population has ready access to a full range of health services and that they will also have a legal duty to provide services for the elderly and the chronically sick.

There are three broad categories of service which DHAs will be able "to buy in a more flexible way": those which most Districts provide, but for which patients may be prepared to travel if a better service is available elsewhere; those not provided in every District e.g. Ear, nose & throat(ENT); other services for which patients may wish to choose the location.

*Self-governing hospital trusts:*

NHS hospitals must apply to the Secretary of State for self-governing status. Approval of the application is conditional on the arrangements for the provision of core services in the relevant district. The application must explain how the hospitals' proposed services match the local DHA's decisions on local core services.

There are, however, two important qualifications to this list of constraints. The list of core services contained in the White Paper is to be regarded merely as guidance. "It will be for each District to consider in the light of their own circumstances what their core services should be." Also agreements reached between DHAs and self-governing hospitals on the provision of services will be subject to review at the request of either party.

## Incentives and disincentives

There would be no need for a guarantee of access to "essential local services" if the internal market were not expected to create incentives and disincentives for purchasers and providers which might work against the interests of the patients. For the main purchasers of hospital services, DHAs, there will be an incentive to seek savings because of cash limits, just as there is now. Hence they will have a good reason to purchase a service outside the District if it is cheaper to do so. (This assumes that there will be genuine price competition and no cartels - and that the DHA will not have to pay or reimburse substantial travelling costs for patients, which will have to be offset against their savings).

For those District General Hospitals which become self-governing trusts, the situation is less clear. One objective of the internal market is to remove disincentives to the expansion of particular services - the so-called "efficiency trap". Whether or not there will be incentives to shift resources from one form of service provision to another will depend on the relationship between the price charged for a service and its "true cost". If prices are an accurate reflection of costs, no form of service provision will be more likely to generate a financial surplus or deficit than any other.

It is however the relationship between prices and costs that is the imponderable factor in such predictions. Some procedures are going to be much simpler to cost than others, in particular surgical procedures with a low incidence of complications and a predictable length of stay in hospital. The predictability of treatment and care required is likely to be a major factor in selecting areas for "expansion". It is possible therefore that

the unpredictability of treatment and care required for complex conditions will lead managers to regard them as "potential loss-makers".

To what extent these perceptions will be acted upon by managers will depend partly on the operation of "market" factors which will limit the freedom of providers to change the level of provision in different services. The purchasers have fixed budgets and will have to allocate different portions of this to the purchase of different services, irrespective of the predictability of their "true" costs. The demand for different services is not very "elastic". The introduction of the idea of core services acknowledges however that these factors may not be sufficient to protect the interests of patients.

## Some comments on "core" services

Various individuals and organisations have already expressed their concern over the specification of core services:

"Whether the market is simple or complex, we are clear that it cannot be unrestricted and "free" - the fact the NHS is publicly financed and the Secretary of State has a duty and a responsibility to secure health services for all, means that the Government is duty bound to impose constraints on, or otherwise regulate, the market." (para.2.94)

".....perhaps the major constraint is its requirement that certain "core" services will be provided locally, which could, if it works, mitigate some of the worst potential effects of a market in health care." (para. 2.95)

"There should be a national policy on which services should be provided locally from which DHAs may diverge if they can make out a sufficient case to the Management Executive."

(Recommendation 7.17 (c)(vi)
Social Services Committee
Eighth Report

"The Council is concerned about the specification of "core" and "non-core" services.....Although it is stated that it is not intended that the list of core services should be definitive, there are several important omissions, including maternity and paediatric services. Decisions on core services should not be made at a local level without advice being sought nationally, for example, through relevant professional bodies.

"The Council believes it would be a retrograde step to introduce a system which obliged patients to travel long distances for treatment. Competitive provision of "other services" could lead to some services being no longer available

within a district, which could mean the end of the concept of the district general hospital."

BMA

"....the imprecision in definition of core services...will make it difficult to ensure that people have access to appropriate locally-based services when they need them. In particular, we are concerned about the continuation or development of geriatric and psychogeriatric services."

Age Concern

Dr.Ian Haslock, President of the British Society for Rheumatology, called for rheumatology to be included as an essential service in all DHAs.

"Independent" 24th Aug. 1989

The British Paediatric Association, the Cystic Fibrosis Trust and the Voluntary Council for Handicapped Children criticised the Government for not including paediatrics as a core service.

"Guardian" 18th Aug. 1989

**Why not have a national policy?**

The White Paper proposal that some DHA services should be designated as core services is reminiscent of the Department of Education's proposals for a national core curriculum to be taught in all schools. There is one important difference. It would be strange, even absurd, for the DES to propose that there should be a national core curriculum whilst allowing LEAs to determine what subjects should be included in the core curriculum. Yet this, it seems, is what the Department of Health is proposing for core health services. The guidance in the White paper is simply that - guidance. Most of the concern about core services already mentioned turns on this point, which is why the Social Services Committee has called for a national policy specifying core services. The Committee believes that the guarantee of local core services can "mitigate some of the worst potential effects of a market in health care", if it works. And how can it work effectively without a national policy?

Are there any reasons why such a national policy should be thought undesirable? The Government clearly has some criteria in mind as to what does or does not constitute an "essential local service"; otherwise it could not have produced guidance in the White Paper. Why not, as Age Concern have requested, offer a more precise definition so that there would be no uncertain cases? Or why not provide a definitive list?

The White Paper's reply to this is that Districts are different and that it would not be sensible to make decisions on core services without taking these differences into account.

The Department does not, for instance, want "locally" to imply "within the District." In some Districts, particularly those in large urban areas, use is made of facilities in neighbouring Districts because of the present level and geographical distribution of services, as well as GPs' preferences for referral. This applies to those services likely to be designated as core services.

This uncertainty about the relationship between a "locally-based" service and a District service highlights an obvious problem in defining core services. One might think that, in order to specify a core service, it would not be enough to say that it should be provided locally or within the District. It would also be necessary to decide how much of the service should be provided within the District. What good is a core service that can't meet the demands likely to be made of it? But does the District plan for the resident population or the actual catchment population? If a core service is defined as one for which a District should not have to use facilities in neighbouring Districts, the outcome, in some cases, is likely to be either wasteful or unduly restrictive. In other words, whether or not a core service should aim at District self-sufficiency will depend, in some cases, on circumstances.

Another major variable in District circumstances is the size of the resident population. It is difficult to argue that this should have no impact whatsoever on planning decisions.

It is also reasonable to suppose that what services should be core services will change according to changing patterns of illness, medical specialisation and medical opinion as to the best methods of care.

It seems therefore that too tight a definition of core services is likely to foreclose too many sensible planning options. On the other hand, it may be argued that too loose a definition of core services emasculates the proposal in such a way that it will not be able to fulfil its purpose - to protect the accessibility of services to patients.

How should this apparent contradiction be resolved? Any devolution of responsibilities from the centre of the NHS to the periphery, from the policy makers to the providers, generates a version of the same "problem". If the aim is to devolve as much authority as possible to the peripheral authorities, it is necessary to ask - how much is possible? There is an inevitable tension between the need for freedom at the periphery and the need for the centre to maintain control. In the context of core services, we are asking what limits should be set to the planning function of DHAs and self-

governing hospital trusts. The more closely those limits are specified, the more the centre is taking on the tasks it is seeking to devolve. Nevertheless it is quite clear that there are and should be limits.

## Planning in the NHS

At present this problem is resolved through the NHS Planning System. Since Districts are the principal operational authorities for the provision of Hospital and Community Health Services, determining the range, level and pattern of services to be provided at the District level is the main task of health planning in this country. The specification of certain forms of provision as core services will, somehow or other, have to be integrated into the planning process.

The present NHS Planning System originated in the mid-seventies, though it has since been adapted to changing circumstances, in particular, the creation of DHAs. The role of strategic planning in this system is assigned to the Regional Health Authorities. They have been the "key players" in the implementation of the now long-standing policy of smoothing out the inequalities in provision throughout the country. Their task of setting targets and objectives for DHAs (usually, though not exclusively, in terms of resource "inputs" rather than outcomes) has to be seen, of course, in the context of evolving national policies and priorities, such as the establishment of District General Hospitals or the development of community care.

Regional strategic plans state how services should be distributed across the Region. This means deciding whether or not every District should have a particular form of provision, and if so, whether or not it should aim at self-sufficiency. As for funding, the plan will also specify whether or not a service is district-based and funded through the basic allocation or a regional speciality for which provider Districts receive an additional allocation. It does not follow from the fact that a service is district-based that each District provides it or even that it should aim to do so (within the timescale of the plan).

Since these decisions determine the accessiblity of sevices to users, they are, in effect, decisions about core services. How are they made and justified?

### National policy

There are some types of provision for which national policy guidelines or a departmentally-endorsed expert report lays down a pattern of provision for all Districts. In such cases, one

expects (and so does the Secretary of State) that all Regions will take their objectives for service development from these sources.

e.g.

The basic objective of a mental handicap service will be to "provide a locally-based service that enables mentally handicapped people to live with their families where possible, or failing that, in a local community setting."
Care in Action (1980)

Following the publication of The Rising Tide: developing services for mental illness in old age (1982), it is accepted policy that each District should develop a comprehensive range of facilities and services for the elderly mentally infirm. In other words, Districts should be self-sufficient in EMI beds.

The 1986 Royal College of Physicians report, Disability in 1986 and Beyond, states that "we wish to avoid rigid rules, but we consider the principle of a substantial number of designated disability sessions held in each Health District to be absolutely essential. These sessions could be held by consultants from a wide number of disciplines, including medicine, rheumatology, geriatric medicine, neurology and orthopaedic surgery."

Regions do not always adhere to national policy guidelines, however. At the time of writing the Oxfordshire RHA Strategic Plan for 1984-1994, it was national policy to have one neonatal intensive care unit in each Region and a Special Care Baby Unit in each District. The RHA wanted to see not only a SCBU in each District, but also wider spread of neonatal ITUs than was expected nationally with the aim of having one in each District.

## The District General Hospital

Another important target shared by all Regions is the development of a basic District General Hospital service in each District. What is a basic District General Hospital service?

The 1962 Hospital Plan for England & Wales advocated the development of District General Hospitals because of "the greater interdependence of the various branches of medicine and the need to bring together a wide range of facilities required in diagnosis and treatment." The DGH would serve a population of 100,000 - 200,000 and provide treatment and diagnostic facilities for acute in-patient care, short-stay psychiatric and geriatric units, as well as facilities for the isolation of infectious diseases. The DGH would also provide the central maternity unit for the population served.

The 1962 report on Accident & Emergency Services from the Standing Medical Advisory Committee of the Central Health Services Council recommended that an accident unit should be provided as a department of a DGH.

The 1969 report of the Functions of the District General Hospital (the Bonham-Carter Report) proposed an increase in the size of population served by the DGH, principally on the grounds that all main specialities should have at least two consultants. The supply of consultants was such that this required an increase in the size of the catchment population to 300,000 in cities and large conurbations and no less than 200,000 elsewhere. As a result of this "rationalisation" of provision, it was expected that some peripheral units would close down even where this might adversely affect the accessibility of services.

The report also specified that each DGH should provide the following specialities: general medicine, general surgery, paediatrics, gynaecology, maternity services, orthopaedic surgery, and an accident and emergency service. It went on to say that "we would concede that in the major conurbations and cities not every DGH need include a department of each of these types; for in these areas the advantages of concentrating these services into larger units may perhaps outweigh the disadvantages of limiting the range of services which the individual DGHs can give to the Districts they serve."

Within general medicine and general surgery, the report identifies "special interests which it would be appropriate for one or two of the general physicians or surgeons at the DGH to undertake." These are: cardiology, thoracic medicine, gastroenterology, endocrinology, nephrology, communicable diseases, rheumatology, paediatric surgery, thoracic surgery, urology, and peripheral vascular surgery. In-patient provision for ENT surgery, ophthalomogy, dermatology and neurology should be provided at selected DGHs only. The same applies to special units providing particlar forms of medical treatment e.g. treatment of severe burns or poisoning.

This was followed by a further report in 1982, Hospital Provision: the future pattern of hospital services in England, which warned against the development of excessively large DGHs and was in favour of the maintenance of some peripheral units or community hospitals.

One point that emerges from this succession of reports is that views change as to the optimum size for the catchment population of a DGH. This will in turn affect views about the appropriate range of services to be provided.

Acute services (excluding paediatrics and obstetrics)

The impact of a variety of planning considerations guiding the distribution of acute services may be illustrated by looking at two regional plans. The Oxfordshire 1984-94 Regional Strategic Plan opens its section on acute services by regretting that "there is a requirement, because of resouce limitations, for Districts to plan for continued reliance upon others for the provision of some individual specialities in limited instances."

These are district-based services, not regionally designated specialities. It is the Region's view that there is no good reason for the absence or inadequacy of provision of some acute specialities in some Districts. There is only an excuse: lack of money. From their point of view, RAWP was not working quickly enough to make up for a low level of provision of acute beds.

A much fuller and more useful analysis of the factors affecting the spread of acute services may be found in the West Midlands Strategic Plan for the same period. This is summarised below:

Each District already has or should have in-patient beds for: general medicine; general surgery; gynaecology; trauma & orthopaedics; accident & emergency; and communicable diseases.

Ophthalmology: each District should provide out-patient facilities, an A & E service and facilities for day case treatment. Specialist in-patient facilities (e.g. detached retinas) should be provided on a sub-regional basis.

E.N.T. : some Districts provide aural services as a basic DGH service; six do not. All Districts provide an out-patient service. The Region specifies the minimum size for a viable unit providing all in-patient and out-patient facilities: 2 consultants, 32 beds and a nominal population of 300,000. Some Districts are therefore too small for such a unit.

Urology: all Districts should have out-patient clinics and there will be designated in-patient beds in most Districts.

Rheumatology: it would be desirable for each District to provide this as a basic DGH service. However because of the previous low level of development within the Region, it is a designated regional speciality to be provided in 7 main centres.

Gastro-enterology: there should be one consultant physician with an interest in gastro-enterology per 150,000 population. "Rapid developments in the investigation and treatment of disorders of the gastro-intestinal tract make essential the development of a gastroenterological service in each DGH." The

plan even specifies what investigations should be available in each District.

Diabetes & endocrinology: it is accepted that not all Districts need have a diabetologist, although they should all have a diabetes liaison nurse.

Dermatology: though each District should have out-patient clinics, the Region does not aim to develop this as a basic DGH service.

Genito-urinary medicine: there should be a special clinic at each DGH.

A number of conclusions can be drawn from this (not exhaustive) list:

1. For the Department of Health to specify in detail what service each District should provide, it would virtually have to take on the function of regional strategic planning.

2. The Region has to look not only at the provision of a service, but also at the form of provision i.e. out-patient, in-patient, day case treatment. The provision of an acute speciality in each District need not entail the provision of in-patient beds.

3. Various factors are taken into account: (i) the present spread of provision and the availability of resources for development; (ii) changes in medical specialisation and treatment, and changing patterns of illness; (iii) the catchment population needed for a unit to be "viable"; (iv) expert recommendations on the organisation of clinical services; and (v) accessiblity.

A further important consideration for the implementation of regional plans is that Districts might well disagree with them. For instance, one District was planning to develop a local service in rheumatology in conflict with RHA policy. The District believed that it could and should develop this service locally. The Region believed that this development was either unnecessary or undesirable i.e. a less than optimum use of resources.

## Accessibility, effectiveness and quality

Is there any way of unifying the various and apparently disparate factors that the strategic planning of the spread of services takes into account so as to generate a single defintion of "essential local services"?

One way of approaching the question of "essential" local services is to ask which forms of health care depend on geographical accessibility for their effectiveness. This will in turn depend on the objectives of the service.

If, for instance, one of the aims of a child health service is to monitor the development and health of all children, the service should be arranged in such a way that it is easy for parents to have their child seen regularly by a doctor or nurse. One can go further than this and say that the service will be most likely to achieve its objective if a health visiting service is available for pre-school age children and there is a school health service. Similar considerations apply to any screening service aiming to cover 100% of some group within the population. The greater the ease of access to the service, the better the coverage. If all the women in a District had to travel to the DGH for a smear test, less women would have smear tests.

If one of the aims of a good health service for the elderly is that as many as possible should be enabled to live at home, this has clear implications for the way in which the service should be delivered. Home visits by various health workers, transport to out-patient and day care facilities and coordination with social services become an essential part of the arrangement of services.

A similar kind of example is provided by mental handicap services. The effectiveness of the service is determined by the outcome for mentally handicapped people and there is widespread professional agreement as to what is a desirable outcome. A central aim of care is to "deliver" the framework for enabling personal development and living a fulfilling life. This depends on the social context in which care is delivered. A "locally-based" service is built into the description of an effective service.

A final example also related to outcome is follow-up care after an initial "one-off" medical or surgical intervention. This could involve continuing treatment and/or monitoring. As well as hospital doctors, GPs, community nurses, physiotherapists etc may all play a necessary part in appropriate follow-up care.

All these examples describe cases where it is either necessary or important, in order for the service to be effective, that it should extend out from a hospital into the community. The way this is done will vary from case to case, e.g. the provision of transport to out-patient clinics or physiotherapy units, home visits or the provision of care in a community setting, location of the service with the GP etc.

Are there also hospital-based services for which good accessibility is a condition of effectiveness? The distance

that has to be travelled to get to a hospital is important for the clinical outcome in some cases, that is clear. For example, the distance that has to be travelled to an out-patient clinic is likely to affect the numbers that turn up for appointments. It is also important for many kinds of emergency admission that the patient is seen by a doctor within a certain time. Generally speaking, this time should be kept to a minimum. Specifying what is meant by a "minimum" is a different matter. This will relate not only to the condition for which treatment or care is needed, but also to the availability of resources and factors such as population density in a given area. A "minimum" in a sparsely populated rural area may have to be greater than a "minimum" in an urban area.

Also, as the White Paper notes, the provision of an effective service in one speciality has implications for other specialities; in particular, it is no good having a "free-standing" A & E department without the "back-up" of other medical and surgical specialities.

**The "principle of maximum accessibility"**

There are, on the other hand, forms of health care which depend hardly at all on geographical accessibility for their effectiveness. The main determinant of the effectiveness of care for the individual is rather the quality of the treatment or care provided. Access does, of course, play an important part in evaluating the success of such a service, but here it is waiting times that one would look to as a measure of the difficulties of obtaining treatment. This is not to say that geographical accessibility is unimportant or undesirable. It is rather that it stands in no direct relationship to the effectiveness of provision.

Indeed, in many such cases it may be necessary to make a trade-off between quality and geographical accessibility; to accept that an improvement in quality may only be obtained at the cost of a loss of accessibility.

The Lothian Health Board audit of surgery revealed significant differences of outcome for general and specialised surgeons undertaking particular kinds of surgery. A poor outcome in such cases might well mean death. It is very likely that the more frequently surgeons perform a complicated operation, the better they will be. The solution, from the point of view of securing a better "success" rate, is to send all relevant cases to the specialised surgeons. The consequences for the geographical accessibility of treatment are plain.

There are obviously many other examples of this kind: services are concentrated in order to improve the effectiveness of

treatment and care, with the consequence that geographical accessibility is limited. It is however widely accepted that the concentration of services can be taken too far. What could be called the "principle of maximum accessibility" often seems to underlie the planning of in-patient services in this country. The maximum spread of services is sought as a desirable end. RHAs, as the the strategic planning authorities, are required to weigh it up along with other considerations - the availability of resources and the effective organisation of clinical care. In other words, the maximum spread of services is, or ought to be, sought within the given economic, organisational and clinical constraints. It is, of course, true that "cost-effective rationalisation" and the benefits to be derived from concentrating services may sometimes blind planners to the inconveniences and hardship some of their decisions cause. Hence the "principle" often needs to be reaffirmed at a local level.

## Conclusion

How can these rather abstract considerations be translated into practically useful guidance for evaluating DHA decisions about core services?

Decisions about core services are only of interest insofar as they clear the ground for changes in service provision or planned service developments.

Any proposal to move some or all of a service outside the District should be justified by the benefits that will accrue to the users of those services. These benefits must outweigh any inconvenience or hardship caused by the loss of geographical accessibility.

Using this criterion, services may be divided into four groups, as follows:

1. There are services whose effectiveness would suffer from any loss of accessibility.

2. There are services whose effectiveness is unlikely to be significantly affected by a loss of accessibility. There will be no discernible benefit to patients (through improved quality of service or shorter waiting times), only a possible loss of benefit caused by difficulties of access. This will apply to those services for which there is sufficient "demand" at District level to sustain a "viable unit" and resources are available for this. In other words, there is a good reason to provide a unit in each District and no good reason not to.

There should be, in principle, no difficulty in determining locally what services fall into these two categories. In some

cases, but not all, there will be relevant national policy guidelines.

3. There are services for which a loss of geographical accessibility may be traded off against other benefits to users ie. a more clinically effective service or shorter waiting times.

Identifying services in this category cannot be done without knowing whether or not users are willing to make the trade-off.

4. There are services for which it is agreed that an attempt to increase geographical accessibility would result in a loss of effectiveness, perhaps because of a shortage of relevant expertise or the relatively low incidence of the condition e.g. regional and supra-regional specialities.

There should be a wide measure of agreement about what services fall into this category.

The idea of specifying core services should be seen as at best a clumsy attempt to ensure that patients' interests do not suffer as a result of the reforms and that decisions about the location of services or the placing of contracts should not be guided solely by financial considerations. Indeed, the White Paper recognises the clumsiness of the instrument it is proposing to use by adding various caveats to guarantee some flexibility in its application. In this respect, the Government is probably right in being unwilling to provide a definitive list of core services. However, it is not enough to say, "Leave it to the DHAs."

In practice, therefore, what is needed is a way of constantly monitoring decisions about the placing of contracts outside the District to ensure that any loss of geographical accessibility is "worth it" from the point of view of the users or patients. A "one-off" set of decisions about core and non-core services is no substitute for this. There should be a set of procedures or a "mechanism" for ensuring that, at a local level, the right questions are asked, the appropriate factors taken into account and the right answer given.

At District level, this means finding out what people who use the service (and their GPs) think. The only people who can decide whether or not a loss of geographical accessibility is "worth it" are the people affected by the decision. In terms of the four categories of service listed above, the real problem for the DHA is to distinguish between services that fall into the second and third categories, and so identify those services for which people are willing to make a trade-off. Only if this is done successfully, will money follow the users, as the White Paper claims, rather than vice versa. It is reasonable, however, despite the Government's protestations, that this claim should be regarded with scepticism.

RHAs, as the strategic planning and monitoring authorities, also have an important role to play in this. Districts should have to justify decisions affecting accessibility of services in terms of patient benefit. The RHA is the appropriate body (a) to assess this justification and (b) to ensure that the right considerations have been taken into account. They will also have to consider the implications of DHA decisions for the best spread of services in the Region. The specification of core services should be integrated into the planning system; it should not be seen as a way of circumventing it.

Neither at District nor at Regional level can this review process be sensibly undertaken without the full involvement of the Community Health Council, as representatives of those actually using the services concerned.

References


1. Department of Health, Working for Patients, 1989
2. House of Commons Social Services Committee, Eighth Report, 1989
3. British Medical Association, Special Report on the Government's White paper
4. Age Concern, Response to the NHS Review "Working for Patients", 1989
5. Ministry of Health, Hospital Plan for England & Wales, 1962
6. Standing Medical Advisory Committee of the Central Health Services Council, Accident & Emergency Services
7. Department of Health & Social Security, Care in Action, 1980
8. Health Advisory Service, The Rising Tide: developing services for mental illness in old age, 1982
9. Royal College of Physicians, Disability in 1986 and Beyond, 1986
10. Central Health Services Council, Functions of the District General Hospital, 1969
11. Department of Health & Social Security, Hospital Provision: the future pattern of hospital services in England, 1982
12. Oxfordshire Regional Health Authority, Strategic Plan 1984-1994
13. West Midlands Regional Health Authority, Strategic Plan 1984-1994


Kenneth Howse
October 1989