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WORKING FOR PATIENTS?

THE PATIENTS' VIEW

RESPONSE TO THE GOVERNMENT'S REVIEW OF THE NHS

APRIL 1989

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C O N T E N T S

WORKING FOR PATIENTS? - THE PATIENTS' VIEW

SUMMARY

1. ACHCEW supports the concept of the National Health Service as a comprehensive national service for the prevention and treatment of ill-health. It believes the NHS should be a service that is free at the point of use and readily available for all (Para 1.2).

2. The White Paper proposals will lead to a fragmentation of the service, where it will be increasingly difficult to co-ordinate initiatives and to take coherent planning decisions (Para 2.4). A two-tier structure of services is likely to develop and it may be difficult to control regional and intra-regional imbalances in provision (Para 2.5).

3. The UK health service represents amazingly good value for money and is inexpensive compared to many other countries (Para 2.11). The NHS also has much lower administrative costs, but these will rise sharply with the White Paper (Para 2.13).

4. The White Paper is a Government exercise in cost containment. The constraints on and the incentives for budget managers will be to seek the cheapest services available. Quality of service may well turn out to be a less important factor (Para 2.14).

5. ACHCEW welcomes the Government's commitment to the widespread introduction of medical audit (Para 4.2.2). However, there is concern that this process is to be dominated and led by the profession concerned. It is difficult to see how patients can have full confidence in a system which involves no independent lay oversight. It will appear to be too easy for concerns about an individual doctor to be dealt with informally and cosily behind closed doors (Para 4.2.3).

6. The White Paper boasts about the chain of command from Ministers down to Districts. It is important in respect to this that emphasis is given to a stronger voice for the user of service within the NHS structure (Para 4.2.3). The removal of local council representatives removes the last health authority members who could have been seen in any way as directly or personally accountable to the local population. The degree of lay influence over the organisation and planning of the service will be sharply diminished. ACHCEW deeply regrets this. The role of CHCs will become even more important as a result and CHC rights should be extended (Para 4.3.5).

7. ACHCEW welcomes the Government's proposals for improving information, waiting times and the physical environment

for patients in hospital (Para 4.4.1). However, it is not clear what mechanism is to be used to ensure progress on these points (Para 4.4.2). Proposals to allow patients to pay for optional extras could emphasise the two-tier nature of the service and clear policy guidance will be needed (Para 4.4.3).

8. ACHCEW is concerned that the time-table for introducing self-governing hospitals may be too ambitious. In any event, developments such as this should be preceded by carefully evaluated pilot schemes and the evaluation should take fully into account the impact on the quality and accessibility of services (Para 5.3).

9. The White Paper seems likely to extend the degree of professional domination of the Health Service (Para 5.4).

10. Before a hospital becomes self-governing, some system of testing local opinion should be prescribed. There should be a formal consultation document, spelling out the implications for the services provided to the local community, and CHCs should have a formal right to comment and object with the option to take their case directly to the Secretary of State (Para 5.6).

11. Some self-governing hospitals may over time choose to specialise in those services that are more glamourous and will attract more revenue. This could well be to the detriment of local residents whose core services may then have to be provided further afield (Para 5.7).

12. The introduction of self-governing units will marginalise the planning process and the input from patients (Para 5.9). By paying more than NHS-agreed scales, these units will drain staff from non self-governing local services (Para 5.10). Department of Health directives will not apply, so it is not clear what will prevent a decline in standards (Para 5.11).

13. NHS Hospital Trusts should conduct their business in public. CHCs should have observer status and formal consultation should be required on major decisions (Para 5.13). All CHCs covering Districts with patients in a particular hospital should have the right to visit and inspect (Para 5.14).

14. There is little evidence that the establishment of Hospital Trusts will do anything to improve the quality of services to patients and will certainly do nothing to improve patients' choice (Para 5.16).

15. Only 'core' services must be provided locally, which may mean by a neighbouring DHA. Other services will be provided further afield. Patients will have to travel to services outside their districts much more frequently

than is currently the case. This will inevitably cause inconvenience and hardship to some people (Para 6.3).

16. In referring a patient to a hospital, a GP will need to make sure that any referral is covered by an appropriate contact. This is not even provider choice, let alone patient choice, as the contracts will be placed by the DHA (unless the GP holds a budget) (Para 6.4). Administrative costs will rise substantially with no improvement in service delivered to patients. Indeed, patients may no longer get the referral most appropriate to their needs (Para 6.5). There will also be strong pressure on hospitals to reduce their costs, so as to win contracts, making it more difficult to spend money to improve the service (Para 6.6).

17. CHCs must be consulted fully by their DHAs on the definition of core services, on the range and location of contracts, on the detailed content of the contract specification, and the monitoring of contract performance. Unless this takes place, it is difficult to see how the interests of the users of services will be protected, given the pressures to reduce and contain costs (Para 6.7).

18. Proposals on GP budgets and on the GP contract will lead to upward pressure on list sizes and may mean less time is devoted to individual patients (Para 7.4).

19. Practices may be reluctant to take on to their lists patients who may be more expensive than the norm and such patients may be more prone to being struck off (Para 7.5).

20. Practices which hold their own budgets will in effect be operating within a cash limit. Doctors will no longer decide where their patients should be referred solely on the basis of the patient's needs, but will now have to take account of the cost of the treatment in the light of the practice's budget. This may undermine people's confidence in their GPs (Para 7.7). There are particular concerns about diagnostic tests (Para 7.8) and that there will now be an incentive for GPs to encourage patients to refer themselves to accident and emergency departments (Para 7.9).

21. Clinical budgets for GPs will do nothing to improve patient choice, as the choices will be exercised by the doctor. This may mean longer and more difficult journeys for patients (Para 7.10). There will be extra administrative costs (Para 7.11) and little monitoring of GP activities unless GPs are given specific powers (Para 7.13).

22. The overall effect of the White Paper will be to promote cost containment at the expense of a high quality service that is responsive to the needs of those who use the service (Para 8.1). The proposals are untested and

barely thought out with no opportunities for piloting them (Para 8.3). Patients' interests are likely to be ignored totally unless the representative voice of users is strengthened (Para 8.5).

The paper incorporates the views of member CHCs and reflects a wide level of concern about the general opposition to the proposals expressed by CHCs at a Special General Meeting of the Association held on Monday 10 April 1989.

2. THE SCOPE AND OBJECTIVES OF THE WHITE PAPER

2.1 The Prime Minister in her foreword to the White Paper reaffirms that "The National Health Service will continue to be available for all, regardless of income, and to be financed mainly out of general taxation." (4) This reaffirmation is most welcome. However, it remains to be seen whether the new-look NHS will, in fact, continue to provide a broadly equal level of care for all citizens, irrespective of where they live and their ability to pay to supplement NHS provision, and any problems or disability they may have.

2.2 The White Paper states that the two objectives of the proposals it contains are:

- "to give patients, wherever they live, better health care and greater choice of the services available; and

- to produce greater satisfaction and rewards for NHS staff who successfully respond to local needs and preferences" (5).

The proposals should be measured against these objectives. However, for the first of these to be achieved, not only is it necessary for people to have much better information about the services available and their quality, but it also has to be the patient who chooses rather than a GP or a health authority on his or her behalf.

2.3 There are also some general concerns about the scope of the White Paper. There is clearly intended to be some flexibility in the way in which the proposals contained in the the White Paper will develop. In some instances the details are yet to be worked out, in others it is the intention that a number of different models should be tried. Moreover, moves towards self-governing status or towards holding a clinical budget will - initially at least - be optional and discretionary. This in itself will lead to a fragmentation of the service. This becomes even clearer if one looks ahead a few years to a situation, in which a significant number of hospitals have become self-governing, but many have not. They may or may not take some surrounding community services with them, and there may also be self-governing community units as well. As a result, some DHAs will have merged with their neighbours and others with their FPC. At the same time some GP practices will have their own clinical budgets and will relate to RHAs, whereas those that do not will relate to FPCs. Patient care meanwhile will be governed by a web of contracts criss-crossing district and regional boundaries.

2.4 Under such circumstances, not only will the service be fragmented, but it will be increasingly difficult to co-ordinate

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1. INTRODUCTION

1.1 There are 215 Community Health Councils in England and Wales. Their job is to keep under review the operation of the Health Service in their districts and to recommend improvements. They represent the interests of the community within the NHS and have to be consulted by health authorities on any substantial development or variation in services. The Association of Community Health Councils for England and Wales (ACHCEW) was set up in 1977 to represent the user of health services at national level and to provide a forum for member CHCs.

1.2 The Association has consistently supported the concept of the National Health Service as a comprehensive national service for the prevention and treatment of ill-health. It believes that the NHS should be a service that is free at the point of use and readily available for all.

1.3 In 1986, ACHCEW adopted the Patient's Charter (1) as a statement of principles and as a framework for further consideration of the ways in which health care is provided and of the rights and responsibilities of patients. ACHCEW believes that the seventeen points of the Charter should underpin the organisation of health services in this country and provide the basis for running services in the interests of their users.

1.4 The Prime Minister announced in January 1988 that there would be a wide ranging review of the National Health Service and its finances. ACHCEW submitted a paper (2) in evidence to the review and this paper concluded as follows:

- The existing financial framework of the NHS provides for an equitable system of delivering health care. This is not only necessary for social justice, but provides for the most effective use of resources.

- Radical change to the system can only be justified, if modest administrative reforms and increased central funding will not solve the resourcing problem of the NHS. However, this has not been demonstrated by those calling for major changes.

- The allocation of such resources for the health service should not be left to a free market, nor to the professional providers of care.

- General taxation should be retained as the principal source of revenue for the NHS.

1.5. The Government has now published the conclusion of the Review in the form of a White Paper "Working for Patients" (3), and this paper seeks to look at the implications of the proposals in the White Paper in the light of the principles above.

initiatives and to take coherent planning decisions. In many ways, the efforts of the last twenty years to bring the acute services and community services together for planning purposes will have been set aside, as it is difficult to see how parts of the service falling outside health authority and FPC structures will be properly integrated when future plans are discussed. Such concerns apply not only to self-governing hospitals and to GPs holding their own budgets, but also to ambulance and transport services.

2.5 There must also be a fear that the quality of services available to patients will depend on whether their GP holds a clinical budget or not, and on whether their local hospital is self-governing or not. Under such circumstances, it may be hard to avoid a two-tier structure developing and it may be difficult to control regional and intra-regional imbalances in provision.

2.6 It is also noticeable that the White Paper is oriented almost entirely towards the acute sector. Huge sections of the NHS are omitted or dealt with only cursorily. Nothing is said about community care because the Government is still deliberating on the proposals contained in Sir Roy Griffiths' report (6). However, it is difficult to see why the issues could not have been addressed in the White Paper, given that the Government has had Sir Roy's report for a full year. Similarly, there is nothing in the White Paper about ambulance and other transport services, which is a striking omission, given that many of the proposals will mean that patients may have to travel further for treatment.

2.7 The White Paper focuses on services for ill people rather than what the NHS should be doing to promote good health and to reduce inequalities in health status. Such omissions seriously flaw the White Paper's intended objective of reviewing in depth the way in which the NHS operates and provides a comprehensive service to the country as a whole. There are still major inequalities in the nation's health. For example, men in social class 5 have a mortality rate twice that of men in social class 1 for the age group 15 - 64. The risk of lung cancer is more than twice as great for manual workers as for non-manual workers. Heart disease and cerebro-vascular disease are respectively 40% and 65% more common in the manual categories. The evidence is that inequalities have actually widened since the 1970s.

2.8 There are also major health inequalities for people from black and minority ethnic communities. For example, the maternal death rate per live birth is nearly two-thirds higher for women born in the New Commonwealth and Pakistan than for other women.

2.9 At the same time there is an increasing concern about the general health of the population compared with overseas. On a European league table, England and Wales has the third highest mortality rate or circulatory diseases, heart disease and cancer. A third of the population still smokes, leading to 100,000 early deaths a year. Alcohol consumption and associated problems are

budgets, will be to seek the cheapest services available. Quality of service may well turn out to be a less important factor. This is obviously of concern to patients and there is no evidence that the proposals on clinical audit and the other measures focusing on quality will be sufficient to produce a quality-promoting incentive that will over-ride the pressures to cut costs.

3. THE STRUCTURE OF THE WHITE PAPER

3.1 There are three core proposals within the White Paper: the creation of self-governing hospitals; the establishment of an internal market through a system of contracts for hospital services; and the enabling of large general practices to hold their own budget. All the other proposals in the White Paper are largely peripheral to these three core elements and could stand as proposals independently. Comments on some of these "peripheral" proposals are made in section 4 of this paper. The core proposals are dealt with in sections 5, 6 and 7.

3.2 The White Paper was also notable for the large number of questions that it left unanswered. At the time of publication, the impression was given that these matters would be dealt with in the eight Working Papers (9). When these eventually emerged, although they did provide some additional details, many of the questions remained unanswered and indeed new questions emerged. It follows therefore that there is still substantial scope for the proposals to be refined during the next few months. So far Government Ministers have implied that the White Paper is not out for consultation and have expressed their determination to implement the White Paper without amendment. This diagnostic approach is regrettable and and it is to be hoped that the Government will respond carefully to the issues raised by those commenting on the White Paper.

4. THE "PERIPHERAL" PROPOSALS

4.1 The term "peripheral", is not intended to be pejorative. Some of the proposals which fall in the category are those with the most undeniable benefits for patients. Instead, the term is used to imply that they could stand alone from the core proposals and be implemented in their absence. The paragraphs which follow comment on some of these in detail.

4.2 Audit Arrangements

4.2.1 The White Paper proposes that arrangements for financial audit with the NHS should be changed. In future, the Audit Commission will have its remit extended to cover the auditing of health authority financial accounts and to undertake wide-ranging value for money studies. At present, the Audit Commission's activities are restricted to local government and enabling legislation to extend the remit is currently before Parliament. The Audit Commission started life perceived as being very much a creature of central government. However, some of the studies it has produced have been independent-minded and,

on a rising trend. Yet nothing is said about any of these issues in "Working for Patients" or any of the Working Papers, and health promotion is barely mentioned.

2.10 It is also ironic that given the widespread concerns about the resources available to the NHS at the time the Review was launched that so little is said in the White Paper about the future level of resourcing for the health service. Until towards the end of 1987, the Government's response to criticism of the level of NHS expenditure had been to offer statistical reassurances of the services' well-being. Since then, two successive increases in NHS funding have been agreed. Neither has perhaps been quite as significant as presented at the time, but both were welcome and long overdue. More significantly they represented an admission by the Government that the original allocation had not been enough.

2.11 As has been pointed out in the 'National Health Success', a booklet prepared by Margaret Whitehead and published by ACHCEW in conjunction with South Birmingham Health Authority to make the 40th Anniversary of the NHS, (7) the UK health service represents amazingly good value for money. It is inexpensive compared to many other countries: of the 23 OECD countries only Spain, New Zealand, Portugal and Greece spent a lower share of Gross Domestic Product on health care, while the other eighteen spent more with Australia, Canada, France, Germany, Iceland, Ireland, the Netherlands, Sweden, Switzerland and the United States, spending at least 30% more as proportion of GDP. The rate of growth of spending in the UK has also been less than in most other OECD countries.

2.12 The UK health service also provides a much more universal service than that in other countries with a wider range of health care services reaching all of the population. In particular, there is a strong tradition of primary health care in the UK which means that far more work is done in the community and on an out-patient basis. This is much envied overseas and for that reason the hospital bias of the White Paper is so surprising.

2.13 Margaret Whitehead points out (8) that the NHS has less bureaucracy that its foreign counterparts and has much lower administrative costs. She estimates that NHS administration costs only between 4 and 6% of the total budget, compared with administration costs, which are twice as high in France and Germany and reach some 22% under the US system. Again it is surprising that the proposals in the White Paper are likely to lead to a sharp increase in administrative costs.

2.14 "Working for Patients" has been perceived by many as a Government exercise in cost containment. The total sum available for health care will be cash limited and no significant additional resources are envisaged in the White Paper, apart from those needed to finance the information technology developments essential to make the proposals work. Moreover, the constraints on and incentives for budget managers, whether they are in health authorities placing contracts or GPs with their own practice

on occasion, critical of Government policies. For example, the Audit Commission's report, published in December 1986, on "Making a Reality of Community Care" (10) not only provided a devastating critique of the chaotic nature of existing policies on care in the community, but led directly to Sir Roy Griffiths being asked to undertake his review. It may be therefore that the voice of the Audit Commission will be helpful in highlighting future inconsistencies in Government policies towards the NHS.

4.2.2 Even more significant, however, is the Government's support for the extension of "medical audit" throughout the NHS. The intention is that this would cover both primary care and the hospital and community health services. Working Paper 6 (11) defines medical audit as "the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient." The Working Paper points out that a patient's primary concern is for "a correct diagnosis to be made and for effective treatment to be given," and it is for this reason that ACHCEW welcomes the Government's commitment to the widespread introduction of medical audit. It trusts that this commitment will be seen through with determination to make sure that the systems which are eventually established are sufficiently robust to deal with poor practice and to protect the interests of the patients.

4.2.3 There are, however, major concerns about the mechanisms to be adopted. The Working Paper takes it as axiomatic that "the quality of medical work can only be reviewed by a doctor's peers" (12). There is no doubt that any process of professional audit must involve representatives of the profession concerned to ensure that issues of professional competence and judgment are adequately addressed. However, it is less clear that the entire process should be dominated and led by the profession concerned. The classical question "Quis custodiet ipsos custodes?."* remains and it is difficult to see how patients can have full confidence in a system, which involves no independent lay oversight. It will appear to be too easy for concerns about an individual doctor to be dealt with informally and cosily behind closed doors.

4.2.4 Indeed the Government is quite explicit that "the results of medical audit in respect of individual patients and doctors must remain confidential at all times" (13). No-one would wish to see the personal details of particular cases being published, but where there are concerns about the competence of a clinician it is important that these are not only resolved but are seen to have been resolved. In any event, in making a referral to a particular specialist team in a hospital, should not information be available about that team's track record to enable an information choice to take place?

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*"Who is to guard the guards themselves?" (Juvenal)

FPCs will also be made up of 11 members: a chairman again appointed by the Secretary of State, four professional members, five lay members and a Chief Executive.

4.3.5 The removal of local council representatives removes the last health authority members who could have been seen in any way as directly and personally accountable to the local population. All members of RHAs, DHAs and FPCs, will now be appointed by the Secretary of State or his/her nominees. When this is coupled with the overall reduction in size of health authorities and the greater role of professional managers, it is apparent that the degree of lay influence over the organisation and planning of the service will have been sharply diminished. ACHCEW deeply regrets this. While the CHC observers at health authority meetings have often been better informed about what has been going on in the local services than the DHA members themselves, there is no doubt that the presence of a range of lay DHA members did at least provide some occasional check on rampant managerialism. The role of CHC's observers on DHAs and FPCs will become ever more important as a result. Indeed, CHCs should also now be given the right to observer status on DHA and FPC Committees, sub-committees and Working Parties, together with access to their papers. A similar right of involvement should also be extended to cover health service planning teams and joint planning bodies. Access to information legislation, similar to that applying in local Government, should now be introduced to cover all health service bodies.

4.4 HOSPITAL SERVICES

4.4.1 The White Paper spells out what the Government expects each hospital to offer:

- effective appointment systems, banning long waits;
- quiet and pleasant waiting areas with facilities for parents and children;
- clear information leaflets (presumably these will be in appropriate languages);
- better explanation to patients;
- a rapid notification of test results.

These issues, of course, have formed the substance of several hundred CHC reports and surveys over the last fifteen years. Many of the points are explicitly contained within the Patients' Charter (17), within the joint ACHCEW/IHSM publications, "A Time to Move" (18) and "Managing A and E" (19), or within resolutions submitted by ACHCEW to the Department of Health. ACHCEW therefore has no hesitation in welcoming the Government's commitment to these points.

4.4.2 It has been said, however, that progress could have been made in the last ten years or so and that the White Paper itself

4.2.5.The Working Paper proposes that by April 1991 each District Health Authority should have established a District medical audit advisory committee, chaired by a senior clinician and including representatives of the major medical specialities. The District General Manager should be represented by an appropriate doctor. Parallel structures would be set up by Family Practitioner Committees. It is of considerable concern that no lay members are all seen to be proposed for these bodies and there is only the vaguest reference to the need "to devise ways of ensuring that a patient's perspective is incorporated into the audit programme" (14). At the very least a CHC perspective must be seen as a central theme of audit work.

4.3 NHS Structure

4.3.1 The NHS is now to be run by an NHS policy board chaired by the Secretary of State for Health. He or she will be joined by a number of external people but is not all clear that anyone on the Policy Board (or for that matter the Management Executive to be chaired by the Chief Executive) will have a remit to represent the interests of users of service. There is, of course, no reason why a representative of ACHCEW could not be involved in the Policy Board and/or the Management Executive in an observer capacity, in the same way that CHCs have observer status or DHA and FPC meetings.

4.3.2 Responsibility for the management of family practitioner services will be brought under the NHS Management Executive. This is sensible and will promote the better integration of primary care and hospital services, given that the opportunity has not been taken to promote greater integration at local level, apart from making FPCs accountable to RHAs.

4.3.3 It is the White Paper's proud boast that "The overall effect of these changes will be to introduce for the first time a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State" (15). This intention has, in fact, been evident for some time and has led to the increasing marginalisation of health authority members as general managers have appeared to respond to directives from on high. It is important that in establishing such a chain of command, increased emphasis is given to a stronger voice for the user of service. This point was well recognised by the Institute of Health Service Management in the report of their Working Party on Alternative Delivery and Funding of Health Services (16). This saw it as essential for there to be "truly powerful local bodies .... for the purposes of representing consumers and allowing groups in the community to affect the health system as it operates in their locality."

4.3.4 The size of the RHAs, DHAs, and FPCs is to be cut significantly. Local authority nominees are to disappear. RHAs and DHAs will consist of up to 11 members: a chairman appointed by the Secretary of State, up to five executive members (the RGM and DGM and other senior managers) and five non-executive members.

although the Government has made clear its intention that consultants should be rewarded for their contribution to "the effective use of resources" (21).

4.6 Tax relief for pensioners' medical insurance

4.6.1 In a few lines at the end of the White Paper the Government signals its intention to introduce legislation to give tax relief from April 1990 on private medical insurance premiums for those aged 60 and over. This will apply whether they pay the premiums themselves or their families pay them on their behalf. This proposal sits uneasily in the White Paper and does not fit in at all with its other contents. It seems likely to lead to a further expansion of the private insurance market, thereby worsening the two-tier structure of health care. Moreover, unless it can be guaranteed that private insurers will offer comprehensive medical care to those aged 60 and over, there can be no assumption by the Government that there will be any reduction in demand for NHS services.

5. SELF-GOVERNING HOSPITALS

5.1 The proposal in the White Paper that hospitals should be enabled to opt out of the mainstream NHS and achieve "self-governing" status as an NHS Hospital Trust has probably attracted more comment than any other. Despite this and a 24 page Working Paper, (22) there is still considerable uncertainty about how the concept will work in practice.

5.2 The first point to note is that the Government envisages that all hospitals are potentially eligible to opt for self-governing status. Moreover, the Working Paper is quite specific that "there will be no rigid definition of what a 'hospital' should be for the purposes of self-government" (23). It is suggested, for example, that it may be sensible for a self-governing hospital to run a range of community-based services, that community-units themselves could be self-governing, or that several hospitals could combine under one management unit and become self-governing. The only requirements will be that the hospitals concerned must have sufficiently good financial and management systems in place and that professional staff - "especially consultants" (24) - must be involved in the management of the hospital.

5.3 The Government is setting a rapid pace for the introduction of the necessary financial systems and is making substantial sums of money available for the new technology required. There have, however, been concerns expressed by a variety of professional groups that the timetable proposed is too ambitious. If it is the case that the Government seriously expects a substantial number of hospitals to have become self-governing by April 1991, ACHCEW is concerned that the necessary systems will not by then be well-enough established and tested. In any event, developments such as this should be preceded by carefully evaluated pilot schemes and the evaluation should take fully into account the impact on the quality and accessibility of services.

gives no indication as to what mechanism is to be used to ensure that progress is made on this occasion. Exhortations have been tried in the past and have failed to achieve universal results. Something more will be needed if the Government's commitment is to be seen as any more that window-dressing.

4.4.3 The White Paper also says that hospitals should provide "a wider range of optional extras, and amenities for patients who want to pay for them - such as single rooms, personal telephones, televisions and a wider choice of meals" (20). Again no details are spelt out. There has, however, to be a real fear that this will emphasise the two-tier nature of the services available to those who cannot pay. In any case, CHCs have frequently been on record as saying that such things as a wider choice of meals should be available to all patients not just those who can pay extra. It goes without saying that extra administrative staff will be needed to run the charging system and to chase unpaid bills. Of more concern is the proposal on private rooms. In many cases a private room may be clinically desirable (for example, for the mother of a still-born child on a maternity ward). It is not clear what safeguards there will be to ensure that such a room would be vacated if others without a clinical need had already opted to pay extra to occupy all the available single rooms. Clear policy guidance on this is essential.

4.5 Consultants

4.5.1 The Government intends to increase the number of consultants by 100 over the next three years. This is obviously welcome, although it is not clear that it will be sufficient to meet the Government's objectives of reducing waiting lists and helping to cut the hours worked by junior doctors. A hundred consultants are likely to be spread rather thinly over nearly 200 DHAs and the full range of specialisms. Nor is it clear whether extra posts will come with the necessary juniors and support staff, including paramedical staff. Moreover, the long-term future of the posts must be uncertain, as the Government's new proposals for financing the NHS come into force and Districts are funded increasingly pro rata for their population.

4.5.2 The Government intends to revive the existing systems of consultants contracts, appointments and merit awards. Consultants will in future have fuller and more precise job descriptions, and, although contracts will still be held by RHAs, DHAs will be more involved in the appointment process, and in drawing up and monitoring job descriptions. It is envisaged that the job descriptions will provide a work programme showing consultants' main duties and location each morning and afternoon and their rota commitments out of hours. For these minority of cases where consultants do not pull their weight, this will be a step forward, provided proper account is taken of teaching and research responsibilities. In this respect, there may also be benefits in the opportunity for some regular review of consultants' activities in response to these job descriptions and the introduction of new disciplinary arrangements by the end of 1989. It is less clear how the distinction awards will operate,

5.4 The requirement concerning the involvement of consultants in the management of hospitals raises another issue: the extent to which the White Paper proposals are going to extend the degree of professional domination of the Health Service. Indeed, since the NHS was established 41 years ago, there has always been a tendency for professional concerns to dominate. It has sometimes seemed that it has been forgotten that the NHS is run for the benefit of its users, rather than for the convenience of senior consultants. The introduction of general management was an attempt to break with this tendency and there has been some success in this. It would be of considerable concern if the effects of the White Paper proposals were to reverse this.

5.5 The White Paper envisages that the process of establishing an NHS Hospital Trust might be initiated by a variety of interests: the DHA, the hospital management team, senior medical staff, people from the local community who are active in the hospital's support, or even the Secretary of State. This raises the prospect of any of these interest groups, who may be disaffected as a result of some decision, initiating a long and costly process that may not lead ultimately to the hospital becoming self-governing but will instead introduce time consuming delays. Secretary of State will take the final decision and will presumably arbitrate if some of the interests above disagree. However, there will be no appeal against the Secretary of State's decision and there is no indication as to what criteria he or she will adopt in deciding whether to agree to a particular hospital becoming self-governing. This is important because the effects on the remainder of DHA's services need to be assessed properly.

5.6 The Government says that Regional Health Authorities "will seek out the views of those with an interest" (25) before the Secretary of State makes a decision on an individual hospital. However, no details are given of how this process will take place. ACHCEW believes that there should be a formal consultation document issued in respect of any proposal for a hospital to become self-governing. This should spell out what is proposed with a clear statement of the implications for the services provided to the local community. CHCs, as the local representatives of the users of services, have a formal right to comment and object to these proposals with the option to take their case directly to the Secretary of State.

5.7 A self-governing hospital will earn its revenue from the services it performs and will enter into contracts with health authorities for the provision of services to local residents. It will also sell its services to the private sector, insurance companies etc. Whilst its contract with its local DHA may specify a range of core services to be provided to local residents, it is envisaged that the hospital will be able to cease to provide such services after due notice has been given, subject to the approval of the Secretary of State in the event of any disagreement. This leaves the fear that some self-governing hospitals may over time choose to specialise in those services that are more glamourous and will attract more revenue. This could well be to the detriment if local residents whose core

services may then have to be provided further afield and it is difficult to see how services for elderly people, for those with mental health problems, and for people with learning difficulties will be safeguarded.

5.8 The concerns are intensified by the fact that self-governing hospitals will apparently play virtually no part in the NHS planning system. The only obligation placed on them will be to submit an operational plan on an annual basis to the Regional Health Authority (not even to the District or Districts to who, they provide the bulk of their services). The implication of this is that Hospital Trusts will make decisions on their operational arrangements purely on the basis of commercial considerations and will then merely inform the RHA of their intentions. No consultation is proposed in such matters and they will not be reviewed as part of an overall planning system. Indeed, it is difficult to see how any coherent planning will be possible. District Health Authorities will be left to administer and plan the "rump" services that are nor part of the self-governing unit, and will merely respond to decisions made by the Hospital Trust without any real ability to influence those decisions.

5.9 This has particularly serious implications for the input of lay user representatives into the planning process. Over the last fifteen years, CHCs have taken an increasing prominent role in may parts of the country in NHS planning. Managers have recognised the value of having this input at an early stage in the planning process. As the planning process is itself marginalised by the arrival of self-governing units on the scene, so too will be the input from the patients.

5.10 The autonomy given to self-governing hospitals will have other major effects on local services. They will be free to set their own rates of pay for staff. Many may therefore start to pay more than NHS agreed scales and will drain staff from non self-governing local hospitals.

5.11 Most Department of Health Directives will not apply to self-governing hospitals, As these directives are frequently to do with the quality and range of services to be provided, it is not clear what safeguards there will be to prevent a decline in the standards and a drift away from the overall objectives set for the health service.

5.12 Self-governing hospitals will also have the right to dispose of assets. The only restraint on this will be that the Secretary of State can intervene, if it is left that such a disposal would be against the public interest. Again nothing is said to what criteria will be used in assessing the impact on 'the public interest' of any proposals , nor is it clear how such a proposal will be notified to interested parties and whether any consultation will be required.

5.13 Given the enormous direct and indirect impact of the decisions made by NHS Hospital Trusts and given that the

Government continues to stress that the Trusts will continue to be part of the NHS, it is unfortunate that so limited a system of public accountability is proposed for them. The Trusts will be required only to hold one meeting per year in public. It is not clear why other meetings need to held in secrecy and it would seem appropriate that Trusts, like other public bodies, should be required to make their decisions openly and subject to public scrutiny. ACHCEW believes that NHS Hospital Trusts should be required to admit a CHC observer to all their meetings with the same rights of participation that CHC observers currently have at DHA and FPC meetings. If the bulk of the work of the Trust is to be done in committees then a CHC observer should be invited to those meetings as well. NHS Hospital Trusts should also be obliged to issue consultation documents concerning their short-term and long-term plans and any proposals to close or change services in any substantial way.

5.14 The Working Paper envisages that it will be the responsibility of those placing contracts with a self-governing hospital to monitor the performance of that hospital in providing an agreed level of service. CHCs will still have visiting rights in respect of self-governing hospitals, but the rights may be vested in the CHC in which the hospital is located. Other CHCs whose Districts may be placing large numbers of patients in the hospital will not automatically have any right to visit and inspect. This is unsatisfactory and impeded CHCs in pursuing their responsibility to represent the interests of their local communities. ACHCEW believes that all CHCs covering Districts with patients in a particular hospital should have the right to visit and inspect that hospital if they so choose.

5.15 It is also envisaged that CHCs will be expected to pursue unresolved concerns and complaints through their DHA rather than through the NHS Hospital Trust. Similarly, they are to look to the DHA rather than to the Hospital Trust for any information they require. This too is unacceptable. It creates an arms-length relationship which is likely to make it very difficult for CHCs to be effective in representing the interests of users of service.

5.16 Taking all these factors together, it is difficult to see how self-governing hospitals will be publicly accountable and how the patients interests will be adequately protected, and how the wider needs of a properly-planned NHS will be served by their separation from the DHA structure. There is little evidence that the establishment of Hospital Trusts will do anything to improve the quality of services to patients and will certainly do nothing to improve patients choice.

6. FUNDING AND CONTRACTS FOR HOSPITAL SERVICES

6.1 The White Paper proposes that the RAWP formula should be abolished. RHA funding will now be based on population with some allowance for morbidity and age. It is not, however, clear that this will adequately reflect the differing needs of the various parts of the country. Form next year's financial allocation

there will be no adjustments for cross-boundary flows between RHAs and direct payments will be made between Regions to compensate for these. This system will be extended to District Health Authorities in the following two years. It is important to note that the total funding of the NHS "will continue to be subject to annual vote approval by Parliament and will be cash-limited" (26). It will remain important therefore for the Government to be sensitive to the needs of the service and its users. Indeed, the concern must be that in any cash-limited system, as has been mentioned already in paragraph 2.14, pressures to contain costs will lead to the cheapness of a service becoming more important that its quality.

6.2 An internal market will be established with health authorities charging each other for the services provided to people from outside their boundaries. At present, of course, there is a free flow of patients across health district boundaries, but each District tries to provide all the more common specialities for its residents so as to minimise the need for long travel by patients and their families. In the future this will change. DHAs will have a responsibility for ensuring that "their resident population continues to have access to a comprehensive range of services". However, the expectation that the bulk of these will be provided by the DHA concerned will change, and the DHA will take out contracts with other DHAs, with self-governing hospitals, with private facilities etc to provide the services needed.

6.3 The White Paper draws a distinction between 'core' services and 'other' services. Core services must be provided locally. However, locally in this context may mean that services are provided in a neighbouring district. Given the size of many existing districts and given the White Paper's expectation that a significant number of DHAs will merge in the coming years, this implies that the distance patients will need to go to reach a 'local' service may be quite large. It will be for each DHA to determine what should constitute the core services for its district. Other services will by definition be likely to be provided further afield. The implication of this is that patients will have to travel to services outside their districts much more frequently than is currently the case. This will inevitably cause inconvenience and hardship to some people, particularly those who are elderly or are disabled, those with small children, and those without cars. As has been pointed out earlier, no mention was made of ambulance services or transport services within the White Paper.

6.4 Not only will these proposals mean that patients will have to travel further, but in practice patients will have less influence on where they receive a service. There will certainly be no increase in patient choice. At present, patients are usually referred to a hospital via their GP. Ideally, such referrals are made by the GP in consultation with the patient, taking account of his or her needs. This will continue, but in future GPs will be responsible for ensuring that any referral they make is covered by an appropriate contract. The GPs

themselves will have little choice in the matter (unless they are in a practice which holds its own clinical budget): they will have to make a referral on the basis of the contracts placed by the local DHA. This is not even provider choice, let alone patient choice and as such certainly undermines the clinical freedom of the GP.

6.5 The Government's intention is that DHAs should enter into sufficient contracts to cover the likely referrals. In practice this means, however, that either GPs will have only a limited choice of possible referrals and will thus have their clinical freedom constrained, or there will be a huge and immensely complicated network of contracts for GPs to choose from. In either case, GPs will have to receive regularly updated information from the DHA on the contracts which have been taken out and the usage to date in any financial year. The administrative complexities are substantial with bills and money flowing backwards and forwards from one DHA to another. It is inevitable that administrative costs will rise substantially with no improvement in the service delivered to patients. Indeed, patients will be conscious that they may not be getting the referral most appropriate to their needs, either because their DHA has not taken out a contract with that hospital or because all the available places under the contract have already been utilised. This will do nothing to improve the patients' confidence in his or her doctor.

6.6 There will be strong pressure on hospitals to reduce their costs so that they can win contracts. This will lead to pressure to discharge patients even earlier that at present so as to cut costs, but liaison with local community services will be more difficult as the distances involved are likely to be placed greater. A greater emphasis will need to placed on the quality of service, but it is not clear that there will be much incentive on a hospital to spend money to improve quality, if the result is higher costs.

6.7 As with self-governing hospitals, it will be for the DHA placing a contract to monitor the performance against the contract specification and it is not clear what rights, if any, a CHC will have in respect of services provided outside their district's boundaries. ACHCEW believes that it is essential that CHCs are consulted fully by their DHAs on the definition of core services, on the range and location of the contracts the DHA intends to place, on the detailed content of the contract specification, and on the monitoring of contract performance. Unless this involvement takes place, it is difficult to see how the interests of the users of services will be protected, given the pressures to reduce and contain costs.

7. INDICATIVE PRESCRIBING AND CLINICAL BUDGETS FOR GENERAL PRACTITIONERS

7.1 The White Paper says that Family Practitioner Committees are to set indicative budgets for the costs of drugs prescribed by each GP practice. The aim of this is to tell GPs how much

they ought to be spending on drugs for their patients. This scheme is to start in April 1991 and the allocation of budgets to RHAs and to FPCs will initially be based on the existing prescribing pattern. However, over time the financial allocation will gradually move towards being totally based on a weighted capitation formula, taking account of the age, sex and morbidity of the population, the number of temporary residents, and the extent of cross-boundary dispensing. This will, of course, mean that in due course the money available for drugs (and whether or not it is sufficient) will depend on the sophistication of the formula and the extent to which GPs take notice of the indicative limits.

7.2 Indicative budgets will then be allocated to each GP practice and the Government intend to take powers to allow FPCs to impose financial penalties on GPs who persistently refuse to curb excessive prescribing. The Working Paper (28) suggests that in those cases where discussions and peer review have no effect, the FPC may be able to with-hold re-numeration as a last resort. There will also be an incentive scheme where by FPCs will spend half of any target reduction in prescribing costs achieved on improving local primary care. Despite the protestations that that budgets set will merely be indicative, it is clear that the combination of sanctions and incentives will put considerable pressure on GPs to comply.

7.3 Clearly it is in nobody's interest (apart from perhaps the pharmaceutical companies) for there to be excessive prescribing. Moreover, as the budgets will be calculated on the basis on the basic list price of drugs, the pressure will not only be to curb excessive prescribing but to promote generic prescribing. This should help lower the NHS drugs bill and in theory could release resources for other developments. Nevertheless, there is inevitably some restriction on the GP's clinical freedom involved, particularly where a GP has already for whatever reason, exceeded his or her indicative limit. This may conceivably lead to tensions in the doctor/patient relationship.

7.4 The other major proposal affecting GPs is the idea that the larger GP practices should be able to apply to have their own budgets for buying a range of services direct from hospitals. This will initially apply to practices with more than 11,000 patients (these cover about a quarter of the population) but the limit could be reduced in due course. Coupled with the changes in the GP contract whereby doctors' re-numeration will be based more on list size than hitherto, this will lead to upward pressure on list sizes, as GPs seek to qualify for practice budgets. This goes against the long-term trend for list sizes to fall which has, in theory at least, enabled GPs to devote more time to each of their patients.

7.5 Practices, who wish to join the scheme, will apply to the RHA and will be set an overall budget. This will probably amount to several hundred thousand pounds and there will be an upper limit on the cost of hospital treatment for any one individual that will be charged to the budget. Budgets will also

reflect the number of elderly patients on the practice's list and will exceptionally take account of the costs of other 'expensive' patients. It is not clear however, what these exceptions will cover. For example, will people with Downs Syndrome, with diabetes or with sickle cell anaemia be covered? Similarly, will special account be taken of the number of heavy smokers? In any event, it seems unlikely that the scheme for allocating budgets will be particularly sensitive to variations in individuals' needs. This may mean that such practices will be reluctant to take on to their lists patients who may be more expensive than the norm and such patients may be more prone to being struck off.

7.6 If a practice overspends against its clinical budget, the overspend will be recovered from the following year's allocation. If the practice overspends by more than 5% two years in succession, then the practice will be subjected to a "medical audit" and may lose its right to hold its own budget. On the other hand, if a practice underspends, then it will be allowed to keep the underspend and use it within the practice. It is not clear what restrictions there will be on the use of the underspend and how such decisions are to be scrutinised. Presumably clear guidance will be needed to avoid underspends being used to purchase a practice porsche or other items irrelevant to patient care.

7.7 The effect of these proposals is that practices will be operating within a cash limit. The constraints imposed by this may well have the effect of compromising the clinical freedom of the GP concerned. Doctors will no longer decide where their patients should be referred solely on the basis of the patient's needs, but will now have to take account of the cost of that treatment in the light of the practice's budget. Even if doctors do not compromise their clinical decisions as a result of cost concerns, patients may still perceive that this has happened and there must be a concern that people will not have the confidence they previously had in their GP.

7.8 Moreover, the details of the proposals raise additional concerns about how the budgets will operate. Diagnostic tests will be charged to the practice budget on a fixed costs basis. This may act as a disincentive for patients to be sent for diagnostic tests by their GP. Whilst nobody would wish to see unnecessary test carried out, there is in fact little evidence that this is currently a significant problem compared with overseas. If, however, a patient has been referred for a test, the cost paid from the GP's budget will remain the same whatever additional diagnostic procedures may be carried out at the hospital: the cost of extra tests will be borne by the hospital and not reimbursed by the practice making the referral. This will mean that there will be a disincentive for hospitals to carry out additional tests. The concern must be that patients may in future either not get or feel they are not getting the diagnostic tests they need.

7.9 A different procedure will follow when a patient is referred to a hospital for treatment. In this case the GP

practice budget will bear the cost of whatever treatment is deemed to be necessary by the hospital consultant (subject to the overall individual maximum). Thus the budget holder will have no control over the charge to be made to the budget following referral and this may lead to referrals to consultants known to pursue only limited or less-costly courses of treatment. There will also be anomalies in respect of patients who refer themselves to accident and emergency departments. Indeed there will now be an incentive for GPs to encourage their patients to do just that, as the costs of treatment will not be borne by the GP's budget.

7.10 The proposals will do nothing to improve patient choice. The choices that are exercised will be exercised by doctors. Moreover, if it is cheaper to send a patient to a particular hospital, then presumably that is where most GPs will refer the patient. This may mean longer and more difficult journeys for patients to reach hospitals which offer a marginally cheaper deal to the GPs. Again the pressure will be to reduce the costs, possibly at the expense of quality and convenience of service. The only option available to patients if they are unhappy about their doctor's choice of hospitals, will be to change doctors, if there is a suitable practice which will take them and if they are prepared to undergo the change which many may feel is daunting and traumatic.

7.11 There will undoubtedly be extra administrative costs associated with these proposals and these will have to be found from GP practice budgets. GPs will have to place and negotiate their own contracts with hospitals in their area and around the country. It is not at all clear that this is a reasonable extra burden to impose on already over-stretched GPs.

7.12 ACHCEW is deeply concerned about the implications of the proposals for GP budgets. The arrangements will impose a significant cost constraint on medical treatment and diagnosis and this will be to the detriment of the patient. At the same time there may well be a lessening of trust by patients in their doctor, who may no longer feel that they are receiving the treatment they need rather than the treatment that the GP can afford.

7.13 There are also major concerns about the accountability of GPs who have opted to hold their clinical budgets. There will be no CHC access to the decisions made by doctors as to which contracts to place or the content of such contracts. It will be difficult for CHCs to monitor the quality of care given, as this will be the responsibility of individual GPs. Complaints procedures and systems of redress will need to be redefined if patients are to have any degree of protection and CHCs will need to be given explicit power to monitor the way in which the GP budgets operate. In this context, it is very important that practice accounts are published and are subject to scrutiny.

8. CONCLUSIONS

8.1 Although there are a number of proposals which will undoubtedly be beneficial to the users of the NHS, the main themes of the White Paper do nothing to strengthen the position of patients or to improve patient choice. Indeed, the overall effect of the White Paper will be to promote cost containment at the expense of a high quality service that is responsive to the needs of those who use the service.

8.2 This is not the view of ACHCEW alone. The British Medical Association has expressed open opposition to the White Paper, warning that it will destroy the comprehensive nature of the NHS and seriously damage patient care, and pointing out that the White Paper has ignored the critical issue of inadequate funding (29). The Joint Consultants Committee of the Royal Colleges say that there will be risks to patient care if the White Paper is implemented and that old people and those who are chronically sick will suffer because they are "bad business" (30). Concerns have also been expressed by the Royal College of Nursing, the National Association of Health Authorities, the Institute of Health Services Management and virtually every other organisation associated with the NHS and health care provision.

8.3 There are striking omissions from the White Paper. Nothing is said, for example, about the overall level of resourcing of the NHS in the future, even though this was the issue that precipitated the NHS Review in the first place. Little is said about community health services, even though these will become an increasingly important part of health care provision over the next ten to twenty years. Instead, there are a series of proposals for self-governing hospitals, for GP budgets and for contract-based financing of health care which are untested and barely thought out. Many of the details of the proposals have still to be developed. Yet implementation will proceed on a tight timetable with no opportunities for piloting the proposals or for testing the effects on patient care.

8.4 Virtually nothing is said in the White Paper about CHCs and the increasing importance of effective independent representation for users of service both individually and collectively, if the White Paper proposals are enacted. As the IHSM has put it, what is needed are "truly powerful local bodies alongside DHAs for the purposes of representing consumers and allowing groups in the community to affect the health system as it operated in their locality ..... In future, CHCs will need a much firmer foundation in terms of resources and their relationships to community and a far greater capacity to take an informed independent view of health service provision in their locality. It will be important that the necessary investment is made to produce these results" (31).

8.5 Despite the rhetoric of the White Paper, the NHS of the 1990s will be dominated by managers, cash limits and marketing. There can be no guarantee that the interests of patients really

will come first and, indeed, their interests are likely to be ignored totally unless the user's voice is heard clearly at every level of the NHS.

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