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Association of Community Health Councils for England and Wales

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"WORKING FOR PATIENTS?"

THE NHS REVIEW - SOME INITIAL COMMENTS

Introduction

The Prime Minister announced in January 1988 that there would be a wide-ranging review of the National Health Service and its finances. The Government's White Paper was finally published almost exactly a year after the review was set up.

ACHCEW submitted a paper in evidence to the review and this paper concluded that:

**** 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 administration reforms and increased central funding will not solve the resourcing problems of the NHS. But this has not been demonstrated by those calling for major changes.

**** The allocation of scarce 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.

These conclusions need to be borne in mind then considering the contents of the Government's White Paper. The comments which follow provide an initial reaction to the Government's proposals and will be developed further in the light of comments received from Community Health Councils in the next few weeks.

General principles

The Government has indicated that it will not be changing the general principles of the National Health Service, which will continue to be available to all, largely free at the point of delivery and financed mainly out of general taxation. The support for those general principles is obviously welcome, but 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 regardless of where they live and their ability to pay.

Self-governing hospitals

There has already been much public comment on the proposal that some hospitals should be enabled to opt out of the mainstream NHS and achieve "self-governing" status as an NHS Hospital Trust. Initially, it is expected that only a handful of major hospitals could go down this road but the number will depend on those taking part in the "Resource Management Initiative" and this is expected to rise rapidly in the next few years.

This proposal raises a number of crucial questions:

(a) The White Paper envisages that the process of establishing an NHS Hospital Trust might be initiated by a variety of interests: eg the DHA, the hospital management team, senior medical staff, or people from the local community who are active in the hospital's support. What will happen if some of the interests disagree and will the effects on the remainder of a DHA's services be taken into account in deciding whether a hospital can opt out? Will the local community and its CHC be consulted?

(b) 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. Although there will be a requirement for essential core services like accident and emergency facilities to be provided to the local population where no alternative exists, the fear remains that the opted-out remains will choose to specialise in those services that are more glamorous and will attract more revenue. NHS Hospital Trusts will be required to give three years notice to DHAs if they intend to stop providing accident and emergency services for the District. How will services for elderly people, for those with mental health problems, and for people with learning disabilities be safeguarded?

(c) Will self-governing hospitals be involved in the NHS planning system and, if so, how? If they are not involved and simply make decisions on the basis of commercial considerations,

the consequences for remaining DHA facilities will be serious. DHAs will be left to run a "rump" service and will become candidates for mergers with neighbouring DHAs or with the FPC.

(d) Will CHCs have the right to be consulted on the plans of a self-governing Hospital or on proposals to close a ward? Will CHCs have the right to visit and to inspect facilities? Even if they do, it may well be that this will only apply to hospitals physically located within their District. Will the Hospital Trusts make their decisions in public or in private?

(e) Presumably self-governing Hospitals will have the right to sell their services anywhere in the world. What is to prevent an NHS Hospital Trust deciding to offer all its facilities on such contracts or on contacts with the private sector and offering virtually nothing in its local catchment area?

(f) Self-governing hospitals will be free to set their own rates of pay for staff. What is to prevent them paying more than NHS agreed scales and draining local services of staff?

(g) Hospitals which opt out will have their own Boards of Directors. Two of these will be appointed by the RHA to represent the "community." The White Paper suggests that nominees might come from "Hospital Leagues of Friends and similar organisations". Will CHCs be represented and, if not, why not?

It is also not clear how the proposals can conceivably add to consumer choice. If a DHA has contracted all of its work for a particular specialism to one particular hospital, then presumably that is the hospital to which a patient will have to be sent, irrespective of whether it fits in with such practical consideration as ease of access by public transport (indeed some patients may well have to travel further).

GP practice budgets

The White Paper proposes that large GP practices will be able to apply to have their own budgets for buying a range of services direct from hospitals (either NHS or private). Initially only practices with lists of at least 11,000 patients will participate, but this will enable up to 1000 practices to take part and these cover about a quarter of the population. Each practice will be set a budget - typically this will be of several hundred thousand pounds.

Any overspends will be recovered from the following year's budget. However, if the practice overspends its budget by more than 5% in two years in succession, it will lose the right to hold its own budget and will also be subject to a "medical audit". It is not clear who will then decide whether a particular patient's treatment can be "afforded" or not.

If a practice "underspends", then it will be allowed to keep half of the underspend to use as it sees fit. The remainder will revert to the RHA.

In essence such practices will be operating with a cash limit and in effect the principle of clinical freedom will have been undermined. 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. They will will also have a personal incentive to spend less. Whilst this may overall reduce NHS costs, will people still have confidence in their GP under such circumstances?

Again, it is also likely that this proposal will limit consumer choice. If it is cheaper to send a patient to a particular hospital, will GPs, in fact, allow a patient to go anywhere else? This may mean longer and more difficult journeys for patients to reach hospitals which offer a slightly cheaper deal to the GPs. The only option open to patients will be to change doctors, if they are unhappy about their doctor's choice of hospitals. New negotiations will make changing doctors easier.

There must also be big questions about the extra administrative load that this proposal will place on already over-stretched GPs and their practices. Will each practice now need its own qualified accountant to manage the budget?

The NHS structure

The NHS is now to be run by an NHS Policy Board, chaired by the Secretary of State for Health. He will be joined by a number of external businessmen, but it is not clear that anyone on the Policy Board (or for that matter the Management Executive to be chaired by Mr Duncan Nichol) will have a remit to represent the interests of users of service.

The size of RHAs, DHAs and FPCs is to be cut significantly. Local authority appointees are to disappear. RHA and DHAs will consist of 11 members: a Chairman appointed by the Secretary of State, five executive members (the RGM or DGM and other senior managers) and five non-executive members. FPCs will also be made up of 11 members: a Chairman appointed by the Secretary of State, four professional members, five lay members appointed by the RHA, and a Chief Executive. FPCs will now be accountable to RHAs. With smaller health authorities, a greater role for professional managers, and the loss of local council representatives, the degree of lay influence over the organisation and planning of the service will be diminished. The case for strong independent representation for users of service, via the CHCs, will be even greater as a result.

NHS financing

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 whether this will adequately reflect the differing needs of various parts of the country of the pattern of services currently available, although the Thames regions will receive an extra 3% to reflect higher costs in London.

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 patients so as to minimise the need for long travel by patients and their families. If districts start to specialise and drop some of their services, patients may well have to travel outside their districts more often than at present. Again, this may well reduce the patient's choice, but it may also cause hardship for people who are elderly or are disabled or with small children or who do not have cars.

Increased specialisation of hospitals and health authorities will mean that DHAs will cease to provide a full range of services locally. This will complicate the planning process and may make CHC involvement in the services more difficult.

There are also likely to be significant administrative costs, as DHAs will have to spend time costing their services, marketing them to other DHAs, and ensuring that the best deal was achieved for services bought in from outside the DHA.

Hospital services

Hospitals will be allowed to charge for optional extras for those patients who are prepared to pay for them. This will include a choice of meals, single rooms, TVs and personal telephones. This will emphasise the two tier nature of the services available and will limit what is available to those who cannot pay. In any case, should not meal choices etc be available to all patients? Extra administrative staff will be needed to run the charging system and chase bills.

The Government apparently intends to specify that all hospitals should offer appointment systems and that long waiting times in clinics are unacceptable. This, of course, is long overdue.

Prescribing costs

The White Paper says that FPCs are to set indicative budgets for each GP practice. The aim of this is to tell GPs how much they ought to be spending on drugs for their patients and the Government intend to take powers to allow FPCs to impose financial penalties on GPs who persistently refuse to curb excessive prescribing. While obviously it is in nobody's interest (apart from the pharmaceutical companies) for there to be excessive prescribing, this does represent a restriction on clinical freedom and there must be concerns that the Government's

or the FPC's definition of excessive prescribing may not be consistent with medical views.

Medical audit

The White Paper also intends that there will be a national system of monitoring post-operative deaths with a view to identifying what procedures go wrong and why, so that practice can be improved. This is clearly a welcome development and it is to be hoped that the information resulting will be publicly available.

Consultants

The Government intends to increase the number of consultants by 100 over the next three years and is also revising the system of consultants' merit awards, so that consultants' contributions to the effective use of resources, are taken into account. Consultants contracts will still be held by RHAs, but DHAs will be more involved in appointments and in drawing up job descriptions.

Tax relief

Tax relief is to be given to pensioners who face higher health insurance premiums. This intensifies inequalities in health care for elderly people.

Conclusions

The White Paper introduces very important changes into the operation of the National Health Service. Despite the rhetoric in the White Paper, the effect of these is likely to diminish consumer choice. Some of the proposals, such as those on GP budgets, are frankly frightening and the overall conclusion must be that the NHS of the 1990s will be dominated by managers, cash limits and marketing.

The White Paper gives no indication of the future prospects for community care and it is by no means clear when the Government intends to respond to the Griffiths report. Nothing is said about the need to strengthen CHCs given the changes proposed in the NHS, yet the need for strong and independent representation for users of service will be all the greater following the White Paper.

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