Working for patients?

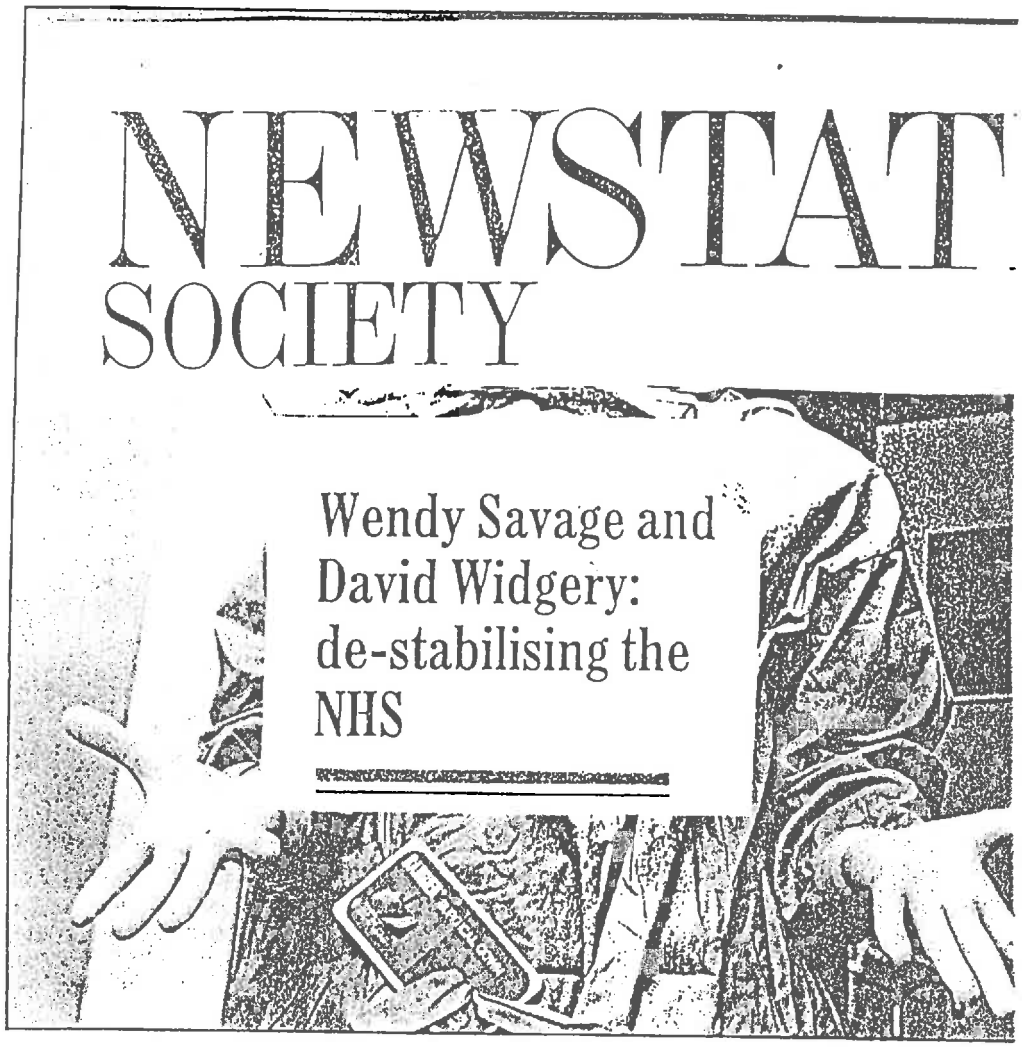
Reading the glossily produced white paper and observing the media blitz designed to promote it, our reactions have ranged from disbelief to anger. Mrs Thatcher is not a stupid woman; can she really not understand that the end result of the "business-like" approach to the provision of health care is the sale of human organs which she describes as "utterly repugnant"? The media report this soundbite endlessly without questioning her sincerity or her motives, and meekly report the high-sounding rhetoric of this white paper without examining the underlying premises or philosophy.

These can be summarised as: the NHS is inefficient, poorly managed, and requires an ever-increasing proportion of the country's GNP. Doctors are responsible for the majority of this expenditure and are unaccountable to anyone for their actions. Consultants abuse their power by not fulfilling their contracts in the hospital service. The drug budget is excessively high, so GPs' expenditure must be curbed. The manual workers in the NHS are a greedy undisciplined body. The district health authorities are unworkable because of the anarchic tendencies of the local authority members. Proper financial management and a "market strategy" will make the service more efficient, and we can have a better service for less public money by cooperating with the private sector.

The underlying philosophy is that those who have money should pay for their health care, so that "scarce" resources can be used for those who cannot, and that private care is more efficient than NHS care. The "crisis" in the NHS is sold as being a result of its underlying structure and aims of the service, and not as a result of prolonged underfunding.

Having got the diagnosis wrong—the NHS is, in fact, a low-cost system, British doctors have relatively low prescribing rates, private care is inefficient, expensive and not interested in a large proportion of the population anyway—the proposed treatment is impractical and undesirable. The central proposals would extinguish what little democracy remains within the system, returning the big hospitals to their pre-NHS state and lumbering GPs with an immensely time-consuming variant of the Health Maintenance Organisations, a North American solution to a North American problem which is failing even in North America. This ad man's dream of the medical future would take us back 40 years, tearing up the present pattern of services with no guarantee of improvement.

Of course, the details are still lacking and there is a plum or two. A hundred new consultants sounds marvellous, yet a mere 0.00005 per cent budget increase is earmarked for it and it represents only half a consultant per health district. And we agree that audit is useful and efficiency is desirable.



Wendy Savage gowns up: services for women don't count as "core services" for opt-out hospitals in Clarke's NHS white paper

But the proposal to let large hospitals opt out is akin to the oft-quoted action of Nye Bevan's in "stuffing their mouths with gold", a cynical bribe to buy off the powerful elite who dictate policy and training in the Royal Colleges. It flies in the face of government policy to give more cash to the less prestigious specialities such as mental handicap, psychiatry and geriatrics.

There is a serious risk that the teaching hospitals will pull up the ladder on the local services they now provide, since they will be under powerful pressure to direct their activities towards more "profitable" lines of clinical work. If the "internal market" encourages the big hospitals to deal directly with budget holding mega-practices in the home counties, whose patients will come bearing gifts, what happens to the bread-and-butter clinical work on their inner-city doorsteps?

The probability is that the geriatrics will be shipped out to the nursing homes offering the lowest rates and that the hernias, hip replacements and terminations would be sent off to the private sector. Instead of district general hospitals offering a full range of services to their locality, we shall see a return of super-specialist hospitals, in competition with each other and with a catchment area covering the entire country.

As for services for women, they are not mentioned in the "core services" which these opting-out hospitals will have to provide for their districts. So is maternity care seen as a likely plum for the private sector? Abortion is not referred to in the page about the number of private operations performed, although it is the most commonly performed operation for which either sex pays.

If the big hospitals go solo, it will destroy the network of services which the NHS provides — a network which has enabled hospitals to discharge people earlier into the hands of increasingly hard-pressed GPs, district nurses, community midwives, health visitors, and commun-

Wendy Savage and David Widgery—a hospital doctor and GP—argue that Kenneth Clarke's proposals for the NHS get both the diagnosis and the treatment dangerously wrong

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ity physiotherapists. The integration of primary and secondary health care which is the real way to make the system more efficient and responsive would, in the name of patient choice, be dealt a terrible blow.

The proposals for general practice are even more curious. They blatantly contradict the ideas in the white paper on primary care which the General Medical Services Committee thought it was currently negotiating. The idea that GPs themselves become budget-holders would inevitably exercise a powerful pressure on them to avoid registering patients likely to be high users of medical services and drugs.

There is no guarantee that a self-held budget would be spent on expanding the staff and range of services available in primary care. It is equally likely to encourage a GP to tell a patient to grin and bear it so that the practice pockets the money "saved". Anyway, an increasing number of GPs and health centres are already expanding their range of services within the present set-up. The few GPs who have a fixation on holding their own budget will rapidly lose enthusiasm when they realise how much of their time will have to be spent cross checking prices and availabilities of treatments once they have made their diagnoses. After all, most of us studied medicine to practice as doctors not accountants . . . or travel agents!

The "fine print" proposals on capitation fees, basic practice allowance and drug budgeting are still more alarming. The capitation fee is the payment the GP gets per head of registered patients. The proportion it contributes to the doctor's total income is probably the most significent factor affecting that doctor's total list size. In the bad old days, a GP had to take on more patients than could be comfortably handled simply to make a living. Over the past few years there has been a steady and welcome fall in the average list size of GPs, allowing them to spend more time with individual patients. The white paper proposes to yank up this capitation element in GPs' income from 49 per cent now to 60 per cent, presumably under the misapprehension that a doctor with a lot of patients on the list must be a good one. Kenneth Clarke is also talking about the removal of the Basic Practice Allowance, an element in pay which many GPs, especially in inner cities, depend upon.

Further curbs on drug spending which are to apply to all GPs, not just the budget-holders, will create more problems and ill-will. At present, hospital clinicians are forced into making (nominal) savings on their budgets by sending their outpatients and newly discharged in-patients back to the GP to get their prescriptions. Apart from being inconvenient, this maneouvre is cost-ineffective (because the drugs will probably cost more from a high street chemist than a hospital pharmacy) and ethically dubious (because the doctor who signs the prescription has the clinical responsibility if there are problems). But it will be ten times worse for the patient if the GP bounces them back because their budget allocation is spent too: patients with chronic illness, and that predominantly means the old, will be shunned by GPs. Tax relief on private care might help the affluent pensioner (a rarity) but opens the door to tax relief on private medicine at all ages, a further fillip for commercial medicine and the well-off.

Overall, the policy will put the same fiscal clamps on the GPs that have the hospitals in such public pain. This despite the fact that GPs are internationally recognised as being exceedingly cost-effective in view of the vast number of patients they see and screen. Yet there is hardly a word about prevention in the white paper. Instead, the GP is invited to become the agent of unpopular cuts rather than the politicians, an offer which they would be wise to decline.

There is no need for this radical revision of the NHS structure. It's already been reorganised three times in ten years, 1974, 1982 and 1984. The effects of the last two upheavals are still being felt. Managers who suffered from two rounds of "musical jobs", are only now getting to grips with the complexities of managing their units. What the NHS needs is a period of stability during which time the systems to show exactly how money is spent are installed. Clinicians could then, with the information provided by management, see rationally how to reduce their expenditure without harming patient care. Further, the proposal to reduce all consumer or local input on the new boards of management bodes ill for patients. It concentrates power in the hands of a few non-elected people and managers who will be rewarded for not spending money, not for the quality of service provided (since the shake-up provides no real patient or local pressure).

The NHS is a complex organisation which has provided a comprehensive service with certain drawbacks: old buildings, long waiting lists, often a lack of patient choice, and little consumer representation on decision-making bodies. Most of these things could be dealt with by increasing the proportion of our GNP spent on health from 5.9 per cent (the lowest in the Common Market) to 7 or 8 per cent; and secondly, by changing the composition of local health authorities and consultant and senior management appointment committees by adding directly elected representatives of the community. But this white paper is not about patient care. It is an exercise of authoritarian control over a service provided with our money through taxation. As such, it is an abuse of power, packaged as a rational economic reform, and sold with £1,000,000 of our money – a technique criticised by the government when used by local authorities facing loss of local autonomy (or even their demise) against the will of the majority of local people. Some of the proposals, cross-boundary charging, flexibility about salaries and wages – could be implemented without this drastic change which has neither electoral mandate nor professional support.

We remain convinced that the majority of the population, including many people who voted Conservative in the last election, want an NHS which is humanitarian, efficient and compassionate, not price-tagged and dependent on market forces. We urge clear-cut and united rejection of the white paper's proposals and philosophy by the medical and nursing professions, the unions and the general public. Managers who want their large hospitals to opt out of the districts, GPs who want to opt into budgeting and the commercial medicine tyros should be made aware of the grave reservations the rest of us have about the whole exercise. ●

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