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The College

Comments to the Social Services Select Committee of the House of Commons on the Government's White Paper *Working for Patients* and the accompanying Working Papers

This is the initial response from the Joint Consultants Committee, whose membership includes the Royal Medical Colleges, and has the College's support. A working group, chaired by the President, is studying the White Paper and the eight Working Papers, and will be preparing a more detailed response focusing on the implications for psychiatry.

Briefly

In general, the National Health Service has been successful and his highly regarded by the public. The Joint Consultants Committee (JCC) is in favour of change provided the evidence shows a genuine advantage to the patients. The proposed changes are, however, radical and require very careful evaluation. The Committee sees real risks to patient care inherent in the White Paper and suggests that a number of *modest* changes in both funding and management could bring about significant improvements without exposing the Service to these risks. The Committee feels also that it is a matter of regret that the profession was not consulted on the White Paper proposals at an earlier stage and that the time-scale set by the Government to discuss these radical proposals is grossly inadequate. Although it has asked (20 February 1989) for a meeting with the Secretary of State for Health there has been no response to this request to date.

Introduction

(1) These comments are submitted by the Joint Consultants Committee, which represents all hospital doctors working in the National Health Service on matters *other than* pay and terms and conditions of service.

Aims of the White Paper

(2) The JCC strongly supports the aims set out in the Prime Minister's Foreword to the Government's White Paper *Working for Patients* (January 1989). It believes, however, that the means put forward in the White Paper to achieve these aims need very careful assessment to ascertain whether they are practicable, desirable or appropriate.

Principles

(3) The review is based upon an underlying principle that competition, in the shape of 'market forces', increases efficiency and increased efficiency releases resources. It presupposes this must allow a better standard of treatment or more treatment within the same level of resource. The general validity of this principle in the world of business is not questioned.

(4) The proposals brought forward now have been drawn from a variety of sources in different countries. In some instances the original concepts are still experimental and in others they have already failed. The Committee will need to be convinced that the application of these proposals is compatible with a National Health Service which uniquely aims to provide universal equity of care. Encouragement of many NHS hospitals to become self-governing, for general practices to have practice budgets, for district health authorities to be purchasers of health care rather than providers – all of which will mean some hospitals 'succeeding' and others 'failing' – will interfere with the proper planning of this equitable provision of care for the community as a whole.

(5) The proposals and the implied expansion of competition is also dependent upon accurate costing. Currently it is generally accepted that the level of management information in the Health Service is woefully inadequate. The JCC has collaborated with the Department of Health in the establishment of six resource management pilot schemes, which have proved expensive, and of limited success to date, and are not yet properly evaluated. Indeed the JCC and the NHS Management Board had already agreed on the necessity for and the time-table of a programme of evaluation. On present information, however, the JCC seriously questions whether it will be feasible to introduce the information technology needed to provide the facts, upon which the competition must be based, within the time-scale suggested. Accurate costings cannot be generally available for at least several years and will be enormously expensive to introduce throughout the Health Service. It will involve both acquiring the appropriate computer systems needed for the NHS, and also recruiting the

skilled staff needed to install and modify the systems to suit the varying demands of individual hospitals. To introduce such an expensive and wide-ranging reorganisation before the resource management initiatives have been adequately evaluated is bad management.

Detail

(6) Very little *detailed* information is in fact available, so reference will be made only to some of the very many proposals put forward.

(a) *Proposals to create self-governing hospitals*

(7) These proposals inevitably change the prime aim of the management of these hospitals, from the provision of adequate care to the community as a whole to the financial success of the hospital. The considerable experience of such hospitals in the USA shows clearly that there will be pressure to encourage admission of patients with conditions that can be treated with financial benefit to the hospital rather than to admit those patients – often the chronic sick – whose treatment is likely to lead to little or no such financial benefit. The organisational costs of hospitals in the United States exceeds 15% of the budget, in comparison with around 5% in the NHS, they therefore spend proportionately much less on direct patient care. Moreover, the service to patients – particularly the poor and the chronic sick – falls far short of the comprehensive service available under the NHS.

(8) The JCC is concerned too about the absence of adequate mechanisms to ensure the maintenance of standards in self-governing hospitals. The profession has co-operated with the Department of Health at national level in working out solutions to problems which can then be implemented throughout the whole of the Health Service. Complaints procedures, management of private practice, data protection, discharge of patients and the waiting lists initiative are recent examples of detailed discussions which have resulted in helpful improvements throughout the Service. Under the new proposals there would be no method of ensuring that guidance on issues agreed nationally would be implemented in self-governing hospitals.

(9) The absence of a clear commitment to the continued implementation of centrally agreed medical manpower policies is a matter of particular concern to the JCC, which has worked closely with the Government to draw up the detailed strategy set out in *Achieving a Balance* and *Plan for Action*.

(10) Finally, the Committee believes that the abandonment of a national remuneration structure for hospital doctors might increase salaries for some doctors, but nonetheless would be a retrograde step, and is not consistent with the long-standing principle of uniform standards throughout the country. An even spread of the best consultants, both geographically and by specialty, has been essential in maintaining equality of access to health services. It was for precisely this reason the Spens Committee recommended in 1948 that a national remuneration structure be adopted for consultants. The introduction of 'market forces' would damage gravely this principle.

(b) *Funding and contracts for hospital services*

(11) The aim of relating hospital funding more directly to the work done is welcomed. However, any proposed system for achieving this needs to be considered carefully. If some hospitals are encouraged to attract more patients, and therefore more funds, within a global total, it follows that the funding of some other hospitals will suffer. The budgets of the 'losing' hospitals could well fall below the critical mass necessary to sustain core services in their own areas. Furthermore, there needs to be a more specific national definition of core services, with greater emphasis on the elderly, the chronically sick and the mentally ill. The fixed price contract funding mechanism suggested is untried in the context of the National Health Service and will clearly limit patient choice. The documents suggest that the final decision on referral of a patient to another hospital for treatment will depend more on the managerial and financial considerations, rather than the patient's wishes and a medical assessment of clinical needs.

(c) *Practice budgets for general medical practitioners*

(12) The JCC, composed of hospital doctors, will deal with this proposal only briefly. Its main concern, however, is that the trust between the doctor and the patient might be impaired when the patient knows that the doctor's decision on his treatment might be directly influenced by the doctor's limited budget, or by prior contractual arrangements with a particular hospital. In addition, hospitals may have a weakened incentive if practice budget-holders retain any savings that accrue from increased hospital efficiency – given that the hospital services elements of such budgets are to be derived by Regional Health Authorities from the hospital and community health services allocation. At present comparable savings arising from increased hospital efficiency can be used by the hospital itself to improve its services elsewhere.

(d) *Capital charges*

(13) The proposals are interesting, but could well be impractical, because the effect on patient care is far from certain. The Committee is seeking more information on these proposals.

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(e) *Medical audit*

(14) In recent years, the profession initiated, and has been increasingly involved in, medical audit, particularly through the Royal Medical Colleges and Faculties, and it will continue to be so. A major extension of audit, however, requires good information systems, and the Committee welcomes the Government's recognition that it will be very expensive in terms both of time and of money. It hopes this money will be provided separately and not be taken from existing resources for patient care.

(f) *Medical education and research*

(15) The White Paper contains few direct references to medical education or research. However, the major changes that will occur when the White Paper is introduced may have serious deleterious effects on both of these subjects, and very much more detail is required. There is little reassurance that the present support for medical education at all levels in NHS hospitals will be maintained in self-governing hospitals, or that the present facilities – for example, postgraduate medical centres – will continue to be supported. The careful medical manpower planning of hospital posts for postgraduate training may be jeopardised by the need for self-governing hospitals to put their own priorities before those of national requirements.

(16) The JCC questions whether the environment that allows clinical and laboratory research to take place will be maintained or that the new initiative will be allowed to develop when the emphasis is on patient costing rather than care for a community. For example, it doubts whether pain clinics or the new hip replacement operation, both developed by research within the NHS, would have occurred had the new system with its financial imperatives been in place.

(17) The interface between academic and NHS medicine is extremely important to both sides – for undergraduate and postgraduate education, and for both basic and applied medicine; it is essential that the universities and the Royal Medical Colleges and Faculties are given adequate time for full consultation on the complex issues involved.

Consequences of failure

(18) If this scheme is to be introduced throughout the Service in essentially its present form some thought must be given to the consequences of complete or partial failure. If, as the JCC fears, the information systems are simply not able to provide the accurate information needed within the time-scale suggested, then there will be a prolonged period of great uncertainty and confusion in the Health Service. If inaccurate estimates are substituted for accurate costing information, then hospital planning and the service to the community will be greatly distorted. Furthermore, some of the proposals must mean a substantial increase in organisational costs without any corresponding improvement in patient care. Indeed, unless the total NHS budget is increased substantially, there would be a significant reduction in the resources available for the treatment of patients. It is essential, therefore, that a careful evaluation of pilot studies is undertaken before a more widespread implementation of these proposals. It should be noted that such studies were in fact proposed in Alain Enthoven's monograph on the management of the National Health Service – a document seminal to the White Paper itself. The JCC believes that a failure to test these proposals in practice before their general introduction will inevitably be shown to be a major error of judgement.

March 1989

Child and Adolescent Psychiatry

The College's Child and Adolescent Psychiatry Specialist Section is now inviting submissions for a session of ten minute presentations by senior registrars in child and adolescent psychiatry to be held as part of the Canterbury Residential Conference from 21 to 23 September 1989. Those interested in submitting papers should contact Dr Ian Berg, Department of Psychological Medicine (Children), The Clarendon Wing, The General Infirmary at Leeds, Belmont Grove, Leeds LS2 9NS as soon as possible.

Health Policies to Combat Drug and Alcohol Problems

Consensus Statement prepared by WHO expert working group

The above Statement was developed and agreed at a WHO Meeting on health policies to combat drug and alcohol problems. The meetings were held in Sydney and Canberra, Australia on 24–31 March 1988 and the Statement represents the consensus of experts from 12 countries drawn from all WHO Regions.

Copies of this document can be obtained by writing to the Secretary at the College.

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