

National Health Service White Paper

Will it work for patients?

Repeated attempts to reorganise the National Health Service (NHS) have in the past concentrated on the differing layers of consensus, management, and varying sizes of the administrative unit. Paediatricians have continued to 'manage' their clinical services for children without adequate information and no control over or knowledge of the resources available to them. They have had to face a continuing shortage of manpower and aging and inadequate facilities against the background of increasing demands being made upon them. The Government's White Paper *Working for Patients* with its eight satellite working papers is a fundamental and radical rethink which will have a direct effect on our everyday professional lives and the way we care for our patients. The Government has set itself two objectives: (1) to give patients, wherever they live in the United Kingdom, better health care and greater choice of the services available; and (2) to give greater satisfaction to those working in the NHS who successfully respond to local needs and preferences. The quest for value for money 'must be an essential element' and those who take decisions which involve the spending of money must be accountable for them.

Internal markets

To achieve greater choice the Government are to establish an internal 'provider' market for hospital services. The district health authorities and budget holding general practices of over 11 000 patients will act as 'commissioning' authorities with individual hospitals: self governing Trust Hospitals, the district managed hospitals, and independent hospitals who would compete with each other as 'providers'. All general practitioners will be informed of the hospitals with which the district health authority has entered contracts and the nature of these contracts. They will be expected to refer patients within the terms of the contract and to those hospitals or departments which (in the district's view) offer the best 'value for money' care.

This internal market will require a much more sophisticated information system than is currently available. It will also require more accountants and a new breed of lawyers to advise about how

contracts will work and what to do if they fail. The Government recognises the need for 'better information' and has committed itself, in advance of the agreed evaluation by the profession due to be conducted this October, to the Resource Management Initiative (RMI). This initiative involves doctors, nurses, and other professional staff having information 'at their fingertips' about the care that their patients are getting. This is a welcome goal. But the information system needs to be 'patient' based and available on computer 24 hours a day seven days a week. It will cost a lot of money which must not come from the existing patient services. Unless such an operational system is sound and reliable, serious and costly errors by management will result as they do now from inaccurate, out of date, narrow based and irrelevant information. Before embarking on any responsibility for managing their clinical resources, paediatricians must be confident in their information system for children's services.

Funding

The central funding of the NHS will be cash limited by Parliament. The resource allocation working party formula is to be revised rather than discontinued. The formula is already based on populations adjusted for standardised mortality ratios. These ratios are still to be used as a morbidity measure for death rates to people under the age of 75. The new feature added to the formula will be the cost of providing services. The problem with paediatrics is that child mortality being low is not a good indicator of child morbidity, which is relatively high. The new formula will still not take into account the social factors in a population which have a major impact on child morbidity. The Government has recognised that 'sudden and substantial change' in the money available for services in a district population would occur if the revised Resource Allocation Working Party (RAWP) formula, originally designed for regional populations, was to be applied immediately to each health district. Children's services would be particularly susceptible to such swings. On the other hand paediatricians will be able to price the child health services more accurately in the

future and therefore make an improved, well thought out, and supported case for the provision of additional services by the identification of local needs. The imposed central formula from above is likely to cause a cash clash between the operational data available at local level.

District services

Two other important principles have emerged from the White Paper working papers. Firstly, each health district will 'open its account in a position at least to continue to provide health care at the level which that population has enjoyed' and that secondly 'emergency' treatment should always be immediately available and without question. The majority of hospital paediatrics involves emergencies but the child health services which provide preventive developmental education and social paediatrics are non-acute but have considerable impact on the 'acute' services. It is thus essential that an appraisal of the existing services provided in each district is made so that they at least are not compromised and that information is developed on which the service can be improved. Some definition of what comprises an emergency will be necessary.

Districts are to identify their own 'core' services. Core services are those that must be provided locally. They include accident and emergencies and central public health services. The existing guidelines refer indirectly to the maternity services but not specifically to paediatrics and child health. It is essential that the services for children both in acute hospital departments and in the child health services are locally available. Otherwise the services for children will disintegrate. Each health district must have a fully staffed acute children's unit in association with a maternity department.

There are opportunities in the White Paper for 'community services' to merge with hospital services. Paediatricians should seize on these in order to achieve full integration of the services for children in their districts. By joining together they will be able to make better use of their combined resources and it would be timely if the British Paediatric Association could issue some guidance to their members and health authorities about how this could be implemented. The danger to the community child health service lies in the lack of information about their activities particularly with regard to their support of the education authority and the social services. Health service indicators abound for acute care but there are very few for the 'community'. Those that exist are very narrow based. Managers therefore could cast a blind eye and cut services without any

discernible effect on those health service indicators which provide them with their merit payments.

Self governing hospitals

The lynch pin of the Government's new design are the self governing hospitals. In its words they will have 'a major role to play in improving services to patients'. These hospitals will remain 'firmly in the NHS'. Self governing status will be thought to be 'appropriate' for any major acute hospitals providing a reasonable comprehensive service. It will 'often be sensible for a self-governing hospital to run a range of community-based services'. There are certain considerable attractions to this idea from the point of view of the devolution of management responsibility and the greater involvement of clinicians in running their services. There are very real dangers, however, particularly to professional independence and the standards of care for children. For instance these Trust Hospitals will not have to pay any regard to the Department of Health circulars on subjects such as services for children in hospital. Paediatricians will have to think very carefully and seek further advice before they hand their contracts to untried and transient local managers.

Supraregional services

Existing supraregional services that predominantly involve children will have direct funding from the 'centre' for their fixed costs to ensure their continued viability. Variable costs will be met by general practitioners and district health authorities under contract. These variable costs will include capital charges on the valuation of expensive land and buildings in central London. The traditional referral of patients based on medical knowledge of what is right for the individual patient through personal contact is in danger of being replaced by the district health authority's preference for a cheap alternative. Careful auditing, both financial and medical, will be required of these decisions by district health authorities that may have medicolegal consequences. Indeed it is likely that one successfully fought case in the courts about a 'medical disaster' might bankrupt a Trust Hospital.

Medical audit

Medical audit is a central pillar of the Government's programme. It is defined as 'the systematic critical analysis of the quality of the medical care, including procedures used for diagnosis and treatment, use of resources and the resulting outcome and quality of life for the patient'. The Government

wishes to see a comprehensive system of medical audit in place within three years and 'does not under-estimate the degree of challenge'. Its approach is firmly based on the principle that the quality of medical care can only be reviewed by a doctor's peers. The existing audit, especially that promulgated by the Royal Colleges, will be built upon. The Standing Medical Advisory Committee chaired by Sir Eric Stroud has been charged with producing a report on audit within the next few months. Little more than a basic framework is likely to be suggested in the limited time. The development of indicators of clinical outcome will take time and require a major investment in information systems. Rigid protocols based on existing inadequate data are likely to lower medical standards and stifle advances in medical care rather than improve it. On the other hand better information about the use of resources can be used by the profession to put pressure on local managers and bring medical issues into sharp focus both locally and nationally. A related issue not addressed in the Government's White Paper is a problem of medical 'negligence'. Increasingly decisions about medical outcome are being made in the court of law rather than in the conference room and recent judgments are likely to put pressure on for more defensive medicine and therefore an increasing use of expensive diagnostic tests. The department's own recommendations about the discharge of patients from hospital, for instance, are likely to have the adverse effect of increasing patients' length of stay in hospital.

Training and research

The cost of training and research will be removed from the primary decisions of the 'internal markets'. The cost of medical teaching will be 'ring-fenced' and the distribution of resources will reflect locations

—not just teaching hospitals—where the medical teaching is carried out. Cross charging in respect of clinical teaching by NHS staff and the provision of patient care by clinical academics may occur. The Government recognises the technical difficulties of cost allocation between service and teaching functions should 'not be underestimated'. Hospitals are enjoined not to cut back on postgraduate training in order to achieve cost reductions if long term effects would mean poorer standards of service.

All medical advances are research based though they may be triggered by chance clinical and laboratory observations. Some new treatments involve expensive high technology but the majority, especially new drugs, have been highly cost effective. It is essential for the future development of the NHS that both pure and applied medical research are maintained and improved.

The Government will be reporting separately on the question of research in the NHS once the recommendations of the report of the House of Lords Select Committee on medical research have been considered.

The success or failure of the Government's initiative will depend crucially on the quality of the information supporting clinicians and their staff and the involvement and commitment of the clinicians themselves to the new culture. Such a commitment by consultants, general practitioners, and other NHS staff can only be earned by the demonstration that the new system really will work for the benefit of patients.

W J APPLEYARD
Kent and Canterbury Hospital,
Canterbury, Kent CT1 3NG