Contemporary Themes

RAWP and the Oxford Region

Part I—The impact on medical care of DHSS economies

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All NHS regions have been affected by the economic recession and the consequent low growth in Government expenditure. In some, however, the problems have been exacerbated by a virtual standstill in resources imposed as a result of the recommendations of the Resource Allocation Working Party, aimed at redistributing NHS finances more equitably among the health authorities throughout the country.

The Oxford Regional Health Authority is one of those identified as relatively rich, and its annual revenue of £163m is said to be nearly £11m more than the RAWP calculations would allow. In practical terms this means that the region has found its income virtually frozen for the next three years—the growth figure allowed this year was 0.39%. On this income it must meet existing commitments as well as plan for the needs for a rapidly rising population. The RHA staff see the proposals as fundamentally equitable, but the sudden implementation could, they believe, lead to severe cutbacks in health provisions for the region's population of about 2.3 million people.

Oxford Regional Health Authority spans four counties—Oxfordshire, Buckinghamshire, Northamptonshire, and Berkshire. Though predominantly rural, its health responsibilities range from the more affluent London commuter belt of Berkshire and South Buckinghamshire, north-west beyond the Chilterns and Vale of Aylesbury, to Oxford's "dreaming spires" and the remoteness of Cotswold villages—though for the health administrator remoteness means higher costs of health care delivery.

In common with the rest of Britain at the end of another difficult year, the bills have flooded in. At one time it was estimated that, without the most stringent economies, Oxfordshire would be overspent by £300 000, Buckinghamshire by £750 000, and Northamptonshire by £1 300 000. Berkshire would have been on target. Mr Raymond Bailey, the Regional Treasurer, has the task of advising the RHA on the financial art of the possible in the light of the RAWP proposals. "One needs to be able to plan 10 years ahead in the health service; that's how long it takes to plan and open a hospital," he said. "I don't like to use the phrase panic measures—but we have certainly got to do some urgent replanning because of the RAWP report. Even before the RAWP report we were already facing extra financial problems in the region," he explained. "Awards to junior hospital doctors and the Halsbury awards to nurses have all added up to an extra cost of about £1.5m in this region this year."

For instance, the teaching area of Oxfordshire has been forced to consider closing almost the whole of the Radcliffe Infirmary at Oxford and transferring patients to the new £25m John Radcliffe Hospital Phase 2, or else using smaller hospitals

as day units only and amalgamating some of the psychiatric services. Oxfordshire's medical, nursing, and ancillary staff have been invited to comment on the various alternatives before a decision is taken early this year. In a mammoth AHA consultative operation views have also been sought from the community health councils, voluntary organisations, local authorities, and the public.

The AHA pamphlet distributed to the public sets out the budgetary facts of life and concludes on the plaintive note: "... Perhaps you can suggest measures not so far considered. ... Perhaps you have other ideas for put forward. ...". The ideas and advice are rolling in from cranks, experts, and amateurs all hoping to find a way out of the financial mess.

"Creeping growth"

With financial difficulties in maintaining the fabric of old hospitals like the Churchill and Bradwell Grove Hospitals, Oxford (recently found to have corroded roofs), plus the "creeping growth" of new drug treatments and advances in clinical equipment, such as the EMI scanner, an increased budget of 1.5% is needed each year to remain in balance. In fact, Mr Bailey is suspicious of the whole basis of the RAWP computations and its algebraic equations. "In the first RAWP report we were a financially gaining region, when standard mortality rate was not used in the calculation. Now in the final report we have become a losing region. I'm not sure that money allocated has much to do with death rates."

Even so, Mr Bailey is not depressed. He sees the crisis as a challenge to his professional expertise, and he is appreciative of the way doctors and clinicians are co-operating and starting to look for cost effectiveness. The predicted overspending of £2 350 000 has already been whittled down by some very tough financial measures, which, in conjunction with the decrease in the rate of inflation, will help the region to end the year perhaps slightly underspent: but the effect has been that standards are threatened in a region that has long taken pride in its centres of excellence. As a result, changes are taking place in medical and administrative thinking in the Oxford region with implications beyond those of provincial health service finances. Innovations and reforms in health care have been set into train that might otherwise never have been considered. These changes may eventually challenge the boundaries of clinical freedom and medical ethics if they progress too far; but they may also force clinicians to take account of the financial implications of their decisions—something that otherwise they might never have agreed to do.

Among measures already planned in the Oxford Area's attempt to keep its health service accounts in balance are the curtailment of the hospital drugs bill by prescribing clinicians. Already, however, the economies are leading some clinicians to

question the effect of financial pressures on the quality of patient care. The Oxford region has always had a high turnover rate for its acute hospital beds—an inevitable consequence of a chronic shortage of beds in well-equipped units. But the recent statistics on throughput of patients might be setting unacceptable standards. DHSS figures show that the average length of stay for patients in acute hospital beds in the Oxford region in 1976 was 8.2 days. The average for England as a whole was 9.8 days, and in the four Thames regions it varied from 9.9 to 10.8 days. "We may be sending out patients too quickly," said several doctors. "Possibly other doctors in less affluent regions such as Trent—which will benefit from the RAWP redistribution—may not thank us if restrictions in their clinical freedom follow our efforts for financial survival."

Future plans

Perhaps the most difficult task for the planners is to reconcile the financial restraints with the plans they had made to cope with the expected rise in its population. The Oxford RHA has the highest population growth rate in the country—15.6% over 10 years (or a rise of 30% between 1974 and 1991) compared with the national average of 1.2%. Over the 17 years to 1991 it is estimated that the population will increase by nearly a third at Milton Keynes, the new town already partly built and occupied between Aylesbury and Northampton. Its population is expanding by about 8000 people a year and should eventually total around 180 000 by the late 1980s. True, this expansion in the population will eventually mean that the RHA will qualify for more cash—but at present it is facing three years of limited growth in revenue. Yet it already needs an extra 1½% income a year "just to stand still," as Dr Ronald Pollock, Oxford RHA community health physician, explained.

He sees little room for manoeuvre in juggling the finances to make ends meet. "You can consider our region's budget like a piece of steak. We have already cut the fat off the outside in previous economies. Now we have got to get at the marbling—the tiny pieces of fat in the tissues." This is extremely difficult to get at, since no longer in its budgeting can the RHA easily save £1m in a single change or reduction in a service. "The savings are now made up of a few pounds here and a few pounds there," he said. He disputed the RAWP philosophy in several ways. For example, new-town dwellers were often young families who could be very demanding on health care resources. Milton Keynes would get a 100-bed community hospital in 1978-9. This will be followed by a general hospital for the area which is already being planned. Meanwhile, Aylesbury and Northampton, both of which have their own expanding populations to contend with, are also feeling the pinch in ministering to Milton Keynes's patients.

With primary care teams a long-standing commitment in the region, the demands are heavy in the Milton Keynes housing estates, where a high proportion of GPs operate out of new medical centres. "We need strengthened primary services, which means more GPs, taking on more health visitors and nurses, and building more health centres," Dr Pollock said. This was merely one example of many demands for extra money the RHA faced in the new town. "As a result of our financial problems we are finding that we cannot develop any further plans to build up primary care in the region." At present there are more community nurses than the national average—in line with higher standards. Now it seems possible that the policy of not replacing staff may reduce this level. In other parts of the region, however, small GP maternity units with 20 beds were finding themselves underemployed and were in line for closure owing to the falling birth rate.

Hospital building

Without doubt the hardest financial equation Oxford RHA faces is what to do about five hospitals now being built and not

yet open in the region. It will cost an extra £6m a year just to run the John Radcliffe Stage 2 (450 beds) along with Northampton's Phase 1 hospital (200 ?), Royal Berkshire's Phase 6 hospital (116), and two 100-bed community hospitals in Milton Keynes and Witney.

"With no extra money coming in we cannot find all the extra £6m" Dr Pollock said. "We have paid out millions of pounds in building them—can we let them stand empty or do we try to get them open?" This is already a rhetorical question, since in the case of the John Radcliffe Hospital, at least, the Secretary of State for Health has made it clear that he expects the new building to be opened in 1979. "We have to think of a way of operating the hospitals' services at much lower cost—around £1.5m," he continued. In fact there are some areas, the RHA staff believe, where the job requires near-miracles. Hospital closures, curtailment of services, redundancies, and patients travelling further for treatment will inevitably evoke strong opposition from NHS staff and the public. "Just to close one hospital takes anything from nine months to three years," says Dr Pollock. "It is fair to have a national formula so that everyone should have a fair share of the cake, but the RAWP proposals must be implemented at a sensible pace."

This view was reflected in the RHA's annual planning report last autumn. Discussing the series of hospital closures now planned, and its policy of cutting back on building maintenance and certain other action, it added: "... There is a limit to the amount which can be achieved, particularly in the short term without precipitating open conflict with the staff side organisations and completely alienating community health councils, local authorities, and other representative organisations." Since then, relatively small extra funds have trickled in from various Government departments to ease transitional problems for regions, relieve those coping with population pressures, and stimulate hospital building to help the construction industry. The RHA now thinks it can only just scrape by. Even so, they are perilously close to the point where the NHS breaks down.

Next week Michael Jeffries will examine some of the specific economies introduced in Oxford in an attempt to balance the budget.

What is the treatment of cat bites?

Man's best friend is said to be the dog but when it comes to falling out the dog bites more often than the cat, whose bite seldom takes people to the accident and emergency department. In any animal bite the inflicted wound is caused by a mixture of crushing and tearing. This predisposes to pain, swelling, and sepsis—the last caused both by tissue damage and contamination from dirty teeth. Cleaning, wound dressing where appropriate, and tetanus prophylaxis are therefore necessary.

Rabies fortunately is not yet a problem in Britain but should be considered if patients have returned from endemic areas. Pasteurella infection and cat scratch fever are the likely infections to result in Britain. Pasteurella infections occasionally cause unpleasant systemic effects; a swab should therefore be taken before treatment. Benzylpenicillin and ampicillin or amoxycillin-ampicillin (Amoxil) would be antibiotics of choice.

With cat scratch fever the problem is more difficult as the organism responsible has not yet been grown in culture and few cases are seen. The wound may heal but swelling of regional glands and even local suppurative lymphadenopathy may develop. Skin tests (based on antigens available from the Central Public Health Laboratory Service) can exclude other causes such as Hodgkin's disease and tuberculosis. Perhaps the safest course, however, is to take a 5-ml sample of clotted blood for baseline serology, and to ask the laboratory to keep the serum and explain why. Evidence of a changing antibody titre will be important if cat scratch fever has indeed developed.

Cat scratch fever is best treated with tetracycline, but as it is not common and tetracycline is not the antibiotic of choice for bacterial sepsis this should not be given prophylactically. The greater likelihood of a pasteurella infection suggests penicillin as the first choice if a prophylactic antibiotic is given.