Contemporary Themes

RAWP and the Oxford Region*

Part III—Closures, economies, and cuts

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Facilities at the teaching centre at Oxford have clearly been seriously strained by economies forced on the Regional Health Authority by the Resource Allocation Working Party's Report. How have other parts of the region been affected?

RAWP is seen by some clinicians and administrators as, at best, a general "levelling down" instead of upwards in the NHS. At worst, it is seen as the cause of unhealthy and potentially damaging changes; and between the lines of official regional documents now circulating is an unmistakable suspicion that the working party may have got its algebra—and therefore its sums—wrong. The Oxford Region has tried to cope with the crisis by getting all the health authorities to look for ways of reducing expenditure, with emphasis on non-clinical services. As one recent planning report said, however, "in order to meet the requirements of the prevailing resources allocation rules, particularly in the short term, further cuts in clinical services are likely to be made."

Existing strategy

Before RAWP the region had drawn up a strategic plan that included some rationalisation to make for a more compact service, and particularly to relate the elderly, the mentally ill, and the mentally and physically handicapped more closely to their communities by emptying much of the older hospital accommodation. The plan had envisaged 5900 more beds and 2155 day places to match the needs of the growing population up to 1991—a programme that would have needed capital investment by 1991 of £183m (at 1977-8 prices) and revenue of £196m a year. Application of the RAWP proposals would lead to a cut of about £33m from the region's capital sums and £13m a year from revenue. Inevitably, therefore, both long- and short-term strategies are now in the melting pot.

How, for instance, will the clinicians concerned be able to cope with the primary and community services for the elderly and the care of the mentally and physically handicapped? Will the services for these patients be able to compete for the extra resources—despite money designated by the DHSS for them—against the demands of new capital works?

The standstill in growth imposed by RAWP over the next three years means a lot of closures in the region. Many of these affect smaller units providing short-term care. As a result there will not be so many so-called "social" beds. It does not follow that any patients will lose all possibility of treatment, but they will have to travel further for it. With many branch railway lines

now closed and rural bus services in the region dwindling, this can mean that some patients in remote districts travel for several hours to and from, say, a 15-minute outpatient appointment.

Building programme

The biggest drain on resources in the region is the heavy capital costs of building new hospitals. Most of the present buildings are the product of 19th-century medicine. As in other parts of the country, major hospital rebuilding did not really get under way until the early 1960s, and there is still a lot of leeway to be made up.

Above-average population growth throughout the region has accentuated the problem. The population served by the Oxford RHA is estimated to increase by 20% between 1974 and 1991. Already the rate of change in Northampton and Milton Keynes, both "new town" areas, is creating acute hardships in all three divisions of the service. "In Northampton there is a sharp contrast between, on the one hand, the expected growth of population of about 10% between now and 1981 and, on the other, by the necessity to reduce levels of service also by about 10% in order to restrict expenditure," said Dr Ronald Pollock, the regional community physician.

Some gaining areas

Northamptonshire, however, may well have cause to be grateful to the RAWP report. For some years clinicians there have regarded themselves as the poor relations of the region in terms of finance, but they gained when the sums were worked out under the RAWP formula. Of the £10.8m excess that the region had been receiving, Oxfordshire (annual budget £43m) was £4.1m over target for 1977-8; Berkshire (£51m) was £3.8m over; and Buckinghamshire (£30m) £2.3m over. Northamptonshire, receiving £34m annually, was only £529 000 above target—and should get an extra £452 000 next year, building up to £2m more a year over the next 20 years at the expense of the other three regions. Nevertheless, said Mr Raymond Bailey, the regional treasurer, Northamptonshire will have some cuts in services in the immediate future.

Among the proposed cuts are the closing of Wellingborough College Hospital and Pitsford House Hospital. A further two hospitals, a maternity unit, and a preconvalescent unit may also need to be closed.

Blocked beds

Dr Michael Gallant, of the department of radiology at Northampton General Hospital, believes that this policy of

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closing smaller units may prove to be counterproductive. "In the case of some hospitals in this area it means that convalescent beds are cut off. That leads to patients blocking acute beds in hospitals," he said. "And these are the beds in short supply."

This view was confirmed by the experience of Dr Shaun McCarthy, consultant geriatrician at the Churchill Hospital, Oxford. There were, he said, already problems in providing proper follow-up care for elderly patients because of cutbacks by local authorities in their social services budgets. "I have 20 out of 100 patients in my acute beds waiting to go to old people's homes," he said. "They could have gone a month ago if we had had somewhere to send them."

The problems of Northampton stem partly from sharing some of the hospital cover of the other development area, the new town of Milton Keynes. The position should ease slightly when a new 100-bed hospital is opened in Milton Keynes later this year. In addition, there will be a £6m 275-bed first phase of a new district general hospital in Milton Keynes by the mid-1980s.

Also sharing the Milton Keynes burden is Aylesbury to the south, where there has been a rapid growth of large housing and industrial estates and dormitory areas for London commuters—with high expectations in health care.

GPs in many parts of the region—particularly in Oxfordshire—are opposing the decision to open new hospitals if this is at the expense of community hospitals or domiciliary care. Compromise is leading to further dilemmas with the "half-opening" of some hospitals. Dr Russell Ballantyne, a Market Harborough GP, said that phase 2 of Kettering General Hospital, providing some 430 beds, had suffered that fate. "There is not enough money to run it and half of the wards are standing empty," he said.

Dr John Rodgers, the Oxford AHA community physician with responsibility for geriatrics, foresaw strong opposition by local people, which would delay closures. "I think local feeling is so strong that some local communities might take on their local hospitals and try to run them privately themselves," he said.

Hospitals idle

At High Wycombe District Hospital, Buckinghamshire, a new, £125 000, six-bed intensive care unit completed two years ago to augment the modern hospital has lain idle for want of money to open it. Dr John Preece, a consultant haematologist, summarised other problems of the district as cuts in cash for new and replacement medical equipment, maintenance of buildings, and the scrapping of some posts. "Because of the policy of economies, future developments are getting smaller and further away," he said. Heavy cuts are in train to save £210 000 in the district this year. "RAWP is a good idea, but if you don't put new money into the service, you will beggar regions like ours," he observed.

A consultant surgeon, Mr Peter Lord, was concerned with the waiting list for cold surgery, which could be as long as three months. He and his colleagues were unable to cope at all with conditions such as varicose veins. Both he and Miss Esme Hadfield, consultant ENT surgeon, also operated at Amersham General Hospital's two outmoded operating theatres. (One of them is a converted sterilising room and so small that the surgeon cannot leave before the instrument trolley is wheeled out.) Two new theatres (with provision to expand to four when funds permit) are now to be built—a scheme just approved by the Region—but plans to upgrade the hatted wards had been shelved owing to cash shortages.

Rapid population growth had also brought difficulties for Berkshire, though the problems were, perhaps, not so bad as in the north of the region. An "irrational" grouping of services in east Berkshire—a historical quirk—had led to an excessive provision of services. Surgery, gynaecology, and anaesthetic services were found on five sites; and obstetrics on three (though not always together with gynaecology). Paediatrics was found on two sites, but linked with obstetrics on only one.

Rationalisation would bring compactness, limiting these services to three sites, with substantial savings all round. But the lack of financial growth in the region, together with the rising population, made it difficult to free money for the necessary "pump priming" to make such changes. The same district also urgently needed revenue to develop mental illness services, for which it depended almost entirely on the North-west Thames Region.

Increasing delays

Dr John Rogers, a Slough GP and spokesman for the local BMA division, reported a severe shortage of hospital beds in his area, particularly in ENT and psychiatry. Ironically, the only way a colleague and he could get a certified suicidal patient into hospital recently was by sending her to the casualty department at one hospital, where she was admitted to an ENT ward.

"Until 18 months ago general referrals could be seen in a fortnight to three weeks," he said. "Now it takes two or three months. It is usually quicker to send Slough ENT patients to London for an operation."

The annual planning report of the Oxford RHA for 1977 had warned of the impossibility of the region not overspending in the current financial year. Nor could expenditure be contained next year unless "further restrictions are placed on the service provided and a significant number of staff are made redundant." When this got to the ears of the DHSS meetings were held, and towards the end of last year the region was asked to submit a new plan (which inevitably would be unconventional in regional accounting) for solving the dilemma.

In December 1977 the region's latest proposals were sent to Mr Roland Moyle, Minister of State for Health and Social Security. These were: borrowing £3.75m from the region's capital account for revenue purposes over the three years 1978-9 to 1980-1, to be repaid over two years starting five years from now. Next, the region suggested selling off spare land, which should bring in a further £2.6m after paying off existing commitments of £900 000, together with savings from further cuts in management costs. This plan, supported by a modest rise in the financial allocation for 1978/79 and including some of the extra £10m the Government recently allocated to health regions with financial problems, plus further capital help from the Government's commitment to aid the construction industry, and a little extra money Whitehall has provided to cushion the burden of new towns, might prove Oxford Region's salvation.

But whatever the tribulations and financial crises that the Oxford RHA has been facing and still has to come it has gained an inner confidence that somehow or other it will get by. Much of the initial bitterness and frustration over the RAWP proposals—though still present—seems to have been overtaken by the challenge to the professionalism of the administrators, and a kind of medical "Dunkirk" spirit is showing signs of emerging.

For all its problems, the Oxford region (and no doubt others) believes it will in the end come through as a better health service organisation. This view of both medical and financial administrators is exemplified in the words of Mr Bailey: "If you are not lean and hungry there is no need to be so efficient. This RAWP exercise has tended to reveal some of the 'fat' in the region. Our acute financial position will last only about three to four years and by 1981-2 our population will have increased so that we will qualify to receive growth money again."

(concluded).

A 36-year-old healthy, sensible patient has been having headaches for two months. No cause for these is evident but he and his wife say that during an attack the irises in both eyes are seen to change colour from their normal blue to a very pale blue. What is the explanation?

I cannot think of any explanation for a transient change in colour of the iris. If there is any contraction in pupil size during the attacks it is just possible that the colour might appear to change.