For Debate . . .

Cutting the cost of the National Health Service—a personal view

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The new stringency in social benefits, the folding of celebrated orchestras, the predicted demise of world-famous medical schools, all indicate that the British economy has major problems and that "cuts" must be the order of the day. No amount of managerial skill or shop-floor effort to improve the productivity of all types of industry will redress the balance if the enormous costs of the "non-productive" components of the economy are not curbed. The National Health Service which formerly, but quite mistakenly, was thought to dip into a bottomless pool of resources, and indeed is one of the most expensive parts of the economy, must become more cost effective. If this can be achieved without detriment to the patients served by it—all to the good.

Admittedly British doctors can view with some pride—although paradoxically many regret it—that the percentage of the gross national product spent on health in the United Kingdom is much lower than in almost all other sophisticated Western countries. Having seen health care operating elsewhere, however, I know this is not due to any particular merit in our system but more to the profligacy of the less effective systems in other countries. I truly believe that if the workers in the NHS—and doctors in particular, they being a very large part of the labour force and the most highly paid—examined what they did in their day-to-day routines and rituals—for many activities have become merely ritualistic—and improved their work methods, then huge economies could be effected.

It was with such thoughts in mind, but perhaps less imperative only a few months ago, that nine doctors and one nurse writing in a series "If I was forced to cut"¹ contributed their views to economies within the NHS. Almost all the contributors were hospital doctors for whom financial worries were a somewhat new experience and usually remote from their own immediate activities. General practitioners on the other hand, and particularly those like myself in group practices, are used to the continuous problems of making a profit at the end of each year despite increasing costs of both staff and facilities. We are fairly familiar then with the problems of financial management.

Accordingly, I would like now to add my suggestions for saving money, and at the editor's suggestion I am presenting these as a fairly bald list for serious consideration by all people involved in health care. I do not exclude the patients from this involvement—indeed their "contribution" comes first.

Encouragement of a change in public attitude

(1) There should be a major health education campaign, frequently repeated, to make clear to the public that most minor illness and in particular upper respiratory tract infections, bouts of diarrhoea, sprains,

strains, aches and pains and the like do not need a doctor's attention. Many patients underestimate particularly the *time* required for recovery. If patients require or want simple symptomatic relief this can be readily obtained at their local chemist.

(2) Members of the public should be persuaded always to think carefully about whether they need to attend a health care worker before they do so. In particular they should be encouraged—even instructed—to cancel follow-up appointments if they think that their condition has recovered and attendance is no longer worth while.

(3) Patients should be made aware particularly that a referral to out-patients should only be for more severe illness and that inpatient care is only for those whose degree of illness is so grave that they cannot be satisfactorily managed at home. Early discharge from hospital after illness or operation should become part of "conventional wisdom."

(4) Perhaps the public should be acquainted with the actual costs to themselves (via income tax, National Insurance contributions, etc) of (a) consulting their general practitioner; (b) attending a child-welfare or well-baby clinic; (c) seeing a nurse at a surgery; (d) going to a casualty department; (e) attending an outpatient department; and (f) spending a day in hospital.

When the costs of administration, records handling, secretarial staff, note keeping, not to mention the consultation itself are added together the total sums will prove to be very considerable; certainly if patients had to hand over the actual money then there would be a more careful assessment of whether they needed to attend. (I am not suggesting that they do pay directly but perhaps an awareness of the ultimate cost to themselves might limit demand.)

General practitioner work load

(1) General practitioners should no longer anticipate smaller lists nor employ extra doctors to achieve this. List sizes should increase. The ceiling should be raised from 3500 to 4500 patients per doctor. These measures are long overdue considering the growth of the primary health care team with its frequently documented potential for decreasing doctors' work loads.

(2) As an incentive general practitioners should be offered loaded capitation fees for all patients over 3000, and there should be greater differentials in income between general practitioners with small, medium, and large lists. More work—more pay!

(3) All general practitioners could reduce their work load if they immediately curtailed, and ultimately ceased, medicating for minor self-limiting illness. The projected prescription charge should facilitate this.

Decreasing and cheapening medication

(1) All doctors should be issued with a bound volume of histograms showing comparative drug costs of similar preparations and highlighting the name and cost of the generic equivalent. This should be updated frequently and would be an extension of the DHSS publications that currently appear too sporadically to be of continuous value.

(2) All repeat prescriptions should be for one month's treatment only.

(3) All doctors—but particularly general practitioners and doctors in accident and emergency departments—should be encouraged to be more selective about prescribing antibiotics and psychotropics.

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(4) Night sedation for inpatients should cease, unless there are very specific indications for it.

(5) Patients should pay prescription charges for drugs prescribed in accident and emergency and outpatient departments.

(6) As a condition of funding for postgraduate education centres, there should be a minimum of one lecture a term on the cost of prescribing and how to minimise it. Lecturers could be drawn from all types of clinical practice.

Reducing the work in hospital outpatient departments

(1) Consultants should appreciate that there are an increasing number of interested, well-educated, and caring general practitioners who are both able and perfectly content to manage the continuing care of acute or chronic disease once it has received specialist diagnosis and assessment; more particularly if guidelines for continuing care are suggested. Accordingly, consultants should organise their work so that a maximum of only one follow-up outpatient appointment a case be ordered unless there are specific indications for more.

(2) Follow-up that has been delegated to a houseman, senior house officer, or registrar should be followed by automatic discharge to the general practitioner.

(3) If despite these measures the outpatient load does not fall sufficiently for the waiting list for new patients to be eliminated then follow-up appointments should be spaced out and fitted in between new-patient appointments rather than the reverse as seems to happen now.

(4) Prescribing from outpatient departments should largely be abandoned, and patients should be told to see their general practitioner regarding the advised medications.

(5) Appointment systems at hospital outpatient departments do not work. There should be four rough groupings—early morning, late morning, early afternoon, and late afternoon. Patients should be patient!

Minimising inpatient care

(1) No illnesses—as opposed to genuine accidents or self-poisoning—to be seen in accident and emergency departments except for obviously ill and collapsed patients.

(2) Ambulances should not take collapsed or other ill patients to hospital from their own homes without the patient seeing a doctor first, or at least receiving a doctor's instructions.

(3) Earlier and earlier discharge of more surgical cases and the publication of average durations of stay in different hospitals for various operations. Preferential finance for units with earlier discharge averages.

(4) Patients recovering from illnesses for which they have been admitted to hospital by their general practitioner to be discharged as soon as recovery is seen to be taking place; the treatment to be continued at home—for example, most patients recovering from myocardial infarction could be discharged on the second to fourth day; all patients with pneumonia could be discharged once there is clinical improvement.

(5) Follow-up of inpatients to be passed to the general practitioner unless the specialist has very specific reasons for seeing the case *himself* at the outpatient department—for example, complicated problems, research.

(6) All "routine investigations"—for instance, blood counts, biochemical profiles, chest radiographs, intravenous pyelograms, etc.—to be abandoned and ordered for each patient specifically.

(7) Except in exceptional circumstances all patients to pay a flat rate of £1 a night towards their prescription charges, food, bed linen, and other "household provisions."

Reducing note keeping and communication

(1) Hospital notes to be pruned drastically, ritualistic recording to be abandoned, and junior staff to be congratulated on brevity.

(2) Letters to outpatient departments from general practitioners for obvious clinical problems to be reduced to one or two words—for instance, "inguinal hernia for surgery in fit man." The patient can after all speak to the consultant as well as his general practitioner. Surgical note on discharge would be "hernia repaired—please follow up at six weeks." Copies of operation notes need not be sent to general practitioners, and case summaries should be extremely brief.

Obstetrics

(1) Decrease the duplicated care currently carried out by midwife, general practitioner, and specialist. Patient-owned co-operation cards would aid in this.

(2) Fortify the belief that pregnancy and birth are potentially normal physiological processes and freeze "technology" (for instance, monitors) as at present.

(3) All puerperal patients should be discharged after 48 hours unless there are strong contraindications.

Caveat

It is possible that with the extra numbers of sick people in their own homes and the increasing amount of follow-up and continuing care to be carried out by general practitioners there may be initial difficulties in achieving list sizes of around 4000. Nevertheless, with enlightened sharing of care with an increased number of nurses (deployed from the empty wards) the 4000 patient list size should ultimately be achieved.

Conclusion

Obviously all these economies are not universally nor immediately applicable, but many could apply now in many places, and the remainder could happen fairly soon. Overall they should lead to:

- (a) a decrease in doctor dependence by patients;
- (b) a decrease in drug prescribing and resultant iatrogenic disease;
- (c) a decrease in the number of investigations;
- (d) a decrease in outpatient attendances;
- (e) a decrease in duration of stay in hospital;
- (f) a decrease in hospital beds;
- (g) a decrease in the number of doctors in the NHS;
- (h) a decrease in notes and letter writing;
- (i) a decrease in secretarial, reception, and administrative staff;
- (j) a decrease in all training grades; and
- (k) an increase in the number of health care workers in the community.

Overall a more cost-effective system.

Reference

- ¹ Anonymous. If I was forced to cut. *Br Med J* 1979;iii:905-6, 985-6, 1057-8, 1122-3, 1203-4, 1276-7, 1351-2, 1429-30, 1490-1, 1570-1.

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A married man of 40 has had diabetes (controlled with insulin) since childhood. During the past year he has become impotent. Is diabetes likely to be the cause, and if so what treatment is advised?

The impotence is probably related to the diabetes, though that does not mean the diabetes is necessarily the cause. The questioner does not say whether the patient has any complications, such as vascular insufficiency or autonomic neuropathy. Impotence is often included among the features of autonomic dysfunction in diabetes,¹ and some success has been claimed for treatment with penile prostheses. But a recent study of penile erection during REM sleep² found that fewer than one-third of impotent diabetics had a response similar to that occurring in organic disease. The majority had an erection that was comparable both in size and duration with normal subjects, which strongly suggests a psychological cause.

¹ Clarke BF, Ewing DJ, Campbell IW. Diabetic autonomic neuropathy. *Diabetologia* 1979;17:195-212.

² Hosking DJ, Bennet T, Hampton JR, Evans DF, Clark AJ, Robertson G. Diabetic impotence: studies in nocturnal erection during REM sleep. *Br Med J* 1979; ii:1394-6.