can be made about initial management and transfer of the patient to the specialist centre.⁴

Early transfer is desirable for virtually all patients. For example, the spinal unit in Perth, Western Australia, succeeds in admitting 91% of patients within 24 hours and 95% within 48 hours.³ The figures in Britain fall seriously short of this ideal. If we are to improve our results all spinal units should have direct access to the facilities of a district general hospital with an intensive care unit and an orthopaedic surgeon, a neurosurgeon, and a urologist, all with training in spinal injuries.⁵ A plastic surgeon and maxillofacial surgeon should also be available as patients often have multiple injuries.⁴

The spinal unit must always be in a position to admit patients promptly; a better geographical distribution of beds would help. For patients with major trauma early admission may be life saving, and this may be best achieved by rapid transfer by helicopter to the most appropriate hospital.⁶ In Switzerland the introduction of a nationwide helicopter rescue system for patients with spinal cord injuries reduced overall mortality by 80%.⁷ Initiatives of this kind are needed if we are to reduce the rate of complications and achieve optimum management for our patients.

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The NHS bill

Doctors, nurses, and others still unconvinced

“Our recipe for the NHS is more taxpayers’ money, less waste of that money, and a better service for the patient.”¹ That was the way that Mr Kenneth Clarke introduced the National Health Service and Community Care Bill last week (p 1355), and no one would quarrel with his objectives. So why is the legislation opposed not only by the BMA but also by the royal colleges, the universities, the Royal College of Nursing, and the health service unions?

The central objection is to the underlying theory. The government has made no secret of its belief that in health care as in every other aspect of society it wishes to see competition between the private sector and the state funded service and that it also intends to promote competition within an internal market in the NHS. Most British doctors oppose this approach—and they do so on the basis of the experience of other countries. Whenever and wherever medical care is fragmented with a few centres of excellence and a basic service for the mass of the population the care provided by the mass service tends to become second rate. This was the case

in Britain before the NHS—perhaps the most important achievement of which was to raise the standard of medical care in former local authority hospitals. Within Europe the best overall health care is provided by those countries with uniform systems used by all their citizens. The anxiety among health professionals in Britain is that much of the NHS hospital service may be reduced to providing safety net medicine while a few flagship institutions become ever more successful. Nowhere in the world is there an effective national health care system of the pattern proposed by the government; the medical and nursing professions know this and their apprehension is based on that knowledge.

Their other reasons for doubt are more down to earth. Mr Clarke promises “more taxpayers’ money.” The “extra £2.6 billion” announced for the NHS in the autumn statement caused problems for health service economists as they tried to work out how much actual extra money there would be—when account was taken of inflation, NHS inflation, savings not yet achieved, and the cost of the NHS review.² A sensible guess is that £500 million will be available for extra patient care—but as has been said so often before the NHS needs around 2% more money each year to cope with demographic change and technical innovations.³

Mr Clarke talks about less waste and greater efficiency. The internal market that will be created when the bill becomes law will require a vast and complex system of record keeping and accounting. This will take some years to get into action. Around 3500 more staff will be needed, many of them with skills in accounting and information technology. In recruiting these staff—and this applies to all NHS staff from secretaries to porters, from electricians to kitchen workers—the NHS has to compete with the rest of the labour market, and the rates it can offer are mostly non-competitive. There must be serious doubts that the NHS will be able to find and keep the staff it needs in the coming years. Possibly a few hospitals run by NHS trusts (opting out is no longer an acceptable phrase) may be able to pay rates that will attract first class workers, but most will have to continue to hope that people will be willing to accept low pay because they think the job worth doing. But the tradition of giving a lifelong unquestioning loyal service to the NHS has gone.

The third reason for professional doubt is that patients seem unlikely to gain from the breakneck speed at which everything seems to need to be done. Many of the new ideas—from internal markets to fund holding practices (another mollifying change in wording)—might well prove innovative, stimulating, and possibly money saving. But why the hurry? Why not try, test, and evaluate these projects and only then decide whether to restructure and redesign an organisation with one million employees?

The bill will be debated and analysed clause by clause in the coming session. The government should remember that the opposition of NHS staff to its proposals is not Luddite, nor is it politically motivated, nor is it irrational. NHS doctors and other staff are committed to the service and want it improved.

But any large organisation that plans a programme of major changes has three requirements; firstly, there must be a clear, detailed plan; secondly, a majority of the workforce must be committed and enthusiastic; and, thirdly, enough money must be available to lubricate the changes. On these criteria the NHS looks to be facing a depressing and testing time.

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