MEDICAL PRACTICE

Contemporary Themes

New Alternatives in the N.H.S.

I. Economic Benefits of Restrictions on Clinical Freedom

On 5-6 October the B.M.J. held a conference in Winchester of 14 invited speakers to consider "New Alternatives in the N.H.S." The theme underlying this meeting was that the N.H.S. is likely to remain seriously short of money for the foreseeable future, and that if improvements are to be made they will have to come from rationalizing the present set-up. Each participant prepared a working paper which was circulated before the conference and the four used for the first session, on the Economic Benefits of Restrictions on Clinical Freedom, are printed below, together with an edited version of the discussion. Each session was chaired by a member of the B.M.J. editorial staff.

Those attending the conference were Dr. M. C. Bott, Consultant Psychiatrist, Hellingly Hospital, Hailsham, Sussex; Dr. A. J. M. Cavenagh, General Practitioner, Brecon; Dr. A. Colling, General Practitioner, Stockton-on-Tees; Professor Hugh Dudley, Professor of Surgery, St. Mary's Hospital, London; Miss Jacqueline Flindall, Area Nursing Officer, Oxford; Dr. J. M. Forsythe, Area Medical Officer, Maidstone; Dr. R. H. Hardy, Casualty Officer, Hereford General Hospital, Hereford; Professor D. N. S. Kerr, Professor of Medicine, University of Newcastle upon Tyne; Mr. Rudolf Klein, Senior Fellow, Centre of Studies in Social Policy, London; Dr. S. P. Lock, Deputy Editor, B.M.J.; Dr. G. Macpherson, Assistant Editor, B.M.J.; Dr. Noel D. L. Olsen, Medical Registrar; Professor Philip Rhodes, Professor of Obstetrics and Gynaecology, St. Thomas's Hospital, London; Dr. N. K. Shinton, Consultant Haematologist, Coventry and Warwickshire Hospital; Dr. A. J. Smith, Assistant Editor, B.M.J.; Dr. M. Ware, Editor, B.M.J.; Dr. W. E. Waters, Senior Lecturer in Clinical Epidemiology and Community Medicine, University of Southampton; and Dr. R. A. Wood, Consultant Physician, Bridge of Eam Hospital, Perth.

Reports of the other two sessions, on "What Advances in Treatment Can We Afford?" and "How Many Doctors Do We Need?," will appear in subsequent issues of the B.M.J. A leading article appears at p. 247.

Working Papers

The N.H.S. and its Financial Implications

R. A. Wood

When politicians openly admit that living standards will fall it is realistic to look for economies in the public sector. The National Health Service cannot be exempt from restraint and I believe that it was unrealistic of the medical profession to ask for an extra £500 million in 1974 to offset wage and cost inflation. The fact remains that economies can be made and that the income of the N.H.S. can be increased in ways which the public would accept.

Much of the resentment against direct and indirect taxation is felt because no exact end can be seen. Thus an increase in National Insurance contributions would be unpopular, not to mention inflationary. Nevertheless, the cost to the consumer of tobacco and alcohol has risen far less steeply than incomes and the cost of living index. The public, who have adapted rapidly to oil prices, would not turn their backs on a political party which imposed a "health tax" on these commodities, earmarking the revenue for the N.H.S.

There need be few exceptions to a regulation that patients in hospital should pay up to £5 a week for their board and lodging, always provided that the costs of collection were not more than the

revenue. It is hard to justify special taxes on successful drug companies, but it does not seem unfair to impose a levy equivalent to the sums spent on advertisement and sales promotion. Though private practice will not survive for long in N.H.S. hospitals, this source of income is highly desirable and should not be lost.

Economies

Swept by the tide of technological progress, the N.H.S. has favoured the development of an expensive hospital service which is now being overused. By contrast, the family doctor services are cheap, under-equipped, and under-exploited—while the preventive and community services are underfinanced and have failed to capture the imagination of an uneducated public. If these imbalances could be corrected, the percentage of the gross national product spent on the N.H.S. might drop. The 1974 reorganization of the N.H.S. actually makes correction possible provided it is generally understood that it is intended to be functional as well as administrative. In the context of the Health Service economy is also a byproduct of efficiency, and I believe there are some obvious ways of reducing costs and increasing efficiency. Firstly, economies can be made in the hospital service. We would save money by reducing the number and duration of hospital admissions and by cutting staff. The progressive patient care system has some minor disadvantages, but these should not rule out the concept as a way to cut costs. When patients are stratified according to their need for care or technical equipment both staff and equipment could

Classification of Inpatients by Needs

Staff/Patient Ratio	Facilities Required	Categories of Care
High	High	Coronary care, poison unit
Moderate	Medium	Intensive care, renal dialysis
		Routine acute care—for example, geriatric assessment, elective surgery, progressing seriously ill, etc.
Low	Low	Five-day investigation units, rehabilitation, convalescence
Moderate	Low	Day stay units—minor operations, specialized acute investigation, cytotoxic treatment, etc.

be distributed more efficiently and hence economically. Various categories may be identified (see table).

This sort of organization fits into a divisional system and is in operation, in part at least, in several hospitals. Districts served by several hospitals could benefit if divisional concepts developed among hospitals.

Consultants and registrars could be more energetic in their efforts to complete investigations in outpatients. Good clinic organization, with appropriate paramedical staffing, can probably reduce the burdens on the inpatient departments attributable to diabetes, hypertension, and chronic respiratory disease. Day-stay units, if used properly, can treat many patients at present managed in hospital. Extension of facilities in the home, and better liaison among all the groups concerned may yet avert the expected geriatric avalanche, as well as many other so-called acute admissions. Consultants could be used on a domiciliary basis rather more than appears to be the present pattern.

In many hospitals investigations continue to be poorly planned. Though entitled to practise what they believe to be right, clinicians could pay more heed to publications showing how admissions can be cut short by quicker mobilization of patients or by changing surgical procedure. Too often the work expands to fill the beds available. Waiting lists are not always the result of high demand and low facilities: they may be a sign of pride, or inefficiency.

If action was taken on all the above points it might, in many areas, allow a statutory cut in the allocation of beds. Where pressure is great this need not be proposed, but in most areas beds could be cut by between 10 and 25%.

Non-clinical Savings

A strong stimulus to devolve patient care would be a policy (temporary and selective) of non-replacement of staff who resign or retire. This most certainly would arrest the growth of the consultant ranks and reduce the reliance on immigrant doctors. The cost of extra duty payments could be removed almost completely in an efficient hospital service. Projects whose efficacy is not certain, such as the N.H.S. Occupational Health Service, should not now be introduced in new areas. During the recent work to rule of ambulance staff the surprising mobility of many outpatients showed how much the service was being misused. Planners do get things wrong; just as Maplin was rendered unnecessary by an unexpected decline in air traffic so also can large parts of the hospital development programme be reviewed and postponed indefinitely. It is also inconceivable that nothing should be done to reverse the exponential demand for laboratory tests.

Capital investment need not be banned if rapid returns can be foreseen. The upgrading of outpatient departments and the introduction of progressive care are possible examples. Money spent improving records systems and communications is money saved in medical time and bed occupancy. Outside the hospital, delays and cancellations in building health centres have inhibited the primary care sector from growing in scope. This money must be found now, if need be from the local authorities—and would go almost unnoticed as a single 1-2% loading on the rates.

General Practice

The necessary changes in general practice are the corollary of those proposed for the hospital service. Supported by nurses and social services, well-trained doctors, combining individual interests with general family medicine in well-equipped health centres, can cut the pressure on the district hospital. Some also believe that family doctors should operate community hospitals, and there is general agreement that properly qualified doctors can conduct outpatient sessions in various specialties. General practitioners should organize

themselves so that they dispense with the night deputizing services, which are one source of hospital overuse.

No short-term saving can be expected from developments in the field of preventive medicine, and detailed planning of future programmes must proceed. Savings from the results of health education and early diagnostic services seem the most promising areas.

Administration

So far little optimism can be felt that solutions to present day problems will come from changes in administration. All the specialist posts in community medicine are going to former regional board and local authority doctors who are founder Fellows and members of the new Faculty. Certainly many of these are excellent, but surely doctors from these backgrounds have no monopoly of the ideas needed to salvage the N.H.S. during the present economic drought. Indeed, the selection procedures, along with incomprehensible delays, have meant that most community physicians have spent most of 1974 in a state of personal professional concern while all the impetus of reorganization was lost. The advisory services look to be forming along hierarchical lines and, influenced by traditional consultants and family doctors, appear to be reshaping the pattern of the old N.H.S. within the new administrative framework. Administration at area and district level can gain respect and co-operation by itself reducing expenditure. But real co-operation from clinical staff will come only when proposed economies can be seen to be part of a coherent, well-publicized national plan.

The enthusiasm and initiative needed to bring about economy cannot be expected from staff who, at all levels, have been poorly paid for years. But staff cuts should make funds available, and the redistribution of these to those remaining (including junior doctors losing their extra duty payments) could be seen as productivity allowances. In fact, as largely untaxed money will be redistributed as taxable pay increases, probably 10% staff cuts could allow 20% increases for those remaining without any further cost to the taxpayer. It should be perfectly clear to everyone that people must be paid better if they are to co-operate in the type of changes I have suggested.

Conclusion

The problem of the N.H.S. is that its financial difficulties cannot be solved by individuals taking individual action, yet little seems likely to emerge from the essentially political confrontations between Government and health professions, and the professions and other N.H.S. employees. The N.H.S. is too unwieldy, hierarchical, and administratively constipated for much effective economy to take place. So probably services will decline and the strain will be taken off as private alternatives begin to flourish.

Bridge of Earn Hospital, Bridge of Earn, Perth
R. A. WOOD, B.Sc., M.R.C.P., Consultant Physician

Restricted List of National Health Service Drugs?

Noel D. L. Olsen

In 1972-3 pharmaceutical services (£226 million) and the hospital drug bill (£33½ million) came to a massive £260 million or 10% of the total cost of the Health Service, (80% of this money was paid to manufacturers.) Most of this money is well spent, but some is wasted and enormous savings could be made. Doctors are rightly most resistant to any change that restricts their traditional clinical freedom, but clinical freedom should not be used as an excuse to cover incompetence or ignorance. Nevertheless, in the present economic situation, we must review all spending and make cuts wherever reasonable in the hope that money saved in one area might be used to better effect elsewhere.

While few doctors would support the limitation of prescribing to a government-controlled list of drugs—which would inevitably be inflexible and slow to change—I believe that voluntary limitation to