GMSC discusses NHS planning system

A report of most of the topics discussed at the April meeting of the General Medical Services Committee was published last week (p 1492). There was also a short discussion on the DHSS’s consultative document, Review of the NHS Planning System (HN(81)4), which was reproduced in the BMJ on 21 February (p 669).

Dr Williams, the chairman of the Welsh Council, had commented on the document. Referring to the statement in the document, “An opportunity for the Government’s policies and priorities to be reconciled with available resources,” Dr Williams said that no planning system could do this unless the Government ensured that its policies and priorities were matched overall by resources. Previous administrations had imposed additional burdens on the Service—for example, the contraceptive services—without matching resources. The present administration had imposed cash limits at a time of inflation and yet expected services to be maintained. If the planning system was to achieve its stated objective, the Government must be prepared, at a national level, to restrict the range and scope of the NHS to stay within the resource limitations. If the Government could not afford to pay for the Service that was provided now it should state clearly what it could afford to pay for. A general dilution of standards was not acceptable.

Dr Williams also said that it would be unfortunate if the planning of postgraduate teaching hospitals were to be divorced from the needs of the populations they served.

Pointing out in his commentary that there were not enough family practitioner committees in the document, he said that some mechanism was needed whereby the expanding part played by general practice could relieve the hospital service of work that could be more economically performed in general practice and of the funds that now financed that work. It was important that user groups were fully consulted rather than being faced with unilateral decisions. Changes made by the service specialities—x-ray services, pathology, etc.—regarding access required full consultation with GPs and the consultants using the services. Clinical specialities provided for by the NHS in London were asked to consult the users fully before changes were proposed.

It seemed likely from the document, Dr J F Milligan said, that the region would be the seat of power. On the question of consultation it seemed that in the case of the region’s five-year strategic plan the districts would consult locally between October and December. The whole consultation process had to be completed by the DHAs in six weeks, whereas consultations at regional level would take place between May and October the following year.

G R Outwin pointed out that full consultation at district level was done through the district management teams, on which general practitioners were represented.

There were comments in the document, Dr James Richardson said, to do anything that the district asked for. There had to be a commitment further than a year ahead.

It was high time, Dr Alan Rowe suggested, that it was emphasised that the Government should state what it could provide. The document implied that there would be an annual document stating what the resources would be, but the difficulty was that the figures always arrived late and it was not possible to plan in the time available. Firm information was needed concerning the basis on which the financial resources for the next year would be calculated.

Dr G W Taylor referred to Dr Williams’s comment that there had to be some mechanism by which general practice could relieve the hospital service. Anything that weakened the GP’s independence in the reorganised structure would be disastrous, he said. It was concerned above all with any mechanism that involved general practice in planning with the authorities. Dr Williams explained that that was not his intention.

In Dr Michael Wilson’s view the consultative document simplified the complex planning system that existed at present. It was necessary to ensure that LMCs were informed of strategic plans and the annual programme so that they could contribute to the planning process.

The committee endorsed Dr Williams’s comments and agreed to forward all the points made to the DHSS.

Medical advice for DHAs

The National Association of Health Authorities has recommended that the new district health authorities should be left to establish their own medical advisory machinery in consultation and agreement with the medical profession at district level. The report of the Chief Medical Officer’s working group on district management arrangements for medical advisory and representative machinery (17 January, p 239) said that there was no need for a statutory district medical committee. The association agrees but has emphasised that the health authorities need strong medical advice and need to know that the advice is generally supported by the profession in the district. The NAVA recommended that the number and structure of hospital medical committees should be decided at local level in response to local circumstances. The committee’s purpose should be clearly defined before it is established to ensure that each one is really necessary.

Corrections

From the JCC

In the second column of the report From the JCC under the heading “Hospital medical staffing structure” (18 April, p 1332) Dr J F Nunn is quoted as saying in reference to anaesthetics: “In 1980, 93% of those appointed senior registrars were British.” The sentence should read: “In 1980, 93% of those appointed senior registrars were British.”

In the fifth item under “Briefly...” the first sentence should read: “A joint working party has been convened by Professor John Forrester with representatives from the RCGP; the Faculty of Community Medicine; the Joint Paediatric Committee of the Royal Colleges of Physicians of London, the Royal College of Physicians of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow; and the British Paediatric Association on the training of clinical medical officers.”

In brief

Teach-ins on private practice

Following the successful national teach-ins on private practice held in January, the BMA is to hold a series of regional teach-ins. The first will be held in the West Midlands Region on Friday, 29 May, at the Medical Institute, 36 Harborne Road, Edgbaston, Birmingham B15 3AJ.

The aim of the teach-ins is to make hospital doctors aware of the recent contractual and legislative developments and the greater potential for private practice.

Increased grants to voluntary organisations

Sir George Young, junior Health Minister, told the Volunteer Bureaux National Conference that the £1m grants to voluntary organisations in 1981-2 had increased by 16%, to nearly £8 5m. The money would help over 200 bodies mostly towards the headquarters expenses of national organisations working in the health and personal social services.

Sir George emphasised that the Government’s objective was not to save public expenditure and there was no question of the Government seeking a takeover by volunteers of work being done by paid employees.

Senior registrar establishment in Scotland

A new circular from the Scottish Home and Health Department (1981(GEN)16) revises the existing hospital medical registrar establishment. The forecasts reflect the likely effects of the current financial constraints on expansion, but no account has been taken as yet of current discussions on the possibility of changes in the hospital medical staffing structure. The total number of hospital medical posts has been reduced from 455 to 444. The circular includes details of the establishment of trainees in community medicine and explains the system for part-time senior registrar posts for doctors with domestic commitments.

Private health schemes maintain growth

The growth in numbers covered by private health schemes was sustained during the first quarter of 1981. The total population covered rose by 147 000. At the end of March the three major schemes—British United Provident Association (BUPA), Private Patients Plan (PPP), and the Western Provident Association—had 1 715 000 subscribers, covering a total insured “provident population” of 5 724 000. This represents 6.7% of the total national population or about one person in 15. The rate of growth during the first quarter slackened compared with the high rates during the first halft of 1980. Nevertheless, the total provident population has shown a rise of 726 000 in the 12 months to March 1981. If the current growth rate persists the provident population will exceed 10m by the mid-1980s.