The new NHS

Better to go forwards than backwards

With the new NHS almost upon us should we be looking backwards, forwards, or sideways? Nostalgia for the time before the NHS review has its attractions, and mourning the loss of the "good old days" is a common enough response to enforced change. But idealising the past also helps us to avoid dealing with the good old problems that faced the NHS.

Not that the new reforms manage to address all or even the most important of these problems. The obvious omission is the underfunding of the NHS, which the government has never accepted despite its role in triggering the review. Instead the government redefined the problems of the NHS as the need to find ways to control costs in the face of limitless demands for health care, identify value for money, and increase consumer choice. This was a highly selective interpretation, particularly as spending on health in the United Kingdom was not escalating (6-09% of gross domestic product in 1981; 5-98% in 1988, the year of the review).

As the BMA has been saying for the past two years, not everything that emerged from the review was bad. Its focus was not entirely on efficiency and the crude cost cutting mechanisms of old: health outcomes and ways of identifying a "good buy" replaced the past emphasis on manipulating inputs. And while accepting the principle of public funding, the review correctly challenged two assumptions on which our public service organisations have been based.

The first is that large hierarchically managed institutions have enough flexibility to respond to the diverse demands of heterogeneous populations. The second is the assumption that employing highly trained health professionals ensures that users get what they want. In practice, these assumptions have led to patterns of NHS spending that are linked more closely to the status of medical specialties and powerful doctors' research interests than to the health needs of communities. This is the "provider capture" of resource planning within the NHS, which contributes to the pressure to extend services—acute hospital services in particular—without reference to their relative benefits to the public health.

That this government should have chosen market forces to remedy this is not surprising, although no evidence exists that competition alone reduces costs. In fact, the opposite is more often found as competing providers invest heavily in improving quality, which drives up the price.

Recent experience in the United States suggests, however, that having competing providers and powerful, discriminating purchasers may reduce costs without compromising outcomes in acute care. These were the conditions that the NHS reforms attempted to recreate here. District health authorities will shop around competing providers, buying health care for their population. Authorities will be funded according to the size and needs of their population (weighted capitulation), not the size of their acute hospitals.

Previously doctors have "known what's best" for their patients, but now purchasing health authorities will become the people's advocates. A new group of professionals will act as discriminating purchasers of services by becoming expert in assessing health needs and in monitoring the quality and effectiveness of health care. Anyone hoping for greater public accountability—which was meant to be part of the deal—will be disappointed.

So what will happen from 1 April. Firstly, funding of health authorities by weighted capitulation will not be introduced fully until 1992-3. Secondly, much of the information needed by purchasers to compare relative costs and benefits does not exist. (Ironically the NHS's failure to invest in information and audit is one of the reasons why its costs are so low by international standards.) Thirdly, closer examination of what happens in the United States shows that the "powerful, discriminating purchasers" are more generously funded and can buy from providers with surplus capacity—conditions that do not apply here after decades of underfunding. Finally, true separation between purchasers and providers within the district health authority is impossible. District general managers, responsible both for buying the best possible services for their population and keeping their directly managed units solvent, are unlikely to shift business away from their local units, thereby bankrupting them.

As for contracting, it seems right that public money should be accounted for openly. Inevitably, given the lack of investment in information systems and the very slow development of medical and care audit in the NHS, detailed service specifications will not be available from 1 April. Skills needed by discriminating purchasers—such as those for negotiating and commissioning service agreements—also need developing. Service agreements, with or without expensive billing procedures, could enable us to challenge the current practice of paying for care that is of untested value, inappropriate, unnecessary, or unkind—while starving more valuable services. To become discriminating district health authorities will need adequate investment to support their public health functions, which have long been neglected. Without this contracts may merely reflect the status quo or reduce what counts in the complexities of providing care to what can be counted.
As 1 April arrives simply calling for a return to the old ways or for more of the same will not do. The reforms may not address all the problems of the NHS, but they do improve our capacity to specify the quality of services and to price improvements. They also move rationing decisions away from the private domain of doctors into a more public arena.

More public debate could have the entirely unintended effect of increasing the demands for more money for the NHS—which is about where we came in. Regardless of whether these demands are heeded doctors must realise that the world has changed. They should be working to make the best of the changes.

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Home peak flow meters

Now available on prescription, they should be used as part of a self management plan

Home monitoring of peak expiratory flow improves the management of asthma,1,2 and making peak flow meters available on prescription in the NHS could improve the management of many patients. The initial cost of providing a meter for all asthmatic patients capable of using one, however, might be as high as £18m, so the cost must be justified by appropriate use.

After asthma has been diagnosed and an acceptable degree of control established self management should be the aim. A peak flow meter can enhance self management, but merely providing a meter is not enough. Before a meter is prescribed a baseline value of the patient’s best attainable peak expiratory flow must be established, and the meter should then be used as part of a self management plan.

The best attainable peak expiratory flow should be established early in a patient’s management. If the initial value is low (less than 80% of that predicted) regular bronchodilators and prednisolone 30 or 40 mg a day should be given for one to two weeks before the best value is determined. Patients then require clear instructions—both verbal and written—about using their peak flow meters to manage their asthma and on the action they should take when it deteriorates. This self management plan could be outlined on the adult’s asthma card provided by the Asthma Society with special care being given to the peak expiratory flow value at which the dose of inhaled corticosteroids should be increased or oral corticosteroids started. Patients should be told that their perception of airways obstruction is likely to be poor3,4 and that use of the meter will help them detect early deterioration of lung function.4

Patients with stable asthma should be encouraged to measure their peak expiratory flow at least one or two days a week to detect any slow deterioration and to start recording it regularly if they develop a respiratory tract infection, increase in wheeze, or other symptoms of increasing airways obstruction. Patients should normally measure their peak expiratory flow twice daily, on waking and in the evening, before using a bronchodilator, and perhaps four times a day during exacerbation of asthma. On each occasion three readings should be taken and the best recorded graphically for easy inspection.5 Although form FP1010 issued for this purpose provides clear instructions on using and caring for the meter, the accompanying chart is poorly designed. General practitioners may therefore want to design their own charts or adopt those used by their local hospital.

Patients at increased risk,6,12 who include those recently admitted to hospital with acute asthma, “brittle” asthmatics, unstable asthmatics (recognised by excessive use of bronchodilators, nocturnal wakening with wheeze, or morning “dipping”),7 those requiring varying doses of systemic corticosteroids to control their asthma, and those prescribed domiciliary nebulisers, should record their peak expiratory flow more often. Frequent measurements allow rational alteration of drug treatment and these should be continued until the peak expiratory flow is maintained at the patient’s best levels with minimal diurnal variation.

Home recordings of peak expiratory flow should improve the detection of undertreated asthma. Patients thought to overuse their β₂ agonist inhalers may show previously unrecognised nocturnal asthma or pronounced morning dipping of their peak expiratory flow. Recordings may also allow unnecessary drugs to be withdrawn, thus reducing morbidity and treatment costs. Although high doses of inhaled steroids may be required initially to control asthma, they may not need to be continued. Once stable, these patients can be advised gradually to reduce the dose, and the minimum daily dose necessary to maintain the patient free of symptoms and the peak expiratory flow value at an optimum level can be established. Alternatively, some patients started on inhaled corticosteroids may no longer need previously prescribed oral theophyllines or β₂ agonists; again, careful monitoring of symptoms and peak expiratory flow values may enable these drugs to be withdrawn.

Provision of a peak flow meter with an appropriate self management plan should provide greater autonomy, better patient compliance, and improved overall control of asthma. Wider use of these meters should reduce morbidity from asthma and may even help to reduce mortality.

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