

# HEALTH CARE ISSUES IN LANCASTER – CURRENT AND FUTURE

Paul C Whitfield, District General Manager  
Lancaster Moor Hospital, Lancaster LA1 3JR

Any analysis of current health care provision in Lancaster must start from the basic and simple fact that demand is exceeding supply to an alarming extent – if judged by the waiting times for an out-patient appointment and the number of people awaiting treatment. Even more depressing is the fact that the situation is deteriorating. A few examples are set out below.

Speciality	Out-patient Waiting Time for non-urgent appointments (weeks)	Total number on the Waiting Lists (in-patients/day patients).
General Surgery	37 Weeks - 53 Weeks	645
E.N.T.	16 Weeks - 27 Weeks	420
Orthopaedic	70 Weeks	746
Ophthalmic	17 Weeks - 40 Weeks	637
Gynaecology	19 Weeks - 34 Weeks	653

Source: Lancaster Health Authority Monthly Waiting List date – 30/9/89

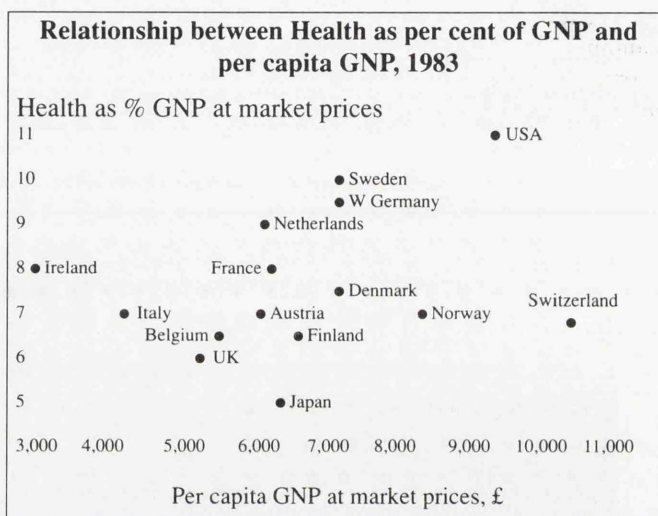
The often stated solution to the problem is more money. Supporters of this view need look no further than the proportion of the nation's wealth (Gross Domestic Product) devoted to health care compared with other developed countries.

## Public and Private Health Expenditure as a percentage of Gross Domestic Product 1984

	TOTAL	PRIVATE	PUBLIC
Sweden	9.4	0.8	8.6
France	9.1	2.6	6.5
Netherlands	8.6	1.8	6.8
West Germany	8.1	1.7	6.4
Ireland	8.0	1.1	6.9
Switzerland	7.8	–	–
Italy	7.2	1.1	6.1
Denmark	6.3	1.0	5.3
Belgium	6.2	0.5	5.7
Great Britain	5.9	0.6	5.3
Spain	5.8	1.5	4.3

Source: OECD (1987) *Financing & Delivery Health Care: Paris*

As a further example of the gap between UK spending and other Western countries, it is interesting to compare the relative wealth of the nations and spending on health care in percentage terms. On this analysis the UK is lower than most countries on both per capita spending and its proportion of Gross National Product [figure].



The difficulty with this simple analysis is two-fold. First, the Government argues that it has invested vast sums in the NHS in the last 10 years and will continue to do so but wants changes to the present system and structure of delivering health care. Secondly, how much money is the Government to make available and over what timescale. Professor Enthoven, a distinguished American health economist, recently stated that health care spending in the USA will reach 13 per cent of gross national product in 1995 and 15 per cent in the year 2000. There is also another awkward fact to recognise in the 'more money leading to more treatment and reduced waiting lists' debate; each year more patients are treated, more operations are performed and more patients attend out-patient departments than in any previous year. In Lancaster in the six months April to September 1989 compared to the same period in 1988, some 200 more patients received in-patient or day-case treatment. Not the evidence to support a declining service. Clearly, there is no right amount in absolute terms for spending on health care. It is a judgement of the Government of the day – whatever sum is provided will be consumed.

If questions about funding are a matter for Parliament, and for all practical purposes outside local discretion, how can the Lancaster Health Authority influence events? The first point to make is that a substantial amount of money is

currently spent on providing health care by the District Health Authority and the Family Practitioner Committee. Health Authority spending in 1989/90 will be around £53 million. Expenditure by the Family Practitioner Committee for the Lancaster area is estimated at some £12 million in 1989/90.

It is necessary to ensure that the public obtain value for money and, more importantly, that the quality of the service provided is of the highest possible standard. It is these two issues that the Government White Paper 'Working for Patients', and the new contract for general practitioners aim to tackle.

The Government's proposals cover a large number of issues, not all of which are directly related to questions of quality and value, for example, capital charges. However, there are several key proposals that are intended to change the traditional style of health care delivery. The most notable of these are:

- \* Self-Governing Hospitals
- \* G.P. Practice Budgets
- \* Medical Audit
- \* Membership of Health Authorities
- \* G.P. Contracts:
  - Health Promotion/Illness Prevention
  - Practice Leaflets
  - Annual Reports
  - Targets for Vaccination/Immunisation and Cervical Cytology
- \* Consultant Contracts

In examining these proposals it has to be remembered that some changes concerning the organisation and provisions of health care are voluntary, whilst others relating to quality of health care are more or less obligatory.

At this point it is worth stating that difficulties arise because two separate Authorities are responsible for the provision of health care, namely the Lancaster Health Authority for Hospital and Community Services and the Lancashire Family Practitioner Committee for primary health care. The planning and provision of comprehensive health care for the community requires a close inter-dependence of primary and secondary care. Indeed clinical policies require agreement between doctors in both hospital and community - early diagnosis and early discharge require a co-ordinated service. There is no identifiable mechanism for achieving such an outcome.

There are two principle elements of the White Paper which, if accepted will change the future provision of health care. These are self-governing status and G.P. Practice budgets. Under these proposals the District Health Authority will become a purchaser of health care. Its primary task will be to assess the health care needs of the population including health promotion and prevention. This is no easy task as there is only limited data available on which to base a valid judgement. Having assessed the need, District Health Authorities will arrange contracts with providers of health care. The contracts will require providers to make available a range of services prescribed by the purchaser at a given volume and quality. Therefore, it will not be possible for a provider to decide what they will and will not provide.

Nonetheless, the difficulty for the purchasers is going to be how to specify volume and quality in such a way that control can be exercised and performance monitored. There is no experience of preparing specifications of such complexity. The experience of preparing specifications for competitive tendering in domestic, laundry, catering services, etc, is only of limited value and principally points to the problems and difficulties. Specifying the quality of service and monitoring its performance has not been one of the successes of competitive tendering. It has, it must be said, been successful in financial terms, having saved to date some £500,000 a year in Lancaster. The change to a Purchaser and Provider model of service provision is far-reaching and raises a plethora of questions to which answers are scarce. It is to commence in April 1991 with either self-governing trusts or Health Authority Managed Units as providers. The establishment of self-governing trusts in the time available will be difficult and the complexity of contracting with independent providers considerable. One trust estimates a need for contracts with over 250 purchasers.

For these reasons it is sensible to limit the number of hospitals seeking self-governing status from April 1991. There are likely to be only two established in the North Western Region, both in Manchester. The experience gained from this limited beginning can then be shared with other applicants.

The task from the provider's standpoint seems much less problematic. Managing the provision of a hospital service within a fixed budget is current practice for NHS managers. It could even be easier in a sense as the doctors will be employees of the Trust and, therefore, directly accountable to it for their actions. Establishing the Trust with all the attendant legal and personnel issues is unlikely to cause too many problems, although the timescale is tight. In my opinion the benefits to the hospital and the community could be considerable. The hospital will be able to attract staff of the highest calibre and in the right numbers. Decisions about service developments will be taken locally without the need for outside interference and approval. Doctors will have a bigger say in the service they are providing. There will be a clear purpose and direction for the entire enterprise. The biggest problem will be the need for the Trust to determine a level of service well in advance of the start of the financial year and thereby commit substantial resources of money, staff and accommodation to provide that level of service. The purchasers who have the funds - the District Health Authorities and general practitioners - may choose in part other providers or may not have available sufficient funds to maintain the previous year's level of care and delay a decision. In other words will the Trust be able to attract sufficient business to sustain its investment?

The other purchasers of care will be general practitioners holding practice budgets. To qualify, a practice will need a minimum of 11,000 patients. The practice will probably be allocated around £1 million to purchase health care for their patients. It is perhaps the most innovative proposal and the most widely criticised. So far the proposal raises more questions than answers. Indeed, if most of the general practitioners in the District became eligible and opted for practice budgets, the Health Authority, having assessed the need, will be powerless to do anything about it.

Nonetheless, in principle, it would allow patients, advised by their family doctor, to choose from the available options for treatment. To be in a position to decide which hospital, which consultant, and at what time treatment is provided, must be an opportunity to be explored.

A final intriguing issue in the organisation of services is the future membership of Health Authorities. From April 1991 the Lancaster Health Authority will comprise a Chairman appointed by the Secretary of State, five non-executive Directors appointed by the Regional Health Authority, up to five Executive Directors appointed by the Chairman and Non-executive Directors and General Manager. The Non-executive Directors will be chosen for their industrial and commercial experience, or local specialist knowledge, and come from outside the NHS. The Executive Directors will work in the Service, and will include the General Manager and Treasurer and up to three from amongst the doctors, nurses, and other NHS workers in the Lancaster District. Currently the Authority has some 17 Members drawn from the community generally, Local Authorities, consultant medical staff, Trade Union movement, general practitioners, Manchester University, and the nursing profession.

For the first time the employee Directors of the Authority will vote and influence policy. Whilst they will be in the minority, their knowledge, and thus influence, will be considerable. It is vital that Non-executive Directors have sufficient time to devote to Health Service matters, in order that they have a firm grasp of the issues and can effectively challenge the power of the Executive Directors operating in consort. To achieve such a level of commitment by high calibre people from industrial and commercial sectors, will obviously be difficult.

In considering the questions of quality and choice, it is necessary to draw a distinction between current local initiatives to improve the personal service approach to patients and the structural changes proposed by the Government. In this particular context, there are three specific proposals: medical audit, general practitioner budgets, and the new general practitioner contract.

In regard to medical audit, there are two principal aspects that need to be resolved if the experience of North America is to be applied. Firstly, all information is confidential and is privileged, that is, it cannot be used in litigation. Legislation to this effect is desirable, but unlikely. Secondly, arrangements are needed for non-stigmatised re-training of doctors. There are currently no plans to establish such arrangements. There will be a District Audit Committee to plan and monitor a comprehensive programme of medical audit. It will produce an annual report on the general results whilst maintaining confidentiality about patients and doctors. Relevant parts will be available to Health Authorities considering placing contracts with the hospital of that District. Separate arrangements are planned for medical audit in primary care. It is not clear to what extent the results of medical audit in primary care will be made public. What is certain is that the demand to make the results public in ever-increasing detail in both hospital and primary care will be a continuing feature of the debate in the years ahead. There are two states in America where the publication of a specialist's

individual audit results is a requirement to assist a patient to choose 'the best' surgeon. The application of medical audit in North America functions in a different environment as the number of clinicians in a particular speciality is much greater, with as many as 60 doctors with admission rights plus a clinical head of service. It is possible that the problem of the relatively small number of consultants in most specialities within a District could be overcome by sharing of data and discussion across a number of Districts. The lack of an effective clinical hierarchical mechanism may lead to opting out by some doctors. In the absence of Clinical Directors it is hard to see how this problem can be overcome. The connection between general practice and hospital medicine is not easy to separate in the totality of treatment from the patients' perspective. For example, in many conditions early diagnosis significantly improves the chances of survival, or the course of treatment; early discharge requires general practitioners to provide continuing clinical support. These issues will need to be connected if the public are going to regard medical audit as an effective safeguard of clinical standards. In support of medical audit, a qualitative measure that could be pursued with success is Accreditation. In Canada a team of three (doctor, nurse, administrator) visits hospitals at pre-determined intervals to carry out a searching evaluation under a number of headings. The evaluation is extremely detailed, comprehensive and well documented and lasts a week. The results are published and the hospital categorised 1, 2 or 3 to denote the number of years to the next review. The accreditation visit is feared and respected by doctors and managers alike. Such an arrangement would be an important safeguard in the future as provider hospitals in competing for contracts would need to demonstrate openly the maintenance of high standards.

In the UK the general practitioner is the primary source of health care; they are variously described as the 'gatekeepers' to hospital care. It, therefore, follows that their role in handling practice budgets would be pivotal from the patients' standpoint. For the foreseeable future in most specialities, some person, hopefully always a doctor, has to allocate priorities for treatment. At present this is undertaken by the hospital consultant, but with rising numbers on waiting lists how effective can this be for the majority of patients when the consultant may only have seen the patient for a brief consultation several months ago. The practical problems associated with practice budgets, lack of funds, increased paperwork, more administrative/financial staff etc, have been well documented. It deserves to be tested if only for the potential benefits it could bring to patients, but its success in part will depend on the overall funding of the NHS by the Government. The changes proposed by the Government in the new contract for general practitioners do take as their principal aim improving the quality of the service to the patient. The various measures, including providing more information for patients about available services, and setting targets for levels of service, are aimed at ensuring that patients are seen to be getting an acceptable standard of care.

All these changes will begin to have an impact in Lancaster in the coming months and years. However, two issues that will probably have an even bigger impact will be changes in the method of allocating funds to Health Authorities in 1991 and changes in medical manpower as 'Achieving a Balance' is implemented.

In regard to funding from April 1991, Health Authorities will start the changeover to per capita funding – an allocation based on the resident population of the Region/District. The cost of treating patients who live outside the District will be re-charged to the Health Authority in which the patient normally resides. At present the Lancaster District has a resident population of some 130,000. However, in hospital acute services some 30% of patients treated live outside the district. This figure converted to population means funding provided for hospital services for up to a population of around 200,000. Therefore, to maintain present levels of funding and thus service, staffing, etc, patients must continue to be attracted from outside the District in large numbers.

All the plans of Health Authorities, purchasers and providers, and general practitioner practice budget holders could be seriously blown off course by the changes in medical manpower and particularly the training of doctors. Discussions are proceeding in some Districts on reducing the range of in-patient services because of current or impending problems of recruiting junior doctors. The specialities include ENT, dermatology, ophthalmology, and urology, with one District providing the service for one or more adjacent Districts. Whilst in some cases these changes may be planned in others it may be forced upon them by a failure to recruit. Clearly if for whatever reason no service is locally available patients will be required to travel. The option to move to a consultant-led service whilst intrinsically desirable will not in the short-term overcome the problem. There are insufficient doctors available for appointment, nor are they likely to accept appointments without resident staff. The creation of more consultant posts is required, but costs are high and few facilities are available. This could in part be accommodated by existing consultants reducing some of their clinical commitments. As an example many patients complain about waiting time in the Out-Patient Department, that is the time taken to see the doctor. There are simply too many patients. More out-patient clinic sessions and fewer new patients per

session as well as reducing the number of re-attendances by earlier discharge to the care of general practitioners would be welcomed by patients. If medical audit, training and resource management are to be successful, they require a major time commitment of each individual consultant. The sessional timetable for a recent consultant post was 3 Out-Patient Clinics, 4 operating sessions, 2 ward rounds, which in effect consumes all the NHS time in direct patient contact work and leaves no time for other important areas of activity.

The expansion in the number of consultant posts is unlikely to be fast enough to achieve significant improvement in the next five or even ten years, for example, the 100 additional consultant posts amounts to less than half a post per District in the next 3 years. These 100 new posts are supposed to be in addition to a growth in consultant posts of 2% a year; but without significant central funding it is unlikely this growth will be achieved as many Districts seek to restrict development and contain clinical activity. The need for an early and radical review of medical manpower plans is required.

It is clear that the early 1990's are to be a period of rapid change from all directions with some issues in conflict each with another – providing greater choice for patients at the same time as restricting services. The re-organisations in 1974, 1982 and 1985 were predominantly concerned with the structure of the service and were largely unnoticed by patients.

The Government's proposals are aimed specifically at improving the service for patients and present an immense challenge. Whilst there will be many problems, Lancaster should do better than most Districts, given its relative size and location, its close working relationships between hospital doctors and general practitioners, and its willingness to push forward to test new methods and solutions. It will, as always, need much hard work by everyone concerned.

**Answer to quiz on page 19**

1. A double contrast barium meal.
2. An active duodenal ulcer on the anterior wall of the cap.  
(The patient is lying prone).