NHS SUPPORT FEDERATION

NHS Matters

# Free up to a point – free for how long?

Until now, the government's mantra has always been that the NHS remains "Free at the point of delivery". But in a speech to the London School of Economics, Blairite policy trailblazer Charles Clarke openly declared his belief that under a future New Labour government, 'some levels of charging, along the lines of university tuition fees', will be necessary to meet demand. Describing a radical shift in how public services are delivered, he raised the possibility that people will be forced to choose private sector options "to meet needs that they want to address but the public sector cannot meet."

The government seems to be preparing the public for a stripped down NHS on the grounds that it is becoming unaffordable. Moving toward a system where a basic service remains free but extras are paid for is reminiscent of the demise of NHS dentistry. Charles Clarke's idea of co–payments would lead to the public having to take out health insurance and to them meeting sizable health costs from savings.

## Charges deter patients

While patients may have got used to the idea of packing a credit card for a hospital trip to pay for parking and telephone charges, what is less obvious is the way a cash-strapped NHS is looking to save money by restricting access to treatment, driving patients to pay for their own care. Opthalmics, dentistry and long-term care for the elderly have shown us what happens when tax-based funding is removed. The impact of charging is felt by those on lower incomes – introducing fees for eye tests reduced numbers attending by half – affecting their health care decisions. Those who might hesitate to see a GP if even a nominal charge is introduced may not be caught until a condition is further advanced, and costs more to treat.

As reconfiguration continues to close community hospitals, patients are being handed on to social services, where means testing determines the level of care provided. Community nursing is not expanding fast enough therefore it will fall to private providers to pick up care that a primary care trust (PCT) says it can't afford. With more healthcare to be delivered this way, and following the trends with long term care, it's not hard to see charges emerging where NHS services are kept in short supply.

**Charges lying in wait**

> "If your GP can't argue your case strongly enough you could end up having to go private."
> **Dr Jacky Davis**

Camden PCT's list of 'low priority treatments', which GPs are not allowed to refer to a consulant includes: cancerous skin conditions, varicose veins, asthma, grommet surgery, carpel tunnel surgery, minor skin surgery, various cosmetic surgery, gender reassignment surgery, viral warts, eczema, acne and psoriasis. GPs seeking to refer for these conditions will be simply overruled.

## Wait, pay or give up

Confronted by a long wait for treatment and the presence of a private alternative, it's easy to see why patients sometimes choose to pay. PCTs are adding to this through their use of 'referral management centres' to restrict the range of health care available. Some GPs are finding their referrals are being rejected on the grounds that the patient is not sick enough to justify seeing a hospital consultant. Other trusts have gone further, establishing lists of 'low priority treatments', which ban GPs from referring patients with certain conditions to hospital specialists. Unlucky patients may be left with the choice of abandoning treatment, or if they are able, turning to the private sector.

The affect of the market is: if you can't wait, you might end up paying for it. We are slowly drifting towards a position where people are picking up the tab for their own health care. With senior politicians putting universal access in doubt, the concept of an NHS 'free at the point of use' is changing. While Wales has recently announced that all prescriptions will be free and Scotland can provide personal care for the elderly free of charge, this government is leading us as fast as they can in the opposite direction.

## CAMPAIGN UPDATE

Around the country campaigners have been continuing to put pressure on politicians and NHS management.

### Gloucestershire victory close

In Gloucestershire the fight to save Cossham Hospital from closure has come closer to victory as a consultation held by the NHS in Bristol and South Gloucestershire recommended that the hospital remain open. This latest consultation was in response to the public outcry caused by the original proposals.

### Get back

Plans for a privately run GP surgery in Merseyside have been defeated after public consultation, with the PCT now having to restart the tender process for a new clinic in Maghull.

### Foresting complaints

At Sherwood in Nottinghamshire a mental health unit has been saved after 234 responses were received in opposition to the planned closure of the Span centre (Skills and Practical Activities Network). The Notts Healthcare NHS Trust was forced to reverse its plans, and the trust board has now approved plans to keep the centre.

### Cuts plan falls at Newmarket

The axing of all the in-patient beds at a ward at Newmarket Hospital in Suffolk has been halted after local opposition to the PCT's plans. Also in Suffolk, two community hospitals in Sudbury won a reprieve from closure and sale when the health scrutiny committee agreed to refer the proposals to Health Secretary Patricia Hewitt, citing a lack of consultation and claiming patients' needs could suffer.

### Manchester review

Health Secretary Patricia Hewitt has ordered an independent inquiry into plans to cut overnight maternity care in Greater Manchester. The review by the Independent Reconfiguration Panel, announced in the Commons, follows great pressure from the public and politicians from Salford, Bury and Rochdale all trying to save their local services.

### Riding delay

A huge outpouring of public anger at plans to cut services at four community hospitals in the East Riding of Yorkshire has forced the PCT to delay its final decision on the proposal, with thousands of responses having been received following public consultation.

### Lancashire success

A Clinical Assessment Treatment and Support (CATS) service in Lancashire is to be run by a NHS hospital instead of a private company, in a major success for campaigners against the controversial plans.

# NHS Reconfiguration: case unproven

When Tony Blair announced that concentrating specialised services into fewer regional hospitals would save “hundreds of lives a year”, he was backing the government’s deeply unpopular reconfiguration plans to deliver safer and more cost effective care. Following on from Patricia Hewitt’s triumphant claim that bed closures were a sign of "success", the PM is seeking to persuade the country that losing local hospital services is in the public interest.

Government policy argues that new community and regional specialist services should replace some services currently provided by District General Hospitals (DGHs). If these plans were realised, more patients would have to travel further to receive treatment. Blair’s headline grabbing statement came after the Institute for Public Policy Research (IPPR), which is close to the government, published a report called The Future Hospital: The Progressive Case for Change, which appears to offer an intellectual argument in favour of reducing local hospital care.

### Standing logic on its head

In some areas of treatment, evidence does indeed show that concentration of resources can lead to better care, such as for cancer and neuro-surgery. But the report attempts to apply the same principle to A&E and maternity – where speed of access can be critical. Despite a lack of conclusive evidence, the government is making the counter-intuitive claim that more lives will be saved if patients travel further to receive specialist care.

This argument is being used to justify downgrading local units, particularly A&E, where some very urgent care patients – those with heart attacks, major accident trauma or needing vascular surgery for aortic aneurysm -would benefit from attending a regional centre with a clinical network of cardiologists and other specialists plus support resources.

But the idea that changing the level of care available at A&E units will improve overall safety is fiercely contested by the British Association of A&E Medicine and by the College of Emergency Medicine, which warns that casualty departments operating without vital hospital services such as intensive care, paediatrics and acute surgical care will put patients’ lives at risk. Clinical specialists must be on hand, they argue, for those cases which turn into non-trauma emergencies, such as when serious illnesses are not picked up directly by paramedics.

### Is bigger better?

The key issue in this debate is whether local needs are better served by DGHs or whether services should

**Public confused by the fuzzy logic over future of hospitals**

be devolved into the community, leaving acute care in the hands of fewer, larger, specialised hospitals. In terms of size, there is no evidence that bigger hospitals are necessarily better. In fact, research shows that they rarely result in lower costs or better outcomes for patients – facilities of 100 to 200 beds are as economically efficient as hospitals get. The case for fewer local hospitals relies partly on the claim that delivering care in the community is more cost-effective. Some early studies are showing, however, that procedures performed by GPs rather than hospital doctors cost more, rather than less.

In terms of safety, the largest category of people likely to need inpatient care are seriously ill medical patients. According to the Royal College of Physicians, what these patients require from a local hospital is acute general surgery, an A&E department, resident anaesthetist cover, intensive care and cardiac care: a typical District General Hospital.

This is undoubtedly what most people want. Additional travelling for patients and for their visitors has been shown to be a key factor expressed in consultations, for services to be delivered closer to home.

## Safety first

Where DGHs are closed or downgraded, patients would need to be sent out of the locality to a specialist hospital. The payment by results structure (whereby funding follows the patient) means money would drain away from local services. Hospitals seeing fewer patients will receive less funding, jeopardising their future and creating the problem of specialist staff not being able to maintain professional standards if their caseload is reduced in this way. The IPPR report maintains this is an argument for larger hospitals. Patient safety would not be compromised however, if doctors in training were rotated through specialist and general units in a planned way, ensuring skill-levels are maintained.

While opposition to these plans has been mainly focussed on acute care, there is worrying evidence that patients who live further from a hospital are less likely to take up diagnostic, outpatient and screening services. More work needs to be done on examining the effects of transporting someone for a longer time prior to giving them treatment - particularly in emergencies – before this policy convinces patients they will be safer.

Whereas people will accept reorganisation if it results in better services, they remain deeply suspicious when major reforms are pushed through in the context of a budget crisis. There is no evidence to show that reconfiguration will benefit the majority of patients, who are making it clear that they want their health care close to home.

**The NHS Support Federation** is one of the groups, along with the **NHSCA and Health Emergency** that started the KONP campaign. It has been campaigning around the health service since 1989, is independent of any political party and works to promote and protect the idea of comprehensive healthcare that is freely and fairly available to all. It provides staff and its office and resources to the KONP campaign. It is funded by a membership of NHS staff and supporters, who share its commitment to the NHS.

Keep Our NHS Public has produced two recent campaign documents that are available in hardcopy from the NHS Support Federation, 113 Queens Road, Brighton, BN1 3XG olivia@nhscampaign.org

**Patchwork Privatisation of our health service: a users guide**

**NHS Reconfiguration: Case unproven by Sally Ruane & David Byrne**

**AVAILABLE NOW**

# ICATS, good for patients or "fat cats"?

Going are the days when your GP would send you to a consultant to run tests and decide your treatment. Now there is a new stage of assessment. In a radical move altering the GP-patient relationship, patients will attend clinics to investigate their problem and then be referred to treatment centres for the solution. Controversially, these centres will be largely provided and run by the commercial sector, prompting concern that patients will be referred between healthcare businesses for profit, cutting out NHS staff altogether.

Sitting between the GP and specialist consultant services, these centres are called CATS, (Clinical Assessment Treatment and Support), and ICATS, (Integrated Care Assessment and Treatment Services). Set to roll out across the country, they will offer assessment, diagnosis and even treatment in specialisms like ENT, gynaecology, orthopaedics, rheumatology or urology.

### Easy pickings for private sector

Conflicts of interest are already arising, for example, when South African company Netcare, who run the Greater Manchester Surgical Centre, was awarded the contract for an ICATS in the same city. Netcare's ICATS now has the option to refer patients to their own surgical services. Not being subject to NHS checks and balances, Netcare is in an excellent position to increase referrals to their own centres, 'cherry picking' the more profitable, straightforward cases. Conversely, they can direct patients with complicated and chronic conditions away from their Surgical Centre back to the NHS.

Reaction to the centres has so far been broadly negative. Penrith and the Border MP David Maclean claims CATS centres proposed for his constituency are unnecessary. While the policy is supposed to cut waiting lists, he points out that "The current locations providing this service offer better patient access than the proposed CATS ones as there is only a six-week waiting time list for ENT consultation in Cumbria. The proposals fail to take account of those suffering from chronic ENT problems who would not be eligible for the quick-fix CATS services".

### Body blow to NHS hospitals

Agreeing that these facilities are neither necessary nor a good use of public money, the British Medical Association sees them as a further fragmentation of the NHS. Speaking for the BMA, Dr Jonathan Fielden warns of a significant threat to local acute hospital trusts:

"When work goes to the private sector, they lose income. If hospital units become unviable, NHS capacity is wasted, jobs are lost, and services that patients have valued for years are cut. Unless they are carefully integrated, and local clinicians engaged, the number of specialties and cases involved means that core NHS work is likely to be hit, rather than surplus capacity being created."

The Chief Executive at the Royal Bolton Hospital estimates that 50% of the hospital's total outpatient workload could be lost through the introduction of CATS & ICATS, equating to £3.7 million in lost income and possibly 130 lost jobs. Patients may also find themselves travelling further for services that traditionally have been provided on their doorstep.

With no evidence that CATS/ICATS will improve accessibility, value for money or quality of care, these centres are being seen as merely another opportunity for PCTs to cut costs and for commercial gain to conflict with public service.

Dr Fielden continues: "One of the many benefits of the integrated care the NHS provides is that patients can stay with one consultant throughout their treatment. CATS/ICATS would fundamentally threaten the safe continuity of patient care."

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