

## THE NATIONAL HEALTH SERVICE PLAN

*The NHS plan – “a plan for investment, a plan for reform”* was published by the Government in July 2000. Public consultation showed that people wanted more and better paid staff using new ways of working, reduced waiting times and high quality care and improvements in local hospitals and surgeries. The plan recognises that as well as being underfunded, the NHS lacks national standards, there a lack of incentives and levers to improve performance, that it is over-centralised and patients are disempowered.

In summary, the plan proposes:

Increased funding and investment

- NHS funding will grow by one third in real terms in the next five years
- Investment in NHS facilities: 7,000 extra hospital beds, 100 new hospitals by 2010, 500 one-stop primary care centres and 3000 GP premises modernised
- Investment in staff: 7500 new consultants and 2000 more GPs, 20,000 new nurses and 6,500 new therapists. 1000 more medical school places

New reforms in the NHS

- The Department of health will set national standards, regularly inspected by the independent Commission for Health improvement.
- The National Institute for Clinical Excellence (NICE) will ensure cost effective drugs are available to all
- Local NHS organisations that perform well for patients will be given greater autonomy; those underperforming will be subject to government intervention
- New Care trusts will commission health and social care in a single organisation – the first time the NHS and social services have come together
- GPs and hospital consultants will have new contracts, based on quality of service and increased productivity. New consultants will work full-time for the NHS and not be permitted to work in the private sector for (perhaps) 7 years.
- Nurses will have greater opportunity to extend their roles – half will be able to prescribe medicines by 2004. 1000 nurse consultants and consultant therapists posts will be created.
- Patients will have more say in the running of the NHS
- Partnerships with the private sector – where value for money is demonstrated – but available at no cost to patients

**How patients will benefit:**

- Reduced waiting times for treatments as new staff are recruited – see a GP within 48 hours (by 2004), and maximum outpatient waiting times three months by 2005
- Improved services for cancer, heart disease and mental health: expanded cancer screening services and provision of cancer drugs, rapid access chest pain clinics (2003) and the creation of quick response mental health teams.
- The elderly: nursing care in nursing homes will be free, national standards for the care of the elderly and a £900 million package of new intermediate care services (by 2004)

**A national inequalities target** – to address the inequalities in health in the country:

- Increase and improve primary care in deprived areas
- Screening programmes for all women and children
- Smoking cessation services
- Improving the diet of children aged 4-6– fruit freely available in school

Three editorials from the two leading UK Medical Journals are summarised below. The British Medical Journal (BMJ) and the Lancet reviewed the NHS plan on 5 August, and in an editorial on 12 August the BMJ fears that the plan heralds the end of the NHS commitment to services free at the point of delivery. The full version of the NHS plan may be downloaded from the NHS internet site: <http://www.nhs.uk/nationalplan>

Reviews of recent articles relevant to health sector reform from the British Medical Journal, the Lancet and other key journals may be found on our website <http://www.ihsd.org>

The Lancet: The NHS plan; promises that fail the most vulnerable  
*Ed: Lancet 2000; 356: 441*

In response to successive organisational failures the NHS plan sets new targets for numbers of hospitals, beds, doctors, nurses, midwives and therapists. Health expenditure is to be increased by a third over the next five years. The plan is “designed around the needs of the individual patient”. A reasonable test is to see how the plan will meet the needs of the most vulnerable – the elderly, the poor and children.

The elderly will benefit from a standards commission monitoring domiciliary and residential facilities, a retirement examination and additional screening programmes. Intermediate care will be strengthened, and all nursing care will be provided free of charge in intermediate care institutions, although personal care will not be funded. 35,000 patients will benefit from free nursing care, but 100,000 will no longer benefit from free personal care, therefore increasing individual’s financial burden. Worse, patients with considerable personal care needs, for example, those suffering from dementia, will not be helped.

For the poor, national targets on inequalities will be set, and evaluated. There will be incentives to address the inequalities in the provision of primary care services, with extra payments to locate and retain medical staff working in deprived areas. No arrangements will be completed until 2004 – an unacceptable delay.

Children benefit little. There are no new initiatives except the provision of a free portion of fruit for nursery and primary school children (aged 4-6). This will not address the three-fold variation in infant mortality rates according to geography, social class and ethnicity. Yet children and adolescents make up a quarter of the UK population.

Unless the elderly, the poor and children are given greater medical and social protection, the NHS cannot be said to be universal, comprehensive or patient-driven

The British Medical Journal: The NHS plan  
*Editorial BMJ 2000;321: 315-6 5 August*

The significant injection of money, and a comprehensive plan for the NHS are welcome, clearly reflecting messages coming from staff and public in the recent consultation exercise. Capacity, standards and targets, delivery and partnership stand out. Capacity will undoubtedly increase; standards and targets, skewed towards increasing responsiveness to patients, may be achieved, but will be dependent on GP referrals “remaining broadly in line with the current trend” – need for more systematic gatekeeping by GPs. This will involve the introduction of tighter guidelines and clinical priority scoring systems.

Delivery of services is more difficult. A Modernisation Agency will be based in each region, as well as a Modernisation board to oversee the plan’s implementation. In addition, at least 10 task forces to drive implementation in key areas will be established. How will these organisations work together? What is the new role of the NHS Executive? Performance of local NHS organisations will be classified using a traffic light system: green, the best performers, will receive extra money and autonomy; yellow, not so good, will attract more scrutiny from the Modernisation agency; red, poor performers, will be managed by a number of bodies. Who will be in charge locally? Where will the extra cash go? Incentives to reward improved delivery are likely to be small compared with those to boost capacity. Management costs are to be cut by 2004; will this provide enough incentive to make people work more effectively?

The government has a contradictory attitude to partnerships. There is a concordat with the private sector to provide cost-effective services for the NHS, yet newly qualified consultants will not be allowed to perform private practice for seven years. Partnerships with the public, and closer integration between health and social services will allow the new care trusts to commission and deliver primary community and social care.

If the NHS is not to slip back after this boost in funding (which is unlikely to be sustained long-term), we should be more open to thinking about alternative forms of finance, so far discounted in the plan. For now, the plan is good news for the NHS.

British Medical Journal Editorial 12 August  
*Will intermediate care be the undoing of the NHS?*  
Pollock A. Ed. *BMJ* 2000; 321: 393-4

The NHS plan spells out the government’s commitment to the principles of a universal comprehensive health service. However, for the first time, the NHS will levy charges for the personal elements of care; the NHS commitment to services free at the point of delivery no longer holds.

This has arisen from the proposed creation of 7000 new NHS beds by 2004, 5000 of which will be “intermediate”, bridging the gap between hospital (freeing up acute beds) and home; providers will include private nursing homes and cottage hospitals.

The NHS, from 1 October, is committed to meet the costs of nursing care in nursing home residents, but not the charges for personal care. Many of the 160,000 nursing home residents in the UK will benefit, but 8%, whose care is currently being fully funded, will be worse off. It is anticipated that 270,000 patients will move into intermediate beds each year; under the new scheme, all could be made to pay for their personal care. Under the new plan, the new care trusts will commission and deliver both primary and

community health care, as well as social care. They will define NHS care and social care, with the latter elements subject to local authority charging policies. Defining the boundary between nursing and personal care is not easy; there is a real concern that primary care trusts will reduce NHS provision if financial savings are to be made. Coupled with the recent expansion of private nursing and residential care (encouraged by the government allowing residents to use income support to meet the costs of care), it is likely that the intermediate care market will be funded out of user charges.

This represents a fundamental change in the way health care is delivered in the UK; the NHS will no longer be universal or comprehensive. Until now, the NHS has pooled the cost of care across the whole population, but devolving unified budgets to primary care trusts will reduce the size of the pool, passing on the liability to small institutions. Trusts could minimise their financial risks either by selecting patients, or by contracting with the private sector (where charges may be levied).

The funding mechanism governing the payment of providers in the NHS is critical. There are three possible mechanisms: reimbursement based on levels of service provision; an unadjusted per capita reimbursement (devolving the risk to the provider); an adjusted per capita reimbursement based on dependency levels of individual patients. The third option is advocated by the World Bank who advocate a move away from systems with universal risk pooling towards targeted, risk adjusted capitation payments (typical of private voluntary insurance). There are dangers. In the US, providers have not been obliged to spend the extra payments on patient care, or maintain staffing levels (resulting in staff expenditure in long term settings of 37%, compared with 65% in the NHS). In Australia, similar reductions in numbers and the skills of care staff have been reported.

The government must not allow this to happen. The risk pooling model of universal provision must be restored by bringing the nursing and care elements of the workforce in the private sector under NHS control. Bricks and mortar may be owned and operated by the private sector, but clinical services must remain under the control of the NHS

*John James, September 2000*

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