WORKING FOR DRUG USERS?

Drug services and the NHS review

When health services go to market, will caring for drug users become an unmarketable commodity?

Mike Blank

AFTER A YEAR of indecision and dithering the government finally went for broke earlier this year when at the cost of a mere £1 million it launched its plans for reform of the NHS. Its *Working for Patients* white paper is being paraded as a review designed to produce a leaner, fitter NHS which offers shorter waiting lists and greater customer choice.[1]

Yet almost without exception the plans have been greeted with anguish and derision. August bodies such as the British Medical Association are "convinced that many of the proposals would cause serious damage to NHS patient care, lead to a fragmented service and destroy the comprehensive nature of the existing service".[2] The BMA has been joined by the Royal College of Nursing, various royal medical colleges and numerous other institutions which consider the white paper to be a recipe for disaster.

At first the plans were presented as a *fait accompli*. But in the face of the public concern aroused by such determined criticism, the Department of Health has appeared to moderate its line. Although there is no formal consultation exercise underway, there are signs that the department is prepared to compromise on some issues and may now welcome some comments from interested parties. Comments were due to be in by the end of May before the primary legislation begins to be drafted in June or July. But even after this date fine tuning may be possible and how the national legislation is implemented at local level may be influenced by local pressure.

Throughout the papers the words 'drug users' don't make an appearance. But, to be fair, the needs of other small groups of people who use the NHS heavily (for instance, those with chronic conditions such as diabetes) don't get much of a look-in either. We can only attempt to crystal-ball-gaze what the consequences might be for such groups on the basis of the sketchy outline of the overall service so far available.

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The white paper's primary aim is to introduce market forces into the NHS. The Tory tenet that competition encourages efficiency and a higher quality of service is now being applied to health care — and by 'efficiency', this government means 'cost-effective'.

So before considering the details of the proposals it is important to ask whether cost-effectiveness equals a high quality of service. Caring for drug users is expensive. One of the major requirements is to establish a trusting relationship. This takes time and skill, and in the post-white paper NHS, time will mean money out of somebody's limited budget. With a ceiling on costs it's being suggested that competition between service providers may concentrate on economy in a way that jeopardises quality.[3]

Drug users are resistant to packaging and hence a financial risk for all concerned

According to the psychiatrist Philip Maclean in his recent address to the SCODA AGM,[4] the white paper is essentially about introducing management systems to reduce the waiting lists for 'cold' surgery (ie, non-emergency work which can be done at a convenient time and place) such as hip replacements. Unfortunately, these systems will be applied to other areas within the NHS to which they are clearly inappropriate. You can't process drug users in the way that you process bunion removals.

The fate of chronically ill patients, especially those subject to unpredictable and possibly expensive relapses, is a central concern. In its response to the white paper, even the National Association of Health Authorities, which supports the creation of a health services market, was concerned lest "the emphasis on acute services in the white paper led to a neglect of long-stay and other priority services".

To be specific we need to look at some of the plans in more detail. Eight working papers flesh out the main areas in the white paper. All these papers will impact on the care of drug users, but the ones likely to have most effect deal with hospital services and with general practice.

Selling treatment to hospitals

Hospital services are dealt with in the working papers on *Self-governing Hospitals* and on *Funding and Contracts for Hospital Services*.

The first of these encourages hospitals and in some cases community units to opt out of health authority management control. Health authorities will contract with these newly independent hospitals to provide set services for their catchment populations.

This could have profound implications for drug users. A health policy analyst has made the point that "services offering clear revenue earning potential will become more attractive ... Providing long-term care for the mentally ill and ... chronically sick may hold less attraction as a source of revenue."[5] Somewhere in the latter category are drug users, resistant to packaging as uniform units susceptible to clear contractual arrangements, and hence a financial risk for all concerned.

If self-governing hospitals do opt out of treating dependence, this can only result in a lower uptake of services by drug users reluctant to travel at a time when it is vital that as many users as possible get in touch with drug agencies. In addition, pressure on remaining drug dependency units to be cost-effective (ie, reduce waiting lists and see more users) may result in 'revolving door' methods of care as they attempt to shoe-horn drug users into a contractual framework. This last point applies also to hospitals that stay under health authority management, as these too will provide services along contractual lines to their own authority and to any other authority they can sell to.

Will more GPs just say no?

Working papers three and four deal respectively with "practice budgets" and "indicative prescribing budgets" for GPs. The practice budgets plan is the one which has received the greatest publicity and which causes most worry to providers of services to drug users, whether in the voluntary or statutory sectors.

Basically it will allow larger GP practices (11,000 patients or more) to take control of their own budgets including allocations for the drugs they prescribe and the hospital services they

refer patients to. Government has been quick to reassure both GPs and the public that no practice will be allowed to run out of money, but the suspicion remains that your doctor will be examining you with one eye and the bank statement with the other. This suspicion is reinforced when one takes in to account the fact that GPs will be able to plough back a proportion of any underspend in to their practices. So for the first time in modern NHS history a doctor's relationship with his patient will have financial as well as medical implications.

GPs who are budget holders will contract for hospital services in much the same way as health authorities, though with less clout. How many will stipulate dependency treatment in the contract, and how many of these will be in a position to assess the quality of the treatment on offer? In a field where there is no agreement over what constitutes good or bad care, might GPs simply choose on the basis of how big a slice it will take out of their budget?

Many drug agencies have spent the last few years diligently building up relationships with local GP practices, particularly where local hospital services are sparse or non-existent. Despite the government's protestations to the contrary, it seems possible that GPs with their own budgets will be increasingly reluctant to take on or treat people with drug problems.

Introduction of indicative prescribing budgets may spread this reluctance across GPs as a whole. The problem seems particularly acute when we consider prescribing injectables to those unable to stop injecting.

Methadone ampoules at £0.53 a time are not cheap. That means an average cost per patient per week of perhaps £15, or £750 a year. Doubtless the doctor's family practitioner committee will encourage them to swop the patient to oral methadone (10p for an equivalent strength swig) at the earliest opportunity, whether they're ready for it or not. This would only result in users increasing their illicit injecting behaviour, with potentially disastrous results vis-a-vis AIDS.

Talking of AIDS, drug users who are HIV positive or who require treatment for ARC or AIDS aren't cheap either. The thought of GPs becoming increasingly reluctant to take on drug users is worrying drug agencies in both the voluntary and the statutory sectors.

Any further restrictions on GPs' rights to prescribe as they see fit may see an increasing reluctance to be led by the users' needs rather than to follow the needs of the budget. Some GPs, for instance, are prepared to prescribe Palfium or other types of opiate where methadone is not an option — will they still be able to do so?

The relevant working paper says yes: "The scheme will be structured in such a way that patients will always get the drugs they need. It will take full account of the fact that some patients and groups of patients, eg, elderly people, diabetics, patients on home dialysis, need a greater volume of drugs than others."

All well and good, except that in the same paragraph it says: "Some prescribing is wasteful or unnecessarily expensive. The objective of the new arrangements is to place downward pressure on expenditure on drugs in order to eliminate waste." Is prescribing an 'expensive' drug to a drug user in order to assist him or her to avoid AIDS a waste?

Opportunities

The above examples highlight some of the concerns workers and users of drug services must have about the NHS restructuring. Yet, despite the potential disasters, there are also potential opportunities for services for drug users.

Health authorities will be slimmed down to managing boards purchasing the most cost effective care they can find for their resident populations. They will be responsible for providing a "comprehensive range of services". Crucially, these are to include certain "core" services which must be available locally. Mechanisms will be set up to prevent self-governing hospitals opting out of providing these services if they are the only feasible suppliers.

The white paper does not exactly define what it means by 'core services' — these are to be decided by each health authority depending on local circumstances. But among the categories within which core services would fall are "public health, community-based services and other hospital services which need to be provided on a local basis, either as matter of policy ... or on grounds of practicability".

There is no doubt that the government still sees the provision of services for people with drug problems as a high priority. This is the first government in modern times to take the problem of drug misuse seriously and to pump significant amounts of money into both the statutory and voluntary sectors.

Given this it is highly unlikely that it will take the politically damaging step of allowing funding to be reduced or withdrawn. Drug services are likely to continue to be protected by earmarked funding and by instructions to regional health authorities such as that issued in 1986 which stipulated that every health district should have advice and counselling services and access to a hospital-based consultant.[6]

The opportunity exists for drug agencies to persuade the government at a national level and health authorities at local level to include drug services as part of the core services and to take account of drug users' care and prescribing needs in setting GPs' budgets. Indeed it is vital that they do so. For drug services to be reduced to providing a peripheral service within the NHS, fighting with other services for the residue of money not allocated to core services, can only result in poorly funded services losing clients. The result could be an increase in HIV as users are forced back on to the streets through lack of help or the need to travel long distances.

Government isn't automatically going to stipulate that drug services need to become part of the core services and some health authorities most definitely don't like the idea of providing services for drug users at all. Government and health authorities must be informed of the need for the proper provision of services for drug users, but time is running out. National organisations such as SCODA and the Advisory Council on the Misuse of Drugs must lobby the Department of Health and lobby it hard in order to ensure drugs are in the core services.

At a local level we have to be certain that every contract provides for the appropriate care of users — and that means quality of care which isn't just tied to expenditure but also takes account of the very special needs of our client group.

In drugs work the voluntary sector and the statutory sector are inextricably interlinked. The NHS white paper will affect all of us and it is up to all of us to ensure that the health authorities and the government continue to provide adequate services for drug users. There is a great potential for harm in this white paper, but there may be a potential for good — at least for our clients. ■

1. UK government. *Working for Patients*. HMSO, January 1989.
2. BMA. *Special report on the government's white paper Working for Patients*. BMA, 1989.
3. Ray Robinson. "Self-governing hospitals." *British Medical Journal*, 25 March 1989, p.437-9.
4. Dr Philip Maclean. Speech to SCODA AGM, 1 April 1989.
5. Ray Robinson. "New health care market." *British Medical Journal*, 18 February 1989, p.819-821.
6. DHSS. Health Authority Circular HC(86)3, February 1986.

Further information

◆ For the official line consult the white paper itself: *Working for Patients*, CM555, HMSO, 1989. £8.80.

And for (a little) more detail, the working papers, all published by HMSO in 1989:

1. *Self-governing Hospitals*, £2.80.
2. *Funding and Contracts for Hospital Services*, £2.80.
3. *Practice Budgets for General Medical Practitioners*, £2.80.
4. *Indicative Prescribing Budgets for General Medical Practitioners*, £2.20.
5. *Capital Charges*, £2.60.
6. *Medical Audit*, £1.90.
7. *NHS Consultants: Appointments, Contracts and Distinction Awards*, £1.90.
8. *Implications for Family Practitioner Committees*, £1.90.

The full set of eight working papers are £8. All these documents are available from HMSO. Prices inc. p&p.

◆ For the potential impact on drug services, see the papers prepared for the the AGM of the Standing Conference on Drug Abuse (31 March-2 April 1989). One paper outlined the government's plans and a second listed the questions these raise for drug services. See also the report of the AGM's discussions on the white paper in the *SCODA Newsletter*, May/June 1989. Contact SCODA's Policy Officer Rosemary Morle on 01-831 3595.

◆ On the implications of statutory bodies contracting out services to voluntary agencies, contact the National Council for Voluntary Organisations who have helped set up a working group on contracting out. This group produces a bulletin for voluntary projects — order from Nazma Hallim, NCVO, 26 Bedford Square, London WC1B 3HV, phone 01-636 4066.

◆ ISDD's library holds a file including the NHS white paper and associated working papers plus responses to these from the BMA, National Association of Health Authorities, etc, and comments in the medical press — phone 01-430 1991.