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# Editorial

# The British Health Service reforms and elderly care

The British Government wishes to transform the National Health Service (NHS) into a market system, with contracts being made between providers of health care (hospitals) and purchasers (general practitioners/health authorities).

At present, district hospitals are accountable to their local population, providing a free and basically comprehensive service; clinical decisions are made according to medical need and administrative costs are low (5%). This will all change, with hospitals concentrating on profitable services, clinical decisions being based on finance and high administrative costs (15–20%) diverting money away from patient care.

The implementation of a market system requires accurate financial information. This is not available. Further, contracts for elderly care are impracticable since outcome is utterly unpredictable (variables include concomitant medical, psychological, psychiatric and social conditions, plus the aging process itself).

The reforms require GPs to control budgets and hospitals to be run by self-governing trusts (SGTs). The latter will negotiate contracts with 'purchasers', including the private sector and medical agencies abroad. Priority will be given, as in the USA, to the 'haves' rather than the 'have nots'.

In the community, frail elderly people may well have difficulty registering with GPs either because they are costly in terms of health care or are work-intensive (without financial reward). GPs may also be reluctant to pay for hospital referral, day hospital attendance, respite care etc., and 'expensive' elderly patients living at home may be encouraged to move into nursing homes, thus transferring costs to local authorities. Inadequate financial incentives will ensure that only limited medical care is available in such homes.

In hospitals, a prime purpose of SGTs will be financial success. Profitable contracts will be sought and here elderly care will be uncompetitive; it is time-consuming, labour-intensive and 'low-tech', with relatively slow turnover. Also, in supply and demand terms, there are many elderly care departments with which 'purchasers' can negotiate. Thus, in a cash-limited NHS the elderly will be low money-generators and will occupy the lower rung of a two-tier system. Money cannot be transferred from profitable departments to support struggling departments and geriatricians will have to maximize income by increasing throughput, minimizing rehabilitation and not allowing patients to overstay 'contracted' bed days. (No money = no treatment.)

The elderly have multiple pathologies and as hospitals stop providing a comprehensive service patients will have to travel to different centres for treatment. Continuity of care will be jeopardized, as it will when contracts are not renewed because 'better' (e.g. cheaper) contracts are offered. The quality of medical care will depend on where a person lives, the most deprived being those living near hospitals which fail in the competitive market, for all services will then be run down.

Mistrust of the Government is considerable. It

refuses to acknowledge the fact that the NHS is underfunded; it ignores both the suffering in America from 'market medicine' and the grave misgivings expressed about the reforms by the BMA and all the royal colleges; it also denies an unwritten agenda of privatizing the NHS (despite privatizing continuing care, promoting privatized domiciliary services, allowing SGTs to negotiate private contracts and introducing tax relief for private medical insurance).

Sadly, the increasing elderly population in the UK will experience a marked deterioration in health care.

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