Saturday 12 August 2000

BMJ

Will intermediate care be the undoing of the NHS?

Here's another bit of covert privatisation

The government has won praise for its new plan for the NHS,[1] where it reaffirms its commitment to the principles of a universal comprehensive health service. Yet for the first time in its history NHS bodies will be able to levy charges for the personal elements of care. The commitment to services free at the point of delivery is absent from the NHS plan.

Following the National Beds Inquiry[2] the government has announced the creation of 7000 extra NHS beds by 2004, 5000 of which will be intermediate care beds and 1700 non-residential places. Intermediate care will "build a bridge between hospital and home" to speed discharge from acute care and provide a range of recovery and rehabilitation services. Cottage hospitals, private nursing homes, and domiciliary and community settings will form the heart of the new intermediate sector. What has received less attention is how these services will be funded.

In the plan the government also published its response to the Royal Commission on Long Term Care.[3] From October 2001 the NHS is committed to meet the costs only of nursing care for nursing home residents; personal care will be charged for. This means that in future nursing care will be free for all of the 160 000 nursing home residents in England who need it, but many other patients may be financially worse off. The future position over the funding of personal care of the 8% of nursing home residents who currently have their care package fully funded by the NHS is unclear[4]—as is the funding of personal care for the 270 000 NHS patients expected to move annually from hospital into intermediate care.

Under the plan, new care trusts will be able to commission and deliver both primary and community health care as well as social care. These trusts (single, multipurpose legal bodies) will hold capped, unified budgets. They will define what is NHS care and what is social care, with the social care elements subject to local authority charging policies. But there is inevitable debate about the boundary between nursing and personal care—when does a bath move from being personal care to nursing care?—and the concern is that leaving the decision to cash strapped primary care trusts will result in reduced NHS provision. In the absence of clear national guidance, the only redress against unfair decisions will be legal action against individual trusts.

Because they can levy charges for personal care, primary care trusts will have clear financial incentives to shift intermediate care into non-NHS settings. The likely result is that intermediate care will follow the same trajectory as long term care in the 1980s.[5] Then, the UK government pump-primed the massive expansion of private nursing and residential care by allowing patients in such accommodation to use income support to meet the costs of care. Patients in local authority and NHS accommodation could not claim income support for this purpose, so local authorities encouraged residents to opt for the private sector and thus released funds for themselves through reducing expenditure and selling assets.[6] The main difference between the two cases is that the expansion of the private residential and domiciliary intermediate care market will be funded mainly out of user charges, not social security.

These measures will fundamentally change the principles under which English citizens receive health care. The NHS will cease to be a universal, comprehensive service. The NHS pools the costs of care across the whole population, so that no individual or institution is liable for the risks and costs of care. Devolving unified budgets to primary care trusts reduces the size of the pool and devolves some of the risks to these small institutions. Trusts can minimise their financial risks either by selecting less risky patients or, more likely, by contracting with the private sector, where user charges can be levied.[7] Private providers minimise their risks, as they always have, by accepting less risky patients or levying higher charges.

In such a situation the funding mechanism governing the payment of providers will be critical. It will signal the government's intent about the principle of universality in the NHS and determine the ability of the new National Care Standards Commission (legislated for in the Care Standards Bill last week) to protect the public against poor quality care in the private sector. Three methods are open to the NHS: reimbursement based on levels of service provision (mainly staffing and equipment); an unadjusted per capita reimbursement, which effectively devolves risk to the provider; or an adjusted per capita reimbursement based on the dependency levels of individual patients. The long term care industry prefers the third option, as does the World Bank, which advocates a move away from systems with universal risk pooling such as the NHS towards targeted, risk adjusted capitation payments typical of private voluntary insurance. Yet such systems have dangers, as experience in the United States and Australia shows.

BMJ 2000;321:393–4

In the US providers have not been compelled to spend the extra money they receive for higher dependency patients on patient care. Nor have they been required to maintain higher levels of staffing: in US long term care settings 37% of expenditure is on staff; in the NHS the figure is 65%.[8 9] The US experience also shows how tying reimbursement to levels of disability can provide perverse incentives for homes to accept residents who are more disabled and allow them to become more so.[10] A similar picture is emerging in Australia.[11] Before 1997 a set percentage of the funding received by care home owners had to be spent on care and could not be diverted to non-care staff, capital maintenance, or profit. This requirement was removed in 1997, and staffing levels have since fallen, with experienced nurses being replaced by those who are less costly to employ. This has led to scandals about the quality of care and claims by the Australian Nursing Federation that the industry is facing a quality of care crisis.[12]

A government committed to a universal, comprehensive, high quality NHS would not embark on this path. It would restore the risk pooling model of universal provision by bringing the nursing and care elements of the workforce in the private sector under NHS control. This would bring it into line with its policies for the rest of the NHS, where under the private finance initiative bricks and mortar are owned and operated by the private sector but clinical services remain under the control of the NHS.

Allyson M Pollock *professor*

Health Services and Health Policy Research Unit, School of Public Policy, University College London, London WC1H 9QU

1 Secretary of State for Health. *The NHS plan: plan for investment, a plan for reform*. London: Stationery Office, 2000.
2 Department of Health. *Shaping the future NHS: long term planning for hospitals and related services: consultation document on the findings of the National Beds Inquiry*. London: Department of Health, 2000.
3 Secretary of State for Health. *The NHS plan: the government response to the Royal Commission on Long Term Care*. London: Stationery Office, 2000 (CM4818-II).
4 *Laing's health care market review 1999/2000*. London: Laing and Buisson, 1999.
5 Klein R. Big bang health care reforms: does it work ?: The case of Britain's 1991 NHS reforms. *Milbank Quarterly* 1995;73:299-337.
6 Harrington C, Pollock AM. Decentralisation and deprivatisation of long-term care in UK and USA. *Lancet* 1998;351:1805-8.
7 Pollock AM. The American way. *Health Service Journal* 1998;9 Apr:28-9.
8 *The guide to the nursing home industry 1998-1999*. Baltimore: HCIA and Arthur Anderson, 1998.
9 Shaoul J. Charging for capital in the NHS trusts: to improve efficiency? *Management Accounting Research* 1998;9:95-112.
10 Harrington C, Carillo H, Thollaug SC, Summers PR, Wellin V. Nursing facilities, staffing, residents and facilities deficiencies 1992 through 1998. San Francisco: Department of Social and Behavioral Sciences, University of California, 2000.
11 Fine J, Chalmers J. "User pays" and other approaches to funding long term care for older people in Australia. *Aging and Society* 2000;20:5-32.
12 Illiffe J. Achieving quality in aged care. *Australian Nursing Journal* 2000,7:1.

Controlling glucose and blood pressure in type 2 diabetes

Starting treatment earlier may reduce complications

Papers pp 405, 412

Strategies for treating disorders of public health interest such as high blood pressure, dyslipidaemia, and hyperglycaemia have been debated ever since they were considered to be conditions for medical interventions. The main questions have been when should we start treatment, what is the target level during treatment, and what is the best method of treatment? Since there are no obvious cut-off points for blood pressure or glucose or cholesterol concentrations that would guide clinical decisions, the justification must come from clinical and epidemiological research.

Data from randomised clinical trials are considered necessary these days for defining treatment practice, but there are limits on the generalisability of their results.[1] These results are important in proving causality between risk factors and outcomes and in showing the reversibility of the disease process by therapy. Observational data, on the other hand, are needed to describe the target population included in the trials and thus to inform doctors how the trial results may be best translated to the community. This is particularly important for defining treatment strategies in disorders where many patients are asymptomatic, such as type 2 diabetes, hypertension, and dyslipidaemia.

The evidence from previous clinical trials has established that it is beneficial to treat hypertension and hypercholesterolaemia.[2 3] Only recently have the results of randomised controlled trials shown the benefit of reducing blood pressure in isolated systolic hypertension.[4 5] Comparisons with observational data have shown, for instance, that antihypertensive drugs reduce the risk of stroke as predicted, but the reduction in the risk of myocardial infarction is less than expected.[2] Treatment of hypercholesterolaemia with statins reduces the risk of myocardial infarction as predicted, whereas the effect on the risk of stroke seems to be larger than expected.[6]

The good news from the United Kingdom prospective diabetes study (UKPDS) in this week's *BMJ* (p 412) is that patients with type 2 diabetes whose hypertension is tightly controlled reduce their risk of macrovascular complications to a greater extent than estimated by observational analysis.[7] Also, in the Systolic Hypertension in Europe trial antihypertensive treatment in patients with diabetes with isolated systolic hypertension got rid of their excess cardiovascular risk related to diabetes.[8]

There are recommendations about the target levels for glycaemia, blood pressure, and lipids in the treatment of patients with type 2 diabetes.[9] These are based largely on expert opinions, with only limited evidence from trials. The degree to which these target levels can be reached depends mainly on two factors: the intensity of treatment and the level of these variables at the start of treatment. The epidemiological data clearly show that there are no natural thresholds under which the risk of microvascular and macrovascu-

BMJ 2000;321:394–5