Does the district general hospital have a future?

Chris Ham

Increased patient choice and a bigger role for the independent sector threaten the future of district general hospitals. As the public remains firmly attached to these hospitals, a managed transition represents a huge political challenge

It was in 1962 that Enoch Powell, then minister of health, published the *Hospital Plan for England and Wales*.¹ The plan served as a framework for the development of hospital services in the decades that followed, leading to the building of many new hospitals and the refurbishment of others. At the heart of this framework was the district general hospital, designed to provide a comprehensive range of inpatient and outpatient services to populations of 100 000 to 150 000. District general hospitals have formed the backbone of NHS hospital care ever since.

Today, many of these hospitals face an uncertain future. The uncertainty has arisen as a result of advances in healthcare technology enabling more specialist services to be provided outside the hospital, changes in the workforce (particularly a reduction in the hours worked by doctors in training), evidence that some services are better concentrated in fewer centres able to achieve superior outcomes, and government policies designed to increase patient choice and stimulate greater efficiency in the use of resources. Here, I focus on the effect of government policies.

Market reforms

The over-riding objective of health policy since the election of the Labour government in 1997 has been reducing waiting lists and waiting times for treatment. In pursuit of this objective, the government has procured extra treatment capacity and introduced reforms to increase patient choice. These reforms include a new approach to funding hospitals, payment by results, under which money will follow patients to the hospitals of their choice. Patient choice and payment by results create the conditions in which hospitals will compete with each other for income, with independent sector providers co-existing with NHS hospitals in the emerging market. The devolution of budgets to general practices adds to the pressures facing hospitals by creating incentives for primary care providers to manage demand for care by providing patients with alternatives to hospital.

Treatment centres

Extra capacity has been obtained partly by launching free standing treatment centres. By the summer of 2005 over 50 centres had been established, 36 of which were run by the NHS and the rest by the independent sector. The number of centres is expected to increase to 80 by the end of the year. Treatment centres do surgical work that is simple and repetitive and does not require the full facilities of a district general hospital. Some centres are also providing diagnostic services, and more diagnosis will be supplied by the independent sector as part of the government's next

procurement of treatment centres. With up to 15% of elective surgery and 5% of diagnostic services (more in the case of magnetic resonance imaging) to be provided by the independent sector, district general hospitals will find their share of these markets increasingly under challenge.

Patient choice

Extra surgical and diagnostic capacity has facilitated greater patient choice. The government has enabled patients waiting longer than six months for surgery to choose to be treated at hospitals able to offer care more quickly and has announced plans to offer patients choice at the point of referral by general practitioners. The aim is that from the end of 2005 patients should be offered a choice of four or five local NHS providers as well as all NHS foundation trusts and independent sector treatment centres. By 2008, patients will be able to choose from any provider able to deliver services to NHS standards and at the NHS tariff.

In the pilot programmes offering choice to patients waiting longer than six months, around two thirds of patients waiting for a range of surgical procedures in London and 50% of patients waiting for heart surgery across England opted for treatment at another hospital. Although it remains to be seen how many patients will choose an alternative to their local NHS hospital as waiting times come down, an indication of what might happen can be gleaned from a survey conducted by MORI for the Birmingham and Black Country Strategic Health Authority.² Around 30% of those surveyed said they would prefer to use a private hospital. The reasons cited for the use of private hospitals centred on perceptions that these hospitals provided higher standards and better quality of care.

This article is part of a series examining the government's planned market reforms to healthcare provision

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The public feels strongly about local hospitals

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Movements of patients on this scale to the independent sector will create instability for many district general hospitals.

Payment by results

Choice will be facilitated by payment by results, the new funding system under which money will follow patients to hospitals. This will create competition for patients. Competition between hospitals will not be based on the cost of treatment as the government is fixing prices through a national tariff. Rather, hospitals will compete on the basis of their accessibility and quality.

Experience in other countries indicates that one of the consequences of fixed prices is that providers seek to reduce the length of stay of patients in hospitals in order to cut costs. Payment by results will also create stronger incentives to substitute less expensive forms of care, such as day surgery and outpatient treatments, for inpatient care. When fully implemented, payment by results should stimulate greater efficiency in the use of NHS resources.

It may also have the unintended consequence of undermining the ability of district general hospitals to function effectively. If other providers take the simpler cases, competition could leave these hospitals to provide care that is more complex. The interdependencies within hospitals may mean that care for patients who are critically ill is difficult to sustain when some of the simple and repetitive work has moved to freestanding treatment centres. The relaxation of the additional-ity principle, under which independent sector providers were expected to recruit new clinical teams to deliver care, increases this risk. The economics of providing care could also be affected if district general hospitals are less able to subsidise the costs of complex treatments by providing high volumes of elective and diagnostic care. Some services will then become uneconomic and may no longer be viable in hospitals struggling to achieve financial balance.

Practice based commissioning

District general hospitals may also find themselves under pressure from the devolution of budgets to general practices. Practice based commissioning is intended to create stronger incentives for general practitioners to manage the demand for care by offering patients alternatives to hospital. As an example, a report by the NHS chief executive, Nigel Crisp, suggested that up to 15 million hospital outpatient attendances each year, around one third of the total, could be safely and effectively offered in community settings.³ If general practitioners can provide care directly or through cheaper alternatives outside the hospital, they will be able to use the savings to develop services they see as priorities. Experience of fundholding in the 1990s suggests that the incentives in practice based commissioning are likely to result in practices providing a wider range of care.⁴

Practice based commissioning is also designed to help reduce emergency hospital admissions. The NHS has been given a target by the government of reducing the use of emergency bed days by 2008. Although the headline figure is 5%, when allowance is made for expected increases in demand, the reduction is 12%.

A small number of patients use a high proportion of hospital beds, and these patients can be helped to live healthier lives at home through the use of specialist community nurses and the provision of alternatives to hospital. The policy on payment by results means that general practitioners who hold budgets will receive an invoice for every patient admitted to hospital. They will therefore have a financial as well as a clinical interest in ensuring that admissions are limited to patients who need the expensive and specialist services that hospitals provide.

Alternative futures

Taken together, these policies mean that many district general hospitals are about to embark on a period of fundamental change. The shift of some surgical and diagnostic services to freestanding treatment centres, the scope for many outpatient services to be provided in community settings, and the incentive under practice based commissioning for general practitioners to reduce emergency admissions suggests that dealing with spare hospital capacity may soon be a bigger challenge than procuring new capacity. This is already the case in areas of the country such as north west London, where NHS planners have estimated that as many as 600 beds may be surplus to requirements.

In these circumstances, one strategy is for hospitals to compete aggressively to maintain and, if possible, increase market share. The financial commitments built into the private finance initiative create incentives for district general hospitals funded in this way to pursue this approach because they will have to cover the costs contained within contracts that typically extend over 35 years. These incentives will be sharpened by the financial regimen for NHS foundation trusts, under which all district general hospitals are expected to be working by 2008; these require trusts to show good financial performance. The ability of hospitals to pursue a strategy of expansion will be limited, however, when the annual increases in NHS funding revert to the historic trend after 2008 and an increasing number of providers are competing for a more constrained budget.

An alternative and more plausible strategy is for hospitals to reduce or cease some activities and to focus on improving productivity in areas where they have competitive advantage. In essence, this means hospitals cutting their costs by concentrating on providing services for which their performance enables them to attract patients and income. District general hospitals choosing this approach might find advantage in horizontal integration, including partnerships with independent sector providers and collaboration with specialist centres, to enable patients to access care at different sites.

A third strategy is for hospitals to diversify into other services—for example, sub-acute and primary care. Several NHS foundation trusts are already exploring the opportunities to develop vertically integrated models of care. In this respect, there are warning signs from the United States, where in the 1980s some hospitals pursued this approach after the introduction of prospective payment and managed care. Vertically integrated organisations in the United

States found it difficult to bring together the different cultures of hospital medicine and primary care,⁵ with the exception of long established integrated delivery systems such as Kaiser Permanente.

Will it work?

In the NHS of the future, district general hospitals will compete with other NHS hospitals, NHS treatment centres, independent sector treatment centres, and established private hospitals. Planned care, outpatient services, and diagnostic facilities will be available in a range of settings, and primary care providers will develop alternatives to hospital for unplanned care. The services available at most district general hospitals will be more limited than in the past, with the public using other providers for some forms of treatment, both routine and specialist.

On an optimistic reading, it is possible to envisage enhanced primary care facilities and independent sector providers acting as a one stop shop for most forms of care apart from hospital inpatient services. Under this scenario, reductions in the services provided by district general hospitals will be more than compensated for by the provision of a wider range of services outside hospital and by increasing patient choice of providers. Whether the incentives are strong enough for a sufficient number of general practitioners to respond to this challenge is one of the major uncertainties facing government.

On a pessimistic reading, the changes could result in reduced access to services and ultimately hospital closures. Lack of co-ordination between different providers may lead to the withdrawal of essential services in some localities. In view of the iconic status of hospitals in the eyes of the public, government risks huge unpopularity in dealing with the consequences. The decision to commission work on market exit strategies, and to contemplate the possibility of hospital closures, indicates that the new secretary of state for health is preparing for this eventuality.⁶ Whether the deliber-

Summary points

Increased patient choice about where to be treated and a bigger role for the independent sector will create competition between providers

Independent sector providers will concentrate on simpler, elective treatments and diagnosis

Practice based commissioning will lead to some outpatient and other services being provided outside hospitals

Payment by results will increase efficiency but could lead to some hospital services becoming uneconomic

District general hospitals may find it difficult to sustain a full range of services and could be left providing expensive complex care

Managing the effects of choice and competition represents a huge political challenge

ately destabilising effects of current changes can be managed effectively must be doubted.

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Obesity, hunger, and agriculture: the damaging role of subsidies

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Globally, we are producing more food than the population needs. Subsidising overproduction in Europe is affecting the health of people in both Africa and Europe

Being overweight is becoming the norm rather than the exception in most developed countries, and obesity is a serious health problem worldwide.¹ Many people see obesity as a lifestyle issue. However, behavioural interventions to prevent obesity in both adults and children have generally been ineffective,² indicating strong influences beyond individual control. Considerable resources are currently invested in developing drugs to prevent and treat obesity. However, from a

societal perspective, prevention of obesity through diet and physical activity should be given priority for both economic and ethical reasons.¹⁻³ Chopra and Darnton-Hill recently suggested that we need a global strategy on food similar to the Framework Convention on Tobacco Control.⁴ Their suggested actions are mainly aimed at reducing demand for food. But we argue it is equally important to tackle the oversupply of food, driven by agricultural subsidies.

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