The Royal College of Midwives Trust

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19 May 1988

The Rt. Hon. Margaret Thatcher, MP
Prime Minister
10 Downing Street
LONDON

Dear Mrs. Thatcher,

The Royal College of Midwives was pleased to be asked, whilst meeting with Mr. Moore, the Secretary of State, to submit comments to the Cabinet Review Team that is examining the funding and resource allocation for the National Health Service. I enclose these comments.

Yours respectfully,

Ruth M. Ashton

RUTH M ASHTON
General Secretary

THE ROYAL COLLEGE OF MIDWIVES RCM/145/88

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EVIDENCE TO THE PRIME MINISTER'S REVIEW OF THE NATIONAL HEALTH SERVICE

1. The Royal College of Midwives (RCM) has considered both the level of funding of the National Health Service (NHS) and the alternative methods of resourcing which are now under discussion. This paper sets out the College's view on these issues and the way in which they could impact upon the maternity services.

2. The Nation's Health and the Government Role

The College believes that no Government can abdicate responsibility for the health of the electorate. There is firm evidence that factors such as housing, environmental controls, nutritional standards and policies on smoking and alcohol affect health status. The outcome of

pregnancy can for instance be improved as much by enhancing the social environment of mothers as by high-technology medical intervention. The RCM does not consider that it is appropriate to consider the NHS in isolation from wider public health issues and it would urge the Government to review the health implications of their policies in other sectors. Failure to do this is detrimental to the overall level of health in the population and increases the call on the NHS

HEALTH CARE FUNDING

3. The Existing level of Funding

3.1 From the evidence available it is not possible to endorse assertions that the present level of N.H.S. funding is adequate. It is the view of the College that the general inflation factor used is unrealistic in relation to NHS cost inflation. Furthermore the impact of demographic change particularly the increase in the elderly population has been underestimated and the real cost of the Government's own priorities, (e.g. the transfer to community care), has not been accounted for. The

reliance on "efficiency" or "cost improvement" savings to maintain current levels of service or to undertake planned development have placed great strains on services and in many instances have proved counterproductive.

The past two years have seen increasing difficulties as a result of the failure to fully fund agreed pay awards.

On the capital side there has been an inappropriate level of investment in the infrastructure of the health service. The age of many hospital buildings, the poor quality of modern developments, the inability to fund and then utilise national computer and information systems, the changing nature of service provision, the need to accommodate shifts in revenue resources from Region to Region or from programme to programme and the pressures to reduce unit costs all indicate that more capital expenditure could be used effectively by the N.H.S. and should be provided for this purpose. To facilitate this, the College believes there is scope to introduce the use of private sector

borrowing for capital requirements in order to release revenue funds.

3.2 Data from abroad indicates that there is significantly less spent by the Government on health care in this country than our economic position would suggest. It would seem that no matter how health care is funded in the future, it is highly unlikely that the public element of spending can decrease and the College would support the view of many that it is desirable that public spending is increased. Any structural change in the present pattern of provision would undoubtedly entail vastly increased capital expenditure. At present, it would seem that the Government could accommodate increased spending without having to restrict other programmes. The conclusion must be drawn therefore that any further restrictions in health spending are not concerned with priorities or economic necessity but rather the Government's philosophy of the way in which health care should be provided.

4. Funding the Health Service - the national alternative

The College believes that there is still scope for change in the provision of health care within the present tax-funded system. Such a system is the most equitable. Any move away from general taxation would disadvantage low-paid workers and especially women who tend to defer expenditure on their own needs in favour of their children and families. Funding from general taxation is also administratively efficient. At present the administration costs of the N.H.S. compare very favourably with most commercial and charitable enterprises, while alternative systems would entail much higher costs in this respect. However, the College considers that a major drawback to funding from this source is that the level set has become a political decision unrelated to national health needs. It is proposed therefore, that the resource voted to the N.H.S. each year should be determined by a formula based on agreed demographic and other criteria, linked to per capita G.D.P.

5. Other options for funding

The College has examined the range of options being suggested as possible replacements for funding from general taxation:-

5.1 Earmarked Taxes - The College recognises that such funds would not have to compete with other claims on the national purse. However, it would seem administratively inefficient to collect a separate income tax for health, while a move to indirect taxation, such as increased V.A.T levels, would penalise those who at present do not pay income tax. In addition it may well be difficult to set the tax to raise the resources required for the N.H.S. reliably.

5.2 Social Insurance Schemes - (or National Health Insurance Schemes) The College would oppose any flat-rate insurance as estimates suggest that this would take a large proportion of the income of the low-paid and could become a real poverty-trap factor. It would be preferable to seek contributions on an ability to pay basis, although the same argument against an earmarked income tax would apply to a progressive insurance fund. If

such a fund operated the College would wish to see care still free at the point of need. A payment and claim-back system would be expensive to set up, would operate against the most vulnerable members of society and administrative costs would absorb resources which could otherwise be spent on direct health care. Finally, the RCM would oppose any contracting-out mechanism. It is not considered that the private sector can provide at present, or is likely to be able to ever provide an alternative comprehensive system of health care. Therefore, the vast majority are likely to require the N.H.S. at some stage of their lives. Contracting out would tend to be by the healthier and better off members of the population at certain periods in their lives and it is difficult to see how such a fund would operate on an insurance basis with only those less able to pay and most likely to require health care contributing to it. The College is concerned that contracting out, even with the provision of a safety net for those who need care but cannot pay is likely to lead to a two-tier system which would be unacceptable.

5.3 Private Health Insurance - The College recognises that international data suggests there is some scope to increase the contribution from private sources to health care in this country. However, given the present health infrastructure even a very much expanded private sector would not offer comprehensive care and the R.C.M would object to the introduction of a compulsory scheme of private health insurance. An expansion of supplementary or top-up private health insurance would be accepted with reservations. Firstly, any increase in private spending on health care should be matched by an increase in public spending, i.e. the value of total spending on health care should be maximised. Secondly, the effect of increased spending in the private sector should be monitored in relation to outcomes to ensure that resources were not being diverted to unnecessary treatments or higher administrative expenses. An inspectorate could ensure the maintenance of reasonable and comparable standards in both private and N.H.S. sectors. Thirdly, in those areas where the private sector absorbs staff it should provide and/or pay for training places. The College would suggest that if there is any large expansion of the private

sector, the N.H.S. will have to compete for staff and this will entail a realistic review of the pay and working conditions offered to N.H.S. employees. Finally, the College opposes the introduction of tax concessions to encourage the uptake of private health insurance.

5.4 <u>The Private Sector and the Maternity Services</u> - If there is to be an increase in private sector provision there are specific issues affecting the maternity services which the Government must address.

5.4.1 There are good public health reasons for keeping maternity care within the NHS and the RCM continues to support this system; maternity care safeguards the health of the next generation; a system that is not universally accessible, such as that in the United states, often leaves the at-risk mother vulnerable to poor care and has an adverse effect on perinatal mortality rates.

5.4.2 At present all health insurance policies exclude normal pregnancy and childbirth and maternity care

has to be provided by the NHS or paid for by the individual as opposed to the insurer.

5.4.3 Most health insurance covers "complications of pregnancy" and this could be a factor leading to more women having high technology births. There is some evidence that obstetricians are willing to help patients claim from their insurance by generously interpreting the criteria for certain procedures such as caesarean section. This could inflate the overall amount spent on maternity care without producing any comparable benefit in outcome statistics.

5.4.4 It will be essential to establish standards and monitor outcomes to ensure that national maternal, perinatal and infant mortality rates do not suffer. In a system where clients self-select into a variety of facilities - moderately well-off couples might choose to have their babies in pay facilities - it would be difficult to compare the effectiveness of different types of care meaningfully.

5.4.5 The present system that allows a consultant to conduct some private practice whilst holding an NHS contract can result in his being required to make clinical decisions simultaneously in separate locations. In order to minimise the effect of this, provided there is only a limited expansion in private care the private facilities should be in close proximity to the NHS unit. Should there be greater expansion of the private sector, consultant contracts will need careful examination and it may become necessary to separate those who practice privately from NHS consultants.

5.4.6 The RCM believes that there could be a place for some limited expansion in private health care even in the maternity services. The private sector might also be the main source for some advanced techniques, an example being in vitro fertilisation.

6. <u>Other Ways of Increasing N.H.S. Income</u>

6.1 All the suggested ways e.g. contracting of services, sale and leaseback, commercial trading,

part-pay charges, have been examined. The College believes that none of the methods currently under discussion would raise money reliably, uniformly or necessarily where it is most needed, neither do they provide a long term solution to the problem of attempting to provide health care with inadequate levels of national funding. Such activity is also likely to divert limited management resources away from the management of care. In addition certain factors, for example the sale of capital assets, sponsorship, deals with the private sector, can lead to considerable distortion in the planning of service provision. Furthermore, an increase in private facilities within the NHS would require considerable capital and revenue expenditure to improve available facilities and staffing levels if they are to compete with the commercial private sector. It would seem short-sighted to depend on such sources in preference to an adequate level of national funding.

6.2 The College would make comments about two specific suggestions to generate additional NHS income, which it believes would be inappropriate to maternity care.

6.2.1 Part-Pay Charges - The RCM would object to pregnant women being asked to contribute financially to their care. There is a very important public health dimension to maternity care and women should not be deterred from seeking care by being obliged to make any payments.

6.2.2 Sponsorship and Commercial Trading - Mothers with new babies are recognised to be vulnerable to advertising and commercial pressures. The ethical dimension of sponsorship (e.g. by baby food manufacturers) or commercial deals (e.g. with photographers) requires close examination.

7. RESOURCE ALLOCATION

Maternity Services - an acute facility? - The RCM notes that most of the alternative methods of sharing out national resources concentrate on the acute sector because it absorbs the most resources and because a significant proportion of users might be able to contribute to the costs of their care. The maternity services are presently classed as an acute medical service, however there are certain features which distinguish maternity from other specialities:-

- Pregnant women are not ill

- Health education promotion and preventative objectives are major components of maternity care

- There can be no waiting lists

- The majority of care is given in the community, not in acute facilities

- Research would suggest that the majority of women can be delivered without high technology care.

- Outcome data is relatively easy to collect and has been kept since the inception of the N.H.S. although this data has been 'broad-brush' and there is scope for improvement in the collection of data relating to care outcome.

Thus, in many of the proposed arrangements the maternity services need to be dealt with separately in order to ensure an appropriate standard of care.

7.1 Controlling Costs

One of the central features of the alternative proposals for distributing resources is that they focus on cost-containment. The RCM has supported the concept of cost effective care for some years, arguing that maternity services in this country could be provided within the N.H.S. at less cost and more effectively. Particularly within the following areas:-

- eliminating the duplication of midwifery and medical skills (the midwife is the appropriate practitioner for normal pregnancy and childbirth).

- developing and assessing evaluated protocols to ensure that costly high-technology procedures do not slip into standard use.

- ensuring that women receive appropriate care not a standard catch-all package that is largely unnecessary.

- refining outcome data in relation to patterns of care.

7.2 The College has also examined some resource allocation alternatives to see how far they would permit these measures to be implemented. The RCM considers it paradoxical that the Government has shown so little enthusiasm to tackle open-ended medical spending or to ensure that clinical services, as well as say ancillary services, are provided in the most cost effective way. It would view most favourably those proposals which apply a rigorous framework for all health professionals to operate in.

7.3 Funding of Service Plans and Internal Markets - If an approach were adopted which moved away from district self-sufficiency or towards a competing market for health care provision, it would be theoretically possible for mothers to have to travel to a neighbouring district or beyond to have their baby. This would generate problems of accessibility, take-up and continuity of care. The College is of the view that only in exceptional

circumstances should mothers travel any distance to receive care or to be delivered. Maternity should therefore be designated a "core" facility provided by every health district. The College recognises however that certain very specialised functions, such as neonatal intensive care or neonatal surgery will continue to be best provided in sub-regional or regional centres.

7.4 Funding of Costed Workloads - The problem with using Diagnostic Related Groups (DRGs) in the maternity services is that it could reward the tendency to "over treat" women. There would be considerable scope for slipping women into higher risk-groups to attract more money. It is also not clear how the maternity services, which are essentially local, could or indeed should benefit from improved cross-boundary flow payment arrangements.

7.5 Vouchers - The level at which the voucher is set would be unlikely to cover the costs of maternity care. While a separate maternity voucher could be issued there would be many difficulties. Would it, for instance, cover simply normal pregnancy,

childbirth and postnatal care or extend to all risks, including special and intensive care of the newborn?

8. Health Maintenance Organisations (HMO)

8.1 The College finds certain elements of this concept attractive. The contracting of professional staff within well-defined operational procedures, the use of medical audit and utilisation review, the importance of community services and the emphasis given to health education and patient participation in care programmes are all consistent with the College's policies. The RCM would endorse arrangements which enabled groups of professional staff to form partnerships to operate health care shops at primary level and contract their services to an H.M.O type authority. It would also support arrangements which enabled an H.M.O to contract directly with individual professionals such as midwives. Both these options would give midwives a place in the community to practice, along the lines of the Community Midwifery clinics advocated for some time by the RCM. Also, the emphasis on performance review and cost-effectiveness would

strengthen the midwives' ability to assist as many women as possible to experience a normal delivery in hospital, without unnecessary technical intervention. Midwives offer a cost-effective form of maternity care. Finally, the H.M.O's concern to monitor costs at secondary care level would also be an antidote to any drift to a high technology medicalised model of birth. Care would have to be taken to ensure that hospitals contracted by the H.M.O to provide facilities for confinements were local.

8.2 Transferring HMOs to the U.K. Situation - The RCM does not support proposals which suggest basing a UK HMO system on general practitioners. This would offer patients little choice and the focus on a medical practitioner paid by item for service would weaken the cost-control elements which are an important feature of the American prototype. The College finds proposals which envisage the patient registering directly with an H.M.O authority more acceptable. However, the College is seriously concerned with the implications of forward planning for secondary care in a health service which was reliant on a system of freestanding hospitals all

aiming to sell services to HMOs. Arrangements would have to be made to ensure that groups of high-cost patients or more difficult cases were properly catered for.

9. Maternity care in the Future

The RCM believes that with adequate levels of funding and the political will the possibility exists for change within the present system. The College is of the view that wholesale change of the structure of health services in this country will further delay necessary changes to develop a cost-effective and client-orientated system of care. However, no matter how health care is funded or organised in the future the College would only support change if certain principles are safeguarded for the maternity services

- maternity care provision must remain a free at the point of need service in order to safeguard the future health of the nation.

- The care of a woman through the process of childbirth extends through pregnancy, labour and to the post natal period - a time span of some nine to ten months. The process itself represents a normal life event which is based fundamentally within the context of the family. To be meaningful, therefore, any system in which care is delivered should maximise the objectives that care should be as near to a woman's home and family as possible, and should encourage continuity of professional support.

- Whatever health care system prevails it must be designed so that maternity care can more sharply be focused upon the groups who consistently show patterns of poor pregnancy outcome. Not only should this be the aim because of the greater need of these groups, but for a given input of resource such targeting will have the potential for increased marginal improvements in health.

- an integrated midwifery service must be maintained and strengthened; it should be lead by a senior midwife with overall responsibility for coordination and maintenance of standards, in which programmes of continuity of care can be developed.

- maternity care provision must fully recognise that the women requiring the service cannot be stereotyped; they present a range of health, socio-economic, educational and cultural needs which have to be identified and met if the service is to be effective.

- the midwife's role as an independent practitioner must be recognised and facilitated.

ERJ/mm
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