HEALTH CARE UK

1992/93

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an annual review of health care policy

Editor: Anthony Harrison
Assistant Editor: Shirley Bruscini

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INTRODUCTION TO THE 1992/93 EDITION

We concluded last year's Review with the remark that while it was hard to see where policy was going it was 'certainly moving somewhere'. If anything, the events of the past 15 months have served to emphasise that conclusion. Well before the third and fourth wave trusts were created, the Government was assuming they were a success and commentators that some would in effect be planning their own extinction.

In this year's Review, for the first time based on the financial rather than the calendar year, we have attempted once again to describe and assess the main developments in health policy. Compiled as before by Anthony Harrison from contributions from the Institute as a whole and, in the case of the calendar, of events, with the assistance of Joanna Grey-Lloyd of the King's Fund Centre's Information Resources, it aims to describe what has actually happened and also to reflect on some of the wider issues that events within the NHS and the wider world give rise to.

The theme of change continues through the other articles making up this edition of *Health Care UK*. They begin with a series of articles focusing on the balance of care between hospital and community. Over the past ten years that balance has gradually shifted as the government has committed more resources to primary care and as hospitals have reduced their role in the provision of long term care, managing to shift most of the financial burden to social security (and now local authorities) and the task of provision itself to the private sector. But the overall workload, as measured by the number of cases handled, has continued to rise and the total volume of resources absorbed by hospital services continued to rise.

Developments in London during the past year have served to raise the question of whether or not that is desirable. The report of the King's Fund's own commission on acute services in London suggested that the balance should be shifted but it did not aim to provide a blueprint of how it should be achieved. Nor did Sir Bernard Tomlinson's subsequent report for the Government.

The first group of articles, resulting from work carried out within the joint King's Fund/Milbank Foundation policy review of the acute hospital, looks at the scope for transfer in a range of particular services. It begins with maternity and paediatrics, which were both the subject of substantial reviews in 1992, and then goes on to look at two main user groups, elderly people and the mentally ill: Eileen Murphy takes the first, Matt Muijen the second. The final article by John Stilwell takes a different approach, taking a service, pathology, to be found in nearly all large hospitals and considering whether it has to be provided in that centralised way.

Next comes two articles focusing on the task facing those responsible for deciding on health resources should be used. The creation of purchasing authorities has brought to the surface the painful choices which must be made when resources are not sufficient to fund all evident needs. David Hunter considers the value of the concept of health gain, and Ray Robinson the value of the economist's approach, in helping to determine how resources should be put to best effect.

We then take a broader perspective, with three articles looking at the NHS as a whole. In the first, John James attempts to identify the changes within the NHS that are likely to occur over the next five years, while Rudolf Klein takes a backward look at the NHS since its inception and discusses how its central objectives have changed in that period. In the third article in this group, Bill New considers the implications of the 'new' NHS for its accountability, having first set out a comprehensive analysis of what accountability means and the different ways of achieving it.

CONTRIBUTORS

With the exception of the contributors listed below, all the authors work at the King's Fund Institute and can be contacted at: King's Fund Institute, 14 Palace Court, London W2 4HT, Tel: 071-243 8848.

David Hunter is Professor of Health Policy & Management and Director of the Nuffield Institute for Health, 71-75 Clarendon Road, Leeds LS2 9PL, Tel: (0532) 459034.

John James is District General Manager at Parkside Health Authority, 16 South Wharf Road, London W2 1PF, Tel: 071-725 1001.

Rudolf Klein is Professor of Social Policy and Director of the Centre for the Analysis of Social Policy (CASP), University of Bath, School of Social Sciences, Claverton Down, Bath BA2 7AY, Tel: (0225) 826826.

Matt Muijen is Director, Research and Development for Psychiatry, 134/138 Borough High Street, London SE1 1LB, Tel: 071-403 8790.

Elaine Murphy is Professor of Psychogeriatrics at UMDS, Guy's Hospital, London Bridge, London SE1 9RT, Tel: 071-955 4831.

Ray Robinson, formerly Deputy Director of the King's Fund Institute, is now Professor of Health Policy, Institute for Health Policy Studies, Faculty of Social Sciences, University of Southampton, Southampton SO9 5NH, Tel: (0703) 595000.

John Stilwell is Director of the Health Services Research Unit at the University of Warwick, Coventry CV4 7AL, Tel: (0203) 523523.

HEALTH POLICY REVIEW 1992/93

CONTENTS

PART 1 MAIN EVENTS

The return of the Conservatives to power in April confirmed that the direction of change begun in 1991 would continue. Furthermore, Labour's new health spokesman, David Blunkett, announced in September that it had softened its opposition to the reforms. For this Parliament and possibly beyond, the general direction of change is clear.

And so in the first section of this year's Review, we record the steps the Government took to implement the reforms for which the foundations were laid last year. This year, however, we pass more quickly than last over the introduction of trusts and GP fundholding to consider in more detail the second leg of the reforms, the development of community care. Policies for implementing it were just beginning to shape up in 1991, but during 1992 were in active preparation for the due commencement date, April 1993.

We then look again at London. Last year the overcapacity within central London hospitals was already apparent. This year, the King's Fund published its own analysis followed by that of the Government's adviser, Sir Bernard Tomlinson. Although not identical, both analyses agreed that major changes had to be made. The issues and recommendations are relevant not just to London but to all areas with large concentrations of acute beds or indeed more generally still, since the factors which both reports identify as making for change within the acute sector are at work everywhere. We look at these in more detail on pps 49 – 98.

In the field of public health, the Government followed up last year's green paper, *The Health of the Nation*, with a white one, which confirmed the basic approach while modifying some of the specific proposals. We therefore look again at this policy area.

As far as health service users were concerned, the Government continued to develop the Patient's Charter: within social services, the Audit Commission, as part of the application of the Citizen's Charter to local government, was given the task of producing so-called performance indicators for local authority social services, which were to reflect the interests of citizens rather than managers. In the final section in this part of the Review, we compare and contrast these two approaches to promoting the interests of consumers.

1.1 Creating the new NHS

At the most obvious level, 1992 saw a speeding up of the process of implementing the new structure for the NHS allowed by the NHS and Community Care Act – free-standing providers in the form of trusts and the further development of GP fundholding. We take these in turn.

Trusts

Already in 1991, the Government's intention to create more trusts had been plain. With the election behind them, the way was clear to realise those intentions and to plan for their extension. On 8 October, the establishment of 128 new trusts as from 1 April 1993 was announced, putting about two thirds of the NHS under trust management at that date. Two weeks later, the Minister for Health announced that, if the 121 applications for fourth wave trusts to become effective in April 1994 were successful, 90 per cent of the resources of hospital and community health services would be managed under trust status. Thus by the end of 1992/93, it had become clear that trusts would shortly be universal even though the Government committed itself not to make them compulsory.

Dr Brian Mawhinney, the Minister for Health, launching the fourth wave of trusts, stated:

> *NHS trusts are the management model of choice within the National Health Service*

The evidence available by the end of the year to support that choice was limited. One source quoted by the Government was a survey of patients that: according to a report for the Department published in January of work carried out during 1991, 48 per cent out of 900 patients surveyed who had been in the same hospital before trust status was awarded thought that services were better since the eight hospitals concerned had become trusts and only seven per cent thought it had got worse – the remainder detected no change.

The Government also pointed to the fact that trusts were handling more cases than before. As we showed last year, that trend was established well before the reforms were implemented, but the Secretary of State claimed that the increase in trusts was greater than in other units – 8.2 as opposed to 7.2 per cent. However, research carried out at the University of Bristol suggested that the units which had become trusts in the first round were the relatively efficient units, in which case the difference was to be expected and might indeed have been predicted to be greater.

Furthermore, as the Joint Consultants Committee pointed out in its evidence to the Health Committee's study of trusts:

> *Greater activity and throughput can be achieved by concentrating upon minor cases, increasing day surgery and allowing patients to go home when it is not necessarily safe for them to do so. Information is needed on the nature and quality of the 'increased activity'.*

That is clearly correct: the evidence available is simply not of the right kind or quality to provide a basis for measuring the almost immeasurable, the 'output' of a hospital.

While the Government was confident that trusts are the correct form of organisation for the NHS, issues emerged both as to how they should be configured and how they should be controlled. In August, the NHS Management Executive indicated that it did not favour applications for whole district configurations or from units combining acute and community services. The reasoning appears to be that community services are more likely to thrive if independent. Andrew Foster, then deputy chief executive of the NHS, put it this way in a letter to NHS managers of 20 August:

> *Expressions of interest from whole district configurations and from units providing a combination of acute and community services are strongly discouraged. Ministers are keen to see strong, independent community units which can respond effectively to the opportunities and challenges presented by changing patterns of health care and by the implementation of* Care in the Community *and* The Health of the Nation. *Only in very special local circumstances will an expression of interest in a whole district or joint acute and community trust be approved.*

The same view was expressed by Sir Bernard Tomlinson in his report on London hospitals:

> *We agree with the Audit Commission's view, in its report* Homeward Bound *that if community health services are broken up and spread among clinical directorates this will reduce their flexibility. When both services are placed under the same management, the prestigious inner London teaching hospitals tend to draw resources away from the community services. Many purchasers, and the contracts they place, are insufficiently robust to prevent such misallocation of resources. This may not be equally so throughout the country, and indeed may have less strength in some of the outer London districts; in any case this balance should eventually change. As a general principle, however, we recommend that in future the formation of whole-district trusts should be discouraged unless there is a clear case that service benefits will be gained.*

The reasons given both by Mr Foster and Sir Bernard are less than convincing, indeed if taken literally represent a lack of confidence in the structure being created. The theology of the new NHS is that it is purchasers who determine what services should be provided, not the providers themselves. There are of course grounds for scepticism about the reality of that belief. Providers remain the main source of expertise about what services can and should be provided and in what ways. But the explicit aim of many of the measures, initiated last year, to strengthen the hand of providers was to create countervailing power. It would seem from the passages we have cited that the top end of the NHS is not confident they will work.

Furthermore, neither the management letter nor Sir Bernard's report comments on the relative merits in terms of management structure of retaining community services close to acute as opposed to running them separately. There are argument both ways: in some areas, such as hospital at home schemes and measures to promote early discharge, close management co-ordination may be better achieved by linkage within the same organisation rather than through contracts between organisations. The same might be true for services such as those for children where the view for some years has been that the different strands ought to be integrated into a single management hierarchy running across acute and community services.

However, there is a general argument in favour of breaking districts into their component services: that it allows competition to develop between them in those areas where there is, or could be, the same degree of overlap. If it is right to assume for example that some services could be provided either in the hospital or in the community, that would create scope for competition between organisations which are currently serving entirely different 'markets'. In other words, organisations now serving distinct markets may seek in time to expand into each other's market area.

The second issue, already apparent in 1991, is how much freedom to allow trusts to make their own decisions. In 1992 the immediate focus for debate round that issue was the question of what a trust's reporting lines should be. One of the initial attractions of trust status was direct access to the Management Executive, by-passing the regional tier of control. But with trusts set to become the standard, the regional structure as it stood began to appear redundant, while direct access to the Management Executive was clearly impossible for all trusts with their numbers running into the hundreds. Some merger of the two lines of control seemed desirable, but in the event the Government decided to retain separate regional structures while clearly indicating that the existing organisations should be slimmed down.

From the trusts' viewpoint, any move to put them back under regional control threatened their *raison d'etre*, freedom from the old-style line management. Evidence presented by all the operational trusts to the Health Committee (*NHS Trusts* HC 198-vii) indicated that they did value the freedoms they had been granted, particularly over staffing arrangements. A survey by the *Financial Times* (reported on 14 May 1992) also found that trust personnel managers were aiming to introduce new pay structures which would replace those based on Whitley Councils negotiation, and some were recognising unions and negotiating with them directly. In addition, as we indicated last year, some trusts are looking at their skill mix, aiming to substitute cheaper for more expensive staff and also their overall need for staff.

From the evidence submitted to the Health Committee of the House of Commons by all operational trusts, it is clear that most value freedom in the area of pay and personnel. But in the field of capital development, originally one of the main attractions of trust status, trusts have come to recognise that they have gained only limited advantage.

The methods proposed by the Management Executive for determining capital programmes look strangely like the methods in use before trusts were established. In particular, trusts appeared to have very little advantage over other parts of the NHS in terms of the conditions under which they have access to capital. The bulk of capital funds are to be allocated through a project approval process which is the antithesis of a competitive arrangement. The implications of these arrangements are further discussed below.

Overall, however, this year as last, it is too early to comment on the impact of trust status in the light of actual events. The implications of the new arrangements will emerge gradually, as people adapt to the new circumstances. As the House of Commons Health Committee put it in its 1992 report on trusts (HC 321):

> *The evidence showed that it was then too early to draw definite conclusions about the operation and effectiveness of Trusts because:*
>
> i *during the first year of operation a policy of 'steady state' was enforced by the Department and the NHS Management Executive with the declared aim of effecting a smooth transition to a 'market' economy;*
>
> ii *first-wave trusts inevitably received close attention and special treatment from the Management Executive by virtue of their special status and small numbers: the corollary of this was that they also received close attention from those who were opposed to the whole thrust of the reforms;*
>
> iii *it remains difficult at this stage to distinguish what is a benefit of trust status from what might be the result of the momentum of events prior to trust status, the broader effects of the purchaser/provider split, or the impetus which might be expected to arise from any extensive re-organisation of the management structure. It is also therefore equally difficult to identify what problems result specifically from trust status as opposed to those common to all NHS providers...*

On the evidence available so far, it is hard to dissent from the Committee's conclusion that 'the establishment of trust status itself could be seen as no more than another, albeit radical,attempt at hospital management reform.' Put another way, the main trust freedoms enjoyed so far could have been given to unit managers under the old regime. However, their creation as free-standing units does potentially allow a much greater degree of change than any possible under previous management reforms. In particular trust status implies the potential for complete withdrawal from the provider role in the face of competition: the question, which we return to below, is whether the Government will exploit that potential.

GP Fundholding

The urge to press ahead, apparent in the rapid creation of more trusts, is apparent also in primary care. The Government not only encouraged more GPs to become fundholders but also extended to community health services the range of services they can purchase. In January 1992 the Government announced that as from April 1993, the minimum list size for fundholders would be reduced to 7,000, thus allowing some 5,000 more doctors to take on that role. Already however a number of pilot projects were underway in various parts of the country with lists as low as 2,000.

In February 1992 the Government announced an expansion of the scope of fundholding: from April 1993 fundholders receive allocations to purchase district nursing and health visiting services from NHS community units. Dietetics and chiropody it was announced would also come into the scheme in due course. In March, the Government announced that a further 1,400 doctors would become fundholders in April 1992, bringing the total to over 3,000, caring for some 6.7 million people or 14 per cent of the population: a further 2,500 followed in April 1993.

The Government's plans to expand GP fundholding, unlike those for trusts, are supported to some degree by research findings. In January 1992, Howard Glennerster and colleagues from the London School of Economics published, in *Foothold for Fundholding*, the first results of their study of ten practices in different parts of the country. They found that:

- some practices had shifted referrals from hospitals not providing a good or convenient service to others which did;
- in some cases, consultants were giving outpatient sessions in the GPs surgery;
- closer collaboration between hospital and surgery led in some cases to cost savings eg through more accurate prescribing;
- better services were obtained by using the threat of moving to the private sector.

In an article in the Guardian (17 February 1993) Professor Glennerster reported that subsequent monitoring confirmed these early findings.

Useful though these benefits undoubtedly are, they are not, as the authors point out, sufficient in themselves to justify making fundholding virtually universal. As the study focussed on fundholders at a time when there were few of them, it could not isolate those benefits which were both unique to fundholding and obtainable by fundholders if and when this become the standard model for primary care.

Furthermore, no evidence was presented in the report about the costs incurred in achieving these benefits. Evidence from North West Thames region (Health Service Journal 25 February 1993) suggested management costs had been heavy relative to the general level of practice management costs, but there is as yet no clear evidence of other costs, such as those resulting from denial of care or through loss of quality in traditional primary care services.

Towards the end of 1992 it became apparent that many GP budgets for hospital services had been set too generously. It was accepted at the time that, with the aim of smoothing the path of the reform, some GPs' allocation had been set on the generous side – as data on referrals was typically poor it was in any case hard to prove that a proper allocation should be.

While some have offered to return the spare cash, others are clearly enjoying the benefits, as the rules allow, of being able to improve their practice facilities. What cannot be known from the evidence available is whether the value of doing that is greater than the value of using the resources involved in other ways. Furthermore, there is some evidence, though of an anecdotal nature, that some GPs are setting up dummy companies through which any surplus can be extracted for their personal benefit. That may be regarded simply as a teething problem though clearly not one that the Government can ignore if it does prove to be a common practice.

Another quite different development – the creation of large groups of GPs in some areas – raises a different question: whether regulation of such mergers or agreements is necessary to defend the ability of every patient to choose their own GP. They also lead to the question whether such groupings actually threaten to undermine the role of the district health authority as purchaser, on the one hand, and the close relationship between patient and the GP purchasing on their behalf on the other.

Finally, towards the end of the year, as many health authorities were having to cut back on activity because their budgets were spent, fundholders were still able to refer patients. To many this confirmed the existence of a two-track system: those patients in fundholding practices were clearly able to leapfrog those registered elsewhere. Again it is hard to tell whether this is just a teething problem or a symptom of something more fundamental – that the discipline of a budget had proved effective in keeping referrals down: if the latter then the issue is not so much whether some patients have done better by leapfrogging others, but whether others had or had not suffered by not being referred. We have no evidence which bears on that issue.

Purchasing

We emphasised last year, drawing on statements by the Secretary of State, the central importance of purchasing to the effective working of the new arrangements. While as we noted the Government had taken a number of initiatives to support purchasers, these were far from providing a blue-print for exercising that role.

A number of reports during the year have shed light on the way the purchasing role is being developed. In this, the second year of the new arrangements, the evidence still suggests that a great deal remains to be done. One study, *Effective Purchasing* by Chris Ham and Peter Spurgeon (Discussion Paper 28, Health Services Management Centre, University of Birmingham), concluded that:

> *All those involved in purchasing are much clearer about the strategic tasks involved and the changes that need to be made in transforming district health authorities from provider dominate organisations to genuine champions of the people. In this sense, the vision that guides purchasing has been clarified, and the key components of effective purchasing have been identified.*

But, the authors go on:

> *Much less progress has been made in creating purchasing organisations equipped to take on the range of responsibilities described in this paper. Not only is there a lot to be done by purchasing authorities themselves, but, as a number of other reports bring out, the way they are approaching their task and the guidance offered raise a number of broad issues about the way the new regime is developing.*

In other words, a lot still needs to be done before the purchasing function is fully established. Evidently recognising that, the Secretary of State announced on 23 February 1993 a four point plan to develop the purchasing role, in the following words:

> *First, I have asked the NHS Management Executive to concentrate attention on the following key purchasing issues during 1993/94:*
>
> *– making sure health authorities as purchasers set a strategic direction for the future and that they make tangible progress, year on year, towards their strategic goals;*
>
> *– ensuring that effective working relationships exist between district health authorities, GPs, fundholders, professional advisers and other local agencies;*
>
> *– and ensuring too that good working relationships exist between purchasers and providers, not just in the black and white of contracts, but in an organic relationship which works creatively to develop services for the long-term.*
>
> *Secondly, I can announce today that I have earmarked £4 million specifically to stimulate further progress on purchasing in 1993/94.*

> *Next, I have asked the Management Executive/Regional General Managers Focus Group to determine how best this new money can be put to use. They will look at:*
>
> *– centrally-commissioned development work, identifying and spreading good practice;*
>
> *– joint Management Executive/Regional Health Authority initiatives, encouraging regions to act as 'national product champions' on specific aspects of purchaser development;*
>
> *– rewarding purchasers for success, so that the new money is linked to specific progress.*
>
> *The Focus Group are also finalising a programme of national workshops for dissemination in 1993/94. We will announce further details in April.*
>
> *The fourth part of our strategy will be the publication shortly of our guide 'Good Practice and Innovation in Contracting'. This pulls together [your] good ideas, projects and initiatives.*

This statement does not explicitly refer to some of the central issues that purchasers have to grapple with: some of these are primarily technical, others raise more fundamental issues.

One important technical area, if market relationships are to be established, is that of costs and prices. The NAHAT financial survey 1992/93 reported that authorities were moving away from block contracts but many were hindered by lack of suitable activity and cost information. A survey of the methods being used to link costs to activity by Sheila Ellwood (*Cost Methods for NHS Healthcare Contracts*, Chartered Institute of Management Accountants 1992) brought out some of the difficulties. The overall conclusion of her survey was that the basis for moving to more detailed contracts was not yet in place.

Several difficulties were identified which go beyond costing methods themselves:

- no way of grouping patients had achieved wide acceptance: purchasers were likely to define groups differently from providers;
- costing systems were still broad brush;
- in most cases, the 'product', *ie* the service expressed in terms of both quantity and quality, was rarely defined.

She also points out that even in the USA, where patients or their insurers must be charged for particular operations, many hospitals did not base these on a detailed cost analysis but rather worked to the prices obtaining in the market facing them.

The Management Executive however is intent on persuading providers to base their prices on specific costing formulae, the outlines of which are set out in *Costing for Contracting – 1993/94 Contracts*. This was not the first such document: in 1990 the Executive had issued *Cost Allocation Principles* which allowed a large degree of discretion in the methods adopted for allocating costs to activities, provided that prices are 'based on full (net) costs so that, for a provider's annual assumed volume of service, income from contracts will recover the quantum of cost with no planned cross-subsidisation between contracts.'

The new document sets out a series of rules for cost allocation and concludes:

> *It is essential that provider units follow the minimum standard framework for 1993/94.*

Further work to improve the framework is promised.

It is understandable that the Management Executive should seek to improve costing methods: as we noted last year and as is further confirmed by Sheila Ellwood's survey, the prices charged to GP fundholders vary by such large factors that it is hard to believe they can be linked to costs or quality variations in any systematic way. If prices are to guide purchasers to the most efficient providers, then the link to costs must be closer. But how close? What exactly is cross-subsidisation? Does it matter if the mark-up to allow for central overheads, such as the cost of the general management team, varies from contract to contract? Is it to be welcomed or the reverse if provider units offer 'off-peak' prices to encourage use of facilities that would otherwise be idle?

Questions like these raise the issue of how relationships between purchasers and providers should be managed. They can only be answered by taking a general view on whether or not they should approximate to what would obtain within a normal market. The Secretary of State's four point plan uses rather different language, talking as it does of 'organic relationship(s) which works creatively to develop services'. There is a case for that sort of relationship between purchasers and providers but it is not clear, as we go on to argue in the next part of the Review, how compatible that is with other objectives the Government is pursuing for the NHS.

The development of the purchasing role raises however more than technical issues. The task of defining what would be purchased leads to the question of how priorities should be assessed and by whom. The purchasing role is intended to produce a better match between resources and needs. Detached from the responsibilities of actual provision, purchasers can select a 'best' pattern of services. But how should this be done? This question is discussed in more detail by Ray Robinson in an article in this volume. Here we draw on some work published during 1992 which bears on this issue.

An examination of purchasing plans by Rudolf Klein and Sharon Redmayne, *Patterns of Priorities* (NAHAT, 1992), found that only 12 out of 114 plans showed evidence of decisions not to buy particular services or treatments, but even here they are typically available in 'exceptional' cases. Some evidence of explicit priorities within broad groups also emerged. For example, both mental health and mental handicap attracted a large number of what the authors term as aspirational priorities, or declarations of intent without commitment to spending particular sums of money: see Table 1

Table 1: Aspirational Priorities: The Top Ten

Mental Health	42
Mental Handicap	37
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Heart disease	28
Children's services	28
Disabled	28
Health promotion	27
Maternity	26
Services for elderly	25
Ophthalmology	21

Some of these 'aspirational priorities' reflect national priorities as set out in *The Health of the Nation*. But purchasing plans are also intended to reflect local needs and local views of what needs should gain priority. *Patterns of Priorities* reports a number of attempts to involve the public but it is clear, and understandably so, that such attempts are still in their infancy, as the following extract shows:

> *A variety of techniques were used. In most cases, the consultation process took the form of a public survey, carried out either by face to face interviews or by a postal questionnaire. But in other cases, there were experiments with public meetings, group discussions and panels.... clearly, there is a difficult choice to be made between interviewing a representative sample of the population – which means relying on conventional survey instruments – and using more intensive, in-depth methods involving small groups which may yield more interesting insights that are not necessarily generalisable.*
>
> *The problems involved in this kind of exercise are apparent from the issues covered. There were some attempts to make people prioritise between services (for example, North Essex Health Consortium) but given the difficulty involved in providing sufficient contextual information to allow a rational choice to be made – many of the purchasing plans are themselves deficient in this respect – it is not surprising that most of the questions addressed to the public were about their own expectations rather than about their views on the pattern of resource allocation. Thus they were asked about their expectations about the quality of service, how long they would be prepared to wait for an appointment or an operation and about how far they would be willing to travel. This information is highly relevant to some resource allocation decisions – such as whether or not to invest in making services more accessible locally – even though it may not provide clear cut criteria for choosing among competing priorities.*

In January, the Management Executive issued *Local Voices*, guidance to health authorities on how they should consult with local people. As the Secretary of State put it at the time:

> *The NHS needs to be a listening service. Giving people a greater say in decisions about their local health services calls for a radically different approach to that adopted in the past...*
>
> *One-off consultation exercises or surveys are not enough. Health authorities need to be proactive in involving people in their decision-making. They need to listen and provide ongoing opportunities for discussion.*

It is hard to disagree with the general tenor of this advice, just as it is hard to disagree with the idea underlying the Patient's Charter: clearly it is desirable that monopolistic public services should have some regard to their users views. But it is curious for a Government to emphasise the need to consult the general public while at the same time pursing policies which pull in the opposite direction, *ie* the creation of large purchasing authorities, resulting from formal or informal merger of district purchasers.

As Toby Harris, chair of the Association of Community Health Councils for England and Wales, put it to the Health Committee:

> *There are trends which are taking purchasing decisions further away from the local community, such as the establishment of consortia covering several health authorities. It is very much more difficult in those circumstances for those decisions to be taken, taking into account local views and the feelings of users in the service.*

In principle, larger consortia can be combined with smaller purchasing units through what has come to be known as locality purchasing. A few authorities, reviewed by Chris Ham in *Locality Purchasing*, (Birmingham University Health Services Management Centre, 1992) have started to move in this direction but according to this study none have yet actually devolved budgets and so are some way off the parallel developments in local government which have led, in many authorities, to effective devolvement. Short of financial devolvement – in effect the recreation of a mini-authority – the main function of a locality arm appears to perform better the intelligence functions of a purchasing authority rather than purchasing itself.

Important though the developments we have described are, perhaps more important is one which it is hard to document precisely – the increasing realisation among able managers of the importance of the purchasing role. Precise figures are, obviously, hard to find, but a number of observers have suggested that, whereas in the very early days of the reforms, the role of chief executive of a trust seemed the more attractive, now the perception was beginning to change in favour of leading a purchasing team. How long-lived such a change in performance will be depends critically on how much leverage purchasers actually enjoy. And that depends on many other factors in particular the final scope of GP fundholding and the strength of the competitive forces that are allowed to develop.

London

The main issue facing London was already apparent in 1991: its share of acute hospital capacity is too great. In April 1992, the Commission set up by the King's Fund to examine the issues facing health care planners in London confirmed this.

Its recommendations, that there should be a substantial reduction in hospital capacity in London, was based on a broad analysis of changes taking place in health care provision in the UK as a whole, and indeed on a world-wide basis: see Table 2.

On 23 October, Sir Bernard Tomlinson expressed agreement with the general drift of the Fund's analysis by confirming that in his view hospital capacity had to be rationalised and more resources put into primary and community care.

> *Primary and community health services are comparatively underdeveloped in London. Resources need to be diverted from the hospital sector into these services in order to bring standards up to those found elsewhere, and to enable the rationalisation of hospital services in inner London. In particular, additional funds need to be made available for raising the standard GP premises in inner London. Greater flexibility needs to be introduced into the General Medical Services so that, within designated 'primary care development zones', FHSAs will be able more effectively to secure strategic health objectives.*

He went on however to make a number of specific recommendations, as follows,

- *More money should be put into general practice and community health services. Savings arising from hospital rationalisation should be ploughed into community-based services.such as GP premises and community care centres.*
- *Barts and the Royal London Hospitals should merge, with the Barts site being closed.*
- *The Charing Cross Hospital building should become the new home of a range of specialist services and research, including the Royal Brompton and Royal Marsden Hospitals.*
- *The Middlesex Hospital should close and merge with University College Hospital.*
- *Medical schools and postgraduate institutes should merge within four faculties of medicine in Imperial College, University College, King's College and Queen Mary and Westfield College.*

A number of other closures were recommended including Queen Charlotte's, Royal National Throat, Nose and Ear and St Marks. The report also makes a series of proposals, equally controversial, on the organisation of medical teaching and research in London.

Table 2

- The Commission considers that there needs to be a major shift of services and resources from hospital-based to primary care. The aim must be to locate many diagnostic and investigative procedures, and much treatment and care, in primary and community health settings close to where specific live, where this can be reconciled with quality and cost criteria.
- Primary health care practitioners will need to draw on services which provide care for people with a wide range of needs for whom specialist acute hospital provision is inappropriate. This will include convalescence and respite care, rehabilitation, care for people who are dying and for people experiencing mental health problems.
- Community-based treatment of this kind will often be provided in people's own homes and through hospital-at-home schemes, or from nursing beds and care centres which are convenient and accessible to London communities. Nurses can manage much of the care at this level, with contributions from medical and therapy staff when required.
- Acute care hospitals will provide diagnoses, investigations, treatment and care which require the use of expensive equipment and a range of highly skilled personnel.
- Dedicated day-case facilities – which could be attached to acute care hospitals or freestanding – will handle a high proportion of all planned acute interventions.

Neither the King's Fund Commission nor Sir Bernard put forward a detailed plan, nor did Sir Bernard, even though he came to precise conclusions as to which part of the hospital system should close, offer any detailed figuring in support of his views. That work was left to a large team of consultants which the Government had hard at work by the end of 1992 looking at individual hospitals, and the London Implementation Group, announced in February 1993.

Predictably, the proposals aroused opposition from unions and many other interest groups. But what was less predictable, even surprising, the British Medical Association indicated that it would not oppose proposals for rationalising London's hospital capacity, while most of the hospitals affected by the proposals stated soon after Sir Bernard's report was published that they would go along with them.

But that is far from saying that difficult issues do not arise. The actual process of implementation will be difficult even if the general direction is clear. Although the two processes – running down hospital capacity while building up primary care – have been presented as complementary, in fact they are not. Rationalisation of hospital services is necessary whatever happens to primary care. Equally, the need to build up primary care is independent of any change in hospital capacity. But will it be done?

From the recommendations made in both reports, it seems clear that the process of change, while impelled by the market processes that have led to large deficits in inner London hospitals, is not likely to be best promoted by simply allowing market forces to work.

This is not just a matter of central government coming to a view as to the future of this or that acute unit: it is also a matter of how to ensure that the weaknesses in London's health care system, which the King's Fund Commission identified and which Tomlinson confirmed, should be remedied.

Both reports confirmed what previous studies had shown, that the standard of London's primary care services was low and both contained recommendations as to what should be done to improve them. Some are specific to conditions in London but one, the designation of primary care development zones, raises wider issues.

The Tomlinson report recommends:

> *... that the Department of Health should explore with GPs' representatives the scope for designating parts of London as 'primary care development zones' in which some of the normal arrangements could be suspended, so as to secure a better service, in line with local health needs.*

The report goes on:

> *... FHSAs have no management control over the allocation within their areas of the most important resource: skilled manpower, in the form of GPs. At the overall level, this is the responsibility of the (centrally-based) Medical Practices Committee (MPC). We have discussed this with the MPC, and we recognise the valuable work it does, within the terms of its remit. We recognise a continuing need for a national overview of the distribution of GP manpower. But we do question whether the same degree of MPC involvement is needed in the local configuration of manpower and partnerships. We therefore recommend that, within the London 'primary care development zones', the MPC should devolve to FHSAs the responsibility for deciding, in consultation with the profession locally, how the GP manpower available to the area might best be organised to meet local needs. This would facilitate coordinated plans for GP manpower, premises and practice staff.*

The Government announced its response in February 1993 in *Making London Better*. This confirmed that the Government had accepted the need for change with the words: 'No change in London is no option'. The statement also made it clear that many issues remained undecided. The London Implementation Group was left with a large number of tasks including reviews of particular proposals for closure, the future organisation of six specialties – cardiac and cancer services, neurosciences, renal services, plastic surgery and specialist children's services – and the implementation of a London Initiative Zone, within which funds are to be targeted to bring the level of their primary care up to a higher standard. Some £170 million of capital funding is to be made available over six years to improve primary and community service in the Zone, which covers most of the more deprived areas of inner London and some in outer London, containing about four million people in all. The announcement does not make clear how the total was arrived at – it is less for example than the King's Fund Commission's report suggested was required. And there remain obstacles other than capital finance including the quality of the GPs themselves and their readiness to change.

Whatever emerges from these further considerations, the loss of contract monies to central London hospitals is likely to force the pace of change. But just how large should the scale of the adjustment in the acute sector be?

The answer is far from obvious. Some part of the higher cost of inner London hospitals can be eliminated by improving their efficiency. The Tomlinson report suggests that beds in Inner London are used less efficiently than the national average but some Institute analysis has suggested that there has been some catching up recently, thus reducing their cost disadvantage. Furthermore higher cost may well reflect both a higher quality of care and the greater complexity of the cases handled. It is not inevitable that inner London will lose all its 'export' markets.

As for the size of its 'home' market, that depends critically on whether or not the current share of resources that London enjoys is correct. The work done for the King's Fund London Commission did not suggest that Londoners health status would justify a larger share than they at present enjoy, but during 1993 the (delayed) results of the 1991 Census will become available. That, for the first time, contained a question bearing on the incidence of long-standing illness which may, or may not, support the case for London enjoying a larger share of the national cake. Tomlinson recommended that 'the inclusion of these data in the formula be urgently tested'.

Finally, although there is a lot of evidence that some functions can be switched to community settings – GP surgeries or health centres – the scale of such a transition and the speed at which it can be carried out is far from clear. As the articles in **Changing Boundaries between Hospital and Community** pps 49 – 98 show, while there does appear scope for such switches, precisely how it should be done remains unclear, and there are massive obstacles to making such changes, in the field of finance, professional roles and many other areas. The Tomlinson report fell far short of being a blue-print, despite the specific nature of its recommendations and has come in for criticism for precisely that reason. The Government's response was also very short on specific figuring. That will have to await the results of the implementation programme, including in particular the specialty reviews and the option appraisals of the various possible configuration of acute care services, which are the responsibility of the London Implementation Group.

Given the massive complexities, arising from the inter-action between hospitals and hence options for rationalisation and closure, and between hospitals and other services, it is unrealistic to expect the Government to come up with a detailed plan within a short time-table. Yet, given the nature of Tomlinson's recommendations and impact of contract switching, a rapid response was required. In practice, therefore the report may well serve as merely the starting point of a sustained period of adjustment of a nature which is likely to be necessary in all parts of the country in response to the general forces making for changes in the organisation of acute units.

Conclusion

At the beginning of 1992, the chief executive of the NHS, Duncan Nichol, welcomed the 'successful first six months for the NHS reforms', citing reductions in long waits, increases in immunisation rates and an (unspecified) range of local initiatives to improve the quality of care for patients'. While it may be natural for a Government approaching an election and vulnerable to criticism of its record on the NHS to cite such evidence, none of it bears on the impact of the reforms themselves, for not only is it, as we have already remarked, too early to see what their impact has been, but even in the fullness of time it will be virtually impossible to determine 'what would have happened in their absence', the base-line for any proper evaluation.

By adopting an across-the-board approach and pushing ahead with trusts and fundholding as fast as it has, the Government has in a sense covered its tracks. It is impossible now to compare the performance of the new with the performance of the old. But that said, the 'new' is itself a moving target. As we said last year, the NHS is certainly moving fast, but quite where it is going is another matter: a further year's development only serves to bring out the open-ended nature of the enterprise the Government is engaged on – a theme we further develop below.

1.2 Community Care

So far our Review has revealed a Government anxious to progress as fast as possible to introduce a new system of care. But as we saw last year, the Government decided, in the case of community care, to make haste slowly, by deferring the introduction for two years of the measures set out in *Caring for People*, until 1 April 1993.

The most clearly defined change due to take effect then is a financial one: from that date, local authorities will be responsible for the finance of all publicly supported long term care outside the NHS. Social security funding under income support arrangements will be run down and a majority of the sums saved there re-allocated through the revenue support grant to local authorities.

At one level, the move makes eminent sense. The Department of Social Security have not been in a position to administer assessments of need for residential care: the Department was, by 1992, paying out some £2 billion without much evidence of the care needs of those receiving support. Local authorities already had the responsibility for residential care homes of their own or for supported placements. With the budget in the hands of one authority in each locality, the way is open for properly considered choices between different forms of long term care – nursing home, residential care home or own residence.

However, although the Government knew where they wanted to get to at the beginning of 1992, they did not have a precise plan for getting there when they made their original proposals. In particular, they had not determined the amount to be transferred to local authorities nor the way in which it should be distributed between them. Both tasks proved difficult and contentious. A working group was established – generally known as the algebra group – consisting of local and central government officials to suggest how the transfer should be made.

The core difficulty was the lack of reliable information on the use to which social security monies were being put. There was no reliable information available to the working group on the length of time people spent in nursing homes – and hence the speed at which existing residents would be replaced by new – nor on the origins of people in them. The working group did obtain information from the Department of Social Security on the location of people receiving income support for residential care, but as far as length of stay was concerned, it proved possible only to infer the distribution from surveys of existing residents. No information is available on the length of completed episodes of care in nursing homes.

On 3 October, the Secretary of State announced that local authorities in England would receive £539 million in 1993/94 made up of £399 million transferred from social security and £140 million of so-called new money for one year only. Of the total, half is to go to authorities on the basis of population, half on the presence of residential care facilities in their area. 75 per cent of the 1993/94 sum was to be spent on care in the independent sector – a figure later reduced to 63 per cent. The sums transferred are to be ring-fenced – *ie* to be spent on community care alone. The ring-fencing of the total is to continue for two more years, a concession granted by the Government in the face of pressure from local authorities and others.

However the effect of this protection is diminished by the fact that ring-fencing is not being extended to the finance that authorities receive under existing arrangements for social services. The standard spending assessment for the social services element of the revenue support grant will remain part of the overall block allocation of funds. So it will remain open for local authorities to raid this budget if they wish.

Local authorities disputed the adequacy of these sums. The department's calculations did not allow for the fact that current fee levels often fall short of actual charges – according to local authority estimates the difference is some £145 million. According to a report from the Association of Directors of Social Services, *Private Residential*

Care in England and Wales, of a survey of private nursing and residential homes, nursing home fees were in line with income support in most parts of the country, that was not true of residential care homes: see Table 3.

Table 3: Average Weekly Residential Home Fees by Type of Authority

DSS Rate (£) Type of Authority	160	165 – 290	195 – 220	225 – 250	Over 250
All Authorities(91)	4	43	20	13	11
(% total)	(4)	(47)	(22)	(14)	(12)
Met Districts(33)	1	23	7	2	0
Shire Counties(31)	1	15	10	3	2
Welsh Counties(6)	0	5	1	0	0
London Boroughs(21)	2	0	2	8	9

In fact only four per cent of cases were charged at the Department of Social Security rate. Not surprisingly, some homes do not take people reliant on income support, or require those that are to use their personal allowances to top-up payments or rely on relatives to do so: nearly all the authorities surveyed reported difficulties in getting beds for residents on income support: see Table 4.

Table 4: Number of Authorities Reporting Difficulties Obtaining Bed for Residents on Income Support

Type of Authority	Difficulty	No Difficulty	No Response	Total
All Authorities	53	41	22	116
(% total)	(46)	(35)	(19)	(100)
Met Districts	16	18	2	36
Shire Counties	20	12	7	39
Welsh Counties	3	4	1	8
London Boroughs	14	7	12	33

Some of the difficulties reported, such as delays in selling off homes to pay for fees may, be regarded as short run – though the short run may endure for some time. But if the findings on the cost of residential care are correct, then the implication is that authorities will find themselves paying more per place than now, or relying more on top-ups from whatever source. But, as the report suggests, relatives' willingness to make such payments may be reduced when they know that 'their' authority has accepted financial responsibility for their relative and is not bound by national rates.

Furthermore, the Department assumed that 110,000 elderly and disabled people will require support: the authorities, assuming that the rapid growth of the 1980s will continue, argued that the figure is likely to be higher by some 12,000. Local authorities estimate a shortfall here of some £62 million in the first year, a shortfall which will grow rapidly if their views on likely growth of nursing and residential care is correct.

In fact, of course, neither side knows how demands upon social services are likely to develop since the reasons why institutionalised care grew so rapidly in the 1980s are not perfectly understood and therefore the scope for modifying or even reversing the observed growth cannot be estimated with confidence. Not only did the total number supported grow rapidly in that period, but the average cost per supported person grew nearly ninefold: see Table 5.

Table 5 Income Support Recipients in Private and Voluntary Nursing and Residential Homes (all client types), Great Britain

	Numbers 000s	Average payment* £ per week
December 1979	11	
December 1980	13	27
December 1981	13	34
December 1982	16	47
December 1983	26	77
December 1984	42	92
December 1985	70	96
February 1986	90	98
May 1987	117	110
November 1987	130	114
May 1988	147	115
November 1988	155	119
May 1990	189	129
May 1991	231**	156

Source: Department of Social Security

* Income support payments are net of other social security benefits and do not, therefore, give an accurate picture of total charges met from all social security sources.

** *Hansard* 21 October 1991, Vol 196 col. 431W

One interpretation of these figures is that private care simply took over more and more people from local authorities without the means to pay for care: another is that as people realised that social security funding was available, they or their relatives became increasingly adept at minimising their assets ahead of the time that residential care was needed. If the latter then it may well be that financial support per resident will continue to rise faster than the number of residents, since average payment still falls short of average fees.

While the total transferred may be challenged so, too, may the method of distribution – the half and half approach. This apparently even-handed approach may have unfortunate, indeed perverse effects. In those areas, mainly counties, where there is an above average representation of nursing homes, and which will receive more funds than population alone would justify, authorities will be able to finance – although they may not choose to do so – more generous support, including more residential care, than their local populations would justify. In those areas where the reverse is true, if authorities decide to finance long term care at previous levels they will find it more difficult to finance support for people in their own homes.

Work carried out by Sean Boyle and Chris Smaje on London brought out the significance of the two approaches. They showed that London's low rate of private provision could not be explained by a high rate of provision in the public sector. The implication is that many of the long term care needs of Londoners are actually being met outside London itself.

Thus a crucial part of the jig-saw – which partly explains the rough justice of the proposals – is the extent to which people move from one local authority to another just before or when they move into residential care. But existing information does not allow these movements to be tracked accurately.

Furthermore, because the reasons for the rapid growth in residential and nursing home care are not fully understood, any predictions must be hazardous. Clearly, availability of social security funds did have some influence as did the rundown of long stay facilities within the NHS, but other factors were at work, including changes in social factors which are likely to continue to have effect in the 1990s. These include a rising number of single person households, more women in paid employment and fewer people of early retirement age. Taken together they could imply a reduction in the supply of informal care and a greater burden on the statutory services.

The need for residential care in part depends on factors such as these, in part on the extent to which authorities are able to provide home-based substitutes and hence reduce costs. Some of the other elements of the community care policy come into play here – principally the formal assessment of the needs of each potential user and the preparation of care packages in the light of that assessment. If entry into care is to be avoided, both these processes must be efficiently organised. That will not be easy.

Local authorities have been urged for some time now by the Social Services Inspectorate to concentrate their resources on the more dependent, so as to defer the time of transfer to residential care. As things stand, domiciliary services are still spread very thinly, so in that sense there is scope for greater concentration.

But evidence on the effectiveness of this policy is discouraging, as David Challis set out in a memorandum to the Welsh Affairs Committee whose study of Community Care (HC lll) appeared in 1992:

> *Evidence from studies of carefully targeted case management services, focused upon people with considerable needs and a high probability of entry to institutional care, suggests that although the results indicate that they achieved greater efficiency than existing services (greater improvements in welfare at similar cost), relatively few indicate cost savings and usually in comparison to hospital care. It would therefore seem probable that, if the similar case management approaches were applied to cases with a slightly lower level of need, where the opportunity for substitution of institutional by community care were less then there is a possibility of rising costs. This is because individuals whose needs fall just below that of present criteria of entry to institutional care currently receive relatively low levels of provision, and it is likely that the case management approach, with its more detailed assessments of needs, could well lead to increased expenditure beyond that currently incurred.*
>
> *While this might be justifiable in welfare terms it would not contribute to a policy of 'downward substitution'. Indeed, it is precisely the management of this dilemma between meeting broader welfare needs on the one hand and careful targeting of case management services on the other that would seem to account for the inability of a series of large scale case management initiatives in the USA to achieve the desired downward substitution despite demonstrating welfare gains amongst those receiving the service. It would therefore seem that careful targeting is an important factor associated with the reduction of admissions to institutional care.*

The essence of good targeting is anticipation of the need for residential care. The force of Challis' argument is underlined by a survey by Tim Booth for the National Council of Domiciliary Care Services, *Reasons for Admission to Part 111 Residential Care*. This points to research which found that a high proportion of people moving into residential care were not known to social services immediately prior to admission. It also cites evidence which suggests that much larger numbers of infirm people are living in the community than are in residential care.

The first point stresses the need for very rapid response if admission into residential care is to be avoided; the second to the risk that focussing on the highly dependent mean more support for people who would not in fact enter residential care in the near future but who might be judged likely to. On the other hand, the finding that a significant proportion of people admitted are largely able to fend for themselves suggests that better domiciliary provision may make it possible for them to continue to live in their own or a relative's home, if they so choose.

Thus if the care management policy is implemented, the prospect would appear to be that some will benefit – those receiving more intensive packages of care. But unless targeting is very precise and there is no 'leakage' *ie* no overgenerous packages are allocated to people thought, wrongly, to be at risk of entering residential care, those now receiving small, but nevertheless important amounts of care will lose. The conclusion that the position will become worse for the many to the benefit of the few is not inherent in the overall structure of the Government's policy. But it is a necessary consequence of continuing pressure on the resources available to authorities to provide domiciliary care.

Important though the transfer of finance is, it is far from being the only major change which is due to be effected from 1 April 1993. To provide a context for their new responsibilities, local authorities have been required to develop community care plans, and financial and management structures to cope with the new arrangements. This has involved them in a vast amount of work, for which, many have argued, even the two year extension from 1991 to 1993 for the implementation of the community care reforms, may not prove enough. The Department of Health's concern over implementation emerges from a series of official letters issued in the run-up to the target date.

On 11 March Andrew Foster, then Deputy Chief Executive of the NHS and Herbert Laming, Chief Inspector, Social Services Inspectorate, wrote to all directors of social services and NHS general managers and chief executives of trusts. The letter says that although progress has been made 'it was clear ... that many detailed and difficult issues of implementation will need to be tackled positively over the next few months'.

The letter identifies eight key tasks, as follows:

- Agreeing the basis for required assessment systems for individuals.
- Clarifying and agreeing arrangements for continuing care for new clients in residential and nursing homes including arrangement for respite care.
- Ensuring the robustness and mutual acceptability of discharge arrangement.
- Clarifying roles of GPs and primary care health teams.
- Ensuring that adequate purchasing and charging arrangements are in place in respect of individuals who will be receiving residential or nursing home care.
- Ensuring that financial and other management systems can meet the new demands likely after 1 April 1993.
- Ensuring that staff are suitably trained, wherever appropriate on a joint basis.
- Informing the public of the arrangements made by the authority for assessment and the provision of care.

On 25 September, all senior NHS managers and directors of social services were sent a further letter. This said that:

> *all authorities will need to achieve at least a minimum level of progress against the eight key tasks ... the first priority remains a smooth transition from the old to the new systems of:*
>
> - *assessing need, particularly in relation to the 120,000 or so people, including those discharged from hospital who would have entered residential and nursing home care and been supported by Department of Social Security benefits;*
> - *purchasing residential and nursing home care, and as a consequence,*
> - *effectively managing the resources available, particularly those transferred from the Department of Social Security.*

The letter goes on to emphasise the need for close co-operation between health and social services authorities.

> *We consider it essential that all authorities reach agreements by 31 December on:*
>
> - *agreed strategies governing health and local authority responsibilities for placing people in nursing homes and the numbers likely to be involved during 1993/94;*
> - *how hospital discharge arrangements will be integrated with assessment arrangements. These agreements should be between the main purchasing District Health Authority for the unit and the local authorities within whose boundaries the unit is situated. 1993/94 NHS contracts will need to reflect such agreements. Where residents of another local authority use the hospital we expect that the general approach adopted by the main user will be followed. If there are equal main users, joint agreements between the authorities involved should if possible be reached. Authorities having difficulty reaching agreement at local level may wish to invite Regional Health Authorities and Regional Social Services Inspectorate to assist. The Community Care Support Force will also be available to help.*

The Community Care Support Force referred to in this letter had been set up a little earlier to offer practical support to local and health authorities in implementing *Caring for People* through:

- wide dissemination of good practice relating to implementation of tasks and development of practical guidance
- support in resolving across-the-board implementation issues
- work, by invitation, with individual local and health authorities and other organisations which may be experiencing difficulties with particular aspects of implementation.

The Department's concerns emerge very clearly from this official correspondence and also from the requirement set out in the letter just cited that monies would be transferred to local authorities only if satisfactory arrangements on discharge from hospital had been agreed by the end of 1992 with appropriate health authorities. It appeared that all authorities had, by the end of the year, met this requirement, but whether all the other elements of the new policy would be in place is another matter. The Chief Inspector, Social Services Inspectorate, concluded guardedly in his first annual report, *Concern for Quality*:

> *My overall assessment is that local authorities will have the minimum necessary arrangements in place for 1992 but the majority have a great deal of hard work still to do and a number are seriously behind timetable.*

One such area appears to be preparation for the transition to an enabling from a providing role. As we have noted, one objective of the reforms is a greater sensitivity to user needs. One key step in that direction is the creation of more service options which will allow identified needs to be met in different ways, not through standardised services.

Unlike health authorities, social service departments were not required to split up into purchasers and providers. Nevertheless, *Caring for People* and the policy guidance issued to authorities on how to implement the proposals contained in the white paper, made it clear that the Government expected that authorities would move in this direction.

> *The role of an enabling authority is to identify the needs for care among the population it serves, plan how best to meet those needs, set overall strategies, priorities and targets, commission and purchase as well as provide necessary services and ensure their quality and value.* Caring for People *also endorsed Sir Roy's vision of developing a mixed economy of care, seeking out and purchasing services from a range of providers in the voluntary and private sectors as well as the public sector.*

The first results of a project funded by the Department of Health into 'The Mixed Economy of Care' at the Personal Social Services Unit at the University of Kent and the Nuffield Institute for Health Services Studies at the University of Leeds, indicated a widespread reluctance on the part of authorities to move in this direction.

> *However, local authorities have different views of what the enabling role entails; and this accounts for wide variations in the ways in which implementation was being approached. Thus, notwithstanding the broad cultural shift, there was a strongly and widely held belief that local authorities should remain significant service providers – albeit of a set of much more tightly defined services. In addition there was a reluctance in many authorities to reduce public sector provision rapidly because alternative suppliers either do not exist, are not willing, are not competent, or are unsuitable by virtue of being profit-motivated....*
>
> *....Finally, although it is too early to judge the effectiveness of any of the enabling approaches in the delivery of the White Paper's objectives for users and carers, it is clear that unless those objectives are reinforced and form the basis for monitoring the mixed economy, the new framework is more likely to be driven by resource and process factors than by the needs of the population and the outcomes for users.*

Similar findings are reported by the Audit Commission's 1992 report on progress with implementation, *The Community Revolution: personal social services and community care*:

> *Some authorities accept the division between commissioning and providing without any difficulty, but the concept is a problem for others.*

and:

> *A number of authorities are hesitant about the notion of a mixed economy of care. They often have a justified pride in the priority given to services for their more vulnerable citizens. Some consider that their duty is to continue to be the main provider of support ... But exclusive provision denies choice to users and carers.'*

In the light of weaknesses such as these and the general anxiety exhibited in the flurry of circulars and advice directed at local authorities, it would be bold to predict that the introduction of community care in 1993 would be trouble-free. Evidence from one of the few elements of community care where implementation has already begun, care for people with mental health problems who have been discharged from long term care, is also not encouraging. There were two elements: care programmes for those discharged from hospital and mental illness specific grant.

A report by the National Schizophrenia Fellowship published in October 1992 on the first year called *Window Dressing*, suggested that implementation had been patchy:

> *The Care Programme Approach could be a very important element in the long term success of community care in the mental health sphere. However, the lack of clear guidance as to what it is, who it is for, how it should be done, who should be responsible, and how it should be monitored, means that very different interpretations have produced very different plans.*
>
> *Regrettably the survey we have conducted shows that, at the moment, although many authorities are attempting to implement the Care Programme Approach, it appears that the policy has done little more than provide 'window dressing' without substance. Community care for people with long term continuing needs, especially for those who exhibit particular difficulties for management, cannot be realised without adequate and well-targeted resources.*

The Social Services Inspectorate also reported (in *Mental Illness Specific Grants, Monitoring of Proposals for use 1991/92*) the way that authorities were using mental illness specific grant:

> *The monitoring exercise has reinforced much of what was already known about the place of mental health on the social services' agenda. Many authorities have only limited information on the need in their locality but also the full range of what exists. It did not come as a surprise that authorities had problems in costing the service, as the first step is to identify who is doing what and for whom as far*

> *as non-specialist provision is concerned. Whilst authorities' plans for monitoring services were encouraging in the main, the development of outcome measures is a whole new area of activity required. Authorities themselves point to the need for more imaginative ways of consulting with and involving users, and this must surely be on the agenda if community care policy is to become a reality.*
>
> *The apparent absence of mental illness plans and/or the lack of a strategy for implentation in many authorities suggest the need for many local authorities to give this urgent attention. As indicated earlier, however, the monitoring information was collected, for most authorities, in advance of the production of even draft community care plans. It is also expected that the community care planning process, will be an evolutionary process which is hopefully informed and developed as a result of implementing assessment and care management and the purchaser/provider split.*
>
> *The above reflects quite a daunting agenda but is central to the successful implementation of community care policy. The introduction of the first year of the specific grant and the availability of an increased amount in year two present social services authorities with the opportunity to focus on a much neglected client group in a climate which urges a more individualised approach to meeting need.*

The Inspectorate then set out what it considered local authorities should do:

> *In summary, the first year of the monitoring has highlighted the following as issues for further activity by social services authorities if they are to move towards a needs-led service for severely mentally ill people and those suffering from dementia:*
>
> - *a comprehensive service audit of existing provision and skills;*
> - *a strategy for involving service users and their carers in planning, monitoring, evaluation and research;*
> - *improved sensitivity to the needs of minority ethnic groups;*
> - *the development of a costed and realistic strategy which reflects stated values and objectives;*
> - *an agreement on terminology with health authorities and other agencies and a clear definition of responsibilities where appropriate;*
> - *a needs survey;*
> - *the establishment of joint information systems with health authorities which are acceptable to users;*
> - *the establishment of monitoring systems for all services including purchased services;*
> - *the establishment of quality assurance systems in all service units.*

In brief, a system of planning and delivering care and support for mentally ill people remains to be created. On this basis, it would seem unlikely that significant progress towards transferring care for this so-called special needs group will be swift.

The Royal College of Psychiatrists also expressed concerns in their 1992 report *Mental Health of the Nation: the contribution of psychiatry*:

> *Next year will see the implementation of the Community Care Act. This is anticipated with some apprehension. That the needs of our most disabled patients have been recognised by government is welcomed, but we have grave reservations about the ability of local authorities to identify the most needy and to administer and provide a service for them.*

Those reservations may in part reflect differences of view about the proper mode of care for the mentally ill. Nevertheless in the light of the Inspectorate report just cited, it is hard to dissent from the overall conclusion.

Conclusion

Overall, the transition to 'community care' appears an even more hazardous exercise than that involved in the creation of a market for health care services. Both involve a great deal of internal reorganisation and learning on the part of the authorities and their staff. But in the case of community care, the context within which the changes have to take place is far from ideal. The changes introduced in 1993, while far-reaching, do not bear on most of the difficulties that have delayed the process of transferring care from the hospital 'to the community' for the 30 years since the intention to make that transfer was announced in the Hospital Plan for England & Wales. Division between authorities' responsibilities and multiple channels of finance remain. We return to these difficulties in the following part of the Review.

1.3 Public Health Strategy

Just over a year after the publication of their green paper the Government published their white paper *The Health of the Nation; a Strategy for Health in England.* The green paper had set out a number of possible candidates for so-called Key Area status: most of these are included in the white paper, in most instances with more challenging targets. Thus the target for reduction in coronary heart disease has been increased from 30 to 40 per cent. So has that for stroke.

On 8 July the Secretary of State and Sir Duncan Nichol made separate statements indicating how the white paper would be implemented. This was further amplified by a statement by the Secretary of State on 29 September.

At the top is a Cabinet committee which will 'place health explicitly on the whole Government agenda'. Working groups have been established to oversee the whole strategy. The first, under Dr Brian Mawhinney deals with wider health aspects, the second under the chief medical officer, provides epidemiological advice and the third, under Sir Duncan, oversees implementation.

Further working groups have been set up for each of the areas covered in the white paper and a multi-professional task force working at national level to ensure coordination. Each area will have its own detailed handbook, the first of which appeared in early 1993. In addition, task forces have been established to tackle specific areas *eg* nutrition and accidents.

Below national level, there will be a network of regional co-ordinators. Below that, the health promotion element of the GP contract is to be altered from 1 April 1993 to better relate that activity to national and local priorities. 'The idea is to promote local ownership of health promotion within a national framework' and also 'to ensure consistency of approach – so that as many patients as possible across the country have access to health promotion'.

In *First Steps for the NHS*, the results of the initial work done by the area – or as they are called in the document – focus groups – were published in November 1992. Under each area, a large number of recommendations are listed aimed at regions, districts, purchasers and providers, and GPs.

On the surface, this appears to represent a determined attempt to implement the notion of a policy for health, as opposed to health care. But what is being attempted is in fact very difficult. In part the difficulties arise because the technical base for implementing a public health strategy remains weak. Just one of the common set of recommendations runs:

> *Influence the direction of R & D strategy through local perceived needs in the key areas with particular attention to:*
>
> - *developing techniques for needs assessment*
> - *evaluating effectiveness of prevention and treatment strategies*
> - *developing more effective ways of seeking local views*
> - *research into audit and quality improvement.*

All these represent very substantial tasks in themselves but they are only a fraction of those listed. In fact it would be hard to over-emphasise how much remains to be done before enough is known not only about 'what works' but how whatever is done under this branch of health policy compares with the value of traditional treatment services.

There are other difficulties, stemming from the Government's commitment to policies outside health. Although the Government has committed itself to discouraging smoking – see Table 6 – it has continued to resist pressure to ban advertising:

As the Secretary of State put it in her response to the Select Committee report on Tobacco Advertising:

> *The Government has made it clear, not least in evidence to the Select Committee, that it accepts that effective controls on tobacco advertising are a key element of the strategy aimed at reducing the harm from smoking. That is why we have developed stringent voluntary agreements with the tobacco industry. These have contributed to the UK's excellent record in reducing smoking – one of the best in Europe. We have also made clear both to the Committee and in* The Health of the Nation, *that we continue to believe that the best way to control tobacco advertising is through voluntary agreements.*

Table 6: Government Measures Against Smoking

Chancellor of the Exchequer: committed at least to maintaining the real level of taxes on tobacco products;

Secretary of State for the Environment: aiming to ensure that 80 per cent of public places are smoke-free by 1994;

Department of Health: working with the Health Education Authority to develop health education programes aimed at specific groups including young people;

Secretary of State for Employment: aiming to see that the majority of employees are covered by no-smoking policies at work by 1995;

Education: more action on smoking in schools, through the statutory requirement to including smoking education in the national curriculum and through the implementation of no-smoking policies in schools;

Secretary of State for Health: committed to reviewing the effects of tobacco advertising.

While the measures listed in Table 6 involve interdepartmental co-operation, in general it will be far from easy to alter the priorities of a large number of organisations, including the main departments of state, at a time when public expenditure pressures are intensifying their natural inclination to concentrate on their core businesses.

As David Hunter pointed out to a conference in September organised by the Public Health Alliance and Radical Statistics Health Group, there are barriers to effective joint working at national level:

> *Research into cross-departmental working in the sphere of social policy has identified several barriers evident within Whitehall including policy ownership and policy streams. The first of these barriers refers to the territorial boundary issues and fierce ownership of areas of policy and by individual departments. Whitehall is riddled with interdepartmental committees but these are designed less to promote cross-departmental working than to provide a mechanism through which to defend departmental interests and prevent them from being diluted or lost sight of altogether. They are a negative force to preserve the status quo rather than an instrument for policy change. Depart-*

> *mentalism is compounded by interprofessional boundary issues and protectionism both within individual departments and between them.*
>
> *The second barrier – policy streams – refers to the divisions between service policies, resource policies, and governance policies. These are not complementary in practice but tend to run counter to each other with resource policies all too often driving the other streams while remaining uninformed by them. There is no point in having policy/service objectives without willing the necessary means to achieve them. Yet, all too often, in the UK, policy is made in a vacuum and without attention being given to the resources necessary to achieve its aims. Such fragmentation can only hinder a coordinated approach to health policy.*

The intellectual underpinnings of the *Joint Approach to Social Policy*, an attempt made in the 1970s to integrate policy making in the social field across departments, were very similar to those of *Health of the Nation.* Even though it provided a strategic forum for Ministers in which they could think about social policy in the long term, it failed, because Ministerial commitment was not strong enough. The objectives of their own departments were put before those of others. In other words, the failures we have referred to at local level in the context of care in the community occurred at national level also.

A critic, recalling how not just the *Joint Approach to Social Policy* but also other attempts to reform central government failed in the 1970s under the pressure of poor economic performance, might well conclude that nothing of substance is in fact likely to happen. Hunter however is a supporter not a critic of the Government's policy but he recognises the force of precedent: his suggestions for progress are modest but realistic, emphasising as they do the need to build up general public support:

> *Crucially, a coherent intellectual climate of opinion and growing public constituency in favour of a health strategy is beginning to take shape. Public opinion could prove to be the most powerful ally available to supporters of the strategy in government. Evidence of a more health conscious public is particularly noticeable in the area of food policy where concern over food safety and supply has led to a desire for increased intervention in food production and not merely food consumption.*
>
> *It will not be appropriate for the health strategy steering group to conduct its business in secret nor for it to act in the tradition of an interdepartmental committee. It must seek to establish its own modus vivendi. The more its activities are open to public view and scrutiny the better.*
>
> *A possible mechanism to be put at its disposal is a requirement that the health implications of other departments' policies be subject to analysis through the device of a health impact statement. Such statements will be published in much the same way as, for instance, the reports of the Health Advisory Service are now. The value of such statements would lie in sensitising policy-makers in particular problems especially those arising from the activities of other departments or agencies. Health impact statements would inform the debate on a particular health policy question by bringing together all the issues that need to be considered. In short, they are a means of institutionalising an interdepartmental approach to interrelated problems.*

His overall conclusion is sobering:

> *Whatever mechanisms are adopted to secure the implementation of the government's health strategy, the hole at the centre needs to be filled effectively if the health strategy is to survive.*

Hunter is clearly right to stress that while a public health strategy may be desirable if we start from the health end, it may look less attractive to, say, a Department of the Environment, with priorities of its own, or to a district health authority anxious to keep its waiting lists down. So while the Government has made a good start, the real test of its commitment will occur when these tensions start making themselves apparent, as in due course they certainly will.

Although *The Health of the Nation* does represent a genuinely new initiative, the NHS has always been engaged in public health work. In one area, vaccination and immunisation, the Government were already able to claim some success for targets in preventive activity. By May 1992, the existing targets of 90 per cent uptake set had been met and the more demanding target of 95 per cent was set which one region, East Anglia, had already met.

As far as the overall surveillance of children is concerned, the position is much less clear. Here the Government have not set down clear guide-lines on what should be done nor is there any standard statistical return which requires health authorities to report on what they are doing. Instead, in HSG (92)19, the Management Executive put forward, on an advisory basis, the programme of surveillance suggested in the second edition of what has come to be known after its chairman as the Hall Report. This presented the results of a working group convened to define the content of a child surveillance programme. It recommended a relatively limited programme, suggesting the elimination of some commonly used tests on the grounds that there was little evidence to support them and tentatively recommending a number of others where there was some, if imperfect, evidence for retaining.

But like the Hall report itself, it did not tackle the issue of implementation, even though, as the Court enquiry found in the mid-1970s and as subsequent evidence has shown, who should do what is often not clear. The confusion of professional roles and lack of an agreed definition of what should be done have meant that no clear standards have been set and so no satisfactory monitoring measures as to who is getting what exist. For that reason, an article on school health services which appeared in *Health Care UK* in 1986 was sub-titled *The Invisible Service.*

The GP contract has given a direct financial stimulus to GPS to become involved more widely in child health surveillance but it remains true that hospital and community paediatricians, health visitors and other nurses all have a, sometimes overlapping, role to play: despite the efforts of the Hall Committee there is no consensus on what should be done by whom.

A similar contrast in performance was revealed in a report by the National Audit Office and then subsequently by the Public Accounts Committee, in HC 58, on the cervical and breast cancer screening programmes. The contrast between the two programmes is instructive. Whereas breast screening has been operating well, that for cervical screening has had mixed results.

The Chairman of the Committee pointed out during the taking of oral evidence that:

> *... the acceptance rates for cervical screening varied significantly across the region with inner-city areas in London having the lowest rates. 'Newham for example was achieving 40 per cent acceptance. That is a very sad situation is it not.'*

Duncan Nichol replied as follows:

> *Yes, absolutely. Despite what I said about the broad coverage of cervical screening we have an analysis district by district, FHSA by FHSA, as to where the black spots are, and if we take a cut-off of below 50 per cent, then those districts are all concentrated around London.*

The National Audit Office itself concluded:

> *There are clear differences in the organisation and management of the two programmes. The breast screening programme, which was developed and funded from the start as a national programme, is operated on a consistent basis and is managed well. In 1990-91 its running costs amount to £24 million. The cervical screening programme developed initially at local level in the 1960s subsequently became a national programme. It continues to exhibit local variations and management responsibilities are split between the primary and secondary healthcare sectors. There is no reliable current estimate of its cost.*

The lesson appears to be straightforward. The one programme was well set up, proper management systems were put in place, and it worked. The other did not have the benefit of that degree of central attention, and it has not. It is not just a matter of the high turnover of population in Newham.

The National Audit Office went on to suggest that some of the obstacles facing a successful screening programme might be less important in future:

> *Managing the cervical screening programme presents a particular challenge. Inviting women and taking the smear generally fall to the primary sector, while the interpretation of the smear and further investigation and treatment fall to the secondary sector. This requires effective liaison. Following a 1986 recommendation of the Committee of Public Accounts, the Department require health authorities to make a specific individual responsible for the organisation and effectiveness of the programme at local level. The individual generally works through a co-ordinating group as he has no formal authority over those providing the service.*
>
> *The National Audit Office conclude that the separation of purchaser and provider roles presents authorities with an opportunity to review and strengthen the management of the cervical screening service. In particular, purchasers should use the contracting process to specify the levels of service required, including quality standards and waiting times. The Department told the National Audit Office that, in addition, the management arrangements introduced by the reforms whereby Districts and Family Health Service Authorities are managerially accountable to Regions should help forge stronger links between those authorities, and with laboratories and hospital services.*

The same point applies to the wider public health policy that the Government has launched: the introduction of 'uncommitted' purchasers should make it easier to make any shifts in resources that the new policy suggests. But, as we have already suggested, there will be pressures on the purchasers as well, not least from the Management Executive, as it continues to try to derive more measurable output *ie* more cases treated. We can only wait and see how that conflict will be resolved.

1.4 Serving the Consumer

The task that the Government has set itself, in the NHS, as in other parts of the public sector, is to make service providers more responsive to the needs of their users. The structural reforms already described are intended to promote that objective by creating the conditions within which users can either exercise choice directly as they may, within limits, in selecting a GP, or purchasers can exercise choice for them, having established what their needs are through research or consultation. At the same time, the Government has taken another route to the same objective, laying down in the Patient's Charter, on behalf of all patients, certain rights and standards.

During 1992, the Government pressed ahead both with implementing and extending the Patient's Charter. In January, guidelines were issued to health authorities for implementing the Charter, followed in August by advice on monitoring and publishing information on the performance of health authorities in meeting its requirements.

On 4 December 1992 , the Government announced an extension into primary care; Family Health Service Authorities were asked to concentrate on the following standards from April 1993:

- helping people who need to find a doctor or who want to change doctor;
- improving the information they give their community about local health services;

- moving patients' records efficiently and quickly from one surgery to another; [within two working days when doctors need them urgently and within six weeks in routine cases];
- improving the way in which they deal with comments, suggestions and complaints about local services.

In addition, local GPs and health teams are being asked to consider setting quality standards for their own practices and health centres, for their health promotion activities, for their facilities for disabled people and for parents with children, and the services they provide for cultural minorities. Finally in January 1993 the Health Information Service was launched. This enables anyone ringing the freephone number 0800 66 55 44 to enquire about local health services.

A survey by Roy Carr-Hill and Fowie Ng – reported in the Health Services Journal (5 November 1992) of how the Charter was being implemented at local level – revealed considerable variations, due, the authors suggest, to a lack of clarity over its different elements. The national charter distinguished rights from standards and allowed for national and local contributions to each, but these distinctions appear to be lost in the process of implementation. Furthermore, different Charter documents may be available – from district, family health service authorities and trusts in the same area – but they may not be worded in precisely the same way.

These might be irritations which will disappear very soon: more important is the question of whether or not it is possible to check whether the standards put forward at national and local level are in fact being met.

The Department of Health, in circular HSG (92)36, asked authorities to report on:

- percentage of patients assessed immediately after arrival in accident and emergency;
- percentage seen within 30 minutes, or between 30 minutes and one hour, of the time of their appointment, in out-patients;
- numbers of operations cancelled for the second time, on the day of, or after, admission, and numbers not admitted within one month after that second cancellation.

As Carr-Hill and Ng point out, these measures are treacherous: what exactly does 'seen' imply? Furthermore, answers could depend on perfectly legitimate variations in the organisation of services. According to a further report in the Health Services Journal (3 December 1992), a trial assessment within North West Thames Region showed some hospitals did not have a system for identifying patients whose operation had been cancelled twice, furthermore:

- hospitals had different definitions of 'immediate assessment' in accident and emergency departments;
- individual provider results were submerged within district returns;

In addition, the Audit Commission's study of hospital services for children, *Children First*, found widespread shortfalls from Charter standards.

These findings suggest that a great deal remains to be done to improve the match between the intention and contents of the Patient's Charter and what is actually happening. So far the evidence is very limited, but during 1993, authorities will be themselves reporting on their progress, making it clearer how well implementation is proceeding.

Even at this early stage, however, rather wider issues are emerging than those arising from the process of implementation. We approach these by looking next at the rather different developments within social services. Local authorities fall within the ambit of the Citizen's Charter, but its manner of implementation has been quite different.

Instead of defining rights – however limited – to care, the emphasis has been put on providing users with information about the services being provided. Following the 1992 Local Government Act, the Audit Commission was charged with developing performance indicators for all local authority services including social care.

Unlike the performance indicators in use within the NHS, these were not to be aimed at managers but at citizens, either as taxpayers or users. In the words of the Act:

> *The Audit Commission … shall give such directions as it thinks fit for requiring [local authorities] to publish such information relating to their activities … as will in [its] opinion, facilitate the making of appropriate comparisons (by reference to the criteria of cost, economy, efficiency and effectiveness) between:*
>
> *a) the standards of performance achieved by different [authorities]*
>
> *b) the standards of performance achieved … in different … years*

The Commission argued in its consultation paper:

> *The wider framework for this Act is the government's Citizen's Charter programme. This comprises a series of initiatives designed to improve the quality of services to the public, and to make them more responsive to the needs of those who use them. As set out in the 1991 White Paper, there are four main themes;*
>
> *Quality – A sustained new programme for improving the quality of public services.*
>
> *Choice – Choice, wherever possible between competing providers, is the best spur to quality improvement.*
>
> *Standards – The citizen must be told what service standards are and be able to act where service is unacceptable.*
>
> *Value – The citizen is also a taxpayer; public services must be able to give value for money within a tax bill the nation can afford.'*

In September the Commission published a list of indicators for consultation. After revision in the light of the comments received, they were finally published in the form shown in Table 7. These proposals served different functions: some are clearly contextual and do not bear directly on performance in terms of service quality. Others, such as the indicator suggested for fitting of equipment, are very close to the spirit of the Patient's Charter. This list clearly only covers part of the ground, concentrating as it does on what is being provided rather than how effective provision is in terms of cost, or user satisfaction. The Commission began in early 1993 a programme of work to extend and improve this initial list.

Nevertheless, the contrast between the approach adopted in the NHS and in local authorities is striking. Despite the Audit Commission's responsibility for monitoring NHS performance, it was not charged with developing a similar range of indicators for the NHS. The Management Executive publishes a large amount of information about the workings of the NHS but there has been no attempt, since the Koerner working parties to define a set of indicators which might allow the Executive or the Government or both to be accountable to the users of the service. In February 1993 the Government announced its intention to introduce a short list of indicators which would be the basis of a league table of hospitals. But that falls a good way short of what the Commission is committed to attempting on behalf of users of local authority services.

Yet another difference emerges from proposals put forward in October for the inspection of social services departments, as yet another branch of Citizen's Charter activity. The Social Services Inspectorate and the Audit Commission are to work together to provide overall asssesments of the departments' performance. How this is to be done has not been specified, but it appears far in advance of anything yet proposed for health authorities or indeed any other public sector bodies.

Moreover, while the Government appeared intent on applying the Charter more widely within health care,

Table 7: The Provision of Social Services: Audit Commission Indicators

The Elderly

a The number of elderly persons aged:
  (i) 65-74;
  (ii) 75 and over.

b The percentage of elderly persons receiving help from the authority to live in their own homes aged:
  (i) 65-74;
  (ii) 75 and over.

c The percentage of elderly persons supported by the authority in residential care aged:
  (i) 65-74;
  (ii) 75 and over.

People with Learning Disabilities

a The number of adults under 75 known by the authority to have learning difficulties.

b The percentage of such persons receiving help from the authority to live in their own homes.

c The percentage of such persons supported by the authority in residential care.

People with Mental Health Problems

a The number of adults under 65 with mental health problems receiving help from the authority to live in their own homes.

b The number of such persons supported by the authority in residential care.

Helping People to Live at Home

a The total number of persons receiving help from the authority to live in their own homes.

b The percentage of those receiving such help who receive help from the authority on:
  (i) 2-5 visits per week.
  (ii) 6 or more visits per week.

Assessment for Social Services

a The number of adults referred to the authority for assessment for the provision of social services.

b The number of assessments recommending:
  (i) No service;
  (ii) Service by a single agency;
  (iii) Service by more than one agency.

Provision of Equipment

a The number of requests for bath board and/or bath seat.

b The sum of the number of bath boards and bath seats provided.

c The local target(s) for speed of provision.

d The percentage provided within target(s).

The number of respite nights provided or funded by the authority.

The net expenditure per head of population on social services, as follows:

a Elderly and physical disabilities.

b Learning disabilities.

c Mental health.

there would appear be no plans to extend the charter rights approach to social care. There is a large gap between an agreed right and the duty to publish information about performance. The former may, if with difficulty, be enforced, if it is indeed a legally enforceable entitlement. The latter can, at best, be the focus for complaint and political pressure. But if the 'rights' approach is appropriate to health care, why not to social care? Before answering that question, we look first at the implication for consumers of other initiatives the Government has taken in locally provided service.

As we have noted, the Government's proposals for community care are aimed at producing a better match between services and the needs of the person requiring care. Within that unimpeachable objective lie two distinct ideas:

- that people's needs should be better met if professionals can draw on a wide range of services from a range of suppliers;
- that people should be able to choose the services which suit them best.

We have commented earlier on the progress being made in introducing the purchaser/provider split, which bears on the first of these principles. It seems that some authorities are dragging their feet, continuing to believe that they know best what should be provided and how. Where this attitude prevails, users will have little to choose from. When announcing her proposals for the transfer of social security funds, the Secretary of State emphasised the importance of preserving choice for individuals:

> *Choice is commonsense and an individual right. The elderly and the handicapped must not be denied their right to choose how they wish to be cared for at perhaps the most vulnerable stage of their lives.*

In December the Department issued a circular (LAC (92) 47) on choice of accomodation which was designed to implement this general commitment. In its own words:

> *This direction is intended to ensure ... that people are able to exercise a genuine choice over where they live.*

The circular makes it clear that authorities are not bound to pay above 'what they usually expect to pay' and hence acknowledges the budgetary constraints which authorities face. However, it failed to define what should happen if someone wanted to remain at home, even if that were more expensive to the authority than moving into residential care – or indeed vice versa – or if they wanted to remain close to their old home, or to be near relatives.

Nevertheless, the circular does embody a commitment to choice, albeit a circumscribed one. How far other government departments appear to be from viewing things in this way can be seen in the austere managerialism of the Housing and Community Care circular (LAC (92) 12) issued by the Department of the Environment:

> *Both community care planning and individual assessment and care management must take account of all the costs involved, including housing and other accommodation costs, and of the resources available to the various parties and of the other claims on such resources. In no case should the resources of any authority be committed without the agreement of that authority. The ideal solution for an individual or group of individuals, based on a systematic assessment of needs, may not be achievable either immediately or in the near future, but it should inform the planning process. Community care in itself creates no new category of entitlement to housing, and housing needs which are identified by community care planning and individual assessments should be considered alongside existing processes and local priorities.*
>
> *Social services authorities and housing authorities should construct an individual's care plan with the objective of preserving or restoring non-institutional living as far as possible, and of securing the most appropriate and cost-effective package of care, housing and other services that meets the person's future needs. For some people the most appropriate package of care will be in a nursing or residential home, but in many cases this will be achieved by bringing in domiciliary support and making any necessary adaptations to the individual's existing home. The balance between these should be considered carefully. For example, where expensive or disruptive adaptations or improvements are being considered it may be more cost-effective to provide domiciliary care and support together with more minor works. In other cases adaptations or improvements (eg to help people bathe or cook by themselves) may reduce or obviate the need for domiciliary support.*

Here the professional viewpoint dominates – the user apparently has no say in what should be done. Community care presents no special claims – traditional housing priorities will continue so choice by the individual is subordinate.

The reason for the circular's cautious drafting is obvious: there is a fundamental difficulty in promising choice within limited constraining resources. Evidence offered by Professor Grimley Evans to the Welsh Affairs Committee investigation into community care posed the issue as follows:

> *The response to an old person's dependency may take two forms. One is a therapeutic intervention aimed at improving the person's functional abilities. The second is a prosthetic intervention in which a service is provided that compensates for the old person's disability. The provision of a prosthetic service where a therapeutic intervention would have been applicable is often expensive in the long-term and renders what could have been a temporary disability permanent. Most old people value independence and would opt for the offer of therapeutic rather than a prosthetic intervention. Some however will find the option of being waited on more attractive than undergoing a period of treatment and rehabilitation. This raises the question of whether an old person who could benefit from a therapeutic intervention (eg physiotherapy) should*

> *be required to undergo this before qualifying for a prosthetic service (such as a home help). Such ideas have been resisted in the past particularly by social workers, on the grounds of social equity in the view that clients of the State should be able to obtain on demand what the rich can purchase for themselves. It may be asked on the other hand whether it is indeed unreasonable for a consumer of public funds to be required to co-operate in the most efficient use of those funds. Such issues as this need to be addressed in the context of a general policy for community care rather than imposed locally and verbally.*

While this is a personal view, the point it reflects will no doubt occur to many authorities faced with more need than they can meet. Choice will be constrained for some, in order that others may continue to receive services. If choice is offered, it is likely to lie within a pre-determined care cost, not of the care package itself. Furthermore, in the absence of any clear rights to care, the chances are that policy will be determined locally and verbally – *ie* in a way which leaves no trace behind in the case notes.

If, as seems likely, assessments reveal more need than can be met, the Government's evident reluctance to apply the Patient's Charter approach to social care is not hard to explain. The risks of major resource commitments are too great. That fear clearly underlay a letter from the Chief Social Services Inspector issued in December, which advised authorities not to define a person's need in terms of particular services unless they were prepared to pay for that service. At one level this was good advice: the whole aim of the new policy has been to try to get people's needs defined, not need for a particular (traditional) service. But the underlying message of the circular was that authorities should be cautious about committing themselves and creating rights which might be enforceable in the courts. The Department went on to tell the Health Select Committee that it did not intend to collect information from authorities on what they have not been able to provide, even though such information might have made some contribution to improving the standard assessment forumulae underlying the distribution of funds to authorities in respect of social services.

By March 1993, with the new arrangements about to come into force, the position remained ambiguous. According to press reports at the time some local authorities were intending to record all 'unmet needs' while others were not, and a number of charitable organisations representing the interests of social service users, declared their intention, after taking legal advice, to challenge local authority decisions in the courts.

The irony of the present situation is that a government committed to spending restraint has introduced a new policy designed to reduce spending in one area, residential care, which threatens to make the case for spending more in another, domiciliary care, and that the latter effect could easily outweigh the former.

These difficulties arise because of the need to combine choice with budgetary constraint. Yet the promotion of choice does not necessarily require extra public funds: instead, it may imply new methods of service delivery, as became apparent from hearings before the House of Commons Health Committee on maternity services.

The Committee concluded:

> *that the choices of a home birth or in small maternity units are options which have been substantially withdrawn from the majority of women in this country. For most women there is no choice. This does not appear to be in accordance with their wishes.*

Furthermore, as we point out in another article in this volume, the non-hospital options are not necessarily more expensive.

The Government's response runs as follows:

> *There are no hard and fast rules about how the maternity services should be organised in a particular locality; nor could there be. The key factor is the outcome: a well baby and a healthy, happy mother. Most births take place in district general hospitals because of the ready availability of emergency facilities in case something goes wrong. But that is not and must not be a mandatory arrangement. Among the many varied kinds of provision to be found within the NHS there are examples of novel and effective arrangements for delivering maternity care and the Health Committee has commented on some of these. Two major principles emerge from these considerations:*
>
> - *the importance of providing safe maternity care*
> - *the need to enable women to make choices about the maternity care they receive including, for women for whom the risk of complication is low, the choice of care in a low technology environment, in a hospital or at home.*
>
> *The Government supports these principles and, within the framework of the initiatives ..., will facilitate choice within the NHS.*

If the Government were to heed what they are advocating for social services, measures could be devised and published which would bear on this issue. Some could be quite easy – *eg* proportion of home births for each purchaser. Others would be more difficult to devise *ie* tests of the reality of choice.

Even where resource limits do not apply, because costs of alternative action are similar, creating 'real' choices is a far from straightforward matter. In the case of maternity care, in the words of a King's Fund paper written in response to the report:

> *Helping a woman choose the 'best' care for her and her child during pregnancy depends upon information about the range and quality of services available and matching the appropriate care to her individual needs and circumstances. Exploring these areas takes time, requires good information about the likely outcomes of possible options for care and is not ideally suited to the pressure of traditional consultation processes with professionals during pregnancy.*

The work being done within this project suggests that interactive videos may assist in making informed choices. The Royal College of Surgeons for its part has been testing leaflets on hernia operations and hip replacements with the same end in view. The Government's response to the Committee shows no acknowledgement of what needs to be done to satisfy these criteria and what might be appropriate measures of the reality of choice.

But, as the Audit Commission has clearly taken to heart for social services, measures or explicit statements must be available if the operation of policies of this kind designed to benefit patients are to be monitored. At present there appear to be no plans to develop a full range of indicators for such purposes within the NHS.

Conclusion

As with public health policy, the Government is tackling an important question: can public services respond better to their clients? But what they have not done – and it would be no small task to do it – is work out the full implications of adopting a user-orientated approach. It is too large a task even to sketch out here what is involved, but as far as community care is concerned, our argument suggests that current policy is not internally consistent: choice is being proclaimed on the one hand, while it is effectively being circumscribed on the other. As for the NHS, there is a risk of inconsistency too but not in the same way.

The risk of inconsistencies arise, as we have pointed out already, between the broad changes that the Government is encouraging in primary care, and the effective ability of users to choose their GPs. It also arises between the targets set for waiting lists, as provided for in the Patient's Charter, and other objectives. The Government managed, more or less, to eliminate two-year waiting time before the 1992 election, but there continues to be evidence that achievement of that target had costs of its own – in terms of more important cases being put to one side and also of poor quality work being done in the rush to meet targets. Exactly what the trade-offs were between meeting the targets and other objectives cannot be established with any precision, but it would be hard for the Government to argue the opposite case – that no trade-offs were made. Yet the Secretary of State managed to do just that in February 1993 when announcing the latest waiting list figures.

Those figures showed a fall of 45 per cent in the numbers waiting over one year, in itself, a considerable achievement. But in the same period, the numbers waiting under a year rose, and overall numbers waiting went up. But instead of recognising that there might be some connection between the two trends, the Secretary of State argued:

> *The increase in the number of under one year waiters reflects the fact that more patients are now being referred for treatment as the NHS works more effectively and is able to offer many more services.*

As we suggested in last year's review, there are reasons for thinking that referrals will increase, the higher activity goes, which in itself makes a nonsense of using the length of waiting lists as a measure of success or failure. But exactly how much of the lengthening is due to extra referrrals and how much to people being delayed to meet the two year target, we do not know. Once again therefore, our overall conclusion is that the implications of the policies the Government has embarked on are just becoming apparent. The goals are desirable: what we do not know are the costs of achieving them.

PART 2 COMMENTARY

In the second part of our Review of 1992/93, we stand back a little from the main policy initiatives which the Government took during the year and attempt an overall look at the whole of publicly financed health and social care. Last year's review focused on boundaries, taking first the boundaries of public provision and next boundaries within public provision. We return to this theme but in this year's Review we take as our starting point the public expenditure settlement of Autumn 1992.

That gave very little extra to the NHS – indeed if pay is not contained within the 1.5 per cent limit set by the Government, there may be no increase at all. Furthermore, economic commentators have suggested that the Government is going to continue to find it hard to make extra resources available to the NHS: if so, then the question of what the role of the NHS should be – and complementary services provided by local authorities – will reassert itself.

Throughout the 1980s the Government relied on efficiency savings to bridge the gap between growing needs and limited resources. The introduction of the new arrangements, described earlier in the Review, represent the latest and most ambitious attempt so far to extract more care from the resources allocated to the NHS. To do that, the Government intends to replace traditional managerial pressures with those of competition. But if their hopes are to be realised, competition must be allowed to develop. We therefore go on to consider the rules governing the way the new health market is intended to work.

But at the same time, the Government is preaching to another text, that the different parts of the health and social care system should so inter-relate to each other that users experience a 'seamless' service. In the final part of this Review we look at some of the tensions between pressing down the competitive route while seeking at the same time to ensure that seamlessness is achieved.

2.1 Public Expenditure

The introduction of the new regime for the NHS coincided with a very favourable public expenditure settlement prior to the 1992 election. But thereafter, as the 1992 Autumn Statement made clear, the overall outlook for public expenditure in general and health care in particular is not good. On the one hand, the performance of the UK economy has been poor, so that extra resources have not come from growth. On the other, the pressures for more spending right across the board have continued. There have been some savings in defence, the peace dividend, but there have been strong pressures to expand other programmes including the largest, social security. All these forces have been present during the 1980s, but while the economy was expanding the Government was able to cope with them.

But now public expenditure is expected to rise as a proportion of gdp and the public sector borrowing requirement has reached record levels. Against this economic background, and given the Government's commitment to keeping direct taxation levels low, increases for any programme will be difficult to find, not just this year but for the foreseeable future. This gloomy forecast was endorsed by the OECD's most recent report on the UK economy which argued that a sizeable proportion of the deficit reflected long term factors, not the current level of unemployment. The Treasury and Civil Service Committee issued a similar warning and the Government itself, at the beginning of 1993, announced that it was beginning a fundamental review of public expenditure which would question the basis of programmes, not simply whether they should get a bit more or a bit less.

As the editorial in *Health Care UK 1991* pointed out, the reforms which began to be introduced last year are partial: they do not address the central issue of what the role of publicly financed services should be. Instead, the question has been addressed indirectly, through a gradual squeeze on the boundaries of free provision, particularly of long term care. While the objective of a universal health service free at the point of use has been maintained for nearly all hospital and community health services, extra contributions have been required from those 'able to afford them', as Government ministers put it when announcing increases in the cost of prescriptions and other charges in March 1993.

If public sector resources are going to be scarcer relative to needs than they are now, then the issue is whether these strategies – increasing efficiency, reducing the scope of free provision and raising existing charges – for reconciling limited resources on the one hand and growing pressures to spend more on health on the other can be maintained.

Two questions arise: can existing resources be made to do more either by keeping costs down or raising efficiency? Should some current NHS activity be financed in other ways?

Restraining Costs: as far as restraining costs is concerned, the most important single area is pay. The Autumn Statement indicated that public sector workers would be limited to increases of 1.5 per cent. As the Secretary of State put it:

> *The pay restraint measures which the Chancellor has announced will apply to NHS staff in the same way as they do to others in the public sector as a whole. I want to make it clear now that the Review Bodies for doctors and dentists and for nurses, midwives and the professions allied to medicine have a continuing role and we greatly value their advice.*
>
> *For this year we are amending the Review Bodies report and inviting them to consider the sum available for the groups they cover. It is this Government which established the Review Body for nurses – and it is important that the Review Bodies should continue to play their part in NHS pay determination.*

But a very limited part. By changing their terms of reference in this dramatic way, the Government have effectively brought the Pay Review Bodies to heel. What we can expect is that in future they will be invited to advise on how the amount allowed for pay increases in the annual cash limit should be allocated. The Pay Review Body for Doctors and Dentists, perhaps recognising this implication, declined to make recommendations at all this year and so withdrew from this year's round leaving the Government to negotiate directly with the professions concerned.

It may be therefore that the Government will achieve greater control over the NHS wage bill in the medium as well as the short-term, since throughout the 1980s the Review Bodies have persistently declined to treat the overall cash constraint as binding on their recommendations. But of course there is a limit to the extent to which NHS pay can be held down below levels in other types of employment. Pressures to catch up will re-emerge as soon as unemployment starts to fall significantly. Any benefit, therefore, is likely to be short-lived.

The other arm of the Government's policy is to allow trusts more freedom to determine their own pay and conditions in the light of local conditions. The evidence so far is that trusts are moving cautiously in the direction of exploiting their freedom to determine pay structures which should allow them to take advantage of local market conditions, even possibly to pay less than national agreements. But at the same time they are paying higher salaries to attract more experienced staff while reducing staff numbers.

In a paper for the Management Executive's Personnel Development Unit, Professor Roger Dyson argued that in a sense more could be done with less:

> *A key to success in changing labour utilisation lies in getting across the message that it is possible to change labour utilisation and reduce costs, whilst at the same time improving benefit to staff and the quantity and quality of patient care.*

He recognised that the process would be difficult, involving as it must, an attack on established positions:

> *The National Health Service employs an unusually large proportion of staff who are professionally, technically or commercially qualified. It possesses an intricate and long established pattern of demarcations between these groups of staff involving a range of clinical hierarchies between eg doctor and nurse, technician and pathologist, radiographer and radiologist etc. These hierarchies may have some instability caused by professional rivalries and challenges to the establishment of managerial relationships between them but at heart they are fiercely defended...*

Why should these difficult tasks be attempted? Dyson's answer follows the logic set out above:

> *The creation of the internal market and its implications are unquestionably the most radical change in the NHS since its inception. If free at the point of delivery health care is to survive the 1990s, it has to deliver an increasingly complex range of clinical services with a fixed budget... It is hard to see how this can be achieved by maintaining the present pattern of labour utilisation. There is no longer an option to ignore the challenges of efficient labour utilisation and the hospitals that continue to ignore those challenges may not survive in their present form into the second half of the decade.*

Competition is to be the spur to reducing staff costs – but that presupposes that it will be sharp enough to provide sufficient incentives to change – whether it will be is considered further below.

The Government has also continued to take further measures to control spending on drugs, spending on

Table 8: Extension to Limited List

anti-diarrhoeal

drugs for allergic disorders

hypnotics and anxiolytics

appetite suppressants

drugs for vaginal and vulval conditions

contraceptives

drugs used in anaemia

topical anti-rheumatics

drugs acting on the ear and nose

drugs acting on the skin

which has continued to grow faster than the overall NHS budget.

On 1 December 1992, it announced plans to extend the limited list in the areas shown in Table 8 and also to increase the range of medicines available through pharmacies, a renegotiation of the pharmaceutical price regulation scheme and a task force to promote better prescribing. No estimates of potential savings were put forward. It is hard to see that these measures will do more than slightly modify the existing rate of expenditure growth.

Raising Efficiency: in response to the Autumn Statement, the Department announced that efficiency gains worth some £390 million, or about twice the current level, would be requested. How attainable is this higher level?

In *Health Care UK 1990* Anthony Harrison reviewed the efforts that the NHS had made in the 1980s to raise the efficiency with which it uses resources. His overall conclusion was that while the NHS had performed quite well in relation to other parts of the public sector, there was no reason to believe that greater savings could not be made. Since the earlier article, the scope for further cost savings has been identified in a number of reports from the National Audit Office and the Audit Commission on such diverse matters as the use of medical beds, more day surgery, the supply of sterile dressing, and purchasing supplies.

Savings from sources identified in these reports could in principle be made within the old arrangements: they all fall within traditional areas of management action. The introduction of a purchaser/provider split will not in itself make the extraction of savings any easier – indeed, it is not clear which 'side' will be responsible for volunteering to provide cost improvements, to use the old terminology.

The essential difference between the new arrangements and the old is the ability of purchasers to move to cheaper – or better – sources of supply. None of these audit reports bear on the potential benefit that market processes can bring within the NHS, nor has any estimate been offered by the Government.

It has of course been Government policy for nearly ten years to exploit the potential of competition for keeping costs down by requiring competitive tendering for support services. Extension of that policy was announced in the Treasury white paper *Competing for Quality* which appeared in November 1991. This set out the scale of the achievement so far in NHS support services, claimed to be the equivalent of 200,000 hip replacements. As the white paper reports, a number of health authorities have moved beyond the range of services for which tendering was made compulsory: see Table 9.

Table 9: Examples of Services Put out to Tender

Building services and maintenance

Engineering services and maintenance

Domestic and cleaning services

Equipment maintenance

Computer hardware and software maintenance

Hire of transport

Data processing

Laundry and linen services

Transport maintenance

Grounds, gardening and farming

Legal services

Car parks

Audit

Sterile services

Waste disposal

Window cleaning

Pest control

Management consultancy services

Source: Competing for Quality

The white paper goes on to say that, in order to extend the market testing programme to cover a wider range of activities and functions, the Department is intending to carry out:

> *... a full examination of the services currently supplied centrally to internal customers, including certain pay and personnel management, job evaluation and workload assessment, internal consultancy and audit functions, to determine the scope for providing services on a full repayment basis, and possible contracting out.... and to examine the Department's purchasing and supply functions, to remove obstacles to tendering and ensure managers are equipped with the necessary purchasing skills and expertise.*

The white paper does not however put forward a target or suggested level of savings from this extension of the contracting-out process within the field of support services, nor for the contracting process for health care itself. While it may seem foolhardy for a Government to embark on reform of the scale required by *Working for Patients* without such an estimate, the fact is that both the costs and the benefits of the new arrangements are inherently hard to predict. All the Government has offered so far is the rather slender evidence of a higher rate of activity. It is not, however, easy to remedy this deficiency.

It was one of the criticisms of the figures for cost savings made by introducing tendering for support services, that the management costs of carrying through the process were not taken into account. The same point holds, even more strongly, for the introduction of contracting for health care itself. The full costs, in terms of the opportunity costs of management time, can never be known, but even the 'official' figures are large – over £700 million according to the Department's own figures, as Table 10 shows:

Table 10: NHS Review Expenditure

	1991/92	1992/93
	£ million	
Total NHS Review	383	382
HCHS Revenue		
100 Consultants initiative	37	36
Resource management initiative, clinical audit and IT	87	103
Enhancement of personnel, finance and other key staff functions and training	87	93
NHS Trusts	22	34
Family Health Services Authorities – Administration	36	36
Other Revenue expenditure	34	37
Total revenue	303	339
HCHS Capital Resource management initiative, medical audit and IT	65	28
Quality initiative	5	5
Total capital	70	33
FHS Practice funds management allowance	6	6
Total FHS	6	6
Other – Prescription Pricing Authority	4	4

Source: departmental reports.

However, this Table makes no allowance for the continuing costs of implementation, though these absorb large amounts of increasingly well paid senior management time.

The scale of just the quantified expenditure presents a large challenge for the new arrangements in terms of achieving either greater cost savings or greater benefits than the previous arrangements were producing. Curiously, the case for the new arrangements as presented by the Government has not been supported by any analysis of the economic factors underlying the provision of health care which would suggest that benefits are to be gained from a competitive process. For example, it has not argued that currently hospitals are too small to be efficient in terms of cost and quality or both, nor that existing arrangements were insufficient to eliminate units that were not efficient. Furthermore, gains of this type are likely to be limited by the nature of the market served which, for most services, most of the time, will continue to be a local one.

We know from NHS indicators that there are very wide variations in costs, bed utilisation and staffing ratios between different authorities, but that information in itself gives no indication of the scope that market processes have for eliminating them, since many hospitals will be largely immune from them. In any case, many apparently competitive private sector industries also display very wide variations in efficiency from the best to the worst: the process of eliminating the poor performers is slow, even in circumstances where there are no obvious impediments to change.

Nevertheless, if we knew the range within the NHS, that would give some indication of the scope for improving performance by bringing the worst up to the best or, more realistically, the current average. The early days of the 'new' NHS have produced a very wide range of prices for the same operations. If we could rely on these prices being close reflections of variations in the actual cost of carrying out each operation, then an estimate might be made of the benefits of trading. However, it seems highly unlikely that the spread of prices accurately reflects the spread of costs. If we look at costs themselves however, some indication of the scale of the 'once and for all' gain from switching to cheaper sources of supply may be obtained.

As we have noted, the first 'victims' of the market may well be among the inner London hospitals. According to calculations by Sean Boyle and Chris Smaje (Public Money and Management, October-December 1992) their average costs are some £400 per case above the average for the rest of the Thames regions, including outer London, perhaps because their most expensive cases are dealt with in inner London. Some 100,000 non-resident elective cases are treated in inner London out of a total of 240,000. If all these were treated elsewhere, at the average cost prevailing there – clearly an extreme assumption – and if costs were reduced proportionately in London – also an extreme assumption – the saving would be some £40 million per annum.

There is no simple way of moving from this figure to a national total, but as the inner London hospitals are the largest exporters of care in the country, and as the hypothetical switch and the cost difference assumed here are both very large, it is hard to see how total effects of switching contracts, on the basis of present costs, could be larger for the country as a whole. Indeed, if we look at the flow of cases into other large urban centres, assume a similar proportion of those patients now travelling in for elective surgery stay outside and use the average cost difference between provincial teaching hospitals and others, then the benefit is around £25 million. This is a benefit of the same order as the Audit Commission suggests could be achieved by improving the management of sterile services and energy use.

Combining the two figures gives a total of £65 million. Given the way the figure has been arrived at, not much weight can be given to its precise value. But it is sufficiently robust to suggest that 'once-and-for-all' gains cannot provide an economic justification for the 'new' NHS.

These estimates moreover apply only to acute hospital services. As far as mental health care and other community health services are concerned, the prospect of inter-authority trading is less and the scope for productivity improvements of the type that the acute hospital, such as a switch to day surgery, is able to make seem to be much smaller.

The Audit Commission report *Homeward Bound* which examined community health services was very short on specific recommendations for raising the efficiency of service delivery: this is not to say that improvements cannot be made nor that, in the long run, new and more efficient sources of supply will emerge. But the short-term gains from trading seem likely to be modest.

£65 million is a small figure relative to the costs incurred in introducing the new arrangements. It would therefore seem that increased efficiency in the existing pattern of operations is likely to be more important rather than the once and for all switch to lower cost suppliers which the initial establishment of the 'market' allows – in other words the longer term effects of competitive processes.

As we have seen already, the Government, for understandable reasons, has been slow to give market forces their head. According to John Butler, *Patients, Policies and Politics* (Open University Press 1992), the review group responsible for *Working for Patients*, thought that the market should 'achieve a level of competitiveness commmensurate with the attainment of genuine gains in efficiency'. But in the time since the white paper was published, language has tended to soften with references to 'organic relationships' and the commitment to more competition remains unclear.

If a more cautious policy continues, then the hoped for additional cost savings may not ensue. Yet, as we have already argued, making the purchasing process and its concomitant rationing explicit, will tend to reveal the limits of what the NHS can be relied upon to supply, and that in turn could well lead directly to public debate about what precisely the role of the NHS should be. To this we turn next.

Role of the NHS: the question is: if a higher level of cost savings does not ensue, can the Government continue to try to meet ever rising expectations across the health and social care spectrum? If public resources become tighter, then it has to considered whether they are being put to best effect within the public sector.

At the local level, that is the task of purchasing authorities, both for health and social care. A survey of public health directors, reported in BMA News, found that a good proportion thought that explicit rationing rules would have to be introduced. The NAHAT study referred to in the first part of the Review, found a limited number of moves in this direction. So far only a few health authorities have formulated explicit rules on procedures they will not carry out, so the expenditure 'saved' is small.

Although some items on the list do not derive from any Government directive or guidance, the 'narrowing down' strategy does typify the Government's approach: dental and eye care for example are not regarded as health care as far as the Patient's Charter is concerned, though the principle of exclusion is far from clear. Similarly, as we pointed out last year, the boundary between health and social care is equally hard to define and so can be pushed in whatever direction the Government wishes.

Given the Government's basic strategy and the need to contain public spending, it is an obvious tactic to shift the margin of health care, where services that can arguably be presented as serving other objectives, such as self-esteem in the case of plastic surgery, are concerned, and to attempt to shift the margin of health and social care by switching most social security funding for residential care to local authorities. The logical extension of that policy would be to apply it to other social security support for disability, though the Government has shown no sign of going down that path. Similarly, it is easy to understand the political if not the 'health' logic of regarding eye and dental services as distinct, in view of their separate and almost entirely private method of provision.

What sense can be made of the differences between the different areas of what still remains the NHS? One way of approaching the question is to regard the NHS as a compulsory insurance system.

From the patient's viewpoint, the question relevant to that way of expressing its role is: if public funds are limited, against what risks would I prefer to be fully insured by the state and what risks am I prepared to accept myself or insure in part or whole through the private market? The question has not been put to the electorate in that form. Instead, the question has been answered implicitly. The last ten years have seen the NHS, as general insurer, pull out of the long term residential care market, and leave it to the individual, or, in the case of people with low incomes and few assets, social security, to meet the risks of long periods of expensive residential nursing care. But as far as the bulk of acute care is concerned, the Government, through the NHS, has maintained complete cover while passively watching the private sector increase its role in this area by some £1 billion. At the same time, it has concentrated on improving its managerial performance so as to reduce, or at least maintain in real terms, the cost of acute episodes.

On average, an acute sector episode costs some £600, or somewhat more than the cost of a week in a nursing home. When the NHS was established, the situation was quite different: very long stays were common; even acute episodes were some three times longer than they are now. Day cases were rare: now they are becoming commonplace. Thus relative costs have shifted in favour of the acute episode as it has been possible to improve productivity there; the opposite is true of long term care which was and remains labour intensive.

Today, an increasing number of acute care episodes are matters of less than a day; in a few years' time the number will be much greater. This not only reduces direct hospital costs but also disruption to work and domestic arrangements. It is not much more expensive or disruptive than a serious car repair. Hence, as Rudolph Klein suggests in his article, the role of this part of the NHS is becoming more like a 'garage' which offers a high-speed repair service.

In contrast, long term care, may extend for many years, indeed a whole lifetime. Against this background, it is not clear that the Government is providing the appropriate balance of complete and partial insurance by concentrating full cover on precisely those areas where private insurance is obtainable and where costs of care in the NHS are easiest to maintain, or even reduce in real terms.

Melanie Henwood's article in *Health Care UK 1990* looked at the scope for further off-loading to the private sector through long-term care insurance and concluded this was likely to be small. Since that article was published, a number of insurers have moved into the market for long term care at home, with policies which are triggered by inability to perform a number of basic functions. Because the scale of the benefits is limited, the premiums are fairly modest. Those for long-term, full-time nursing care are not. Despite the higher level of incomes prevailing there, American evidence suggests that it is hard for private insurers to provide long term care cover on a comprehensive basis. Some degree of risk sharing typically remains. In contrast, in the area of acute elective care, the private sector is well established and can offer a range of cover, reflecting different degrees of 'self-insurance', side by side with the full cover offered by the NHS. At present the NHS attempts to cover a broad spectrum of health care while social services attempts to do the same for social care. In the case of health care, queues are long: in the case of social care, services are not provided if funds are short. People have to struggle along without. Where they are provided, charges are often imposed – and are the rule for residential care. Why the difference?

Currently the debate about the margin between health and social care has been conducted in terms of the service offered or the skill of the person offering it. For example, the Department of Health circular to local authorities on contracts for nursing home care distinguishes between routine nursing and the specialist nursing service provided by someone advising on – but not actually giving – diabetic treatment. The current theology is that the latter is a health service and should be provided free by the NHS; the former is not and must be paid for by those with adequate resources.

From the viewpoint of the user, the health/social distinction has no meaning. The benefits received from a typical orthopaedic operation, whether these are defined narrowly as a specific improvement to mobility or broadly as improved quality of life, are essentially the same as that provided as 'social' care. An improvement offered by surgery may be more effective than one created by personal care or aids and adaptations to the dwelling, but it is essentially of the same kind. Indeed, the 'specialness of health' is hard to discern, just as in fact, the assumptions underlying *The Health of the Nation* imply. If a wide range of policies can contribute directly to health as the white paper assumes and as few would deny, it becomes all the harder to see why the terms at which the state should offer them should differ from one area of policy to another. In some areas, such as occupational therapy, precisely the same service is available from different authorities on different terms.

One approach to 'drawing a line' is suggested by the evidence of Professor Grimley Evans to the Welsh Affairs Committee, which was addressed to the issue of the health/social care boundary. It runs as follows:

> *There is a conceptually simple way in which this problem could be solved. If the NHS became responsible only for investigation, diagnoses, treatment and rehabilitation, and long-term care of all forms in the community or institution became the responsibility of the Community Agency, the boundaries of the two agencies could be unambiguously defined. A specific period of rehabilitation, following a stroke, for example, could be part of the NHS contract of care, with the understanding that a patient who could not go home at the termination of the period would at that time become the financial responsibility of the community agency.*

This suggestion makes sense, given the muddle identified above, over responsibilities for long term care. But the crucial question is whether the administrative divide should be parallelled by a divide in the rules of access. Grimley Evans is not explicit on this point, but appears to assume that health care would be subject to NHS rules. Following the insurance logic set out above, there is a case for the opposite, with the individual or private sector taking on the short term insurance role, either in whole or in part, where risks are well understood and bounded, and the public sector absorbing the large and less predictable risks of long term care.

In fact, this is the direction in which funds have been moving for the last ten years. Privately financed acute care grew very rapidly during the 1980s while the bulk of public funds are now being devoted to care outside the hospital, and most of that, though by no means all, is for long term care. However, the terms on which those funds are made available still differ.

It may seem unrealistic to suppose that any Government is going to reverse the policies of the last ten years and extend the NHS' role in long-term care.

However, American experience suggests the Government may be pushed that way, if against its will, as people generally come to realise the implications of the charging regime now in force and ensure that their assets are so disposed that they cannot be called upon to pay for it, if they do need residential care. Indeed, as noted in the first part of the Review, there are signs that this is happening already. If that is right, then the Government may have no choice but to consider reducing its commitments at the other, *ie* the short end, of the care spectrum.

Conclusion

Our starting premise was that given the nature of the current economic climate and the broader policy aims of the Government, it will become increasingly hard to maintain the current range of care commitments. If the existing broad commitment to provide care has to be rejected, it is not obvious that the course the Government is on is the right one. Present policies seem intent on preserving 'free' care for those areas where costs are relatively stable and private insurance is likely to be most easy to organise, and on extending the scope of financial contributions to those where they are likely to rise, where insurance is likely to be harder to organise and where people can take action to avoid those contributions. On the face of it, that seems precisely the wrong way of using public funds.

Of course, any suggestion that the current commitment to free care across the broad range of health services should be abandoned would be greeted with horror and dismay by Government supporters as well as their opponents. The question raised here is for how long can that commitment be maintained if the Government continues to pursue its low tax policies?

Up to the end of 1992/93 the Government succeeded in putting the financing issue off the agenda. But two of the developments described in Part 2 will tend to question this way of allocating resources: the development of explicit purchasing plans and the development of a Patient's Charter. Together they lead to the contract between patient and provider being both more limited and more explicit. Thus the harder the Government pushes the policies it espouses in respect of new structures of provision, the harder it may well be to continue with present policies in the area of finance.

The point applies as much to care provided by local as to health authorities. The effect of what is in itself a commendable policy – the assessment of people's needs on a case by case basis – will serve to point up what is not being provided and inevitably lead to pressure to define what it is the publicly financed services can be relied upon to offer. During the 1980s the Government has relied upon ambiguity to balance the conflicting demands of rising pressures to spend and a commitment to lower taxation levels. Its own policies are now forcing it out into the open.

2.2 Managing Markets

In its first year, the new NHS regime was in the so-called steady state, rocked only by the movement of funds for hospital services within the control of GPs and showing signs of strain over extra contractual referrals. The difficulties such referrals posed is just one indication of the issues that can arise when rules are imposed on free agents – in this case the independent GP. Their behaviour cannot be easily forecast nor constrained to a centralised view of what should happen. As a result, tensions arise when providers lose revenue. Should freedom to redirect funds be constrained, or providers encouraged to respond more flexibly to changes in their 'business' environment?

Dilemmas like these arise because, once a new framework comes into operation, behaviour that was once acceptable becomes unacceptable, while the rules themselves may induce unacceptable behaviour that would once not have occurred. Measures designed to promote benefits, as we remarked in section 1.2 above, may turn out, even if successful, to impose costs as well. The task of those designing the 'new' NHS is to take into account both sides of the coin.

The creation of a new NHS is perhaps the most far-reaching reform of public service provision ever attempted in this country. The pace of change is already fast and, as we pointed out last year, while it is clear that the NHS is going somewhere, its final destination is far from clear. To borrow from the title of John James' article, we are in a period of continuous change which stretches out into the indefinite future.

There is nothing wrong with that. Indeed to its defenders, the prime characteristic of a market process lies precisely in its adaptability in the face of change and its responsiveness to new information, in the broadest sense of the term. Administrative systems on the other hand, tend to emphasis stability and the merits of continuity.

This leads back to the dilemma posed earlier: should freedoms be curtailed to adjust to the administration model, or administration be made more flexible? If it is the latter, then institutions have to be created which fit the market mode better than the traditional public administration model which has dictated arrangements up to now. If the former, then the existing framework will no doubt work but the benefits of a market will be lost.

The issues have been brought out by a number of events of 1992/93. We take first the inevitable concomitant of market activities – the need to withdraw capacity. The circumstances within which capacity may be withdrawn will be defined by the Government's response to the situation in London and, to a lesser extent, other large cities. The previous Secretary of State indicated that the situation in London ' would need planning' but without setting out what sort of planning framework he had in mind. Presented with the arguments of the Tomlinson report, the Government does not have a planning framework within which it can respond, but neither do the suppliers under threat have a genuine market framework within which they can react. They are caught in a halfway house between a market and an administered system.

This ambiguity is reflected in official advice on what the relationship between purchasers and providers should be. The present expectation, in the words of Departmental evidence to the Health Committee is 'that purchasers should give reasonable notice of planned service changes. We would not wish to define that nationally in absolute terms, it will clearly depend on the nature of the service in question. However, for 1992/93 contracts we did suggest that purchasers who significantly change their intentions are expected to notify providers by the end of September before the following contract year. Regional Health Authorities have an important arbitration and conciliation role in this process'. As to the future: 'The NHS Management Executive will need to reflect as to how to handle future change'.

Indeed they will. Because of the cash limit set for the demand for care on the one hand and of the nature of health costs – a high proportion of fixed labour and capital costs – on the other, any significant switch in contracts will be hard for a trust or directly managed unit to respond to. The scope for either getting new custom to replace lost revenues or reducing costs rapidly is small.

As things stand, supplier units have little room for financial manoeuvre on a year by year basis, so removal of even a small slice of income threatens to create a deficit that cannot be funded. In the first year of the market, regional funds have been used to stabilise the position, but that cannot be a long term solution.

What would a long-term solution look like? Other parts of the public sector provide little guidance. Experience with competitive tendering for ancillary services in local government and the NHS has demonstrated that the process of competition can impose severe costs, but in general it has been certain groups of workers, *ie* public sector employees losing their jobs or accepting poor conditions of employment, rather than total organisations which have suffered. Some parts of central government such as HMSO are operated as trading funds and do face competition from the private sector. But their market position has so far been strong enough to dispel concern about the possibility of financial failure. So it may be necessary to create new financial frameworks which allow explicitly for the possibility of carrying deficits for a period of time.

That is an exceedingly difficult task with a conventional public finance framework. The closest precedent is perhaps the nationalised industries, many of which were in deficit within public ownership. However, the difficult task of defining a satisfactory financial framework for them provided one of the strongest grounds for privatisation. The essential dilemma is how to offer support for deficits without undermining the will of the management to eliminate them. That dilemma remains unresolved and may indeed be insoluble within the public sector as long as people either as workers or users continue to regard the public sector as a source of stability rather than of change.

The proposals which emerged during the year for the allocation of capital funds underline just how hard it is to combine administrative and market processes. As was remarked above, they look remarkably like the system in place before. Capital allocation is to be made through an administrative rather than a market process. Investment proposals must be supported by purchasers. While at first sight that may seem to reflect a commitment to market processes, in fact it is the very antithesis of competition since the essence of any market process is that suppliers have to take risks: views on what should be provided have to be taken independently of actual commitment by prospective customers. Furthermore such a process implies a central decision-maker, be it a regional health authority or a management executive out-post, choosing between the merits of proposals from different suppliers, not the 'market'.

Of course some private sector market relations are governed by long-term contracts, *eg* those governing joint production of aircraft where firms have to commit themselves for very long periods, but where two firms are happy to work in this way others are still able to come in and compete. To do that, they have to have access to capital resources: a managed system would not allocate any in these circumstances, risking as it would excess capacity and capital losses: a free market system might.

If the NHS is to go down the second, market route, the process of allocation would have to be much more akin to that of a private sector investment banker, looking for the best – not necessarily the highest since risks vary – return and looking for opportunities to back innovation from newcomers. Such a Health Investment Bank would have to abandon the rules governing the required rate of return on public service investment and charge rates relating to the perceived risks of different forms of investment.

At the moment, such an idea seems far-fetched, but if the Government is serious in its intention, outlined in the Autumn Statement, to introduce private capital then such an institution could provide the route. It would have the important function, in any market, of providing finance to the health equivalent of the high tech growth stock – people with bright new ideas for services that currently are not available – as well as funding 'mainstream' facilities.

A third example of the ambivalence of the Government's commitment to market principles is apparent in the proposals made in the Management Executive document *Costing for Contracting*. which sets out rules for allocating costs to particular services for use in contracts. The chair of the NHS Trust Federation, John Greetham, took exception to the proposals, saying in a letter to the Secretary of State:

> *To exhort that costs should be made available by NHS Trusts to our purchasers appears to be an unreasonable requirement and against the principles of the NHS reforms*

But, as Duncan Nichol replied:

> *There is a major issue on costing and sharing information and openness. We need to get down together and work out our own salvation on that.*

But of course to put it that way begs the question. If the aim is to create a market, then it is not a matter of 'working it out together' but of letting prices, and other conditions of contract, do the talking, *ie* allowing contracts to be switched on price or other grounds whenever purchasers wish and if trusts fail, actually letting them go under entirely, or allowing them to be restructured by the equivalent of a commercial liquidator under entirely new management.

It could readily be argued that such an outcome is unthinkable. But if it is, then the rhetoric of independence which has led to the creation of trusts has to be abandoned. The Health Committee report on Trusts puts the issue very clearly:

> *The Department and the NHS Management Executive appear confident that they can both retain all the benefits of an integrated and strategically-planned service and simultaneously absorb all the benefits of delegated management, market forces and competition.*

But while it is clear that the Management Executive's confidence is misplaced, since trade-offs do have to be made, it is much harder to discern just what the choices facing the Executive are. Engaged as they are in an undertaking without parallel, certainly in this country, there are no blueprints for them to follow.

This is particularly true with respect to the regulation of competitive behaviour. As Frances Miller pointed out in *Health Care UK 1991*, discussions of the new arrangements for health care provision have been largely conducted outside the framework which governs competition in the rest of the economy. However, the kind of issues which have given rise to the need for that framework in the wider context will also arise within a publicly financed health care market.

The point was well put by Martin McNichol of the NHS Trust Federation at the first annual conference of the National Association of Fundholding Practices, where he argued that GP fundholders could put hospitals out of business, and predicted that providers would form cartels as protective measures. His argument serves to underline the arguments of Francis Miller's point that creation of competition is not just a matter of 'letting go' but also of regulating, *ie* intervening to ensure that competition is maintained.

The central issues in the regulation of competition and monopoly are posed by the existence of 'natural' monopoly positions and of restrictive practices such as price cartels designed to create 'artificial' monopolies. In the larger field of competition, policy and regulation of monopoly, the most common issues turn on conditions governing access to the market, which may be affected by predatory pricing designed to make entry unprofitable, and agreements to suppress competition by, for example, agreeing common prices.

The first issue has provided a great deal of work for the regulators set up to oversee the privatised utilities and it is perhaps their experience which bears most on the health sector. In the case of monopoly, recent experience with privatised nationalised industries has shown that structural measures may be necessary to ensure competition exists. These include: giving protected rights to newcomers so as to encourage competition in the longer-term, insisting on separate accounts for related activities so that cross-subsidiation can be identified; divestment of activities where some face competition and others do not, and in the last analysis even break-up if that is the only route to genuine competition. The recent proposals by OFGAS for the break-up of British Gas make that point: but prior to this proposal, both OFGAS and OFTEL had broken new ground in insisting that nominally private firms allowed other firms access to these national networks.

At present, the possibility of a Government pursuing such rigorous policies within the NHS may seem somewhat remote, with the elements of the new arrangements not yet in place, but already there are signs that issues of this kind are emerging. The merger of large GP practices is one example: at present that looks like a sensible administrative move, to reduce the overheads of individual practices. Seen in another light, it looks like a restrictive practice. Another is the establishment of community trusts with effective monopolies in their area for services which GPs cannot purchase. Similarly there are signs that the other kind of monopoly behaviour, the banding together of economically weak suppliers such as nursing homes, is emerging to attempt to impose common prices, just the kind of response that Mr Greetham warned of. Given the market power that local authorities may have that is scarcely surprising. Equally, it is not surprising that authorities should, in areas where nursing home places are in short supply, consider joint action to keep prices down. But what may be a genuine attempt to get better use of public funds looks like what, in other contexts, would be regarded as an abuse of market power.

Thus a number of steps may have to be taken both to create competitive conditions and then to ensure that competition is maintained. Such positive steps may take several forms of which we give a few examples here:

- Deliberate breaking up of large units into smaller ones. In the rush to create trusts in general the groups of units coming forward have been accepted. But even as they stand, some units are large and dominating in their local markets: where they consist of more than one site they could easily have been divided.

- Allowing non-hospital doctors to use hospital facilities – in effect the US model. At present this happens in some small hospitals and larger ones only in exceptional circumstances – it is not a general right. But the main economic lesson of British privatisation has been that it is important to identify those areas where monopoly is inevitable, such as expensive and specialised facilities of the kind found in hospitals, or nearly so, and protect or grant access rights to those facilities.

This has been the solution in gas, electricity and telecommunications. In the NHS it would mean allowing a GP practice access to certain hospital facilities, as of right.

- Prohibition of agreements which restrict choice. This may mean prohibition of GP mergers: it may mean that certain kind of purchasing contracts would be outlawed – *ie* those which in effect prevented a supplier trading elsewhere and which tie, in the case of the NHS a trust or nursing home, to one source of income.
- Where separate hospital and community trusts have been set up, encourage them to diversify into each other's 'territory' through new policies towards the allocation of capital funds.

These few examples are sufficient to demonstrate that thinking about what it would mean to introduce a competitive regime within the public sector in general and the NHS in particular has a long way to go. In some areas however, the issue of market management is much closer to the surface.

On the boundaries of health care are residential and nursing homes where market conditions already prevail. The vast majority of nursing and private residential homes are privately owned. They could therefore go out of business, and indeed that does occasionally happen. Many are as dependent on public funds as trusts: they present a difficult 'market management' task, to which it would appear only limited thought has been given.

This is not just a matter of cartels developing but also ensuring quality while keeping public sector costs down. For the past few years the general pattern has been for the income support allowance to fall behind the charges imposed by private sector homes and then be brought into line through major adjustments after an investigation by consultants of current charging levels and costs. According to the Association of Directors of Social Services survey cited above, nursing home allowances are currently in line with fees, while those for residential care homes are not: 'very few residential homes offer places at the basic rate of £160 per week'. As a result, residents dependent on income support are having to use their personal allowances to meet their fees, leaving them without resources of their own. According to this survey, the practice is common. If it is, then national price regulation has failed its highly dependent clientele.

However, the survey also found that it was very rare for owners to evict those who could not pay the full cost. Instead, they turned to relatives, or offered cheaper accommodation or cross-subsidised poorer residents out of clients paying their own way, or even got their residents admitted to hospital. Another strategy was to decline to take people on income support or to offer them inferior accommodation, although in some areas a shortage of clients has meant that access is still easy. All these responses are, given the policies pursued by the Department of Social Security, entirely predictable, though nonetheless undesirable for that. They suggest that the Government is passing over to local authorities an awkward problem in market management for which very little preparation has been made: that of balancing the need for economy with quality, using price control on the one hand and quality inspection on the other.

Up to now there has been one basic national rate for nursing and for residential homes, with a supplement for London, and a number of allowances for extra dependency: see Table 11.

Table 11: Income Support Limits: April 1992

	Residential Homes	Nursing Homes
Client Type	£ per week*	
Elderly	175	270
Very dependent or blind elderly	205	-
Mentally ill	185	270
Drug/alcohol dependent	185	270
Mentally handicapped	215	275
Terminally ill	–	280
Physically disabled below pension age	245	305
Other	175	-

* The Greater London supplement of £23.00 per week for residential homes and £33.00 per week for nursing homes is payable in the year from April 1991 (£25.00 and £35.00 respectively from April 1992). In addition, claimants are entitled to a personal allowance of £11.40 per week in the year from April 1991.

Such a simple approach may not be adequate. In particular, it makes allowance for neither quality nor cost variations and the relationship between them. In the USA a variety of payments systems are in operation, reflecting a range of attempts to get the balance between economy and quality right. As we have noted, when fee levels are inadequate, owners resort to various stratagems to survive, some of which may be at the expense of patients. The argument against paying whatever owners want to charge – effectively the system in the early 1980s – is obvious enough. But equally, over-emphasis on cost control puts at risk whatever quality objectives are set. Some American states employ two-part tariffs, with part of the rate set in advance, part determined by actual cost data. In this way, they can ensure that returns earned are neither too high nor too low, on a case by case basis, while reducing the risks to quality that too harsh a regime would pose. This two-part approach can be particularly helpful where inflation is rapid and unpredictable and where occupancy rates are variable. Both factors make it hard for purchasers and providers to set appropriate prices in advance.

At present, inspection by district health authorities emphasises quality of care rather than economic performance *ie* value for fee. Nursing homes will continue to be the responsibility of health authorities even though they will generally not be paying for them.

Residential care homes will fall to local authority inspection units, so responsibility is split. Neither are well equipped for the task of balancing quality with economy. The idea of merging inspection arrangements was mooted at the time of the debates on the NHS and Community Care Act but rejected: nor is it obvious why inspection should continue to be the responsibility of individual districts. Pooling experience and expertise over a large area is likely to be beneficial as most units are small. Furthermore, given that both kinds of home will be largely funded by local authorities, there is a case for merging the two and determining support levels by the needs of the people being looked after rather than the type of home. Given that care needs are 'continuous' it is hard to see that the current sharp division of regime and cost makes sense.

The various strategies used by home-owners to make ends meet – or maintain their accustomed levels of profitability – reveals a further weakness in the existing regime. Although places are paid for out of public funds, no effective contract for the individual residents exists nor has the Patient's Charter been extended into this area. It is not clear therefore what exactly can be expected for the sums charged to individuals or authorities. As a result, there is plenty of legitimate scope for extra charges to be made – for newspapers, for extra fruit, but also for medical supplies such as incontinence aids where owners are feeling financial pressure.

The Department of Health has issued guidelines to local authorities about what health services should not appear in contracts for nursing home care but it has not positively defined what should be in them. The Consumer's Association spotted this gap and floated their own ideas as to what the form of contract should be: so far however the proposal does not seem to have progressed beyond the status of a discussion document.

Our analysis suggest there are a number of areas of policy towards the management of the long term care sector where more consideration is required:

- whether it continues to make sense to maintain a sharp division between residential and nursing homes;
- whether the structure of regulation with its emphasis primarily on quality is appropriate to present circumstances;
- whether, in order to promote choice, active intervention in the market is required, particularly in areas where the level of provision is low;
- whether inspection particularly of nursing homes ought to be organised on a national basis;

Finally, the dominant position of local authorities in the nursing home market may itself need some regulation. Like hospitals, nursing homes have a high proportion of fixed costs, mainly capital: see Table 12.

Table 12: Structure of Long-Term Care Costs

	Nursing	Residential
Staff	44.9	32.2
Other direct running costs	15.8	18.2
Corporate	4.6	7.7
Capital	28.7	29.9
Profit	6.0	12.0
Total	100.0	100.0

In the short-run therefore homes are vulnerable to loss of business in the same way as much larger units. That puts extra responsibility on purchasers, since to remove some custom may undermine the finance of a home to which they have already entrusted the care of some of their residents. Furthermore, when quality is found to be low, the best response from the viewpoint of residents may not be to put the home out of business but rather to take it over and run it up to an acceptable standard. Such an arrangement might be reached informally: it might also be assisted by the introduction of bankruptcy regimes which would allow homes to be kept going even when the owners have had to withdraw from the business.

On the other hand it is possible to envisage an abuse of monopsony power. While there are reports of owners banding together to maintain prices there are similar reports of some authorities doing the same to push them down. If authorities do screw prices down and reduce earnings on capital, there is not much owners can do, since the value of their assets depends on those returns. They can only leave the industry by absorbing a capital loss.

In her speech to the Social Services Conference on 2 October, the Secretary of State urged authorities to act as 'fair but tough purchasers. They have the advantage of a competitive market and should use that advantage to negotiate keen prices'. What has been said here suggests the task is rather more complex than that advice acknowledges.

2.3 Seamless Care

Perhaps the most difficult task which faces health care policymakers is to create the conditions within which the different providers work effectively together. Last year we looked at the boundaries between health and social care and, within the former, between primary and secondary care: the Review quoted selectively from evidence showing how poor relationships were across these divides, while Linda Marks's appraisal of hospital discharge procedures in *Health Care UK 1991* underlined that conclusion. The fact that the Department of Health felt it necessary to link the availability of community care finance to the existence of satisfactory agreements on discharge from hospital suggests that, since her appraisal was published, authorities continued to be slow to respond to what they had already been asked to do in the 1989 circular. That conclusion is also suggested by a report by the Social Services Inspectorate of five Social Services Departments published during 1992 (*Social Services for Hospital Patients: Working at the Interface*). One conclusion runs:

> *Social services workers interviewed were uncertain about the implications of community care developments for their role.*

The need to get this particular interface right is evident enough: if proper arrangements are not in place, there is a risk on the one hand of blocked hospital beds, or on the other, of poor home based support leading to a poor standard of care and possible re-admission, particularly of frail elderly people. Nevertheless, while the Department evidently felt that authorities had done enough by the end of the year, a survey of GPs by the British Medical Association published in January 1993 suggested nine out of ten had no knowledge of a formal policy for the discharge of patients from hospital and eight out of ten said they had not been consulted about their local authorities' community care policies.

The sluggishness of the response to such a central boundary issue suggests the existence of a deep-seated problem. That is confirmed by an extensive literature review, *Co-ordination and Child Protection*, prepared for the Social Services Inspectorate and published in 1992. This covers a field at the edge of health and social care but nevertheless serves to confirm that effective joint working is rare across organisational and professional boundaries anywhere in the public sector. Success stories can be found but typically they can be ascribed to conditions, situations or personalities which are unique to the areas concerned.

The authors of this survey, Christine Hallett and Elizabeth Birchall, begin by emphasising the lack of agreed terms for describing the such concepts as collaboration, co-ordination and integration, all expressions used to describe attempts to work across boundaries, be they between organisations, professionals or types of service. Equally there is no agreed set of procedures for 'boundary bridging'. Although effective examples can be found, the general implication of this review is that effective joint working is hard to achieve in practice. A number of reports during the year confirm that conclusion.

We quoted earlier from the Chief Inspector's First Annual Report: another section is pertinent here, bearing as it does on the links, or lack of them between services:

> *Most Social Services and Health Authorities were some way off agreeing joint purchasing strategies or common inspection standards for residential and nursing homes. There was scope for much better exchange and use of information on population needs and resource inventories. Many authorities had difficulty in providing details of existing patterns of resource use and obtaining similar information from partner agencies. There has been little participation by Housing Authorities in the preparation of community plans, and insufficient involvement of the independent sector, particularly private home proprietors and organisations representing black and ethnic minority interests, in preparing for the changes. Considerable work would be needed in a number of authorities to establish the new assessment, purchasing and charging systems in time for April 1993. Development and pilot project work was generally at an early stage on care management, information systems and the separation of assessment, commissioning and providing roles.*

The failings of links with housing are further brought out by a report from the Joseph Rowntree Foundation, *Housing and Community Care*, which shows how deep the obstacles are to effective co-operation even within the same authority. Some key passages are cited in **Housing and Community Care: Rowntree Findings** which highlight the failure of the formal machinery to bring together the various elements required to provide appropriate mixes of housing and care. No element of the community care reforms currently being introduced bears on this issue.

It is only too easy to find further evidence supporting this conclusion. We cited the Joint Approach to Social Policy above: in their review of this and other parts of Government where attempts had been made to co-ordinate policies (*Joint Approach to Social Policy: Rationality adn Practice*), Linda Challis and colleagues came to the following conclusion:

> *Where there is co-ordination as between government departments, it tends to be defensive in character: designed, that is, to protect existing organisational interest rather than to produce policies cutting across those interests. Where a machinery of co-ordination has been developed its productivity is – as our locality studies demonstrate – at best uncertain and at worst poor. The preconditions assumed by the 'optimistic model' – consensus about objectives, analytical capacity, systems wide perspectives and organisational altruism are all in short supply: consensus is hard won and altruism is comparatively rare. Divergences on the choice of means tends to be embedded in professional and organisational paradigms while divergences on priorities are embodied in the competition for resources.*

These conclusions are echoed in a more recent wide-ranging review by Adrian Webb (Policy and Politics 1991):

> *Co-ordination is an incubus for all public services. Exhortations to organisations, professionals and other producers interests to work together more closely and effectively litter the policy landscape. Complex and multi-faceted problems cry out for systematic and well ordered*

Housing and Community Care: Rowntree Findings

The report cited here, by Peter Arnold and Dilys Page, was prepared for the major city councils' housing group. The research was carried out during 1990 in ten cities in England and Wales, with responsibilities for housing but not social services.

Our first extract came from the section of the report dealing with joint planning.

Most of the criticisms of joint planning we have reviewed are drawn from the comment of senior managers in the authorities included in the study. At worst, joint planning was barely working at all or, at best, it was working despite (not because of) the system. There was little difference between Health, Social Services and Housing managers in this respect. With the notable exceptions of Nottingham, Hull, Swansea and to a lesser extent Leicester, the picture of the system as a whole – in contrast to some of its parts – was disappointing. The monumental ineffectiveness of joint planning has frustrated and wearied its participants. The following comments from interviews and questionnaires are illustrative:

> *Interminable meetings but nothing seems to happen... Talking-shops (the favourite phrase)...So little to show for the huge amounts of time and effort...The whole system is moribund...A system designed to fail...Ineffectiveness causes poor attendance and the whole thing follows a downward spiral...*

Apart from its value in improving inter-agency communication many respondents believed that joint planning simply had not worked. Some drew a clear distinction between joint planning and joint working. Most projects however were no credit to the joint planning system as such. Most had been conceived, planned and implemented outside the formal structures. A Social Services Manager summed up the situation as follows:

> *Experience in Leicester mirrors that elsewhere – Joint Planning Groups are largely seen to be discredited in terms of their ability to plan jointly. They have provided a useful point of contact for dialogue and exchange but have tended to be reactive in the sense that they endorse policies and developments worked up outside the Joint Planning Group. Most of the proactive work has been undertaken in small working groups outside the Joint Planning Group structure.*

Against this background, it is not surprising to find that formal systems were by-passed:

Joint working had frequently been more successful outside rather than within the formal joint planning process, often supported by joint funding arrangements and sometimes by joint finance. The development of a legally constituted Housing Consortium in North Staffordshire and informal consortia in several other areas (see below) had provided more successful structures for joint working than the formal process. Some were specifically a response to the ineffectiveness of formal structures, but others had grown out of informal groupings loosely attached to the formal structure. All were characterised by across-the-board representation from statutory and voluntary agencies. Bilateral arrangements facilitated by joint funding were also common. They had usually been initiated outside the formal planning process, being fed in for 'rubber stamping' once the bargains were firm. Others seemed to have entirely ignored the formal structures and there were many comments which suggested that side-stepping the process had become routine, especially for health authorities – 'the only way to get anything done'. Sometimes bilateral arrangements with a voluntary organisation had been resorted to after long periods of wrangling between Health and Social Services. Such friction was much in evidence.

Perhaps the strongest concern of housing authorities was about lack of credible guarantees from Social Services and Health for the continuing support of special needs tenants. When difficulties arise they swiftly become a housing management problem: 'Housing feels it first'. One Housing Officer said Health was simply offloading patients into the community for its own financial purposes, with no thought to their future support. Others were reluctant to co-operate with requests for sheltered housing tenancies for ex long-stay hospital patients. In some areas, attempts had been made to 'build bridges'.

There were two opposing reactions to the problem of providing workable housing-with-support packages. Some authorities had worked out contractual arrangements with housing associations and voluntary agencies in which a tenancy would revert to the Council only when it was agreed that the tenant was able to manage without support. A less common view expressed by a Senior Housing Officer in Hull was that:

> *Housing authorities should not blame the lack of support services for problems they encounter but should look critically at their own organisation. The culture of housing needs to change in order to keep in step with its new responsibilities and this will need to be done through specialised training to some extent and more general awareness raising.*

The report, it should be added, concludes positively. The authors believe that housing departments and housing associations have an important contribution to make to the areas of community care. But the framework within which they operate makes it hard to realise their potential.

> *responses, yet the reality is all too often a jumble of services fractionalised by professional, cultural and organisational boundaries and by tiers of governance.*

He goes on further:

> *What we know of co-ordination and collaboration suggests that it is highly unlikely that otherwise distant bodies will successfully act in concert on an issue which spans their worlds.*

Such pessimistic conclusions could be matched from other sources. Yet in many of the key areas of the policies that are taking shape as the National Health Service and Community Care Act is implemented, success is critically dependent on different organisations working effectively together. At the same time Government policy is intent on creating new boundaries between organisations: trusts are free-standing bodies which, under the new rules, do not comprise a full range of hospital and community services, GP fundholders remain independent contractors who, while enjoying control over district health authority funds, are not accountable to the authority for their use. More generally, in both health and social care, policy supports encouraging a range of suppliers from the private and voluntary sector.

Furthermore, as we noted last year, the main structural features that led to criticism of existing structures in the 1980s, lack of co-terminosity, divided responsibilities, and divided financial regimes, all remain: there has been no fundamental change here. Indeed to judge from the Government's proposals for reform of local government in Wales, the situation may even get worse.

Finally, in one crucial area, responsibility for long term care, the Government has continued to leave the situation ambiguous. In September, Tim Yeo, Parliamentary Under-Secretary at the Department of Health, told an Age Concern conference that:

> *The transfer of social security funds to local authorities has ... no bearing on the proper responsibilities of the NHS ... where securing long-stay provision is appropriately a responsibility of the NHS, its costs must be met in full by the responsible health authority.*

What this statement fails to do is define how NHS responsibilities are to be determined in practice. The Patient's Charter prescribes no rights in this area. There is no definition of where the NHS boundary lies. With the Government exploiting ambiguity in this way, the chances of successful boundary relationships at local level are reduced. Incentives to cost shunting are maximised. As we note in **Planned Ambiguity in Wales**, the Government is actually making a virtue of relationships at local level being ambiguous.

The Audit Commission report, *The Community Care Revolution* concluded with a list, set out in Table 13, of what authorities should do to promote joint working. At local level, there is a great deal of evidence of attempts being made to bridge boundaries in line with this advice. A large number of Family Health Services Authorities have made a *de facto*, but not *de iure*, merger with their health authority, through joint appointments. And as the list shown in Table 14: **A Checklist for Successful Partnership** illustrates, great efforts are being made to create the conditions for effective joint working. Equally, however, it shows just how many conditions must be fulfilled to achieve it.

Table 13: Working with Others

(i) A Seamless Service

- (a) Interpret 'consultation' with NHS as 'involvement'. Develop working agreements with both purchasers and providers. Agree distinction and responsibilities between health and social care.
- (b) Develop closer liaison with housing agencies with joint reviews of dependencies and agreements on support in sheltered housing.
- (c) Involve independent organisations in the planning process. Understand and make appropriate responses to the varied nature of the voluntary sector.
- (d) Consult users and carers directly.

(ii) Working Together

- (a) Work towards joint local budgets for the purchase of social and health care.
- (b) Agree and implement arrangements for discharging patients from acute hospitals and for providing them with care in the community.

Examples such as these can be multiplied from similar documents from other authorities. But the evidence we have briefly referred to suggests a great deal of this effort may be in vain.

The Government would argue in its defence that it is introducing a number of new mechanisms that make joint working easier to achieve: care management, GP fundholding and contracting. Each of them offer managers the means for integrating service provision across boundaries. What can we reasonably expect these to achieve?

Fundholding: Even before fundholding was introduced, GPs were already rapidly expanding the resources available to them, particularly practice nurses and, as Sean Boyle and Chris Smaje showed in last year's edition of *Health Care UK*, they have responded to the new opportunities for surgery presented to them by the new contract. They are also taking on increased responsibilities for the surveillance of children and for health promotion generally. Some have good links with social services. Their potential for integrating service provision would seem to be great.

Table 14: A Checklist for Successful Partnership

The following checklist has been compiled by consulting those working in partnerships in South East Thames.

The Partners

1 Trust and openness between, and confidence in, partners.

2 A commitment by partners to the shared objectives of working as partners, and a willingness to facilitate the process.

3 Understanding between partners of each other's structures, duties and responsibilities and decision-making machinery, and time set aside for furthering such understanding.

4 Accountability of partners for undertaking their agreed tasks.

Partner Presentation

1 The appropriateness of partners' representatives to the task in hand. Representatives may need to change according to the task in hand.

2 Clear lines of accountability and good communications between the partner's representative and the partner's decision-making machinery.

Resources

1 The commitment of resources by partners to the tasks in hand.

2 A multi-agency budget to service the partnership and if appropriate co-ordinate partnership activity.

3 A restricted agenda which acknowledges the limitations of available resources.

4 A clear understanding and agreement by each partner of the outcomes which will constitute the success of the partnership and how these are to be measured.

5 Time to work on and develop a shared understanding of proposals, etc., in recognition that the concepts and language used by different agencies may differ.

Maintaining the Partnership

1 Periodic (at least annual) review and restatement of the aims and objectives of the partnership.

2 Appropriate induction and support of new representatives to the partnership. (*eg*, if personnel change or the focus of the group changes.)

3 The earliest possible involvement of all key representatives on any new issue; delayed involvement may be perceived as inequity and result in reduced participation or 'ownership'.

4 Good communications systems within and between partners are essential for information about partnership workings to flow.

Working Together – A Framework

1 An independent chairman of the partnership or some other approach to ensure neutrality of the co-ordinating function.

2 An agreed system for co-ordination of the partnership and ensuring a common front on the health strategy.

3 Time set aside for team building between partners' representatives.

4 Information, education and training for all staff in partner organisations and commitment at all levels to the objectives of the partnership.

5 Partnership terms of reference which develop by agreement between partners.

6 Operating machinery which is flexible and which is responsive to the needs of new partners.

Working Together

1 Clear tasks for each partner. Tasks which the partner recognises as priorities for their service, agrees to implement and from which they can see they will derive some benefit.

2 The priority to be assigned to each task needs to be negotiated and agreed, together with an understanding by partners of how their tasks fit into their total business programme.

3 A timetable with a series of short-term goals which will provide positive feedback for each partner as well as the partnership as a whole.

Source: Partners in Health, South East Thames Region

But a central obstacle to the further expansion of their role is their status as independent contractors which allows them to attract patients from wide catchment areas which do not necessarily conform to the boundaries of other suppliers or purchasers. Furthermore, although GPs are strengthening their management abilities, some would not find a major expansion of that role attractive.

Finally, there is the question of incentives: GPs have been urged in the departmental pamphlet *GPs and Caring for People* to contribute to social services led assessments but there is no reason, apart from personal interest, why they should: many will, but where they are reluctant, the mechanisms for making them participate are weak.

Thus although some GPs, in some areas, may well take on more responsibility for ensuring that services are better related to each other, there can be no general assumption that that is how things will work.

Contracting: at its simplest, the argument for the purchaser/provider split and the contracting process that links the two sides, assumes that there is scope for purchasers, free as they are of direct responsibility for particular groups of staff and professions, to cut through professional boundaries and create new forms of service. The introduction of the contracting relationship does change the terms within which boundary issues can be resolved by creating, in the form of the purchasing agency, an independent locus for overcoming them which, by virtue of that independence, may have a better chance of freeing itself from the interests of any one provider.

As the Audit Commission put it in *Managing the Cascade of Change*:

> *... the commissioner or care manager arranges through service agreements for providers to provide services; and because there is no involvement with existing services there should in theory be no commitment to the status quo, so that users' and carers' needs should not be compromised by any requirement to make full use of existing provision. Commissioners and care managers should co-ordinate service packages to make best use of the limited funds available.*
>
> *This apparently straightforward redirection of finances through a commissioner and care manager thus appears (on paper at least) to overcome many of the difficulties encountered in the past.*

The basic argument is strong: purchasers should be able to 'knock heads together' in a way that authorities previously could not and produce agreed modes of care, or protocols, for services where a number of different professionals are involved. But the parenthesis, 'on paper at least', suggests a degree of unease as to what will actually happen in practice.

The Commission did not attribute its unease to specific sources, but it is not difficult to infer what these might be. First, contracts can actually create barriers to co-operation. As we have suggested already, effective cross-boundary working has sometimes been possible because an atmosphere of give-and-take has been created, due, often, to particular individuals and particular circumstances. The introduction of contracts, with their formal definition of who does what for how much, may actually reduce the scope for such give-and-take, by removing the element of personal discretion that my be decisive at local level to make cross-boundary work possible.

Second, contractual relationships do not in themselves remove some of the obstacles that have proved important in the past such as different boundaries: indeed they could exacerbate the difficulties these give rise to if providers must, within what is to them a homogenous territory, work on contracts set to different standards.

Third, there is no reason to expect that in all circumstances contracts will prove more efficient than conventional management structures. The most detailed analysis of their comparative merits by Oliver Williamson (in for example *Economic Institutions of Capitalism*) identifies factors which may work in favour of both. The issue is empirical, but the evidence one way or another is, in the present context, thin.

Care Management: last year Bob Hudson discussed the potential of care management and hence our comments here will be brief; his conclusion was:

> *The overall verdict on care management has to be one of caution verging on pessimism about what can reasonably be expected of it.*

This cautious verdict stemmed from a careful analysis of the conditions which have to be satisfied if care management is to work in line with the Government's stated intentions. Care management can work: the question is whether it can do so when introduced as a general policy. A large number of things have got to be got right for it to do so.

In particular, care managers and their health counterpart, the purchasing authority, will have to span organisational boundaries if they are to achieve joint working

As David Challis put it to the Welsh Affairs Committee:

> *Whatever the organisational variations between different settings, the need for case management services to maximise their linkages with appropriate health care services would seem to be highly desirable ...*
>
> *A joint purchasing approach by Health and Social Services Agencies, both at the macro level (by agencies) and 'micro' level (by multi-disciplinary teams including care managers for individual cases), particularly if long-term health care expenditures could be identified, offers opportunities for interesting service developments and reduces the risk of cost-shunting between agencies.*

The Audit Commission – in *Managing the Cascade of Change* – also pointed to the advantage of pooled budgets, the situation now in Northern Ireland where, in organisational terms at least, there is no health/social care divide:

> *An essential first step is to strengthen the framework within which agencies can work together. The Government's stated objective is to provide a service in which 'the boundaries between primary health care, secondary health care and social care do not form barriers seen from the perspective of the service user'. These same objectives have led others to provide a single commissioning authority. For example, in Northern Ireland, acute services, community health, social services and the transferred social security funds will all be channelled through a single appointed authority. Real progress is being made – especially in the last eighteen months with increasing integration of local health and social services management. Services and payments plus other local services are also brought together in Norway, but in this case the authority is a locally elected one. In Arizona, a US federal demonstration project has brought health and social services together under a single management to great effect.*

Planned Ambiguity in Wales

In oral evidence to the Welsh Affairs Committee the Welsh Office appeared sanguine about the prospect of bridging the health and social care divide despite the lack of clear rules:

(Mr Woodward) *Where people are trying to define their roles too tightly I think that that produces much more in the way of problems of co-ordination. What we were seeking was a collaborative arrangement whereby the person who felt in the best position to provide care was the person who organised it. We did not say that it should always be a community nurse or a social worker who organised care but rather that they work together to see who is the best person to lead and co-ordinate in those circumstances.*

(Mr Martin) *Perhaps I may add that one of the ideas that seemed quite exciting to us, through our discussions in April, was in the case of the one or two authorities who had already begun to think about breaking down existing organisational boundaries and having joint budgets and joint management structures for a whole range of activities, including community nursing services, residential nursing home care, home care support and so on, so that instead of each as it were bringing to the table from their own organisations what they felt able to bring they would genuinely work together as a team in a joint way.*

The Committee went on to consider the new arrangements.

> *Let us move on now to the relationships between services for elderly people. Does the Welsh Office consider that there are any areas where the responsibility for services between health authorities and social services departments is likely to be unclear when the Community Care Act comes into full implementation?*
>
> (Mr Martin) *We think that it is impossible to set out in a helpful way the precise responsibilities of each organisation. It is a very tempting scenario that one specifies precisely at the centre exactly what everybody is responsible for, but there is an element of substitutability of services at the margin of health and social services, and it seems to us as well to acknowledge that. That is why we have required authorities in their joint plans, that is, in the statutory guidance that we have issued, to spell out who is going to be responsible for what and on what terms. It seems to us that the balance that will be struck will quite reasonably differ a little from area to area at the margin – this is very much at the margin. I suppose the area that needs the greatest working through is the new responsibility that social services authorities will have from 1993 to purchase nursing home care. They will be able to do this, except in an emergency, only where they have the agreement of the district health authority. The district health authority will continue to be responsible for registered nursing homes. However, when we have talked that through with people it appears that it is more of a problem in theory than it is in practice. What is in fact happening is a growing recognition as people work through their plans that they need each other and cannot actually do their jobs very sensibly without each other. I think that it is one of the most exciting possibilities – I will describe it as no more than that at the moment is – of actually getting clearer thinking about assessing need and then deciding what services to procure for a population because it brings health and social services much closer together in fact than the historic arrangements. Under the historic arrangements they had a vested interest, as it were, in protecting and filling the places in the services that they happened to run. Under the new arrangements one can actually get some clear water, if you like, some clear thinking between, on the one hand, assessing need and, on the other, deciding what you in fact need to provide. Just as health authorities are going to need to work closely with social services authorities to ensure an appropriate range of placements in those areas where social services have budgets, so the social services authorities simply cannot do their jobs unless there is appropriate input from health practitioners, from community health staff and so on. There is a growing recognition as people work through these things that it really is in all their interests to co-operate.*

That 'growing recognition' might well be wishful thinking.

But the report goes on to say:

> *Merged arrangements like this are not now possible in England and Wales. But the essential features can, with goodwill and co-operation, be duplicated. This could involve authorities pooling their budgets for particular policy areas by mutual agreement to form commissioning consortia. In its 1986 report the Commission proposed either that one authority should be given lead responsibility for some policy area of mutual concern to act as agent for others with local authorities being made responsible for people with learning disabilities for example; or that some sort of joint framework should be set up for services for elderly people, for example. Such options could still provide practical solutions, without the need for complete integration. However, any consortium arrangements should be mutual agreement locally, rather than by central direction. Such local agreements have been formed by district health authorities setting up commissioning consortia.*

From the regional document we have cited, and evidence of the close links developing between FHSAS and district purchasers, it would seem possible that such agreements might be widely reached. But they may well not be, particularly if each 'side' is feeling budgetary pressures. These will tend to push each agency back into its core areas and make them reluctant to indulge in the give and take necessary to make the interfaces with others work.

One result could be poor quality services: another, where responsibilities overlap, could be dual track provision. According to Values into Action, a mental health voluntary organisation, in many areas such a dual track mode of provision has already developed. Its evidence to the Health Committee's inquiry into Trusts reports as follows:

> *The absence of plans for the implementation of joint strategies is not limited to Surrey. Other areas known to Values into Action include Avon, Cornwall, Hereford and Worcester, Lancashire and Leeds. Virtually the only people currently moving out of mental handicap hospitals are doing so through programmes designed exclusively by Health Authorities. One Social Services senior manager told Values into Action: 'The funding mechanisms for resettlement are owned by Health here, and the are driven by Region', and that consequently 'there's been no role for the Local Authority in community care'. We have also frequently been told that Health Authorities consult with the Local Authority on resettlement plans only when they need planning permission, day care or other services.*
>
> *'Dual-track' or 'parallel' provision is therefore not only a continuing but also a developing feature of community care. This means that the Local and Health Authorities are making separate and simultaneous provision, in the community, of similar services to people with similar needs. What distinguishes the users of Health services from those of Social Services is the fact that the former are ex-hospital residents whereas the latter are not.*

The difficulties are not confined to situations where different parts of Government are involved. Within the NHS itself, purchase of some services requires contributions from different suppliers. In the case of services for children, the case for integrating prevention and treatment services within one line of management has been accepted since the Court inquiry in the mid-1970s. A skilful purchasing authority should be able to define the elements of service required, but what it cannot do is provide integrated management across the boundaries of different trusts and between trusts and GPs. The previous arrangement had not guaranteed that either, so the new ones do not exacerbate the position. But even in principle, they do not make a solution easier to arrive at. Indeed, the Government's decision to keep acute and community trusts separate could make things worse. Moreover, the Government's commitment to competition creates boundaries of its own, as well as new incentives which may not be compatible with the promotion of seamlessness.

The precise implication of these developments takes some disentangling. Market relations can be highly effective in co-ordinating the activities of multiple suppliers – witness any supermarket. But they can also make it harder – where, for example, concerted action is to the benefit of all – *eg* a move to common standards – but any one party would lose out by adopting them independently. Informed co-operation between firms can achieve the needed co-operation, but may well not.

Alternatives

A possible conclusion to draw from the evidence presented here is that the public sector is chronically unable to organise itself or to organise others to provide services across professional and organisational boundaries and that things will get worse within the 'new' NHS. If so, is there a way forward?

Hudson pointed to one: giving users direct control over the financial resources expended upon them – in other words – vouchers or cash transfers.

As things stand, local authorities are not allowed to offer cash instead of care – although some may come close to this by offering what are in effect personal budgets cum vouchers, *ie* allowing users to choose care packages within a given cost ceiling. Government policy, however, is moving in the opposite direction by winding up the Independent Living Fund which does have experience of offering help in cash terms: see **The Independent Living Fund**.

Cash for Care by Ann Kestenbaum describes the experience of this form of assistance to the Foundation's clients. Unlike the attendance allowance, the support offered by the Fund must be spent on care assistance; in this sense it is not 'pure' cash. Within this restriction, the scheme appears to have worked well for most people. *Cash for Care* concludes:

> *The choice and control they valued so highly could not in their experience be provided by statutory authorities. It is not simply a matter of resource levels, though these are very significant. As important are the qualities that any large-scale service-providing organisation would find hard to deliver:- choice of care assistant, flexibility, consistency, control of times and tasks etc.*
>
> *To a remarkable extent, given the severity of Independent Living Fund clients' disabilities, the recruitment and management of care assistants was straightforward. In many cases this was because they employed people whom they already knew, or discovered through grapevine contacts. The great majority of care assistants found in this way were treated as self-employed and often the disabled person did not feel in any formal sense an 'employer'.*

Although the scheme had not worked well for some people – in particular, agencies did not appear to offer a satisfactory service in many instances – overall it did appear to have met its main objectives:

> *The findings from this research challenge the assumption that disabled people are incapable of exercising effective choice and control over their own care arrangements.*

The Independent Living Fund

The Independent Living Fund was set up in 1988 for a period of five years. Financed by central government it was intended to fill the gap left by the withdrawal of Domestic Assistance Addition when the Supplementary Benefit Scheme was replaced by Income Support.

Awards are means-tested and are based on an assessment of care needs. They enable recipients to employ the regular help they need in order to remain living at home, or to move out of institutional accommodation into their own homes. Most Fund clients would be found at the very top of the ten categories of disability used in the OPCS Disability Surveys 1985-88.

Fund money is available only for the employment of care assistance. Successful applicants do not have the choice to spend it on aids or adaptations or on any other living expenses even if directly related to their disability. This makes if fundamentally different from Attendance Allowance. Before hearing about the Fund, an applicant may not have seriously considered the possibility of buying private care. Dependent upon family and friends or upon services organised by statutory bodies, some may initially have been very reluctant to do so because it was the necessary condition attached to getting more help.

The Fund does not become involved in finding care assistants or managing subsequent care arrangements. Practical help is limited to the issue of a leaflet on the subject to all clients and the distribution of the Disablement Income Group's booklet *Recruiting and employing a personal careworker* to clients offered large awards.

> *They also show that independent living is a relevant and important concept not only for the young disabled, but also for older people with many different kinds of disability, including the most severe. The experience of ILF clients detailed in this report shows how, with enough money to have care assistance under their own control, or that of a chosen advocate, many disabled people can greatly improve the quality of their lives as well as stay out of residential care.*

As the law now stands, authorities cannot pay out cash, but they can go a long way down that road. For example, Hampshire's Self-Operated Care Scheme allows people being cared for to choose who cares for them and what the carers do. Both the work reported here and a similar study not yet reported on by the Policy Studies Institute suggests that such schemes are beneficial. They would appear to serve the Government's stated objectives of offering choice, yet policy is headed in an entirely different direction.

Conclusion

In summary, the mechanisms the Government is relying on to produce seamless care are, as general policies, untried and the obstacles to their successful achievement very great. What if it becomes apparent that they are not succeeding?

There are many things the Government could do: it could re-draw all the relevant boundaries to ensure coterminosity: it could restructure finance into specific grants earmarked for particular care groups. But these policies have been available for a long time, and urged on the Government by bodies such as the Audit Commission, the British Medical Association, the House of Commons Select Committee on Health and many others. It is both unlikely that they will be implemented, and even if they are, be totally successful. For while they address some of the obstacles to seamlessness, they are far from addressing all of them, particularly those which stem from professional rivalry and cultural differences.

It may be that progress can be made within existing structures: for example the idea of the patient friendly hospital is essentially a management response to overcome the Balkanisation of hospital service delivery into so many different skills that the user is totally bewildered and sometimes badly served. But it may be that more radical measures may have to be adopted.

The evidence cited from the Independent Living Fund suggests that handing over co-ordination to care users can work. This approach may be more difficult to apply to health services but even here users can be given a greater role. In the case of children, the parent held record is becoming more widely used, not simply because it encourages parents to play a more active part in monitoring the development of their children but also on the more narrow ground that centralised information systems are not providing satisfactory records of the most basic kind on how the child is progressing, what tests or other surveillance have been carried out and what the findings and follow-up were.

There is no way of course that the need for professionals to work together can be eliminated. But if such interfaces are persistently problematic, then it would seem a sensible strategy to try to minimise the extent to which people are reliant on them.

PART 3 – OVERALL CONCLUSION

Last year we concluded our review with conscious imprecision: the NHS was clearly going somewhere but it was not clear where. The Government's re-election confirmed the general direction of change but while that reduced a large area of uncertainty – that posed by the possibility that Labour would win the election and reverse many of the reforms which were just coming into force – it still left a large number of issues unresolved.

In July 1992, Duncan Nichol, NHS Chief Executive, set out the Government's view of where the NHS was going: Ministers he said, had three priorities:

- implementing *The Health of the Nation*
- ensuring high quality health social care in the community by partnership with local authorities.
- developing the Patient's Charter at national and local level.

These three priorities are to be underpinned by two key objectives:

- achieving more effective management of resources through the drive to improve efficiency and value for money
- improving effectiveness of the NHS for the benefit of individual patients and the population as a whole.

Rather confusingly Sir Duncan went on to restate these, as follows:

> The overriding aim is to make improving health the focus of all our efforts in health promotion, illness prevention, treatment, rehabilitation and prevention of impairment and disability. To achieve this we must:

- embrace a wide role as champions of health in the local community.
- develop strong alliances with other agencies.
- invest in primary and community care and ensure a better balance between hospital and community services.
- set an example as a 'healthy employer'.

The letter then goes on to set out a series of tasks under four headings:

- Improving Health
- Better Services
- Efficiency and Value for Money
- Effective Organisations

While this announcement may help NHS managers, it leaves open the basic strategy within which all this change is taking place. Rudolf Klein argues in his article in this volume that there has been a change during this Government in the assumptions underlying the NHS – a move from the sacred to the secular to use his metaphor – or more exactly, a new secularism overlays the old religion which still persists. It is not clear whether the new will become dominant or in turn be overcome as the old values re-assert themselves.

But if the current reforms do not address these issues directly, they do have the merit, or possibly the demerit, of bringing out what the nature of the choices facing the Government for the NHS are. The best example of such a gain in transparency is the situation in London: the situation which the King's Fund and Tomlinson found was well known but nothing had been done because the obstacles had been deemed to be too great. The transfer of cash forced the issue.

The same forcing role is beginning to emerge through the purchasing function. The more the Government emphasises the need for precision in contracts on the one hand, and listening to user views on the other, the more it will force out into the open the limits of what a publicly funded NHS can do. The same process is at work within social services as well, through the needs assessment process.

Similarly, the Government is soon going to have to declare its hand as far as the establishment of market processes are concerned. This is not just a matter of how to control trusts or what to allow GP fundholders to get up to. More fundamentally, it is also about competition in the demand for care itself. As the *Health Care UK 1990* editorial put it:

> *One possible option for reforming the financial base of health services and empowering consumers at the same time is the introduction of demand-side competition .... Working for Patients can be seen as the first step along the road to a health care system in which public funds are used to purchase a basic care plan, but where citizens can purchase additional services with private funds.*

The Government continues to ignore this and other options. But if the analysis set out in this Review is correct, the very policies it is applying to the NHS as well as to social services will compel an examination of the basic options, of which that just cited is one.

PART4: 1992 IN BRIEF

January

7 **Junior Doctors' hours of working:** Secretary of State sets out progress of terms and conditions of service for junior doctors in UK.

8 **Women in the NHS:** *Women in the NHS: an action guide to the Opportunity 2000 Campaign* published.

9 **Purchasing:** NHS Management Executive publish 'Local Voices', guidance for health authorities on public involvement in purchasing strategies.

Heart and Liver transplants: Transplant services to be expanded with an increase in funding to over £40m and two more hospitals in national network.

10 **Dental provision:** Survey of NHS dental provision published, reporting that about 3/4 of dentists are routinely accepting all patients under the NHS.

Health care for children: £5m programme of pilot projects to identify good practice in caring for children with life threatening illness announced.

13 **Nurse education:** £98m allocated to implementation of Project 2000.

14 **NHS Trusts:** Department of Health reports results of survey which suggested NHS Trusts are popular with patients.

NHS reforms: Duncan Nichol, NHS Chief Executive, presents review of the first six months of the 'new' NHS.

16 **Brain injury rehabilitation:** £1m for brain injury rehabilitation initiative announced for 12 sites in UK.

16 **Gene Therapy**: Advisory Committee recommends safeguards for the introduction of gene therapy into medical practice.

Maternity services: Maternity services initiatives announced, including Confidential Enquiry into Stillbirths and Deaths in Infancy and review of clinical standards in normal labour.

21 **Health Advisory Service:** Dr Richard Williams appointed as new Director of NHS Health Advisory Service.

GP fundholding: Secretary of State announces reduction of minimum list size to 7,000, thus allowing 5,000 GPs to become fundholders from April 1993.

Mentally ill homeless: £8m allocated to help mentally ill people who are homeless in London.

27 **Food Safety Act 1990:** Two codes of practice for local authorities dealing with food premises and quick-frozen foods are published.

Psychiatric care: Capital funding of £18m announced for increased provision for medium secure psychiatric care.

29 **Black and ethnic minorities:** Code of practice on primary health care for members of ethnic minorities is launched.

February

3 **Family planning services:** New guidelines announced for regional health authorities to assist them in reviewing family planning service provision.

4 **Drug Abuse:** Government launches £2m drug abuse prevention campaign.

6 **Mental Health:** Health authorities and NHS Trusts invited to bid for extra resources for mental health schemes under the Capital Loans Fund.

7 **NHS Manpower:** Two NHS manpower statistical bulletins show progressive increase in hospital medical and dental staff over last ten years.

10 **Waiting Times:** Largest ever quarterly drop in long waiting times;a further £39 million allocated to the Waiting List Fund.

12 **Ambulance Facilities:** Guidance issued on transport of people in wheelchairs to hospital appointments.

13 **NHS Charges:** New NHS charges and spectacle voucher values announced.

20 **GP Fundholding:** GP Fundholding scheme to be expanded to include community nurses.

Dental Services: Department of Health and General Dental Services Committee agree on fees and payments to dentists: proposed cuts from 1 April suspended and a joint enquiry set up into why estimated payments level had been exceeded.

24 **Purchasing:** £10m initiative is announced to develop purchasing role of District Health Authorities.

Hospices: £37.2m in Government support to be given to the voluntary hospice movement.

March

3 **Community Pharmacists:** Report of a Working Party on the future role of Community Pharmacists is published - *Pharmaceutical care: the future for community pharmacy* – which recommends a more active role for them.

Nursing Audit: £6.3m allocated for 1992/93 to continue the development of clinical audit by the nursing and midwifery professions and professions allied to medicine.

5 **GP Fundholding:** Second wave of fundholders announced, which included some 1,400 GPs in about 280 practices, caring for 6.7 million people.

6 **Medical Equipment:** Allocation of £20m to hospitals for scanners, linear accelerators and other equipment in 1992/93 is announced.

9 **AIDS:** £181.4m allocated for HIV and AIDS services in 1992/93.

Day Surgery: £15 million allocated to expand facilities for day surgery.

11 **Smoking:** Tax increases on cigarettes announced in budget.

April

10 **General Election:** Government returned for fourth term.

May

1 **AIDS:** The Chief Medical Officer launches an AIDS education pack for hospital doctors.

Community Care: Secretary of State confirms that introduction of community care under the 1990 NHS and Community Care Act will go ahead as planned.

11 **Junior Doctors' Hour of Work:** New target to reduce Junior Doctors' on-call hours to a maximum of 83 per week by 1 April 1993 announced.

19 **Medical Research:** New agreement between UK Health Departments and Medical Research Council for clearer link between medical research and health needs.

21 **Human Fertilisation and Embryology Bill:** Bill which seeks to amend 1990 Act published.

June

2 **Dentist's Pay:** Government proposes new package on dentist's pay.

12 **Mental Health:** Appointment of David King as leader of Task Force on Mental Health Services announced.

19 **Patient's Charter:** Extension of Patient's Charter into primary care announced.

22 **London's Health Services:** King's Fund report, *London health care 2010: changing the future of services in the capital* published.

July

1 **Community Care:** Allocation of £69 million for community based health care announced for people with learning difficulties and mental health problems.

8 **Health of the Nation:** *The Health of the Nation: a strategy for health in England* published.

Chief Executive outlines the steps the NHS will take to implement the *The Health of the Nation* .

15 **Maternity Services**: Two new initiatives announced for improving maternity services provided by NHS: task force to disseminate information in NHS on good practice in the management of health care in pregnancy to postnatal period; appointment of expert committee to review policy on care during childbirth.

20 **Priority getting**: NHS chief executive sets out *Priorities and Planning Guidance 1993/94*

22 Dental Services: Enquiry into dentist's pay established.

August

5 **Mental Health**: Report published on conditions in Ashworth Special Hospital.

17 **Immunisation**: New guidance on vaccination published.

20 **NHS Trusts:** Fourth wave NHS trusts: invitations to apply issued.

September

25 **Community Care:** Guidance issued to Directors of Social Services and senior NHS managers on strengthening community care implementation.

29 **Citizen's Charter**: First awards made of Charter Mark seal of approval to three NHS units.

October

1 **Medical Training:** New policy announced for the separate funding of the cost of the training and service elements of employing NHS hospital medical and dental staff in training grades.

2 **Community Care:** Central Government's level of support for community care implementation announced.

7 **Smoking:** New guidance to the NHS on its in house policies on smoking launched.

8 **NHS Trusts - third wave:** Announcement that 128 NHS Trusts are to become operational in April 1993.

9 **Technology assessment:** NHS Management Executive publish *Assessing the effects of health technologies, principles, practices, proposals.*

15 **Psychiatric services:** A working party announced to consider how best to help psychiatric patients needing treatment in highly secure conditions.

16 **Maternity services:** Membership of the Expert Maternity Group announced, to review NHS maternity care particularly during childbirth and to make recommendations.

Whistleblowing: New guidance announced by Department of Health for staff to speak out on concerns about health care.

20 **The Health of the Nation:** Task forces announced on nutrition and activity in the workplace.

21 **NHS Management Executive:** Alan Langland appointed deputy chief executive.

22 **Elderly people:** The Government launches the sixth 'Keep warm keep well' campaign for elderly people to prepare for the cold weather.

23 **London's health services:** *Report of the inquiry into London's health service, medical education and research* (Tomlinson report) is published. Government promises detailed response in New Year.

28 **Air pollution:** The Advisory Group on the Medical Aspects of Air Pollution Episodes publishes its second report.

Smoking: Official study on advertising and tobacco consumption published.

November

2 **Smoking:** Minister for Health sets out Government policy on reducing smoking.

Diabetes: Membership of a task force set up by the Department of Health and the British Diabetic Association announced.

12 **Palliative care:** The Report of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee Principles and Provision of Palliative Care published.

National Health Service: Spending on NHS announced in Autumn Statement.

17 **Staff accommodation:** Guidelines are announced on the disposal of surplus NHS residential property to staff.

Nursing: The first meeting of the Practice Advisory Group for the development of nursing, midwifery and health visiting held.

18 **Education and Training:** A major new staff training and development initiative for 15,000 finance staff in the NHS launched.

19 **Drug misuse:** The Government's five point plan for tackling drug misuse announced.

23 **Health promotion:** Initiative allowing family doctors to promote healthy lifestyles and to prevent disease among their patients agreed with BMA.

27 **Mentally disordered offenders:** Final report of Reed Review is published on the care and treatment of mentally disordered offenders.

National Blood Authority: National Blood Authority launched to take charge of all blood supplies in England.

30 **Elderly people:** Age Concern and Department of Health establish eight new projects to improve the health and well-being of elderly people.

December

1 **Drugs Bill:** Secretary of State outlines the way forward on controlling the increase in NHS drugs bill.

The Health of the Nation: Two new initiatives announced -a series of conferences for 1992 and newsletter called 'Target'.

3 **Pay and conditions:** Doctors and dentists' review body not asked to make recommendations on general practitioners for 1993-94.

4 **Patient's Charter:** Patient's Charter extended into primary health care.

8 **NHS Trusts:** A further 121 units express interest in becoming fourth wave NHS Trusts in April 1994.

9 **Women in the NHS:** Women managers in the NHS: a celebration of success published as part of NHS' commitment to Opportunity 2000.

16 **NHS Trusts:** House of Commons Select Committee report on NHS trusts published, accepting trusts as model for the future.

21 **The Health of the Nation:** Specification of national indicators for progress in meeting targets set in white paper announced.

Drugs and Substances: New remit announced for advisory committees on NHS drugs and borderline substances.

22 Dental Services: Report of committee of enquiry into payment of dentists published.

1993

January

5 **Advertising:** Television advertising used for the first time to promote organ donation to save lives. £1.5 million campaign is launched.

7 **Health Promotion:** Better living, better life published-the culmination of a joint initiative by the Department of Health, General Medical Services council, BMA and Royal College of General Practitioners.

7 **NHS staff:** NHS staff statistics show that up to 170,000 doctors, nurses and other NHS staff suffer from depression, anxiety or some form of mental illness.

12 **Maternity services:** A report on good practice in commissioning and providing maternity services in units led by midwives and/or GPs published by the Department of Health and NHS.

Mental health problems: Review announced of legal powers for mentally ill people.

15 **NHS Management Executive:** John Shaw succeeds Mike Malone-Lee as Director of Corporate Affairs in the NHS Management Executive.

20 **Secure psychiatric care:** £22 million to be spent on funding medium secure psychiatric care in 1993/94.

21 **Health education:** New education campaign on osteoporosis aimed at family doctors and practice nurses launched.

25 **The Health of the Nation:** A series of regional conferences launched.

26 **Patient's Charter:** Health Helpline, a new telephone health information service, established under the Patient's Charter.

28 **The Health of the Nation:** Two handbooks launched on accident prevention, and HIV/AIDS and sexual health.

February

2 **Learning difficulties:** Mansell report published and two initiatives to help to improve services for people with learning difficulties and behaviour disturbance announced.

Junior medical staff's hours: £12 million of new funding allocated to reduce junior doctors' hours.

8 **NHS Trusts:** A further four new NHS trusts to become operational in April 1993, two in South Western RHA, two in South West Thames RHA, and one in West Midlands RHA.

10 **NHS drugs:** New members of the advisory committee on NHS drugs are announced.

11 **Clinical audit:** Chief Medical Officer announces £51.6 million for clinical audit.

14 **Project 2000:** £114 million allocated for Project 2000 in 1993/94 which will enable all schemes ready for implementation to start in 1994.

16 **London's health services:** Government's response published to the Tomlinson report on the future of London's health services.

18 **Gene therapy:** New committee established to consider proposals for the use of gene therapy on patients.

19 **Cigarettes:** Clampdown on illegal sales of cigarettes to children announced.

25 **London Ambulance Services:** Report published of the independent inquiry into the failures of the London Ambulance Service Computer Aided Dispatch system in October and November 1992.

NHS treatment: Surveys are published by the Medical Royal Colleges; guidance to be developed for patients requiring urgent treatment.

26 **Mental health services:** £20,000 grant is made to Good Practices in Mental Health to tackle the special problems of delivering mental health services in rural areas.

March

1 **Advertising:** New campaign launched to encourage people to carry donor cards for organ transplants.

2 **NHS charges:** Increases in prescription and other NHS charges, and higher voucher values to help people with the cost of spectacles, are announced - to come into force from April 1993.

5 **Mentally disordered offenders:** Membership announced of a new Government advisory committee on mentally disordered offenders.

NHS Low Income scheme: Responsibility for administering the NHS Low Income Scheme to be transferred from the Department of Health to the Prescription Pricing Authority.

15 Community Care: Further guidance issued on implementation.

23 **Health advisory panel:** Panel of health experts who are to advise the Health Advisory Service on aspects of their work meet for the first time at the Royal Society of Medicine.

Junior medical staff: The Government gives approval for 125 more consultant posts to be created from April 1993 to help to reduce junior doctors' hours.

Black and ethnic minorities: A new task force to improve the health of black and ethnic minorities announced.

29 **The Health of the Nation** The Department of Health issues popular versions of the booklet *The Health of the Nation* in ten minority languages.

Ambulance services: New management arrangements announced for the London Ambulance Service.

CHANGING BOUNDARIES BETWEEN HOSPITAL AND COMMUNITY

In the 1991 edition of *Health Care UK,* we devoted several pages to the theme of changing boundaries within the field of health and social care. That commentary looked at the boundaries between public and private sectors and that between health and social care. In this part of the review we focus on another boundary, that between the hospital and services based in the community.

In 1962 when the first comprehensive plan was announced for hospitals in England and Wales, the principle was put forward that care which need not take place in the hospital should take place in the community.

> *In drawing up the hospital plan, it has been assumed that the first concern of the health and welfare services will continue to be to forestall illness and disability by preventive measures; and that where illness or disability nevertheless occurs, the aim will be to provide care at home and in the community for all who do not require the special types of diagnosis and treatment which only a hospital can provide. Thus any plan for the development of the hospital service is complementary to the expected development of the services for prevention and for care in the community.*

In the 30 years or so that have elapsed since the plan was promulgated, there has been no concerted attempt to implement that principle across the full range of services that hospitals offer. Nevertheless, many long stay facilities for frail elderly, the mentally ill or people with learning difficulties, once mainly provided in specialised, often very large, institutions, have been closed and alternatives created, more or less adequately in other settings. The long term care role of the hospital has as a result, been radically diminished.

In the case of acute services, change has been more rapid within the hospital itself. The level of activity and bed utilisation rose steadily since the Plan was put forward, and continued to do so right through the 1980s, as Sean Boyle and Anthony Harrison showed in the 1991 edition of *Health Care UK*. But while lengths of stay have fallen right across the spectrum of care,and the number of acute beds fallen, there have been no nationally led attempts to shift whole groups of patients out of acute facilities. Indeed in the case of maternity services, the reverse is true: provision has become almost totally hospital centred, at least as far as delivery itself is concerned. And right across the spectrum of specialties, hospital activity has continued to rise.

As far as the work done within the hospital itself is concerned, there appears to be little doubt that further change will occur. The proportion of day surgery in total activity has been growing rapidly and there is every likelihood that it will grow further towards the 50 per cent level currently achieved in American hospitals, thus further reducing bed requirements. And in both countries minimal invasive surgery has, within the space of two to three years, become the dominant mode of treatment for some conditions: that too reduces the need for in-patient facilities.

Developments such as these however in a sense strengthen the role of the hospital even if they lead to a change in the kind of facilities it offers, since they reduce the costs to the NHS and to patients of providing treatment. In its report on London however, the King's Fund Commission identified a number of forces working to change the pattern of service provision in the capital in such a way as to reduce the role of the acute hospital:

- users are seeking greater involvement in service provision, in some areas making their preferences known for patterns of care which reduce hospital use;
- chronic conditions are becoming more important in terms of caseload than acute illness so that more care has to be provided on a continuing basis;
- technological change is making it possible to shift care from the hospital which hitherto could only be provided there by, for example, making it possible for patients to monitor their own condition and for GPs to carry out tests in their own surgeries.

The forces at work are by no means peculiar to London. Although London has unique features, the work of its hospitals, like those in other parts of the country, will be affected in the same direction, if not in the same degree.

But if we accept that the forces referred to are likely to have an impact on the way that health care is delivered, that still leaves open the question of how much care can be shifted, how beneficial that would be to the patient, how much extra or less it would cost and how it should be organised.

In 1992, the King's Fund Institute made a small number of commissions focussing on this particular boundary as part of a broader review of the role of the hospital being carried out with the Milbank Foundation in New York. We draw on some of the results in this part of our Review in the articles by Elaine Murphy, Matt Muijen and John Stilwell which follow.

In all three cases, the authors were asked to consider the scope for alternative patterns of provision, what would be needed to produce them and the obstacles to achieving change. The elderly are now the dominant users of hospital facilities and that dominance is likely to grow. But is that growth inevitable? In the first article in this section, Elaine Murphy considers the range of strategies that could be deployed to modify it.

The following article considers what is in a sense more familiar ground: the objective of reducing the role of the large mental hospital, though not yet fully realised, has been accepted for some time. Yet that does not itself mean that the role of hospital facilities of other kinds should be eliminated also. Indeed, admissions continue to rise. In the second article Matt Muijen examines what evidence there is on the costs and benefits of different forms of provision, emphasising that what has to be found is not one single preferred form but rather the right balance between different ones.

Finally, John Stilwell examines the central hospital support services pathology. All parts of the health care system, primary as well as secondary, rely on the tests that pathological services provide. But do they have to form part of the complex of activities that make up the modern hospital, or could they equally well be provided in other locations?

We turn first however to services for children and to maternity care by drawing on two reports which appeared during 1992 which bear directly on the boundary between hospitals and other service providers. The first, the Audit Commission study of hospital services for children, *Children First*, looked at an area where the principle that hospital use should be minimised was formulated in an official report even before the 1962 Hospital Plan was formulated. The second, the House of Commons Health Select Committee report on maternity services (HC 59), takes an area where precisely the opposite principle has, until very recently, ruled unchallenged.

We have focussed on these two areas for different reasons. In the case of children, it has been accepted, at least in official reports, for over 30 years that the time spent by children in hospital should be minimised, so as to minimise, in turn, the period of separation from family and home. This is therefore a good test case of the responsiveness of care deliverers to the needs of patients, a test which, as we shall see, they fail.

In the case of maternity services, another minimisation principle has been in operation, that of risk to child and mother. The dominant role of the hospital, a relatively modern phenomenon, has been justified by the argument that, ex ante, there is no such thing as a risk-free birth and that if that inherent risk is to be reduced to the lowest possible level, all births should take place in hospital.

PAEDIATRIC SERVICES

Anthony Harrison and Sally Prentice

In *Children First* the Audit Commission reported on hospital care for children. The introduction to that report remarks that the principles of good hospital care for children have been established for some time, in particular it has been accepted that use of hospital facilities should be minimised. As the Department of Health drawing on the Children's Charter developed by the National Association for the Welfare of Children in Hospital, put it in their 1991 *Guidelines for the Welfare of Children and Young People in Hospital*

> *... children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis.*

That 'minimisation' principle was promulgated by the Committee on the Welfare of Children in Hospital, known as the Platt Committee, which reported in 1959. In a section on alternatives to inpatient treatment, it stated the general principle:

> *Children, particularly very young children, should only be admitted to hospital where the medical treatment they require cannot be given in other ways without real disadvantage.*

In the 1970s the Court Committee, which looked at all child health services found that:

> *Paediatrics is beginning to move beyond the old hospital-bound concept, but progress has not been as fast as the needs require. Day care services have developed slowly and have only rarely been backed up by paediatric home nursing schemes, despite the obvious advantages of avoiding separation from family and home or shortening the length of stay in hospital.*

Taking these reports together, there appears to be general agreement on the underlying principle of minimising time spent by children in hospital and has been so for some time. Nevertheless see **Hospital Services for Children** – admissions to hospital of children have been rising rapidly, though quite how rapidly it is hard to be sure from the available figures because of changes in definition. In Wales and Scotland which did not make this change, growth in admission rates has also occurred.

Hospital Services for Children

Children and young people aged up to 18 years represent 28 per cent of the population of England and Wales. For most children, when they are sick, their parents and other members of the family provide care at home. If medical advice is required, the family GP will provide support and guidance either at home or in the community. Figures from the 1980s show that 98 per cent of children under 5 years see their GP each year, on average for 4 episodes of illness.

Children account for 10 per cent (almost £1.5 billion) of expenditure on hospital and community health services; about half of this is spent on hospital services. Child in-patients (excluding children who are mentally ill) are evenly split between the medical and surgical specialties. Paediatrics, a medical specialty, deals largely with babies and young children, whereas children admitted to surgical specialties are more evenly spread across the age groups. But most child admissions to the hospital are to accident and emergency departments: approximately one child in four attends A&E in any one year. In-patient admissions occur at the rate of about 1 per 11 children per year, amounting to about 16 per cent of all in-patient admissions to hospital. Almost all admissions in paediatrics are emergencies, compared to about two-thirds of children admitted for surgery. The average length of stay of children in hospital is currently about 4 days. Children also attend hospital as day cases, out-patients or 'ward attenders' (effectively out-patients who attend at short notice) – all categories of care which do not involve an overnight stay

The Audit Commission report confirmed that a great deal still could be done to implement the minimisation principle. In particular, it identified two main reasons why it had not been more influential:

- the interests of service providers and professional rivalries tended to dominate the interests of patients
- emphasis on a single integrated management structure had drawn attention away from detailed consideration of the objectives of patient care.

Drawing on this report, and on work by Jean Lovell Davies and Rosemary Thornes as part of the King's Fund's programme on the acute hospital, we set out below the steps that might be taken to implement it.

We begin with the time spent in the hospital itself and then look at alternative care settings.

Reducing Inpatient Stays

As with other age groups, the average length of stay for children in hospital has been falling and paediatricians more than most consultants have traditionally tried to discharge their patients quickly, even late in the evening. Nevertheless, the Commission points to a number of measures that could take this process further.

- Appropriate lengths of stay should be part of the recommended guidelines for the management of particular conditions and should be regularly reviewed as part of medical audit.
- For conditions that are relatively rare, such as diabetes, care should be managed by one consultant who can develop a special expertise in that condition. Evidence has shown that this approach reduces length of stay and improves management of the condition.
- Discharge procedures should be improved by consultants delegating responsibility for discharge to junior staff or carrying out more frequent ward rounds; by giving children and parents the results of tests after discharge if their stay in hospital is no longer necessary for medical reasons; by assigning a named discharge co-ordinator to each child in order to co-ordinate discharge with primary care services.
- Increased use of day surgery is possible, preferably in day surgery units in children's wards: see **Children's Day Care Units.**

Many of these recommendations can be implemented without the need for additional community support. Some can be difficult to implement in the absence of appropriate skills outside the hospital. There are a few paediatric nursing teams, see **Nottingham Community Paediatric Nurses.** While GP practice nurses may have a role, their skills are not necessarily known to hospital staff who, therefore, are not able to rely on them. Furthermore, as lengths of stay fall, the time available for parents learning how to cope with a sick child is limited. Clear written instructions may be needed to help provide care at home.

Children's Day Care Units

The paediatric unit at the Royal Brompton National Heart and Lung Hospital comprises a 16 bed critical care unit, a 22 bed children's ward and a self-contained day care unit with four beds attached to the main ward. The day care unit was set up because it was felt that some children were being admitted overnight who, with good planning, could receive appropriate day care treatment; there was also concern about the quality of care offered to many ward attenders who waited, sometimes for unacceptable lengths of time, until a nurse who was already committed to the acutely ill patients found time to attend to their needs. The day care area provides access to trained paediatric staff and facilities, but in an area away from the sicker children. Consultant staff have referred children who would otherwise have been in-patients, for treatment of conditions such as cardiac catheterisation and bronchoscopy, phrenic nerve stimulation, transoesophageal echocardiography, transoesophageal pacing and desensitisation tests for serious allergies. Parents are offered accommodation the night before treatment or on the completion of treatment if travel arrangements became complicated.

The day care unit at Hillingdon Hospital was established when a closed surgical ward was reopened as a day care ward. Since the unit has been in operation, the size of the paediatric waiting list has been reduced and pressure on casualty has lessened as the unit takes responsibility for all child A&E cases. A consultant from Harefield Hospital comes to the ward one a fortnight to carry out echocardiagrams which has reduced travelling times for many families. The day care unit is currently expanding the scope of its work by carrying out minor ENT surgery on a day case basis. Few children require overnight stay and post-operative problems have been minimal. All children and their families come to the ward for a pre-operative check the day before they are due to have their operation. The modification of the type and routine of premedication and anaesthesia has meant that most children can be discharged within four hours of entering the recovery area. In the post-operative period parents receive support and advice from a team of community paediatric nurses.

Alternative Settings

If care is to be transferred to other settings, the appropriate skills must be available outside the hospital. As the remarks above indicate, these have not been systematically developed. The Court report recommended that some GPs should become general paediatric practitioners, but while GPs have gained a larger role in child health *eg* through payments made to encourage them to carry out routine surveillance, that proposal was not accepted as national policy. Further, while the steps required to reduce bed use within hospitals can be taken more or less unilaterally by hospital managers, that is not feasible in the case of moving care out of the hospital.

One way forward appears to be agreement on a case by case basis between consultants and GPs on exactly how they should divide up the care of children between them *eg* in the field of diagnosis. Such protocols may extend beyond diagnosis to treatment. In Bath, a protocol has been developed for patients requiring burns dressings to

Nottingham Community Paediatric Nurses

The philosophy of the Nottingham Children's Unit is that 'children should not be admitted to hospital unless their nursing and medical needs demand it.' At present half of all paediatric surgical operations are done on a day case basis because 'day surgery is thought to hasten post-operative recovery and the child feels more comfortable at home'. Nottingham have a team of 17 specialist nurses including 6 paediatric community nurses who are based in the hospital. Paediatric community nurses work with families and liaise with primary health care teams, in particular health visitors and general practioners. There are also nurses who specialise in treating particular conditions such as diabetes, cystic fibrosis and asthma.

Prior to the introduction of paediatric community nurses, nursing staff on the hospital wards had dealt with any post-operative problems, usually through seeing the child in out-patients or re-admitting the child. Now the community sister can visit the child in his or her home, give advice and reassurance, and if wounds have broken down, care of these can be instituted at home or following just one return visit to the hospital. Community nurses also liaise with the primary care team, ensuring better communication and involving the GPs in the post-operative care of the child. Improvements in primary care have meant that children can be discharged quicker following major operations such as urinary tract surgery and abdominal surgery and children with chronic conditions can be looked after at home. Children who have drains, nephrostomy tubes and supra-public catheters can easily be looked after by parents with nursing support. Children with tracheostomies can be nursed in the community; parents are taught how to look after their child and can contact the hospital at any time if problems arise. There have also been attempts to transfer orthopaedic care into the community: the number of admissions of children requiring long and complicated dressings following crush injuries have been reduced; children with minor injuries receive treatment at their local health centre. Children who need to be immobilised using ordinary bedrest, traction or splints can be looked after at home with support from community nurses, but it is not always appropriate in all cases.

Nottingham has two oncology nurses who are both based in the hospital. One has responsiblity for the management of children attending the unit as day cases such as chemotherapy, blood transfusions or investigations. She acts as the co-ordinator of the service and the link for the families between the home, outpatients and the ward. The second nurse has taken on an educator's role. She has responsibility for ensuring that family information leaflets are up to date and instigates parent workshops such as how to care for indwelling lines. The asthma nurse will spend time in an asthmatic child's play group, nursery or school explaining to the staff what care is needed and how to support a child to enable him or her to live as normal a life as possible. The paediatric community nurses work closely with the specialist nurses. Infants with bronchopulmonary dysplasia require long term oxygen therapy. Initially the family care neonatal nurse will visit the family at home, but the paediatric community nurse will have met the parents before discharge and will have attended the discharge case conference, so that when she takes over the long term care she is already aware of the treatment provided and the background of the child and family.

Source: Working with Specialists, Elizabeth Fradd, 'Community Outlook', June, 1992.

Care in the Community, Sue Dryden, 'Paediatric Nursing', October, 1989.

Paediatric Medicine in the Community, Sue Dryden, 'Paediatric Nursing', November, 1989.

be seen in local community hospitals or health centres after visiting a (more distant) specialist centre. A recent study of review attendances at a paediatric medical clinic show that the children from larger general practices return less often to hospital for review procedures, which may be due to the practices' having a partner with a particular interest in paediatrics, more able to undertake review of complex and serious disorders.

Individual cases like this suggest that shifts may be feasible but their total potential impact on hospital based services cannot be estimated. At the moment, the evidence remains very limited.

Care at Home

The possible changes described so far depend largely on better management and agreed changes of role. But home care is one area where technical change does appear important. Intravenous drug therapy and parenteral nutrition allow these procedures to be carried out in the home environment for children as well as for others. There are additional costs for parents, but the evidence suggests that most parents prefer to look after their childen at home rather than visit them in hospital, and what limited data is available suggests that clinical outcomes are not inferior.

The Commission also point out that hospitalisation can be reduced by developing hospital care-at-home schemes. Such schemes can be used to enable earlier discharge to primary care for routine post-operative care and long term management of chronic conditions such as asthma. Home care nursing schemes can also be used to reduce hospital admissions by providing long term support at home for conditions such as cystic fibrosis: see **The Value of Home Care Teams**. The limited evidence available on how such schemes can be made to work in practice means that no general blueprint can be laid down: it remains unclear how much care can be transferred in these ways, and with what results.

The Value of Home Care Teams

The results of a survey of 48 families of chronically ill children carried out as part of the Audit Commission study showed that home care nurses can:

- reduce the amount of time some children need to stay in hospital;
- present information in a more considered, calmer atmosphere, reinforcing what they have already learnt in hospital;

  'You are confused, you rush into the hospital, you sit awake overnight: tired and worried. And then you are bombarded with information.' (Parent surveyed).
- reduce the number of unnecessary hospital admissions;
- provide a vital link with primary care teams and schools.

Source: Children First, Audit Commission 1992.

Preventing Admissions

The number of admissions for paediatrics has been increasing, largely as a result of an increase in the number of cases of asthma and the need for special and intensive care for newborn babies. It is impossible to say from national data whether rising admission rates are due to more children being admitted to hospital or the same children being admitted more frequently. However, analysis of data from the Oxford Record Linkage Study covering that region up to the mid-1980s shows that most of the growth has been in first time, rather than multiple admissions.

The Commission suggest a numbers of ways in which admissions could be reduced:

- Effective management of in-patient admissions for specific conditions can be assisted by written protocols which are agreed between all professionals involved, including GPs and primary care nurses. These should be reviewed as part of joint clinical audits. Such guidelines could cover the complete management of the condition, out-patient attendances and long term care as well as hospital care. In Southampton, guidance has been prepared for the referral of children to ear, nose and throat consultants and in Portsmouth, a protocol for the management and investigation of urinary tract infection. The latter includes agreements on GP arranged urine culture and ultra sound scanning which means that children are referred to a hospital clinic only when they need more invasive investigation.
- Better staff training and employment of experienced medical staff in accident and emergency: in one hospital admissions fell from 86 per cent of emergency attendances for asthma, to 56 per cent as a result of a training programme for junior doctors.
- GPs should have access by telephone to experienced medical staff for emergency consultations. Some hospitals hold rapid access clinics at peak times while others publicise a time when the consultant is likely to be in his office.
- Short term observation facilities: hospitals should have facilities to observe children for up to 8 hours without the need for routine admissions. The lack of facilities for monitoring children with asthma has led to automatic admissions on some wards.
- Provision of home care nursing services to families with chronically ill children to provide them with long term support and encouragement, avoiding in some cases the need to attend accident and emergency departments when crises arises.

Conclusions

Overall, commitment to the 'minimisation' principle is weak, even though for children the arguments for applying it are inherently strong and, on paper, widely accepted. Nevertheless, the nature of the proposals set out above is far from radical. Very few depend on new technology. In some cases,such as the community paediatric nurse, the proposals were made decades ago. In some parts of the country, the suggestions set out here are already being followed up.

The Commission make a large number of recommendations for improving hospital services for children, not all of which bear directly on the boundary issues. But they clearly identify commissioning authorities as the most important catalyst for change.

At present however, the overview that the commissioners can in principle take is missing. To achieve and devise services accordingly will require, as the Audit Commission put it, 'a major shift in the attitudes and approach of management'. It also needs a much clearer vision on what role the services should play and decisions about who should be responsible for them. Only then can the financial implications be fully asssed. Last but not least a financial framework is needed that promotes rather than hinders any worthwhile transfers: we return to the point below.

MATERNITY SERVICES

Anthony Harrison and Sally Prentice

There is a widespread demand among women for greater choice in the type of maternity care they receive, and that the present structure of the maternity services frustrates, rather than facilitates, those who wish to exercise this choice (House of Commons Health Select Committee Report on Maternity Services HC 29, 1991/92).

The Health Select Committee's report on the future of maternity services refutes the central arguments of successive governments that maternity care should be centralised in consultant obstetric units and that care by general practitioners and home births should be phased out. The Committee concluded from the large volume of evidence presented to it that 'the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety' and that 'it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions'.

That model has led to the hospital playing a dominant role in the provision of maternity care. That role is closely identified with the management of pregnancy and childbirth by consultant obstetricians, a form of service in which priority is given to the detection of abnormalities and the avoidance of complications, with medical technology used to a much greater extent in the delivery process than had been the case when giving birth in small hospitals and at home was more common. Involving women in planning their pregnancy and providing information with which they can make informed choices about the place of birth of their child has not been part of routine care in most consultant units. To give weight to personal choice will require a different pattern of services to that which obtains now, with a diminished role for the hospital, a shift within hospital from medical to midwifery care and expansion of community based services – a shift, in other words, in the boundaries of care.

Drawing primarily on Committee evidence, this article begins by describing government policy on maternity services and then presents evidence which suggests that some of the basic assumptions underlying it are unfounded. It then looks at the role of the hospital and other health care professionals and suggests how a move towards providing maternity care more tailored towards the needs of individual women and less reliant on the hospital, can be achieved.

Policy Development

The movement of childbirth from the community to the hospital during the first half of the 20th century was largely due to widespread concern among health care professionals, members of the public and policy makers about the level of perinatal and maternal mortality. The proportion of births taking place in hospitals, nursing homes and Poor Law institutions rose from around 1 per cent before the First World War to 54 per cent in 1946. By 1990, 98 per cent of all births in England and Wales took place in hospital.

Over the same period there has been a sustained reduction in both the infant mortality rate and the maternal mortality rate: the infant mortality rate fell from 154 per 1,000 live births in England and Wales in 1900 to 105 per 1,000 in 1910 and 80 per 1,000 in 1920; by 1990 the rate had fallen to its lowest level of 8 per 1,000. Reductions in the maternal mortality rate were more difficult to achieve: in 1918 the maternal mortality rate was 3.79 per 1,000 live births; by 1934 the figure had risen to 4.6 per 1,000 births. It started to fall after 1936 even before new drugs to fight sepsis became available. In 1990 the rate was 0.081 per 1,000 births.

As these changes were taking place, professional roles also changed: the National Health Service Act of 1946 provided for maternity services to be available for all free of charge and for the payment of a specified fee to GPs on the obstetric list; this encouraged a large number of GPs to take an interest in maternity care, reversing the previous trend to leave this work to midwives. But more significant, nearly all pregnancies subsequently came under the ultimate control of the hospital-based consultant, *ie* fewer and fewer women were looked after entirely by community-based professionals. Now, most are looked after on a 'shared care' basis, in which care is shared between community midwife, general practitioner and hospital clinic, or between midwife and hospital.

This shift away from a community-based midwifery service towards one almost entirely dependent on the hospital was encouraged by a series of official reports. In 1955/56 the Guillebaud Committee reported on *The Obstetric Service Under the NHS*:

> *The College believes that institutional confinement provides the maximum safety for mother and child and*

Table 1: Trends in Maternity Services

During the 1980s, the number of births in England rose from 623,000 in 1980 to 670,000 in 1990. As in other acute specialities, average length of stay fell, and so the number of beds in use also fell, though only slightly.

Beds available	**1980**	**1990/91**
Obstetric	15,541	14,000
GP maternity	3,009	
Average duration of stay (days)	**1980**	**1990/91**
Obstetric	5.9	3.5
GP maternity	4.4	
Births and Deaths	**1980**	**1990**
Neonatal mortality per 1000 live births	7.6	4.6
Perinatal mortality per 1000 total births	13.4	8.1
Maternal mortality per 1000 total births	0.11	0.08
Gross Current Expenditure on Obstetrics (£ million, 1990-91 prices)	**1980/81**	**1990/91**
Inpatient	612.7	578.2
Outpatient	91.0	73.2

> *therefore the ultimate aim should be to provide obstetric beds for all women who need or will accept institutional confinement.*

The Guillebaud Report was followed by the publication of the Cranbrook Report in 1959 which recommended the provision of sufficient maternity beds to enable a national average of 70 per cent of all confinements to take place in hospital. These recommendations became national policy with the implementation of the 1962 Hospital Plan. Each district general hospital would have a maternity unit with full consultant cover; the retention of maternity units at small towns could only be justified if the nearest district general hospital was at least 15 to 20 miles away. The building of new hospitals, the upgrading of existing facilities and the emphasis on providing a comprehensive hospital service, in addition to specific measures such as the introduction of the GP obstetric list, account for the movement of maternity care from a community-based, midwifery-led service to one increasingly centred on the hospital in which consultants oversee the management of childbirth.

The Peel Committee's report, *Domiciliary Midwifery and Maternity Bed Needs*, published in 1970, recommended further centralisation of maternity services in order to enable all mothers to have a hospital delivery, on the assumption that hospital confinement was safer for both mother and child. For the next 20 years official policy was determined by considerations of safety and the need to ensure further reductions in the perinatal mortality rate. Official guidance during the mid 1970s advocated hospital births for all expectant mothers on the grounds that 'even if a woman is at "low risk", and likely to have a normal birth, one cannot be sure it is normal until it is over'. In 1980 the Social Services Select Committee continued to advocate that all babies should be born in consultant obstetric units:

> *An increasing number of patients should be delivered in large units; selection of patients should be improved further for smaller consultant units and isolated GP units; home deliveries should be phased out further. We consider that the safety of the mother and baby in labour are of paramount importance and recommend that the labour ward should be regarded as an intensive care area and that staffing and equipment be optimal.*

As recently as 1984 the Maternity Services Advisory Committee Report stated that:

> *The practice of delivering nearly all babies in hospital has contributed to the dramatic reduction in stillbirths and neonatal deaths and to the avoidance of many child handicaps.*

Underlying Assumptions

The national policy of successive governments that every woman should give birth in a district general hospital rests on two assumptions. These are that that the reduction in perinatal mortality noted above has been a consequence of the increase in the proportion of women delivering in large hospital obstetric units and that the safest place in which any woman can give birth is a consultant obstetric unit. Evidence presented to the Committee suggested that there is no reliable statistical evidence for either.

A review of the available evidence by the National Perinatal Epidemiology Unit prepared for the Committee suggests the following conclusions:

- the statistical association between the increase in the proportion of hospital deliveries and the fall in the crude perinatal mortality rate seems unlikely to be explained by a cause and effect relation.

It is true that the move towards hospital births has been accompanied by an increase in intervention and a fall in the perinatal mortality rate. But factors such as improvements in diet, housing, family planning have all been contributory factors; advances in neonatal intensive care have improved the outlook for preterm babies, and some fetuses with congenital abnormalities are aborted, thus reducing the perinatal mortality rate. Thus the hospital service has been 'credited' with achievements to which it is only one of several contributors.

As for comparisons between different settings, these are far from straightforward, because it is hard to ensure that like is being compared with like. The Unit however came to a series of conclusions which suggested that when allowance was made for differences in the type of case being cared for in different settings, non-hospital settings performed as well as hospital. They run as follows:

- The rise in the crude perinatal mortality rate for births at home can almost certainly be explained by the increase in the proportion of unplanned births at home relative to those planned to occur there, as a consequence of the fall in the number of planned home births. A detailed analysis of the perinatal mortality rates for births at home in England and Wales in 1975–79 showed that a high proportion of perinatal deaths among births at home, rising from 12 per cent in 1975 to 20 per cent in 1978 and 1979, were of babies born to unmarried women under 20. Perinatal mortality among them ranged from 150.6 per hundred thousand in 1978 to 201.8 in 1979. In contrast, rates for married women in their late twenties compared very favourably with those for births in consultant units.
- The Home Births Survey showed perinatal mortality among births to the select group of women who had planned deliveries at home to be very low, particularly among parous women;
- For women at low risk who give birth in hospital, there is no evidence of differences between those who give birth under the care of consultant obstetricians and those whose deliveries are supervised by general practitioners, in the perinatal mortality and morbidity among their babies.
- There is some evidence that morbidity is higher among low risk women who give birth under consultant care, compared with those who give birth under the care of general practitioners and midwives.
- Thus, overall, there is no evidence to support the claim that the safest policy is for all women to give birth in hospital, or the policy of closing small obstetric units on the grounds of safety.

Denial of Choice

The main consequence of centralising maternity services in acute hospitals has been to deny women effective choice in childbirth. Less than one per cent of babies are born at home: maternity homes, GP maternity units and maternity services in small hospitals have been systematically phased out. Many GP maternity units in rural areas have been closed in recent years on the grounds that it is not safe to give birth in them and that such units are not cost-effective.

Evidence from GP maternity units indicates that the quality of care and levels of patient satisfaction is as high, if not higher, than the standard of service provided in consultant obstetric units, see **GP Maternity Units: Bath District Health Authority**.

GP Maternity Units: Bath District Health Authority

Bath district is very unusual in that it has a high proportion of general practice maternity beds relative to the number of beds in consultant obstetric units. There are seven local GP maternity units; five of the units are more than 15 miles from the consultant unit in the Princess Anne Wing of the Royal United Hospital in Bath. Over 30 per cent of babies are born in GP units. Isolated maternity units offer the majority of women, for whom childbirth is a normal event, a personal service in which they can be looked after by their GP and midwives with whom they have built up a good relationship; antenatal visits, classes, health promotion, some admissions and delivery itself take place in a local unit, easily accessible to the women it serves. The continuity of care that can be provided by the primary health care team antenatally, during delivery and postnatally is of a very high quality. National research, and experience in Bath district health authority suggests that the safety record of GP maternity units is as good as consultant units, and in some situations GP maternity units have been shown to lead to fewer interventions in 'normal' births. Bath community health council undertook a survey in 1989 to determine the level of support for local GP maternity units: 91 per cent of recent mothers were satisfied with nursing and medical support during the birth itself, whether the birth took place in GP maternity units or at the consultant unit, but only 65 per cent of mothers were satisfied with care in the two days after the birth in the consultant unit, compared with 97 per cent satisfied in the small GP units.

The Health Select Committee concluded that 'the choices of a home birth or birth in small maternity units are options which have substantially been withdrawn from the majority of women in this country. For most women there is no choice. This does not appear to be in accordance with their wishes'.

Only 20 women each day now deliver their baby at home, compared with 2,000 who have their babies in hospital. In 1988/89, of the 98 per cent delivered in hospital, just 4 per cent were in a GP ward. Yet, two surveys reported to the Committee suggested that between 5 and 15 per cent of mothers would at least seriously consider home birth if they felt it was a real option.

The reluctance of obstetricians, doctors and midwives to actively involve women in choosing and planning their care partly reflects the unclear guidelines from the Department of Health. The advice from the Department is that:

> *It may be possible for a woman and her partner to choose between birth in a consultant maternity unit, in a* GP

> *maternity unit, under a 'domino system' [which allows continuity of midwifery through pregnancy and delivery in hospital] or at home, depending on the facilities available in the area.*

Yet the Department also advise professionals, in the Maternity Services Advisory Committee's second report on intrapartum care, that every woman should be encouraged to have her baby 'in a maternity unit which can offer a range of obstetric, paediatric and supporting services necessary to cope with an emergency'.

The inconsistency in national policy may help to explain why professionals are reluctant to provide information to enable women to make an informed choice about where to give birth but it also reflects the paternalism inherent in the 'doctor-patient' relationship and territorial disputes among professionals involved in providing maternity services. The issue of choice and control in health care is fundamentally linked to the level of patient involvement in the planning and implementation of care: doctors are reluctant to relinquish control by giving women the necessary information which would allow them to make informed choices and be active participants in their own care.

As things stand, women who would like a home birth can find themselves in a confrontational situation with the group of professionals responsible for their care, as the following extract from the evidence of an individal mother to the Committee shows:

> *For my second child the midwife used the booking 'interview' to fill in her form and tell me the type of care I would get – a domino delivery in Basingstoke hospital. I had to refuse and insist I wanted a home birth. She reluctantly said 'they would consider it'. It was only because I had read books following my first labour, that I knew I had a choice and could insist.*

The Maternity Alliance, drawing on the experience of a number of women in its oral evidence, further illustrated the nature of the obstacles:

> *Hardly a week goes by at Maternity Alliance without somebody phoning to say they would like a home confinement and they are being obstructed ... Usually these women have said they have not been given any medical reason why they should not have it, but they have had all sorts of threats held over them, they have been made to sign forms that absolve the* GP *or midwife from any responsibility if anything goes wrong. They are fairly desperate panicked women.*

Underlying experiences such as these is a difference in view between clinicians and others about the nature of maternity care.The major concern of the medical professions is with the complications of childbirth and they are anxious to ensure that facilities to deal with the unexpected catastrophe are available to all.

The comments of Mr Macfadyen, a consultant obstetrician in Liverpool, reflect the concern of many obstetricians:

> *There are low risks and high risk pregnancies, but there is not a no risk group. Because all are at risk, the delivery suite is an intensive care area and should be staffed as such, both to deal with emergencies and to monitor mother and fetus in labour to prevent serious problems.*

The non-medical professions approach the place of birth issue from a different perspective, that of expecting normality. The Royal College of Midwives maintain that a 'non-medical model of care' should be available to all women and that home births should be an integral part of maternity services. Their antagonism towards the 'potential disaster' model stems from a concern about the routine use of interventions such as fetal monitoring without sufficient explanation or evaluation of the procedure and the lack of attention given to the physical and psychological needs of individual women. It is technology such as this which has underpinned the case for the hospital taking over maternity services.

The Use of Technology

The move away from natural childbirth towards a medical model of care is closely related to developments in obstetrics and the power of hospital consultants to determine patterns of care which have involved applying ever greater degrees of technological sophistication to the process of care. Yet Ian Chalmers *et al* argue in *Effective Care in Pregnancy and Childbirth* (Open University Press 1989) that the 'representation of obstetric medicine as a science is considerably more powerful and has contributed much more to its success, than its actual scientific basis would or should merit. Much that is routinely done or contended in modern obstetrics still has the status of fashion or hearsay; very little is based on the rigorous controlled evaluation of different approaches or strategies'.

Nevertheless in their response to the Select Committee report, the Royal College of Obstetricians and Gynaecologists continued to argue for the value of 'science':

> *For a significant number of women the application of science remains the only means by which they can achieve safe motherhood or a healthy child.*

Overall, however, the evidence suggests that such belief in 'science' must be qualified. As the Committee concluded:

> *that until such time as there is more detailed and accurate research about such interventions as epidurals, episiotomies, caesarian sections, electronic fetal monitoring, instrumental delivery and induction of labour, women need to be given a choice on the basis of existing information rather than having to undergo such interventions as routine.*

Options for Change

If hospital-based high technology care is not always necessary and if a substantial minority of women would prefer to give birth elsewhere, the present pattern of services has to be restructured. In the next part of the paper, we consider how this might be done, taking first antenatal care and then birth itself.

Antenatal Care

At present, antenatal care is given by midwives, general practitioners and hospital doctors. The type of antenatal care that is selected for an individual patient depends on local arrangements. By far the most common form of provision is care mainly provided by midwives but with responsibility shared between general practitioners and hospital clinics. In some areas, midwives are entirely responsible, in others responsibility is shared between midwife and the hospital.

The Select Committe received a great deal of evidence which suggested that antenatal clinics often fail to satisfy women's needs for continuity of care, choice and control in the management of their care and that the present pattern of provision was wasteful.

Poor Service: The National Childbirth Trust in its written evidence stated, that from members' comments:

> *A very clear picture has emerged of lack of time at antenatal clinics, failure to explain reasons for procedures and failure to offer information clearly ... many commented that their antenatal care was conducted in an impolite, inconsiderate and off-hand way ... Antenatal visits often involve long and expensive journeys, sometimes with young children in tow.*

Other evidence suggests that in hospital antenatal clinics the personnel change and the ambience is impersonal, often waiting times are long, facilities are poor and communication inadequate. On these grounds therefore some change would appear desirable, though that could be within the hospital itself.

Inefficiency: But not only is service poor, it is often inappropriate and wastefully provided. Dr Marion Hall, a consultation obstetrician said in her evidence:

> *Because a scientific basis for much of it is lacking, antenatal care is often inappropriately delivered, especially in respect of uncomplicated low risk pregnancy. Such women are seen more frequently than is really necessary because of inflexible adherence to out-dated routines. Present schedules of antenatal care are almost certainly not cost effective and routine care could be reduced with an individualised programme of individual care for each woman according to her needs.*

Dr G N Marsh, a GP from Stockton-on-Tees, stated in his written evidence that:

> *There is probably no more wasteful area in the National Health Service than the present system of maternity care. Gross overlaps and duplication take place between community midwives, general practitioners, hospital based midwives and consultant obstetricians and their junior staff.*

On this basis, there is clearly a case for reviewing the existing pattern of antenatal services and the 'shared care' approach to providing maternity services. One step would be to reduce the number of visits. The Royal College of Gynaecologists has recommended that women with normal pregnancies probably need only four or five antenatal visits, as opposed to what has become the tradition of every four weeks until the 28th week and then fortnightly until the 36th week and then weekly.

Such a move towards fewer antenatal appointments needs to be implemented alongside a more informal support network for pregnant women which could involve a telephone advice service (which may solve the problem or suggest that a visit is necessary) or a community setting which encourages a woman to call in if she feels concerned about anything to do with her pregnancy.

As for who should provide antenatal care, there was general support in the evidence to the Select Committee for a community-based antenatal service in which midwives supported by GPs would play the dominant role. The Royal College of Midwives not surprisingly argued that the present system failed to utilise the professional skills and abilities of the midwife and 'the role of the GP ... should be to only provide the medical support for the woman while she is in the community, in the same way as happens when she is not pregnant'. However, the Royal College of General Practitioners largely accepted that GPS should play a smaller role in antenatal care but in oral evidence stressed that what they were against was 'moving the GP out of the field'. A general consensus seems to be emerging that antenatal care would be provided by midwives in the community with obstetricians providing specialist advice on referral. The Royal College of Gynaecologists in their evidence emphasised that 'for antenatal care in low risk women the combined team of General Practitioners and midwives in the community was most appropriate': see **Community Antenatal Care Schemes**.

To implement a community midwifery service,the National Childbirth Trust recommended that

> *Midwives should be organised into small group practices and have specific case loads of women for whom they provide antenatal, intranatal and postnatal care. Community midwifery clinics should be established where midwives can be the first professional a mother encounters at the beginning of her pregnancy.*

In community-based antenatal care there could be much greater emphasis on tailoring the type of antenatal care to the requirements of individual women: see **Community Midwifery Teams**. Women with uncomplicated pregnancies could be cared for by midwives which would enable consultants to spend more time with high risk mothers in whom complications may arise both during pregnancy and delivery. The development of day care obstetric assessment units would allow for rapid referral of pregnant women for further investigations and specialist opinion.

For such a system to work there would need to be agreed policies between obstetricians and midwives as to

Community Antenatal Care Schemes

In Tower Hamlets the consultant obstetricians provide a support service for GPs; consultants continue their inservice training by visiting the surgeries and seeing women with their GPs, discussing problems with them and the midwife and health visitor. Pregnant women with medical problems have been looked after in the community and only those with diabetes have needed to visit the hospital clinic. Similar schemes exist in Sighthill, Lambeth and Huntington. In Sighthill the perinatal mortality rate was shown to fall faster than in the district as a whole; Huntington has the lowest PMR in the country and in Tower Hamlets the PMR has fallen below the national average despite its deprived population. In Tower Hamlets an audit of the women receiving antenatal care in the community compared with those in the district as a whole in 1989/90 confirmed that the incidence of pre-eclampsia had fallen amongst those women who were looked after by midwives and health visitors.

what constitutes high risk pregnancies. There would need to be an assessment procedure which identifies a spectrum of maternal and fetal risks at critical points during the course of pregnancy, which may result in some women moving up the ladder of sophisticated care in accordance with perceived risk factors and complications. Consultant obstetricians should be encouraged to visit pregnant women in surgeries or health centres.

Thus as far as antenatal care is concerned, it would seem that for the majority of women the boundary of care could be redrawn, with hospital based services providing less, and community services, particularly midwives, more. Unlike many changes in the NHS, it could provide both a better and a more cost-effective service.

Birth

A substantial proportion of women will undoubtedly continue to have their babies delivered in consultant obstetric units, partly for reasons of choice but also because of the associated risk factors. That does not mean however that the present form of care needs to be retained. Options can be provided within the hospital environment itself.

Women may wish to choose the position which they prefer for labour and birth with the option of a birthing pool where feasible; all women should be able to exercise choice over the personnel who will be responsible for their care within the hospital. Many hospitals use birth plans which allow women some say in planning their care, but the importance of these plans in practice varies from hospital to hospital: some hospitals enable women to consider carefully what care they would like during labour with the full support of doctors and midwives, but often the process merely involves 'ticking boxes' for different procedures.

Community Midwifery Teams

In Riverside district health authority there is a team of six midwives who provide continuity of care for women all the way through pregnancy, labour and the postnatal period. They are based in community clinics so that care can be provided near to where the women live. The midwives are fully responsible for the care they provide and work in liaison with consultant obstetricians and general practioners. The midwives will be on-call for each woman's labour and will look after them during the postnatal period. The midwifery teams have experienced some difficulties with the local GPs because, if given the choice, women have opted to have all their care with a team of midwives rather than their GP; the major difficulty has been that if a woman does not see her GP during her pregnancy, then the GP will lose his fee. The fees paid to GPs for care of pregnant women are £221.08 for antenatal and postnatal care excluding delivery of the baby; if the GP provides care during labour, he or she is only paid an additional £35.19.

In Bloomsbury, midwives work in teams in community clinics, in co-operation with the consultants in University College Hospital. A woman's right to determine the place and style of delivery is actively encouraged: midwives assume that given the right information, a woman can decide for herself how and where she wants to give birth, whether in hospital, at home or using the domino scheme.

The maternity unit at Leicester Royal Infirmary provides for 6,000 deliveries a year. In March 1988 a home-from-home scheme was introduced which involved two teams of hospital-based midwives providing total care for a defined group of women. At booking clinics women who have 'low risk' pregnancies are referred by the consultant to a team of midwives who then take on the total care of women before, during and after giving birth. Antenatal care is conducted in midwife-only clinics and intrapartum care is provided in one of six delivery rooms that are decorated and furnished to emphasise a low-tech approach to care; postnatal care is conducted in a midwife-only ward. There is a higher level of job satisfaction among midwives working in this scheme and greater patient satisfaction with this type of care. In early 1991 seven midwifery teams were set up, each linked to one community midwifery team. They provide total hospital-based care for a defined group of women from one area who are deemed to be in the 'high risk' group and did not want or could not have the original home-from-home scheme. This group included women who had previously had a post partum haemorrhage or forceps delivery. This development gives hospital midwives links with their community team colleagues, autonomy over their low risk caseload and strong links with an obstetrician who leads the care in consultation with the midwives for the high risk caseload.

Another option is for women to have their baby in a birthroom adjacent to the main consultant unit and the option of having a domino delivery, *ie* one where the midwife offering domiciliary care goes into the hospital with the mother and looks after her on return home. That would allow contintity of care between community and hospital. Birthrooms provide a compromise between giving birth at home and having the backup of specialist staff and equipment. When labour begins the woman, her partner and her community midwife go to the birthroom; usually there are no complications and after a short rest the woman returns home with her baby. If, however, complications were to arise, obstetricians, paediatricians and anaesthetists and their equipment would be available to support the mother during labour.

Such domino deliveries involve early discharge from hospital; if such schemes are to become more popular, then arrangements need to be made to cater for unexpected and potentially damaging problems arising in the baby or mother in the first few hours and days of life. Midwives and GPs need to be trained in neonatal examination and resuscitation. The same requirements apply to births in GP units or home deliveries.

While measures such as these would combine choice within hospital care, a full range of options requires the development of maternity services in other settings. There are several alternatives. The services provided by GP maternity units, whether in small rural hospitals or in urban settings offers a model of care which is particularly suitable for women who are in low risk groups and experiencing normal pregnancies. It offers a compromise between delivery in a consultant obstetric unit and at home; an option which is attractive to many women who are anxious about the risks, whether illusory or otherwise, of home births.

Midwife managed units can also provide a compromise combining many of the advantages of a home birth with the perceived security of a hospital environment. In these units midwives provide intrapartum care to all low risk women booked for delivery, and in some areas they provide antenatal and postnatal care as well: see **Midwife Managed Delivery Units**.

For home births to become more widely available GPs, need to be appropriately trained and encouraged to provide such a service themselves or support community midwives when required. Furthermore for women to be able to give birth at home or in community units not attached to a district general hospital with instant access to blood transfusion and other emergency facilities, requires that emergency arrangements are available to respond to the unpredictable need for resuscitation of the mother or baby. The traditional 'flying squad' which involves obstetrics and anaesthetic staff going to where the emergency is, needs to be replaced by teams of paramedics and suitably equipped ambulances. Paramedical training in emergency obstetrics has already been introduced in some areas.

Midwife Managed Delivery Units

The Midwives Unit was opened within Aberdeen Maternity Hospital in March 1990 following the closure of some cottage hospitals and maternity homes in the area. The unit has five single rooms and a sitting room and is geographically located within the labour ward. It is staffed and run by the same hospital midwives who work in the labour ward. There is no imput into the unit by medical staff, but there are strict criteria for booking and for transfer of the women to the labour ward. Labour is managed traditionally without the use of electronic fetal monitoring or epidural analgesia. Emergency obstetric, anaesthetic and paediatric services are available in the consultant unit nearby.

Achieving Change

Shifting the boundaries of maternity care and developing new forms of service will require action at various levels.

At the national level, the Committee itself recommended that the NHS Management Executive establishes a forum, modelled upon the Welsh Health Planning Forum, to prepare a national protocol which defines targets for the maternity services in terms of health care, with the purpose of requiring health service purchasers to produce specific plans for meeting those needs.

In response to the Select Committee recommendations, the Department of Health has taken two main initiatives. It has set up a maternity services task force to disseminate information widely in the NHS about good practice in the management of health care during pregnancy, childbirth and the postnatal period. An expert committee has also been appointed to review policy on care during childbirth, including home births. This will examine how women can be given more say in the care they receive during pregnancy and childbirth and will consider ways in which the work of the professionals can be best integrated. The committee will include strong representation from women who use the service.

Other changes must be made at local level. The case for shifting the boundaries of care in maternity services rests partly on the need to provide choice and partly on cost-effectiveness. We take these in turn.

Providing Choice

If choice is to be exercised, women need to be consulted as to what options they want to see available and information about them needs to be easily accessible.

Consultation: If women's views are fully to inform the decision-making process, then service users should be fully involved at the planning and monitoring stages of the contractual process. The Government accepted the need to involve women in planning services:

> *Health authorities as purchasers and those who provide care need to recognise a women's right to state her preferences in the type of care she receives, and to accommodate her wishes as far as possible, within local policies and resources. This is in line with the principles of the Patient's Charter, which places a greater emphasis on the need to provide more responsive health services.*

Some regions such as South East Thames have already demonstrated that it is possible to investigate consumers' views and choice of maternity services and to effectively utilise such information in the planning and provision of services. However, in other parts of the country such consultation mechanisms are not as well developed mainly because maternity services liaison committees are not fulfilling their intended function of providing the opportunity for consultation and joint planning. They do not have any powers to implement policy and are frequently ignored.

The Health Committee recommended strengthening the role of the committees by increasing lay representation and developing mechanisms to ensure that the committees are an integral part of the planning process. As part of their work in monitoring and evaluating services, districts will need to develop systems of medical audit and quality assurance which incorporate measures of patient satisfaction; maternity service liaison committees will need to set up systems to obtain and evaluate users' views, including any complaints that have been received.

Information:District health authorities and FHSAs will need to ensure that all pregnant women are given sufficient information to enable them to make informed choices about the maternity care they receive and where to give birth.

In itself, the provision of information through routine publicity and booklets ought to be straightforward enough: it does however depend on the willingness of the professionals to ensure it is available and that in the past, could not be taken for granted. Moreover, as the Policy Review points out (page 23), it is not just a matter of providing information but also of ensuring that the implications of potential choices are appreciated.

Cost-Effectiveness: Effective choice in childbirth will only be achieved if the professionals involved are prepared to accept the need for change and develop new forms of maternity service. The Select Committee concluded that:

> *there was a clear indication of the potential for a damaging dispute between the professional groups over how labour should be supervised ... there is an urgent necessity for the* NHS *and the Royal Colleges to address and resolve this dispute.*

The most pressing requirement is for a radical reappraisal of the role of midwives . Their skills are currently underused and their time is used inefficiently under the present system of shared care. A midwifery-led service may be cheaper and should provide a more effective service although the detailed evidence for both is not yet available. It would allow midwives to operate as independent practitioners with their own caseload and take full responsibility for the women who are under their care. Recognising that midwives should have the opportunity to establish and run midwife managed maternity units within and outside hospital, the Department of Health has already provided pump-priming funds to the NHS for the development of clinical midwifery and nursing audit. To date £8.6 million has been made available and an additional £3.2 million announced in May 1991 has been provided for a four year period for further midwifery and nursing development units.

The GP's Role:The establishment of a midwifery-led maternity service for normal pregnancies will in turn require the reassessment of the role of GPs. At present less than one in twenty births are delivered under the care of a general practitioner. GPs are most likely to be involved in intrapartum care in rural areas where babies are delivered in GP maternity units or small community hospitals. Very occasionally a GP assists at a prearranged home delivery; any GP may be called upon to give assistance at a home delivery in an emergency.

In reconsidering the role of GPs in providing maternity care two issues need to be looked at. First, the system of shared antenatal care and item-of-service payments for maternity care has produced either unnecessary duplication of the work of midwives or undesirable marginalisation of the role of community midwives. Second, as virtually all babies are delivered in consultant units, GPs have lost skills and confidence in the provision of intrapartum care which to a large extent has made it impossible to provide the continuity of care which is important to many women. Some midwives have argued that GPs should not be involved in maternity care and that midwives should totally manage pre-pregnancy, intrapartum and post-partum care and have the right to refer women to obstetricians for specialist advice. However, this ignores the central role GPs play in providing primary health care for mothers, babies and their families and the desire of many GPs to look after their female patients during pregnancy.

The Select Committee concluded that in the interests of consumer choice the option of GP care for women in pregnancy and childbirth should be retained and that the role of the GP should be flexible and adaptable to local circumstances. To encourage this, the GP contract and item-of-service payments would need to be revised and system of payments to be heavily weighted towards those doctors who provide intrapartum care and who could also provide medical check-ups before and during pregnancy. The choice of having a home birth or giving birth in a community hospital will only become a real option when GPs have sufficient confidence and expertise to manage intrapartum care; at present many women who want to have a home birth are frustrated, and in some instances obstructed, by GPs who are very resistant to providing emergency cover because of their lack of experience in delivering babies.

Conclusion

Although the majority of pregnant women will continue to choose to give birth in consultant obstetric units, the evidence suggests that a significant minority would choose to give birth in a GP maternity unit, or a midwifery unit or at home if these options were more widely available. From the evidence presented to the Select Committee the options would not necessarily lead to an increase in the perinatal mortality rate, nor raise costs. It would appear that a shift in the boundary of care is justified, in terms of choice, clinical standards and probably costs as well.

If more care comes under the management of midwives the role of the acute hospital in maternity care will be more narrowly focussed: midwives will hold regular antenatal clinics and consultants will provide specialist advice on referral from GPs and midwives, often in primary care settings; intrapartum care will be managed by midwives with specialist advice and facilities available if required. Hospitals will continue to provide specialist facilities for the care of premature babies and support for women with high risk pregnancies. Overall a service less dependent on the hospital would emerge.

SERVICES FOR ELDERLY PEOPLE

Elaine Murphy

This paper examines the appropriate balance of acute health care services for elderly people between hospital based services on the one hand, and services delivered from primary care and community settings on the other. It is concerned with issues which must be considered in deciding whether a shift towards a greater emphasis on primary and community care is desirable and feasible and, if it is, what would need to be done to move a substantial proportion of the medical, nursing and rehabilitative care which is now delivered in acute hospitals into patients' homes, general practice surgeries, health centres or other community settings.

It is important to be clear at the outset what is meant by 'acute health care'. We have interpreted it to mean all episodes of ill health which demand a rapid response from skilled health care professionals. Acute health care is defined by the speed of the response required, not by the place where care is delivered nor by where health care professionals are based nor on how often an acute episode recurs. Older people, especially those in late old age, are particularly vulnerable to rapid worsening of their condition as a result of physical illness and therefore require a service in which rapid accessibility is given a high priority.

The views expressed in this paper reflect the broad consensus developed at a workshop on 17 November 1992 at the King's Fund Institute. The workshop drew heavily on the opinions of many others who were approached to comment on a preliminary paper circulated in early Autumn, 1992.

Workshop participants were:
Dr David Challis, Reader, Personal Social Services Research Unit, University of Kent, Canterbury.
Professor Shah Ebrahim, Professor of Clinical Epidemiology, Royal Free Hospital School of Medicine, London.
Professor J Grimley Evans, Professor of Geriatric Medicine, University of Oxford, Radcliffe Infirmary, Oxford.
Mr Robin Flower, Chief Executive, Community Healthcare Trust, Isle of Wight Health Authority.
Dr Doug MacMahon, Consultant Physician with Special Responsibility for the Elderly, Cornwall.
Mr Stephen Onyett, Research and Development for Psychiatry, London and Medway Health Authority.
Dr Alistair Tulloch, Unit of Health-Care Epidemiology, University of Oxford.
Dr Paul Wallace, Department of General Practice, St Mary's Hospital Medical School, London.
Ms Sally Prentice, Research Officer, King's Fund Institute, London.

The underlying premise of this paper is that much acute care traditionally provided in hospitals would be better provided outside the hospital. This premise rests on two assumptions. First, that most elderly people prefer to avoid hospital admission or, if there is no alternative, to reduce it to a minimum period. Furthermore, an improved quality of care and rehabilitation can be achieved in a setting where the individual is as least dislocated as possible from his familiar surroundings and sources of social support.

Second, that this model of care will be a more cost-effective use of resources, that the same or improved quality of care and better outcome will be achieved at lower costs.

Neither assumption can be rigorously demonstrated to be correct. Only a limited amount of cost information is available, some of which we cite below, while what kind of services elderly people prefer has never been fully explored, and even if such information were available for current patterns of service, it would not apply to any new pattern that might be developed, from more friendly and welcoming hospitals on the one hand to better delivered community services on the other.

With these provisos, we take our two assumptions as our starting point, and explore how service delivery would have to alter if the balance of care were to be shifted away from the acute hospital to other settings.

We begin with the acute hospital itself where, as the evidence presented in *Trends in Hospital Care* suggests, rapid changes are already underway and are likely to continue.

We then turn to alternative care settings, taking first nursing and residential care homes and then home based care. Finally we consider some general issues which must be resolved if care is to be shifted away from the hospital.

Trends in Hospital Care

The key demographic change affecting the UK as a whole is the dramatic rise in the over 75's. It is the over 75's, and especially the over 85's who are the heaviest users of health and social services. While the 65–74 year age group will drop slightly before the end of the century, the rise in the over 75's and over 85's will have a very significant impact on services.

In England in 1990/91 over 45 per cent of all acute sector hospital bed days are occupied by elderly people of 65 years or over: see Table 1.

Table 1: Acute Beds Occupied by Elderly People

% total 1981	 1990/91
43.7	45.5

Source: Department of Health Statistical Bulletin, 1993/2.

This figure excludes admissions to specialist geriatric units. If these are included, approximately 60 per cent of bed days in general hospitals are occupied by those of 65 years and over. The vast majority of admissions are for chronic obstructive airways disease, ischaemic heart disease and other vascular diseases, neoplasms, fractures and cerebral organic disease, but as many as seven per cent of hospital episodes could be classified as 'housing, household and economic circumstances'. This last category is a 'catch all' classification of elderly people, often with mild or moderate degrees of dementia who have a motley collection of physical disorders and who have been admitted in crisis at the end of a long saga of failure of appropriate community care services where inadequate housing, social isolation or difficult family circumstances provide a context in which home treatment has proved impossible.

The vast majority of older people admitted to hospital are diagnosed, treated and discharged quickly, exactly the same way as everyone else. Like all other specialties, throughput per bed has risen rapidly in geriatric units: see Table 2.

Table 2: Throughput per Bed: Geriatric Units

Cases per available bed 1981	 1991/92
5.1	12.1

Source: as for Table 1. The figures cited here are not strictly comparable since the unit of measurement has changed from deaths and discharges to consultant episodes.

A consultant physician in care of the elderly medicine has an average caseload per year of between 700 and 900 discharges and deaths, with patients staying on average 10.3 days for 65 to 74 year olds and 13.8 days for 75 year olds and over. This is a few days longer than younger adults mean duration of stay: see Table 3.

Table 3: Length of Stay: Acute Sector

	Days 1981	 1990/91
All ages	12.5	8.8
75+	16.9	11.6

Source: as for Table 1.

The mean length of stay for older people is lengthened considerably by a minority having much longer stays, particularly those with strokes. It should be noted, however, that there is much variation between districts and even between different consultants' patients within the same hospital.

The increased possibilities for short stay day-care and ambulatory care – less toxic anaesthesias, the development of minimally invasive diagnostic and treatment techniques such as imaging, endoscopy, and drug treatments for conditions which would formerly have required surgery – are likely to reduce the use of acute beds by elderly people without any fundamental change in the organisation of care.

Other current developments which are likely to increase treatment rates include coronary and peripheral vessel angioplasty and coronary artery bypass surgery, at present believed to be subject to rationing for older patients; joint replacement surgery; operative intervention for urinary incontinence; cancer therapies. There is likely to be widespread future use of streptinokase therapy for myocardial infarction and acute thromboembolic stroke and, further into the future, mechanical heart pumps may revolutionise the treatment of heart failure. Safer methods of abdominal 'keyhole' surgery could well lead to increasing numbers of operations in people who would formerly have been considered a bad operative risk.

However, much of the fall in the mean length of stay is a simple consequence of the change of use of large numbers of beds formally designated as 'long stay care' beds into acute beds, a change which has occurred on a massive scale as long stay care has transferred out of the National Health Service into independent sector registered care homes and nursing homes as a consequence of the change in social security funding policies.

Philosophy of Acute Care

It is axiomatic that any strategy aimed at reducing older people's use of hospital beds must be driven by a vision of what can be achieved in terms of what is now called 'health gain' for individuals and collective populations of older people. There is no discontinuity in the biological ageing process which clearly separates elderly people from the rest of the adult human race. The prevalence of disability and use of health and social services increase through adult life, but there is extraordinary variability in the rate of ageing of organs and systems within and between individuals. Impairment and disability affect people unequally. Older people's response to acute medical interventions is broadly as good as for younger people, if physiological status and chronic physical and mental disorders are taken into account.

There is an assumption implicit in the way many health services are organised that the effectiveness of medical interventions for elderly people contrasts poorly with those for other younger age groups. But in those studies which have examined the relative outcome for younger and older adults in intensive care units, elective orthopaedic operations, renal dialysis, coronary artery bypass surgery and cardiac pacemakers, the vast majority of older people will benefit substantially; it is only those with extensive multi-system failure of all ages whose chance of benefit is small.

It follows that strategies for shifting the balance of care away from hospitals towards primary care must not disadvantage older people from full access to medical technologies or deny them access to specialists other than in geriatric medicine. Services for older people must be designed in a way which does not discriminate against them but rather enhances their chances of being treated equitably and with the highest skill available. Community care should only be a policy for older people if it is good enough for younger people.

Ill health in the very old is characterised by six features:

- multiple pathology in the setting of chronic disease
- non-specific presentation of acute illness such as confusion, falls, incontinence, which make it difficult to diagnose specific conditions
- rapid deterioration if untreated because of impaired physiological defences
- a high incidence of secondary complications of disease and treatment
- a need for intensive rehabilitation to regain function
- a background of social, psychological and environmental factors which disadvantage our current cohorts of older people compared with younger adults.

While good medicine for people of all ages operates best when practitioners adhere to these principles, medical interventions for many older people will be counterproductive and anti-therapeutic if these principles are forsaken.

Improving the use of Acute Beds

The Audit Commission in *Lying in Wait*, its 1992 report on the use of medical beds, identified five problem areas of poor use of acute beds which have as great a relevance to older patients as to younger ones:

- poorly organised or inappropriate admissions;
- inappropriate placement on the wrong ward;
- variable treatment regimes, poor consensus by consultants;
- poorly organised discharges, delays in finding long stay care places;
- inefficient bed management.

Three factors were identified by the workshop participants as crucial in improving the use of acute beds for older people; first, the rapid accessibility of specialist consultant opinion for GPs treating patients at home; second, the development of clinical treatment protocols and the use of shared guidelines for care planning and, third, a fully integrated specialist medicine service for adults of all ages. These factors are considered now in more detail.

Accessible Consultant Advice: in the UK, the tradition of domiciliary visits by consultants in geriatric medicine at the request of GPs to assess patients at home has been widely established for 20 years or more. Consultant practice differs markedly between districts and between consultants in the same district, ranging from those who do none to those who manage five or six such visits every week. Each visit attracts a fee which for some individuals is sufficient to top up their annual income by a sum which has been amusingly referred to as a 'D merit award'. This has led to an unfortunate suspicion by some managers and doctors in other specialties that the domiciliary visit is an outmoded and unnecessary luxury.

The overwhelming consensus of the workshop was that there remains a role, but a very minor one, for the traditional domiciliary visit to an ill old person who can be treated at home if the GP has the right consultant advice and support, but is too frail, bed bound or disabled in some other way which prevents him or her from being seen rapidly as an out-patient or at a day hospital or other day unit. More important, however, than the conventional domiciliary visit is the provision of rapidly accessible consultant advice, at a hospital out-patient department, at a day hospital or locally at a community health centre or surgery. GPs should be able to get their patients seen by a specialist team within a few hours; such a service is likely to reduce the need for emergency admissions and reduce requests for domiciliary visits. Wherever the place of assessment, it should provide opportunities for investigation, therapy and good liaison with community based services. It must have its own dedicated transport available to ferry patients very quickly between home and the assessment site.

At present in far too many districts patients are 'sent up to accident and emergency' for assessment, which may result in inappropriate admissions. The hospital based junior doctors usually responsible for the initial assessment of such patients rarely have sufficient experience to have a good overview of what community based treatment alternatives might be offered and the 'hole in the community' closes up very swiftly when a sick older person vacates the fragile tenure of their home support systems. The role of day hospital units in providing rapid specialist assessment is under-used in many districts at present and could provide the normal place in which rapid assessments take place.

While consultants in geriatric medicine do not necessarily need to make many home visits, it is important that other specialist professionals, such as occupational therapists and physiotherapists, do. They need to assess people's ability to function in their own home environments and convey to the whole clinical team an appreciation of the patient's home circumstances. In Australia, specialist therapists and nurses form a single multi-disciplinary geriatric assessment team. They work in the community but are closely linked to specialist teams. Some districts have developed similar models in Britain. The Italian Department of Health has recently issued a directive to health authorities to create similar teams.

Clinical Treatment Protocols: clinical treatment protocols are easier to develop for specific single system disorders than for multi-system disorders and disabilities. Treatment protocols, agreed hospital wide, are important for ensuring that older people in hospital have access to the same high standards of care as younger people, given the same physiological status. They are useful in comparative audit studies, may in time have an important medico-legal role and are likely eventually to be built in to contractual agreements between purchasers and provider units.

Treatment protocols have an important role in achieving quality standards, but rigid clinical protocols designed for hospital use have little place in the shared management of complex individual problems between the hospital and primary care team. Guidelines on the process of care, however, are valuable as long as they are developed jointly by colleagues in both hospital and primary care settings who have to use them. Thus guidelines might cover agreements on criteria for discharge, the process of discharge and the management of common complications and problems arising after discharge. Guidance should take account of local factors and its development should involve all disciplines, especially community nursing personnel who are often the people called on to implement them. To be effective these guidelines must take account of the need to improve liaison between primary care and hospital teams so that care is far better integrated between hospital and community.

Integrated Service: the workshop consensus was that the organisation of hospital acute services must ensure equality of access of older people to the best medical and nursing care and this will only be achieved nationwide by the provision of a fully integrated acute general medicine service for adults of all ages. Important core features of such a service are:

- Each medical team has one geriatrician attached to it who also acts as an acute admitting physician for all medical 'take' patients from time to time. This ensures that all acutely ill elderly people are assessed by a team which includes a geriatrician but also ensures that older people are treated by skilled and experienced doctors regularly practising all aspects of acute general medicine. The vast majority of older people admitted with single system disease uncomplicated by other problems can be treated and discharged in the same manner as younger patients. On the other hand, a relatively small proportion, between 5 and 10 per cent of older patients, who have complex multi-system disease or difficulties in the family/social environment which warrants more detailed assessment can be transferred to a specialist care of the elderly team and more specialist rehabilitation facilities. A fully integrated system does not reduce the need for specialist assessment and therapy staff and it is crucial that appropriate facilities should be provided in separate wards for patients needing more intensive or prolonged rehabilitation than the general acute medical patient. These specialist facilities should also be available for younger stroke patients and others who do not necessarily fall within the 'very old' age group.
- One single team of junior medical staff serves both sets of physicians. This ensures equitable distribution of trainees between the services and provides all junior medical staff with training in care of the elderly medicine. As junior doctors' hours reduce there is a pressing need to make best use of their time; separate teams for the geriatric medicine service will rapidly become untenable.

There are at present many well known successful 'age related separatist' services, and partially integrated services, which through the drive and charisma of their consultants have achieved a national and international reputation for excellence. One model called 'needs related' is a partially integrated model where a decision is made on admission about who needs a geriatrician and who does not. Its contribution to developing good practice is widely acknowledged. Regrettably, there are also many age related, 'needs related' and semi-integrated services where acute medical care for older people is delivered in second rate wards or in secondary hospitals at some distance from the district general hospital. Recruitment of staff, of both the right quality and quantity, remains a problem in such 'Cinderella' services.

We conclude that effective use of acute beds and hospital staff is fostered by a fully integrated general medicine service for adults of all ages. The fully integrated model is understandably unpopular with many geriatricians, who feel their traditional bed empire will shrink, that the elderly will not be able to compete for attention in wards focused on younger people and that standards of discharge and community after-care may be ignored in such wards, although there is no evidence for this from the few services which work in this way at present.

We recognise however, that outcome studies using these different models of hospital care have never been undertaken. There is a pressing need for a methodologically sound evaluation of both the fully integrated, age related and 'needs related' models of hospital care. In some regions, purchasers are adopting an age related approach for convenience of bracketing older people's services with other 'community care' focused specialties. While applauding the intention to develop a good hospital/community balance of services, they may be doing older people a disservice in terms of access to good hospital care. Our own view is that separate services use the total acute bed complement less efficiently and make comparative audit studies impractical.

Long Term Care

The Audit Commission highlighted delays in finding appropriate long term care places for elderly people who could not return to their own homes, as being an obvious area in which to improve the use of hospital beds. Elderly people with severe disabilities need to be provided with skilled health and social care in the most appropriate environment as soon as the decision is made that they cannot return home. The decision should not be made precipitately, as quite frequently happens at present. Patients should be allowed time to consider radical changes to their lifestyle and be able to participate fully in the decision, but once it is made patients should be able to consider a range of options quickly.

There is no hard evidence that any long stay beds need to be provided specifically in a hospital setting as opposed to good nursing home type of accommodation, but the distribution of provision of long term care between hospital type accommodation, registered care homes and nursing homes must be decided locally by the purchasers of health and social care services, taking into account what now exists and what can be developed locally. Until nursing homes can cope skilfully with people with severe disabilities, there will be a need for some hospital places. Independent sector homes have so far been reluctant to take the most seriously dependent elderly people, particularly those with behavioural difficulties. This is perhaps fortunate when so few have appropriate staff or resources to manage them. The consequence is that elderly people in long term hospital care and those that remain unplaced for many weeks and months in acute wards, are more physically dependent and have more profound cognitive and behavioural disturbance than those in long term nursing home care.

It may be surmised, however, that the rejection of those who are most dependent by private sector nursing homes is largely a consequence of the funding mechanism which has, until now, allowed homes to pick and choose their customers. From April 1993, when responsibility for payments currently made through social security for nursing home accommodation will largely pass to local authorities, they will be able to determine which patients will take priority for funding. This should mean that, in the longer term, nursing homes will be caring for those who would formerly have been cared for long term in hospital. This has occurred in Australia, where the level of Commonwealth, *ie* central government, funding for nursing home residents is based on a five point dependency scale, scored by a skilled geriatric assessment team. Competition for funds has driven nursing home proprietors to acquire the necessary skills and staff to enable them to manage residents who would formerly have been rejected. An assessment system of this kind will be needed for nursing homes to take on people with the full range of disabilities.

Three essential criteria for the swift and appropriate placement of people in need of institutional care are: local joint purchasing agreement between health and social services, an effective assessment process and good information shared between all services.

- **Joint Purchasing**: there must be a local joint purchasing agreement across health and social service budgets to ensure that the full range of provider facilities is appropriately used and places are offered to people on the basis of individual need. This should include a joint agreement about the use of any long term hospital beds. A major concern of the workshop was that while joint purchasing agreements are currently proceeding in a handful of health and social services authorities, the majority are pursuing individual policies with the aim perhaps of protecting their own budgets. The inevitable result will be that frail old people will remain too long or inappropriately on acute wards and independent sector homes will remain under used and unskilled. It will also lead to duplication of some services and a mismatch of clients to available places.

  The workshop supported the principle that health and social care service budgets should be unified under one agency. It was felt that an important opportunity had been lost in the current Community Care legislation. At present there is no real incentive for health and social services authorities to work together towards a joint purchasing strategy and while much was being achieved in some places by goodwill and enthusiasm, the fundamental structural blight will continue to hinder the appropriate development of community services for older people.

  Joint purchasing strategies should cover two levels. First there should be joint purchasing at agency level to avoid the duplication of services, enabling the purchase of a spectrum of contractual agreements with a range of provider services. A second level of joint purchasing is that done on behalf of an individual by a care manager holding a devolved budget for buying in a co-ordinated mix of services to meet an individual's assessed needs.

- **Effective Assessment**: common assessment procedures, developed jointly by health and social care professionals, but which can be used by individuals from either side of the statutory sector divide, work well if staff trust each other and do not, as sometimes occurs at present, repeat assessments to conform to the idiosyncrasies of their own agency's forms. Assessment protocols should be designed to provide clear direction for the placement of an individual. The Australian geriatric assessment teams, specifically developed to assess older people prior to admission to nursing homes, have in some states become an integral and valuable part of the comprehensive hospital and community service. Some authorities in the UK may wish to consider the possibility of deploying health and social services staff in teams of this kind.

  It has been suggested that whoever is responsible for placement should have a target time set within which the majority of placements should be made, but such 'performance criteria' would need to go hand in hand with an assessment of the quality of outcome of the placement in terms of the individual patients and their relatives' satisfaction.

- **Shared Information**: better information about the levels of disability and need for a variety of types of residential accommodation is needed for rational planning. While there are possibilities of substituting long term care at home for some of those who currently occupy independent sector residential and nursing homes, there is insufficient detailed information for a rational purchasing strategy across all residential, nursing home and long term hospital care in individual districts. Current provision is based on historical numbers of health and social services places modified by the recent growth of the independent sector.

  It is also vitally important for there to be a smooth flow of personal and clinical information to follow the patient from home to hospital and onwards to other care settings, especially information gleaned from health checks by practice nurses and GPs. New technologies for swift communication between hospitals and surgeries by means of 'smart cards', video phone links and electronic mail should all be developed as a means of improving communication between sites. Individual care plans need to be comprehensive, clearly written and accompany patients when they move.

Much can be learnt about discharge, long term placement and aftercare procedures from recent initiatives for adults with severe mental illness. The care programme approach identifies individuals at risk who will need an identified key worker to organise, implement and monitor a package of services. In some districts the key worker will be a budget-holding care manager. While most individuals monitored by the 'care programme' will have long term disabilities, some of the elements of that programme could be adapted to ensure that there is a key professional managing the transition of an elderly person out of acute hospital care into residential care.

Care in Registered Care Homes and Nursing Homes

Long term care for severely disabled people is provided by a multiplicity of homes and hospitals. There is now a true 'mixed economy' of care providers in the statutory and independent sectors providing care for people who 20 years ago would almost all have been cared for in long stay hospital beds within the NHS. Long stay patients used to comprise a major 'constituency' for consultants in geriatric medicine. As geriatric medicine has focused increasingly on its rapidly growing acute work, patients receiving long stay care outside of the NHS have increasingly been deprived of specialist advice, both from consultants but also from skilled specialist nurses and therapists. The key issue in the context of this paper is how to ensure that those in institutional care receive high quality acute health care in the course of receiving care for long term mental and physical disabilities.

There is currently a debate in the services as to whether medical care in homes should remain exclusively the province of GPs and that efforts should be directed to promoting better quality primary care, or whether there might also be a role for specialist community based geriatricians to work directly with staff of homes.

The consensus of the workshop was that the backbone of acute health care for people in residential and nursing homes should be provided by GPs with a special interest and preferably additional training in care of the elderly medicine backed up by an 'instantly' accessible specialist opinion from the hospital based service. The willingness of consultants and their teams to visit urgently on request, the availability of rapid day unit or out-patient assessment and the availability of specialist nurses and therapists able to give rapid, on the spot advice, were all important. In each district it should be possible to identify one or perhaps two consultants willing to develop an interest in community work who would have sessions specifically allocated for the purpose. This would require a commensurate reduction in hospital focused responsibilities of the 'community focused' consultant. The work of GPs and specialists would be facilitated by a community based multi-disciplinary team 'the geriatric assessment team' of nurses and therapists. At present some districts have these teams, most do not.

It is recognised that there are areas of the country in which a new animal, 'the community geriatrician', has already evolved; these posts should be carefully evaluated. In some inner city areas and, rarely, in isolated rural areas, where primary care is less well developed, there is pressure from local authorities and voluntary organisations for the specialist services to fill the gap left by the inadequacies of primary care. In these circumstances there is room for local experimental projects to meet specific local problems. Innovative projects should be welcomed but carefully evaluated. In general, enhancing GPs' awareness of the needs of elderly people and encouraging those who work with patients in institutions to take specialist qualifications such as the Diploma in Geriatric Medicine, is the preferred route to improving acute medical care in institutions and to prevent unnecessary admissions to hospital. Perhaps GPs could be registered on a 'care of the elderly list' in the same way as many are proud to be on the 'obstetric list'. Financial reward as recognition of further training in this field would be helpful. It would also be helpful to have an increased percentage of geriatric medicine training slots in GP vocational training programmes. At present approximately 40 per cent of such schemes have appropriate slots.

Training for Quality Care in Residential Homes

The quality of health care delivered in both residential homes and nursing homes depends on the skills and commitment of the care staff. Staff need extensive training in high dependency nursing, but also need to develop a model of care based on sound principles of functional analysis of an individual's capabilities and, most importantly, an understanding of the psychological, that is emotional and behavioural, problems associated with physical disabilities, depression, confusional states and dementia.

While it is important to have qualified staff available to supervise, train and monitor the quality of care being delivered, there needs to be a fundamental reappraisal of the relationship between qualified and unqualified staff and far greater focus on training and enhancing the skills of the unqualified majority of staff. Initiatives such as the joint care training approach for National Vocational Qualifications for care staff is much welcomed. Qualified staff must be better trained to manage, supervise and pass on their skills to untrained staff. A major step forward in enhancing the status of unqualified care staff would be their regrading as 'white collar' salaried staff rather than weekly paid manual labourers. Some local authorities have already done this.

Welcome training initiatives have mushroomed in local authority run homes over the last five years largely as a result of specific government funding. The need now is for the private and voluntary homes to take seriously the need for training and to review their employment practices. This is unlikely to happen unless ongoing training is required by registration units and purchasing authorities comprehend that investment in training requires financial resources.

Long Term Care at Home

There are now numerous studies of home care support services for severely disabled people using care management principles which aim to provide an alternative to long stay residential care. The evidence is that for the same costs, or less, it is possible to sustain at home old people with moderate degrees of mental disability or severe degrees of physical disability, as a substitute for residential care homes and some nursing homes. But these schemes do not necessarily reduce the need for long term 24 hour nursing care of the intensive kind provided in some high dependency nursing homes and hospitals.

This may seem at odds with the evidence that acute care can be provided at home as an alternative to hospital. In the case of the acutely ill patient, however, recovery or partial recovery is expected to take place in days or weeks whereas for those who are permanently dependent on nursing care for most daily tasks of life, it is unlikely to be an economic proposition to provide intensive nursing care at home on a permanent basis. There are clear economies of scale in providing nursing care in institutions where one or more care staff must be present round the clock on a permanent basis. Furthermore, there are some emotional and behavioural disorders, especially in those with severe dementia, which are so emotionally taxing that a supportive environment of several staff working together may be preferable to having one nurse working alone with one individual at home.

Effective home support schemes for people with mild and moderate disabilities using care management principles to deliver a set of services tailored to an individual's needs are, however, important in reducing the use of hospital beds. These schemes involve the employment of a skilled care manager who usually controls a budget, to buy in an appropriate mix of personal and domestic services for each individual. They are effective for the following reasons:

- They enable many old people with chronic disabilities, who are at risk of emergency admission for a minor health crisis, to remain at home during the acute phase and out of hospital beds altogether; they can be treated by the GP and district nurses working in tandem with the home care support staff.
- They promote early discharge from hospital following an acute episode of illness.
- They enable the local authority to reduce the number of care home places required and free up valuable resources for the provision of nursing home care for more disabled people, which in turn frees up hospital beds.

To work effectively, care managers need good access to both GP and specialist services. While the development of care management is largely the responsibility of the local authority, they can transform the work of health professionals working with elderly people, simply by providing the back-up personal care to enable people to stay at home.

At present home support schemes provided by local authorities tend to be poorly integrated with GPs and the district nursing service. Once again, the current structural divide between health and social care organisations creates a barrier which discourages joint health and social care assessment and care planning. It has been suggested that fundholding GPs might eventually wish to employ their own budget-holding care managers to co-ordinate health and social care provision or commission a care management service for their own patients from the local authority service. The current budget division is unlikely to encourage such innovations however and since on any one GP's list there will be relatively few patients who require an extensive care management service, such initiatives are likely to develop only in large group practices.

Nevertheless, the advent of the annual health check at 75+ will enable a care manager to link in closely with the case-finding process and if satisfactory financial mechanisms were in place for the purchase of social care, primary care could provide the basis for care management. A development of this kind is currently taking place in the context of the North Kensington Elderly People's Integrated Care System which includes resources from the health authority, social services department and the family health services authority managed 'as if from a single budget' in order to provide care management for elderly people resident in the locality.

One successful care management home support scheme for people with advanced dementia in the author's home district, Lewisham, locates local authority care managers within a joint funded community mental health team. This model is well suited to mental health services where there will be insufficient numbers of people in even large practices to justify the employment of a care manager with special training in mental health problems, but may also have applications for elderly people with severe physical disabilities in districts where primary care services are underdeveloped. The Darlington Project described by David Challis and colleagues in *Supporting Frail Elderly People at Home* (PSSRU, 1989) located care managers with devolved budgets in a specialist geriatric multidisciplinary team. The costs of this scheme suggested that very substantial savings could be achieved in provision of long term care for very disabled older people in the scheme compared with an equally disabled comparison group.

Treating Acute Illness at Home

It is clear that some acute hospital admissions can be prevented if sufficient concentrated nursing, domestic and personal care are available over a crucial period of days during an acute illness. GPs feel they could avoid many admissions if they had instant access to a team of people who could give round the clock cover for a few days or a week or two, perhaps with some specialist guidance of a minimal kind. This work is popular with community nurses, and community based therapists, who are keen to use their professional training to the full. A handful of districts have developed specific projects, 'Hospital at Home Schemes', targeting a particular client group – usually elderly medical patients. Some operate as outreach services from hospitals, other from community health services. The consensus is that these schemes tend to be one-off innovations by local enthusiasts which are not sufficiently comprehensive to make a district-wide impact on the use of beds.

This is an area where prospectively designed evaluative research is badly needed. The research literature describing existing schemes is disappointingly poor and it is difficult to draw conclusions about the costs of effective schemes, how they are best commissioned and organised and what order of reduction of bed days might be predicted by the introduction of a comprehensive scheme.

The evaluation of the Peterborough Hospital at Home Scheme by Parker and Pryor (*Geriatric Medicine*, August 1991) suggests that this style of working could be both economical and popular with patients but a question remains as to whether such one-off local schemes are advisable. Even in Peterborough only half the local GPs are willing to participate in the scheme. It might be better to concentrate management and planning effort on to a shift in assessment and admission policies and a general improvement in provision of health and social care services delivered in patients' homes, both in terms of the volume of services and how they are managed. GPs need to be able to trigger a joint team of nurses and personal and domestic care staff to be available over a period of days in response to an emergency. It may be that in some districts at present this is more feasible if the team carries a label called 'Hospital at Home'. There are comprehensive schemes operating in Pittsburgh, USA South Hills Health System Home Health Agency treats 3,000 patients per day and employs 300 staff; and in France, Santé Service Bayonne supports 360 patients per day, but neither of these schemes has been evaluated.

Discharge Schemes

Most Hospital at Home schemes operate as early discharge schemes, providing concentrated but diminishing input over the course of several days or weeks after a rapid discharge following acute treatment. Specific discharge schemes are increasingly popular and many districts in the UK now have a special team of specialist nurses, therapists and home care personnel which swings into action on request. Again, the schemes tend not to be comprehensive or district-wide and many are poorly coordinated with primary care teams and local authority community care services. They have, however, been successful in improving discharge of elderly people, and a few schemes have demonstrated a significant reduction in re-admission rates and subsequent use of in-patient beds. The success of these schemes seems to depend on the level of 'hands on' personal care available over the crucial period following discharge; this is an expensive commodity and costs may not be reduced to significantly less than hospital costs over a similar period.

What is now required is a system in which every discharge is subject to the same comprehensive assessment and an individual care plan is designed which includes an appropriate aftercare package and an effortless 'baton change' of responsibility between the hospital and community based teams of professionals.

At present, the most cost effective home care schemes are those in which most hands on personal and domestic care is provided by home care services contracted or provided by the local authority where there is no artificial demarcation between 'housework' such as cleaning and shopping, and personal care to maintain cleanliness, comfort, feeding and so on. The workforce available for this style of comprehensive home care consists largely of people in mid life who are entering such work for the first time but often have a lot of relevant life experiences. Suitable individuals do however need in-service training. The new National Vocational Qualifications system will provide a context for development of training in the workplace.

Recruitment of unqualified care staff to work with isolated, vulnerable people raises important questions about how flexible employers' rules should be for neighbours and other very local people and what standardised controls should be in place. For example, should all such workers be subject to normal checks on criminal records? In the light of experience of the selection of staff to work with children, it seems crucial that employers should have rigorous selection procedures for all people who will work with vulnerable old people.

Finally, for home treatment schemes to be effective, specialist nursing and therapy staff must be available to give specific advice when it is needed. GPs must also be able to call on consultant colleagues for rapid advice and assistance particularly at the point when the GP feels 'enough is enough', and the need for admission arises quickly.

The Role of Relatives

The reality of much care of acutely ill elderly people at home is that hands on nursing and domestic care is provided by relatives – usually a spouse and often a female relative. Sometimes this care is of a remarkably sophisticated kind – relative carers give drugs, even injections, drain and monitor urinary catheters, and conduct physiotherapy in addition to supervising bowel habits, monitoring sleep and keeping an eye open for untoward signs and symptoms. While 40 per cent or so of people over 75 years live alone, relatives who live nearby quite frequently spend a lot of extra time with acutely ill older people in direct care tasks. In addition, considerable help may be provided by near neighbours, voluntary visitors, old friends and so on. Professional assessment of the suitability of an individual patient for care and treatment of an acute episode of illness at home should include:

- an assessment of the main carer's ability and willingness to provide care;
- the provision of support which suits the carer as well as the patient;
- the need to give the carer necessary information about treatment;
- the need to involve the carer in admission and discharge planning;
- the provision of training for the carer as well as the professionals;

These principles should also apply to other involved carers, whether relatives, friends, neighbours or volunteers.

Care Management

The principles of care management have only recently become widely accepted in the UK as necessary to the delivery of a well managed service. The phrase has generated some suspicion among GPs that these are the latest 'buzz words' for the solution of problems which are insoluble in the face of inadequate resources. Care management systems have however been in effective operation in the USA for many years, working well most notably with a client group notoriously difficult to serve, adults with severe, chronic mental illness. Care management structures which foster effective operational management of individual cases to deliver the right mix of services are crucial to developing any acute health care service outside hospital. Services break down not because of a lack of skilled professionals but because of a failure of co-ordination of health and social care inputs over a crucial period of hours, days or weeks.

Who will these new care managers be? While skilled social workers have many of the right attributes, senior geriatric liaison nurses could also develop this role, or community nurse team leaders or managers, but whoever does it, the role must be clearly specified and lines of accountability clear. Care management is usually thought of in the context of people with long term disorders but the same principles can be employed on a short term basis. A GP in Lewisham recently remarked 'When my surgery needed rebuilding, there was a site manager, who organised the bricklayer, the painter, the roofer and so on. Community care is no different, someone's got to be in charge and that's what I'm hoping care managers will do'.

Capital Developments for Community Resources

At present the capital stock of GP surgeries, health centres and bases from which community health services operate is small, often over-crowded and inconvenient. There is rarely space or equipment for specialist team clinics to operate effectively. In many city areas, GPs, district nurses and health visitors operate from separate bases, to the detriment of the development of effective primary care teams. A radical re-distribution of capital development funds away from hospital building would be required to foster good community care. A network of primary care and community centres would be required, perhaps some of them operating as Community Resource Centres from where generic and specialist teams of nursing, therapy and social care staff can provide outreach services in people's homes and where rehabilitation assessments and specialist treatments could be given on a day care and out-patient basis. Some of these resource centres might also provide short term rehabilitation beds for the '10,000 mile service' type of intervention, or respite care provision for those being supported at home by relatives. Wherever possible new facilities should be on site with local GPs and their attached staff. Capital developments should be designed to encourage singled handed and small practices to coalesce in groups.

While some people hanker nostalgically for the 'good old days' of local cottage hospitals, the broad consensus is that community health centres with beds or local small hospitals are in great danger of deteriorating into 'forgotten long stay units'. This risk is best prevented by ensuring that beds are used only for acute care, short stay, rehabilitation or respite care, by basing at the centre a multi-professional team of therapists and nurses with ready access to hospital based specialists, but where the day to day medical care is provided by local GPs. In areas of the country where this model has been working for some time, for example in Oxfordshire and West Lambeth, community hospitals remain a vigorous and healthy part of a popular local service.

Community hospitals are not always popular, however, with specialists, who complain that patients admitted for acute care do not always receive expert diagnosis and management. Furthermore, community hospitals can be expensive to run, are often poorly managed and may lack expert medical direction. There needs therefore to be close liaison between community hospitals offering acute care and the district geriatric service. Patients receiving treatment in community hospitals should have the same opportunities to receive skilled management as those treated in district hospitals and their care should be subjected to the same rigorous evaluation of outcome. Costs should also be rigorously examined.

There are at present many redundant buildings, especially residential care homes, owned by local authorities and disused buildings on old NHS hospital sites. Few turn out to be suitably located or well designed for new health care services. Some may usefully serve as office bases for community workers but in general purchasers should learn the lessons of the past – that stigmatised old buildings refurbish badly for new uses, when the same disadvantaged group of people continue to use them. Endless cosmetic work has not satisfactorily transformed old workhouses into 20th century hospitals for older people. It may be possible to use refurbished old buildings if they are turned into places where 'ordinary' mixed groups of health centre attenders, for example mothers' and children's groups, fitness groups and so on also use the space, bringing the building into the general life of the community.

Small community resource centres, especially those with beds, may be expensive to run if managed as free standing units. The concept of core and cluster, developed in mental health services, of an administrative centre linked managerially to a number of residential and day care outposts, provides an economical means of staffing small units dispersed across one neighbourhood. Technological developments, including videophones and community alarm systems operating between units and between patients' homes and a central base, could also provide a means of supervision and contact between multiple locations.

The use of existing geriatric day hospital buildings needs to be reviewed in many districts. They are often housed in expensive but under-used buildings, and operate for a few hours on weekdays only. Their role in the total community service could be much wider; for example they could provide an extended out-patient service, provide an emergency clinic, provide a base for community therapists, an overnight care respite centre and so on.

New buildings should be developed only where it can be shown that the new service will benefit substantially in terms of revenue savings for the same level of service or where very significant quality advantages can be demonstrated, for example in enabling a high percentage of users to access the facility on foot.

Finally, it should be remembered that many patients remain in hospital simply waiting for adaptations to their homes and safety measures to be installed. In some local authorities a wait of a year or more is not uncommon for the installation of a simple additional stair rail. Many older people's homes are poorly maintained, difficult to heat and unsuitable for residents with physical disabilities. While there are many 'care and repair' schemes available to older tenants and owners, these are poorly advertised and understood; furthermore there are few real incentives for older people to improve their homes. A vigorous campaign of improvements for existing properties would be substantially cheaper than the provision of more purpose built sheltered accommodation and likely to be more attractive to current occupiers.

Staffing a New Style of Service

Working in the community requires a degree of experience and confidence in staff beyond that necessary to work in the closed supportive environment of a ward, day hospital or clinic. The work requires greater attention to role clarity and issues of responsibility and accountability. Furthermore, it is harder to support, harder to supervise, harder to train and harder to manage effectively, staff working in isolation or in small teams away from a central base. At present much training of professional staff is institutionally based and there is also currently a lack of satisfactory information about what actually goes on out there; information systems for management purposes and to support clinical work are in their infancy.

While GPs and primary care staff have a fair understanding of what goes on in hospitals as a result of their own training, hospital doctors, nurses and therapists often have a poor understanding of the possibilities and problems of community based work. The workshop was particularly concerned that physicians in geriatric medicine should receive higher training in primary care medicine, perhaps in the form of a regular attachment to general practice at senior registrar level, perhaps on a sessional basis once per week, with the aim of sensitising the future consultant to the realities of general practice. Such attachments need not only be a one way learning process for the trainee, but mutually beneficial. For instance, the trainee might assist/advise on the 75+ health check process. We have stressed earlier the importance of a fully integrated hospital medicine service in which all senior house officers and registrars gain experience in geriatric medicine. The Royal College of Physicians and the Royal College of General Practitioners could give stronger guidance on the content of training to ensure that it reflects the demographic changes taking place.

Working in the community requires a substantial change in staff perceptions of their function. Basic foundation training about the purpose and aims of the organisation is essential to underpin new systems. Training has been dominated hitherto largely by stress on technical clinical skills and it is often assumed that all involved know the purpose of what they are doing. Teams of professionals delivering a community service need to engage in training which defines the purpose of the service, identifies service values, clarifies functions and roles within the team, establishes the quality standards which can be realistically expected and gives participants an understanding of the structure which supports them and to whom they are accountable as a group. The involvement of locals GPs in team training is crucial.

Unqualified care staff in both health care and social care settings tend to do very similar work. The establishment of transportable joint National Vocational Qualifications acquired during periods of employment across a wide range of possible health and social care settings will enhance the attractiveness of posts and create a more flexible and mobile workforce.

Information Systems

The workshop participants and consultees could not identify anywhere in the UK which currently operates a fully integrated information system which links data from primary care, social services and hospital services. Kent has a project taking early steps in this direction with six pilot GP practices accessing social services care management data, and in Medway Health Authority, NHS and social services information systems are planned to 'talk to each other' in that one system will download information to the other system overnight. The development of a fully integrated system, comprising data on medical problems, functional abilities and socio-demographic information, can provide agencies with assessment information which does not simply focus on what their own agency can provide, will greatly enhance the delivery of joint care systems. A first step towards this would be a joint agency agreement on a common minimum data set.

Since comprehensive data systems are likely to be a long way off in most districts, at least there can be a shared record card held by the patient to which all agencies contribute. This might usefully include the explicit agreement between the services and the patient and/or carer about what care plan has been agreed, how it will be monitored and how patients can appeal or complain about the service they are receiving.

Opportunities for Prevention

Compared with younger adults, older people in Britain tend to be poorer – or at least to have less immediately disposable income – are likely to live in worse housing, to be less mobile by personal transport and to have experienced poorer educational and work opportunities. Many diseases of old age can be attributed to lifelong styles of diet, exercise, smoking and occupation. In spite of this, there remain substantial opportunities for primary prevention of diseases in old age. The maintenance of regular exercise; the control of blood pressure and body weight; stopping smoking; the provision of housing which is cheap to heat and well insulated are all well known ways in which direct action can have an impact on health in old age.

Housing authorities, primary care teams, health education and environmental health departments could collaborate to promote local initiatives. In the longer term, it might be argued that substantial improvements in pensions and realistic financial assistance to informal carers might be money better invested than the provision of elaborate service programmes. But even if we were to invest substantially in making older people wealthier, it is unlikely that this would have a significant impact on the use of hospital services for many decades to come. At present it would seem more sensible to emphasise those primary and secondary preventative measures likely to produce measurable benefits in the short term, but keeping in mind that financial independence brings choice to enable elderly people to participate more fully in decisions made about their care.

Some simple measures which can be undertaken now by GPs and their teams and which might well have an immediate impact on the use of acute beds include the following:

- Reviewing all patients taking night sedation.
- Seeing all patients taking more than three drugs to review the necessity for them.
- Identify all elderly people who smoke and give direct advice.
- Identify all women under 45-52 kgs, men under 55 kgs, women over 70 kgs and men over 75-80 kgs in order to assess the malnourished and give advice on obesity.
- Incorporate a question on mood state into 75+ checks to detect depression and devise a specific care plan to tackle it.
- Visit all patients recently discharged from hospital to assess their care plan.
- Screen elderly people for hypertension and treat it.
- Check all 75+ for vision, hearing and foot care and ensure appropriate aids and services are provided.
- Prescribe aspirin to those suspected of having myocardial infarction or stroke.
- Identify those whose cognitive impairment has become evident to relatives and neighbours and carry out a full assessment of the patient's and their carer's needs.

If a programme of this sort is run in general practice, although there is no firm evidence that it will improve health in the short term, there is evidence – cited by Alistair Tulloch in a letter to the British Medical Journal, 14 November 1992 – that it reduces significantly time spent by older people in institutional care. Some of these activities fall naturally out of the annual health check for those of 75 years and over, and none poses serious practical difficulties. The current 75+ screen is insufficiently developed, without clear objectives and lacks inbuilt audit. It is poorly regarded by many GPs at present; if it is to be more useful it must have clearer objectives and generate specific targets.

Barriers to Change

Changing a style of service is notoriously difficult, especially perhaps in the circumstances which prevail now, where advances in services for older people have been fought for long and hard in the acute hospital sector by a beleaguered minority of very committed staff. Senior staff will inevitably find it threatening to see hard won existing facilities shift or change in ways which may not be attractive or comfortable for those running existing hospital services. Nevertheless, the consensus was that if the right organisational structures and financial arrangements which fostered intersectoral working were put in place, the majority of professionals would welcome a shift towards providing more acute health care outside hospital. There remain however major barriers to change both inside and outside the system:

Age Related Prejudice: expectations of success of health care interventions for older people remain low compared with younger adults. Older people themselves tend to share the stereotyped pessimistic view that they are too old for certain operations, should accommodate themselves to disability and adapt to a restricted lifestyle. Fortunately, as younger cohorts of older people grow old, expectations and demands on services are rising, a trend which will helpfully exert pressure on purchasers of services to consider older consumers' views. Planning for older people still tends to be dominated by a paternalistic vision of care in which the recipients have very little to say but ought nevertheless to be grateful. The innovations in care planning for example for people with learning disabilities and younger people with physical disabilities, which has led to a more individual approach to planning care for seriously disabled people in the UK, has largely bypassed services for older people. These still tend to be considered in terms of home helps, meals on wheels, district nurses and institutions. 'Ageism' in health care can only be fought by insisting that older people's access to services and the quality standards of care should be audited and monitored on the same dimensions as those used for younger adults' services. Anti-ageist principles should be built into contracts. Fundholding GPs should be closely monitored on their use of resources to ensure older people are not disadvantaged.

The Effectiveness of Interventions: health services must be able to demonstrate the effectiveness of interventions in improving health status. There is at present a singular lack of good research evidence on the effectiveness of treatments and methods of management which undermines the drive to rational service planning. Three kinds of research are needed; first, clinical and quality of life outcomes; second, service research focused on how best to deliver care with regard to costs, the use of personnel and other resources and, third, research into the experiences and preferences of patients and their carers about the services they receive.

At the workshop several participants remarked that professionals in medical and social gerontology are not recognised by others as specialists with a coherent body of sound knowledge. While one would not, for example, expect to hear a physician colleague expressing derogatory or disparaging views about another specialty's scientific knowledge base or treatment expertise, it was the experience of many people working with older patients that they were not regarded as having special expertise. The remedy for this would seem to be greater attention to methodologically sound research into health and disease in older people and the acquisition of a sound scientific knowledge base and demonstrably effective medical applications.

Organisational Barriers: the health and social care divide: the current split in purchasing arrangements between the health authority, the family health services authority and the local authority is undoubtedly the single major barrier to change. While the current move to amalgamate primary care and hospital and community care services under one health commissioning agency is to be welcomed, and we assume paves the way for the creation of full joint health services authorities, there is unlikely to be any major shift of services out of hospital while social services care budgets are purchased from a separate statutory source. The management styles of health and social services, their hierarchies of accountability and overall statutory responsibilities are so fundamentally different that priorities are difficult to align. A coherent joint plan may be achieved in a handful of places but this is no way to build a national strategy for developing services for older people. Significant change will be achieved by having one statutory agency for purchasing all the health and social care needs of older people.

Professional Training: at present the hospital focused nature of medical, nursing and therapist training is a serious barrier to shifting acute health care out of hospital. A radical overhaul of undergraduate medical training, nurse education and therapy training in shared health care sciences colleges would promote the interprofessional respect so necessary to good hospital and community work and a syllabus in which students spent the majority of their working time in primary and community care settings. At postgraduate level, training in general medicine at present focuses excessively on a stereotyped disease model which has left many senior physicians poorly equipped to manage the complex health and social problems of older patients. Postgraduate training must focus more on the management of multi-system disorders in the context of existing social systems.

Incentives for Change

The NHS and Community Care Act 1990 has already produced very major changes in culture in both health services and local authorities. The new purchasers of services are flexing their muscles for independence from local providers and seeking closer alliances with consumer groups and voluntary organisations. They are beginning to use the contractual process to develop improved quality standards and asking uncomfortable questions of traditional NHS and local authority providers about the rationale of current service designs. They are also beginning to consider how best to use the independent sector for more than the traditional purchase of one-off residential placements. The strongest incentive for purchasers to review current hospital services is the high costs of hospital admissions and the need to be absolutely sure that beds are used most cost effectively. The closer relationship of health and family health service authorities developing in parts of the country – for example in Bromley, Kent, and in the Wessex and South Western Regions – will undoubtedly foster more coherent planning across the hospital and community health service divide.

The speed of organisational development has not allowed for more fundamental changes in culture to take shape in a consistent way. Senior managers have too few performance targets aimed at developing the joint commissioning culture. Their performance is still judged on financial disciplines which are agency related. It is feasible to implement co-operation targets but these would need to be developed with the support of ministers working together at Cabinet level. While central government's attitude to the activities of local authorities remains ambivalent, and the cultures of the health service and local authorities are so different, true joint working across health and social services will remain an elusive dream in many areas of the UK.

Concluding Remarks

The opportunities for shifting the balance of acute care services for older people towards primary and community care settings have never been better. Regrettably, however, the organisational structures of statutory agencies are frustratingly difficult to work round and professional training and current clinical practice tend to slow the pace of change. Furthermore, we do not know enough about how best to manage illness in later life. The history of health services suggests that new styles of delivering ineffective care may be grasped with naive enthusiasm on the grounds of fashion alone. Missionary zeal will be needed by managers and clinicians to make major shifts in services but changes must be rooted in careful evaluation studies of efficacy and cost effectiveness. Finally, it must be remembered that good hospitals have traditionally provided more than treatment and nursing care. They have provided a setting in which some patients have found during an illness the social support and encouragement which was lacking from their lives in the community.

As Elizabeth Barret Browning puts it:

I think it frets the saints in heaven to see
How many desolate creatures on the earth
Have learnt the simple dues of fellowship
And social comfort, in a hospital.

Good community care must provide that fellowship and comfort too, if it is to be effective.

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MENTAL HEALTH SERVICES

Matt Muijen

The statement that mental health services have entered a critical period of change has been a truism for at least 35 years, but never more so than at the present. Not only are irreversible changes in the structure of the mental health service continuing at accelerating pace, but the reorganisation of the roles of the NHS and social services add another complex layer of uncertainty to future care of people with serious mental health problems. Most of the interest tends to concentrate on the changing balance within the mental health service, with on the one hand a reduction in the numbers of hospital beds and on the other hand an increase in community services such as residential places, day centres and community psychiatric nurses. At least as significant for quality of care are shifts across services, with responsibilities for co-ordination moving from health to local authorities, with a growing role as providers for the non-statutory sector within a mixed economy.

The move from hospital based services towards community care has aroused passionate disputes about the merits of de-institutionalisation. One corner strongly argues that most people can be treated at home or in hostels without the use of hospital beds, with a gain in quality of life and at no higher if not lower cost. The disadvantages of hospital care are depicted as the excessive emphasis on psychopathology with a medicalisation of psychosocial problems; the poverty of the environment leading to negative symptoms; its inability to teach people skills in the environment where they will have to be applied, *ie* in the community; and the stigmatisation of 'mental illness'.

In the other corner stand the critics of community care, who have brought to attention the potential neglect suffered in the community when hospitals are closed without the provision of a comprehensive range of community services; the misery imposed on patients and their carers; trans-institutionalisation towards prisons; the increasingly inadequate resources; the de-professionalisation of staff; and the lack of valid evaluations. Much publicity has been secured by isolated examples of human tragedies which have been attributed fully to failures of community care, simplifying the complex causes of deprivation.

It is all too easily disregarded that the concepts of community care and hospital care in isolation are a caricature of real services, reducing mental health care to the extremes on a single dimension. Nothing like a perfect correlation exists between the rundown of hospitals and the neglect of psychiatric patients. In 1966, when 120,000 mental illness beds were available nationally as compared to the 57,000 in 1990, a study in East London found that only 54 per cent of patients with schizophrenia discharged to known addresses could be traced after a year, and only about a third of these lived in satisfactory circumstances and a third neglected themselves.

More recently, in West Lambeth and Lewisham, 140 patients with schizophrenia were followed up after discharge from an acute unit. After a year, only a single patient was lost, but four had died, three probably through suicide. About half could be diagnosed as psychotic, not receiving the care they needed. Two thirds of them had moved at least twice during the year. Many lived in deprived circumstances, and only 10 per cent were employed. Little coordination of services was found.

It is somewhat futile to pursue the theoretical question whether these two examples represent the weaknesses of a hospital based system of care, with its inherent neglect of aftercare, or the failure of community care. What is obvious is that the system failed, in both 1966 and 1991, because the services were poorly organised. Clearly, no service component, whatever its quality, can provide acceptable care in isolation.

The Present State of Hospital Care

The concept of traditional psychiatric care for mental health problems is based on the medical model, assuming that the 'illness' can be treated best in an active treatment setting, *ie* hospital. Globally, indications for hospital admissions are crisis intervention, assessment and observation, treatment of specific disorders and a place of safety to self and others. Reasons for discharge are the resolution of problems present on admission, in practice meaning symptom control and behaviour management. All these factors rely heavily on subjective clinical judgement, since none are absolute indicators. No studies comparing clinicians' opinions and agreement on indication for admission and discharge are known of.

Until the beginning of the 1960s, psychiatric treatment was concentrated in the hospital, which was the base for a range of well trained professionals. The growth of outpatient clinics and day hospitals created the opportu-

Mental Health Services: Current Hospital Provision

The data in the table show changes in service provisions over the last decade, based on Department of Health statistics, unless otherwise stated. Some caution is necessary, since the data rely on returns from providers. In particular the day hospital places and homes seem to be unreliable. Several changes of definitions and collection methods have occurred during the decade.

Available places for adult people with mental health problems in England

	1980	1989/90
Hospitals:		
Beds	87,396	59,290
Outpatients:		
New patients	184,000	207,000
Day places:		
Local Authority	4,967	6,979
Voluntary	621	2,903
Health Authority	na	18,000*
Homes:		
Local Authority	3,724	4,349
Registered	2,142	7,377
Nursing homes	-	8,000**
Health Authority and joint	-	8,000**
Community psychiatric nurses	1,670	5,000***

* estimated from place days

** estimated from A. Faulkner and others, *Who is Providing What?* Research and Development in Psychiatry, 1992.

*** from E. White, 'Surveying Community Psychiatric Nurses', *Nursing Times*, 1990 pps 62-66

The main emphasis is the continuing reduction in number of hospital beds, with an increase in community services such as day care, residential care and community psychiatric nurses. For the adult group as a whole (age range 20-65) the number of admissions has remained about constant, although some underlying trends are hidden. For the 20-44 year old age group admission rate has risen more than 10 per cent, whereas the rate for the 45-65 age group has fallen by about 15 per cent over this decade. Total number of admissions has increased by 13 per cent, but this is mainly due to a doubling in admissions of the over 75 age group. No information is available on changes in the ratio of beds for adults versus elderly patients, but it is likely that this has favoured the elderly, implying that bed reduction for the adult population has considerably exceeded 50 per cent during the last decade alone. An estimate is that about 10 - 20 per cent of this reduction has been absorbed by improved efficiency, such as increasing bed occupancy, but over the last few years this has clearly reached its ceiling. The only way to compensate further for a constant number of admissions with falling number of beds is to reduce length of stay, and evidence from various districts shows that this has happened. Even this has probably reached the absolute minimum.

In practice several factors complicate this scenario. Mental illness beds can be sub-divided in acute admission beds and long-stay/rehab beds. Bed reduction has been largely due to closure of the long stay wards in the large mental hospitals, whereas acute beds, often in district general hospitals, have been less affected. The number of psychiatric units and hospitals with fewer than 50 beds is now, at 250, almost double what it was in 1978: the number of hospitals with more than 500 beds has halved in the same period. However, the shrinkage of hospital facilities for the long stay group meant that an increasing proportion of acute beds can be occupied by patients needing long admissions, either the old long stay patients requiring re-admission or new patients with severe problems – the new long stay. Although only five to ten per cent of people moving into the community are re-admitted for long periods and few new admissions stay longer than six months, they may occupy a large segment of beds. The proportion of patients staying 12 months on acute units was about 8 per cent in 1989. Stephen Hirsch calculated – see *Psychiatric Beds and Resources; factors influencing bed use and service planning*, Royal College of Psychiatrists, 1988 – that a saving of 16 per cent in bed use could be achieved if all patients under 65 staying between six to 12 months were to be discharged at six months, which contrasts strongly with the two per cent saving in bed occupancy achieved if those 20 per cent of admissions who stay in for less than a week were provided with alternatives.

Another trend over the last decades is the increased ratio of re-admissions versus first admissions. About 50 per cent of all admissions in the 1960s and 75 per cent of admissions in the 1980s had been in mental hospitals before. A greater proportion of re-admissions suffer from psychotic disorders, requiring more intensive and longer care.

The above considerations are based on national aggregated data. When local variations are regarded, the picture becomes even more complex. Department of Health figures show a more than twofold variation across regions for bed numbers (range 0.7 to 1.6 per 1000) and throughput (2.9 to 5 per bed year); the two figures are inversely correlated. The highest bed numbers can be found in more deprived regions. These figures include acute, rehabilitation and elderly beds; differences are much more pronounced at district level for acute beds only. These vary in England between about 0.15 and 0.75 per 1000 head of the population.

nity for therapists to work outside hospital settings, and growing numbers of experts moved away from the wards. This trend has continued; an example is the nurse therapist, a specialist in behaviourial techniques selected from the highest calibre of nurses within the NHS. After a year's training, very few are involved in hospital care, either directly or by supervising ward staff, and most work instead in community settings. Another trend is for these high quality nurses to move over to management or research. The same holds for clinical psychologists, a rare commodity within mental health. The consequence is that wards are increasingly becoming places of last resort, both for staff and patients.

As a result of ever continuing pressure to improve efficiency, staff numbers on wards have decreased, while the severity of the conditions of patients on admission has constantly increased. Simultaneously wards have been partially closed and a proportion of the staff transferred, leaving the care of the most difficult patients in the hands of even fewer. The effect on staff morale and quality of care seems self evident.

A typical staff contingent during a dayshift, caring for some 20 patients, will consist of about two or three trained nurses, with a varying number of student nurses, sessional input from an occupational therapist and a psychologist, and occasional visits from social workers and psychiatrists. A consistent complaint of patients is the rarity of sessions with a psychiatrist, which, if they take place, are mostly assessments. Very little specialist therapeutic input is available, and treatment tends to be restricted to the distribution of medication, restraint and an occasional group run by a nurse or psychologist. In conversation with users it has become clear that none of these interventions are popular. Most of the day residents are either involved in routine group activities in the occupational therapy department, if their functioning allows this, or are passively experiencing television programmes.

Patients often consider their interactions with staff as being negative and patronising. Complaints from users also include lack of information, lack of privacy, lack of choice and lack of personal care. If one wants to learn about the characteristics of a total institution, a psychiatric ward, even in the 1990s, is still a good place to start. Patients being put under great pressure to attend groups, queuing for pills and food, having to adhere strictly to ward time-tables, are far from uncommon. This means that long stays, and possibly short stays, as we see below – are not in the interest of patients.

The negative experience of users can be easily corroborated by carers. Ward environments are often so poor that one is reluctant to visit a friend, let alone have a nearest relative admitted. It can be a tough job to find a nurse or doctor for information, or a place for a private chat.

Hospital Alternatives to Standard Hospital Care

The important questions about the role of hospitals are:

- to what extent hospital care improves the quality of life of patients in the community after discharge as a consequence of its interventions;
- whether improved results could be achieved by different interventions in hospital;
- whether alternative forms of care could achieve better outcome or the same outcome more efficiently.

We must also consider what is meant by outcome. Traditionally the disappearance of symptoms on discharge and the reduction of relapse rate have been used, but increasingly the emphasis is placed on improved community adjustment and user's and carer's satisfaction, *ie* a shift from deficits to strengths.

Studies evaluating the efficacy of hospital care can be categorised into three groups: evaluations of ward programmes; studies contrasting long versus short admissions; and comparisons of hospital admissions with alternative forms of care. We look briefly at the first and second of these and then in more detail at alternatives to hospital admission.

Ward programmes: evaluations of ward programmes find consistently that any reasonable innovation leads to improvement. All forms of increased attention and motivation, regardless of ideology, application or therapist's expertise seem to produce better outcomes. The existing research on the effectiveness of ward programmes was succinctly summarised by Erickson: 'There is little order and virtually no replication'. Outcome is mainly defined as ward functioning in these studies, and effect of ward programmes on quality of life after discharge is largely unknown. There is evidence, however, that hospital treatment and improved ward adjustment are not associated with better community functioning.

Short versus long hospital stays: the pressure on beds implies that patients are generally discharged as soon as they are judged to be capable of coping outside hospital. The shortening of admission could produce a higher turnover and more treatment capacity, but this gain in efficiency should not be at the expense of patient functioning and family burden. Gains in efficiency may be short lived if early discharge led to a rapid relapse requiring a longer subsequent stay.

Several controlled studies have evaluated the effectiveness of shortened stay as compared to standard duration admissions. The only UK project studying the impact of shortening admission on future hospital use, functioning and relative's burden was undertaken at Charing Cross Hospital, London. Unfortunately, this project clarified little. Although the reduction from 28 days for standard stay to 22 days for brief stay was about 25 per cent, this difference was compensated for by a higher use of day care in the short stay group. Little effect on number of re-admissions and stay on re-admission was found, and outcome in terms of psychopathology, social functioning and family burden was similar in the two groups. Furthermore, the process of care, which is the essential component, was not detailed.

Several studies in the US report the same findings: short stay does not adversely affect outcome. It appears that hospital duration can be shortened without any untoward impact on patient functioning. Several provisos need to be made. First, none of these studies yielded similar durations for average 'brief' and 'standard' admission. These varied from respectively, 80 to 180 days to 22 to 28 days and 11 to 60 days. This means that some studies' standard care was substantially longer than other studies' brief admissions, making cross-study comparisons haphazard. Second, characteristics of patient groups differed, although all studies included large proportions of patients with psychotic disorders. One project addressed subgroups, finding inconclusive results for patients with schizophrenia, but showing persuasively that patients with neurosis do not require extended hospitalisation. Third, differences in number of therapy sessions, medication dosages and quality of aftercare confounded many of these studies.

The important finding of these studies is not only the similarities in outcome for long and brief admissions, but also the consistent association of better outcome with intensive well co-ordinated care. On discharge, a brief admission group functioned better than the standard admission group at the same time, but the brief group had received more crisis intervention and discharge planning. When eventually the standard group was discharged, they in turn performed better than the short stay group at this point, but standard patients had by then obtained four times the amount of interventions of the short group. During the year after discharge, the standard care patients required more and longer readmissions, but brief admissions had received more medication at higher dosages. When controlling for aftercare and length of admission, it has been found that the level of symptomatology on discharge was related to intensity of care on the ward, but after a year, to amount of aftercare, independent of length of admission.

Jointly, these studies suggest that hospital care achieves symptom control on discharge, but little long term benefit. Gains are related to specific interventions, including a range of aftercare services.

Three important issues remain unanswered by these studies: firstly, to what extent can we reduce the length of hospital care without an adverse impact on quality of life? It is noticeable that the duration of both brief and standard stays in the studies referred to above tended to decrease over the years. A similar reduction has taken place in practice, indicating the general acceptance that long admissions have no place in routine care. Many districts have an average length of stay of about 28 days, increasingly admitting large proportions of people with psychotic disorders. It is likely, though, that a point of diminishing return exists, beyond which improvement in hospital efficiency will be offset by reduction in patients' quality of life in the absence of other interventions. The mean of 28 days hides considerable variation, since duration of stay is influenced by many variables other than diagnosis, such as co-morbidity, social functioning and support systems. Predictors for length of stay have been very elusive so far.

Second, which subgroups may benefit most from certain types of hospital care? The many confounding variables make any definite conclusion hazardous. The finding that neurotic patients benefit little from long admissions has been accepted by clinical practice, which now tends to exclude this group altogether from admission with the exception of the most extreme sufferers. It is timely, however, to investigate indications for care beyond diagnosis and symptomatology, such as the potential of mental health care to improve social functioning, family life and employment, since symptom improvement is not a good indicator of outcome for other areas. Long admissions seem to lead to loss of work functioning in some groups, but it has also been found that patients with schizophrenia who functioned well before admission benefited from longer stays in terms of role functioning. These findings may not be mutually exclusive, since length of stay may be positively related to some and negatively related to other outcomes.

It is likely that different patient groups require different interventions and different environments. So far, most work has concentrated on mixed groups of patients receiving slightly varying interventions in similar settings, not allowing a sufficient differentiation to draw conclusions about strengths and weaknesses of care components for subgroups. It should be doubted whether such care is in the interest of the large majority of patients. Considerable thought should be given to a greater range of small units offering more specialist care to selected groups of people with specific conditions.

Finally, can other service components further reduce the need for or even replace hospital admission? The optimal form of care for most people is likely to consist of an individualised mixture of such services, most of them being offered in the community rather in hospital. Such services could include home care by community psychiatric nurses or multi-disciplinary teams or day care, and the experiences of these alternatives to hospital care will be explored.

In order to appraise the feasibility of such types of care, 'model services' have been developed which aimed to compare a range of alternative services with standard care under controlled conditions. Several of such projects have been evaluated, and their results will be presented next.

Alternatives to Hospital Care

Two UK studies will be discussed in some detail. Both incorporated state of the art evaluation, and their results were representative of other work performed in these areas. The Manchester study compared day care with hospital care for patients who would otherwise have received in-patient care. The London project evaluated home care as an alternative to hospital care for the same patient group.

Day care: the interest in day care is based on its supportive and therapeutic environment for a limited period each day, so that the patient is not separated from the community. This means that patient and any carers should be able to manage independently for at least the night, an obvious limitation of day care. Evaluations of day care programmes study the therapeutic benefits relative to standard hospital care, the amount of input required including cost and the proportion of people requiring in-patient admission who can be cared for exclusively in the day hospital instead. The Manchester project evaluated day hospitals in Manchester and Blackburn. All patients aged between 18 and 65 requiring admission to the in-patient unit or the day hospital were included. Consultant psychiatrists decided whether patients were suitable for randomisation. Psychopathology, social functioning and family burden were measured at baseline and after three and 12 months.

It was found that of those patients considered for inclusion 42 per cent in Manchester and 51 per cent in Blackburn were not randomised. Main reasons for non-allocation of the combined 46 per cent were a section of the Mental Health Act (24 per cent), too ill (32 per cent), refusal (8 per cent), social reasons such as lack of suitable accommodation (16 per cent) and other not specified reasons (21 per cent). The non-randomised patients were more frequently diagnosed as suffering from schizophrenia (50 as compared with 37 per cent). Following randomisation, three (6 per cent) of in-patients in Manchester and three (9 per cent) in Blackpool discharged themselves before the baseline interview. In the day hospital group, 10 patients (24 per cent) in Manchester and 16 (46 per cent) in Blackburn did not attend consistently. Only in Manchester, 6 patients (12 per cent) had to be transferred to the in-patient unit. The various reasons for exclusion and drop-out mean that of all patients eligible for inclusion, 40 per cent in Manchester and 27 per cent in Blackburn were treated in day care without the need for in-patient admission.

Outcome was only reported for the Manchester group, since baseline differences across sites precluded valid combined data. Both treatment groups showed major improvements after three months, and remained stable afterwards. Resource use appeared comparable. The limitations of any type of care are illustrated by the fact that after a year 19 per cent of the in-patients and 7 per cent of day patients were in hospital, and that only 51 per cent of hospital and 41 per cent of day care patients had attained their previous level of functioning. This study suggests that day care can replace hospital care for a proportion of patients. Quite consistently a figure of 40 per cent is reported in the wider literature, and it is obvious that day hospitals will not be able to look after the most severe group of people. It cannot be concluded, however, that day care will allow a reduction in hospital beds of 40 per cent, since the 40 per cent of patients kept out of beds will be the least disturbed group, requiring relatively brief stays. It also emerges that the role of day hospitals can vary quite dramatically even within a single study, presumably with an agreed policy. The opinion of clinicians on suitability seems to have differed in the two places, with Blackburn taking a conservative stand, whereas the Manchester team included a larger proportion of eligible people, some of whom eventually had to be transferred to the hospital. The complexity of any interpretation is exemplified by other confounding factors, such as the differing previous roles of the day hospitals, severely ill patients being treated in Manchester and the less unwell and those requiring rehabilitation in Blackburn. Manchester was staffed with eight nurses and three occupational therapists, Blackburn had six nurses only.

Day care is preferred by patients and their carers, and can be cheaper than hospital care. No comprehensive cost-effectiveness analyses have been performed on day care, however. A strong argument exists for day care, based on a straight hospital day care comparison. But as with so many forms of mental health care, many questions remain. What are the characteristics of patients benefiting most, how long is optimal length of attendance for specified conditions, what are the implications for hospital provisions of a complimentary day care service, and what new staff skills are required? None of these issues have been addressed yet. A further reorientation of day hospitals as well as in-patient units is necessary within a community oriented care system, aiming to support people at their place of residence.

Home care: the logical conclusion of the argument that the objective of care is to maximise functioning in people's own environment and the finding that skills taught in hospital do not generalise after discharge, is to treat people at home, rather than as day or in-patients. Objections against home care have been the supposed risks for people with severe mental health problems both to themselves and to society and the added burden on relatives. It has been argued, with justification in the absence of any decent community facilities, that the consequence of moving patients from hospital to community is to shift the burden of care from the health service to the family. It can be added that only about 50 per cent of people with severe mental health problems can rely on carers, and that the effect of poor community care on single people can be extreme deprivation, including homelessness. It would be unhelpful to accept as the norm a worst case scenario based on discharges from hospital in the absence of community care services. Community care requires a well balanced range of provisions, and the real issue is what can be achieved with a well integrated system of care. The components of care for community support programmes have been specified by the National Institute for Mental Health in the USA for community support programs: see **Criteria for Community Care Support Programmes**.

The Daily Living Programme project was set up at the Maudsley Hospital to evaluate the impact of home care on service use, quality of life and carer burden. Patients deemed to require hospital admission by an independent psychiatrist were allocated randomly to home care or standard hospital care. Inclusion criteria were a severe mental health problem, mainly psychosis or severe depression, age 18-65, living in the catchment area (south Southwark) and no primary addiction or organic brain damage. Patients with aggression, suicidal intent, homelessness, lack of carers, not speaking any English or on a section of the Mental Health Act were all accepted.

The team consisted of 10 staff: a psychiatrist (senior registrar), a social worker, an occupational therapist, six nurses and a secretary co-ordinator. One of the nurses was the team manager (I grade) and the other five were on a G grade. Eventually the team cared for 92 patients, built up over about two years. A case management approach was used, with individual staff being responsible for the co-ordination of all the care required by the patients under their care.

The programme was based in a house within the grounds of the Maudsley Hospital, but the majority of contacts were at patients' homes. Staff worked two shifts between 8 am and 9 pm during weekdays and a single shift (9 am – 5 pm) weekends. At night telephone cover was available, but staff would not make visits. In rare crisis situations patients were advised to go to the Maudsley Emergency Clinic.

Patients randomly allocated to the programme were immediately assessed in the emergency clinic, where most patients had presented themselves, often in the presence of carers. Overnight admissions were seen early the next morning on the ward. Assessments were mostly undertaken by the senior registrar with another member of staff. It was considered whether patients would be able to look after themselves at home with the support of the team, who could visit several times a day if required. Important factors were coherence, availability of carers, housing conditions, financial state and willingness to accept care. Without active night cover, the ability of patients to cope during these hours was essential. Home care meant not that everybody was taken home in all circumstances, but that the use of hospital beds was reduced to a minimum.

The hospital group received standard care during admission and received follow-up care at the out-patient clinic. During the study the hospital set up a community psychiatric nurse team, but very few of their clients suffered from serious mental health problems.

Home care reduced hospital use by about 80 per cent throughout the study: see Table 1. It is striking, however, that home care was less successful in avoiding admission than in reducing length of stay. During the nine months after entry, 83 per cent of programme patients and 100 per cent of the hospital group required hospital admission. Length of stay was very different across the groups: 66 per cent of programme patients versus 15 per cent of hospital patients spent less than 15 days in hospital, but only three per cent of programme as against 38 per cent of hospital patients were admitted for more than 100 days during this nine month period.

The reduced length of admission for the home care patients did not lead to an increased number of re-admissions – the revolving door syndrome. After nine months of care, 27 per cent of programme and 23 per cent of hospital patients had required more than one admission.

Home care patients showed slight advantages in social functioning and symptomatology after a year. There was no area in which hospital group patients performed better than programme patients. The improvement over the year was very large in both groups, however, and differences in outcome between groups were small compared to the magnitude of recovery. Whether this means that hospital and home care are both effective in the treatment of serious mental illness or that patients make recoveries with any type of adequate care is unanswerable in the absence of a no-treatment control group.

One important outcome measure showed a major difference between the two care models. Both patients and carers strongly preferred home care after a year in the programme. At four months differences in preference were very small, indicating that the advantages to users and carers became evident only after an extended period of care. The widening gap in satisfaction with home as against hospital treatment was due to a growing satisfaction from programme patients and their carers, but a

Criteria for Community Care Support Programmes

- Identification of the target population and outreach that can offer appropriate services to those willing to participate;
- Assistance in applying for benefits;
- Crisis intervention in the least restrictive setting, with hospital beds available as a last resort;
- Psycho-social rehabilitation;
- Supportive services of indefinite duration, including employment and housing;
- Medical and mental health care;
- Support to relatives, friends and others;
- Involvement of concerned community members in order to optimise support networks for patients;
- Patient advocacy and;
- Case management.

To these points can be added:

- services need to be available 24 hours a day, seven days a week
- input from a multi-disciplinary team

Table 1: Hospital Stays

	Number in sample	Mean Stay months 3	Mean Stay months 9	Median Stay months 3	Median Stay months 9
Programme	92	12	18	6	8
Hospital	97	53	87	53	72

Source: M Muijen and other, *The Daily Living Program,* British Journal of Psychiatry, vol 306, pps 379–384, 1992 and:
M Muijen and others, *Home Based Care and Standard Hospital Care for Patients with Severe Mental Illness: a randomised controlled trial,* British Medical Journal, vol 304, pps 749–754, 1992

decrease in satisfaction over time in the hospital group. This suggests that it was not in-patient use people were dissatisfied with, since the major difference in amount of hospital stay had occurred during the initial period after which satisfaction with the contrasting treatment strategies was about equal. Afterwards, however, Daily Living Programme patients continued to receive home visits at an average of an hour a week, with attention to all their psycho-social problems. In contrast, the hospital patients received occasional out-patient visits, rarely more frequent than once a fortnight, concentrating on psychopathology, and many received no aftercare at all. Satisfaction seems to have been associated with quality and quantity of aftercare, rather than in-patient versus home care per se.

During the project, three programme patients committed suicide and one patient was convicted for a homicide. Two hospital patients received verdicts of 'unnatural deaths'. The programme cases became the subject of an internal enquiry, which concluded that the team had no case to answer.

In summary, home care reduced the use of hospital beds by about 80 per cent, with slight benefits in clinical and social outcome. Patients and carers strongly preferred home care, although this may have been due more to the superior continuity of care offered by the home treatment rather than just the decrease in hospital stay.

It is intriguing how similar the proportional bedsavings are across three cities in different countries with their widely varying circumstances: see Table 2. Each setting saved about 80 per cent of hospital days with home care. Variations in care structure and process across sites possibly explain the vast differences in absolute days spent in hospital and the proportion of patients requiring admissions during the year. This underlines the difficulties in generalising across projects.

The model of care suggested emphasises comprehensive and continuing community support, rather than the elimination of hospital use. This means a change in balance, transferring resources from hospital to the community, but preserving the positive aspects of inpatient care, such as brief crisis admission.

Costs: in the present economic climate, efficiency is a priority. Although the optimal potential for quality of care is important as an ideal to aim for, the main day-today concern of health service managers and clinicians is to develop a service which offers most for a determined amount of money. More precisely, what change from a hospital to a community service can be afforded within the existing budget, how effective will this service be in terms of outcome, and where will the money come from.

Table 2: Comparison of Outcomes

	London Hm	London Hsp	Madison Hm	Madison Hsp	Sydney Hm	Sydney Hsp
Admitted (per cent)	83	100	18	89	40	96
Mean duration (days)	18	87	2	29	8*	54*

*estimated

Source: as for Table 1 and:
J Hoult and I Reynolds, *Psychiatric Hospital versus Community Treatment: a controlled study,* Department of Health, New South Wales, 1982 and:
J J Stein and M A Test, *Alternatives to Mental Hospital Treatment,* Archives of General Psychiatry, vol 37, pps 392–397, 1980

Several model programmes have incorporated costing in their designs, and community care was invariably reported to cost less than hospital care. Costings can be difficult to interpret, however, due to different approaches, different assumptions and varying inclusions of direct and indirect costs. For example, the Madison study carried out a cost-benefit analysis, including all direct and indirect costs during the 12 months after entry into the project. The conclusion was that community care offers slight savings of about 5 per cent.

The analysis shows that such a conclusion was based on several assumptions. Direct treatment costs to the health service, including hospital and community services, worked out at 25 per cent more expensive for community care. This included an opportunity cost of 8 per cent on capital. If capital cost had been taken as 4 per cent, direct care cost would have been higher by 20 per cent, and community care would have been 49 per cent more expensive than hospital care. The study also included costs to society, earnings lost to carers and patients' employment earnings, even though most of the money was earned in sheltered workshops. In his original model, assuming 8 per cent depreciation, the earnings in the community group just tipped the overall balance in favour of community care. At a lower cost of capital, community costs would have become relatively more expensive than standard care.

A less comprehensive cost-effectiveness analysis was undertaken in Sydney, where only treatment costs were considered. Capital costs were excluded. Community care worked out as 10 per cent cheaper for the service as a whole. If cost per patient is taken, savings from community care might be as high as 22 per cent, because the hospital group contained fewer patients than the community group.

These variations reflect differences in methods of cost calculation and in treatment models. The most thorough and comprehensive analysis produces least savings with community care, and may even lead to somewhat higher costs. Whether home care is cheaper than hospital care depends on the variables included in the conception of costs for which the health service is accountable, the way such costs are calculated, and the role and responsibilities of the health service.

The extrapolation of costs from model services to other settings needs to take into account several factors. First, the largest cost saving component in each of the community studies was due to the vast difference in hospital use between the services. The 80 per cent bed saving may be consistent across programmes, but this does not imply that every community service will be able to achieve similar savings. As we have seen, the Maudsley study reported a mean stay in the hospital group of 53 days and 87 days during, respectively, the three and nine months following entry. Mean stays in other hospitals are far shorter for similar patients, probably about half. This would mean that bed savings would have been reduced, assuming unchanged hospital use for the community group, from 80 per cent to 55 per cent. Moreover, the enthusiasm of staff might be gradually eroded, and the amount of hospital use for patients in community services could creep up, increasing costs.

Second, startup finance is necessary, not only bridging loans to develop the new services while the old are gradually being run down, but also for staff training and small scale community developments. Community services can be very expensive during the first year of operation, since a large staff group will look after a gradually increasing number of patients.

Third, savings in hospital expenditure can lead to higher use of other resources such as hostels, bed and breakfast places and day centres, increasing the costs to primary care, social services and the voluntary sector, with an unpredictable overall effect. This may become an important issue from April 1993, when budget holding practices will begin to purchase psychiatric services, and social services will take on the role of gate keepers to residential care.

Fourth, some costs are fixed; closure of half a ward or half a hospital does not save half the costs. If the planning objective is to achieve a better balance between community and hospital, wholesale closure of wards can be difficult to achieve. Initially it may be possible to amalgamate several wards, but even this will not achieve great savings, since meals, laundry, cleaning, administration and many other hospital tasks are still required.

Finally, staff costs may be higher in the community than in hospital. The pressures and responsibilities of community care require job descriptions which pay relatively high salaries. Many nurses in the community are on G grade who in hospital settings would have been graded as E. This is a pay differential of £4,000. Skill mix reviews are taking place, aiming to reduce the proportion of G grades, and increasing numbers of less qualified staff are employed, reducing the level of skill. This is worrying, since the greater independence required from staff working in the community may demand a relatively high proportion of staff with specialist training at a high cost or more input from expensive professionals such as psychiatrists. Community teams are increasingly employing cheap mental health workers for simple tasks, such as queuing at benefit offices. A concern is that such untrained workers will gradually take the place of specialists, rather than continue to function as aids.

Never fully discussed is the precise role of the various traditional mental health disciplines in the community. The present staff mix of psychiatrists, psychologists, occupational therapists, nurses and social workers needs clarification. The generic community specialist, has not caught on, and the function of the untrained mental health worker has never been evaluated. The Royal College of Psychiatrists 1992 report *Mental Health of the Nation* recommends a doubling of the number of psychiatrists to cope with increased patients' expectations and the new labour intensive psycho-social interventions, with obvious cost implication. The contrast between an increase in highly paid professionals versus skill mix reviews and employment of untrained mental health workers is obvious. It is unlikely, however, that a reduction in quality of staff, whilst producing savings, will have no consequences on quality of care.

Towards a Model of Services

A limitation on the generalisation of service evaluations is that such studies ignore the complexities of mental health services, since only one type of care is compared with another within a system of interacting components. Service evaluations suggest that both day care and home care have advantages over standard care. Home care is consistently found to save about 80 per cent of bed use. Day care might be expected to save a similar proportion of bed days, since admission for 40 per cent of all patients presenting to hospital was prevented altogether, and length of stay of the other 60 per cent might have been reduced considerably. In a regular service, bed savings of home and day care are likely to be less dramatic, since staff motivation would be lower. An estimate of savings is hazardous, but should be around 50 per cent.

Even more difficult to estimate is the impact of an interactive model of care on utilization. What can be achieved by a combination of day care and home care above home care alone? No studies have evaluated home care against day care or their combination against hospital care. The functions of home and day care overlap considerably, however, since both aim to minimise hospital use and maximise community adjustment, and their combination may not be efficient. In practice, patients in a home care service expressed preference for a low-key drop-in centre, and neither patients nor staff considered a therapeutic day hospital as a priority.

In addition, the roles of local authorities, the voluntary sector and primary care will have a major influence on success or failure of community care. The need for co-operation is essential for all parties, especially since the introduction of *Caring for People*, making local authorities the lead agency in community care. Considering the wide range of responsibilities placed on local authorities, great concern about their ability to contribute satisfactorily, especially in deprived areas, is warranted.

Obstacles to Implementing Alternatives to Hospital Care

Community care for people with serious mental health problems has remained controversial. Doubts are still constantly being raised about its efficacy, cost and impact on users and carers. This is despite the rising amount of evidence in favour of home care, based on both controlled and quasi-experimental work. Community services are the exception rather than the rule in the UK, where standard care is still centred around beds. Research findings of community care seem to have made little impact on treatment of people with serious mental health problems in the UK.

Obstacles to implementation are varied, and as so often incorporate an overlapping mixture of rational, emotional, specific and general factors. They include:

Unclear objectives and strategy: although it is often agreed that a move towards community care and greater involvement of users and carers is worth pursuing, the interpretation of such a decision can vary greatly among managers and practitioners. No clear definition of the concept of community care exists, and even mental hospitals are sometimes considered part of community services. This can mean that some change in name of services or staff, *ie* community psychiatrist or community centre, can create the notion of real progress. Agreed definitions and targets would resolve some of these ambiguities.

Lack of knowledge: few people have a full understanding of the research and policy background, and even fewer experience of practice. This means that the implications of alternatives to hospital care are very difficult to estimate for local planners and clinicians. Inability to answer questions such as numbers of beds, staff levels and the optimal skills mix of teams required for new services can be very demoralising, delaying any developments.

Doubts about validity of a model: the consequences of generalisation and its long term impact cannot be predicted in detail. It is often claimed, with some justification, that the results of model programmes are based on short-lived projects inspired by charismatic leaders, implemented by selected staff and applied in atypical areas. The combined experiences of community care in vastly different circumstances with consistently positive results suggest that a general implementation is justified, however.

Fear of the unknown: the concept of community care differs greatly from the traditional medical model practised by clinical psychiatry and nursing care. Many routines would have to be relinquished and new procedures adopted, some of which have not been taught. Moreover, it is hard to predict what irreversible changes would result, adding to the fears. Many of these anxieties could be addressed by inviting experts and visiting successful settings.

Lack of Leadership: essential ingredients of community care are small scale local developments, sensitive to individual needs. This requires either strong and precise directives from the centre or inspired and supported local leadership. Central government delegates the responsibility for service planning to local level, where the presence of people with all the necessary ideas, experience and persistence is erratic.

Role issues: the traditional roles of the disciplines working together in mental hospital settings will change dramatically. Psychiatrists have been in charge of treatment, with nurses providing the care, and psychologists and occupational therapists offering specialist assessment and treatment on request. In the community, most members of the multi-disciplinary team will have to take the responsibility for direct patient care, including key decisions about potential risks or sudden changes to treatment plans. The network model with the psychiatrist at the centre has to be replaced by an interactive model, relying more on individual skills. This invites power struggles, particularly about the various leadership roles, such as manager versus clinician. Unless some vision about roles and functions is present in advance, avoidance of change will be a tempting alternative, particularly to psychiatrists.

Financial implications: a key issue to purchasers is the true cost of community care. Savings are expected without quality of care being reduced. Doubts about the realities of these expectations, centred around points discussed earlier, makes the 'gamble of change' a risk not always worth taking. An honest explicit assessment is necessary.

Financial disincentives: some financial disincentives discourage the development of community services. Consultant psychiatrists can claim £49.45 for home visits undertaken at the requests of GPs. This has a ceiling of 200 visits a year. Only consultants are entitled to claim, and if community team members undertake initial assessment or if the psychiatrist visited a patient already under the care of the team, rather than at the request of the GP, no payment is made. This obviously invites some parallel activities by consultants, rather than an integration with community services. An active and comprehensive community service may also limit the opportunities for private practice, both due to greater demands on psychiatrists' time and less inclination on the part of GPs and patients to bypass the system.

If the benefits of innovative services are to be passed on to the consumers, a well co-ordinated approach is required, offering balanced and clear targets to its various audiences and showing an understanding of the new demands on mental health staff. Such a national strategy needs to include issues such as management skills of traditionally purely skills orientated staff, retraining a large range of professionals, and consideration of a wide range of innovations. It is often at times of crisis when changes are best introduced, and now may be a very suitable time.

The Way Forward

A vast shift from hospital care to community care is not only possible, but likely to be beneficial to quality of life of both users and carers. Several conditions need to be met for community care to live up to its promise:

- An avoidance of a further polarisation between hospital versus community care, since only an integration of the best of both positions will produce an optimal service. The challenge is not to close down all mental illness beds, but to appraise the range required for a comprehensive and balanced service, allowing people to be cared for in the least restrictive environment.
- A greater emphasis on continuity of care and prevention. At present too much significance is placed on symptomatic treatment rather than ongoing attention to the problems affecting people with serious mental health problems. Consideration should be given to social as much as mental health problems, which will result in reduction of relapse and savings in hospital costs.
- The awareness that community care is not a cheap option. At least the same resources are required that are presently being spent on all aspects of mental illness, including expensive asylum. A reduction in money will lead to a reduction in quality of care. Additional investments will be needed initially for the establishment of the necessary structures and support services.
- Ring fenced budgets are essential. This unfailing conclusion in every report on mental health care is based on the realisation that money is likely to leak away to higher profile areas, offering the most vulnerable and least articulate group of people the poorest care.
- The responsibilities of heath and social services need to be clarified, not allowing any opportunity for 'fudging'. Too much is made of the lead agency role of social services, which is unrealistic considering the relative funding contribution to mental health care of the various sectors and the other priorities of local authorities. Social care and health care should not be separated. Joint management and integration at point of delivery should be implemented.
- Priorities have to be made explicit. The increasing cuts in public funding mean that a perfect service for everybody cannot be offered, and a greater mutual understanding of respective priorities and limitations has to be encouraged, so that the available parts can be made to cover as much ground as possible rather than overlap or miss out the essential groups.
- A dialogue is essential between providers and users, with genuine opportunities to users and other committed parties to influence the shape and running of the service. Community care aims to offer individualised care, and unless a routine is established which can respond to feed-back, services could easily maintain a 'carer knows best' attitude.
- Training courses aimed at a wide range of mental health staff are required. Community care differs thoroughly from hospital care, both in philosophy and practice. Staff cannot be expected to adapt from the stability and hierarchical style of the ward base to the dynamism and independent decision making of community care. Brief induction periods are insufficient. This has also funding implications, not presently accepted by health and local authorities.
- The present range of professionals working in mental health care are based on past hospital care provision. These are not appropriate for community care and a thorough assessment of the skill needs of staff employed in community care should be undertaken. Staff training and professional mix should be regulated accordingly. The use of untrained mental health workers and community specialists needs consideration.
- The continuing need for some hospital beds should not imply a continuation of the present style of inpatient care. Admissions will have to be much briefer, with targeted interventions aimed at individual needs, and in close collaboration with community workers. The best setting for such 24 hour care, the optimal size of the unit and the skills of the staff have not been addressed yet. Considerable thought should be given to a greater range of small units offering specialist care to people with specific conditions.
- The abolition of payments for domiciliary visits to consultant psychiatrists. This is a disincentive to the development of active community services, is divisive, and based on obsolete principles of practice.
- Direction should be forthcoming from central government about priority groups, structure and implementation of community care. This needs to be of greater precision than the general guidelines given so far. In addition, the implementation of such direction has to

be accompanied by explicit standards. It is unfair to delegate the responsibility for the future of services to GPs, trusts and local authorities, based on the management principle of passing the problem downwards.

- Urgent clarification is necessary about the role of GP fundholders. Potentially a system parallel to the present purchaser/divider split could be developing, causing duplication and confusion. Any integrated and visionary developments could be undermined by purchasing GPs, preferring small scale traditional services. If GP fundholders are to be given greater responsibilities for the purchasing of mental health services, better information and a greater understanding of all the intricacies are essential.

PATHOLOGY SERVICES

John Stilwell

> *The biomedical science and medical specialty that studies the causes, development and effects of disease as well as the structural and functional changes that are produced by disease*

This definition of pathology, in Churchill's Medical Dictionary, excludes little in physical scientific medicine. The definition of psychopathology is even more inclusive:

> *The study of the essential nature of mental disorder including its causes, its effects on mental structure and function, and the ways in which it manifests itself*

The layman might think that a science so central to the practice of medicine would form a large part of every practising doctor's skills. All doctors are trained in pathology, but after they qualify most doctors concentrate upon their clinical role, leaving the study of pathology to a small number of specialists.

Beyond the simplest examination of diseased tissue or fluid, the facilities of a laboratory are at present necessary for proper investigations, together with an understanding of scientific method. By the normal processes of specialisation, the laboratory elements of the analysis of different diseases have been brought together into the general pathology departments to be found in all major hospitals. Two factors have brought this about; first, many diseases or conditions have some elements of similar pathology – for example, a change in haemoglobin level – and many pathological changes are investigated using elements of the same techniques – for example, staining slides, or observing colour changes. The technique which will probably bring about most change in the next few years, the use of highly specific antibodies to detect antigens produced in different diseases, is used in all four departments of the typical hospital laboratory to investigate many diseases. This advance in immunology illustrates diagnostic techniques where the 'scientific input' to the laboratory test largely takes place outside the laboratory, in the production of the reagents which are used in combination with the tissue or fluid which is being tested in order to determine the level of some substance in that tissue.

Laboratories are necessary – at present – for most pathological investigations. In the past the specialisation to which we have referred has been a specialisation of the workforce as well as instrumentation; many test procedures have been labour intensive. Medical pathologists have found themselves in charge of substantial organisations, pathology has become identified with its laboratories and as a result pathology departments are now essentially departments of laboratory medicine. But the development of automated analysers for the examination of fluids, the appearance on the horizon of new methods for microbiology, and the competence of laboratory scientific and technical staff to undertake laboratory work unsupervised by doctors, has led pathologists in the UK to take on new roles, or to expand old ones.

In most diseases management depends upon information gained clinically – signs, symptoms, history – as well as information only available after specialist diagnostic services, such as radiological imaging, physiological function testing, and laboratory analysis. Only clinicians have patients and beds – where pathologists such as haematologists have patients, they refer to themselves as clinicians; but they never have many, except in a few large teaching hospitals – and hospital prestige is linked to bed numbers.

The traditional area of pathology where the pathologist's work is not subsidiary to that of the clinician is autopsy work. Where all mental and bodily function has ceased explanations of effects must be based upon pathological examination; the clinician as healer has failed.

The morbid anatomist is probably the securist member of the pathology professions. Not only is his the public image of the pathologist (television series all over the world), but the scientific development of computerised pattern recognition is not thought to have approached the stage when his role of identifying disease through the microscope might become redundant.

Pathology laboratory services have developed in the UK in a somewhat different way from services in North America and Europe. The difference which is significant on the one hand for the role of specialist pathology doctors, and on the other for the configuration and viability of individual laboratories, is the rigid British distinction between general practice and hospital medicine, and the enormous economic incentives for GPs, before the introduction of fundholding, to refer their patients to hospitals for tests. Until about 10-15 years ago many GPS could not even request particular tests; they were obliged to refer patients to hospital specialists (clinicians, not

Hospital Pathology in England and Wales

Most hospital laboratories have four departments:

Biochemistry also called chemical pathology, is concerned with the analysis of body fluids for specific constituents in order to diagnose and monitor body states, and to screen for disease.

Haematology is concerned with diseases of the blood, and with evidence which blood abnormalities provide about other diseases. The haematology department is also responsible for the safe supply of blood and blood products to other doctors, mainly surgeons.

Histopathology studies the cellular structure of tissues, and the closely linked cytology examines samples for particular types of cells. Much of the work of the histopathologist lies in differentiating tissue which is benign from tissue which is malignant.

Microbiology is concerned with the identification of organisms which are producing, are likely or unlikely to produce, disease, and identifying the best drugs – if any – to treat the disease.

In 1990 the following staff were employed in pathology services in England and Wales:

Doctors (Consultants)	1,420
Doctors (Juniors)	1,060
PhD scientists	1,400
Lab managers	620
Medical Laboratory Scientific Officers	13,800
MLSO trainees	1,600
Assistants (unqualified)	3,000

Pathology costs about three per cent of the expenditure of health authorities – about £400 million at 1989 prices. Costs rose slowly both in real terms and as a proportion of health authority expenditure until 1987/88; it looks as if costs have now stabilised. Hospital finance officers now see pathology as one of the easier areas upon which to impose budgetary control.

pathologists). They were then, in almost all areas, given the power to request particular tests for their own use. The hospital laboratory service was free. In theory, GPs could perform their own tests – indeed, more of them used to perform tests and use their own microscopes than do at present – but as GPs began to realise that their own time bore a high opportunity cost, and as the simple tests which a GP could perform would almost certainly need further, more complicated complementary tests, this feature of their practice diminished.

The point in the management of a patient's condition when the intensitivity of laboratory testing takes a step up is when, and if, the patient first sees a specialist. This first contact with services beyond the GP has become ritualised in the UK as the 'out-patient appointment'. Tests requested are naturally directed to the hospital laboratory. In other health systems, the specialist physician would be seen at his own consulting rooms, and would have a wide range of laboratories to choose from.

So, unlike in other countries, the hospital laboratory became the single health service laboratory; it became natural, therefore, to attach public health functions as well.

It is commonly assumed among the professional detractors of the NHS that foreign pathology services are more cost effective than British laboratories. This single statement can actually be analysed into two separate propositions – first, foreign pathology practice is more efficient, secondly, foreign laboratories are more productive in the manner in which they produce test results.

The first proposition is arguable. Most other advanced Western medical practice uses far more pathology tests than British practice. Whatever the reasons for this, and whether or not it is objectively better for the patient to use more or less pathology, British clinicians do not, in general, at the moment, want to use many more tests. Their clinical practice still puts a premium on clinical signs, symptoms, history and observable progress.

The second proposition is in general false. Reimbursement and insurance systems have not led to leaner and more efficient laboratories. Some laboratories in North America which deal mainly with work from physicians outside hospitals are very large – possibly thirty times as large as the largest NHS laboratory – and more productive in terms of the utilisation of capital and labour on the production line than any laboratories in the UK. Moreover, their service to the doctor is far better in terms of turnround time. But hospital laboratories, insofar as it has been possible to estimate from observed staffing levels, are little different.

There is a wide range of different types of laboratory on the continent of Europe, but they are in general smaller than laboratories in the UK, and not particularly efficient. As in the UK, institutional arrangements for health service financing have been important in determining the distribution and scale of laboratories.

How are Pathology Services Used?

The opportunities for change in the pathology services are very great, as we shall see, but the hospital clinician is not clamouring for change at all, let alone any particular change. So in order to find out desirable directions of change it is essential first to analyse the way in which pathology tests are used in a hospital, in order to identify areas where the service to the patient might be improved, or the costs of the function reduced.

Test demand can be analysed along three dimensions:

management category, clinical urgency and organisational urgency. The management categories are diagnostic, confirmatory, monitoring, screening and, sometimes, legal. The categories of clinical urgency are usually immediate, same session (half day), same day and same week.

The categories of organisational urgency depend upon the demand for hospital services, the way in which the clinical doctors want to organise their workload, the degree to which the local health care system subscribes to the concept of patient centrality (through hospital attitude or GP fundholder insistence in UK public medicine, through market forces in private systems), and whether or not pathology management sees itself as a change agent. As we have already noted, clinical hospital doctors seem inhibited from demanding changes from their laboratories.

The meaning of the management categories is as follows:

Diagnostic: To differentiate between the possible diseases which might account for clinical signs and symptoms.

Confirmatory: To confirm or negate a diagnosis made on clinical grounds, upon which the clinician has initiated management.

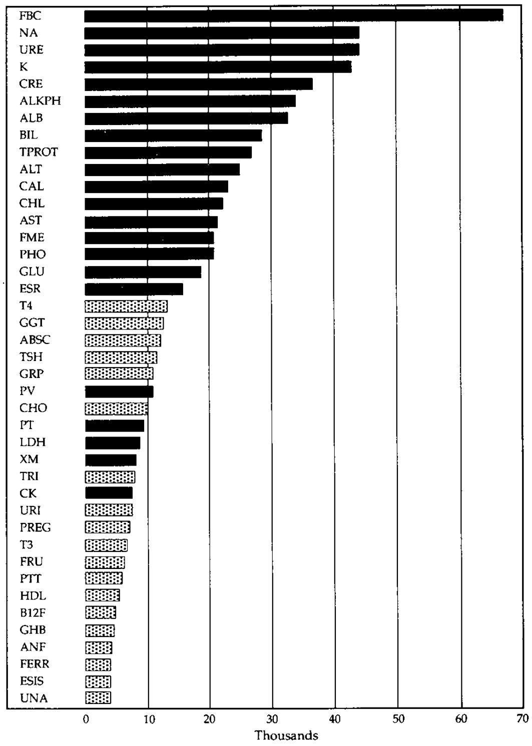
Monitoring: To monitor the progress of a known condition, or response to therapy, or the levels of therapeutic drugs.

Screening: To test for the presence of a disease for which there are no clinical signs or symptoms, but where the patient falls into a risk category determined objectively by characters such as age sex or ethnic origin.

Legal: Where the information is redundant, or the probabilities of disease very low, but to ensure that no legal case for negligence could be brought.

Particular tests can fall into many different cells of the cube. Most of the commonest tests can fall into almost every cell. This is illustrated in Table 1, which lists the most common blood and urine tests performed in over 100 biochemistry and haematology laboratories in England. The tests whose bars are black are those which need to be produced at the highest level of specification, although of course immediate-response requests are a very small proportion of the total. We shall see that this is the fundamental reason why economies of scale in the use of capital equipment will not lead inexorably to giant laboratories serving the acute hospital sector.

Table 1: Biochemistry and Haematology Tests: Average number per hospital lab per year



Although all four of the conventionally (in the UK) separated departments – biochemistry, haematology, microbiology and histopathology – produce test results at every level of urgency, the first two produce far more at high levels. Some of the urgent information from microbiology tends to be from tests which, although conventionally performed in microbiology laboratories, use techniques similar to biochemistry. Other urgent information is produced by means of 'low-level' techniques, such as microscopy. Histopathology is called upon for little urgent work. All histopathology laboratories retain a capacity for urgently examining sections of frozen tissue removed during an operation, the information from which feeds back into the same operation. But this method is now falling into disuse with advances in fine needle aspiration techniques.

The commonest test of all is the 'full blood count' which is a request for a profile of information about a patient's blood. This can be used at every level of urgency and for every management purpose. This highly automated test is complemented by the production of a microscope slide of the blood, which is examined by a technician or doctor. However, the urgently required information tends to be derived from the results which are produced by the automated equipment, and a smaller and smaller percentage of blood samples result in microscopy – the level is about 20 per cent at the moment for samples for hospital patients. An example of the low-service-specification (*ie* non-urgent) use of this test might be in ante-natal screening, and an example of high-service-specification is in an accident and emergency department for patients who have lost a lot of blood.

Laboratory analyses can contribute to diagnoses, together with other scientific tests or images, or they can make the diagnosis. An example of such a pathognomonic test is catecholamine levels in phaeochromacytoma; an example of a contributory test is the liver function battery. It is important to recognize that tests are rarely pathognomonic; levels of analytes in normal subjects are often distributed widely. Normal ranges are defined to make it unlikely, but not impossible, that a result outside the range will denote normality for that subject. Many clinicians, when confronted with an apparent conflict between laboratory and clinical evidence, will base their management upon the clinical findings, especially when test results are only just outside the normal ranges. This behaviour is very important; it rules out many scenarios where laboratory test results might be entirely substituted for the medical input to a clinical decision-making process.

How are Pathology Services Produced?

Within the memory of many senior laboratory staff, most laboratory tests were produced by means of manual, labour intensive methods. Some thirty years ago automated methods were developed for the highest volume tests performed on whole blood or serum. The machines which evolved for serum testing were inflexible and designed to produce up to 30 tests on each sample. This had a profound effect on practice, and for the twenty years up to about five years ago clinicians became used to requesting large batteries of tests, which became known as profiles. Since, however, many tests were still produced on equipment which was hardly automated at all, since many tests were produced by isotopic methods, and since these were years when pressures to economize on labour were relatively low, the potential to design automated laboratories instead of laboratories containing automated equipment, was not realized. Whatever trend toward centralization had started up was reversed in the 1970-80s with the movement away from very large campus hospitals back toward the smaller district general hospitals.

There have, however, been scientific and technological changes in the last five years which are bringing the automated laboratory closer for tests of the chemistry of body fluids, and the structure of the blood. Some of the scientific advances are relevant to the identification of microbiological organisms which cause infections, and to some techniques used by histopathologists, but it is probably true to say that these branches of pathology will not be so radically altered by scientific and technical advances as will biochemistry and haematology.

Since the start of the development of automation it has become less and less clear that all laboratories should be directed by medical doctors. It is fairly clear to any objective analysis that there is now a systematic distinction between the production of test results including quality control, and advice about their use. The main exception is in histology, where the medical doctor is involved in preparing specimens, and in examining the slides which have been produced by technicians.

Although the image of the pathologist is a laboratory bound scientist, in the UK the pathologists' professional association, the Royal College of Pathologists, has, since the start of automation, laid great stress upon the wider roles of pathologists in the hospital wards and clinics.

These roles fall into two distinct categories; those where the pathologists act as advisers and interpreters, and those where the pathologists themselves act as clinicians. It is of course true that the conditions which pathologists treat are managed with a high degree of laboratory input, but there is no necessary link between the management of the patients and the management of the test production process. The areas of disease where pathologists have autonomous clinical roles include blood disorders such as leukaemia, sickle cell disease and thalassaemia; clotting disorders and the monitoring of anticoagulant therapy; treatment and monitoring of lipid levels; and treatment of serious blood-borne infections. But in an average district hospital the number of beds allocated to such activities will be very low, certainly in single figures.

Microbiology pathologists frequently – but not always – act as infection control officers, with a staff of nurses who act as detectives pursuing sources of cross infection, and are often responsible for preparing antibiotic policies for hospitals; this is an important economic as well as therapeutic function. Histopathologists perform postmortems, both for the hospital and for the coroner.

In the UK, the national public health laboratory service which monitors epidemics, services environmental health officers etc – is, in the main, organised by subsidising a network of hospital laboratories. Most virology has tended to take place in hospital laboratories which are also public health laboratories. University hospitals tend to have a complicated laboratory structure where teaching, research and service to local hospitals and family doctors is intertwined, both actually and financially.

How are Pathology Services Organised?

There are various common organisational and institutional aspects of both hospital pathology and clinical practice which it is crucial to understand before change pathways can be suggested. They are all the more critical because we shall argue that they, not scientific nor technical limitations, are the main obstacles to change.

Hospital pathology

- Hospital laboratories work a 9.00 am to 5.00 pm day, with 'out-of-hours' work subject to complicated and very expensive arrangements.
- Phlebotomy (taking blood samples) from in-patients is performed by laboratory staff only between about 8.30 am and 10.00 am. At other times, doctors or other ward staff take the samples.
- Test request forms are different for each of the four

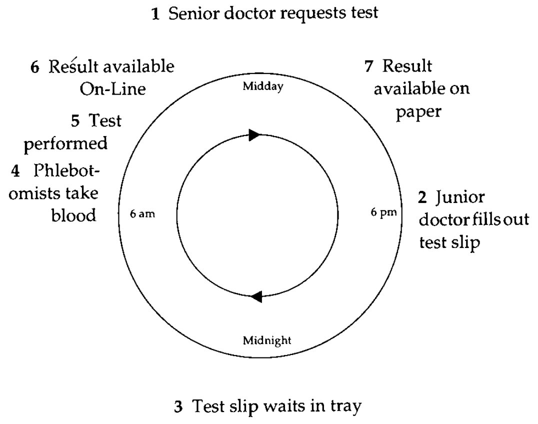
pathology departments. Test results are portered to the wards except in the few hospitals with computerised information systems.

- There is no single contact point. Each department has its own phone system.
- Staffing skill-mix has not adjusted fast enough to increases in automation. Staff in many posts are overqualified, and written protocols are thought unnecessary.
- Where staff have a cross-department role they are marginalised by the departmental managers rather than used constructively.
- There are hardly ever any staff with the identified responsibilities to perform the standard commercial functions of customer relations, planning and investment appraisal.
- Investment decisions cannot be made along standard lines of discounted cash flow because of the arbitrary way in which capital is defined and rationed.
- Laboratories do not control their own transport.
- The use of blood and blood products has been costless to surgeons. The rationing process operated by blood bank staff can cause considerable acrimony and result in the very opposite of good customer relations.
- The use of out-of-hours tests is costless to the requesting physician (who is usually very junior). The rationing process can also cause acrimony, depending upon the out-of-hours payments system adopted.
- The responsibility for managing a hospital's pathology services is frequently unclear, or defined differently from the reality. The departmental laboratory manager is usually a non-medical senior technician, whose line management is often through lay managers to the (usually lay) chief executive. The senior medical staff frequently have titles such as 'Medical Head'. In a cushioned environment, where staff relations are good, such a system can function; but the environment is becoming lumpier, and antagonisms between doctors and technicians much more prevalent. Many pathology departments are instituting more main-stream management systems, but these are often failing to create sensible structures over all four disciplines.

Clinical practice

- GPs use hospital laboratories, accounting for perhaps some 15 per cent of workload. They are accustomed to a seven day turn-round.
- Many GPs do not take blood samples, but send the entire patient to the laboratory for bleeding.
- Diagnostic decision making upon in-patients is centered upon the ward round of the senior doctor. The test request forms are actually filled out by the most junior doctors at the end of the day. Figure 1 illustrates the process.

Figure 1: Stages in the Production of a Test Result



- Many patients are admitted as emergencies to medical hospital wards in the period between 5.00 pm and 8.00 am. The doctor on duty must decide what tests to request urgently, and what tests to leave until the morning phlebotomy round.
- Junior doctors, especially those on duty at night, only stay in the same job for a brief time. All patients are admitted under the care of a particular consultant, and it is very uncommon for different consultants to agree formal protocols with the pathology department for the tests appropriate under different clinical circumstances. All factors therefore militate against a consistent pattern of testing. This is particularly true in the UK as opposed to other European or North American countries, where more pathology tests are requested routinely.

Criticisms

Surveys of clinical users of pathology services have usually shown a high degree of satisfaction. Criticisms have centered on certain organisational aspects; scientific quality is seldom called into question. It is almost certainly true to say that bench level quality assurance and control procedures are performed systematically in all laboratories, although the quality control procedures in some histology and cytology departments are not as well thought out as the quality control which appertains to the more automated processes.

It is a very revealing fact that the organisational issues which come to the fore when clinicians are surveyed are often long-standing. Although the criticisms are brought to light and often admitted, they frequently remain uncorrected. We shall list the four main perceived faults and explain why they are persistent; this will demonstrate some of the forces of inertia which have prevented laboratories becoming more efficient.

Results are late

Results get lost

Both these criticisms centre on transport and data processing. Specimen transport to the laboratory and result transport back to the clinical site (in hospitals without computerised data systems, which are the great majority) can either be generally inadequate or can be subject to delay or failure. The system for telephoning urgent results, either because the requesting clinician defined them as urgent, or because laboratory protocols have classified them as urgent (for example an unexpected highly abnormal result) can fail because of pressure on the telephones or inadequate recording procedures at the clinical end.

Transport and portering systems are generally outside the control of the pathology department. Hospitals seem reluctant to devolve these functions even when no diseconomies would result – when, that is, staff or vehicles would be fully employed. Hospitals' policies on information technology take account of pathology's requirements, but their pace of installation is independently determined. Recording procedures on wards and in departments depend upon systems being agreed by ward managers and senior doctors' secretaries, and adhered to by all staff. These systems, which seem to be in general subject to ward level discretion, sometimes fail. The laboratory procedures for telephoning urgent results are often equally ad hoc, with no single member of staff allotted resposibility for this important area of customer service.

Planned turn-round time for specialist tests performed elsewhere is too long.

Where tests are sent away to a hospital which specialises in them, the service specification has generally been determined by the contractor hospital.

It is difficult to get tests performed between 5.00 pm and 8.30 am.

The perception by laboratory staff of 'out-of-hours' work is often at odds with the perceptions of the ward staff. Protocols can be imposed by consultant pathologists, but these are not necessarily accepted by ward staff. Individual conflicts between requesting clinician and demurring technician are sometimes only resolved by the ad hoc intervention of consultant staff on one or other or both sides. Laboratory technical staff have an ambivalent attitude to 'out-of-hours' work. In some cases the number of out-of-hours requests determines their overtime payments, which can be very high. But set against this is an attitude that the clinical staff could and should organise their own work patterns better. The demands of out-of-hours work, and its relatively high rewards, have led to generally unresolved friction between laboratory, clinical and financial staff. Out-of-hours work remains compartmentalised within laboratory specialty, despite the automated nature of most urgent tests. The simple and obvious solution of a multi-disciplinary twilight shift with economic skill mix has not been adopted anywhere.

Demand Side Changes

Changes in acute hospital care will affect the level of demand for laboratory services. Increases in throughput lead to an increase in overall demand, since the number of tests requested per patient contains a constant as well as a *per diem* element. But for each individual provider unit in the changing acute health service in the UK, the changes in case mix are likely to be much more significant. A small increase or decrease in pathology intensive activities such as heart surgery or renal medicine can have a marked effect on demand. An increase in a particular disease or state which is held to require increased screening or monitoring, such as AIDS or coronary or cervical cancer risk, can of course increase the demand for particular tests.

Changes in demand have tended to mean changes in the quantity of tests demanded, rather than in the speed of response or quality of interpretation. The exceptions to this have been in certain tests for which dedicated equipment exists and which are used to monitor patients in intensive therapy. Here the clinical demand is urgent and obvious. Where the benefits from an improvement in service specification are not so clear cut, and especially where the benefits may be organisational rather than clinical, the system response is slow.

Some hospitals are re-designing their activity pattern in order to make service to the patient their central focus – the concept of the patient centred hospital. Pathology services will be mainly affected in connection with outpatients, where an immediate test result will become necessary, not because of clinical urgency, but for the convenience and peace of mind of the patient.

Some diagnostic processes are being constructed as computer programs which effectively perform discriminant analysis upon a number of un-prioritised variables, including details of symptoms and history as well as laboratory tests. The patient-friendly use of such procedures entails an immediate laboratory response.

Supply Side Changes

The great changes in the pattern of laboratory work have traditionally been led by scientific or technological change. The invention of the automated biochemistry analyser which could perform 20-30 tests on every sample led to an increase in the use of biochemistry tests for screening purposes, and to an increase in the frequency of testing. The benefits to patients were never convincingly demonstrated, and as a different digitally controlled selective technology has been developed the massive screening battery has been dropped.

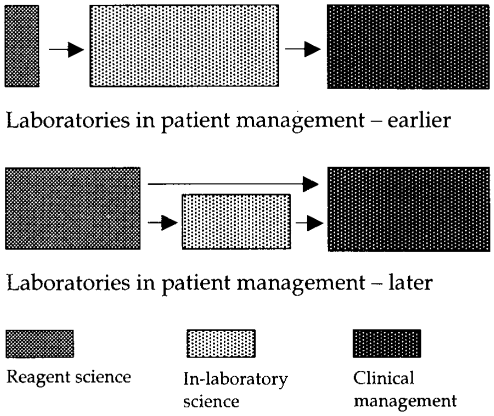
Recent supply side scientific changes are having a profound effect on the in-laboratory analytic process. A combination of factors is leading to the development of equipment which exhibits enormous flexibity, both in the range of analyses performed and the economic scale of their production.

These factors are:

- Cheap microprocessor control
- Cheap data processing and information transfer
- The production of new types of reagents which make the laboratory process relatively simple

The effect of new technologies, based largely upon the controlled production of specific antibodies, is to refocus 'scientific effort' upon the stages in a test process which precede the laboratory activities. To simplify somewhat, in the past laboratories have performed complex scientific procedures, sometimes manual and sometimes automated, with reagents which have been simple to produce, whereas now they perform simple procedures, usually automated, with reagents which have been very complicated to produce. This effect is illustrated in Figure 2. Data transfer to the wards or clinics after the test has been performed can be instantaneous.

Figure 2: Change in Laboratory Systems



These changes are affecting the four pathology departments at a different pace. In biochemistry, all the factors combine and the pace of change is very fast. In haematology computer analysis of the output of the main blood counters is improving fast, the sample handling facilities of the equipment has recently improved – this simple technological change, which has at least doubled labour productivity, has been quite extraordinarily slow to come on line – and blood grouping, antibody screening and cross matching procedures are also improving, but change has not yet had as full an impact as in biochemistry.

Microbiology has seen considerable change in virology and immunology, but the bulk of its work, which is the culture of organisms and the determination of the antibiotics to which they are sensitive, has remained unchanged. New immunological techniques could be, and to a certain extent are, being developed for the identification of organisms, but the determination of sensitivities is not expected to change within the next five years or so. Histopathology and cytology have changed the least. Immunological techniques are used to a small extent (computerised pattern recognition is not yet usable). Some advances have been made in automating the process by which water is replaced in tissue by wax before sections are cut, placed on slides and stained, but the preparation by cutting of specimens and the microscopic examination of slides by medical staff remain the key activities.

Competition Changes

Demand and supply generally only interact to produce a low-cost, high-benefit solution under conditions of competition, or where the signals given in the market place, such as declining profits, or losses, are modelled by information and response systems imposed upon or acknowledged by the actors. These disciplines have been everywhere lacking. No health service has been so constructed that lowest cost production processes are utilised, and that at those costs the optimum numbers of tests are used. In the UK in particular, internal hospital accounting systems have not allowed clinicians to estimate the true cost of a slow response to a test request, involving the engrossment of other hospital resources, let alone to take account of the private cost to patients. Indeed, most hospitals still do not know how much any diagnostic procedure, whether X-ray, laboratory test or ECG, costs. Although many UK laboratories have installed the most up-to-date equipment this has usually been according to the bureaucratic capital rationing process controlled by Regional Scientific departments, and not as a result of an economic capital appraisal exercise. So potential staffing economies have often not been made.

An illustration of the divergence between the actual and the possible is given by the staffing levels supposedly necessary to produce routine biochemical results from a modern selective analyser. When the Audit Commission surveyed laboratories in 1990, the average hospital laboratory processed about 70,000 samples with five staff. In an exercise carried out by the author in 1991, a biochemistry laboratory agreed that it could analyse 100,000 samples with five staff. In 1992, in a laboratory which is particularly cost conscious, 300,000 samples are analysed by 2.75 staff. This is a labour productivity difference of nearly 800 per cent.

The recent division of health service organisations in the UK into purchasers and providers is intended to make services more responsive to patient requirements, and the cost disciplines imposed by the quasi market in health services will, it is hoped, reduce the feather bedding which has protected inefficient services.

It is possible and likely that one of the effects of the new emphasis on value for money in health services on both sides of the Atlantic will be a change in the pattern of use of laboratory tests. But if the instruments of this change are market forces, what sort of developments might we expect?

Conclusion: Two Scenarios for the Future

Scenario One: The Mega Lab

The laboratory structure which most pathology forecasters expect is one where a large central laboratory carries out the bulk of tests, but urgent analyses are performed in "hot" laboratories, even nearer to the patient than existing hospital pathology departments. The central laboratories might serve up to about 12,000 acute beds, or 16-24 hospitals, plus surrounding GPS.
The factors leading to this prediction are:

Transport costs are lower than generally perceived.

The non-urgent workload generated by such a catchment area will efficiently utilise the most modern and lowest cost equipment.

Such a size will enable skill mix discontinuities to be addressed, with senior staff having a sensible number of junior staff to supervise.

Equipment to perform analyses at ward level or in the clinic is improving and becoming cheaper.

This solution has the merit of simplicity, and in terms of the politics of change it has the further merit that it could only be achieved if the dysfunctional link between medical pathologists and the test production process were decisively cut; no-one in their right minds would organise a service where, for example, some 20 consultant haematologists would all have a management input into the laboratory. Other requirements would be; a data system which would communicate with the patient database in each hospital; a re-arrangement of phlebotomy services in order to utilise for transport what is at present dead time; a training programme in near patient testing for clinical staff; a multidisciplinary emergency out-of-hours service at each acute site.

But we should examine the underlying economies of scale argument closely. We have seen that there is evidence that productivity gains with increasing size are possible; but these have probably been due not to the way in which new selective analysers work, but to economic and other pressures upon the laboratories studied. The labour input to new analysers is simply placing samples in racks; the direct labour cost of the most productive laboratory we have seen is probably about 15 pence per sample, with each sample yielding about six separate test results – 2.5 pence per test. The reagent costs are about the same as this, depending upon the test. There need be few discontinuities in the application of labour to modern equipment, which does not need constant attendance. Set up time is also low. It is, in fact, difficult to argue that over all but the lowest levels direct labour bears anything but a linear relation to output.

The argument over equipment utilisation is clearer cut. Capital charges are constant with respect to output, as usually are maintenance contracts. If we consider an analyser costing £150,000, the annual equipment cost would be about £39,000 in the first year after purchase, falling to £30,000 in its tenth year of life. For an annual cost of £30,000, a throughput of 50,000 samples yields a cost of 60 pence per sample, or 10 pence per test, and an annual throughput of 500,000 samples, 6 pence and 1 penny. The important point to note is that an increase in volume from 50,000 to 100,000 saves 30 pence per sample, but an increase in volume from 200,000 to 400,000 saves only 7.5 pence per sample – about a penny per test.

To sum up the economics of modern automated analysers, one of the high throughput biochemistry tests might cost, in a large single-hospital laboratory, 2.5 pence for labour, plus 2.5 pence for consumables, plus 30 pence for the equipment, plus phlebotomy and overhead costs of about 25 pence; doubling throughput will reduce the equipment cost by 15 pence and leave all other costs hardly changed.

The use of near patient testing equipment has not grown as rapidly as expected over the past few years. Some tests are now regularly performed in this way; for example blood gases in ITU, testing for urine infections and glucose levels in every type and level of clinical setting, microscopy for sexually transmitted disease clinics, cholesterol in GP surgeries and chemists' shops. But the general principle that clinical staff should perform more tests closer to their patients has not become well established in the UK, despite frequent predictions in the mid 1980s, and growth of this method of testing in the USA (where physicians do not have the same free access to hospital laboratories which is enjoyed by non-budget-holding GPS in the UK). This is probably because the labour costs of near patient testing have been discounted by clinicians; tests were thought of as relatively costless in terms of the time of the staff who would have to perform them. Consultants thought that their junior doctors would be able to fit them in quite easily, and GPS thought the same of their practice nurses. But it has become clear in settings where near patient testing has been tried systematically that performing these tests is by no means costless; it is a significant job, just like the rest of the junior staff or nurse's workload, and, after allowing for the time taken up by the necessary clerical and quality control procedures, it is more often than not less efficient in terms of health service costs than using the main laboratory. The introduction of a quasi market by means of allocating care budgets to GPS may see an increase of near patient testing if one of the effects is to increase GPS' consideration of their patients' private costs, since near patient testing can clearly reduce patients' travel and time costs.

It is most likely therefore that the megalab scenario would include fairly conventional hot laboratories in each acute unit. We have however drawn attention above to the fact that the tests performed in a hot laboratory, with an immediate response required, are the same tests as those performed in bulk with a lower service specification. Given the relative costs of labour and capital, it would not be a cost effective solution to equip the hot laboratory with labour intensive testing methods. These laboratories would therefore be equipped with analysers whose capacity would far exceed the emergency demands which would be made. So, given the two arguments above, that potential labour productivity gains are not great solely with respect to increases in throughput of the routine tests, and that equipment productivity gains with scale rapidly diminish, the question is raised whether much of the hospital generated workload (not, clearly, the GP work) ought not to remain on the acute hospital site. This argument is reinforced by the difficulty of demonstrating significant economies of scale in microbiological, histological and cytological procedures.

Scenario Two: Small and Flexible

The alternative means of achieving a higher quality and more cost effective service is to exploit local labour economies in the production of routine test results and to use the labour released not to increase the range of tests performed in-house, or merely to reduce costs through redundancies, but to provide a more flexible service by fitting the pathology service more closely to the pattern of clinical activity. It is more than likely that resources invested in portering, transport and phlebotomy services will have the greatest extra benefit, given that information systems must be installed. If hospital laboratories can provide an immediate response service to clinics, then the benefits of near patient testing can be attained, without the attendant costs in terms of clinician's time, and with all the advantages of professional quality control.

If hospital laboratories can take close and effective control, in terms of simply defined line management, of their ancillary staff such as porters and drivers, and if they can utilise phlebotomy staff flexibly, they should be able on the one hand to offer a better service, and on the other to iron out some of the peaks and troughs of demand which reduce overall labour productivity. Pathology staff already tend to offer a high quality service to clinics, such as lipid, coagulation or other haematology clinics, and genito-urinary medicine clinics. Provided that specimen transport can be controlled, and trusted, similar high quality could be offered to a wide range of out-patient services.

In this scenario, which offers a high value-added service, it is possible that the routine service to GPS will not be combined with the hospital service, but will be offered by a larger independent supplier.

But we have argued above that a scale of operation larger than that prevailing at the moment is necessary to attain productive working practices and skill mix within the separate departments. The second characteristic of the smaller-scale scenario is flexibility, and this must include multi-disciplinary working. It is frequently claimed by medical laboratory scientists that the separate sciences involved in the separate disciplines have become so specialised that biochemistry technicians, haematology technicians, microbiology technicians and histology technicians have developed such specialised roles that they cannot perform or be trained to perform each others' tasks. There are clearly some high level expertises, in the areas of interpretation and advice, where it may be the case that specialist knowledge can only be acquired through specialist and exclusive work. At the other end of the spectrum, there are some craft skills such as manipulating a microtome, where specialisation may increase productivity. But in between there are many roles, including supervision and machine minding, where the range of an operative's activities could span more than one of the four disciplines. There is certainly no room for 'out-of-hours' work on a single discipline basis. 'Out-of-hours' must in any case be redefined since it is inconceiv able that a high quality service would be offered on a 9 – 5 basis only. At least a twilight shift would need to be added.

The move to multi-disciplinary working would tend to loosen the management link between medical pathologist and laboratory; this becomes inevitable in any cost effective solution.

Clinical staff would not necessarily initially jump at the opportunities offered. We have already referred to the difficulties of identifying improvements in laboratory services which doctors actually want; it would be necessary for medical pathologists to identify and 'market' these improvements.

But if macroscopic change does take place exogenous to the pathology service – whatever the shape of the acute hospital sector in the future – we would argue that provable economies of scale in the production of test results are not so large that they should feed back in order to influence the pattern of clinical activity. Pathology services should be quite flexible enough to fit themselves economically to a pattern of demand determined independently.

CONCLUDING COMMENT

Pressures of various kinds are leading to questions about how primary and secondary care should relate to each other and what the division of functions should be. The articles in this section simultaneously confirm that shifts can be made to the present pattern of services and that such shifts can produce benefits to users and reductions in costs.

However, taking the spread of services considered here, the evidence is patchy and far from complete and is far from showing exactly what the division of roles should be. So even if we accept the direction of change, a great deal remains to be done to work out how far change should go and how far the resulting pattern of care should be organised.

But if knowledge were more nearly complete and if it confirmed the benefits of further shifts, the arguments and evidence presented here confirm that implementing change would be difficult. In the case of children's services for example, the general presumption that hospital stays should be minimised has been accepted at one level for over 30 years. Yet many of the measures required to implement it have not been taken.

The conclusions to the articles by Matt Muijen and Elaine Murphy identify a number of structural obstacles to the changes they set out, of which perhaps the central one is the division of funding between different health and social care providers. That division, or chasm as we termed it in last year's Review, is a recurring theme in any discussion of the future pattern of care, yet it looks as unbridgeable as ever.

Of the other obstacles they identify, perhaps the most intractable are those stemming from the definition of professional roles. In all the areas considered in this section, the situation resembles British manufacturing industry in the decades after the war when demarcation disputes were the norm and when managements were too weak to impose the division of labour which, over all, is the most efficient. The 1980s saw the end of that form of industrial relations through much of the private sector. There has been nothing similar yet, in the public sector in general and the NHS in particular. Here and there, the boundaries between the profession are nibbled away, as some nurses or some technicians take on the roles of some doctors. But there has been no frontal assault.

Within the NHS itself, the informal mergers that have taken place between districts and family health services authorities reflect recognition of the potential overlaps and links between primary and secondary care. But sensible though such moves are, they represent only the initial steps towards the unification of purchasing that would place a single agency in a position to shift resources freely from one form of service delivery to another in the light of changing perceptions of their value. Full administrative integration is some way off, and beyond that lies the further taks of unifying the financial framework, but for example, introducing a capitation formula that applies to all publicly funded health services. Beyond that lies the further task of tying in those services now the responsibility of local authorities. And yet further down with line is the difference in the rules of access between health and social care, with the one still largely free, the other increasingly not.

To conclude; the articles and evidence presented in this section of *Health Care UK* question the existing relationship between hospital-based services and those provided in other settings. If nothing else they serve to underline that the existing pattern is not sacred, that other patterns are feasible, and may be better, in terms of cost and outcome. Equally, they may not be. In each area, more information is required about the costs of alternative care patterns and the quality of care they offer: that will be hard to obtain, but harder still will be the task of integrating the results of similar work over all the services the existing hospital system requires.

It may well be, as Morton Warner suggested in ***Health Care UK 1991*** that the existing district general hospital will be undermined from below by functions shifting into community settings, and from above, as other functions moving to highly specialised regional centres. Such shifts may well take place on a piecemeal basis: indeed current developments in the organisation of health care would tend to favour that since they make it harder for any one organisation to take a view of developments across the whole field of care.

As far as hospitals themselves are concerned, there would be nothing wrong with that, if there were no merit in the arguments used to justify the current clustering of activity in particular locations. The modern hospital is an exceedingly complex economic institution. It provides a wide range of services, using a wide range of technologies and skills, and unfortunately, there is, in the UK at least, very little hard information about how resources are used within it. But if there are advantages in having major concentrations of skills and special facilities, as to some extent there must be, then piecemeal change could produce the worst of all worlds, where no part of the total health care system is functioning properly. The challenge, which currently looks extremely daunting, is to combine the broad perspective with the detailed evidence needed to justify particular configurations of service delivery.

THE MYSTERIES OF HEALTH GAIN

David Hunter

Health gain has entered the health policy vocabulary in the context of the NHS reforms introduced in 1991 and in particular the developing role of purchasing or commissioning agencies. The emphasis on purchasing is of fairly recent origin and stems from a belief that conflating purchasing and providing functions within a single organisation is unsatisfactory because they are susceptible to provider/professional 'capture' and tend to operate as much for the benefit of those who provide services as for those who use them. As a consequence, combining purchasing and providing functions is potentially ineffective in contributing to health status and unresponsive to client/public opinion. Separating the two functions is intended to tackle these problems and inefficiencies. In particular, the purchasing agency, freed from provider vested interests as well as from day-to-day operational pressures, can adopt a more proactive role in the pursuit of effective health.

Health gain as a concept has caught the public imagination for reasons that are not entirely clear, since the term lacks an accepted definition or any precision. On the other hand, perhaps this very vagueness constitutes its appeal. Such conceptual slipperiness is often attractive to policymakers since a term like health gain has a positive ring to it but does not convey exactly why this should be so.

Health gain is something of a catchall notion insofar as it embraces a number of issues and initiatives that are derived, sometimes loosely, from the NHS reform agenda. Developments in needs assessment, in health outcomes, in listening to local people, in health services research through the central and regional research and development programme and in articulating a health strategy all in one way or another flow from, and impact upon, health gain.

Of course, defining and agreeing what constitutes effective health care or good performance is not straightforward. The tendency hitherto has been to focus on structure (or inputs) and on process (or outputs). Only very recently has attention begun to turn to outcomes (or effectiveness) which are the results, or impact, of processes on the recipients' health status. Outcomes tend to be measured in ways relevant to specific illnesses and interventions, though attempts have been made to derive single measure lowest common denominators such as patient utilities – quality adjusted life years – or health profiles *eg* the Nottingham Health Profile.

Health gain is in essence concerned with improving health status, *ie* producing positive outcomes. In practice, this entails doing as much as possible within a fixed budget. There are two aspects to this which need to be considered. First, whereas outcomes occur after an intervention, purchasing decisions necessarily occur before it. Purchasers must therefore base their decisions on prospective outcomes although in practice if good evidence exists that for a patient in a specified condition treatment produces an improvement in health status then judgement of performance in terms of processes as a proxy for outcomes becomes feasible.

The second consideration is that health status is not only the result of health care; other policy fields and services are important and may be more important and instrumental than health care. Indeed, this constitutes the central challenge to purchasers in the new NHS and underpins the health gain approach. Purchasing authorities are expected to think laterally and transcend the boundaries of the health care system in their investment decisions. The difficulty then becomes one of setting boundaries, if possible, and making the process manageable while also avoiding a situation whereby other agencies and services start to off-load their responsibilities onto health authorities in the expectation that NHS resources may be used to support functions and responsibilities which previously belonged elsewhere.

This appraisal of health gain is in three parts. We begin by examining the conceptual issues: what does the term mean? We then look at ways health gain is being employed in practice by purchasers and others in their attempts to plan and prioritise services. Finally, we consider the wider implications of adopting a health gain approach. If the proponents of such an approach are serious about the shift towards health outcomes and health status, there will be significant implications for the future configuration of health services, since their impact on health status is limited, and may not even be the most important contributor to it.

The Meaning of Health Gain

The notion of health gain has been accompanied by a variety of concerns surrounding the true intentions of central government policymakers. At one extreme are those critics who regard the phrase as mere rhetoric, devoid of all meaningful content. At the other extreme are those enthusiasts who hold possibly unreasonable expectations for the purchasing role and see it as the panacea for switching priorities from secondary care to primary and community care. Somewhere in the middle are a large group of sceptics who want to believe the latter but who fear the former. They see positive potential in the health gain approach, but are also aware of the need for new skills to be developed in needs assessment, user involvement and in identifying effectiveness in terms of health outcomes. They are also aware that these skills are currently in short supply and that if the key stakeholders who benefit from current arrangements *ie* the providers, are to be effectively challenged, then it is vital that the purchasing role be strengthened and that those taking it on are equipped with the requisite skills. Moreover, this developmental task needs to be achieved quickly. Health authorities and the NHS Management Executive are, belatedly in the eyes of many observers, endeavouring to remedy the neglect of the purchasing role in the early years of the NHS reforms and to identify the essential components of an effective purchaser.

In the midst of these ruminations has surfaced a concern with rationing and a sense in which health gain is perceived to be all about controlling costs, attending to the needs of the 'worried well', and about denying individuals essential services. Whichever way the subject is viewed, value choices are integral to purchasing for health gain and new processes and institutions are required to decide priorities.

The Eastern Health and Social Services Board in Northern Ireland is probably not wide of the mark in asserting, in *Achieving Health Gain*, that although health gain 'could be regarded as merely another addition to health services jargon it neatly encapsulates what we are aiming to achieve', namely, 'improvements in the health status of the population'. Few managers or health authorities would take a different view. However, establishing what contributes to health status is not so straightforward. In particular, singling out the contribution of medicine to improved health status as distinct from a range of other policy initiatives, notably housing, income support, social services and so on, is a major issue confronting purchasing authorities in the NHS. They are charged with the task of making investment decisions designed to improve the state of health of their local populations. In order to embrace the important contribution to be made by non-health care services to improvements in health it is necessary to define health status in holistic terms and as incorporating inputs other than those of a strictly biomedical nature.

A close link is often made between health gain and rationing or priority-setting. One does not logically follow from the other. Put simply, health gain in its pure state is about determining whether, in meeting need, a given intervention has a demonstrable impact on health status. If it has, and it represents a measurable (if possible) improvement in quality of life or whatever, then it is an example of health gain. Value judgements are part of the process of determining effectiveness or the worth of a particular intervention but, at this stage, are not part of deciding trade-offs between a range of equally effective procedures. That is a further stage in the process of deciding priorities, once it has been established that there is much more that can be done which constitutes health gain than there are funds available to do it.

There are, then, two types of values at work in the application of a health gain approach: first, values arising from the selection and weighing of information about the effectiveness of different interventions and the impact on health status of these regardless of whether they be derived from health services or other services and policies; and, second, values arising from the need to choose between different options for achieving health gain on the assumption that it will not be possible to do everything and that choices will always be necessary. Of course, if it is possible to be reasonably certain about effective and ineffective procedures respectively in health care, then it may be argued that sufficient resources will be available to support all that is deemed effective by way of contributing to health gain. This is the approach favoured by the Dutch Government. By bringing cost-effective health care facilities into line with demand while abandoning or disinvesting in ineffective care, the Government hopes to avoid any need for rationing. It is not clear how realistic such an approach will prove to be. Certainly, it seems unlikely that countries will ever be in the enviable position of establishing unequivocally cost-effective interventions and services in sufficient time to avoid having to prioritise allocation decisions.

In practical terms purchasing for health gain involves three aspects:

Assessment of a population's health status and needs drawing on epidemiological skills and data
Health gain is relative to a person's or population's current health status. To purchase for health gain it is necessary to have information about both the prevalence and severity of illness and of the situations which are associated with bad health such as poor housing, poverty, and unemployment. Information is required about the incidence of health problems and illnesses and about the degree of severity within the incidence. Such information is essential to decide what proportion of resources to allocate to different areas to try to achieve the maximum overall health gain for a population. Needless to say, information in some of these areas is lacking or incomplete in respect of local populations.

Evaluation of effectiveness of treatments and services drawing on outcome and cost benefit evaluation
Medicine is an inexact science. It has proceeded largely on the basis of custom and practice rather than according to what has been demonstrated empirically to work. It is self-evident that there is no point in purchasing treatments or services which are known to be ineffective. Health gain in the individual case is relative to what a person's global health status would otherwise have been

without an intervention. Some health education or preventive services are very effective. If a person already has a disease or illness they will achieve a health gain if they receive a curative treatment. However, a cure may be temporary, may have side effects which reduce overall health status, or may simply prevent or reduce further deterioration. Not only are some treatments or services more or less effective than others but their costs are different. Purchasers need to know the relative cost-effectiveness of different interventions in the individual case and for populations for each condition or health problem. To purchase for health gain, purchasers are required to make judgements about effectiveness, cost-effectiveness and cost-benefit. These judgements need to be better informed both by evaluation research and by knowledge of social values.

After establishing what needs exist and identifying the range of policies and services that could improve health status, purchasers must choose between different combinations of resources producing different bundles of health gain for different people, for different areas, and for sufferers from different conditions. This crucial step is essentially and unavoidably political involving value judgements in the exercise of choice. There is an issue about whose values should count – those of clinicians, politicians, managers, the public? Probably some combination of them all is desirable but collecting these and then sorting out whose values should be uppermost in decision-making are matters with which purchasing authorities are only beginning to come to grips.

Social value prioritising – the social value and importance the public attaches to certain treatments and services

A sometimes overlooked though critical aspect of purchasing for health gain is that of including social value judgements in purchasing decisions especially in rationing or priority-setting decisions. There are different ways to do this but the need to do so and to involve the public is unavoidable as the pressures on health expenditure increase and more challenges are made to purchasers' decisions. There are democratic and ethical reasons for involving the public in these decisions but if decided entirely by local communities the principle of national equity is undermined. Whether this in fact matters when the reality has always been considerable variation in health services across the country is arguable.

Some evaluations try to include social evaluations of the benefits of treatments. One such method is the QALY – Quality Adjusted Life Year. Cost utility approaches and methodologies have been criticised on ethical and technical grounds. Some observers regard them as an invalid instrument for making appropriate decisions. Among the arguments advanced are those listed in **Problems with QALYs**. There are many health decisions that can only be decided by value choices which demand public debate and political discussion. There is nothing new in this view. Since the NHS began, decisions about resources have involved choices and priorities. The language may have changed, but not the process or practice of priority-setting and exercising choice.

Problems with QALYs

- The technical base upon which QALYs have been formed is inadequate and potentially flawed.
- The variability of valuations across different individuals gives rise to problems of aggregating results.
- QALYs are inherently ageist with greater values being attached to younger people.
- There is a problem over the meaning of information and the approach is unable to capture the dynamic and changing nature of people's views about their health state.
- The approach equates need with ability to benefit and greater importance to duration of life (life years) than to life itself.
- QALYs do not distinguish between treatments that are life enhancing (like hip replacements) and those that are life saving (like renal replacements) and there is an attempt to equate them in some way.
- QALYs potentially impact on the civil rights of individuals in terms of access to health care.

From the above disaggregation of the components of health gain, it can be shown to be a composite of a number of key elements evident in the NHS reforms and in the health strategy, *The Health of the Nation*. There is the focus on health outcomes, the matter of efficacy and disentangling good from bad medicine and, finally, there is the commitment to involving users and the public in discussions about priorities.

Health gain in essence is regarded as being primarily concerned with supporting health interventions that have a demonstrable or measurable impact on the health of the population. A crucial question arises over how a particular impact is to be measured. Two concerns in particular would be, first, the risk of the measurable being accorded a greater weight than the non-measureable or difficult to measure and the consequent neglect or dismissal of qualitative measures which may be less precise than quantitative ones; and, second, the extent to which the measures themselves would be sufficiently challenging in order to bring about real change in the allocation of resources to health care and the delivery of such care. In short, there are issues over who controls the health gain agenda and over whose definition of what constitutes improved health predominates. The notion of health gain has given a new lease of life to public health specialists to influence and shape the policy agenda in their local health authorities although this has given rise to some jostling for position and ownership between public health medicine and general management.

Whatever the difficulties arising from the opacity of the notion of health gain, its strength lies in its attempt to take health outcomes seriously and redirect the attention of policymakers, managers and practitioners from inputs, services and the infrastructure of health care delivery. These are now the predominant concerns of providers, although they cannot afford to neglect a health gain perspective. The central appeal of health gain lies in its thrust to put health before health care services, the logic of which requires a reorientation on the part of decision-makers to think more holistically about the health needs of their local communities. Health policy in Britain has been dominated by an unhealthy concentration on health services. The NHS has diverted policy thinking away from a broader view of health and the appropriate policy instruments available to promote and sustain it. Even the Government's health strategy and its key targets is largely derived from and constructed around the NHS and acute services.

Priorities in Wales

- Maternal and child health
- Mental handicap
- Injuries
- Emotional health and relationships
- Mental distress and illness
- Respiratory diseases
- Cardiovascular diseases
- Cancers
- Physical disability and discomfort
- Healthy environments

Health Gain in Practice

The term health gain appears to have originated in the Welsh Office's strategy for improving the health of the Welsh people. It is the key criterion set out in *Caring for the Future: The Pathfinder*, for judging the effectiveness of the NHS in Wales, the aim being to maximise the health status of the people of Wales, within available resources. The Welsh Office's interpretation of health gain is that it is centred on undertaking interventions which, borrowing from the WHO's *Health for All* initiative, both add years to life and life to years. It explicitly takes health status and social class inequalities into account in this endeavour, although it is unclear in the present political context how far such inequalities will be tackled or seen as a top priority. Indeed, there is a positive and quite explicit recognition that social groups with poorer health status require a disproportionate amount of resources to be directed towards them to meet their greater needs. For instance, *Cardiovascular Diseases: A Protocol for Investment in Health Gain* observes that there are socio-economic differences in mortality due to cardiovascular diseases. 'Deaths due to coronary heart disease are a third higher in manual than in non-manual workers'. The protocol continues:

> *The NHS is a powerful resource and has done much to address the imbalances between social groups. In Wales, however, there remain avoidable differences in health status. The use of health facilities also varies, whether defined by geography, income, gender or ethnicity.*

There is also an acknowledgement that non-manual groups draw more heavily on preventive services than manual groups who need them more. Through tackling these imbalances the 'inverse care law' is directly confronted.

In Wales, therefore, the pursuit of health gain is unequivocally identified as the prime driving force and the key criterion for judging the effectiveness of new investment proposals and existing activity. Through the health gain approach, 10 protocols are being produced – **Priorities in Wales** – which set out to identify where further improvement could bring worthwhile health gain. They also indicate where current practices are questionable and where reinvestment might be considered a viable policy option. Most important, however, is the suggestion that being concerned about health gain shifts the attention of health managers away from an exclusive focus on health services and towards other factors and influences on health that require the fostering of healthy alliances across agencies and policy spheres. As *Caring for the Future* puts it:

> *As the protocols and the local strategies draw on clinical, managerial and policy expertise, their development has signalled the start of the process aimed at transforming the culture of the NHS from one tied to an institutional and service-based sickness system towards a health system, driven by health need.*

This has meant a recognition that the aim of the health service is to achieve improvements in health, not just to increase activity or meet demand.

Elsewhere in the UK, health gain has also entered the 'common currency'. For instance, the Government's health strategy for England, *The Health of the Nation*, is 'founded on selected key areas where there is both the greatest need and greatest scope for making cost-effective improvements in the overall health of the country'. The five priority areas are:

- coronary heart disease and stroke
- cancers
- mental illness
- HIV/AIDS and sexual health
- accidents

It is anticipated that success in these areas would represent health improvements in terms of life expectancy, reductions in premature death and improvements in quality of life.

The strategy explicitly acknowledges the distinction between improving and maintaining health on the one hand and providing health care on the other. While the role of the NHS as the principal provider of health care is a crucial one, it is recognised that the NHS must work with others to initiate and develop common strategies and targets and to form 'healthy alliances' with agencies, notably local authorities.

The Scottish Office's policy statement, *Scotland's Health: A Challenge to Us All*, follows the lead given by England. It, too, emphasises that improving health cannot be achieved by the NHS in isolation but requires the combined efforts of many agencies.

These fine words in both the English and Scottish documents are laudable. Unfortunately there is now a sizeable literature which belies the sentiments conveyed in both documents and challenges the likelihood of achieving effective alliances across central government departments or across local agencies. The history of central government is essentially about departmentalism not about interdepartmental working. Fierce ownership of areas of policy by departments has resulted in a myriad of interdepartmental committees but these appear designed less to promote cross-departmental working than to provide a mechanism through which to defend departmental interests. The network of committees is in place to preserve the status quo, not to promote change in collaborative working.

At a sub-national level, regional health authorities and commissioning agencies are also adopting a health gain approach. For example, Trent RHA's health gain investment programmes are strategic statements of desired patterns of service activities based on analysis of health needs and consumer views and reviews of the effectiveness and cost-effectiveness of service options. In short, the approach embraces the three aspects noted above. Each programme will generally fall into one of four categories depending on whether it relates to:

- a disease or disease group *eg* cardiovascular disease
- a client group *eg* children
- a lifestyle or environmental factor *eg* smoking
- a service area *eg* family planning services.

The sets of questions which health gain investment programmes are intended to generate are in **Health Gain: Key Questions**.

Yorkshire RHA's health strategy, *A Yorkshire Strategy for Health*, has three principal components. These are:

- a means to establish shared goals and clear objectives;
- a detailed and systematic analysis of the range of effective actions that can produce health gain for any given issue;
- a managed approach to the facilitation and support of collaboration within and between organisations to maximise the achievement of the potential for health gain that has been demonstrated.

The Yorkshire strategy for health, which remains at the consultation stage, is inclusive rather than exclusive. It acknowledges the need to encourage a wider view of 'health' amongst individuals and agencies, to recognise variations in health in different localities across the region, to identify health gain opportunities created by other economic and social developments, to develop a strategic framework which combines these and other perspectives and stimulates effective action based on measurable health gain targets.

Following the review of the intermediate tier, regional health authorities in their slimmed down form will be responsible for managing purchasers and for delivering on public health objectives. Their role in developing purchasing and successful purchasers is therefore likely to grow and assume greater importance.

Health Gain: Key Questions

- How big is the problem?
- What possible health promoting, preventive, therapeutic or rehabilitative strategies could be pursued?
- How effective are each of these options?
- How expensive are they?
- How many local people might benefit?
- What services will produce the greatest improvements in health?
- Is everyone agreed that these are the priorities?
- What practical obstacles and opportunities are there for introducing these changes?

Source: Strategy for Health, Trent Regional Health Authority.

Some Implications

At the level of strategic intent and general aspiration, health gain is at the centre of thinking in health authorities and their published strategies. It is too early to be confident of the sustainability of a health gain approach over time. The approach remains extremely fragile and somewhat nebulous. As has been shown, progress has gone furthest in Wales where the commitment to health gain at the 'top of the office' is much in evidence. The NHS Management Executive in England has not displayed quite the same leadership although the pressure now exists on it to do so. The Secretary of State for Health has instructed the Executive to concentrate on ensuring that purchasers set strategic directions and make tangible year on year progress towards strategic goals. But it remains the case that developments outside Wales are at a much earlier stage and have yet to demonstrate a positive impact on priority setting and resource allocation decisions. The position is unlikely to change dramatically over the next few years.

There are two emerging concerns which are likely to have a key impact on developments in the NHS. First, is the extent to which the term 'health gain' risks being hijacked by those who are exercised about other concerns, notably cost control and rationing and the need to deliver quickly on the Government's health strategy. Second, is the realisation that health gain goes far beyond the NHS in terms of the activities of other agencies and of other policy fields impacting on health status. In this situation the role of the NHS both as a direct contributor to the health gain agenda and as an enabler of the efforts of others remains ill-defined.

A health gain approach, as demonstrated above, contains many positive features but is still new for health authorities which have yet to adopt a mind set which makes a distinction between health and health care. The fragility of the notion leaves it vulnerable to corruption. The concept is being used to characterise the purchaser's role as one of purchasing for maximum health gain for the lowest cost, within the resources allocated. The risk is that purchasers become preoccupied with expenditure control and operational issues rather than with the more complex and strategic task of purchasing for health gain. There is nothing inherent in the health gain approach which makes such an interpretation of its purpose inevitable, but it remains a danger in the current health policy context in which managers are desperately seeking solutions to problems of establishing health outcomes, effective health care and so on, and are attending to the matter of disinvesting in services where this can be shown to be appropriate.

Entangling health gain with the rationing debate and with the need to demonstrate quick results in health investment could lead to pressures to act in a discriminatory manner in terms of who gets and does not get treatment. This in turn could result in a form of adverse selection in respect of the purchasing decisions that health authorities make. In essence, there could be a bias in favour of the 'worried well', that is, fit and healthy younger people who make few demands on health services, at the possible expense of older people and the long term chronic sick for whom achieving positive results adopting a health gain approach though not impossible may take longer to achieve.

The risk of 'upward drift' in the allocation of resources is linked to the concept of demonstrable and measurable gain. It may be easier to provide robust evidence in some areas but not in others thereby further skewing the process of determining priorities. At present, there is an absence of empirical data on health outcomes, *ie* on what contributes to them and on how they can be improved. Work in this area is still in its infancy and while the Department of Health is investing in initiatives designed to remedy the knowledge gap there is much to be done. In this situation, moving away from meeting needs to pursuing healthy outcomes is something of a gamble in the absence of reliable data. For this reason, initiatives like the series of effective health care bulletins produced by the Nuffield Institute for Health at Leeds University, the UK Clearing House on Health Outcomes, also based at Leeds University, the Central Health Outcomes Unit in the Department of Health and the joint Chief Medical Officer's and Chief Nursing Officer's Clinical Outcomes Group, are to be welcomed. There is no point in purchasing treatments or services which are not effective. Yet we are some way from being able to say with confidence what is good or bad medicine. Only 10-15 per cent of medical procedures have been rigorously evaluated for their efficacy. Better information on health outcomes and on what works and what does not work ought to inform decision-making in order that only interventions of proven efficacy are funded and best medicine nurtured.

The scope for redeploying resources from ineffective procedures and practices is considerable and getting a grip on this issue would seem to be a higher priority than talk of rationing. The notion of health gain is pivotal to this reorientation from health care inputs to health outcomes. It is also central to a refocusing of health authorities' efforts and energies on a broad conception of health rather than health care. The Secretary of State for Health is also committed to giving greater attention to outcomes. In a speech to a BMA conference on 11 March 1993, she said:

> *Before we can be confident that we are using resources appropriately, we need to have a much better knowledge of the outcomes of clinical interventions. Previously common treatments have been demonstrated to be either ineffective or over-used – for example, grommets or tonsillectomies. At the same time, we need to understand more clearly the health gain that can be obtained from different procedures – for example, hip replacements or medical treatments for leukaemia.*

In order to make a reality of the concept of health gain, it is necessary for there to be an effective research and development strategy in place. Health services must, in the words of the *Research and Development Framework for NHS Wales*, be 'knowledge-driven and evaluation-based'.

But improving health outcomes and effectiveness may not be the sole criterion of evaluating health system performance. People may also value other aspects such as a health service which seeks to help people in need even if the probability of success is low. While heroic, life-saving interventions may score low on a QALY index or on some other cost-utility measure, this will not stop people believing that everything possible should be done to preserve the life of a child, or that an infertile couple should have access to assisted conception services. Therefore, a strict adherence to a health gain approach may conflict with publicly held views which wish to see services offered or attempts made to save lives regardless of the expense involved or likelihood of success. And who is to say they are wrong?

The second main concern over a health gain approach lies in the knowledge that the NHS is only one of many agencies influencing the health status of the population and perhaps not even the most important. A genuine commitment to health gain could mean switching resources from mainstream health services and allocating them to other services or policy initiatives. There are issues, however, about whose responsibility it is to make these resource shifts and about the extent to which the NHS is seen to be taking the lead role in this area. If it is entrusted with a lead role, what incentives will it have to enable it to agree to a shift of resources out of health services and into something else? Or is the role of the NHS simply to get the issue of health onto the agendas of other agencies without putting its own resources into them? There remains considerable uncertainty over such matters.

Meantime, the entire health gain focus is rather unclear because of the perception throughout the NHS that the Government's commitment to purchasing is lacking, may be short-lived and may not be that serious. Unless confidence is perceived to exist, the entire health gain approach will become a victim of the rhetoric which passes for policymaking in the NHS. Underlying this dilemma is a central contradiction between the notion of health gain based on principles of collaborative working and collective responsibility, and the fostering of an internal or provider market in the NHS based on principles of competition and individual responsibility. The two policy streams do not appear mutually consistent, with the focus on markets likely to result in increased fragmentation which the attention to a collaborative response to health problems seeks to minimise or, ideally, overcome.

Concluding Comment

Health gain may be said to be a wholly desirable and useful concept when directed to establishing health outcomes and to looking more broadly in respect of influences on health rather than health care services alone. But there does seem to be a need to avoid the concept being corrupted by, or slavishly linked to, rationing approaches or to economists' methodologies which are of less scientific value than is often professed to be the case.

Health gain is not a panacea for the problem of deciding priorities or of establishing what works or does not work in medicine as far as improving health status is concerned. At this stage in its development it can offer little more than a framework within which to bring together and consider the issues reviewed in this chapter. A key element of this framework is the acknowledgement that effective developments in health demand a multidisciplinary response – they are not the preserve of a single discipline or body of knowledge. Indeed, the integrating, synthesising focus of health gain may constitute its chief appeal for those anxious to mobilise healthy alliances which deliberately seek to blur professional and organisational boundaries.

The principal challenge confronting advocates of a health gain approach is whether or not it can deliver on its promise to bring about a paradigm shift in health care or whether those pursuing it will continue to be diverted by the short-termism of a highly politicised environment in which operational tactical concerns, as opposed to strategic ones, ultimately prevail.

PURCHASING, PRIORITIES AND RATIONING

Ray Robinson

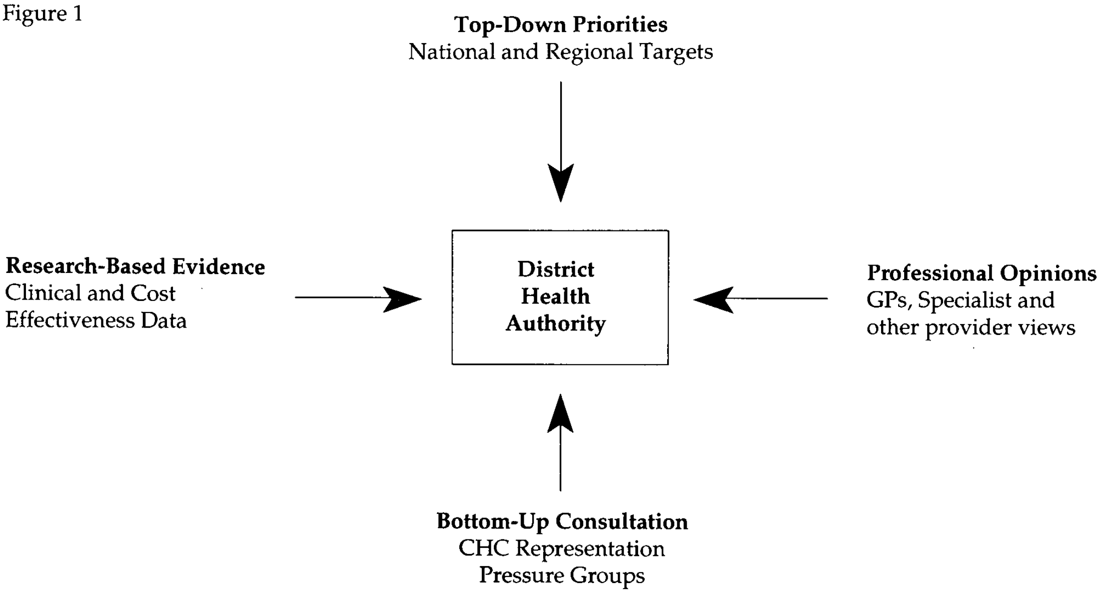
Since the implementation of the NHS and Community Care Act in April 1991, district health authorities have acquired major new responsibilities as purchasers or commissioners of health care. They are now responsible for assessing the health care needs of their populations and commissioning a mix of services which best meets these needs. As before, however, the NHS remains a cash-limited service and so this task has to be carried out within the confines of fixed budget constraints. And, because these budgets will never be sufficient to meet all of their population's health care needs, a series of choices has to be made about which services are commissioned, in what quantities and for whom. The assignment of explicit responsibility for these decisions to district health authorities is one of the main reasons for the heightened awareness about the need for prioritisation and rationing in the NHS.

This article reviews the development of prioritisation and rationing in relation to the district purchasing function. It looks at progress over the first two years of the internal market and considers prospects for the future. One of its main messages is that wider adoption of the standard evaluative framework used by economists offers the prospect of more efficient decision making. Through the clarification of choices and systematic collection of information, this framework provides a powerful aid to the organisation of thought and evidence. It is important to realise, however, that there will always be a number of different inputs to the health authority decision making process and that economic evaluation will need to be used in conjunction with these and not as a replacement for them.

How Do Health Authorities Decide?

District health authorities operate within an environment in which different inputs are drawn upon in determining purchasing decisions. Figure 1 groups these inputs into four main categories: top-down priorities; bottom-up public consultation; professional opinion; and research-based evidence.

Figure 1



Defining Terms

Prioritisation involves ranking activities in terms of their relative importance according to some pre-determined criteria. Over the next few years, a major objective for most health authorities is likely to be the maximisation of their population's health gain (*ie* improvements in health) subject to the condition that this gain is distributed between individuals, user groups and localities in a way that is considered fair or socially just. As such, services are likely to be prioritised in terms of their contribution to this objective.

Rationing refers to any mechanism for allocating goods and services to users when the sum of their wants exceeds the available supply. As this condition is likely to apply to practically all commodities, some form of rationing is inevitable. This highlights an important fact: namely, rationing is a universal practice, even though the instruments for carrying it out may vary between time and place.

The two activities of prioritisation and rationing come together when public sector decision makers – such as health authorities – prioritise services and then, in the light of limited budgets, ration them between alternative users.

Top-Down Priorities

Despite the emphasis placed upon the decentralisation of responsibility through the NHS reforms, there are still some important nationally defined requirements that health authorities are expected to meet. Thus the 1993/94 priorities and planning guidance issued by the NHS Management Executive – EL (92) 47 – identifies three top priorities set by ministers for the service. These are:

- implementing *The Health of the Nation* strategy,
- ensuring high quality health and social care in the community, in partnership with local authorities,
- developing the *Patient's Charte*r at the national and local level.

Over the past year, the need to respond to patient charter standards, particularly in relation to the required reductions in the number of patients waiting over two years for operations, has dominated health authority short-term policy. In the coming year, national targets and objectives for health improvement set out in *The Health of the Nation* can be expected to exert a similarly strong influence.

On presenting *The Health of the Nation* to Parliament on 8 July 1992, the Secretary of State emphasised the compatibility between national and local targets:

> *The priority areas we have selected and the targets we have set match local needs and concerns. The* NHS *Management Executive will require health authorities to build the target setting approach into all levels of local activity. The strategy will become central to the work of the* NHS.

Doctors Pass Back the Buck

Traditionally, rationing in the NHS has only been partly visible to the general public, given the way in which it has been undertaken by politicians, managers and clinicians. The role of individual clinicians has been crucial in this respect. Their decisions about who is treated, when and how are supposedly based upon patients' needs and clinical considerations but, as Aaron and Schwarts have pointed out, they have also been influenced by doctors' awareness that they have to prioritise and ration services in the face of limited resources:

> *The British physician often seems to adjust his indications for treatment to bring into balance the demand for care and the resources available to provide it. This kind of rationalisation preserves as much as possible the feeling that all care of value is being provided ...*
>
> *Most patients in Britain appear willing to accept their doctor's word if he says that no further treatment of a particular disease is warranted.*

Renal haemodialysis is a frequently cited example of this phenomenon. The decision in Britain to emphasise home dialysis and kidney transplantation in preference to far more costly hospital dialysis can be defended on grounds of clinical and cost effectiveness for younger patients suffering from kidney disease. However, these therapies are often inappropriate for elderly patients, many of whom are, therefore, considered unsuitable for treatment because the hospital option has not been made available. Thus, rationing of patient care takes place under the guise of clinical judgements by doctors who are aware that prior resource allocation decisions mean that there are insufficient resources to treat all patients' needs.

In fact, doctors' reluctance to continue to act as covert agents of rationing is yet another factor leading to calls for greater explicitness and openness in decisions governing the allocation of resources. At a special Representative Meeting of the British Medical Association held on 26 March 1992, the following resolution was passed:

> *That this Meeting accepts that rationing of health care is inevitable and that Government must be pressed by the* BMA *to accept their responsibility for rationing decisions and to invite all interested parties, not least the public, into a debate to define mechanisms by which equitable rationing may be applied.*

On the same day, the NHS chief executive announced that regional *Health of the Nation* co-ordinators were being appointed and that the Management Executive would build health targets into its corporate agreements with the regional health authorities and into its systems of accountability at all levels of the service.

While a close association between nationally defined targets and local needs can be expected in many areas, this will not invariably be the case. Although ministers have recognised the need for targets to take account of local variations, it remains to be seen how far this will be permitted. Certainly, the main parameters of the policy constitute a clear example of top-down priority setting. Moreover, through the specifications included in regional and district corporate contracts, there is now a clear line of accountability, from the Executive down to district purchasers, for working towards the achievement of these targets.

Bottom-Up Public Consultation

Bottom-up public consultation adopts the opposite perspective to top-down priority setting. It involves drawing on the views of local people as part of the process of determining priorities. *Local Voices*, published by the NHS Management Executive in January 1992, suggested ways in which health authorities should go about this task. In particular, it emphasised that there needed to be a move away from one-off consultation exercises towards on-going involvement of local people in purchasing activities. This was seen as involving a combination of information dissemination, dialogue, consultation and reporting at different stages of the purchasing cycle.

A perennial problem with public participation in public sector decision making is, of course, obtaining views that are representative of the population at large from the necessarily limited number of people who are able to be consulted. *Local Voices* recognised that there is more than one 'local public' and suggested that a cross-section of views should be obtained from people in different geographical locations, age groups and from different socio-economic and ethnic groups. Leaders of local opinion *eg* politicians, voluntary organisations, Community Health Councils and service users – past, present and potential – were also identified as sources of local input.

Over the last year, many local initiatives building upon these principles have been developed. It is, however, worthwhile stepping back from the detail of the consultation methods in order to ask: how exactly will the information collected be used in determining priorities? In this connection, it is worth dwelling upon this aspect of the much discussed prioritisation process which took place in the US state of Oregon.

As part of its prioritisation methodology, the Oregon Health Services Commission used a non-profit organisation, Oregon Health Decisions, to establish community values in relation to health care. Accordingly, 47 community meetings were held throughout the state at which 1,048 people participated. At each meeting, small group discussions were held which required the participants to make individuals judgements about priorities in health care, to engage in discussion which sought to identify the values underlying their personal priorities, and to establish a set of key, shared values about health care.

This process has been subject to some criticism, not least because of the unrepresentativeness of the people who attended the meetings: almost 70 per cent of them were mental health and health care workers, one-third had incomes of $50,000 or more and two-thirds were college graduates. It is, however, difficult to see how – with the resources at its disposal – the NHS is going to be able to surpass Oregon in terms of the efforts it made to engage the public and to establish their values. Oregon Health Decisions was extremely professional and thorough. If it failed, the prospects for the NHS are also poor.

Oregon

The description in the text of the way the Oregon experiment operated is taken from M J Garland's chapter in *Rationing America's Medical Care: the Oregon plan and beyond*, edited by M A Strosberg and others, (The Brookings Institution, 1993). Information on the characteristics of the people attending the public meetings is given in an article by Dan Fox and Howard Leichter, *Rationing Care in Oregon*, Health Affairs, Summer 1991

Even more serious, though, is the question of the impact that the community values actually had on the prioritisation process. According to Oregon Health Decisions, although the connection between the community values and the prioritisation list is not easily traceable, the values were drawn upon alongside the 'commissioners intuitive habits of thought and … the literature on health care' in drawing up the ranked list of 17 broad categories of treatment into which the eventual 709 individual disease-treatment items were allocated. Against this view, however, individual commissioners have claimed to the author that the community values had little impact upon the rankings they produced. Their justification for the process is that it was extremely important in legitimising the rationing methodology in the eyes of the general public. If such a complex exercise was indeed primarily concerned with providing legitimisation rather than substantive public inputs, this surely sounds a warning for the NHS. If the purpose of public consultation is genuinely about using public views and opinions to shape the future development of services, mechanisms will need to be developed to make sure that information obtained is used in this way. As things stand at the moment, few health authorities have been explicit about how this will happen.

Professional Opinion

In the past, patterns of health service delivery have been heavily service or provider led; that is, health service professionals have exerted a major influence on what is provided and how it is provided. Expert opinion and judgement has played a prominent role in this process. One of the main aims of the purchaser/provider split is to break down this hegemony. Purchasing authorities are expected to act on behalf of their resident populations and to ensure that their interests – rather than simply those of providers – are met. Demand is expected to lead supply.

It would be a mistake, however, to take simple market analogies too far. For one thing, at the service delivery level, there is often no conflict between professionals' and users' interests. Both have a shared concern in good quality care. The absence of financial transactions, such as those found in a fee-for-service system, removes an important, potential source of conflicting interests. Moreover, there are a number of areas where professional opinion will still be relied upon by purchasers as a basis for formulating their own plans. For example, it is well-known that because of patients' relative lack of information about many aspects of health care, they rely upon GPS to act as their agents. And already it is clear that health authorities are being far more active in seeking GPS' opinions about what services their patients require than was the case before the NHS reforms were introduced. Rudolf Klein and Sharon Redmayne in *Patterns of Priorities* (NAHAT 1992) report that GPS' views on service quality, quantity and access was the most frequent source of consultation undertaken by health authorities in drawing up their purchasing plans for 1992/93. GP fundholders, of course, offer a rather different but even more direct example of the combined role of professional opinion and the agency relationship in purchasing.

Yet another area where professional opinion – this time from the provider side – can be expected to inform purchasing decisions is in relation to innovation and new technologies. Within purchasing authorities, the main source of medical advice will come from directors of public health and their professional colleagues. In many cases, however, they will rely upon experts in particular specialties for advice on clinical matters. This is likely to be particularly true in the case of new techniques and practice styles where innovations will usually be provider led.

Research-Based Evidence

Research-based evidence on the effectiveness of different programmes and procedures is likely to be increasingly drawn upon as an information source by health authorities in the prioritisation of services. This evidence falls into two main categories; namely, information on clinical effectiveness and evidence on cost-effectiveness.

Assessing clinical effectiveness is often hampered because, in the case of many health programmes, there are no clear measures of outcome. This means that it is impossible to say whether or not the service is actually effective in improving the patient's health. This uncertainty has given rise to large variations in clinical practice, with the same conditions being treated in different ways by different doctors and hospitals. Even in those cases where there is consensus about the best methods of treatment, this information is not always known or accepted by all doctors, with the result that ineffective or inappropriate treatments often take place. Even more serious problems of establishing the effectiveness of services and the appropriateness of them for individual patients apply in the case of community services. Services such as those offered for people with mental illness or the care of the elderly are frequently long-term processes and not amenable to simple outcome measurement.

The difficulties of measuring outcomes and effectiveness are, of course, well-known and there are many initiatives centred around peer review, medical audit, consensus conferences and other professionally-led activities designed to increase information and improve performance. From the purchaser's perspective, however, there are two recently launched central initiatives designed to increase the level of information at their disposal that are worthy of note.

First, the Department of Health has commissioned a series of bulletins on the effectiveness of health care interventions in order to assist decision makers. These bulletins are being produced jointly by the School of Public Health, University of Leeds and the Centre for Health Economics, University of York in collaboration with the Research Unit at the Royal College of Physicians. Each bulletin is devoted to a particular disease, disability or therapy and takes the form of a literature review, a summary of findings, and advice to health purchasers. To date, four bulletins have been produced. These cover population screening for osteoporosis, stroke rehabilitation, the management of sub-fertility and the surgical management of persistent glue ear in children. Future areas to be covered include depression in primary care, cholesterol lowering mechanisms, the management of alcohol misuse and coronary artery bypass grafting and angioplasty.

The approach adopted by the bulletin teams places considerable emphasis on the presentation of complex information in a way that is accessible not only to public health specialists but also to general managers and directors of contracting. Around 30,000 free copies of each bulletin are distributed widely within the NHS. While it is known that disseminating information is rarely sufficient to bring about change in clinical practice, the bulletin approach differs from any previous strategies because it aims to influence clinical practice through purchasing activity.

Early evaluation of the impact of their work by the bulletin team reveals a promising picture. A postal survey of 237 general managers, directors of public health and directors of contracting carried out in January 1992 indicated that two-thirds of the 172 respondents had read all or part of the first report on osteoporosis screening. More importantly, over three-quarters of them indicated that they felt 'confident to act' on the information contained in the bulletin. In fact, one-quarter of them reported that they had already used the bulletin in situations related to the purchase of services for bone density screening. However, one impediment to the effective implementation of decisions based upon bulletin information noted in the evaluation exercise relates to the broad-brush nature of most existing contracts. In the case of glue ear, for example, the bulletin suggests that the rate of surgery should fall by as much as 30 per cent and yet the majority of contracts for ENT are presently in block form, with only 4 per cent of purchasers including any detailed content. Clearly, the successful implementation of clinical guidelines will require more detailed contract specifications in the future.

The second Department of Health-sponsored initiative aimed at improving the intelligence available to purchasers has involved setting up a UK clearing house for information on the assessment of health outcomes. This is also based at the University of Leeds and is being developed in association with the research unit of the Royal College of Physicians. The clearing house aims to act as a focal point for the exchange of information on health outcomes and to provide critical reviews of outcome measures and methods. At the moment, the project is still in its initial stages of development but its future work programme is planned to include quarterly newsletters, bulletins providing updates about database material, seminars and workshops, and networks to facilitate the exchange of ideas, experience and information between researchers and practitioners.

Over time, the Effective Health Care Bulletins and the Outcomes Clearing House can be expected to provide purchasers with better information on the clinical aspects of the services they are seeking to commission. However, the pressures of limited budgets will mean that they will also need to be concerned with the cost-effectiveness of alternative programmes and procedures. Once again, reliable information is sparse (although the Effectiveness Bulletins also include available evidence on cost-effectiveness). In recent years, however, there has been a fairly rapid rate of growth in health economics research on methods of economic evaluation, and this has the potential to assist purchasers faced with a need to make choices subject to resource constraints.

To date, four main methods of economic evaluation have been applied in different health care contexts: namely, cost analysis, cost-effectiveness analysis, cost-utility analysis and cost-benefit analysis: see **Methods of Economic Evaluation**

From among these alternative methods of economic evaluation, most interest has probably centred on the development of cost-utility analysis. Certainly, this technique seems to offer the most potential for setting priorities on the basis of the relative efficiency of alternative health care options (measured in terms of their respective marginal cost-utility ratios) because it measures the outcomes of different procedures or programmes in common units. By placing options within a comparative context, *eg* a QALY league table, the approach highlights the economic objective of seeking to shift resources away from activities which are expensive in relation to the health benefits they generate towards activities which are of relative low cost.

In practice, however, the adoption of cost-utility analysis for policy purposes suffers from a number of drawbacks. On one level, there have been numerous criticisms of the philosophical basis of QALY measurement and the

Methods of Economic Evaluation

Cost Analysis

Cost analysis has been applied when there is reason to believe that the outcome of the options under consideration are the same so that attention can focus on the choice of the least costly option. Comparing day surgery with in-patient treatment for cataract removal is one example.

Cost-Effectiveness Analysis

Cost-effectiveness analysis has been applied widely where alternative procedures or programmes are expected to have different outcomes, but the outcomes can nonetheless be expressed in common natural units. Life years gained through alternative treeatments for renal failure, 'health days' achieved through alternatibe drug therapies for duodenal ulcers and 'positive cases detected' via diagnostic and screening procedures are all examples of the application of cost-effectiveness analysis.

Cost-Utility Analysis

While information provided through cost-effectiveness analysis can be extremely useful in clarifying choices between alternative treatments for particular diseases or disabilities, it is limited in its ability to assist choices between treatments for different diseases, or between programmes, because the units of outcome vary. Moreover, cost-effectiveness analysis is not able to combine reductions in morbidity and reductions in mortality into a single index. This prevents direct comparison between treatments and programmes that vary on these two dimensions. Because of these and other limitations, a considerable amount of work has been devoted to the development of cost-utility analysis over the last ten years. Cost-utility analysis uses a single measure of outcome that combines both quantitative and qualitative aspects of health gain and thereby enables comparison of options over a wide range of disparate services. The most common measure used is the quality adjusted life year (QALY).

Cost-Benefit Analysis

Cost-benefit analysis is sometimes used loosely as a generic term covering all types of economic evaluation. Within health economics, the term is usually restricted to those forms of evaluation which seek to place a monetary value on benefits or outcomes. This may be achieved by asking how much people would be willing to pay for a hypothetical cure for, say, rheumatoid arthritis by asking them what per cent of their family's total monthly income they would be willing to pay on a regular basis for a complete cure.

methodology it employs. At different times, the approach has been accused of, *inter alia*, discriminating against elderly people, disregarding equity considerations and dressing up value judgements as objective science.

At another level, data limitations mean that there is presently insufficient reliable evidence upon which to base actual policy choices. For example, Karen Gerard, in her 1991 *Review of Cost-Utility Studies*, was able to identify only 51 studies in the English language literature. After a comprehensive evaluation of these studies based upon a set of carefully defined criteria, she concluded that one-third of them were of poor quality and a further 10 per cent were not worthwhile given the nature of the choices they examined. Moreover, all of these studies were heavily concentrated upon medical interventions and none of them examined the important policy areas of mental health or community care more generally. In fact, attempts by researchers to influence the policy process on the basis of their results were extremely rare: only nine studies had been explicitly brought to the attention of policy makers.

A closer link between cost-utility analysis research evidence and policy making was one of the aims of the Oregon experiment previously discussed in the context of public participation in decision making. As part of its initial methodology, Oregon carried out research in order to rank some 1,600 condition/treatment combinations in cost-utility terms. To do this, quality of well-being scores for 30 different states of health and activity were obtained via a random digit dialled telephone survey of 1,000 Oregonians. These scores were then assigned to different condition/treatments, and combined with the expected duration of benefit, in each case, in order to obtain QALY measures. Costs were derived from Medicaid records on average charges. Cost and QALY data were then combined to calculate costs per QALY.

The resulting list – which was produced in May 1990 – produced some strikingly unexpected results. The repair of crooked teeth ranked more highly than the treatment of potentially fatal Hodgkinson's disease. Re-constructed breast surgery was considered more important than surgery for open fracture of the thigh. Tooth capping was rated more highly than surgery for ectopic pregnancy or appendicitis. Overall, many procedures expected to rank highly were assigned low rankings, whereas intuitively less important procedures received higher rankings.

Difficulties in obtaining reliable cost data and quality of well-being scores played a major part in the production of these counter-intuitive results. With little prospect of correcting for these shortcomings in the time available, the commissioners decided not to rely upon the cost-utility approach in the compilation of their revised list and ranked procedures solely in terms of their expected net benefit. Costs were only re-introduced into their calculations in the form of an aggregate budget constraint which determined how far down the prioritised list services would be able to be funded.

The decision to put aside cost utility analysis is worth emphasising because this aspect of the Oregon experiment is not readily apparent from some of the accounts of it reported in Britain. Far from being a positive example of the application of economic evaluation, the Oregon experience demonstrated the very real difficulties of applying the technique given the current state of the methodology and the standard of available data.

An Extended Role for Economic Evaluation?

In the light of these limitations, it is relevant to ask: what is the potential for the application of economic evaluation to priority setting given the present state of the science (or art)? The answer is that economic evaluation can still provide a powerful 'framework for thought' even if data are not available to enable application of the technique in its most sophisticated form. In particular, the economist's approach to priority setting emphasises two crucial aspects that, although they may seem self-evident, are often absent from NHS decision making, namely:

- all decisions should consider both the costs and benefits (outcomes) of the available choices,
- choices will usually need to concentrate on the margin – *ie* what are the consequences of expanding or contracting existing services – rather than the overall level of service provision.

Gavin Mooney and others have recently outlined an approach based upon these principles which involves the application of marginal analysis within a programme budgeting framework. The sequence of tasks involved in this approach is set out in **Steps in Priority Setting**.

Steps in Priority Setting

- Define programmes
- Estimate programme budgets
- Define sub-programmes
- Identify margins
- Draw up incremental and decremental wish lists
- Identify marginal costs/benefits associated with wish list activities
- Set priorities

Source: Gavin Mooney and others, *Priority Setting in Purchasing: Some Practical Guidelines*, NAHAT, 1992.

In essence, programme budgeting provides an information framework in which the services that are currently provided can be divided into 'programmes' – based upon reasonably homogeneous outputs – and their respective costs or expenditure levels identified. These programmes may be defined on a client group basis, *eg* services for people with mental illness or a disease group basis, *eg* renal services. Thereafter, programmes should be capable of sub-division into sub-programmes, *eg* a maternity programme could be sub-divided into pre-natal, labour/birth services, and post-natal sub-programmes. This subdivision is important because the approach will often pose questions about the possibility of shifting resources between sub-programmes. These intra-programme shifts will often be less contentious, and therefore more feasible politically, than shifts of resources between programmes.

An early experiment with this approach took place in the North Mersey Health Agency towards the end of 1992 under the leadership of Gavin Mooney. Two working groups – comprising senior executives, contracts managers, information and finance specialists and public health specialists from the four district health authorities and three FHSAS covered by the agency – were formed to consider priorities in relation to ischaemic heart disease and mental illness services. Both groups succeeded in identifying a sub-programme structure within their area, although this proved easier in the case of the ischaemic heart disease group than it did for the group dealing with mental illness services. Both groups also produced 'wish lists' which identified those services which they would choose to expand or contract if budget constraints were shifted at the margin. However, only the mental illness group was able to cost their list.

One of the most striking features of this experiment was that practical application of economic evaluation in the purchasing context is presently extremely crude compared with the theoretical ideal, and indeed, when compared with the forms of cost benefit analysis found in many other, non-health areas. Nonetheless, everyone involved with the project agreed that it clarified what was involved in making purchasing decisions, in particular, it made the trade-offs between alternative packages explicit *ie* what services of one kind had to be given up in order to have more of another. It also brought out the nature of the value judgements inherent in the choices agreed on *eg* the value attached to benefits from different services or to different groups of people.

Overall, the economic framework proved valuable, even in the absence of the detailed results which cost-utility analysis would ideally provide, in organising what information was available and clarifying what alternative choices entailed. As a result, the group leaders intend to persevere with the approach and to seek to use it to influence purchasing intentions for 1993/94.

Before moving on from discussion of the approach, it is worth dwelling on one aspect of Mooney's work, which he however has sought to emphasise, but which has brought him into conflict with the dominant public health approach to purchasing. This concerns the distinction between *total* and *marginal* needs assessment. Mooney and his colleagues have argued in a paper to the January 1993 meeting of the Health Economists Study Group, that the conventional public health approach, involving total health needs assessment through epidemiological studies designed to establish the incidence and prevalence of disease, is at best unnecessary and, at worst, positively harmful to purchasing decision making. Instead, they argue, what is required for making purchasing decisions is information on *marginal unmet needs*. This view is based upon the fact that the bulk of existing services are given and that changes through purchasing decisions will inevitably take place at the margin – a marginal expansion here, a marginal contraction there. To inform this process, all that is needed, it is argued, is information on marginal needs and this does not necessitate the much larger and more costly task of total needs assessment.

Within its own terms, the Mooney position is correct, but it sets up a false dichotomy because it defines the scope of purchasing too narrowly. Strategic planning requires health authorities to take a long term view and to do this they require some idea of the totality of their populations' unmet needs. Simply focusing on incremental change will be insufficient for these purposes. It is also worth emphasising that the marginal approach is solely concerned with efficiency; that is, the allocation of resources in a way that maximises health gain. If equity considerations are also taken into account, it becomes necessary to establish who is not having their needs met as well as those who are. Again, this requires information on total unmet need.

Another complication arises because of the complex pattern of co-morbidities that exist in the case of many diseases and disabilities. To establish these accurately, and to devise strategies to cope with them, requires population-based needs assessment. For all of these reasons, it will be necessary for purchasing decisions to be based upon elements of both marginal and total needs assessment. Mooney and his colleagues have performed an extremely useful function in pointing out that most decisions should be based upon assessments at the margin, but acceptance of this rule does not mean that information on total needs is redundant.

One final issue concerning the use of an economic evaluative framework in structuring purchasing decisions centres on the current scarcity of economics expertise within the NHS. Without this expertise, there is an obvious danger that methods of economic evaluation may be applied inappropriately, or technical evidence misinterpreted. The potential extent of this problem was revealed by answers to a postal questionnaire survey carried out by the King's Fund Institute during May 1992. This revealed that qualified health economists are a rarity at the district level. Of the 131 authorities that responded, only four reported employing a full-time economist, with another six employing one on a part-time basis: see Table 1.

Among those authorities without a specialised appointment, a number mentioned that other staff – particularly epidemiologists and public health specialists had acquired the necessary skills to be able to apply health economics techniques. A number of authorities also tend to draw upon outside consulting advice. The York Health Economics Consortium was cited by 24 districts as a source of such assistance.

Taken overall, however, it is striking that over half of

Table 1: Employment of Health Economists by District Health Authorities

	Number	Per Cent
Total	131	100.0
Full-time appointment	4	3.0
Part-time appointment	6	4.6
Appointment planned	16	12.2
No appointment planned	74	56.5
No appointment, plans not specified	12	9.2
Other*	19	14.5

* This category included: longer-term appointment possible (5); non-economists with relevant experience (8); currently training staff (3); possible appointment after district merger (2); looking for an epidemiologist with evaluative skills (1)

the districts that responded to the survey reported that they had used no in-house or external economics expertise to date. Neil Craig's and Andrew Walker's paper to the Health Economists Study Group meeting discusses some of the reasons why the NHS has not proved a popular employer for health economists in the past. They conclude that the current and future environment is likely to offer far better prospects for the effective deployment of economists' skills. Clearly, if methods of economic evaluation are to be drawn upon, this skills shortage needs to be addressed. Ways of doing this include making joint district appointments, establishing district consortia or resource centres and forming collaborative arrangements with academic centres.

Muddling Through Elegantly

The approach to decision making described in the previous sections is based upon greater explicitness about criteria for determining priorities than has previously been found within the NHS. The approach also seeks to draw upon the public's views in a systematic fashion and to introduce greater rationality into decision making through the application of methods of economic evaluation. There are, however, some analysts who are critical of these efforts. David Hunter in *Rationing Dilemmas in Health Care* (NAHAT 1993) provides an example of this school of thought.

Hunter is not convinced that greater explicitness in debates about prioritisation and rationing is necessarily desirable. In particular, he is wary about current attempts to increase public participation, believing that the public's views are often ill-informed and that participation is inherently inegalitarian. Furthermore, he argues that widening the debate about rationing could give rise to a new individualism or narrow utilitarianism which may weaken the collectivist ethos upon which the NHS is based. He is also concerned that openness and explicitness will lead to incrementalism and will inhibit imaginative innovation. Lack of visibility in decision making, he argues, may be necessary for the political paternalism required to overcome both consumer and producer lobbies.

Hunter is also sharply critical of the allegedly dominant role played by economists in rationing debates, especially those using cost per QALY calculations. He is distrustful of quantification which he believes leads to spurious objectivity and to an unwarranted belief that the work is scientifically based. He maintains that economics is weak at understanding actual behaviour and concludes that:

> *The introduction of half-understood technical devices on which the careers of economists are built will only serve to mystify and obfuscate discussions about priorities and, paradoxically, remove them further from public debate and democratic control.*

How valid are all of these criticisms? Certainly, undertaking exercises in public consultation involve numerous problems. Those associated with obtaining a representative cross-section of views from a heterogeneous public and ensuring that these views are actually utilised in priority setting, rather than being used as a source of legitimisation, have already been discussed. However, Hunter's more serious charge is that the approach is fundamentally flawed because it could lead to a 'dictatorship of the uninformed'. This is a curious claim to come from a political scientist. It seems that Hunter does not trust the public. It is not as if any thoughtful advocate of public consultation has argued that the public's views should dominate decisions to the exclusion of all other sources of information. As Figure 1 makes clear, the public's views are but one input that will need to be considered by health authority decision makers. In certain areas, these views can be expected to exert more influence than in others. In any case, it is extremely doubtful that implicit decision making, concealed from public scrutiny, is likely to be sustainable politically in a world where greater accountability is being demanded from public organisations.

Hunter's other concern is about the dominance of health economists in rationing debates. It is hardly surprising that health economists have been prominent in these discussions given that the essence of their subject is concerned with making optimal choices subject to constraints. However, as the King's Fund Institute survey described earlier makes clear, this expertise is far from dominant in actual policy making. Over half of the authorities surveyed had no internal or external access to expertise in economics. But Hunter's criticisms go beyond the extent of economists' participation and question the relevance of the subject. In place of explicitness, he offers a 'policy' of 'muddling through elegantly'. This is defined briefly as arriving at an optimal balance between various interests. The weakness with this purely political approach is that it avoids defining what if any information decision-makers should have in front of them. Even the most detailed cost-utility analysis does not, as we have argued, entail any political decision, but it does, if properly used, guide decision makers in the direction of making choices which yield the greatest benefits. Similarly, as Mooney and his colleagues have demonstrated, the economic framework can be useful in defining the issues which have to be resolved, even in the absence of detailed information.

Prioritisation in Practice: Evidence to Date

One area in which the prioritisation and rationing of services emerged as an important, potential source of concern during the first year of district purchasing activity was in connection with extra-contractual referrals (ECRS). These arise when GPS wish to refer patients to hospitals or other providers with whom the patient's district of residence does not have a contract. They can also arise in the case of tertiary referrals by consultants between hospitals and, sometimes, through patient self-referrals.

In order for purchasers to be able to manage the system within budget allocations, providers are required to obtain prior approval from a patient's district of residence before undertaking elective treatments to be paid for as ECRS. (Emergency treatments may be undertaken and paid for without the necessity of prior approval). However, Department of Health guidance issued in December 1990 stated that, as a general principle, GPS should be free to refer non-emergency cases where they wished and that district purchasers should not challenge GPS' decisions:

> *... unless it can be shown that the proposed referral is wholly unjustified on clinical grounds, or where an alternative referral would be equally efficacious for the patient, taking into account the patient's wishes.*

Clearly, however, this arrangement involves a potential conflict between population-based decisions undertaken by districts when placing their contracts, and individual patient-based decisions made by GPS when referring patients. In the event that GPS wish to refer more patients outside contracts than the district had made provision for within its ECR budget, districts would be required to ration care.

Two studies reviewing the first three months of the operation of the ECR system indicated the extent of rationing. J D Williamson has described (British Medical Journal, vol. 303 pps 499–504) how, as director of public health, his district of Richmond, Twickenham and Roehampton had dealt with ECR requests. His data showed that 156 requests for elective treatment had been received and, of those for whom the district was eligible to pay, 41 had been refused. Subsequently, 17 cases had appealed successfully against the initial decision and three unsuccessfully. Barbara Ghodse and Salman Rawaf described (British Medical Journal, vol. 303 pps 497–499) how, in their district of Merton and Surrey, 109 requests for elective treatment under ECR arrangements had been approved and, of those for whom the district was responsible, 14 requests were refused. Commenting on the close scrutiny of ECR requests undertaken by Williamson, Malcolm Forsythe argued (British Medical Journal, vol. 303 pps 479–80) that his approach '... will surprise many consultants in public health medicine. District directors of public health should not be questioning clinical judgement unless it seems totally unjustifiable or perverse'.

Subsequently, the King's Fund Institute undertook a study, *Extracontractual Referrals*, of the arrangements in operation in six districts on behalf of the Audit Commission in March 1992. This study revealed some interesting contrasts in approach. Two districts had adopted a highly *laisser-faire* stance in which they interpreted their role as one of accommodating GPS' preferences. Thus, ECRS were approved almost as a matter of routine. In contrast, two other districts were highly interventionist. They were far more likely to query GP requests and to seek to influence the location and timing of referrals. The remaining two districts operated policies which were intermediate between these two extremes.

However, as far as rationing is concerned, it was significant that outright refusals of ECR requests, for those patients for which the district was responsible, rarely occurred in any of the districts. Certainly, isolated incidents arose, such as those involving requests for services which had not been available prior to the NHS reforms, *eg* in-vitro fertilisation, but most rationing was achieved through the re-direction of cases to providers with whom the district had a contract or through the deferral of treatments. Among other things, this meant that the purchaser's need for expert medical advice from directors of public health was far less than many people had originally envisaged would be necessary. Thus, even in those districts reporting the highest inputs from directors of public health in the management of ECRS, this was only estimated as about 10 per cent of their time. Elsewhere, it was described as 'hours per month'.

Overall, there seemed to be a general desire to accommodate GPS' preferences and this was reflected in the fact that five of the six districts supplemented their original ECR budgets during the year in the light of higher than expected demands. Moreover, information about GPS' preferences gained from the ECR process was also being used in determining the placing of contracts for the following year.

In summary, it seems that the joint working between GPS and district purchasers in relation to ECRS has worked far better than early accounts suggested it might. Potential conflicts have been minimised. Few controversial rationing decisions seem to have taken place. This view is confirmed by the most recent Department of Health guidance on ECRS which was issued in September 1992. This guidance concentrates on the problems that have arisen in connection with the administration of the ECR system, such as the recording and billing arrangements, but does not feel it necessary to develop new guidelines for approvals/refusals.

A more general picture of the way in which prioritisation has taken place during the early years of the NHS reforms is provided by Klein and Redmayne's study already referred to. They examined the purchasing plans of 114 health authorities for the year 1992/93. Their study noted that few authorities were able to sit back and take a strategic view of their overall priorities. Rather, the context in which plans were developed was one of extreme short-term pressure, often inadequate information and overstretched expertise. Given these pressures, it was perhaps not surprising that many purchasing plans expressed their priorities as much in terms of organisational processes as of financial inputs. Moreover, the long catalogue of national and regional priorities – to which authorities were expected to respond when framing their own plans – was seen as a source of serious 'priority overload'. Often, this meant that purchasing plans were a 'laundry list' for making sure that all external constraints were met instead of a way of ranking competing priorities.

Nonetheless, from among the 114 purchasing plans they studied, Klein and Redmayne were able to identify 57 health authorities which allocated a total of £72.6 million of new development money to specific priorities. In analysing the decisions taken by these authorities, they divided their priorities into two categories: aspirational priorities – which were declarations of intent without any commitment to actual expenditure – and funded priorities.

Table 2: DHAs: Aspirational and Funded Priorities

Client Group or Disease/Disability	Aspirational Rank	Funded Rank
Mental health	1	1
Mental handicap	2	9
Cancer	3	14
Heart disease	4	2
Children's services	4	4
Disabled	4	12
Health promotion	7	8
Maternity	8	5
Services for elderly	9	3
Ophthalmology	10	7
Community services	11	5
Infant health	11	10
Diabetes	13	18
Orthopaedics	14	11
Substance misuse	14	13
HIV/AIDS	14	not listed
Rehabilitation	14	not listed
Dentistry	18	not listed
Family planning	18	not listed
Strokes	20	not listed

Source: Rudolf Klein and Sharon Redmayne, *Patterns of Priorities: a study of the purchasing and rationing policies, of health authorities*, NAHAT, 1992

Table 2 indicates the ordering of the top twenty aspirational priorities in terms of the number of authorities which cited each of them in their purchasing plans. It also shows the rank order of the same client group or disease/disability priorities in terms of the number of authorities which actually funded them.

Comparison between the two sets of rankings shows that, in terms of the number of times they were cited, mental illness services emerged as the highest priority on both the aspirational and funded basis. Correlation between the rank orderings of most other services was, however, far less strong. Services for people with mental handicaps, cancer services and services for the disabled all ranked far less highly in funded terms compared with their ranking on an aspirational basis. A similar discrepancy between priorities on an aspirational basis and the ways in which the total funds were distributed between new service priorities is revealed in Table 3.

Table 3: DHAs: Priority Expenditure, 1992/93

Service	£ million	Per Cent
Total	72.6	100.0
Acute	28.5	39.3
Mental Health	12.6	17.4
Community services	6.5	9.0
Services for women	5.3	7.3
Mental handicap	5.0	6.9
Heart disease	4.0	5.5
Services for elderly	2.4	3.3
Disabled	2.2	3.0
Children's services	2.2	3.0
Health promotion	1.7	2.3
Other	2.2	3.0

Source: as Table 2

Thus despite receiving the highest ranking in aspirational/funding citations, mental health services received only 17.4 per cent of the total funding allocated to new priorities. This compared with the nearly 40 per cent allocated to acute services. Funding allocations to mental handicap services and those dealing with heart disease were similarly a good deal lower than their rankings in Table 2 would suggest. These findings led Klein and Redmayne to conclude that: 'there is a sharp contrast between priority talk and priority decisions'.

Finally, the researchers examined the 114 purchasing plans to establish the extent of explicit rationing through the denial of specific treatments in the NHS. Only 12 authorities stated that they would deny or limit treatment, with the frequently cited case of tattoo removal heading the list: see Table 4. None of these procedures, with the possible exception of infertility services, involve much expenditure and so it appears that 'Oregon' style rationing is still in its infancy in Britain.

Table 4: Rationed Services not Offered by NHS

	Number of HAs citing service
Tatto removal	7
GIFT/IVF	6
Reversal of sterilisation/vasectomy	4
General cosmetic surgery	4
Adult bat ears	3
Breast augmentation	3
Cosmetic rhinoplasty	3
Removal of non-genital warts	2
Cosmetic varicose veins	1
Homeopathy	1
Sex change operations	1
Multi-allergy syndrome	1
Bone dentistry	1
Liposuction/lipectomy	1
Mastopexy	1
Repair of nipple	1
Buttock lift	1
Blepharoplasty	1

Source: as Table 2

Conclusion

As long as the population's needs for health care exceed the capacity of the system to supply the necessary services with the resources made available, there will be a need for prioritisation and rationing. Moreover, in those systems, such as the NHS, where decisions about the level of funding are made collectively, the system of prioritisation and rationing will also need to be based upon collective choice. This is a fundamental difference between rationing in publicly-funded systems and those in which decisions are led by individual consumer demands and private finance. The question remains, however: how is prioritisation and rationing best carried out in the NHS?

This paper has sought to identify the main inputs to the decision making process at the district health authority level. It has reviewed the way in which the purchasing task is developing, highlighting some of its strengths and weaknesses. Examination of this evidence suggests two features that are likely to improve decision making in the future.

First, there is a strong case for adopting an economic evaluative framework for assisting decision making. The cost-benefit methodology is particularly suited to the systematic collection of evidence and the clarification of choices to be made. This recommendation should not be taken to imply that the narrow application of, say, cost-utility analysis and QALY league tables should be used to determine resource allocation. Rather, it is based upon a belief that this evaluative framework offers a powerful aid to the organisation of thought and evidence, in situations where trade-offs have to be made between desirable objectives, and choices impose opportunity costs.

Second, though, it is important to emphasise that the economic framework is an aid to decision making, not a replacement for it. Ultimately, district health authority decision makers – *ie* executive and non-executive members – need to exercise their judgement about how resources should be deployed. Exactly how they should weight the different sources of information at their disposal in order to carry out this task is unclear. But what is clear is that economic evaluation is but one input into this process; or, in other words, economists need to be 'on tap and not on top'.

ACCOUNTABILITY AND CONTROL IN THE NHS

Bill New

Accountability is in vogue. The modern state is increasingly populated by agencies, trusts, quangos, and other 'self-governing units'. This fragmented structure is loosely held together by a network of contracts and 'framework agreements'. General managers and executives, often from the private sector, are employed in an attempt to make the state more businesslike. This drive to separate the making of policy from its execution is a drive for efficiency. But these developments have also provided a new lease of life for an old concern: are these agencies and individuals still answerable to their political masters?

The issues are not new. In 1969 a conference was held at Ditchley Park near Oxford, bringing together British and American academics and civil servants. The keynote paper by Bruce Smith, Professor of Political Science at Columbia University in the USA, was entitled 'Accountability and Independence in the Contract State'. Its central concern was strikingly similar to that now articulated in the 1990s:

> *What can be said about the scope, magnitude and policy implications of the widespread delegation of administrative authority to semi-official and private institutions?*

Smith was chiefly interested in what we now understand as 'contracting-out' to the private sector. Since then administrative reforms have become even more ambitious, involving the state effectively contracting with itself – a prime example being the purchaser/provider split in the reformed NHS. The issues are fundamentally the same: how can greater freedom and independence be given to government agencies without jeopardising effective democratic control and accountability?

But what is accountability, how is it supposed to function and what is it supposed to achieve? Like motherhood and apple pie, much of the current discussion merely advocates its desirability, and yet it is a concept which proves hard to define. It shares both these characteristics with the broader notion of democracy. Democracy, too, is a good thing, yet precisely what arrangements count as democratic is just as hard to pin down. The two notions are clearly linked by the belief that in a democracy any public agency is ultimately the servant of the people at large. In the final analysis, therefore, what follows is directed at the question of how to assess whether or not the NHS is a democratic institution.

The first section of this paper presents a discussion of the difficulties of definition and of the significant themes which run through analyses of the concept. Section two offers a conceptual 'map' of the variety of instruments of accountability, with an emphasis on the range of methods of holding government agencies to account. Finally, section three outlines a policy agenda, consisting of the key questions raised by the 1991 NHS reforms and their impact on the accountability of a public service.

The Accountability Debate

Perhaps unsurprisingly, there is little agreement upon a precise definition of accountability. **Defining a Concept** shows there is a disconcerting lack of similarity between various authors' attempts to define the term. We are left with a good impression of what is being discussed, but without a feeling of precision. In *Accountabilities: five public services,* Patricia Day and Rudolf Klein investigate the 'career of a concept' and try to understand why accountability is such a slippery notion to pin down. They trace it back as far as Athenian times, and the accounts which generals and officials gave of their battles or civic duties. Over time, its meaning has changed reflecting changing usages and contexts. But at the same time:

> *the word itself has passed into ordinary language only relatively recently. It is this which helps to explain why accountability as it is used today tends to be such a slippery and ambiguous term. Its various meanings ... have tended to be conflated in what has become a fashionably 'good' word, often with confusing results.*

Before presenting a definition of accountability, we look at three features of the accountability debate which contribute to this confusion.

'Accountability operates through formal channels'

The first of these features is a tendency to regard accountability as relating principally, if not exclusively, to Parliament and other formal political mechanisms. For example, Christine Hogg argues in *The Public and the NHS* that 'debates on policy since 1974 have confused issues of democracy and accountability with representation and participation ... under the present system, democratic control comes through the accountability of the Secretary of State to Parliament'. Similarly the *Leading for Health* places the issue of accountability in terms of ministerial accountability, posing the following question: 'How much

Defining a Concept

The following series of 'definitions' are taken from a sample of recent and not so recent analyses of accountability. They are taken out of context; nevertheless, the reader is invited to decide whether he or she is left any the wiser:

The ability to give reason or explanation, to answer as one responsible, or having responsibility for

Accountability is the central objective of democractic government: how can control be exercised over those to whom power is delegated?

Accountability ... means a liability to reveal, to explain, and to justify what one does [...] It provides a post-mortem of action, the test of obedience and judgement, the moment of truth

Accountability can be seen as involving giving an account for actions taken and being held to account for those actions

How can the organisation ensure that the job done is the job required? That is the problem of accountability

Public accountability simply requires that public bodies give an account of their activities to other people and provide a justification for what has been done in terms of other people's values

To talk about accountability is to define who can call for an account and who owes a duty of explanation

Accountability is about answerability, responsiveness, openness, efficient estate management, not to mention participation and obedience to eternal laws

Procedures for accountability help ensure that arbitrary decisions are eliminated and that policy is made for reasons that are properly related to the objective of the grant of discretionary power

Accountability implies a duty to justify and explain [and] ... in the full and most rigorous sense, involves sanctions

Accountability literally means to give a reckoning of how money has been spent. More broadly, it can be defined as taking responsibility for one's decisions, and being able to explain or measure in some way the results

should the Secretary of State for Health be accountable for the health service?'.

David Hunter, in a response to *Leading for Health*, notes that although the practice of accountability is unclear, 'at a formal level the issue of accountability is deceptively clear and unequivocal: health ministers ... are accountable to parliament for all that happens in the NHS.' Allyson Pollock, writing about the *Local Voices* initiative from the NHS Management Executive, argues that '*Local Voices* can be seen as the latest chapter in the history of consumerism in the NHS. But it can also be seen as marking the demise of local democratic accountability in the NHS. It ... concentrates almost entirely on the process of consultation.' Such processes are clearly not considered to be part of the process of accountability.

These views are perhaps unsurprising, given that formal political channels of accountability are the basis on which our democratic process lies. However, such a focus may be too narrow for a proper understanding of the concept. By focusing on a 'formal' understanding of the term, the subtleties and complexities of the processes at work may be missed. Other forms of accountability, which to some degree complement formal channels, may be neglected. We set out what these are in the second section of this paper.

'Accountability involves reliance on formal sanctions'

A second feature of discussions of accountability is an emphasis on formal sanctions exercised by the electorate or by Ministers, rather than broader notions of 'control' exercised by a wide range of individuals, agencies and informal groups – see **Control**. The former approach, again, limits our understanding of the concept. Furthermore, the common sense meaning – 'to give an account of' – implies that the process signified by accountability involves rather more by way of the supply of information and justification for actions by those who govern, and rather less by way of methods of control from those governed, or from their representatives.

It is often merely a question of emphasis; for example, Diane Longley in *Public Law and Health Service Accountability* notes that 'the central prerequisite for genuine accountability is clearly openness, a transparency which needs to embrace all decision making ...'. This is certainly true, but by failing to emphasise the reason transparency is important – to allow for the proper control of decision-

Control

'Control' in discussions of accountability does not have a mechanistic meaning. The process of controlling administrative agencies has nothing in common with the control a driver has over a car. Control in our sense is inevitably hit or miss – the actions or reactions of an agency or individual cannot be guaranteed.

The control exercised by formal, political channels need not be more effective than that exercised by more informal methods. A Minister acting on statutory authority may find that control of a distant part of the administration is extremely difficult if that authority is attentuated by successive layers of organisational hierarchy. The direct approach of a pressure group or individual compainant may be more effective.

The process of control will inevitably be one of influencing, cajoling, persuading or bullying. The term 'control' is used here as a summary term which, furthermore, clearly indicates that the public agency must, ultimately, capitulate to its political masters.

makers – the range of available methods of accountability is easily overlooked.

In a recent paper given by Patricia Day to the Rowntree Symposium at the University of Birmingham, the author claims that, in the context of new market forms of public provision where the service user is now often termed a 'customer':

> *it does not seem sensible to talk about accountability to customers. This is a misuse of the word. We do not talk about Marks and Spencer or Sainsbury's being accountable to their customers. They may be highly sensitive and responsive to their customers because of market competition ... [and] accountability may be an instrument bringing about responsiveness to consumers, but should not be confused with it.*

While the last point is correct – accountability is far more complex than simply 'responsiveness' – it does not preclude the market mechanism from acting as an instrument of accountability. Why, in this context, can we not talk about accountability to consumers – or customers – of public services?

There will indeed be difficulties in utilising the market to achieve accountability: often people are not well enough informed to make choices as confidently as they would in the private sector. But this difficulty can be over-emphasised, as an example from the field of education indicates: leaving practical difficulties aside, why should a threat to move a child from one school to another, and therefore the funding for that child, not be a powerful means of ensuring that the first school is administered properly and in line with parents' wishes? And although the market for health care has long been used to illustrate the imperfections of market systems, the ability to change our GP gives us the opportunity to hold them to account for being rude, insensitive or unreliable – indeed, for not being 'responsive'.

Other informal methods of control can also be extremely effective. The actions of a pressure group or a complaint from an individual citizen can often stir an agency into action. Decisions made in view of the media, or in partnership with the public, can restrain improper administration. A senior manager can punish shoddy work; even the consciences of the administrators themselves can act to control poor conduct. These examples are elaborated further below. The point is whether effective control is being exercised; any mechanism which achieves this end can be utilised as an instrument of accountability.

'Accountability has a multitude of types'

The third aspect of accountability is the bewildering variety of categories which are used in its discussion – see **Categories of Accountability**. Is there any means of simplifying this array of terminology? The short answer must be no – accountability is chameleon-like and shifts its appearance depending on which group, institution or process one is focused on. However, one simplification is possible and that is to constrain our interest to administrative accountability. The focus here is on the workings of administrative agencies – the 'service delivery' element of the NHS, for example – rather than on the mechanisms of policy formulation in cabinet, think tanks, political parties or other members of the policy community. Our focus will be on the operation of the agencies administering policy, whilst emphasising that much of the current debate on accountability focuses on the policy judgements which are inevitably involved in the decisions made by administrative agencies and their officers.

Defining Accountability

In the light of this discussion, our approach will use the conceptual framework developed by B Guy Peters, Maurice Falk Professor of American Government at the University of Pittsburgh. The framework he adopts provides a basis for comparing a wide range of developed administrative systems. The problem of administrative accountability, he argues, can be defined in the following terms:

> *How do political leaders and the public persuade, cajole or force administrative agencies to do their bidding? What are the instruments available for the control of the administration?*

This definition will provide the focus for our analysis. It emphasises a broad notion of control which does not merely include formal political channels. The full range of instruments of accountability are described in the next section of this paper, with special reference to the NHS. But the central message of Guy Peters' definition is clear: accounting for actions is the basis for, and only meaningful if accompanied by, effective control.

However, the definition immediately begs one question: what is *improper* public administration which is in need of control? There are traditionally three ways in which an administration can act improperly or unjustly. First, by acting criminally – for example, actions involving corruption, bribery or theft. Second, by acting *ultra vires* or 'beyond the powers'. Actions such as these can either involve an action which went beyond the powers conferred by law, or the use of a power for a purpose for which it was not intended. An associated 'inaction' involves the failure to carry out a duty conferred by law. Third, an administration can act improperly by 'maladministration'. Such actions do not involve illegality as such, but rather improper considerations or conduct. Examples include the following: bias, neglect, inattention, delay, incompetence, ineptitude, perversity, turpitude, arbitrariness, and so on. These examples are taken from a speech made by Richard Crossman at the time of the creation of the Parliamentary Commissioner for Administration who was to investigate claims of maladministration.

There is now arguably a fourth form of improper administration, as a result of the growth of the modern state. An increasing proportion of legislation is of necessity 'enabling', thereby delegating political decision-making to individuals within the administration – to local health authorities, for example. Administrators are commonly tasked not just with implementing ready-made

Categories of Accountability

At its most general, accountability can apply to any relationship between individuals or groups, or between oneself and one's conscience or god, or simply to keeping one's financial books in order. Thus, relationships within families, voluntary organisations and businesses will all involve an element of accountability.

The first major sub-category is that of **public accountability**. This form is specifically concerned with relationships between those governed and those governing: public bodies should be accountable to the public at large in western systems of democracy.

Within public accountability we can further distinguish between **political accountability** and managerial or **administrative accountability**. The former is about those with delegated authority being answerable to the people, and involves a discourse based on values whereby the criteria for judging whether the governors are acting properly are themselves contestable. Administrative accountability, on the other hand, is specifically concerned with the agencies and individuals who are responsible for implementing the decisions of law-making bodies. The criteria for judgment are, in principle, not contestable: the process is a technical exercise.

Administrative accountability itself has a number of dimensions:

Fiscal accountability ('inputs') is concerned with making sure that money has been spent as agreed and according to appropriate rules – that health service monies, for example, have indeed been spent on resources concerned with delivering health care.

Process accountability ('outputs') is concerned with making sure that a given course of action has been carried out, and at minimum cost – that a satisfactory number of hip operations were undertaken, for example, without an unnecessary use of resources.

Programme accountability ('outcomes') is concerned with making sure that a given course of action has achieved its intended result – that treating people in the community, for example, has indeed improved individuals' health status.

These three categories can also be thought of as relating to regularity, efficiency and effectiveness audit respectively.

Although this categorisation suggests neat boundaries surrounding discrete areas of activity, this would be too literal an interpretation. The taxonomy acts as a convenient analytical framework, but in practice the boundaries between categories are highly blurred. In particular, political and administrative accountability are hard to separate. Much administrative decision-making is political in nature, a phenomenon which presents one of the main challenges to systems of accountability.

policies, but with effectively deciding what policy should be: what range of health care services to provide to a local community, for instance. These decisions are essentially political, involving judgments relating to competing claims and social justice. Even if the decisions are made speedily, without bias or neglect, and clearly within the powers conferred by law, one could still argue that unless some degree of public debate is involved the decisions may be improperly made. It seems particularly important that strong mechanisms of accountability are in place to monitor and control this form of decision-making.

Accountability requires that answers, reasons or explanations are given for actions. It is closely connected with the notion of control: control can only be exercised under conditions of accountability, and accountability is only useful if control can be exercised. The two terms can often be used interchangeably, so closely are they linked. However, control does not necessarily need to be backed by formal authority. Quite often accountability, and control, is achieved informally by means such as public pressure or by utilising market mechanisms. At its most general, then, the study of accountability involves the study of appropriate control. The next section outlines some of the instruments which have developed to assist in exercising this control.

Instruments for Controlling Administrative Agencies

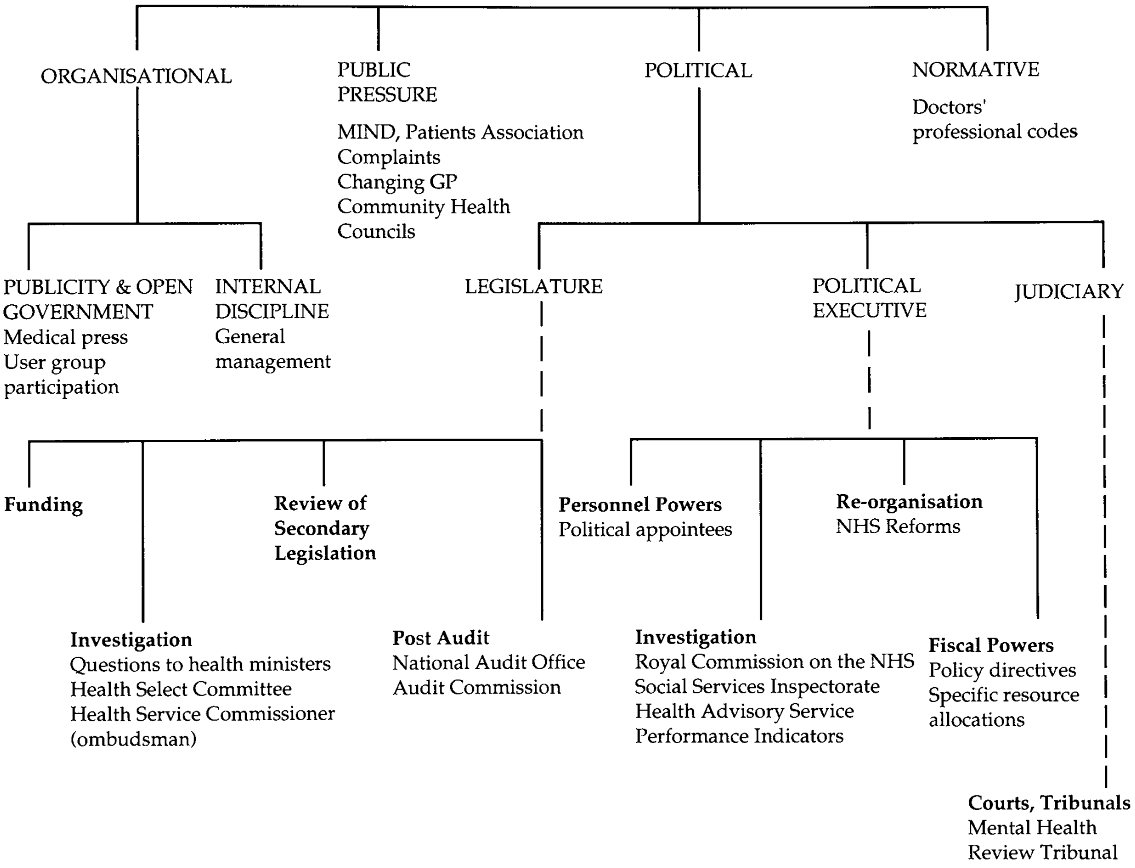
There are four broad categories of accountability instruments: political, organisational, public pressure and normative – see **Instruments of Accountability**. Figure 1 represents a conceptual 'map' of these categories and of the specific instruments in the health and social care field which can be utilised to control administrative agencies.

Political Methods of Control

Traditionally it was assumed that bureaucracies could be held accountable to political authorities through rigid hierarchies and periodic elections. In *The Dilemma of Accountability in Modern Government*, a volume of the papers presented at the 1969 Ditchley conference, the process was described as follows:

> *within the government each level of executive authority is accountable to the next, running up to the ... Cabinet. The executive authority as a whole is accountable to Parliament which is assisted in its surveillance of expenditures by an independent audit agency. [MPs] are required to submit themselves to periodic elections as a retrospective evaluation of their performances and to receive a new mandate from the people .*

Figure 1: Instruments of Accountability



Four broad groups of methods of controlling administrative agencies have been identified by Professor B Guy Peters: political, organisational, public pressure and normative.

Political instruments of control are the most formal and are based on the authority of the sovereign lawmaking body within a nation state. They constitute the basis upon which the other three forms can exercise their control. Nevertheless, they are the most time-consuming and expensive to utilise since they involve conflict between institutions. Political instruments include all the means at the disposal of the legislature, political executive and judiciary.

Organisational methods involve administrative agencies regulating themselves, either through internal discipline and 'good management', or through the influence of publicity and 'open government'.

Public pressure mechanisms include the use of pressure groups and complaints mechanisms – exercising 'voice' – as well as the increasing possibility for individuals to switch from one administrative agency to another – the opportunity for 'exit'.

Normative methods involve the inculcation of a 'public service ethos' within the individuals tasked with undertaking administrative tasks. It is particularly relevant to professional groups working in administrative agencies.

These categories are not mutually exclusive: some groups may operate by exerting public pressure and take part in a more open system of government. However, what distinguishes the four categories is the source of the control mechanism operating on the agency in question. The four sources can be summarised as arising, respectively: from another institution, from within the agency itself, from the general public, or from within the administrators' conscience.

The situation is in fact far more complex than this summary would suggest. The three arms of the state – the legislature, the political executive and the judiciary – each have a number of instruments at their disposal for controlling the administration.

The Legislature

The legislature occupies a position of the greatest formal power over the actions of public agencies. The authority of the state is vested in the sovereignty of Parliament as the main lawmaking body, alongside the growing influence of the European Commission. In practice this authority is severely constrained by the remoteness of Parliament and the sheer size of the monitoring task which faces it. Nevertheless, its powers are more than symbolic. There are four means at its disposal for policing administrative agencies: powers over funding, review of secondary legislation, investigation and post-audit.

Powers over funding: The ultimate sanction available to Parliament is to withdraw funding from programme areas. It is, though, unlikely that maladministration takes place on such a grand scale; it is more often the case that individuals or individual agencies are at fault. Under such circumstances, the annual debate on the Finance Bill offers little scope for effective control. This is particularly true given the control the political executive – the 'government' – exercises over such important legislation.

Review of secondary legislation: The growth in the size and scope of the state has meant that it is simply impractical for all legislation to be scrutinised and passed by the legislature. Much secondary legislation – for example, statutory instruments in the UK – is issued by Ministers or officials in the administration. These binding rules often contain the substance which fills out the original 'enabling' legislation. The NHS and Community Care Act 1990 was just such a piece of enabling legislation; it is the mass of regulations which have followed its enactment which will actually determine the shape of the reformed NHS.

From the point of view of the legislature, the concern is that the original enactment becomes subverted subsequently by administrative agencies. The development of scrutinising committees, such as the standing committee on statutory instruments, reflects such a concern. Many statutory instruments are indeed brought before the House of Commons, which then has the power to repeal or block them. However, within an organisation such as the NHS many binding decisions are made in district health authorities, for example, which are not subject to review by Parliament. We will return to this point below.

Investigation: Members, committees or agents acting on the legislature's behalf can all probe the actions of the administration. They rarely exercise formal or binding decision-making powers, but often have rights of access and the authority to call witnesses to account. In the UK, Parliamentary questions to ministers, the select committee system and the ombudsman all have a role to play in assisting Parliament's investigatory function. The first of these – Parliamentary question time – has the longest pedigree. It is particularly important in the UK where the minister is considered to be responsible for all the actions of his or her department, even those of the most lowly of clerks. In the NHS, as John Pater put it in *The Making of the National Health Service*:

> *the Minister of Health was answerable to Parliament for everything that went on in hospitals, however detailed.*

And as Nye Bevan put it rather more famously 'when a bedpan is dropped on a hospital floor, its noise should resound in the Palace of Westminster'. Often, a question to a Minister will arise from MPs' constituency service, where traditionally the individual citizen has been able to raise grievances about administrative matters. Parliamentary questions to Ministers can extract information, cause embarrassment, or alert the public to current problems of administration – it can rarely go further. Parliamentary questions rely on the actions of government ministers or the administrators themselves to produce any real change.

The inadequacy of the MP's constituency service and questions to Ministers in the face of vast bureaucratic agencies such as the NHS led the House of Commons to review its influence. Two innovations in particular have increased the House of Commons' investigatory powers in recent years: the system of select commitees and the ombudsman.

The first is the system of select committees. All-party committees are not new – the Public Accounts Committee has existed since 1861 – but a *system* of select committees is rather a recent innovation. In 1979 the *ad hoc* development of these committees was rationalised with a committee appointed for every government department. They are tasked with examining the expenditure, administration and policy of the relevant government departments and associated public bodies. They are empowered 'to send for persons, papers and records' and can receive written and oral evidence not only from Ministers but from civil servants, pressure groups and outside experts. The health select committee has recently published reports on NHS trusts and maternity services.

The second important innovation in the investigatory role of the legislature is that of the ombudsman. Scandinavian in origin, the term means 'grievance man' or 'complaints officer'. The development of such an officer arose out of the need for an avenue of redress where tribunals did not operate, and where the relevant government agency had provided an unsatisfactory reply to a complaint.

In the UK, the Parliamentary Commissioner for Administration – as the office is formally known – was established by an Act of Parliament in 1967. However, several fields of administration were outside his competence, including that of health. Subsequently, in 1973, three Health Service Commissioners were appointed, one each for England, Scotland and Wales, to investigate complaints against health authorities.

The Health Service Commissioners differ in some significant respects from the Parliamentary Commissioner. First, complainants may approach the Commissioner directly – rather than via an MP – provided they have first complained to the appropriate health authority. Second, the Commissioner reports to the appropriate Secretary of State rather than to Parliament, though his reports are laid before both Houses. Third, his jurisdiction extends beyond maladministration to injustice or hardship resulting from a failure of a service provided by a health authority, or failure to provide a service which it was its duty to provide. Complaints about general medical and dental practitioners, and opticians, are excluded, as are complaints about the clinical judgements of medical staff.

Post-audit: In contrast with investigation, post-audit is specifically related to how public monies are spent. The function dates from the 1860s when the Public Accounts Committee and the Comptroller and Auditor General were established to examine whether public funds were spent within the terms of the appropriation bills and according to accounting conventions. However, the growing demand for public accountability of government bodies led to numerous reviews into the scope of the Comptroller and Auditor General's responsibilities and the nature of his work. The result was the National Audit Act, 1983. It created the National Audit Office with the Comptroller and Auditor General at its head, and provided statutory authority for work on economy, efficiency and effectiveness – the so-called 'value for money' audit. The new Act re-inforced the Comptroller's financial and operational independence from the executive and brought him into a closer relationship with Parliament.

The National Audit Office is concerned with central government expenditure; the scrutiny of local government finance has traditionally been undertaken by district auditors ultimately under the control of central government. In a move by Parliament to make this function also rather more independent of the political executive, the Audit Commission was established by the Local Government Finance Act of 1982. It, too, has a statutory obligation to investigate the 'economy, efficiency and effectiveness' with which local authorities use their resources. The NHS and Community Care Act 1990 widened this role: from 1 October 1990 the Audit Commission took over the external audit of the NHS from the Department of Health. Although the Audit Commission itself is appointed by the relevant Secretaries of State, it operates under a statute and therefore has an independent basis. It is not closely associated with Parliament, as is the National Audit Office, but its legislative backing and mode of operation indicate its clear independence from the executive.

Both the National Audit Office and the Audit Commission grew out of a general mistrust of the working of public service and, in particular, of the efficiency with which public money was being spent by government bureaucracies. However, these agencies have proved to be a double edged sword for policy-makers. The Audit Commission's *Making a Reality of Community Care* examined the way in which local authorities were implementing a policy of caring for those in need of long term care in the community, rather than in long-stay hospitals. The findings were deeply critical of the financial and administrative arrangements for which central government was responsible and which were supposed to facilitate this process. The Audit Commission's critique was thus an attack on government policy itself, which is not the job of administrative accountability. Such reports are rare, but this example serves to emphasise the potential for independent criticism in these new agencies.

Ultimately, though, the formal authority of the legislature is constrained in the UK by the dominance in Parliament of the government – the 'political executive'.

The Political Executive

Parliament is not the only arm of the state which seeks to monitor and control the actions of administrative agencies. The political executive – government ministers and senior civil servants – also want to be sure that their policies are being implemented. The NHS, for example, is not part of the Department of Health but is an independent Crown service, employing nearly one million people. Controlling a government department is no easy task, but controlling an organisation the size of the NHS represents a monumental undertaking.

The control sought by the centre is not necessarily continual and rigid, however. In the NHS, and in the social care field, independent local decision-making is positively encouraged as the best means of ensuring appropriate care is provided for the individual patient. Nevertheless, the political centre feels entitled to control the actions of those working in service delivery – managers or doctors – for the same reason Parliament attempts to exercise such control: to ensure public money is not wasted and to ensure that the public's values, in the form of the government's policies, are implemented. There are four means at the disposal of the executive: fiscal powers, powers over personnel, reorganisation and investigation.

Fiscal powers The political executive can control how appropriated funds are allocated to particular uses within each agency in question, typically by the authority of the minister as enacted by statute. In practice, and particularly in relation to the NHS, this method has been limited in its effectiveness. For example, a stated policy objective of both Conservative and Labour governments since the 1970s has been a re-allocation of resources from high technology acute specialties to the so-called Cinderella services – those for the old, the mentally and physically handicapped and the mentally ill. In theory, the political executive is in a strong position to re-allocate these funds as policy would dictate, by using specific instead of block allocations, for example, or by issuing directives – the strategy adopted by the Government in this case. However, the sheer size of the NHS insists that the practice of resource allocation between specialties and sub-specialties is left to district health authorities. Changing priorities implies cuts as well as expansion, and opposition to such cuts on the authorities themselves meant that central priorities were repeatedly frustrated by powerful local coalitions more intent on preserving the status quo. Thus the political centre can find it extremely difficult to effect change in the face of a large and distant bureaucracy.

Powers over personnel: Traditionally, these powers have been limited in the UK. Higher civil servants were 'career' appointments – they were anonymous, permanent and politically neutral. The relationship between these civil servants and their temporary Ministers, although unusual in Western democracies, has been defended as providing the benefits of continuity and administrative expertise. However, the radicalism of the Thatcher administrations sat uneasily with notions of consensus and continuity, and the 'generalist' tradition of senior civil servants was viewed with suspicion as opposed to change. The solution, as articulated by Sir John Hoskyns, the former head of Mrs Thatcher's policy unit, is the partial 'politicisation' of the civil service, with perhaps 20 political appointees in each department. Vague, and possibly disingenuous, notions of the public interest would thereby not be allowed to get in the way of democratically decided policy objectives. Thus, 'politicisation', perhaps counter-intuitively, is a means of making the civil service more accountable to political masters, by ensuring that those implementing policy share the values of those who make policy.

Although NHS employees are not civil servants, appointments to key managerial posts could be argued to be 'political' in this sense. For example, Sir Duncan Nichol was appointed as the Chief Executive of the NHS and although not publicly aligned with the Conservative party, he has been a strong advocate of the NHS reforms. His position would have been untenable if Labour had won the 1992 General Election.

Re-organisation: Three major reforms of the NHS have been undertaken in the last twenty years, all with a view to altering the behaviour of those providing health services. The most recent of these, the NHS and Community Care Act 1990, is one of the most far reaching social policy reforms since the war. It is commonly perceived as the unexpected result of an internal review of the funding of the NHS at a time of repeated funding 'crises'. What resulted was, in many ways, an administrative reform elegantly designed to wrest control of the allocation of resources by 'unaccountable' doctors and place them firmly in businesslike and 'accountable' health authorities or so the government would argue.

Investigation: An investigation may take the form of public or internal inquiries, or the activities of specially instituted inspectorates. Many public inquiries are statutory and have an appellate nature, or are instigated in response to a catastrophic event, such as the King's Cross Underground Fire. Other inquiries are private and internal to the department concerned, often so that the minister can act on any uncomfortable findings without public embarrassment.

The format of inquiries is not always to the liking of Ministers or, indeed, Prime Ministers. Royal Commissions, for example, have traditionally investigated wide areas of government policy in a reflective, unhurried and rather scholarly fashion. Mrs Thatcher was deeply suspicious of them, believing they were another civil servant ploy to take a long time to recommend that things should stay much as they were. Instead, she favoured short investigations undertaken by outsiders, such as that by Roy Griffiths into management in the NHS, with a clear remit and six month time-scale.

The other means of investigation available to the political executive is the inspectorate, a division of a department tasked with continual investigation and review, reporting to the Secretary of State. Within the health sector two of these agencies are particularly significant, the Health Advisory Service and the Social Services Inspectorate. The former is a consultancy-type inspectorate, employing fellow professionals to ensure that good practice is followed in long stay institutions for the mentally ill and the elderly. Nevertheless, its director, a medical specialist, reports directly to the Secretary of State for Health, and Patricia Day and Rudolf Klein have argued in *Inspecting the Inspectorates* that it is clearly an instrument of accountability 'to give central government a searchlight, as it were, for illuminating the dark corners of the NHS'. The second body, the Social Services Inspectorate, was formed in 1985 from the old Social Work Service. Its functions are to inspect social services to improve effectiveness and efficiency, to provide professional advice to the Department of the Environment on policy matters, and to implement departmental policy. It is, therefore, at least in part, an agency created by the political centre to ensure that its policies are implemented, and without waste.

Finally, mention should be made of performance indicators in the context of the political executive's attempt to investigate the administration. These summary statistics provide a cross-sectional picture of how local and health authorities compare in their provision of services. This form of control has been termed 'hands off' or 'back seat driving' to convey the absence of any prescriptive element in the indicators. Nevertheless, they are designed to enable managers to improve their performance, and for the political centre to review and scrutinise what is going on in the massive arena of health and social care.

Judiciary

The final political means of control involves the judiciary who can hold an administrative agency acting illegally to account. Doctors have always been liable for criminal acts, although this can often be hard to prove when the act involves medical treatment. However, the recent case of the doctor who was convicted of manslaughter after administering an overdose of a palliative drug to an elderly patient in a terminal condition, is an example of the exercise of judicial accountability over the administration.

It is also in principle possible for an individual to apply for judicial review of an administrative decision if it is thought to be *ultra vires*. For example, the Secretary of

State has a duty to provide health care 'free of charge' to 'meet all reasonable requirements'. Agencies – the relevant health authorities – acting on his behalf can be sued for failing to undertake this responsibility. However, legal precedents have established that this responsibility is only to be undertaken 'within the available resources'. The courts are reluctant to enforce the provision of services from the public sector when it is clear that resources are limited and that limit is politically determined.

In many countries there exists a separate system of administrative law with its own administrative courts – France operates such a system. In the UK the general courts are used for all cases involving illegality; for minor cases it is much more likely that an aggrieved party who is not sufficiently happy with the redress offered by other avenues will take their case to an administrative tribunal.

Tribunals contribute to administrative accountability by providing an independent assessment of the extent to which departmental policies apply in individual cases. They are the final arbiters of disputes between public bodies and citizens (although there is the possibility of applying for judicial review on points of law to the general courts). Within the health care field, the only tribunal with a substantial workload is the Mental Health Review Tribunal which handled 3,347 cases in 1989. An example of this tribunal's work is the review of cases of those incarcerated in psychiatric hospitals under Restriction Orders; it has the power to discharge such patients and move them to a normal prison.

So far in this section we have concentrated on the formal, political accountability mechanisms which rely on conflict between institutions. Although any control mechanism will ultimately rely on formal authority, it is often the case that other means can operate without resort to these formal methods. From the administrative agency's viewpoint, it is often quicker and cheaper to avoid getting involved with political authority, and to respond instead directly to the public or on the agency's own initiative. Public agencies are generally willing to 'do the right thing' when persuaded or when maladministration is brought to their attention. Furthermore, those exercising informal control often have the best insight into where the administration is going wrong. The informal nature of these methods – organisational, public pressure and normative – should not lead us to underestimate their importance.

Organisational Methods

The simplest means of policing public administration is to allow the officials and civil servants to police themselves, through what we term organisational methods of control. There are two types of organisational control: the first operates as a consequence of 'publicity' and open government, the second involves internal managerial discipline.

Publicity and Open Government

In the first of the organisational methods of control, it is the visibility of improper administration to the public which spurs the agency to improve performance, either because it wants to avoid embarrassment, or in response to notions of public duty, or simply because it fears that lack of action will encourage legislative or other more formal and legal methods of sanction to be brought into play. It is often easier and cheaper, however, for the agency to correct matters itself.

Sweden is often noted for the way its public officials work within a 'goldfish bowl'. Their actions are almost entirely open to public inspection, and whenever an official reaches a decision, it must be justified in writing, and the file made available to the individual citizen on request. The system is based on the simple premise that if individuals know what decisions have been reached and why, then they are better able to contest them.

A vigorous, free press is a vital ingredient in such an instrument of accountability, since the media must have the potential to disseminate widely any aspects of maladministration which they can uncover. However, in practice, it is likely that the threat of adverse publicity acts as a deterrent rather than a means of 'punishment'. Public officials are unlikely to act in improper ways if they are aware that all their actions are potentially under scrutiny by members of the public or press.

An important aspect of open government is the development of procedures to involve citizens in the governmental process, including a greater participation in decision-making by the public or their representatives. Public hearings, the opportunity to comment on draft proposals, the inclusion of local representatives on decision-making bodies all contribute to an open and accountable system. This lay participation can be accommodated by the administration in a number of different ways and from a number of different perspectives – see **Lay Participation In Health Care Decision-Making**. In the UK, the development of user or consumer groups is seen as particularly important within the NHS and local authority care arenas: ethnic minorities, the physically and mentally handicapped, and the mentally ill are becoming involved in the design of their services. Much of these groups' care is delivered in the community, in complex settings, and this makes it all the more important that the decision-makers are accountable to those receiving services. Participating in making those decisions is one important element of that accountability.

The UK, however, has in general a closed system of government, and the working of the NHS and social care agencies are no exception. Most of the decisions of health and local authorities are taken in private, without local representation. In light of the increasingly explicit decisions relating to the allocation of resources these bodies are making, such a state of affairs has been criticised as lacking accountability and this question will be raised in the final section of this paper.

Internal Discipline

The second form of organisational accountability is that of internal discipline. Such a method is also potentially cheap and efficient, since it does not rely on external political control. Instead, the method simply involves those in superior positions in the agency hierarchy exercising sanctions over their subordinates (or, indeed, *vice versa*). It assumes that those exercising sanctions have values more in line with the political masters than those who are acting improperly. This is indeed likely: if we assume that the maladministrator – individual or agency – is essentially an exception to the rule, then it is likely that someone in authority will be willing to hold wrongdoers to account. In the NHS, and on a larger scale, the monitoring of the district health authorities by the regions, and of the regions by the NHS Management Executive to ensure that central policy directives are followed, is also a form of internal discipline.

However, it is not a process entirely without cost. The recent case of Graham Pink, for example, who blew the whistle on the conditions in wards for acutely ill elderly patients at Stepping Hill Hospital, caused a considerable degree of bad press for the NHS. Managers could be excused for wishing to conceal instances of malfeasance in these circumstances. But the NHS has had other features which militate against internal discipline, at least until the 1980s. Management in the old NHS was conducted by a variety of boards, committees and consensus groups. Such arrangements made it difficult to identify individuals who could be held to account for poor performance. Add in the complication of professionals, acting to their own systems of proper behaviour, and exercising internal discipline becomes an extremely hard task.

The introduction of general management and the experimentation with clinical budgets during the 1980s can be seen as an attempt to improve the internal mechanisms of hierarchical accountability of a large organisation. By making individuals clearly responsible for certain areas of administration and for the use of resources, it was claimed that the actions and decisions taken would be easier to identify. Administrative decision-making within the NHS should be more 'visible' and thereby easier to hold to account.

Public or Group Pressure Methods

At first it may not be clear how public pressure differs from publicity as an instrument of accountability, as both appear to depend heavily on public action for their effectiveness. The distinction is in the source of those exercising control. With organisational methods the initiative comes from within the organisation itself as a consequence of being in the public view, or being open to public participation. Public pressure methods, on the other hand, initiate outside the organisation, with interest or user groups taking their concerns or grievances directly to the agency involved. They share the characteristic of not involving formal institutional conflict, however. As such they do not hold the final sanction, and political methods of control may need to to be used if the agency ignores all advances. Nevertheless, public pressure is a key form of holding public agencies to account, and it can take a number of different forms.

Lay Participation in Health Care Decision-Making

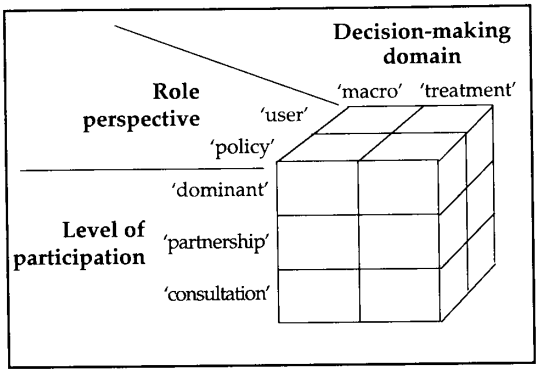
The notion of participation in the field of accountability is increasingly important, with user groups, community representatives and experts from outside the health care system involved in many decision-making processes. 'Lay' simply indicates that those involved are not the traditional insiders: manager, government officials or health care professionals.

A useful taxonomy of the ways in which lay participants become involved has been developed by Cathy Charles and Suzanne DeMaio from the Centre for Health Economics and Policy Analysis at McMaster University, Canada. A summary version of their taxonomy has three dimensions of lay participation: role perspective, level of participation and decision-making domain.

Role perspective has two sub-domains, 'user' and 'policy'. The 'user' perspective reflects a concern with the potential impact of any decision on narrowly defined interests – either oneself, or one's family or particular constituency. A 'policy' perspective, on the other hand, reflects a concern with some broader notion of public or community good.

Level of participation has three sub-domains: 'consultation', 'partnership' and 'dominant'. The 'consultation' level of participation involves an opportunity for individuals to express views or make representations, but offers no guarantee that these views will be taken into account. The 'partnership' level or participation involves shared decision-making processes, involving such bodies as joint policy boards. The 'dominant' category involves decision-making power being handed over to lay individuals.

Decision-making domain has two sub-domains: 'macro' and 'treatment'. The 'macro' sub-domain involves decision-making relating to the allocation of resources between groups or geographical areas. The 'treatment' sub-domain relates to the type or design of treatments or services provided to patients.



Pressure Groups

The pressure group representing a special interest or client has the longest pedigree in the public pressure form of accountability. First identified in S E Finer's *Anonymous Empire*, pressure groups have long been argued to be an essential part of pluralist democracy. In this sense, they comprise an ancillary form of representation, enabling voters to convey more specific information to the Government than is possible at intermittent general elections. They undertake to advise, cajole and warn the Government of the policies they should, or should not, adopt. This analysis applies equally to administrative accountability, and to agencies which are acting improperly. Although many of the pressure groups active in the health and social care field – MIND for the mentally ill, Age Concern for the elderly and the Patient's Association – are chiefly concerned with national policy, they are equally vigilant to examples of administrative wrongdoing. They do not enjoy formal control over these agencies, but are able to cause a great deal of embarrassment, which can have the same effect.

Community Health Councils

Community Health Councils provide a formal channel for the articulation of public pressure. They were implemented in 1974 by the then Conservative Government as part of deliberate separation of the responsibility for managing the NHS from the responsibility for representing the views of the public. The Community Health Councils were to be the vehicle for the user's voice. They have 18-24 members recruited from local interest groups, local authorities and nominees of regional health authorities. They have certain rights: to information, to consultation on substantial changes in service provision, to send observers to health authority meetings (though not necessarily private sessions) and to meet with them once a year, and the right to visit and inspect NHS premises. Community Health Councils are therefore a formal channel, set up by government itself, to ensure that the public's voice is heard on issues of health care delivery. Although lacking formal authority, as Ros Levenson and Nikki Joule from the Greater London Association of Community Health Councils put it,

> *the traditional Community Health Council concern with elderly people and people with disabilities has been an important antidote to the tendency of powerful lobbies to overlook the needs of people who need care instead of cure.*

Individual Action: Complaining and 'Exiting'

The traditional channel for the individual who is dissatisfied with the service they have received from the NHS is a complaints mechanism – a process recently bolstered by a new Patient's Charter 'right'. In fact, one of the conditions for a submission to the Health Service Commissioner is that a complaint has first been made to the relevant health authority. Obviously, making a complaint will not always result in an adequate response, but quite often simply having the agency's attention drawn to misconduct will be enough for the wrong to be righted. Complaints procedures can be more or less formal. Many family health service authorities employ 'lay conciliators' to help doctors and their patients reconcile their differences. On the other hand, hospitals must have a formal complaints procedure under the Hospital Complaints Procedure Act 1985.

But the individual member of the public can exert pressure in another way, and one which is arguably increasing in importance. In some public services it is becoming possible to register one's dissatisfaction with an administrative agency by leaving it, and taking one's 'custom' to another agency. At the moment such opportunities are limited: changing schools and GPs are rare examples of how an individual can directly make such a move. However, rather less directly, GPs can act on behalf of the individual and exert similar pressures on hospitals or other providers who are not offering a good service. GPs have always been able to refer patients to the hospital and consultant of their choice, but a fundholding GP can now exercise financial leverage by removing funds from a recalcitrant unit or consultant. This concept of being able to 'exit' from one part of an administration and join another part is a radical and potentially powerful means of holding public agencies and individuals to account, and will be investigated further below.

Normative Methods

Political control has traditionally been complemented in the UK by well-developed normative restraints. Such 'control' is internal to the bureaucrats and administrators and is more commonly described as the 'public service ethos'. Nurturing this ethos involves the development of mechanisms within the bureaucracy that can serve as a guide to administration 'in the public interest'. Traditionally associated with senior civil servants in central government departments, it is the older of two broad schools of thought regarding the control of administration: an inward sense of personal obligation or external pressure to enforce responsible behaviour. As B Guy Peters argues, it seems likely that a commitment to the public service is generally held, since 'if we look at the volume of complaints relative to the number of decisions and actions taken, it seems that civil service systems on the average do a decent job'. Of course, the reason for such behaviour might in fact be external restraint. But those forms of external control are unlikely, given the sheer magnitude of the public sector, to be sufficient to restrain all the actions of administrators if a significant majority were not acting in good faith and with the best intentions.

But there are a number of difficulties with increased reliance on normative restraint. First, how are we to be sure that the intentions are really in the public interest, and are not instead merely reflecting the values and prejudices of the particular individuals who become public servants? For example, a health authority member, in response to a central policy directive to shift resources from high-cost procedures of dubious effectiveness to long term care for the chronically ill, may feel that he or she is acting in the public interest to resist such change because of personal knowledge of those individuals who may be affected. Does such an individual's accountability to personal codes of moral behaviour take precedence over accountability to policy makers? As we have seen, such difficulties have led, at the higher levels of the civil service, to the increased politicisation of public office holders and, furthermore, to full-scale reorganisations of the NHS.

Professionals offer examples of both the benefits and difficulties with normative means of control, and present particularly acute difficulties for administrative accountability. The hospital doctor offers a paradigm case of such a problem. Professional codes of conduct put the welfare of the individual patient at a premium, and clinical judgements are considered to be the only decisions which have any relevance. However, the agency – in the present context the trust or health authority – will also have to consider how best to use limited resources in the face of unlimited demand. It may be that society chooses not to treat certain medical conditions at all if the cost is so high that many others have to wait months or years for treatment as a consequence. The accountability of a doctor to his or her colleagues for the quality of their medical care – the province of medical audit – is not sufficient in a publicly funded agency such as the NHS which demands accountability for the way in which limited resources are distributed between competing claims. The fundholding GP now presents similar difficulties and is discussed further below.

Normative restraint is, therefore, not without difficulties. Nevertheless, its importance should not be underestimated. Most of us do share values as to proper conduct and act on them whether we work for the government or a private employer; doctors do place the interests of their patient before their own; and managers do discipline acts of impropriety. When normative control works it is cheap, reliable and acts before the grievance rather than simply providing compensation or the assurance that it will not happen again. It may be appropriate to round off this summary of instruments of administrative control by emphasising its fundamental importance.

Our mapping exercise has revealed that a wide range of mechanisms are available through which accountability is exercised. These mechanisms are not mutually exclusive; on the contrary, most are highly complementary. The National Audit Office and the Audit Commission, for instance, assist select committees, Ministers and administrators alike. Direct public pressure can assist in the exercise of internal discipline. More generally, all the non-political methods can, and should, act in tandem with the political methods.

Occasionally, the various methods are seen as substitutes for one another. This can be desirable: if an agency corrects its own malpractice through the actions of a senior manager then this is presumably more efficient than invoking an internal inquiry. Substitution of informal for formal methods causes concern to many commentators, however. Formally appointed local representatives on health authorities have now been replaced with a recommendation for authorities to engage in a 'consultative' process of lay participation. And complaints are being directed to chief executives of trusts rather than the Minister in Parliament.

The analysis presented in this paper does not seek to resolve these issues, but we do suggest that these mechanisms are part of the same process. We contend that it is more useful to conduct a debate on the relative desirability of these instruments from the common starting point that they are all seeking accountable government. In the final part of this paper we take the debate one step further and analyse the impact of the 1991 NHS reforms – which were chiefly concerned with efficiency – on accountability.

The NHS and Community Care Act 1990

The NHS and Community Care Act 1990 constituted one of the most significant reforms in health and social care in the UK since 1947. The legislation created a competitive environment in the delivery of health care by splitting purchasing and providing functions of health authorities and organising the delivery of care by contractual agreements. Health authorities were modelled on boards of directors and formal local representation was removed. The effect was a significant contribution to the fragmented state mentioned in the introduction to this paper.

Economic analyses of 'managed' competition in the NHS are commonplace, as are discussions of the fairness or equity of a system whereby GPs and health authorities are encouraged to be explicit in their allocation of resources between client groups. But the impact of these reforms on the accountability of a public service have also started to create substantial interest and concern. In the final section of this paper, we ask a series of policy questions provoked by the reforms and associated initiatives.

- ***Who is responsible for the actions of providers within a contractual system of service provision – the chief executive of a trust, or the Minister in Parliament?***

Under the NHS and Community Care Act 1990, NHS trusts are managed by boards consisting of executive and non-executive directors. These boards are appointed by, or in consultation with, the Secretary of State for Health. Formally, therefore, they are accountable to the Secretary of State, rather than to a district health authority which, prior to the reforms, included members appointed by the local authority. NHS trusts are not Crown agencies.

These developments have led to claims that trusts are not accountable to their local community, and have 'opted-out' of the NHS. Certainly the local political appointees on the old district health authorities are now absent, and the district health authority now exerts its influence only through the making and removal of contracts. In contrast to these concerns, the creation of trusts, and other similar agencies in the public sector, are claimed by the Government to improve accountability by clarifying responsibility for service provision. A Government press release outlined how the new trusts were 'more open to public scrutiny than ever before':

> *NHS trusts are required to publish their..business plans and annual report...to hold at least one public meeting each year; the local community health council retains right of access, and service agreements between health authorities and trusts are open to public scrutiny* (Department of Health Press Release, 17 February 1993).

But identifying responsibility for maladministration in a hospital and exercising control are not the same thing. We have seen how public pressure and the market can provide some control over administrative agencies such as trusts. But ultimately these mechanisms must be backed by formal authority and institutional control, namely, through political channels. Is this control still effective?

Management boards of NHS trusts are now separated from hierarchical control by the political centre by the purchaser/provider split. Ministers are constitutionally responsible for all the actions of their department, but the suspicion is growing that on occasion they are unwilling to answer for serious maladministration in contracting agencies. As Professor Stewart puts it in a recent paper for the European Policy Forum, *The Rebuilding of Public Accountability*, 'there may be confusion as to whether problems arising in the operation of a contract are the responsibility of the contractor or the client'. If a Minister refers Parliamentary questions to the chief executive of trusts then this, far from clarifying accountability, as proponents of contracting argue, introduces another source of confusion.

Similar concerns are being expressed by Members of Parliament. Gerald Kaufman recently wrote of his experience of dealing with the Social Security Benefits agency, one of the new 'Next Steps' agencies which administer Government policy with reference to 'Framework Documents' – a sort of internal departmental contract. Although nominally still within the relevant department, these agencies are administratively self-contained, with their own chief executive and staffing arrangements. In writing to Peter Lilley the Secretary of State for Social Security, Kaufman reports that his letter was passed on to Michael Bichard, the chief executive of the agency. He found it extremely difficult to get a reply from Lilley concerning the case of one of his constituents. Kaufman argued:

> *MPs have no powers and only two rights. One is the right of privileged speech in Parliament. The other is the right of access to ministers ... If ministers seek to eliminate one of those rights, as they are doing by delegating cases to agencies, units and officials, they are diminishing the rights of our constituents and the rights of Parliament. They are diminishing democracy* (The Guardian, 7 December 1992).

It could be argued that the reply from an agency – or trust – chief executive is more appropriate than that from a minister, since agency chiefs are likely to know more about the case in question. On the other hand, the possibility for embarrassing a minister in the House of Commons is diminished. If local complaints procedures or the Health Service Commissioner fail to provide redress, then the right of access to a minister, via an MP in Parliament, provides the final avenue for correcting maladministration in a government department – and this includes actions which occur within trusts. There seems to be a very real possibility that Ministers may be tempted to absolve themselves from this responsibility, leaving a worrying degree of ambiguity as to where the buck stops.

The justification for this state of affairs, at least in the eyes of the present Government, is that the greater independence of trusts within a competitive environment is likely to produce greater efficiency in the delivery of health care. Furthermore, their dependence on purchasers for their income means that their scope for independent action in the delivery of care is limited. The question becomes whether the correct balance has been struck between political, organisational and public pressure forms of accountability, and the goal of efficient production. A similar question can be asked of the purchasers of services.

- ***Are purchasers in a contractual system of service provision now taking explicitly political decisions on the allocation of resources without appropriate checks and controls?***

Districts are now responsible for assessing the health care needs of their populations and for purchasing a mix of services which best meets those needs by means of contracts with a range of public, voluntary and private sector providers. Since the resources available will never be sufficient to meet the demands made on them, districts must make choices about how much of which services to purchase, and prioritise accordingly. It is the explicit nature of this process, unencumbered by management responsibility and the influence of the hospital doctors, which marks the key departure from the old system. Furthermore, these agencies no longer include local authority appointed representatives: the chair is appointed by the Secretary of State, five non-executive members are appointed by the regional health authority, and up to five executive members are appointed by the other members. The strategy is to create slimmer more businesslike bodies able to take a strategic view of health needs, and to purchase services to meet these needs.

The new 'explicitness' has meant that what these authorities have always done – authorise the allocation of resources between various uses – is now more clearly an exercise in political, rather than merely administrative, decision-making. Competing claims for health care resources are being adjudicated by appointed officials, largely hidden from the public view. Although not strictly speaking delegated legislation – statutory instruments are used for the creation of health authorities and not decisions made within them – the purchasing of a particular range of health services does constitute a binding decision. Furthermore, there are no formal means of reviewing or challenging these decisions. What mechanisms of accountability are available to ensure that they are made with due regard for their political nature?

Although the chain of accountability is in principle clear, running from district to region to Management Executive to Secretary of State, there is little doubt that the sheer number of these authorities – approaching 190 – ensures that most decision-making is undertaken without close supervision from superior officers and political masters, save some centrally determined priorities such as *The Health of the Nation* targets. Furthermore, the individuals involved are unelected officials, often with little or no experience of working in the public sector. If this is accepted as a necessary move to a more businesslike agency, then it is still essential that robust systems of accountability are in place.

As things stand, district health authorities have to produce an annual report from the director of public health and a purchasing plan, both as part of corporate contracts with a parent regional authority. They also have to hold a number of meetings each year in public. However, in practice, many decisions are taken in private sessions, and the published documentation rarely outlines the reasons for decisions taken, merely making a statement of intent. What might be done?

One possibility would involve the utilisation of a method described above under organisational accountability. If it were an obligation to include the reasons behind decisions, rather than simply report the decisions themselves, then health authority members would be encouraged to think more carefully about their impact. Poorly thought out or researched decision-making or inadequate consultation would be open to public view. Crucially, authority members would be forced to enter into a debate as to why they adjudicated between claims in the way they did.

By way of example, some health authorities are starting to question whether certain services should be provided on the NHS. Treatment for infertility is one such service, but it is not clear why one district decides to remove the treatment and another continues to purchase it. Another example relates to non-fundholding GPs. When they refer to providers which do not hold a contract with the parent district, the decision as to whether or not to pay for the treatment is left to that district. However, the individual concerned does not have the right to challenge a decision to refuse treatment. As Professor Bridgit Dimond, a barrister, put it:

> *It would seem reasonable for there to be a mechanism whereby an individual who had been refused treatment either within the district or outside it could learn of the reasons for the refusal and to have an opportunity to bring an appeal against the decision* (*Health Service Journal*, 28 January 1993).

Professor Norman Lewis, from the Centre for Socio-Legal Studies at the University of Sheffield, has advocated a 'one-clause bill' which would allow the courts judicial review of decisions which had not been made with sufficient transparency, justification or consultation. This review could apply as much to decisions made on the NHS policy board as to those on local health authorities. Lewis argues that such an innovation would produce better policy-making at at stroke.

One further complication to this picture is the GP fundholder. This development offers the possibility of financial leverage for improved services from providers, with the fundholder acting as a 'gatekeeper with teeth' for the individual patient. But whilst much is made of the relative benefits to be accrued from fundholders, little has been said about the possibility of GPs taking unaccountable decisions regarding the range of services they are prepared to provide. What is more, GPs are not subject to medical or peer audit, so there is no routine professional check on standards, and now they are being offered financial incentives, albeit not for personal gain. GPs are controlled predominantly by normative means – organisational and political mechanisms are weak, leaving the GP free to operate as his or her conscience decrees. The development of the fundholder places a further strain on this somewhat fragile mechanism.

There is no evidence that a fundholder has yet denied treatment to a patient on other than clinical grounds, but it is in principle possible for these GPs to decide that a treatment is not appropriate or cost-effective and refuse to purchase it. If this possibility is a real one, then the need for national guidelines on basic NHS entitlements becomes stronger, as does the need for an enhanced monitoring role for the Family Health Service Authority. It is in principle now easier for individuals to exert direct public pressure by 'exiting' from an unpopular GP and joining another. Although potentially a powerful instrument of accountability, this practice is not yet commonly accepted amongst members of the public and is thus limited in its effectiveness. As things stand, GP fundholders appear peculiarly unaccountable in the light of their influence over public funds.

As with the situation relating to trusts, there appears to be a trade off between efficiency and accountability in the operation of purchasing agencies. As B Guy Peters puts it:

> *whilst it is certainly important that the public have access to relevant information about administration, working in a goldfish bowl can rarely be as efficient as working in private.*

An appropriate balance must be struck between involving the public and utilising their values and knowledge, and creating efficient and businesslike agencies which are able to fulfill their obligations without undue hindrance.

- ***Can the public be properly accommodated directly in the decision-making process?***

One possible means of improving the accountability of health authority decision-making also uses organisational means of accountability, and involves improving the direct participation of the public and other non-health care officials in the decision-making process. *Local Voices* emphasised the role of the reformed health authorities as 'champions of the people'. They were urged to involve local people in a process of 'listening, informing, discussing and reporting'. The recommended mechanisms include public opinion surveys, public meetings, workshops and user/carer forums. Questions relating to the use of these methods are now extremely topical, and it has been suggested that their use represents a diminution of accountability if substituted for formal political methods. Certainly, the use of the general public, and indeed outside expertise, offers both benefits and dangers. Three questions in particular are outlined here: who is it appropriate to involve in what circumstances, how can the public's valuations of health states be utilised, and what legitimacy do the findings of surveys or public meetings have?

First, if it is accepted that the opening up of government promotes an accountable administration, it is by no means clear who should be involved, what decisions they should be involved with, and how much weight should be attached to their opinions. One way of visualising this dilemma has already been set out in **Lay Participation in Health Care Decision-Making**. The term 'lay' is used here rather loosely, and refers to those participants in the decision-making process from 'outside' the health care delivery system. This obviously includes community and user groups and their representatives, but it also includes outside experts such as health policy academics and economists. Some of these 'outsiders' are formally incorporated into the decision-making process as non-executive directors on trust boards and health authorities to act as 'local community representatives' in place of the local authority appointed members.

The taxonomy developed by Cathy Charles and Suzanne DeMaio suggests that lay participation can be from different perspectives, at different levels, and concerned with different decision-making arenas. The appropriate lay-participants must be accommodated in the appropriate category of participation. It may be that health policy think-tanks (such as the King's Fund Institute) are appropriate to involve in the decisions relating to resource allocation and the design of equitable systems of delivering care ('macro-policy-consultation' sub-domain). On the other hand, where service delivery is concerned, Anthony Harrison and Sally Prentice's article on maternity care shows that the Government has accepted that users should be consulted on the form this provision should take ('treatment-user- consultation' sub-domain).

This taxonomy also provides one clue as to why so many user groups feel their protestations are not being heeded and that systems of participation are substitutes for, rather than improvements to, accountability. If, for instance, the user group identified above feels that part of the difficulty with their service is that it is underfunded, then they may press for increased resources. The difficulty is that all 'interest' groups will have a tendency to press for their own interests to be promoted; the health authority, as we have seen, needs to adjudicate between these claims, and may legitimately feel that only taking note of those who 'shout the loudest' would be inappropriate. Accountability is about more than simply responding to demands from individual groups in society.

Table 1: Priority Ranks of Public and Doctors in City and Hackney Health Authority for Various Health Care Treatments

Treatment	Public community groups	Consultants
Palliative care for the dying	2	4
Infertility treatments	14	14
Disability therapies	7	10
Treatment for children with life-threatening illnesses	1	2
Health education services	12	11
Mental illness treatments	8	1*
Hip replacements	6	5
Preventive services	5	7
Intensive care for premature babies unlikely to survive	9	13
Family planning services	13	9
Alternative medicine	15	16
Medical research for new treatments	3	8*
Long stay care	10	6*
Cosmetic surgery	16	15
Community services	11	3*
Heart transplants	4	12*

Source: Ann Bowling, City and Hackney District Health Authority

* These treatments have statistically significant different rankings as between consultants and public community groups

Nevertheless, the public's values in resource allocation decisions are an important factor in those decisions, and the development of public opinion surveys and public meetings indicates that decision-makers are keen to be seen as acting accountably. One particular type of survey seeks to elicit the public's valuation of various health states, and then use these valuations to estimate the potential benefit to be gained from spending health care resources on various treatments. One application of this information is to purchase relatively more of the treatments which offer the most Quality Adjusted Life Years (QALYS) per pound spent. QALYs promote accountable decision-making in one respect at least – they are based on valuations of the general public at large, and not on the assumptions or presumptions of the medical profession. However, there are methodological and ethical difficulties. It is extremely hard to demonstrate rigorous valuations for health states which command a wide degree of consensus. Even more importantly, it can be easy for decision-makers to jump from evidence on valuations of health states, to assuming that such evidence constitutes the public's implicit desire for a particular distribution of resources.

Another means of attempting to elicit such allocative valuations from the public is the use of the public meeting. It is certainly important to have some idea of the public's relative valuation of treatments for newly-born infants as opposed to heart transplantation, for example. In contrast with the activity of pressure groups, the attraction of the pubic meeting is that one can in theory attract a more representative sample of the local community, which in turn may be a better means of obtaining views on resource allocation decisions. However, the methodological difficulties are substantial. Recent experience in City and Hackney found that it was hard to persuade a large enough sample of people to take part and that the sample was not particularly representative. These difficulties echo the experience of the state of Oregon in the USA which sought the views of its population in drawing up a ranking of treatments for its medicaid programme, as Ray Robinson's article in this volume reveals.

The issue of representativeness becomes particularly important if lay participation is to have an impact on the macro decision-making sub-domain. Table 1 shows the results from a survey of City and Hackney Health Authority designed to elicit and compare the relative valuations which the public and the medical profession place on various treatments. The table shows how the general public tend to place less value on community-based services, long term care and services for the mentally ill; they place rather greater value on life-saving interventions such as transplantation surgery, and on research for new treatments. One concern must be that those who might benefit from the former treatment categories were not adequately represented at these meetings.

But there is an even more fundamental point. Using surveys of public opinion to rank treatments – even if perfectly representative of all groups and classes in society – will favour simple majority opinion. Services for the mentally ill or care in the community for the elderly frail may seem particularly remote to most of us, and thus may not be valued highly. If these values alone are then used to legitimise decision-making, this would constitute a fundamental break with a tradition whereby we elect or appoint officials who are then responsible for taking and implementating these decisions on our behalf. Direct participation could encourage these officials to absolve themselves of this responsibility, claiming that they simply 'did what the public wanted'.

But how can that public be challenged on their decisions, and what weight should their decisions be given when they do not have to bear the consequences of their implementation – refusing care for the mentally ill or for the elderly? Accountability would under these circumstances be fundamentally weakened. Political decisions will always be a compromise, arbitrating between groups in society, made by people who represent the entire community and not just one set of interests. These representatives should be made as accountable as possible, and not absolved of that accountability for making hard political choices. In the macro decision-making domain, to refer to the taxonomy described above, it seems sensible to ensure that the level of participation remains only consultative rather than dominant.

• *What is the significance of rights, and, in particular, initiatives such as the Patient's Charter, for the accountability of public agencies?*

The 'Big Idea' of the Major Government was the introduction of a Citizen's Charter as a means of making public services more responsive and accountable to the public. The charter included ten 'rights' and a number of standards of service which the health service consumer could expect to be met. It was the idea of rights which gave the charter its weight as an instrument of accountability. Rights are usually understood to be enforceable in some formal sense, usually in the courts, by the individual to whom they apply.

However, when the Patient's Charter rights are investigated it turns out that only some have their basis in legal statute and are therefore enforceable in the courts: for example, the right to be registered with a GP. The remainder can only be enforced by writing to Sir Duncan Nichol, Chief Executive of the NHS, who 'will investigate the matter and, if appropriate, ensure corrective action is taken' – see **Patient's Charter 'Rights'**.

This is not to say that these rights are necessarily ineffective: they give the individual a clear reference point for holding the administrative agencies to account. The exercise of control is impossible without information about what is, or should be, happening. The rights offer a clear indication of what should be happening, and therefore in principle deny the administration the possibility of 'fudging' its responsibilites.

However, there are two concerns about the Patient's Charter rights. First, does 'writing to Sir Duncan' offer an effective control on the administration? Many people may feel disinclined to go to the trouble of doing so, and there is no right of appeal or independent panel adjudicating complaints to the chief executive. Furthermore, the Patient's Charter includes many other 'standards' which the Government does not even claim to be rights, and which are used only for statistical and managerial purposes. Secondly, are the 'rights' appropriate? One of the most widely discussed of the new rights is that guaranteeing waits of less than two years for admission to hospital for treatment. If health authorities have to significantly reallocate resources to fulfil their obligation on waiting times, this could have an impact on provision of

Patient's Charter 'Rights'

Not all the 'rights' outlined in the Patient's Charter are enshrined in statute or common law, enforceable in the courts. The following do not appear to be statutorily vested in the individual, although they may constitute a duty on the Secretary of State 'within the available resources'. Otherwise they can only be enforced by writing to Sir Duncan Nichol, the Chief Executive of the NHS, who will take 'corrective action if appropriate':

- to receive health care on the basis of clinical need, regardless of the ability to pay;
- to receive emergency care at any time;
- to be referred to a consultant, acceptable to you, when your GP thinks it necessary, and to be referred for a second opinion if you and your GP think this is desirable;
- to be given detailed information on local health services, including quality standards and maximum waiting time;
- to be guaranteed admission for treatment by a specific date no later than two years from the day when your consultant places you on a waiting list;
- to have any complaint about NHS services investigated and receive a full and prompt reply from the chief executive or general manager.

The following rights can be enforced by the individual in a court:

- to be registered with a GP;
- to be given a clear explanation of any treatment proposed, including any risks or alternatives, before you decide whether you will agree to the treatment;
- to have access to your health records, and to know that those working for the NHS are under a legal duty to keep their contents confidential;
- to choose whether or not you wish to take part in medical research or medical student training.

Sources: The Patient's Charter and the *Patient's Charter Briefing Pack*

emergency care; for example, it may be that long waiting times for certain minor conditions are appropriate in the context of limited resources.

However, the use of rights should not be dismissed, since they provide a certain degree of transparency to the NHS' activities, an important prerequiste for accountability. Perhaps more importantly, they can provide a countervailing mechanism to the adverse possibilities of excessive public pressure described above. In order to be effective, though, the current range of rights would need to be extended to include 'rights not to be excluded' from consideration for treatment. It is likely that such rights would be procedural – guaranteeing that a process of assessing need is undertaken – rather than substantive – that is, guaranteeing treatment. Nevertheless, they could protect vulnerable groups from arbitrary and unaccountable exclusion from NHS services.

- ***Can the new market system for delivering health care be used to hold health care agencies to account?***

The opportunities for those purchasing health care to alter the pattern of that care is now, in theory, greater than in the pre-1991 NHS. District health authorities and GPS can switch their contracts between providers and thereby punish those providers not performing well. Typically, this process has been described as an attempt to improve efficiency and value for money. It is also a means of improving the accountability of public funds by ensuring they are not wasted. But an efficient system may not be accountable in a wider sense if it is merely efficient at producing undesirable outcomes. The question remains: can the market system be used to achieve accountability more broadly defined? Will it not only reduce waste, but encourage a considerate, friendly, user-oriented service?

In principle, there is no reason why the market should not be thought of as a means of controlling service delivery. There is also no reason why the focus should merely be on value for money, narrowly defined as a given level of service provided at least cost, and not on correcting improper administration. For example, it may be that a GP fundholder has a Bangladeshi woman as a patient. This woman may find it extremely important that she is seen by a female consultant. If the GP can use his or her funds to insist on such a consultant from the local hospital, then we may argue that there is an increase in accountability in the system. Furthermore, we are also in principle more able to 'shop around' for GPS themselves. An elderly couple who had been assigned a good but rather brash young GP could change to a GP of their own generation who is more sympathetic to their sensibilities. We have seen how such actions are not yet widely practiced, but by combining conceptions of control with public pressure we appear in theory at least to be able to talk of market systems and competition as potentially powerful instruments of accountability. As John Stewart puts it, the idea is that

> *the citizen as customer can then replace the citizen as voter, and that is the position taken implicitly if not always explicitly by the White Paper on the Citizen's Charter.*

However, this may paint far too sanguine a picture. In the first place, health care does not typically allow the consumer to make informed choices and thereby exercise accountability – we are usually dependent on a third party to guide us in our decision-making. Where the purchaser is working closely with the individual, such as the case of the GP fundholder, this may not present too much of a problem. But the majority of contracts are made by large purchasing authorities or consortia of authorities who have little or no contact with individual users beyond the information provided by public opinion surveys. Many services such as emergency care will never be subject to competitive pressures. These large purchasers will find it hard to move beyond simple 'value for money' accountability.

Furthermore, Stewart argues that there is an inherent limit to the use of the market for achieving accountability in the public service, and this relates to the reason for the service being in the public sector in the first place. Many services are provided not to meet demand but to meet need, and it is often not possible to articulate need in terms of mechanisms for switching demand between suppliers. For instance, one condition for a successfully operating market is free entry and exit. That is, the unsuccessful providers must be allowed to go out of business, and new ones must be free to take their place. In the case of hospital services, this could lead to the forced closure of a local trust, if the actions of purchasers are principally determined by 'value for money' considerations. This phenomenon is currently affecting London, where purchasers are switching contracts to providers outside the high cost areas of inner London.

However, the public sector has more than simply the efficient disposal of public money as its objective; it must also ensure that such disposal is equitable, and that necessary services are seen to be reliably available. These global objectives may not be the concern of the individual customer in a public sector market, nor even a purchaser acting on their behalf. But they must remain the responsibility of government as a whole and the accountability offered by the market is clearly unable to ensure this responsibility. These other condsiderations may lead to an inefficient provider being retained, at least in the short term. Contracts offer their own difficulties: if governing involves change, uncertainty and learning adaptability then these qualities may not fit easily into a contract culture. The clarity with which contracts specify what is required may lead providers to feel less need to co-operate with purchasers in getting those requirements right. In John Stewart's words 'to say one has fulfilled one's contract may be to deny responsibility rather than to accept it'.

Whilst accepting that markets and contracts are limited in their scope for controlling the administration, and the NHS in particular, they do offer a potentially powerful tool if systems can be designed whereby the individual is able to exercise real choice. As things stand such opportunities are strictly limited.

Conclusion

This paper started with a description of how the modern state was becoming increasingly fragmented, and how this was causing concern amongst commentators that the accountability of the agencies operating in this fragmented system was being eroded as a consequence. The paper ended with a tentative example of how this fragmentation can be organised so as to give the individual some direct, or more commonly indirect, influence over these same agencies through the operation of public sector markets. The intention is to indicate the complex and heterogenous range of mechanisms which contribute to the process of accountability.

Accountability is not something that can be quantified, so that we can add up the net effect of a reduction of one type and an increase in another. Nevertheless, it is clear that with such a range of mechanisms at the disposal of citizens, interest groups, political masters and the administrators themselves, we should not be seduced into thinking that a reduction in one form of accountability indicates a reduction in accountability overall. Other forms may take their place. What we need to decide, and this is a continual process, is the particular distribution of instruments of accountability which we as a society consider appropriate.

The introduction of the 1991 NHS reforms reveal a yet more fundamental set of trade-offs, this time between accountability and other goals of public policy. We certainly want to be sure that public agencies implement the values of the public and their representatives, and do so without bias, neglect or ill-manners. But we also want governments to provide public services as efficiently as possible, and we want the outcome of those policies to conform to notions of social justice. In an ideal world we might be able to design systems which accommodate all these goals; in the meantime we need to strike a balance. If the NHS reforms were primarily concerned with efficiency, we may now need to look afresh at accountability.

Exploring Accountability Further

The best overall introduction to public administration in this country is John Greenwood and David Wilson's 'Public Administration in Britain Today', (2nd edition 1989, Unwin Hyman), which also covers briefly most of the accountability instruments analysed in this paper. An excellent comparative analysis of administrative systems can be found in B. Guy Peters' 'The Politics of Bureaucracy', 3rd edition (1989), Longman; this book also provides the framework for analysing administrative accountability used in this article.

A useful historical perspective is provided by Bruce Smith and Douglas Hague's (eds) 'The Dilemma of Accountability in Modern Government: Independence versus Control', (1971, Macmillan), which reports the papers presented at the Ditchley Conference of 1969. John Pater's 'The Making of the National Health Service', (1981, King's Fund) provides an account of how accountability was built into the original NHS structure.

The most substantial analysis focusing exclusively on accountability is Patricia Day and Rudolf Klein's 'Accountabilities: five public services', (1987, Tavistock Publications) which compares the accountability of the NHS, the police, the water authorities, and the local authority education and social services committees in the UK. More recently, the debate on public accountability has been boosted by two papers published by the European Policy Forum: 'The Rebuilding of Public Accountability' by Professor John Stewart from the School of Public Policy, University of Birmingham, and 'Accountability in Education, Social Services and Health' by Professor Norman Lewis and Diane Longley from the Centre for Socio-Legal Studies, University of Sheffield (December, 1992). Diane Longley's 'Public Law and Health Service Accountability' (1993, Open University Press) analyses the potential role of public law in designing an accountable NHS. The formal political channels of accountability, and their weaknesses, are analysed by David Hunter in 'Accountability and the NHS', British Medical Journal, 15 February 1992.

Turning to individual instruments of accountability, Day and Klein's 'Inspecting the Inspectorates', (1990, University of Bath, Centre for the Analysis of Social Policy), looks at three investigatory bodies in detail: the Health Advisory Service, the Audit Commission and the Social services Inspectorate. A description of 'The National Audit Office', produced by the Central Office of Information, (1983), is available from HMSO. The analysis of participation used in this paper was derived from Cathy Charles and Suzanne DeMaio's 'Lay Participation in Health Care Decision Making: A Conceptual Framework', (1992, Paper 92-16, Centre for Health Economics and Policy Analysis), is available from McMaster University, Hamilton, Ontario, Canada. 'Listening to People: User involvement in the NHS - the challenge for the future' by Ros Levenson and Nikki Joule, (1992, Greater London Association of Community Health Councils), gives a good account of participation in an NHS context, including the function of Community Health Councils. The complex NHS complaints procedures are examined in 'Complaints Do Matter: a consultative paper on future NHS complaints arrangements', (1993, National Association of Health Authorities and Trusts).

THE GOALS OF HEALTH POLICY: CHURCH OR GARAGE?

Rudolf Klein

In discussing the evolving goals of health policy, from the foundation of the National Health Service to the present, there is one difficulty which faces the analyst right at the start. This is how to set a boundary around the notion of 'health policy' and, by so doing, making the task manageable. For about three decades after 1948, the notion of 'health policy' was in effect defined by the National Health Service. Health policy was NHS policy; the goals were those explicit or implicit in the NHS. However, one of the most striking developments of recent years has been the growing elasticity of the concept. It has become stretched to cover almost every aspect of public policy. Only consider the implications of the revival of the public health tradition, with its emphasis on social engineering rather than medical intervention. The new goal, as expounded in *The Health of the Nation* is promoting good health, rather than dealing with ill health.

In what follows, however, this analysis will not attempt to deal with this expanded, ambitious definition of 'health policy'. Instead, the strategy will be to use a narrower definition of the concept and to concentrate on the goals of the health care delivery system, as they have changed over time, by examining both the aims of those actually responsible for designing and running the NHS and the criteria used in judging its performance. In doing so, the theme will be that, increasingly, the goals of health care policy have shifted from a quasi-religious to a more instrumental approach: from viewing the health care system in terms of a church – all embracing in its social role and embodying certain moral values – to seeing it as a garage – responsible only for the repair and maintenance of bodies. The two conceptions still co-exist, with the result, it will be argued, that there are contradictory expectations, which in turn explain why Britain's health care system is likely to change even more in the next decade or so than it has in the past 10 years.

Improving Health Care or Changing Society?

This restriction of the scope of analysis needs justification. The first reason for resisting the temptation to explore the new, enlarged definition of 'health policy' is that this analytical path leads in too many directions. If we say that the promotion of good health, and the prevention of ill-health, should be our goal, we are in effect putting forward a criterion for judging a whole range of public policies. There is a long tradition for such an approach, going back at least to the time of Chadwick. Two examples neatly illustrate the implications of adopting this wider definition of health policy.

In 1876 Benjamin Ward Richardson published his vision of a society shaped by health policy *Hygeia – A City of Health*. Both the design of his ideal city and the lives of its inhabitants were to be ruled by the health imperative: the goal was to root out all habits and practices that might promote ill-health.

> *And, as smoking and drinking go largely together, as the two practices were indeed original exchanges of social degradation between man and the savage, the savage getting very much the worst of the bargain, so the practices largely disappear together. Pipe and glass, cigar and sherry-cobler, like the Siamese twins who could only live connected, have both died out in our model city.*

Richardson was a utopian visionary. However, much the same emphasis on social engineering is evident in the submission by the British Medical Association to the 1925 Royal Commission on National Health Insurance. In this the BMA argued that:

> *... the organisation of a National Health Insurance scheme is not necessarily, or even probably, the best means of utilising limited resources for the promotion of national health. It is more than likely that there are a number of other directions in which severally, or collectively, a corresponding expenditure would produce an even more satisfactory return. Such are (1) proper housing (2) town planning with the proper provision of open spaces and recreation facilities (3) smoke abatement (4) a pure milk supply (5) public house reform and the reduction of the sale of alcoholic beverages (6) the destruction of vermin (7) education (8) the aiding of medical research.*

The list of desirable changes could, of course, be extended. So, for example, one could argue for full employment and income redistribution as necessary conditions for improving the nation's health. However, there are a number of problems about this line of argument. Reducing the scale of unemployment and poverty are, surely, important policy goals in their own right. Why should the production of 'health' be wheeled on as an argument for promoting policy goals which are desirable in themselves? Would we be less concerned about trying to reduce unemployment if there was no link between joblessness and the population's health? Would we stop worrying about poverty if it was demonstrated that there was no connection with disease? If the notion of 'health policy' is not to become an all-purpose banner to rally social reformers – thereby losing all precision and meaning – it might be better to see improvements in health as the by-product of policy goals which should be pursued in their own right.

The second problem about using an all-embracing definition of 'health policy' is linked to this. One of the most striking phenomena of the past decade or so has been the process of institutional blame diffusion. Once we saw education as the key to social transformation: as the way forward to producing a more equal society. Now the dominant view is that we asked too much of our schools and that they cannot carry this weight of social expectations: that examination results do not mean much because they are the product not of the school's performance but merely reflect its social environment. Once we thought that it was the responsibility of the policy to deal with crime. Now Chief Constables are vying with each other to point out that they cannot be held responsible for soaring crime rates, since these are the product of social conditions: that the police cannot be expected to cope with the consequences of social dislocation. The same could be said of public housing, where high expectations of its social engineering potential have turned to sour disillusion. And the same, of course, is now being said about the NHS.

There is truth in all these defensive assertions. But there is also a danger. This is that, in our recognition of social complexity and the inter-dependence of a multiplicity of policies, we may lose sight of what can and cannot be expected of individual institutions: that blame diffusion will lead to a blurring of responsibility. If everything is dependent on everything else, how are we to define the goals of specific institutions like the NHS? Another way of putting this would be to ask: what should be the policy goals of the NHS, recognising that the contribution of any health care system to 'health' – at least as conventionally measured by mortality and life expectancy – is very limited.

Hence the case for concentrating on the goals of health care policy in the narrow sense: to focus on what can and should be expected from a health care system. Even with this restriction on the scope of analysis, difficulties remain. Should the goals be defined in terms of the objectives that policy makers have set themselves over the years? Or should they also include the prescriptive policy aims which have been or might be used to assess the performance of the NHS? The distinction is important. If we look at the academic literature, we find that Britain's welfare state is frequently criticised for its failure to achieve greater equality. Yet if we look at the intentions of the policy makers, we find that the achievement of greater equality rarely, if ever, figured among their policy goals. There is a risk, therefore, of retrospectively condemning policy makers for failing to achieve goals which they never set themselves.

In what follows, the analysis deals with both descriptive and prescriptive policy goals, while trying to distinguish between them as much as possible. Knowing what the goals of the NHS's founding fathers were, and what it is actually trying to do, is important if we are to assess its performance. Discussing what the policy goals should be is crucial if we are to develop any criteria for judging the institutional design of health care systems. If we assume that the NHS is very much in a state of evolution, we need criteria for assessing the way in which Britain's health care system develops, which are independent of the historical legacy of assumptions and ambitions built into existing institutions.

The Church and its Founding Fathers

In analysing the goals of the NHS, as perceived by the founding fathers, the metaphor of a church is helpful in illuminating one of its defining characteristics. Its creation rested on an act of faith. Like most of his contemporaries, Aneurin Bevan had no doubts about the powers of medical science to improve health. On this doctors and politicians spoke with one voice. The challenge was to spread the word: to make health care accessible to all by eliminating financial barriers. The aim was to 'universalise the best', to quote from Bevan's speech introducing the NHS Bill in 1946. It was however, a church for rationalists: the element of missionary conviction lay precisely in the belief that it would only be possible to 'universalise the best' by creating an institution which would make it possible to plan rationally, purposefully and comprehensively. Medical science and managerial rationality went hand in hand. From this flowed the emphasis on efficiency and effectiveness: words which were to be used with ever increasing frequency in the 1980s but which, nevertheless, already formed part of the vocabulary used by the founding fathers. Witness Bevan's remark, in the same speech, that 'I would rather be kept alive in the efficient and cold altruism of a large hospital than expire in a gush of warm sympathy in a small one'.

If the metaphor of the NHS as a church seems too far-fetched, consider this quotation from Barbara Castle – one of Bevan's disciples and SECRetary of State for Health in the 1970s – speaking at the time of the dispute over pay-beds:

> *Intrinsically, the National Health Service is a church. It is the nearest thing to the embodiment of the Good Samaritan that we have in any aspect of our public policy. What would we say of a person who argued that he could only serve God properly if he had pay pews in his church.*

In other words, the NHS was seen to have a moral, as well as a scientific, mission. It was not just saving bodies. It was also saving souls by embodying certain values of mutual help: very much the view taken by Richard Titmuss in *The Gift Relationship*, his celebration of the NHS as an instrument for promoting communitarian values. From this perspective, then, the goal of a health care system should be, to switch to the prescriptive mode of analysis, to promote social cohesion. The universality of a health care system is not just a means of ensuring access for all but a celebration of the common humanity of all citizens: rich and poor are treated alike in the cancer ward. Similarly, the stress on providing services free of charge is not just a way of ensuring access for all but a declaration of faith that medical care is somehow 'special' and must be distinguished from goods sold in the market place.

From this alliance between belief in medical science and faith in the social healing powers of a universal health care system, there flowed another policy goal — which still dominates today. This is that health care must be allocated according to need. The reason why Bevan rejected a health care system run by local authorities (medical resistance apart) was that this would inevitably perpetuate a distribution of resources based on the differential ability of councils to pay for it. How could the best be universalised, if there was diversity of provision? While the achievement of equity – *ie* allocation according to need, whether to geographical units or to individuals – was never explicitly spelt out by the original designers of the NHS, it was implicit in their whole approach. It has thus provided a prescriptive goal, or benchmark, for subsequent analyses of health care policy.

There is a further twist to this story. One of the implicit aims of policy has been, at least since 1950, to contain spending on health care. It was in March 1950 that the Cabinet decided to cut the NHS budget. And ever since the NHS has been an instrument of public expenditure control. The point is so obvious that we take it for granted. But it is worth stressing, if only to remind ourselves that it marked a repudiation of the idea that spending on health care should be driven by demand. The goal of achieving equity based on need thus came to be translated into a principle for rationing scarce resources within the NHS, rather than a way of determining what its budget should be: we have never, despite the famous two per cent formula, devised a satisfactory way of designing a needs-driven formula for allocating resources to the NHS. Hence, of course, the never-ending dialogue of the deaf about the 'under-funding' of the NHS. If we reject meeting demands as our policy goal, and if we cannot design a needs-based formula, then we are in trouble when it comes to discussing the appropriateness or otherwise of the NHS's budget.

Two other points need stressing in this context. First, the goal of equity, as defined in practice, was essentially paternalistic in character. Need was something that was defined by epidemiologists and other experts: the invention of the resource allocation formula for the geographical distribution of NHS funds is a case in point. And it was the medical profession who determined which demands ranked as needs in deciding whom to treat. Needs, in short, always trumped demands. Taking equity as the guiding policy goal therefore implied – certainly in practice, if not in logic – downgrading responsiveness to demand as a possible policy objective. Second, using equity as the guiding principle for resource allocation has proved unhelpful when it comes to determining priorities between client groups or between different specialties. The drive to steer more resources to the Cinderella services, which started in the 1970s, did not spring from any statistical or scientific demonstration of inequity but from a gut instinct based on revelation of inadequacy. There was need, for sure. But there was, and still is, no scientific way of weighing this need against competing ones.

If we want to sum up the consensus view about the goals of the NHS, as it evolved through its first three decades, there is perhaps no better way than to quote the report of the 1979 Royal Commission on the National Health Service. This summed up the objectives of the NHS as follows:

- To encourage and assist individuals to remain healthy
- To provide equality of entitlement to health services
- To provide a broad range of services of a high quality
- To provide equality of access to these services
- To provide a service free at the time of use
- To satisfy the reasonable expectations of its users
- To remain a national service responsive to local needs

Like many such mission statements this definition of policy goals begged as many questions as it answered. What are reasonable expectations? Who determines responsiveness to local needs? Is providing a free service an objective in its own right or simply a means of achieving equality of access? Above all, though, there is little or no sense that different goals might conflict. Yet it is precisely emerging conflict that characterises the years that followed the Royal Commission's report – the era of secularisation – and it is to this theme that the analysis turns next.

Consumers and the New Secularism

Moving to the 1980s, there is a transformation. To a large extent the goals of health policy, in previous decades, were expressed in the language of inputs. In the 1980s the emphasis switched increasingly to outputs, as the Government put increasing emphasis on activity figures in response to criticisms about under-funding, and then to outcomes, the language of the *The Health of the Nation*. There is, moreover, no shortage of explicitly stated policy goals. On the contrary, there is an embarrassment of choice, So, for example, the Department of Health's 1992 Annual Report has an appendix setting out four major policy goals, broken down into 45 subsidiary policy aims. Some of these goals are internal to the Department, such as to make best possible use of staff and other resources, and treat all staff fairly and responsibly. Others are more general in character, such as to develop policies to improve the health and well-being of the population and prevent illness.

But before discussing this richness of policy goals, it is worth reflecting on why there has been this explosion. In part, no doubt, it reflects the style of the new public management thinking that has swept through Whitehall over the past decade. Hence the insistence on explicitly stated aims, against which policy performance can be measured. Hence, too, the recurring emphasis on economy, efficiency and effectiveness in the litany of policy aims. The rhetoric of value for money may not be new; indeed it has been used for 40 years or more. However, it has risen to a crescendo as a result of the new Whitehall fashions.

More important, the new style and the new language reflect a different view of the health care system: a move from seeing it as a church to seeing it as a garage. There are a number of components to this change. Faith in medical science is no longer as blind as it was in 1948. The role of the medical care system has changed: the old killer diseases such as tuberculosis have been conquered while the new ones such as cancer and cardiovascular conditions have proved stubbornly resistant to the efforts of medical science. As a result, health care is increasingly concerned with repairing or maintaining people who cannot be cured. The AIDS epidemic is a case in point. Moreover, the medical profession's own concern with techniques – with designing ever more sophisticated gadgetry for intervention – invites the comparison with mechanics, (as indeed does the increasing emphasis put on trade-union activities). Lastly, there has been a more general growth of distrust in experts and professionals.

This process of secularisation is reflected in a linguistic revolution: the transformation of the patient into the consumer. This has enormous implications for the way in which we talk and think about the NHS's policy goals. The patient is someone to whom things are done. It implies a passive role, totally at harmony with the paternalistic traditions of the NHS. The consumer is someone who goes out to satisfy his or her wants, an active role challenging the NHS's needs-based distributive goals. The emphasis has switched from seeing the NHS as an instrument for promoting broad social goals, such as social cohesion, to seeing it as satisfying individual expectations: specifically, expectations that people will get an efficient repair and maintenance service.

It is important not to exaggerate by making the contrast with the past too neat or pat. But the evidence of a radical shift in the way we talk about the NHS, and its policy goals, seems overwhelming. The notion of consumer rights is creeping, albeit timidly, into the debate about policy goals: the obvious example is, of course, the Patient's Charter. There has been a rapid growth in consumer groups within the health care policy arena, just as there has been a growth of consumerism in society at large. Political competition has forced the Government to make the reduction of waiting lists one of its main policy goals: *ie* to make responsiveness to demands the test of its policies. There is more emphasis, at least at the level of rhetoric, on giving people greater choice of the services available, as *Working for Patients* puts it.

Views will differ about this process of secularisation: personally, I would rather see the NHS as a garage than as a church. However, whatever view one takes, the important issue is whether the new goals are compatible with those inherited from the founding fathers. The next, and final, section therefore explores the tensions and strains inherent in the co-existence of two very different sets of policy goals.

Conflicting Policy Goals

Consider the whole question of choice as a policy goal. If consumerism is to be more than a rhetorical invocation then choice is essential. It is, surely, the ability to choose between different garages which distinguishes a consumer from a patient or a client. To use the word is to repudiate paternalism. More crucially, surely, it is also to repudiate the goal of meeting need as defined by the experts. *Working for Patients*, as noted above, defined its policy goal as giving people greater choice of the services available. But what if the available services are not those judged to be appropriate or adequate by the consumers? What if the demands of the consumers do not match expert-defined needs? Do we then stick to the traditional view that needs always trump demands? Or do we reverse the doctrine, and argue that demands should have precedence over needs?

There are other ways in which the new policy goals are at odds with those we have inherited. Choice implies redundancy. There must be some spare capacity. But how are we to square that with the goal of limiting spending on the health care system, of seeing empty beds as a sin against the Trinity of economy, efficiency and effectiveness – the conventional, though not necessarily right, view? Similarly, if we put consumer demands in the saddle, is this compatible with a capped budget?

Most important perhaps, what if consumer demands run counter to the policy goals of trying to bias resource distribution to the most vulnerable groups, *ie* those least able to articulate their case, least able to exercise choice and least able to act as 'consumers' in the full sense. What is the point of improving the garage service to those without cars? What if, as moral citizens, we disapprove of the choices made by the consumers of health care? The question is not just rhetorical. As a consumer, I may well give preference to the kind of repair and maintenance services from which I benefit directly: this is what the evidence of the private sector would suggest. But as a moral citizen I may give more weight to providing compassionate care to those who are beyond repair, those whose bodies cannot be improved by medical intervention but whose life can be made more pleasant and whose death can be made more easy by sympathetic and kind care.

There is no clear cut answer to these questions. But one response might well be to say that by invoking the language of the market, we are striking at the principles of the NHS: that the church should not be turned into a garage. So, moving to the prescriptive mode, can a principled case be made for consumerism and choice in health care? Indeed it can: the case for choice rests on the same set of arguments used to justify State provision of health care in the first place: the argument of autonomy put, for example, by Albert Weale in *Political Theory and Social Policy*. Put simply, this runs as follows. Provision of health care is necessary because, without it, people cannot function as fully autonomous human beings, making their own life plans. It is this which distinguishes it from other goods supplied by the market. Taking this line of argument one step further, we can then ask: how is it possible to be a fully autonomous human being without having choice? It is surely the ability to choose between different, alternative courses of action that distinguishes an autonomous individual from someone who is merely the creature of circumstances without any independent volition.

Certainly the evidence of the private sector suggests that choice is an essential part of autonomy. People using the private sector are more autonomous than those using the NHS: in the sense of being in command of things, as distinct from being treated like a passive object. There are, of course, other reasons for using the private sector: notably queue jumping. And choice is often inhibited by the asymmetry in information between consumers and providers that characterises health care – although it may sometimes be exaggerated. So the private sector shows the limits of consumerism in health care, as well as its advantages.

One final conflict between the traditional goals and the emergent ones – between those of the church and the garage – requires mentioning, since it has very considerable implications. The moral vision of the ecclesiastical model is centred on the notion of equality. The goal of the secular model is centred on the notion of maximising the output of health, or at least, the production of health care interventions: witness the emphasis on meeting demand as expressed through waiting lists. It cannot necessarily be assumed that the two goals are compatible. The first objective would mean concentrating resources on those who are most difficult and expensive to reach and treat. The second objective would suggest concentrating on those who are most amenable and accessible to treatment – so maximising the health gains for any given resource input but also increasing inequalities.

These, then, to vary our metaphor, are some of the tensions between the Old Testament and the New Testament views about what the goals of health care policy should be. They suggest that the last set of health care reforms will not be the last. If the NHS is to meet demand as articulated by consumers – instead of need as defined by the experts – then some other policy goal may have to be sacrificed: notably, that of designing the health care system with cost-control as a primary objective.

RESHAPING THE NHS: FROM RADICAL REFORM TO CONTINUOUS CHANGE

John James

About eighteen months ago I, and a mixed group of individuals from different backgrounds but with a common interest in the National Health Service, agreed that each of us would try to write a predictive paper about health care in this country some ten to fifteen years ahead. Five or six of us eventually put our ideas on paper. Re-reading the different approaches from among members of that group to the question of predicting changes in health care ten to fifteen years ahead has suggested several points of relevance to an exercise looking five years ahead.

The first lesson is that all of us find it much easier to see one year ahead than into the middle or far distance, and a lot of the ideas that were explored were really already with us. One contributor indeed admitted to describing her current experience as a general practitioner dealing with patients whose principal need was for contact and comfort in the relationship with the doctor. The underlying tenet of her paper was that the eternal verities remain unchanged, notwithstanding the appearance of change all around them. Others were keen to explore the impact of technological change and to suggest that revolutions in this field would fundamentally alter both the way in which health care was delivered, and the places in which it would be delivered. Another broad observation was that thinking ahead could be either a matter of predicting what one believed would happen or of what one would like to happen. Where the latter is done by figures in a position of power and influence, the two may merge into a self-fulfilling prophecy.

This paper is about the possibilities five years ahead. It deliberately mixes what I think will happen with what I would like to happen, but with a strong caveat that the events of the last five years in the NHS were poorly understood or predicted and that there is therefore no reason to expect more accurate predictions for the next five.

Structural Change: Providers

There has been so much structural change in the NHS that it is best to begin with the organisation of the health service. On the provider side, there is no reason to expect there to remain a single directly managed unit. Indeed it can be argued that had all districts proceeded with clarity and purpose from the outset, the third wave of self-governing trusts might well have been the last. There should also be a significant reduction in the number of acute hospital sites. The Tomlinson report has focused attention on inner London, but such reductions are likely also in outer London and in major conurbations elsewhere in the country. Reducing the number of sites conveys the ability to avoid carrying the overheads of an excessive number of buildings. Nationally, there remains also further scope for reductions in lengths of stay in all age groups. In addition a recognition that elderly people with substantial co-morbidity are best treated out of acute beds is likely to enable a substantial further reduction in the acute field. The question inevitably arises whether the single specialty hospital will survive as long as 1998. Those that do may be expected to do so in a much closer relationship with the specialties of a general hospital and with primary care. This comment applies alike to special health authorities, which by then will have had three years of operating as self-governing trusts and with a limited degree of protection for their specialist role.

Nationally, closer working between district and family health authorities is likely to facilitate a trend, already apparent, for a shift from secondary to primary care. General practice is likely increasingly to retain to itself activities which are currently carried out in acute hospitals, and also to attract into a general practice setting hospital specialist services and consultants on a visiting basis.

Faced with this evolution, self-governing trusts will need to adapt. Acute trusts may seek to move all the way down the ambulatory care model, operating largely in the medium of primary care. Others may seek, notwithstanding the current thrust of Government policy, to take control of the provision of community and long stay services in order to offset the shrinkage of their traditional area of business. Some will move successfully into niche markets concentrating on particular specialties or procedures, and there will be prizes for those who identify the ones that have a sustainable future.

Small, highly specialised, tertiary centres will evolve able to attract patients through well structured links with other providers. Indeed, it may not be fanciful to think in terms of contracting with a specialty, rather than with an institution in which it is located. The clinical specialists would then receive patients direct, buying in the cost of support services from their host hospital and hospitals. We should also expect to see a substantially greater amount of support services contracted out. It may well be common place for pathology services and probably radiography services to be contracted for with specialist providers, probably serving both a primary and a secondary care market.

It is not only the acute providers who will have to adapt to change. For community trusts, there is a genuine question mark over their survival as a distinct entity. A great deal will depend on the way in which their relationships with general practice develop. In areas where general practice is strong, it is quite possible to see a community trust wither away as practices take over the employment of all primary care staff, but in inner cities they may prove more durable and more necessary. The separate mental health trust, likewise, can be justified at the present time where there may be a substantial transitional task in closing an old long stay institution and in developing the corresponding community based service, but it is highly questionable whether there is a justification for a separate management structure once these tasks have been completed. We should expect therefore a substantial number of separate mental health trusts to disappear over the next five years, and indeed a merger with threatened community trusts may be seen as a mutual survival strategy.

Structural Change: Purchasers

If it is all change on the provider front, what about purchasers? I expect the present legislation preventing the merger of district and family health service authorities to have been amended to allow or to require creation of single authorities.

Some people argue that districts in their commissioning role will be made redundant by the success of GP fundholding, but it is difficult to see how fundholders could ever cover the whole field. It is already clear that an integrated approach between district and family health service authorities can greatly enhance the effectiveness with which their resources are used.

These lessons are likely to be accepted and implemented. The next five years will also force closer working between social services and health authorities than at any time over the last ten years, and there may be substantial pressure before the end of that time for mergers of these two functions. Whether this would take the form of absorption of social care into the health arena or of health care into the local authority world remains to be seen; either are plausible, and the decision would obviously be political. More immediately there must be some anxiety whether social services authorities will in the meantime have coped successfully with the transfer of social security funds and with lead responsibility on community care. And of course a great deal of their ability to cope will depend on the general economic climate facing local government at large.

GP fundholders have proved in many areas a catalyst for change and the numbers joining in the third and fourth wave indicate an enduring, indeed increasing, popularity. It is reasonable however to expect that they will have to operate within much tighter constraints than at the present time. Both financial necessity and closer working between district and family health authorities will cause the closest possible scrutiny of the sums that are allocated to fundholding, and the enthusiasm of some fundholding practices may reduce as the financial climate tightens. We should certainly expect many practices which are currently not fundholding to give it a try, but some who are already doing it may choose over the next five years to throw their lot in with larger locality purchasing ventures. Indeed it is not inconceivable that financial pressures or a wish to control the market more strategically may lead to the abandonment of the fundholding scheme within the period.

Information

The next five years should see a substantial improvement in the quality and availability of information to those responsible for purchasing or providing. Progress has been disappointing to date in this field, but the next five years should see some progress. From the purchaser point of view it is particularly important to have better information about the costs and the benefits of different approaches to health care. The first means knowing what an individual episode of care, however defined, really costs. Benefits equates to outcomes. We can already trace individual patients through a given provider. What we need to do is to be able to track individual patients through all of their contacts with the health care system in order to assess the total benefit of a given episode of intervention.

Information exchange and networking are crucial; they will be practicable within that timescale. Providers will be obliged to be more open than now in relation to the information they make available to purchasers and a degree of mutual trust will need to be developed. Data protection issues may be among the more difficult hurdles to overcome. An alternative approach is to utilise patient-held data, which has the advantage of making data tracking independent of the system of delivery, but is at the mercy of individual rather than corporate unreliability.

It will also have to be recognised that, once knowledge of outcomes is more readily available, there is likely to be an effect on traditional perceptions of clinical freedom. As many have observed, for half of what is done in medicine we simply do not know what is achieved, and half of the remainder may be positively harmful. Knowledge of outcome is likely to raise difficult ethical issues. If these become entwined in the question of adequacy of resources the problems will be even greater.

Resources

Resources will undoubtedly remain an issue. The national financial climate is unlikely to remain as tight as it is now, but the Treasury is likely to want to see a return on its investment in the NHS in 1990/91 and 1991/92. Even though the proportion of GDP spent on health care in this country is low by the standards of the developed world, there will be a substantial macro-economic push for it to be reduced. Governments of whatever political complexion will be tempted to address the difficult issue of whether the health service should continue to be essentially free at the point of use, but they will in large measure continue to fight shy of this issue because of the strength of the national emotional commitment to the NHS.

Those who wish to tamper with free access to the health service will also face the reality, shown by experience in other countries, that people who have to pay direct for their health care consume more of the national resource than those in countries where the services are largely free, and people implicitly or explicitly accept a degree of rationing.

Closures

Governments over the next five years will have to face immense pressure to prevent the closure of much loved institutions. They will probably not be able to give in to those pressures. The genie has been let out of the bottle and cannot be put back. The Government will not have the resources available to it to prop up the casualties of the system; the radical change that has been set in motion, especially in London, is now irreversible. The message is adapt or expire. The area of anxiety must be whether the complementary investment in the development of primary care, and in capital rationalisation within the reduced secondary care sector, will take place. The Chancellor's recent suggestion in the Autumn Statement, that the Government might be thinking of relaxing its stand on the use of private capital, offers a potential way forward, but it is doubtful whether the Treasury will be easily convinced of the benefits of a relaxation that would still be seen as adding, at least in the short term, to the public sector borrowing requirement.

NHS Management Executive

There is another institution by no means as long established, over whose future a question mark must be raised. This is the National Health Service Management Executive. In many ways the Executive has done a tremendous job, but it is questionable whether it has a long term future. First, it is going into voluntary isolation in Leeds, from which the main beneficiaries to date have been British Rail, transporting large numbers of officials between London and Leeds. Video conferencing is all very well, but has not been terribly successful in practice. Will the Management Executive be able to exert sufficient influence on Ministers at a remove to justify its own survival? Second, what will be its role? If the purchasers are being driven by statements of policy emanating from Whitehall, and providers are seeking through increasingly competitive approaches to efficiency gain to sell their services, what will be the role of a body at national level apparently focused on management? In principle a rigid demarcation between management and policy is not necessary; it is likely however that a degree of physical separation both at local and national level may begin to give that distinction greater substance.

Improvements in Health

Health care systems of course should have some impact on the nation's health. What is likely to happen over this period? We can, with some confidence, make predictions about demographic structure, and the targets set in *Health of the Nation* will certainly force a local focus on what can be delivered in particular localities. Some payback is to be expected from a higher and more high profile expenditure on health promotion, and on closer working with other agencies – employers, environmental authorities and the like – which probably have more impact now on the health of the nation than the entire resources of the NHS. Districts will do their best to persuade their populations to smoke less, to eat high fibre diets and to drink moderately. It is far from clear whether these will solve the problem of extending the benefits of healthy living through all social classes or whether they will merely accentuate health inequalities. There is a danger also that there will be a nanny state backlash. One more confident prediction however, is that whatever the Government of the day in 1998, it will have banned tobacco advertising. At the same time, it is likely that new health problems which are not presently recognised will have come along to complicate the picture, perhaps new forms of infectious disease or of environmental hazards.

There is an inherent dynamism in medical practice both in relation to new drugs and to new technologies. Both tend to be eagerly grasped, hard sold by their inventors or developers, poorly evaluated, additive rather than replacement, and almost always more expensive. There have recently been some honourable exceptions, such as the use of lasers and of minimally invasive surgical techniques, but on the whole we have not been very successful in ensuring that we only take on the new when it is at least as cost effective as that which it replaced. We still need to develop a greater willingness to question and to discard what has been tried and seen not to work. The signs are that clinicians are now recognising this. The need to involve purchasers more closely in decisions on investment, as well as the instinct for survival, will force providing institutions to work more closely with the consultant body in determining what to allow by way of development. In medicine, experience suggests that the most formidable group to have to persuade is a committee composed of one's peers.

Teaching

The inherent dynamism, already alluded to, will have a major impact in the teaching and research field. Undergraduate teaching, in particular, will have to adapt very quickly. Almost certainly a substantial proportion of those who are in our medical schools at the moment will require to be retrained, possibly more than once, in the course of their career. The latest estimate of medical manpower training requirements apparently proposes an increase in numbers in training. This conclusion must be open to doubt. It is certain that the next generation will have to be extremely adaptable, and that a much higher proportion of them will need to go into primary care in its broadest sense than has traditionally been the case. It also seems likely, given the major political drive involved, that in five years' time we will have done away with the wholly unreasonable demands made on the working lives of junior doctors in training.

It may seem a little presumptuous to question whether we do in fact need an expansion of the numbers of doctors in training at a time when a learned committee has reached a contrary view, but it was only three or four years ago that we were expecting substantial shortages of trained nurses emerging from our colleges of nursing because of the demographic downturn in the number of 18 year olds. What in fact has happened? Three fundamental changes have occurred. First, in the current recession, against the background of three million unemployed, fewer vacancies are occurring so that many newly qualified nurses are simply not able to gain a job at the moment. For some colleges of nursing, their host hospitals have not been able to find a single placement. Second, views as to the numbers of nurses who would be needed have also altered with the recognition that the pattern of care is changing very rapidly. Third, although of indirect significance, the main rivals to the colleges of nursing for school leavers, notably the banks and buildings societies, are themselves shedding large numbers of staff in pursuit of rationalisation, and as a consequence of computerisation. If we were so wrong in a predictive exercise in relation to nursing manpower requirements less than five years ago, how confident can we be in relation to predictions of medical manpower demand a decade from now?

Research

In the research field there is room for optimism that developments in molecular medicine and in basic medical sciences will lead to improved understanding of the nature and origin of many existing diseases and of disorders of a genetic origin. This is probably the area of greatest potential development over the next few years. Of course, as medicine begins to understand the genetic origins of disease, a strong ethical framework will need to evolve within which such issues can be considered. Pressure to achieve this could be one of the major non-service-development issues facing the NHS in five years' time.

Public Finance: Private Provision

Overall there is no reason to doubt that the NHS will survive, not only for the next five years but well beyond that, and that it will continue to change very rapidly. We should expect, too, that it will remain publicly funded, but that more NHS care will be provided privately. It is apparent that in the fields of long stay and continuing care for elderly people, for the elderly mentally ill and those with learning disabilities, there are many private providers able to provide a cost-effective and good quality service more than able to compete with relatively hide-bound NHS providers. This trend may be expected to continue and develop.

Conclusions

Most people would accept that the NHS reforms which were introduced with *Working for Patients* have their own internal dynamics, and that a lot of further change will inevitably result from them. Government does not have to lift a finger to cause that change to happen, since most of the dynamics operate at a relatively local level. Indeed for Government there will be the general question of whether it should lift a finger or possibly more of its anatomy to prevent change.

It should also be recognised that much change will come not from Westminster but from Brussels. The impact of further changes in European Community legislation is likely to be felt particularly in relation to employment within the health care industry in general. There will also be a major impact from continued international concerns over the costs of health care. Just as quite a lot of the ideas that underpin the reforms in this country have been derived, albeit divorced from their original settings, from experience in America and Europe, so it is certain that we shall continue to exchange ideas. For example the Dutch Government's 1992 Report, *Choices in Health Care*, has become required reading in the UK for anybody thinking about political issues of rationing or choice. Equally the prospects in the future of resisting the international diffusion of changes in medical technologies are no better than they have been in the past; the only area of uncertainty is whether the change over the next five years will continue to accelerate as appears to have been the case in the last five.

Taking the external factors together, it seems clear that the Government in Westminster will be subject to a great many influences which it will not be able to control, both in its external environment and in the dynamics of the system below it. A period of continuous and unpredictable change is unavoidable. The Westminster Government will, however, retain in many ways the most crucial weapon of control, which is the decision on how much money should go into the system. It is to be expected nonetheless that the quality of the debate, about what that sum of money should be, will be substantially enhanced by improved information about what the money will buy. Whether the green shoots of economic recovery will by then have materialised on a scale which would allow an objective view as to the right level of health spending as opposed to a constrained view of what the economy can afford, is a matter on which we might all speculate.

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