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Health Service Objectives

Alan Williams

Based on working papers of the Royal Commission on the NHS

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Secretariat of the Royal Commission on the NHS

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EDITORS' INTRODUCTION

The Royal Commission on the NHS made an early decision to consider the objectives of the National Health Service. As they pointed out in their report, it was felt that:

> 'We could not carry out the task defined in our terms of reference without considering what were the objectives of the NHS, what they should be and how far the NHS does and may succeed in reaching them. We therefore started by asking what as individuals, we could reasonably expect of society in helping us maintain our health and caring for us when we were sick. We found no simple, unique answer to this question. But whatever answer is offered will define the nature of the health service we want and its objectives. It is, therefore, a question which, whether we are patients, providers or policy makers, we all should keep before us' [1]

The papers reproduced here illustrate some of the material made available to the Commission as background to their discussion of health service objectives. The first paper by Professor Alan Williams is a personal statement by one of the members of the Commission. The second is a paper prepared by the Secretariat of the Commission, which draws together the deliberations and views of the group of members whose task it was to consider the objectives of the NHS. Both papers demonstrate the problems and difficulties of setting objectives for a public service which is nationally organised to serve individual needs. The views expressed do not necessarily reflect those of the King's Fund or the Royal Commission.

This is the tenth in a series of project papers based on the working papers of the Royal Commission on the NHS. We are grateful to King

Edward's Hospital Fund for London for giving us a grant to enable this series to be produced and to the Polytechnic of North London where this project has been based.

Christine Farrell
Rosemary Davies

1 GREAT BRITAIN. PARLIAMENT. *Report of the Royal Commission on the NHS* (Chairman: Sir Alec Merrison) London, HMSO, 1979. *Cmnd 7615* pp 7.

HEALTH SERVICE OBJECTIVES by Alan Williams

In discussing the objectives of the NHS, we need to distinguish the following possible foci of interest :

A the objectives served by providing health services of some kind or other for a community which might otherwise not have such services;

B the objectives served by having such services provided by the public sector rather than by the private sector;

C the objectives served by having such services provided by the national government rather than by local government;

D the objectives served by the particular mode of organisation of the actual NHS that we have.

I suggest we conduct our discussions at each of these levels of generality successively.

HEALTH SERVICES: MORE OR LESS OR DIFFERENT ?

In making the obvious statement that a community desires health services in order to promote better health, one is begging two important questions:

1 What is health ?
and
2 What are its major determinants ?

Until we are clear about the answer to 1, we cannot answer 2; and until we answer 2, we cannot sensibly consider the role of health services in promoting health.

There is no simple answer to the question 'What is health ?'. While

certain attributes of 'healthiness', such as long life expectancy with freedom from pain and physical disability, would readily be accepted by most people as essential ingredients, this still leaves us with difficult areas, such as mental handicap and illness, where psychological state and social adjustment play an equally important role as physiological state. Viewing health in this way leads one away from the notion of clinically identifiable 'disease' or 'sickness' as the hallmark of ill health, and towards notions based on people's capacity to go about their normal activities free of difficulties generated by their own physiological or psychological states.

As the general level of health in a community improves, the concern for sheer survival diminishes and other aspects of health, the 'quality' rather than the 'quantity' of life, become relatively more important, leading to a shift in priorities towards these other aspects of healthiness. When this shift is superimposed on demographic and social trends which, even without any change in priorities, would generate much larger demands for care and support of incurable and degenerative conditions, sizeable adjustments are going to be called for in the whole pattern of health service provision in all advanced countries, irrespective of how such services may be organised.

The first major objective of any health service must therefore be:

1 *To discover what relative valuations people place on different aspects of health.*

People's valuations can be 'revealed' in a variety of ways.

(a) We could simply ask them; but if the issues are very complex and they have private incentives to give misleading answers, in the hope of influencing the outcome in a particular way, the answers will not be very reliable.

(b) We could observe how they behave; and infer from their behaviour what relative values they attach to, say, length of life as opposed to

current life-style, the danger here being that they may be ill-informed as to the consequences of their current life-style for their life expectation.

(c) We could let people's valuations be expressed by giving them the opportunity to buy additional protection against particular health hazards, or to purchase health services directly, and thus infer relative valuations from willingness to pay; this has the disadvantage that willingness to pay is closely associated with ability to pay, and we may want to neutralise the impact of ability to pay upon relative valuations.

(d) It may be argued that people, especially when ill, or when contemplating the prospect of being ill, are not always the best judges of their own interest, in which case it may be argued that practitioners, or others with broad and intimate knowledge of the experiences of large numbers of people in these circumstances, could be entrusted with these judgements on the patients' behalf. The difficulty here, of course, is that practitioners may well fall into certain routines which render them relatively insensitive to patients' wishes, and, in any case, if the valuations made on behalf of patients are deeply imbedded in apparently technical clinical judgements, it may be difficult for any of the parties to detect what the valuations actually are.

(e) Finally, the valuations can be taken out of the hands of practitioners and put into the hands of politicians, acting as the representatives of the community at large. They face the same problems as everyone else in determining what the relative valuations of the population actually are, what weight should be given to them, and how the inevitable conflicts of interest that will arise between the different groups shall be resolved. Their strength, and weakness, vis-a-vis practitioners is that they are more detached from the day-to-day service delivery problems, can take a broader view of the situation and, in a democracy at any rate, they can more readily be removed and replaced, than professional people with security of

tenure, if their views get noticeably out of line with those of the community they serve.

This suggests that the second broad objective of **any** health service must be:

2 *To devise mechanisms by which these valuations get translated into decisions about the deployment of the community's scarce resources in the health field.*

This brings us to the question posed earlier about the contribution of health services to the health of the community. It is now commonplace to observe that people's health depends significantly on many factors which lie outside the realm normally associated with the term 'health services'. Housing, education, diet, exercise, occupational and domestic stress, and general life-style all appear to be major influences upon people's healthiness, and it is important to recognise this when considering the proportion of a country's resources devoted to health. It may sometimes be appropriate, even strictly in the interests of health, to take resources away from health services and put them instead into other activities, for example, housing, education or leisure activities. There will, nevertheless, be large areas of activity in which health services are the most efficient means of improving health, and the broad discussion of the respective roles of general social action, preventive medicine, cure, counselling and supportive care is a manifestation of this particular concern.

If therefore seems that the third broad objective of **any** health service is:

3 *To determine how far the health goals identified for the community are most effectively pursued by the provision of health services as opposed to the provision of other facilities.*

PUBLIC VERSUS PRIVATE

The issue of public provision versus private provision is a complex one,

because of the need to distinguish, within provision, between production and control. It is possible to have a large measure of public control without public production, for example, the provision of NHS primary care by general practitioners and it is also possible to have public production alongside private production in a situation in which there is very little overall public control, for example, British Rail's Hotel Services.

If one takes up the **production** aspect first, it may be argued that private individuals working in their own interests have stronger incentives to organise tasks economically, because, part at least of the rewards of such increased efficiency will accrue to them personally, whereas in the public sector this tends not to be the case. This argument depends on the individual private producer facing effective competition from other producers, and not being in a position to shift any substantial part of the costs of his activities on to others. It also assumes that consumers are in a position to judge fairly accurately the quality of the service they are likely to get from the various competitive suppliers, and that those consumers who pay more get better service, and those who pay less get worse service and, in the extreme, those who pay nothing, get nothing. This would be the hallmark of a ruthlessly efficient market in health care. In this extreme form, it is not very appealing.

Public production is one alternative arrangement. In its most limited variant, it might take the form of some public agencies, for example, hospitals and primary health care centres, operating alongside private agencies on much the same terms, but with an obligation, via a discriminatory charging policy, to 'cross-subsidise' between rich and poor users, so that no-one in desperate straits is turned away without care. This limited approach typically degenerates into the public agency taking all the poor people and offering a lower quality of service than is obtained by the rich who (understandably) continue to use the private sector where, if it is operating efficiently, they get full value for what they pay, which they will not get in the public sector. In the more extreme form of public production, viz the establishment of a statutory

public monopoly, this problem obviously disappears, but the problem of maintaining an economical mode of provision becomes exacerbated by the absence of any external competitive pressure, unless it proves possible to devise effective internal incentives for practitioners to behave efficiently.

Leaving the ownership of the facilities on one side, an alternative to public production is public control where a typical situation is public negotiation of standards of performance or competence, with varying degrees of intervention over price-setting and financing, usually through complex provisions for compulsory insurance against certain contingencies, leaving people to insure against other contingencies if they wish. The state may or may not enter the insurance business itself, but it usually finds itself having to regulate the private insurance companies in various ways. Once we start operating at this level of complexity, the model of the efficient competitive market no longer applies, and it tends to be at the interface of the professional organisations, the insurance funds, the private hospitals and the government, central or local, that the issues of resource deployment and entitlement are settled.

At this stage, the central issue that emerges clearly is that of the range of choice that should be open to patients and potential patients, in view of the costs imposed on others by the exercise of such freedom of choice. At one extreme, we have the argument that since the object of paying some people more than others is to reward them for valuable services to the community, it is irrational to destroy this incentive by denying the recipients the right to purchase health care, which is one of the more valuable uses to which one's money can be put. At the other extreme, we have the argument that certain fundamental 'civic' rights, for example, the freedom to vote, freedom from arbitrary arrest or harassment, freedom of speech, are to be upheld irrespective of the wealth of the individuals concerned, and in some cases indeed for example, basic schooling, the exercise of such 'rights' is compulsory. In health care the compulsory treatment element applies only in certain kinds of mental illness and with immunisation in certain circum-

stances, but the 'basic entitlement' philosophy does seem very strong. But its proponents need to identify the circumstances under which people are entitled to what, and at what cost, to themselves or others, and who is going to make the judgements, according to what criteria, in borderline cases. It inevitably shifts the onus of decision from the patient to the practitioner and/or policy maker. And with 'rights', come responsibilities.

Difficult though it is to epitomise the complex issues that underlie the public versus private debate, they seem to me to be essentially these:

4 *To what extent is access to health care to be part of the community's reward system and hence influenced by willingness and ability to pay, and how far is it to be a civic right ?*

5 *To the extent that it is to be regarded as a civic right, what are to be the limits of such rights, who is to judge entitlement, and what priorities are to be established to resolve conflicts of interest.*

6 *Irrespective of the outcome of the rewards versus rights issue, to what extent do problems of quality control and consumer protection dictate public production of health care as opposed to public regulation thereof ?*

7 *To what extent is public ownership justified by the notion that health care is a natural monopoly (like water, gas and electricity supply) where duplication of facilities would be wasteful ?*

8 *If a position is adopted in which there will be no effective competition beween suppliers of health care, what internal incentives should there be to efficient use of the community's scarce resources ?*

NATIONAL VERSUS LOCAL

There are essentially two kinds of consideration which are relevant to the issue of whether the public sector's interventions, as regulators or as direct suppliers of health care, should be at local or national level: demand considerations (priorities) and supply considerations (management + resource provision).

On the demand side, ie in determining the valuations to be placed on different attributes of health, and their consequences for the pattern of provision being sought by the community, this should be local if preferences vary geographically and if there are no 'spillovers' or 'external effects', beyond competition for resources, between one locality and another. There will inevitably be such external effects, if the failure of one locality to control infections or contagious diseases puts neighbouring localities at risk; if people travel about a great deal and hence have a direct personal interest in insuring that, for example, accident and emergency services are available at a certain minimum standard to all citizens no matter where they happen to be; and if people move about deliberately seeking localities offering good levels of care of the kind they happen to want at the time, for example the migration of the elderly to certain resorts. To the extent that these external effects are present, they can only be internalised by treating the services in question as a national responsibility, and even then there will be external effects vis-a-vis foreigners, with the corollary that they should also be regulated, and possibly managed (and even financed) nationally. If the minimum national standards are both pervasive, ie cover a broad range of services, and demanding, ie strongly enforced and costly to maintain, they will pre-empt most of the resources available for the provision of health care, and leave the discretionary element so small as to be insignificant. In this case what is in principle a **minimum** standard becomes, in practice, a **uniform** standard.

This brings us to the supply side, where there are likely to be some additional complications even if the division between national and local interest is clear on the demand side. In the first place, because of

geographical differences in the distribution of wealth, and in the costs of providing certain services, meeting national minimum standards may be much more burdensome in some localities than in others. This fact leads, in the extreme, to demands that such national standards shall be one hundred per cent nationally financed, or, in a more moderate version, that the differences in costs and ability to pay should be made up out of some equalisation fund, hence the Rate Support Grant (RSG) and Resource Association Working Party (RAWP). Once national, as opposed to local,finance comes to play a predominant role, there is a natural tendency for financial accountability to the centre to draw in its train first, managerial accountability and then political accountability, a feature we have witnessed in the UK with local government.

But there is a second consideration, bearing on national standards versus local variability besides costs and resources, which is to do with management problems. A complex centrally managed service may outstrip the capability of those at the centre to collect, analyse and act on all information needed for sensible decisions without considerable delay and confusion, hence the pressure to decentralise within nationally agreed guidelines. This generates a fresh source of local variation, not necessarily connected with local priorities or with local resource problems, but linked to variations in management quality and perhaps management objectives, at both national and local levels.

Summing up the issues raised in this section, they are:

9 *To what extent are health services a matter of national interest, and in what form is this national interest to manifest itself ?*

10 *To the extent that local variability is considered desirable, is this to be left to be financed locally or is some national contribution justified (and vice-versa for national responsibilities) ?*

11 *Are there further limits to effective national control arising in the nature, organisation and quality of the management process ?*

THE NHS WE KNOW AND LOVE

If I were to summarise the apparent rationale of the present system as revealed by confronting it with the eleven issues posed above, the following picture emerges:

1+2 Very little has been done to discover what relative valuations peopleplace on different aspects of health, nor are there any effective mechanisms by which this will happen. Most consultations about policy occur at the level of provision, ie shall we have more health centres, less mental institutions; more services for the elderly and less on maternity care, not at the level of health problems. But if we know relatively little about NHS priorities in these terms, we know even less about the policies of the private sector of health care, and it is hard to see how there can be a policy in a privately dominated system, unless the public sector intervenes via tax/subsidy incentives to push/pull the system this way or that.

3 Responsibility for the distribution of resources between health services and other health-affecting activities is located in the Public Expenditure Survey Committee, with decisions taken ultimately in Cabinet. For all its faults, our system here is probably as rational and effective as any yet devised and operating anywhere in the world. This may help to account for our relatively low level of GNP devoted to health care.

4 The NHS is clearly committed as a matter of principle against regarding access to health care as part of the reward system, though we do permit a private sector to co-exist alongside the public sector, but without exempting anyone from contributing their due share towards the state service. This has led to a very small private sector, which seems unlikely ever to be able to offer a full range of services, virtually limited to the acute sectors.

5 Discussion of the effective limits of the right to treatment and care, has been avoided by pretending that as we got richer, all rationing,

waiting lists and substandard facilities would disappear. Behind this hollow facade, rationing and the determination of priorities has, until recently, effectively been left to practitioners. Attempts to exercise political control over priorities has met with a mixed reception, yet that seems to me the logically inevitable outcome in a system of rights and entitlements, unless such entitlements can be so tightly defined by statute, as with social security, that quasi-judicial processes can be invoked to settle disputes at the margin. It seems unlikely and, as with the current pressures to eliminate the discretionary element in the administration of supplementary benefits, in my view undesirable, even if it were feasible.

6 Whether public regulation of the quality of health care can be made effective without actual public operation of facilities seems to me a matter on which it is impossible to give a general answer. The only advantage of state ownership is that it provides an opportunity to withhold employment from unsatisfactory people without actually denying them the right to practise elsewhere. It does not seem to be widely used, however, mainly because of difficulties in gaining the agreement and cooperation of the professions in internal professional audit above the rock bottom level where a practitioner is demonstrably a menace to his patients.

7 In small communities there does seem to be a strong argument along 'natural monopoly' lines for avoiding duplication of costly facilities. It can be dealt with by 'licencing' or 'franchising', however, and does not in itself seem to warrant anything else beyond public regulation of the quality and range of services offered. This latter consideration is, however, much more important where patients have no effective choice, and I doubt whether the NHS has really faced up to its responsibilities here.

8 The virtual absence of internal incentives to behave economically is a major weakness of the NHS, which relies heavily on the public spiritedness and sense of social responsibility of practitioners backed up, where necessary, by the vigilance and persuasive powers

of administrators and finance officers. Moreover, this is an area in which the private, professional, objectives of practitioners and those they are currently treating are likely to run counter to the public, taxpayers' and future patients' objectives of using the limited resources of the system economically.

9 Our present structure implicitly regards all primary care and all hospital care as of national interest, and most social services support, with the exception of certain statutory requirements with respect to children, the handicapped and mentally ill, as a local matter. The national interest is sometimes made manifest in certain norms of provision, whose exact status, however, is unclear.

10 At present, all the NHS and some of the local services, are financed nationally. This seems as much due to the unwillingness of the central exchequer to yield up any sizeable segment of the tax base for local use as to any deep or well thought out convictions that national financing is justified by the nationalness of the service itself. It is certainly not related at all to any careful costing of minimum national standards, perhaps because, apart from the roads programme, no-one has ever managed to do this very well in other public services where there is a mixture of local and national interests, for example education. This is a matter which cropped up peripherally in the RAWP report over national versus regional responsibilities, and where catchment populations did not coincide with resident populations, but to my knowledge it has not been systematically explored beyond this.

11 By all accounts, there are pretty severe limits, arising in the managerial process, to the extent to which effective central control can be exercised, which strongly suggests that we need to be a lot clearer than we are as to what we want scarce high quality managers in central positions to conserve their talents for, and what should be left to be dealt with down the line.

CONCLUSION

My conclusion from all this is that the rock bottom, fundamental rationale for a free-at-the-point-of-service national health service is that the type and quality of service offered shall not be related to willingness-and-ability-to-pay, and that it shall be provided according to nationally determined criteria of eligibility as uniformly as possible over the country at large, and financed according to ability to pay, not according to benefit received, out of centrally administered taxes. To the extent that the system departs from these principles, it is because of concessions to human frailty: either to reduce abuse or because of inability to control the system financially or managerially without decentralisation, which in turn has generated unwanted variations in provision. In other words, the basic principle is a centralising, egalitarian one, and all departures from it are to be regarded as blemishes or imperfections, to be minimised if they cannot be expunged.

THE OBJECTIVES OF THE NHS by the Secretariat of the Royal Commission on the NHS

WHAT IS HEALTH ?

A question which immediately arises is what is meant by 'health'. If the NHS is intended to promote health, we need to know what this is. Unfortunately, there is no simple answer to the question. While certain attributes of 'healthiness', such as long life expectancy with freedom from pain and physical disability, would readily be accepted by most people as ingredients, this still leaves the difficult areas, such as mental handicap and illness, where psychological state and social adjustment play an important role. Broad definitions, such as that which appear in the WHO constitution :

> 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity',

or, in the Shorter Oxford English Dictionary (Third Edition) -

1 'Soundness of body; that condition in which its functions are duly discharged;
2 Hence, the general condition of the body . . .
3 Spiritual, moral or mental soundness . . . '

are too general to be much help in defining the aims of a health service.

Furthermore, different views of health care can be seen in the attitudes of patients using the NHS , workers in it, and, more broadly, the community and government towards it. The patient is concerned primarily with how he feels and functions. But his view is necessarily a subjective one: he will often not have much idea of what he can reasonably expect.

Thus, an old person will often assign the cause of his infirmities or discomfort to his age, when in fact he is suffering from a complaint which

could readily be treated if he went to a doctor; and there is some evidence that a patient may sometimes not complete the course of treatment prescribed by his doctor because his immediate symptoms have disappeared and he feels better. On the other hand, a patient may expect too much: he may think that he can be restored to full mobility after injury when infact the most his doctors expect is that he will be able to get about on crutches.

A patient will be chiefly concerned with the positive aspects of his health, feeling well and functioning effectively: his doctor is concerned also with the negative aspects, the absence of disease or disability in his patient. The doctor may know that although his patient may seem to himself and his family to be in good health, he is nonetheless, suffering from a complaint whose symptoms will later emerge:

> 'Behind you swiftly the figure comes softly.
> The spot on your skin is a shocking disease.' (W H Auden)

The emphasis for the diagnostician is on ascertainable illness and health is the absence of such illness, though it has also been said that the only healthy person is one who has been inadequately studied.

The scientific or biomedical approach to health in which disease is first diagnosed and then treated underlies the NHS as it has so far developed. The service is in the main, organised to treat ill people rather than to prevent well people getting ill.

The community's view of health may be different again. The sociologist may see ill-health in terms of deviance from the norm. This is perhaps most relevant to mental illness or disability, but it is not difficult to think of examples of physical disabilities which are the norm in some parts of the country; for example, toothlessness in adults in Scotland. Social status may be relevant: different groups of the population will look in different ways upon the implications of the same illness or will see themselves as 'ill' to different degrees. Occupation is important: a strained back may be of little importance to an office worker but

crucial to a labourer.

Governments' attitudes to health and health care have been largely based on national statistics covering, for example, mortality, working days lost, morbidity and costs of sickness benefit or treatment. Because of the difficulty of measuring health of individuals, let alone the health of nations, a government will tend to give weight to what figures of this kind are available despite their deficiencies as measurements of health. Its viewpoint will therefore be somewhat different from the others referred to above, though influenced by them.

As the general level of health improves, the quality rather than the quantity of life becomes more important. This trend is observable throughout the developed world and will lead both to a shift in priorities and to major changes in the pattern of health service provision. Thus it is very important to discover what relative valuations patients place on different aspects of health and to devise mechanisms which will translate these valuations into decisions about allocating resources to health.

HISTORICAL FACTORS

Until the introduction of the NHS in 1948, personal health services were provided mainly as follows:

(a) by local authorities – which provided the great majority of hospital beds (about 130 000 out of 210 000) as well as other services, mainly for schools, mothers and children;

(b) by voluntary bodies – for example the large, and often famous, voluntary hospitals, supported by voluntary subscriptions and providing free services to those who could not afford to pay;

(c) through the National Health Insurance scheme – which provided for the bulk of the working population, with incomes under £420 per annum, general medical practitioner services, some drugs and

appliances and a medical certification service;

(d) privately – by arrangement direct with doctors, dentists, etc or through employers' schemes.

These arrangements had grown up during the 19th and 20th centuries. The main, more recent milestones are the Lloyd-George National Health Insurance Act of 1911, the 1939-45 wartime Emergency Medical Service, and the Beveridge Report in 1942 on *Social Insurance and Allied Services.* The 1911 Act had introduced a scheme, popularly known as the 'Panel' system, operated by local insurance committees, which, for a weekly contribution, provided basic medical care for workers earning below a certain income. GPs were paid on a per capita basis according to the numbers of workers on their lists. Eventually, about two-thirds of GPs joined the scheme. The services provided were not comprehensive, as dependents were excluded. The wartime Emergency Medical Service made many doctors, who had formerly practiced only in well-equipped areas, aware of the major deficiencies which existed elsewhere. The need for some form of nationally-organised service after the war became apparent and gained wide acceptance.

In November 1942, the Beveridge Report on *Social Insurance and Allied Services* recommended the establishment of 'a national service for the prevention and cure of disease and disability'. It suggested that 'a comprehensive national health sevice will ensure that for every citizen there is avilable whatever medical treatment he requires in whatever form he requires it, domiciliary or institutional, general, specialist or consultant'. It should be 'without contribution condition', 'without an economic barrier at any point to delay recourse to it' and 'to every citizen without exception and without remuneration limit'. In February 1943, the Government announced its acceptance of the recommendation and negotiations with interested bodies began.

The National Health Service Act 1946 came into operation on 5 July 1948. It covered England and Wales: similar legislation applied to Scotland and Northern Ireland. The act drew together most of the

previous arrangements and placed significant new responsibilities on central government in relation to the provision of Health Services. Section 1 of the Act reads:

'1 It shall be the duty of the Minister of Health . . . to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with the following provisions of this Act.

2 The services so provided shall be free of charge, except where any provision of this Act expressly provides for the making and recovery of charges.'

OBJECTIVES

The NHS, which has developed from the 1946 legislation, has become a large and complex institution, accounting for about 5.5 per cent of GNP and employing over 900 000, or about four per cent of the total working population. To manage financial and manpower resources on such an enormous scale and to provide the volume of services that are required to meet an almost infinite demand clearly needs an efficient and effective organisation. A study of objectives can provide a way of evaluating the purpose of an organisation and what it achieves against what it sets out to do.

In this paper the word 'objective' is not used in the sense of a closely defined output or target but as a guiding principle indicating the direction in which we want the NHS to progress. The set of objectives put forward is therefore a set of aims which should inform the activities of those who provide and administer services. Different categories of importance can be distinguished among the objectives described below. Objectives mean not only those of the management structure of health authorities which are the main agents in providing services, but also the objectives of Parliament, Ministers and the four UK Health Departments

which have political, policy-making and ultimate financial responsibility for the service.

The hierarchy of objectives for the NHS which follows has to be seen in a context wider than the provision simply of health services. Indeed some goals may be more effectively pursued by the provision of other services for example, housing, education, social work, perhaps even to the point where, to improve health, it is desirable to switch resources from health services to other sectors. Our list of objectives will also have implications for the consideration of detailed issues in the Commission's work. The buck starts here.

An overall objective

The fundamental objective of the NHS needs to be stated in broader terms than those in Section 1 of the 1946 Act. It should be *to contribute to the improvement of the quality of life of the individual and the enhancement of his capacity to use his abilities to the greatest possible extent*. However, this overall objective has to be presented in terms of more limited health service objectives if it is going to be useful. Thus the NHS should:

(a) encourage and assist individuals to remain healthy;

(b) provide a full range of services;

(c) provide equality of entitlement to health services;

(d) provide a service free at the time of use;

(e) provide equality of access to the full range of health services;

(f) provide equality of access to health services of a high standard;

(g) be a national service but responsive to local needs;

(h) satisfy its customers, including providing some choice to patients and operating in a humane manner.

(a) To encourage and assist individuals to remain healthy

Prevention of illness is referred to in Section 1 of the 1946 Act. This objective means not only immunisation and early detection programmes but positive measures which can be taken to encourage good health. For example, general health counselling to emphasise the factors which contribute to ill health; smoking, drug and alcohol abuse, diet, lack of exercise, as well as environmental factors, for example occupational hazards and pollution. Health professionals have an important part to play as have health education programmes and the mass media. Under heading education in self-care and self-medication for minor complaints, information on how to use NHS services wisely and responsibly and patterns of community support to enable for example, the elderly, or the disabled to live at home would be included. This objective has implications not only for the NHS but also for other services and for individuals.

(b) To provide a full range of services

The NHS should continue to carry its present range of responsibilities in relation to the prevention, diagnosis and treatment of disease. This was an original aim of the framers of the NHS and should remain a fundamental objective for the future. This does not mean that the relative importance of these constituents should not change: for example there may be greater scope for self care, and significant reductions in morbidity may come through changes in personal habits rather than new medical treatments.

One question which arises under this objective is whether services which are closely related to the NHS but are provided by other agencies at present should be brought into the NHS or integrated at the point of use. Among these are occupational health services and social services. There is also the question of whether there should be a more flexible

attitude to the provision of certain fringe services within the NHS, for example osteopathy. In examining whether new services should be brought under the NHS, the interests of patients, the scope for improvement if a change was made in the way in which services are delivered to patients, and the likely cost should be the main considerations.

To provide a full range of services effectively may require extra resources. While the overall amount of the national resources spent on health is essentially a matter of political choice and will, the availability of resources is a significant constraint on the achievement of this objective as on those which follow.

(c) **To provide equality of entitlement to health services**

The NHS should be available without restriction of age, social class, sex, race or religion to all people living in the UK. One of the most significant achievements of the NHS has been to free people from the fear of being unable to afford treatment for acute or unexpected illness. Entitlement as a right extends to all people who live in the UK. The NHS should continue its present policy in relation to non-residents who require treatment while they are here.

(d) **To provide a service free at the time of use**

The introduction of schemes for charging patients, even with generous exemptions for the young, the old, and the disabled, necessarily means that different standards of entitlement are introduced. It may be argued at one extreme that, as part of society's reward system by which it pays some people more than others for their services, people should not be prevented from purchasing health care; and the other that entitlement to health care is a civic right in the same way as the freedom to vote, and freedom of speech. Whatever financial justification there may be for introducing charges for certain services, the creation of two classes of user in the NHS is something which creates difficulties. At best charges may discourage people from using services and at worst may effectively

prevent them from so doing. It is, however, one thing to state this objective; it is another to withdraw the various charges which already exist or introduce new ones. The rigorous application of this principle would imply that no-one should be permitted to buy extra treatment within the NHS. It is a further question whether people should be able to buy privacy, for example, through amenity beds. Clearly the implementation of this objective needs separate consideration.

(e) To provide equality of access to the full range of services

The intention of the 1946 legislation, although it did not so provide explicitly, was that everyone should have access to the same range of services. This should be endorsed. There should be a rational geographical distribution of services so that they are accessible as equally as possible to everyone, without regard to age, income, or social class, although clearly it will not be possible to treat rare diseases in every locality. To the extent also that a full range of services is not available, there is not effective equality of access. In practice the degree to which people are able to take advantage of the health service varies greatly. There is considerable inequality in the provision of convenient and continuous treatment. In the remoter parts of the country it will always be very difficult to achieve the same ease of physical accessibility that can be provided elsewhere. Real as these problems are, the overall aim of the achievement of an effective measure of equality of access to NHS services should remain an important objective.

(f) To provide equality of access to services of a high standard

It is evident that there are differences in the quality of health services in different parts of the UK. It should be an objective of the NHS that those who need them should have access to services of the highest quality that is consistent with that quality of care being equally available to all.

There are positive and negative forces implicit in this objective which is illustrated by two quotations, first from Sir George Godber in

Change in Medicine[1]:

> 'The best of our own centres for providing neonatal care for babies at risk produce results as good as any in the world, but the generalisation of such results in regions is not being achieved as rapidly as it should be. A **national** health service is not necessary in order to have special centres which can produce high-quality results. The high quality of service in Aberdeen is not the result of the NHS. Any country, in which the highest quality of medicine can be achieved will show some places where such results are obtained. The burden upon the NHS is that of generalisation from the example of the best and the result of having such a national service should be the more rapid development of improved services available to all'.

Also, as the Archbishop of Canterbury put it in the 1976 Edwin Stevens lecture 'On Dying and Dying Well':

> '(there is) the choice between on the one hand making the most advanced techniques available to a few, and, on the other hand, improving the level of services available to many, and especially to those who have in the past been inadequately cared for'.

Some of the difficulties and questions to be settled here are:

1 how far should 'centres of excellence' be encouraged by the allocation of special resources?

2 how should national and sub-national specialties be financed and provided?

3 how far will a more even distribution of resources improve the performance of health services locally, and how can this redistribution be achieved?

4 to what extent should the patients of today make sacrifices for the patients of the future?

5 a consequence of the pursuit of high standards is the need to make suitable arrangements for education, training and research;

6 the attainment of this objective at a national level could conflict with the emergence of wide variations in local provision.

(g) To provide a national service responsive to local needs

The concept of 'a national service' is changing. Health services have to meet different situations in different parts of the country. Therefore, the range, speed of development and pattern of delivery of services may need to vary. Some matters clearly require national policies, for example, the prevention of epidemics, basic pay arrangements, highly specialised training. But if the charge of inflexibility, often levelled by those who have given evidence to the Royal Commission against the reorganised NHS, is to be avoided, the service should be administered in a way which responds to local circumstances and opinion and geographical differences. This may require changes in the structure and organisation of the NHS.

(h) To satisfy the customer

'Customer' is used here to mean users or potential users of the NHS. Satisfaction should not only be short-term, being well treated in hospital and escaping alive: the real test is whether a patient is satisfied with the outcome of treatment once its full implications become clear. But there are difficulties in the discharge of this objective: what patients regard as a reasonable service varies. It is a feature of the provision of health care that patients may lack the technical knowledge required to make informed judgements about diagnosis and treatment. Therefore while alternatives may be put to them, the practitioner is often put in the position of having to judge what is in the patient's best interest. The choice of treatment available and appropriate should be put to the patient who should be the final arbiter.

An important aspect of this objective is that a patient should have as much freedom of choice as possible. This includes:

- freedom to see a practitioner;
- freedom to consult a particular practitioner and to change to a different one;
- freedom to choose a particular consultant or specialist;
- freedom to refuse treatment or advice given except in a few special circumstances, for example, infectious disease;
- freedom to have direct access to other health workers;

An essential ingredient in satisfying the customer is that he should be humanely treated. Patients place great stress on the manner in which they are dealt with personally by doctors, nurses, receptionists and so forth. However, the humane choice is not always clear. To quote the Archbishop of Canterbury's lecture again: 'The resources of the national exchequer are not limitless, and the prolongation of the life of one aged patient may in fact entail the deprivation of aid to others and even the shortening of their lives'.

These objectives will not necessarily always lead in the same direction. Encouraging individuals to remain healthy may imply deliberately refraining from providing particular kinds of services or treatments, so as to avoid excessive dependence on the NHS. Providing services free at the point of use puts the onus for rationing upon the providers of care, hence making it more difficult for the system to respond according to the patient's own priorities. As patients under a system of this kind do not pay directly for the services they receive, the system is dependent on other sources of finance. Whether these are insurance based or tax based, this inevitably implies the yielding of some financial control, and hence policy influence, to those responsible for financing the service. Their objectives may not coincide in all respects with those of its 'customers'. Moreover, as a general observation, each objective will be costly to pursue, and the community will continually face the problem of choice between one objective and another.

There are two further objectives which are sub-objectives of those listed above, but which follow from them and are instrumental in putting them into effect. They form a bridge with the detailed consideration of management, finance and staffing questions.

The NHS should be a good employer The Royal Commission said in paragraph 7 of *The Task of the Commission* that 'Although we hope that such conflicts (between the interests of patients, and those working in the NHS) will be rare, we take it as axiomatic that if they arise the needs of patients must be paramount'[2]. The maintenance of a high level of morale and job satisfaction, and the satisfaction of legitimate staff ambitions is an important means to the end of providing a service of high quality. Implicit in this objective is good industrial relations. Also important is the freedom to give treatment and care of high quality within reasonable constraints of resources and efficiency. The NHS should behave as a good employer not only to its own staff but to those who contract to work for it, whether in the family practitioner services or elsewhere.

The efficient and effective use of resources This is a pre-condition for the attainment of the objectives stated above. Indeed, to say that resources are being used wastefully is to say that they are not being deployed in a manner consistent with the priority established within the broad objectives set out above, and hence that with some redeployment we could do better. Thus, the test of efficiency is a very general one, 'could we achieve our objectives better if our resources were deployed in a different way?'

CONCLUSION

In judging the performance of the NHS the question 'compared with what?' will in turn lead to the question which of the above objectives is peculiarly part of the remit of the NHS, as opposed to objectives which might well be pursued in any health care system, public or private, national or local. While most of the above objectives might equally well be pursued by means other than a tax financed national

health service of the kind we have, the characteristic element which other systems of provision would not readily encompass is the drive for greater effective equality of access, objectives (e) and (f) above. In assessing the performance of the NHS since 1948 it will be important to concentrate on this criterion, and seek to judge how far it has been achieved compared with the pre-NHS situation, and compared with other (foreign) systems, and at what cost, seen in terms of for example average standards of care, in overall resources devoted to health care.

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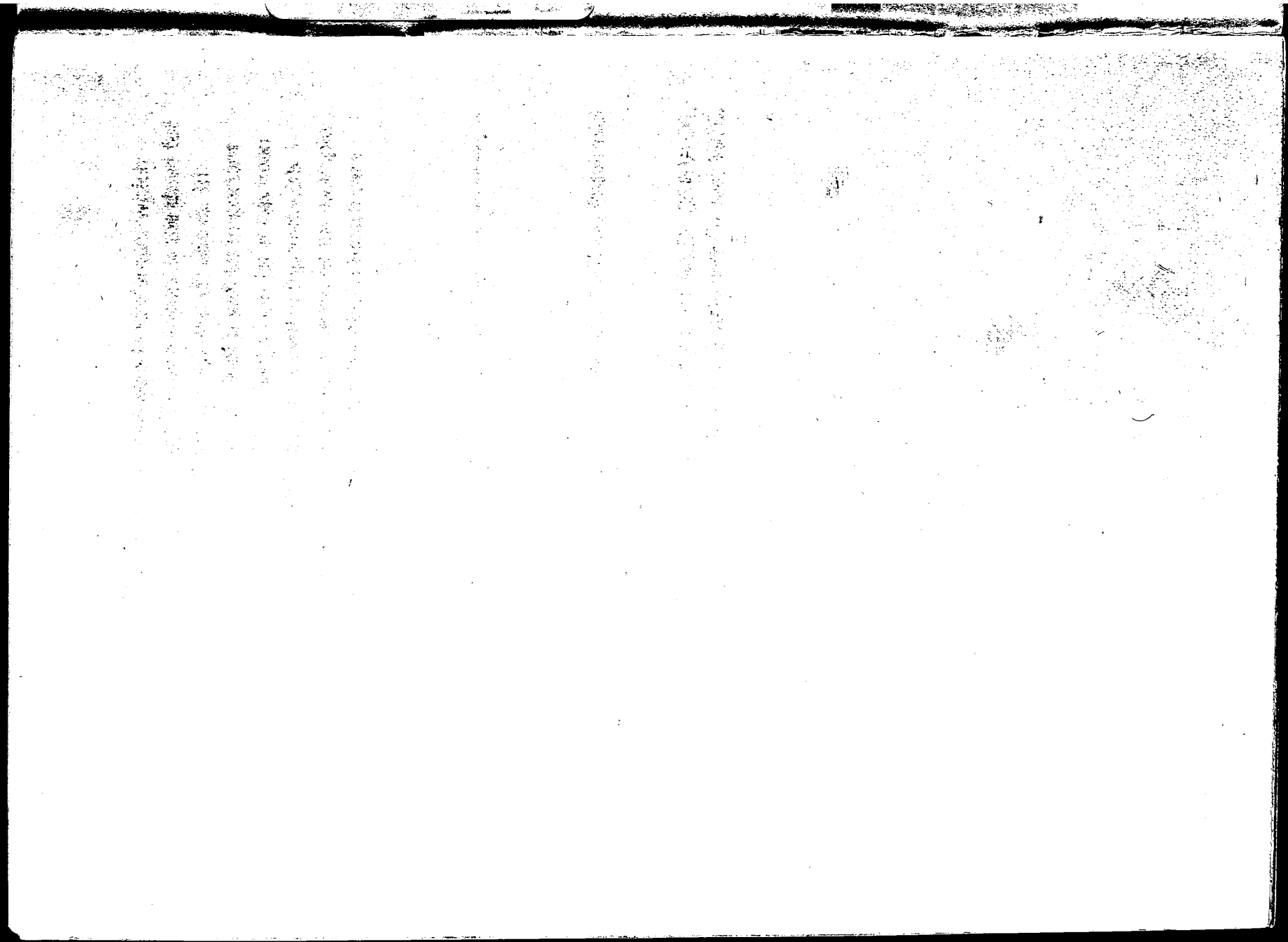

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