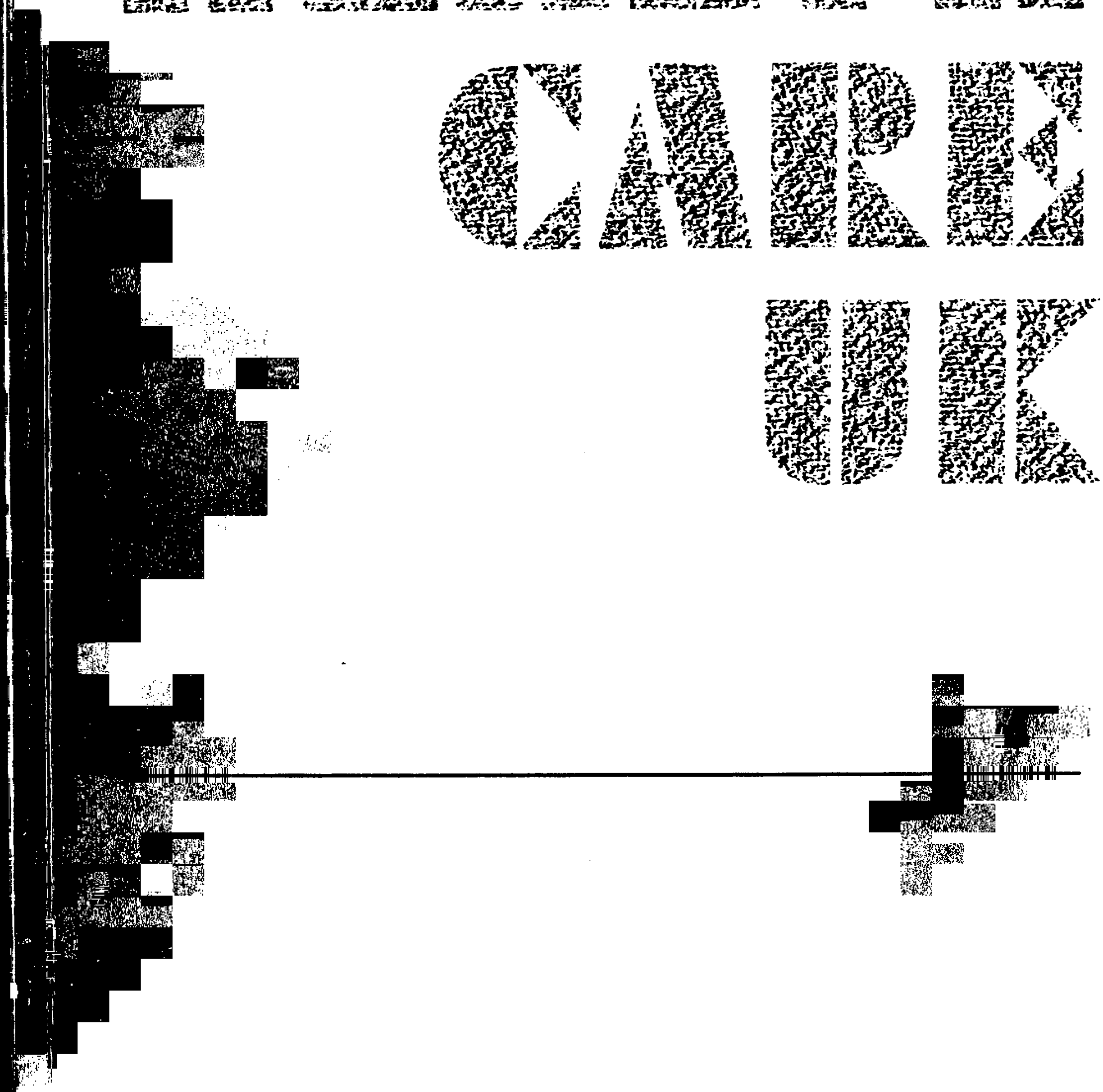
HEALTH CARE UK



1993/94

HEALTH CARE UK
1993/94

an annual review of health care policy

Editor: Anthony Harrison
Assistant Editor: Shirley Bruscini

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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

Adam Darkins is Medical Director, Riverside Community Care Trust, The Parsons Green Centre, 5–7 Parsons Green, London SW6 4UL, Tel: 081 846 7825.

Jeff Girling is Head of Centre for Primary and Community Care at the Health Services Management Unit, University of Manchester, Devonshire House, University Precinct Centre, Oxford Road, Manchester M13 9PL, Tel: 061-275 2908.

Howard Glennerster is Professor of Social Administration at the London School of Economics, Houghton St, London WC2A 2AE Tel: 071 405 7686. The full results of his research into GP fund-holding are being published by the Open University Press.

Joan Higgins is Professor of Health Policy in the Health Services Management Unit at the University of Manchester, Devonshire House, University Precinct Centre, Oxford Road, Manchester M13 9PL, Tel: 061-275 2908.

Bob Hudson is Visiting Fellow in Health and Community Care Studies at the Institute of Health Studies, University of Durham, 46 Old Elvet, Durham DH1 3HN, Tel 091 374 4731) and Senior Lecturer in Social Policy, New College Durham. His book *Making Sense of Markets in Health and Social Care* was published by Business Education Publishers in 1994.

Jane Lightfoot is a Research Fellow at the Social Policy Research Unit, University of York, York, YO1 5DD, Tel: 0904 433608. Her article draws on research funded by the Department of Health into the setting of establishment levels for district nursing and health visiting.

HEALTH
POLICY
REVIEW
1993/94

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PART 1: MAIN EVENTS

In its statement of *Priorities and Planning Guidance 1994/95* issued in June 1993 as EL (93)54, the NHS Executive set four strategic goals:

- improving health through *The Health of the Nation;*
- securing high quality care in the community in partnership with local authorities;
- continuous improvement in the quality of services with particular reference to implementation of the Patient's Charter and the needs and wishes of patients;
- achieving greater efficiency and effectiveness through better use of resources and organisational development.

For the most part, the central features of these policies were already clear last year. During this year, the process of creating a health care market, the main stimulus to greater efficiency, has been further advanced: more trusts have been created, more GPs given control over their budgets and the administrative structures necessary to pursue *The Health of the Nation* and the Patient's Charter have begun to be put into place. Finally, at long last, the community care element of the reforms has come into effect.

In the first part of this Review, we describe developments in each of these main policy areas. For the first time, we are able to draw on the results of systematic research into the effects of the reforms. In the absence of a government' funded programme, the King's Fund supported a series of projects designed to estimate their impact, the results of which were published in *Evaluating the NHS Reforms* (editors Ray Robinson and Julian Le Grand) in February 1994.

In the second part, we turn to a number of general issues which arose during the year. The first of these is finance. The process which led to the creation of the new NHS was itself sparked off by concern about funding. At one level, the 1990 NHS and Community Care Act can be seen as a diversionary tactic designed to distract attention from that issue, or at minimum postpone the time when it has to be tackled. But the more time passes, the less effective the diversion is. During 1992/93, that became apparent as a number of organisations returned to the question of how much we should be spending as a nation on health, and how that sum, whatever it is, should financed. Whatever the volume of resources available, there remains the question of how they should best be used. As the Guidance just quoted put it:

> *Underlying both organisational structure and finance is a yet more basic issue: how should the resources devoted to health – and social care – be used. A combination of the 1990 reforms and a changing perception of the nature of health care itself, is beginning to lead to a restructuring of provision within the hospital sector, and between hospitals and other forms of care which, if realised, would be more profound than the reforms themselves.*

A number of events during the year forced two other broad issues to prominence: the accountability of the NHS and equity in the delivery of care. The first came as a result of a series of scandals, both financial and clinical within health authorities, which raised questions about the adequacy of existing mechanisms for ensuring good performance: the second, from claims that GP fundholding was opening up a two tier service, resulting in inequities between patients who are in fundholding practices and those who are not. However, as we show below, this is just one of several ways in which the changes introduced by the reforms raise equity issues which were present in the old NHS but which did not force themselves to the surface and attract public attention.

1.1 Creating the New NHS

In October 1993, the Secretary of State announced the successful fourth round applicants for trust status and indicated that a fifth round would follow in 1995. With this announcement, the process of transforming hospital and community service provision was almost complete since, with the fourth wave brought into operation from April 1994, 90 per cent of health and community health service spending will be used to purchase services from around 400 trusts. In 1991/92, the year in which the reforms started to take effect, the proportion was less than 25 per cent.

Speaking to the chairs of fourth wave trusts in February 1994, the Secretary of State declared:

Trusts are part of a modern decentralised NHS which is characterised by:

- *greater delegation of responsibility, not just to Trusts but to local health authorities and GPs;*
- *accountability to local people and to Parliament, backed by rigourous systems of independent financial audit;*
- *greater openness and a willingness to inform, persuade and lead the community towards improved care for patients;*
- *a streamlined management system which upholds the coherence and ethos of the service without smothering initiative;*
- *and, above all, a health service where decisions are taken locally, in response to the needs of patients, providing value for money and leading to better health.*

Before Trusts and before our reforms, the NHS was like a monolithic monster, barely able to move forward at all. The day is coming when every patient care service will have taken charge of its own affairs as a Trust. With a clear job to do and clear space to do it, Trusts are the vehicle which will take NHS patient services into the 21st century.

As we shall see, there is an element of fantasy in these claims, but there is no doubt that structural transformation has been rapid. In primary care, change has been less marked. There is no prospect of all GPs becoming fundholders in the near future, in part because many do not wish to take on the responsibility, in part because many would not qualify *eg* all single handed practices, of which there are some 3,000, would not. Nevertheless, the number of GP fundholders also rose in 1993 and was also planned to increase in 1994 to 8,000 GPs in 2,000 practices serving 36 per cent of the population.

The figures for the proportion of patients in each region, given in Table 1, show quite wide variations from one part of the country to another. The regional averages of course hide large variations at more local level. In some areas there are virtually no fundholders; in others, they already comprise the majority of GPs and command the majority of funds for elective care.

Table 1 : The Population in GP Fundholding Practices, by Region, 1993

	% Total
Mersey	35
Oxford	33
Wessex	33
Yorkshire	33
Trent	31
NW Thames	27
West Midlands	26
East Anglia	25
Northern	25
SW Thames	25
SE Thames	22
South Western	19

As foreshadowed in EL (92)48, the Government introduced a widening of the scheme, in April 1993, to include community health services comprising:

- a comprehensive health visiting and district nursing service, dietetic and chiropody services;
- mental health outpatient and community services currently not included and health services for people with a learning disability;
- mental health counselling;
- referrals made by health visitors, district nurses, community psychiatric nurses and community mental handicap nurses.

However, fundholders were not yet allowed to employ community nursing staff within their own practice and the precise interface between practice nurses and those employed by other providers remains unclear. In addition to this general extension, experiments have begun in a few areas with a yet wider range of services including accident and emergency services and a larger tranche of inpatient hospital care. The Secretary of State also indicated in March 1994 that she wanted to see fundholding spread to small practices, perhaps by allowing GPs to take part in only some aspects of the scheme. Howard Glennerster discusses this and other options later in this volume.

Thus, as far as the provision of health care is concerned, the creation of more or less independent agencies is well-advanced. The focus of interest therefore turns more and more to the question of their degree of effective autonomy. The question is particularly significant for trusts since their underlying justification was precisely that they would enjoy a greater degree of independence. Originally, they were offered it in two main areas, personnel – *ie* pay and conditions – and capital finance.

Since the foundation of the NHS, determination of pay and conditions has been highly centralised; pay negotiations have taken place at national level, with central government always having the final say. This degree of centralisation, common to other central government services, reflected a view of relations between the Government as employer and its workforce, in which equity between employees doing similar jobs in different parts of the NHS played a large part.

However, as Frank Glascott and Noelle Bowden have pointed out in their contribution to an OECD study, *Pay Flexibility in the Public Sector*, before trusts were established, the NHS Management Executive was urging health authorities 'to develop a pay policy as an integral part of . . . staffing and management policies'. We reported last year that there were signs that trusts are taking advantage of the freedoms offered to them in respect of personnel, to work out their own pay structures. But, as James Buchan and Ian Seccombe put it in their contribution to *Evaluating the NHS Reforms*:

- the post-reform pace of change in human resource management practices has, with some well-publicised exceptions, been slow and incremental, rather than revolutionary;
- the first years of reform have been largely about scene setting, as the personnel function has recognised the need for change and has begun to gear up with appropriate skills and competence.

Glascott and Bowden however found among a large sample of trusts, that each was 'investing a good deal of effort into developing and articulating a reward philosophy.' What that means, they argue, is that a new approach to equity within the NHS labour force is emerging, away from one underlying the Whitley arrangements, to a concept of equity based on rewarding individual skill, competence and contribution. But the pace of change appears to have been held back in part because of the lack of the appropriate skills in personnel.

Moreover, the Government itself put a major obstacle in the way of more flexible policies by announcing in the November Budget statement that public sector wages would be frozen and increases allowed only in relation to productivity gains. However, when the Pay Review Bodies for medical and nursing staff recommended a 3 per cent increase across the board, the Government accepted it, apparently on the ground that most trusts were not in a position to strike local bargains.

Whether emphasis on the individual rather than the group is desirable is questionable. A good deal of evidence has emerged however (Economist 29 January 1994) that merit and other forms of incentive pay which the Government has been encouraging right across the public sector, does not work and indeed can be counter-productive both in terms of their effect on morale and on pay costs. That does not mean that local bargaining has no advantages but does suggest it should focus on issues such as skill mix and job demarcation rather than on devising performance-related pay systems, which have proved hard to devise fairly and efficiently.

As for finance, the striking feature of the financial regime for trusts is the limited degree of freedom of action they have ended up with. One of the original carrots encouraging directly managed units to transfer to trust status was easier access to capital, but in the event, the rules governing that turned out to be highly restrictive. However, following the wider initiative to introduce private funding for public projects, announced in the Chancellor's 1992 autumn statement, the NHS Management Executive indicated that it wished to see private capital introduced into the NHS. A series of circulars were followed by a briefing pack in November which was designed to encourage trusts to consider the 'private option'. That, the Minister for Health suggested in November, should be the standard option for all investment projects.

In the same month, it was announced that a group led by Sir Alistair Morton was to be set up to promote the introduction of private capital right across the public sector. The aim, it appeared, was to make the introduction of private capital the successor to privatisation as the next broad theme of government policy towards the public sector. The implications for trusts' financial freedom could be considerable, but whether they are or not, turns on the overall framework within which they will work.

The rapid transition of provider units to trust status forced a change in the hierarchy of control. At the outset, trusts were promised direct access to ministers freeing them from the 'dead hand' of regional health authorities. As the number of trusts rose, the Management Executive was forced to create regional outposts to supervise them parallel to the regional hierarchy. But once it was clear that trusts were going to be the norm, the role of the regional authorities was put into question. A review under Alan Langland, then deputy chief executive of the NHS, and Kate Jenkin, a member of the Executive, was undertaken during 1992, and published as *Managing the New NHS*. The Secretary of State responded in October.

Two changes in the administrative structure were announced: first, the abolition of the regional authorities in favour of a smaller number of middle tier organisations which combined the role of the regions and outposts; and second, the merger of FHSAs and DHAs. Both had been expected for some time. It was clear that the period during which the NHS could run two regional hierarchies was limited. The merger was also a widely anticipated change: in 1991, the Management Executive had issued a report urging a tighter relationship between the two types of Authority , and the Audit Commission's ironically titled report *Practices Make Perfect* on the role of FHSAs also brought out both the need for close working between the different categories of health authority and the obstacles to it created by the existing structures. Both this and the merger of districts and FHSAs required primary legislation and so could not be done immediately; interim arrangements were therefore put in place.

These proposals could be regarded as essentially 'tidying up unfinished business' in the words of *Managing the New NHS*. But a great deal of business remains. The respective roles of the NHS Management Executive and the Department of Health were not defined. Furthermore, the task of deriving clear criteria defining '..the circumstances in which it is appropriate for central management to intervene to ensure that providers fulfil national policy objectives . . . ' was left undone.

Yet if these roles are not specified, it is impossible to

Diagram 1: Existing structure of the NHS

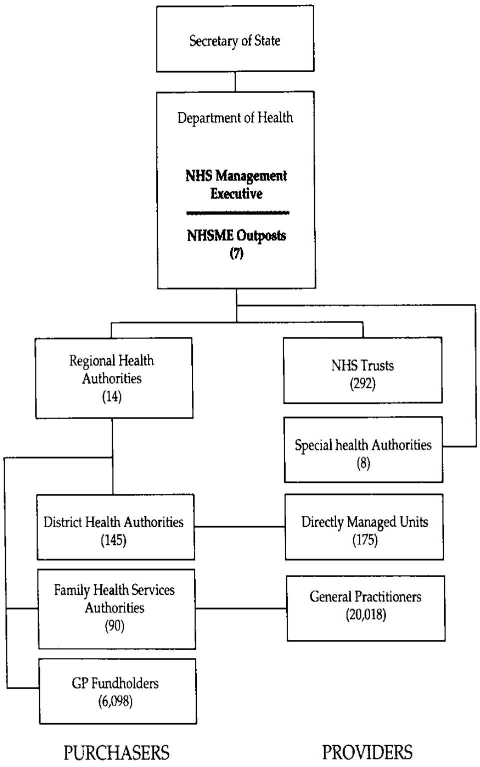
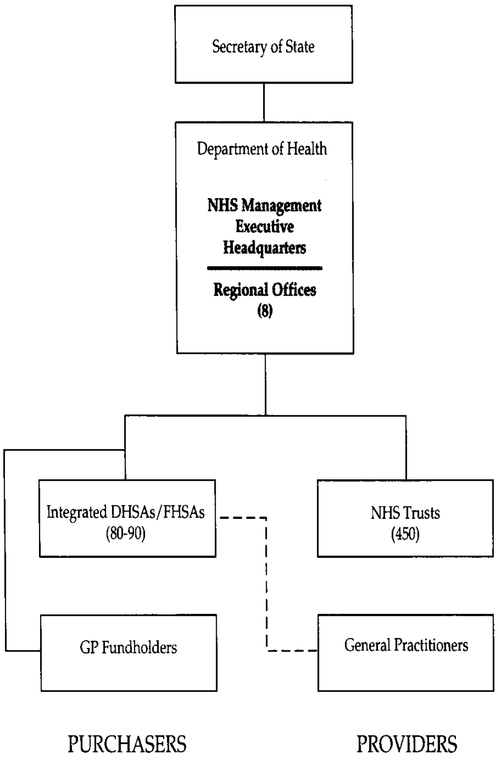


Diagram 2: New structure of the NHS



form any view as to how the new arrangements are going to work: the central task of defining the balance between central direction and local discretion does not appear to have been attempted. The triumphal language used when fourth wave trusts were announced, a sample of which we cited above, contrasts with both the substance of the report and its tone. As far as the substance is concerned, the abolition of the statutory regional authorities and their replacement with a middle tier layer of management which is part of the Executive itself, leaves the way open for a highly centralised regime. As for the tone of the report, with its frequent references to central requirements, that too suggests an Executive more concerned with ensuring the new arrangements work for it, rather than a strong commitment to decentralisation.

Thus, as an attempt to define the shape the NHS is going to take over the next few years, the report was a failure. It may seem in retrospect that, because the merger of the two lines of command will lead to job losses – perhaps as many as 2,000 – its main value was to allow the Secretary of State the opportunity to fend off the charge that the NHS was employing too many managers by an apparent demonstration of willingness to cut back bureaucracy. However, most of the identifiable growth in managerial staff has occurred in health authorities and trusts, not regions which have always been relatively small organisations, so the point is one of presentation rather than substance.

The charge that the NHS was spending too much on 'men in grey suits', to use the expression of the Secretary of State for Wales, John Redwood, who ordered a ban on their recruitment, was boosted by the figures which showed a rapid growth in managerial and administrative staff since the reforms were introduced; however, this growth had begun much earlier, as Table 2 shows.

Table 2: NHS Managerial Staff

	1981	1986	1991
Admin & Clerical	128,180	137,770	157,800
General Managers	-	610	740
Senior Managers		630	12,760

Source: NHS Workforce Statistics

The Department pointed out that some of this growth resulted from reclassification of senior nursing and other professional posts and a deliberate strengthening of certain functions such as personnel and finance, a process which had been going on throughout the 1980s in response to the reforms triggered by the move to general management. And it was in any case only to be expected that implementation of the 1990 Act would speed up this process: running markets involves transaction costs, requiring as it does activities such as costing, pricing and con-tracting, which the old regime had not.

But what no-one knows is what represents a justifiable level of transaction costs nor what proportion of the new or reclassified posts involve work such as that focussed on *The Health of the Nation*, which is unconnected with the 'market' or work such as that involved in introducing changes in skill mix, which would have required investment in personnel skills and would have been necessary if the flexibility theme already apparent before the reforms came in had been pursued. In other words, a before and after comparison risks greatly overstating the impact of the reforms. Whatever the truth of the matter, the Government was sufficiently worried by the apparent growth of management and also by a small number of high salaries to seek the advice of the National Trust Federation on how management costs should be contained.

Purchasers

With the creation of trusts largely complete, the Government began to give more attention to the purchasing side of the new arrangements. The aim, in the words of the Minister for Health, is that the NHS should be 'purchaser-driven'.

A number of initiatives, described in *Health Care UK 1991*, were taken at the very start to help provide purchasers with the information they needed to carry out their role. But as time has gone on, the magnitude of the task facing them has become increasingly apparent. In a series of speeches, published together as *Purchasing for Health: a framework for action*, the Minister for Health stressed the need to develop the purchaser role. Three strategic goals were set out:

- to improve people's health
- to improve the quality of health care
- to achieve greater efficiency in the use of resources

and a series of development projects announced, covering:

- strategic approach
- demonstrating how health authorities and fundholders can develop and apply a more strategic, longer term view of purchasing
- purchasing power; identifying developing and demonstrating how purchasers can apply contracting and other mechanisms to secure desired change;
- market relationships: exploring the scope for and demonstrating how to establish more effective links between purchasers and providers
- responsiveness to local people; demonstrating how local views are reflected in purchasing decisions.

But there are serious difficulties in the way of progress in all these areas. The three strategic goals and the development projects are all about process rather than content. All may be described as work for men in grey suits rather than care providers. And the grey men will find, in these ministerial speeches, very little help indeed on the central task facing purchasers, of getting more value – be that expressed in terms of benefits, health gain or whatever – from the resources at their disposal. Nor on the reverse of this, the setting of indicators or criteria to judge whether or not the purchasing role is being done well, be it by health authorities or fundholders. As Joan Higgins and Jeff Girling point out below, purchasing is not just a technical task: it requires a framework of values or principles, against which to measure its success or failure.

Both the announcement and the ministerial speeches are silent on the structural features of the internal market which will determine the context within which purchasers work beyond a brief mention of 'achieving greater plurality – working with a mixed economy of providers' nor about the role which the central management – to use the term deployed frequently in *Managing the New NHS* – will in practice determine how purchasers work. Nor have they anything direct to say about how hard choices between different patterns of spending – and different objectives – are to be made. Nor about how different categories of purchaser – GP and district – should relate to each other or what the merits are of different purchasing structures.

The creation of purchasing authorities represents a considerable investment but no thought was given initially and there is little evidence of much since, as to what a 'good' purchasing structure would look like. The Government has been strongly enthusiastic about the introduction of GP fundholding and we turn to the evidence on its effectiveness later on. One might see that enthusiasm as a reflexion of their general belief in competition. But it may be that the right way of viewing the two purchasing mechanisms is as complements.

There is some evidence for this view from the work of Howard Glennerster and colleagues, reported in *Evaluating the NHS Reforms*. The central point made by the researchers is that fundholders are in a position to seek out 'micro' improvements as they can perceive for themselves what is beneficial to their patients *eg* bringing consultants to local clinics, though whether this is beneficial taking into account the overall picture is less clear. The district purchasers, pursuing broader issues, are, at this level, not yet effective, perhaps because they have so much to focus on: the public health issues raised by *The Health of the Nation*, population-wide needs assessments and consultations, and the whole area of emergency admissions and expensive treatments which GPs do not have to pay for.

But it is not clear whether in their own domain districts have the appropriate structure to be effective, even if they have the ability to grasp all these issues. A major omission as the reforms were worked out has been the lack of analysis of the proper structure of purchasing given the trends in service delivery that are occurring or being actively promoted. The structure of purchasing has emerged almost by accident. The size of health authorities reflects decisions made more than a decade ago about appropriate administrative structures and these in turn reflected decisions made even earlier which reflected the pattern of health provision, particularly the much larger number of acute hospitals in operation at that time.

The merger of health authorities into larger purchasing units, as has occurred in a large number of areas, makes sense as a means of avoiding duplication of effort and skill-sharing, but it has happened piecemeal, not as part of a considered view on what the right scale of purchasing is. Furthermore, while organisations are emerging serving large catchment areas, they are not yet large enough to cope with the rationalisation of capacity in the major urban areas and to purchase those services which require very large catchment areas if they are to be efficient. At the other end of the scale smaller purchasers are being created in an endeavour to maintain contact with smaller areas as existing purchasers sub-divide themselves into smaller units.

Nominally, then, while most of the elements of a market are in place, purchasers on the one hand and providers on the other, an actual market was far from being realised by the end of March 1994. In the first year of the new arrangements, the NHS Management Executive instructed purchasers to keep things in a 'steady state': as a result the main source of turbulence for providers came from GP fundholders who were uninhibited about shifting monies around. In the following year, that restriction was removed, but the amount of contract shifting was limited. Although purchasers are free to move contracts around, they have not been compelled, as they had been for ancillary services, to seek tenders for medical or other clinical services. A few have done so but it is not yet common practice. In general, therefore, the second year was not a free-for-all.

London

In London however, shifting of contracts from hospitals in the inner areas by purchasing authorities in outer London and further afield, made adjustment inevitable. We concluded last year that the Tomlinson report would serve as the starting point of a sustained period of re-adjustment which was not specific to London. And so it has proved.

The London Implementation Group, established formally in February 1993, began the process of trying to work through the Tomlinson proposals. A series of studies were concluded of six specialties where rationalisation was thought necessary. All reported the number of providing points should be reduced in order to raise the quality of service: in general, London has too many small specialist units for any to perform effectively.

While these reports were being written, the providers themselves were having to cope with reductions in income both from switches of contracts and a smaller overall budget for health care in London, which reflected changes made to the resource allocation formula for hospital and community services.

Not surprisingly, signs of strain were evident: waiting lists continued to lengthen and more beds were closed. As a result, there was no evident sign that services were becoming better. Indeed as London in common with other parts of the country experienced a large increase in emergency admissions and consequent delays in getting patients into beds, the reverse appeared to be true.

In December, the Secretary of State made a series of announcements about the future of some hospital services in the North East Thames Regions. The most significant was the decision to underpin University College Hospital (UCLH) which had appeared to be threatened with closure or drastic rationalisation by loss of contract income.

Announcing the changes, the Secretary of State indicated that the Government was committed – as *Making London Better* had suggested – to retaining an accident and emergency facility at UCLH and retaining it as 'a world-class centre of medical teaching and research. The Government will therefore ensure that UCLH has a secure future.'

She went on:

> *UCLH will need to make further progress to improve its efficiency. We welcome the fact that, after pressure from its main purchaser, the Camden and Islington Health Authority, it has already taken steps to do so. In order to ensure that some local acute services are retained at UCLH, discussions are in progress at local level. In addition, we shall accept the advice of the independent specialty review to develop the UCLH as the major centre for cancer and cardiac speciality services for this part of London. However, we are not persuaded that renal transplantation work should move from the Royal Free Hospital. (H93/1127)*

The remaining decisions related to accident and emergency services, including the politically sensitive closure of the Accident & Emergency Unit at Bart's and Guy's, when the latter is merged with St Thomas'.

The decision to put funds into UCLH can be read in different ways: a failure of nerve in the face of the medical establishment or a sensible decision to override an unfortunate result of the introduction of market processes. Either way however, it appeared as an *ad hoc* intervention unrelated to any overall strategy. The aim of having world-class centres does not, for example, appear in any Government list of objectives for the NHS. The terms of the announcement invite the question: what if the hoped for improvements do not result? The announcement itself creates the signal that there may be hope of avoiding the logic of the market. What neither do is indicate the rules of the game within which providers have to work.

Another example is the decision, announced in March, to allow Hammersmith hospital to continue on a separate site, it under the same management as Charing Cross and two other small hospitals. Here Tomlinson had recommended a physical rather than organisational merger. In contrast, however, the merger of Guy's and St. Thomas's is to result in major switches of service away from Guy's.

The central question is whether the overall process is being correctly managed. The King's Fund London Monitor put the issue this way:

> *We do not argue that change itself is wrong and support strongly the need for a body such as LIG (the London Implementation Group) taking an overall view of the process. However, a definite lead is now required, and urgently, with sufficient funds to drive change through to a positive outcome. The alternative is to risk the disintegration of the system of health care in London with detrimental consequences for the health of Londoners.*

The London Implementation Group itself is not an executive body and its constituents are not independent of the situation it is trying to deal with, but at present it is the only organisation which can take a broad view, other than the Department itself. There is no one London purchaser which can do that.

As we noted in our first review, one reason for caution in pushing ahead with change in London, is the question of whether London was getting a fair share of the national cake. Since then, a great deal of work has been going on under the Department's direction, to attempt to derive a better formula. As far as London, and other large urban areas is concerned, the crucial question is what if any weight should be given to deprivation factors. But if London does deserve more on these grounds, the question remains as to what it should be spent on.

A series of reports over the years, including that of the Tomlinson inquiry, have recommended improvements to primary care as having the first priority on extra funds: *Making London Better* accepted that conclusion, and in particular proposed the establishment of a London Initiative Zone in East London and indicated that additional funds would be forthcoming. In June 1993, the Minister for Health gave what was described as a categoric assurance that £170 million worth of investment would be made in primary care services in London over a period of six years:

> *I accept that GPs in the City and East London practise in a very deprived area, and suffer from the effects of decades of under-investment. To put that right requires substantial investment and we have pledged to make the necessary resources available. The London Implementation Group has been charged with ensuring that Ministerial decisions are carried out on the ground, and that patients and their GPs benefit.*
>
> *Ministers are committed to change. We are determined that by the end of the century, Londoners will have primary health care services worthy of the 21st century.*

Clearly, improvements in primary care, where it is poor, are desirable. But whether the expectation that any such improvement will result in a reduction in demand for hospital care, particularly emergency medical admissions, in another matter.

Overall, policy in London contains elements of boldness, such as the decision to close Bart's A & E Department and Guy's and elements of caution, as with UCLH and Hammersmith. What is missing, at least for hospital services, is a clear statement of where the pattern of services is heading overall and a clear public justification of the particular measures taken so far.

1.2 Community Care

The 1990 Act provided for changes outside the NHS which have nevertheless considerable importance for it. The key financial change it brought in was a switch of funding for nursing home and residential care from the social security budget to local authorities. From the Government's viewpoint this move made eminent sense, since by 1992 income support payments were running at some £2.5 billion with the prospect of further increase to come. From the NHS point of view, the move threatened to curtail the ability of health authorities to offload the costs of long term care to another budget. The risk to them was that beds would be blocked, as old people 'queued' to be assessed by local authorities before they could be transferred to other forms of care. As we reported last year, the Government recognised that risk, if rather belatedly, and took a series of measures designed to reduce it.

During 1993/94, there were a few signs that this health/social care interface was not working properly as a number of health authorities reported difficulties in obtaining nursing home places, but in general the transition appears to have gone smoothly. A report by the Association of Directors of Social Services on the first six weeks of the new regime reported few complaints with regard to bedblocking. And a report by the Nuffield Institute for Health and the King's Fund Centre, *All Change, No Change*, on the first six months of the new regime concluded that:

> *the chaos predicted by some has not happened. A steady hold on the system has been maintained, with special efforts being made to prevent major problems at flashpoints on the health and social care boundary.*

However, the report continues:

> *Users, carers and their advocates as yet see little or no improvement in the system and in services. Indeed from their point of view things have become worse in some ways. Access to residential care is reduced and their prospects of receiving more and better day, domiciliary and respite services have not measurably increased. Their rights to (free) services have been eroded and many, who previously might have expected help are now bring screened out of the service system.*

A report from the British Medical Association was even less sanguine: on the basis of a survey of GPs, it found that: 85 per cent said there was no improvement in services and 40 per cent said they had deteriorated; 72 per cent of geriatricians reported bedblocking and 70 per cent of psychiatrists said there had been inadequate access to day care provision or residential accommodation. Table 3 sums up the main findings.

Table 3: Community Care: BMA Survey

	Improved	Deter	No Change	No Reply
Respite care	7.9	20.5	67.8	3.8
Home help	8.9	44.2	43.2	3.8
Day care/ Meals on wheels	2.7	14.4	76.7	6.2
Adm. to nursing home	6.2	37.7	50.0	6.2
Adm. to res.	7.5	41.8	44.9	5.8
Voluntary help	6.8	12.7	72.6	7.9

Other reports were less gloomy. The Audit Commission followed up its earlier report *Community Care Revolution* with a survey, published in December 1993, of the progress being made by authorities in introducing the new regime. Its overall conclusion runs as follows:

> *Most authorities are putting in place the foundations that will allow the new arrangements for community care to flourish. However some are rather slower than others. The Commission intends to continue checking on progress with the SSI to ensure that the good progress to date continues and that all authorities achieve the standards of the best.*

The Social Services Inspectorate together with Regional Health Authorities also carried out a monitoring exercise; reporting in December 1993 the overall conclusion was similar to the Commission's:

> *Generally, the monitoring present an encouraging picture. Almost everywhere basic structures are in place and beginning to work well in both social services and the NHS.*

Nevertheless, a number of areas were identified for attention:

NHS and local authorities

- *Linking individual assessment and strategic planning more closely together and making users and carers more central to assessment*
- *Developing the role of care management*
- *Ensuring clarity in responsibilities for continuing care*

Local authority lead

- *Developing the role of local authorities as enablers*
- *Assuming an active role in managing the care market*

NHS lead

- *Managing the strategic shift from acute to primary and community care settings*
- *Managing reprovision from long-stay institutional care*

All agencies

- *Ensuring sufficient organisational capacity and momentum to engage front-line staff and to keep new arrangements in place and build on them*
- *Maintaining and improving collaboration between agencies*

All this however is top down: from the user angle, things looked different as several reports appearing during the year indicated:

One of the central issues is the question of eligibility for service. As we noted last year, the Department realised that the 1990 Act and the subsequent stress on identifying needs appeared to have created a process of creating absolute rights to service. The Laming Letter, cited last year, aimed to get round that. However, the issue did not die with that letter. More than 20 years previously, the Chronically Sick and Disabled Person Act 1970 had appeared to give disabled people rights to services. Starting in 1992 RADAR have run a project aimed at clarifying just what that Act means in terms of rights to service. The first report *Disabled People Have Rights*, appeared in September 1993.

Before turning to those rights, the report provides a counter to the optimistic conclusions quoted above, drawing on a series of example case histories.

> *In some instances, social service departments had refused to provide a domestic cleaning service unless it was part of a 'package of care'. In such cases,* RADAR *pointed out to the department that a 'package of care' could consist of one or more services, depending on the individual client's needs.*
>
> *Some disabled people who receive practical assistance in the home are concerned that they have little control over the times the assistant visits and the tasks which are carried out. They feel their lives are dictated by the social services. A disabled lady who is a widow living on her own spoke to* RADAR *about her feelings regarding the practical assistance she was receiving: 'I am put to bed at 7.30pm, curtains are drawn, and doors are locked, it is like living in prison'. The services provided to the disabled person must be tailored to their needs and not to the needs of the local authority* SSD *and its employees.*

Such difficulties may in due course be overcome, but the question of what disabled people can expect or have a right to remains completely unresolved. An attempt to clarify the position with a private members Bill failed in May 1994.

Another report, by Gary Craig, *The Community Care Reforms and Local Government Change,* based on a survey of a number of authorities, also reported a number of difficulties for users. One area is charging. There is no national policy for charges for home-based and day centre services: guidance issued in January 1994 (LAC(92)1), runs as follows:

> ... *The Government's view* ... *has consistently been that users who can pay for (non-residential) services should be expected to do so taking account of their ability to pay.* ...
>
> *Authorities are locally accountable for making sensible and constructive use of the discretionary powers they have, in order to prevent avoidable burdens falling on council and national taxpayers* . .

Some authorities, anxious naturally enough to make the most of the resources at their disposal are following in the track set by Essex - see *Health Care UK 1991* – and introducing charges. According to an unpublished survey by the Association of Metropolitan Authorities, a majority of authorities are now imposing means-tested charges.

Another source of concern to users is the threat, foreshadowed in last year's review, of the actual (as opposed to the potential) clientele for domiciliary care becoming smaller as resources are focussed on the very needy. The logic of such a focus is clear enough, since it is this group for which residential care is the most likely alternative. But the implications for the less dependent are a complete withdrawal of service. While the well off can pay for care, the 'not rich not poor' find that hard.

Yet another area of complaint is the content of support. There are signs, such as the evidence in the RADAR report, of the policy reported last year of local authorities offering personal not home care even though home care is what many users want. This links to the wider question of the form in which support is offered. We commented last year on the favourable response of most of those using the Disabled Living Fund, which provided 'cash for care' for a small number of people. A subsequent report from the Policy Studies Institute, *Economic Problems of Disabled People,* confirmed those findings. The Government opposed a private member's bill which would have allowed authorities to offer cash. However, a number of authorities are known to be in effect doing so by using intermediaries of one form or another to transfer entitlements to care – vouchers in other words. Whether these will survive audit scrutiny remains to be seen.

Thus, while disaster has been avoided, the overall impact is not clearly favourable, as Bob Hudson's analysis below confirms. The question his argument points up, is whether it was ever sensible to believe that the overall impact would be beneficial. The impetus to change was a financial one – the need to 'close-end' an expanding commitment – but that change was accompanied by a series of others designed to improve the position of users, particularly the better identification of their needs. But better identification of needs both raises expectations and in effect creates demand for services, which then cannot be provided.

The clash clearly emerged in the Health Select Committee's report on Community Care, published during 1993, and the Government response to it. The Committee made a large number of recommendations, including the following;

> *We recommend that clear guidance be issued urgently to local authorities and if necessary legislation introduced to make sure that there are no inhibitions on the ability of social services departments and health authorities to make a full assessment of unmet needs. It will be difficult to judge in future whether resources are adequate unless we have a clear indication of the level of need, both met and unmet.*

The Government declined to accept this recommendation. In its response to the Committee (Cm 2188) it argued:

> *The Government accepts the need for proper assessment of individuals' needs. The guidance that has already been issued encourages this. It set out the legal framework within which authorities work, and made clear the distinction between looking at people's 'needs' ie the things they could benefit from help with- and then deciding what services to provide in accordance with statutory obligations, It also encouraged authorities to set out clearly their priorities and eligibility criteria for services and to collect the evidence they need for planning purposes.*

The guidance was issued in the Laming Letter when it became clear that there was a serious risk of challenge in the courts if people were assessed as needing particular services but were not provided with them. Whether this guidance was clear remains to be seen. Reports in the professional press (Community Care 7 October 1993) suggested that the situation remains confused, with authorities adopting different policies as to the recording of unmet need. The letter's purpose was clear enough, to get the Government off the hook it appeared that the 1990 Act had impaled it on, of having created a process which would seek out needs and create a statutory right to their being met. The Government response makes the reasoning clearer.

> *The Committee itself acknowledge that need is not a concept which can easily be defined..needs are therefore best considered neither in terms of an individual's underlying condition nor in terms of the services that may be provided, but in terms of the functional difficulties that have to be addressed if the goals of enabling people to live as normal a life as possible and helping them achieve the maximum possible level of independence are to be reached. Needs in the sense of an individual's abilities and disabilities are not the same as needs for services provided by local authorities. All 'need' is relative to some baseline and depends on subjective professional and lay opinion which is conditioned by what is regarded as 'normal'. Needs are also often perceived differently by users, carers and the professionals concerned, and perceptions of need are often inextricably linked with individual expectations and the resources available.*

And it goes on:

> *The Committee suggest that a national picture of need for services could be calculated from the sum of individual assessments and community care plans. The Government does not share this view. The assessment of needs and decisions about services are distinct processes. Trying to identify and measure need solely on the basis of front line workers' views of the services they would like to provide to individual clients, regardless of competing claims on resources, would be potentially subjective and divorced from reality.*

Against this background, the Nuffield/King's Fund findings and the other reports cited above are only to be expected. There is a fundamental tension between the declared aims of the new policy – to match services to individual needs – the requirements of overall spending control and the allocation formula for determining how much each authority shall be assessed as requiring.

The Government response goes on to comment on the link between the three:

> *... the Government will be collecting substantial information about the services local authorities provide or arranged under contract. This information will provide a basis for assessing progress towards community care objectives. The normal annual discussions with local government interests on social services expenditure will continue: the local authority associations are free to bring to those discussion any material or data their members provide them with.*

Although the community care reforms have been implemented later than those for the NHS, they have already given rise to some of the regulatory issues of a kind which the NHS will have to deal with. By requiring authorities to use 85 per cent of the funds transferred from social security on private, voluntary or other suppliers of residential and nursing care, the Government compelled authorities to quickly come to terms with the private sector.

As we pointed out last year, this gave local authorities a difficult task of market management for which they were not well equipped and further, it was not clear that the regime they inherited was a sensible one in the first place. The Government itself suggested in a consultation paper, *Deregulation of Independent Nursing Homes and Hospitals* that the existing regime is too complex. A report by David Gladstone for the Independent Health Care Association assessing the consultation paper confirmed that:

> *The existing regulatory regime ... is a highly complex one, ... There is considerable duplication and inconsistency throughout the various parts of the regulatory system that impose unnecessary costs without providing compensating benefit for the industries (sic) consumers.*

In particular, the regime does not bite equally on all suppliers. Public sector and some other organisations are exempt but, as Gladstone puts it:

> *... with all NHS hospitals soon to be trusts, any argument for separate treatment seems increasingly anachronistic, especially in the light of the recent loss of crown immunity from other regulations that has taken place in NHS hospitals.*

Furthermore the regulations which do apply to the private and voluntary supplier are not clear. Different rules apply to nursing and residential homes even in areas such as food which there is little justification for. And 'there is no mechanism to ensure reasonably consistent standards across inspectors or over time.'

Thus there is a clear need to consider the framework within which long term care services are provided by the private sector. That need is recognised in the Social Services Inspectorate monitoring report cited above. In a section entitled 'Market Management', it makes a series of sensible points, but falls far short of setting out all the issues:

> *... market management does not mean attempting to secure day-to-day control of independent services at one remove, and authorities should encourage a flourishing diversity inservice provision, from whichever source of supply, to ensure a good range of choice of users.*
>
> *Authorities' new responsibility requires them to work with, encourage and respond to ideas and innovation of providers. It also requires them to be aware of the consequences of changes in the market. For example, although spot-contracting may be the best way to guarantee user choice in a well supplied market, authorities need to consider the effect on current and future users of unplanned service failures. They should also become proactive in seeking to handle the effects of such failures. Authorities will need to become increasingly sophisticated in their contracting (which could include greater use of approaches other than spot contracts) to ensure a continuity of good quality supply where there is a continuing need, and to support the development of new and innovative services.*

Surprisingly, in the light of the events within Wessex and the West Midlands, which we discuss below, this does not acknowledge the risk of contracts being awarded improperly, particularly when close relationships develop between purchaser and provider. The Audit Commission in its survey found that most authorities had separated responsibility for letting contracts from that of placing individual clients. But over half of authorities had not introduced a register of interests for social services staff and members and over a third had no register of any type. Finally most are not using open tendering for contracts and most have not had the criteria used to put homes on to an approved list approved by Committee. The Commission comments that:

> *All must ensure that the list is open to all homes on merit with no possibility of partiality.*

That part of the Community Care policy which related to the mentally ill took effect in 1991 and introduced the care programme approach for those being discharged from hospital. As Bob Hudson showed in his article in *Health Care UK 1991*, the care programme approach is a demanding one. A large number of procedures and resources must be in place for it to work. Evidence becoming available during the year suggested that often they were not.

A small number of well publicised cases of mentally ill people doing harm to themselves or others in the community led to a call for greater control over patients discharged to the community. The Secretary of State appeared to accept the need for this, by supporting the notion of a community treatment or supervision order. As Philip Bean and Patricia Punser point out (Journal of Social Policy 23, pp 71–80) such proposals have been around for some time but they muddle two ideas, refusal to accept treatment and need for treatment. They therefore run the risk of forcing non-compliant people, whose condition is not deteriorating, into hospital – admission being the only sanction. In August 1993 the Government announced a ten-point plan to reinforce community care for mentally ill people which fell short of introducing supervision orders – see list in **Ten-Point Plan** – and from 1 April 1994 every provider of mental health services was encouraged to set up local registers.

As far as the mentally ill as a whole are concerned, further evidence emerged bearing on the health/social care boundary. A report from the Association of Metropolitan Authorities, *Mental Health Services: issues for local government*, indicated that many health authorities are not implementing the care programme approach for the patients they are discharging. Local government itself has showed reluctance to commit resources – only three per cent of the total social services budget. The mental illness specific grant, while rising, remains tiny, though still useful for pump priming purposes. In principle, five per cent of the community care cash transferred to local authorities from social security was for people who are mentally ill, but this nominal earmarking appears to have been disregarded.

A King's Fund Institute report, *Reshaping Mental Health Services* by Judy Turner-Crowson, pointed out that mental health policy is clear about what ought not to happen – long term care in large institutions – but is less clear about what ought to happen. The current pattern, which the Association's report confirms, is that services outside hospitals are patchy and uneven, according to the degree of commitment of each local authority and the manner in which health authorities have redefined their role.

As John Bowis, Parliamentary Secretary at the Department of Health, put it in March 1994 soon after the publication of the Ritchie report into the care and treatment of Christopher Clunis:

> *The argument over the merits of care in the community may be over for clinicians, social workers, patients and their carers, who agree that it is a more beneficial system of care in principle. But as we know, in many areas the practice still has some way to go before it reaches the level of the service we all desire, and the arguments are not over where the public and the media are concerned.*
>
> *Sadly, there have been some tragic cases – fatal cases – to remind us that community care for mentally ill people does not always provide the safety net so essential if mentally ill people are to live to their fullest potential in the community.*
>
> *In particular, the Ritchie Report highlights the lack of co-ordination of care, and the lack of communication between professionals. It is these two points in particular which*

Ten-Point Plan

The ten-point plan comprises:

1. Strengthened powers to supervise the care of patients detained under the 1983 Mental Health Act who need special support after they leave hospital. These comprise:

   a) the new power of supervised discharge; and

   b) extending from six months to one year the period during which patients given extended leave under existing arrangements can be recalled to hospital.
2. Publication of the Department of Health team's report of its review of the 1983 Mental Health Act.
3. Publication of an improved version of the Code of Practice, which spells out clearly the criteria for compulsory admission under the 1983 Act.
4. Fresh guidance to ensure both that psychiatric patients are not discharged from hospital inappropriately, and that those who leave get the right support from the different agencies.
5. Better training for key workers in their duties under the care programme approach. This will cover the new Code of Practice and guidance, and will take account of the lessons from the cases which have gone wrong, and from the Royal College of Psychiatrists' confidential inquiry into homicides and suicides by mentally ill people.
6. Encouraging the development of better information systems, including special supervision registers of patients who may be most at risk and need most support.
7. A review, by the Clinical Standards Advisory Group, of standards of care for people with schizophrenia, both in hospital and in the community.
8. An agreed work programme for the Government's Mental Health Task Force, which supports health authorities in moving to locally-based care.
9. Ensuring the health authority and GP fundholder purchasing plans cover the essential needs for mental health services.
10. The London Implementation Group will take forward an action programme to help improve mental health services in the capital, identifying and spreading best practice.

Source: H93/908

> *crop up time and time again when things go wrong, and which convinced me that this conference on the training of key workers was so necessary. Communication and co-ordination are two of the most important aspects of the key worker role. They are also intrinsic to good professional practice throughout the mental health services, and more widely within the* NHS.
>
> *In not one of the cases resulting in homicide that I have seen, has the key worker properly fulfilled this remit – if, indeed, there was a key worker appointed. And yet by any reckoning these people were severely mentally ill; the very people who should be identified by the Care Programme Approach, and on whom resources should be concentrated.*

More fundamentally, the overall framework is not clear: the Department has not assumed a leadership role, even though it is in a strong position to do so. *The Health of the Nation* has a mental health component – the suicide rate – but that touches on only a small part of the clientele of mental health services – primarily young males. And as Matt Muijen pointed out in the 1992/93 issue of *Health Care UK*, 'what works' is also not clear. What does seem clear, however, is that mental health services, particularly those in inner city areas, will require more resources, as the Heath Select Committee recommended and as the Secretary of State herself more or less admitted by announcing, at the time of the publication of the Ritchie Report, an extra £10 million for community based mental health service. Further moves to strengthen mental health services were also made: a working group under the auspices of the London Implementation Group and the Department's Mental Health Task Force was asked to focus its efforts on London.

1.3 Public Health Strategy

While Ministers have been eager to find evidence of the immediate effects of the creation of the internal market, they have accepted that *The Health of the Nation* initiative has a long term perspective. It involves a number of changes, including redirection of NHS resources, modification to policies outside the NHS and changes in personal behaviour which cannot be achieved quickly.

Smoking is perhaps the single most important area. Although the Government continue to resist pressure to ban advertising outright, it expanded health warnings on tobacco products other than cigarettes and declared its intention to strengthen the existing voluntary agreement with the industry in respect of children's exposure to tobacco advertising and promotion. It also announced a new national health education campaign, as well as increases in taxation in line with previous commitments.

During the year, the process of introducing the new policy was reflected in a series of documents designed to demonstrate what it could mean in practice. *Working Together for Better Health* issued in July, was as its title suggests concerned with getting others – individuals and organisations – to contribute to the strategy. The central, if arguable, principle is:

> *Promoting healthy lifestyles is always more effective when different groups and organisations collaborate.*

The report itself cites numerous examples of such joint working, while recognising that the obstacles are considerable – indeed it is disarmingly frank about the difficulties that joint working has to overcome. It is however lacking entirely in guidance as to what might be worthwhile and hence what partnerships are critical and which not.

In *Local Target Setting: a discussion paper*, the NHS Executive makes some outline proposals for the setting of targets for particular areas. As this note makes clear, there are a large number of technical issues to be solved – indeed the purpose of the paper is to set them out rather than solve them. Clearly, the national targets must be broken down to smaller areas since most action is envisaged at local level, but it is not clear how national targets should breakdown into local ones: in small geographical areas, changes are more likely to be effected by chance events. One response is to average over three or more years. But that hides underlying trends. Another central question is whether or not to break down national targets into proportional changes in each area: the difficulty here is that as areas differ that may be too easy or unreasonable. The paper therefore serves to underline the magnitude and difficulty of the policy: so too did a number of other events during the year.

The Chief Medical officer's report *On the State of the Nation's Health* published in September, which contained a review of activity since publication of the white paper, was not able to point to much by way of solid achievement. The *1991 Health Survey for England*, which was published in July 1993, found:

- among those aged 16-64 the proportion of obese adults has increased from 7 per cent to 13 per cent for men and from 12 per cent to 15 per cent for women since 1986-87;
- among all adults 16 per cent of men and 17 per cent of women had raised blood pressure, almost three quarters of whom were taking no medication to lower it;
- 69 per cent of men and 70 per cent of women had cholesterol concentrations above the desirable level;
- only 20 per cent of men and 12 per cent of women had exercised at least three times a week during the four week reference period, including at least some episodes of vigorous activity;
- 12 per cent of men and 11 per cent of women had none of the four main risk factors for coronary heart disease and stroke. Around one in five had high levels for three of the four and 2 per cent of men and 3 per cent of women had high levels of all four.

In November, the Government issued its first report, *One year On*, which described progress with *The Health of the Nation* as a whole. The main findings were as follows:

> *Overall, the first year of the strategy has been positive. It has been well-received both at home, where there is an ever-increasing amount of activity under way to implement its many and varied elements, and abroad a leading example of strategic planning for better health.*
>
> *As far as individual targets are concerned, the news is mainly positive or neutral – all but one of the mortality targets showed a decrease – the exception is suicide – on the non-mortality side changes are in the right direction except for obesity and smoking among young people – for eight of the targets it remains too early to make even an initial assessment of progress.*

Sir Duncan Nichol, reviewing the first year, suggested that purchasers were reflecting *The Health of the Nation* targets in the purchasing plans, but the examples he cited of good practice, while worthy enough, – bring out the tiny scale of the projects being supported and at the the same time the potential range of activity that might fall within the ambit of the new health strategy.

- North Derbyshire Health Authority have a scheme to loan child safety equipment to low income families in Bolsover.
- North West Herts Health Authority has a contract with the health promotion unit and the general hospitals unit to provide a 'smoking in pregnancy' reduction programme.
- People living in Northamptonshire are being taught resuscitation techniques and being screened for CHD/stroke risk factors.
- The Dorset Health Commission has set up a project tackling sex issues in schools involving teachers, pupils, governors and parents.
- Grimsby and Scunthorpe Health Authority is financing an additional post for Scunthorpe Community Trust to focus on deliberate self harm and suicide.

Whether small-scale initiatives like these can ever cumulate to a major shift of policy remains to be seen. As for established programmes, here as last year, the news was mixed.

On 4 November, the Secretary of State announced the proportions of GPs reaching the targets for childhood immunisation and cervical cytology: as Table 4 indicates, the proportions have been rising.

While these programmes appear to be going well,

Table 4: Percentage of GPs Reaching Targets

Target	higher	lower	either
April 1991			
Childhood immunisation	77	12	89
Pre-school booster	68	16	85
Cervical cytology	72	20	92
October 1991			
Childhood immunisation	81	10	91
Pre-school booster	72	15	87
Cervical cytology	77	17	94
April 1992			
Childhood immunisation	86	8	94
Pre-school booster	76	14	91
Cervical cytology	83	14	97

Source: H93/1040

there was disappointing news from other preventive programmes. A number of cases came to light which demonstrated that the cervical cancer screening programme was not being properly administered in a number of areas. In response, the Chief Medical Officer announced that a national co-ordinator was to be appointed to develop and check national standards.

One Year On is able to report a large amount of activity designed to implement the health strategy. But it also reveals how much remains to be done before the health strategy may be deemed rational *ie* that commitment of resources involved in it can be justified by reasonable evidence of prospective benefits, and also the scale of the enterprise. In the case of air pollution, for example, much of the basic science remains to be done, but if action is required, it will be both expensive and disruptive to established patterns of living.

Two official reports – *Oxides of Nitrogen* 3rd Report by the Advisory Group on the Medical Aspects of Air Pollution Episodes, and *Breathing in our Cities* from the Parliamentary Office of Science and Technology – underlined how, in some respects, the environment was becoming more hostile to health from factors lying completely outside the traditional areas of health policy.

The latter report identifies several ways of reducing emission:

- Measures to ensure catalytic converters maintain their effectiveness throughout the life of post-1993 vehicles;
- Encouraging better control of emissions from pre-1993 cars;
- Encouraging early retirement of the oldest, most polluting vehicles;
- Further controls on VOC emissions at refuelling;
- Cold start emissions control (currently catalysts take a few minutes to warm up and become effective);
- Measures to reduce further emissions from diesel-powered vehicles (both cars and HGVs).

If these do not work, more radical measures to curb road traffic may be required, a step far removed in scale and implication from the examples listed in Sir Duncan Nichol's report.

So as last year, our conclusion is that *The Health of the Nation* does represent a worthwhile approach – a genuine step in the direction of a health rather than a health care policy. But how large that step is can be illustrated by an example drawn from report appearing during the year which illustrates the difference and the implications of changing from one policy to the other.

During the year the Health Committee reported on dental services. Oral health is one of the few areas where, ironically given its semi-privatised status, the Government has regularly monitored the population's state of health over a considerable period of time.These surveys have confirmed that while in general oral health had improved, no one knew why – or rather the contribution of the several causal factors could not be identified. What effort should be put into education and prevention rather than services therefore remains unclear.

More fundamentally however, the current service is not 'needs' driven. It is rather demand driven *ie* by the people who present who may or may not have to pay for their care. The regular monitoring of dental health reveals persistent differences between different parts of the country, which a needs–led approach would aim to rectify. Such a needs approach however implies a larger budget and a complete revision of the remuneration strategy for dentists, or a revision of the scope of the service itself with publicly funded services being targeted on those areas where health gain was likely to be greatest, not where demand presented itself. The Health Committee made these points in its 1993 Report on Dental Services; in its reply the Government acknowledged the need for an oral health strategy and though it promised it, one had not appeared by the end of the year.

We remarked last year that the real test of *The Health of the Nation* policy would arise when immediate sacrifices had to be made – the example we gave was a waiting list target – in favour of a longer term pay-off. The discussion this year has served to reinforce that conclusion but also to suggest that it did not emphasise enough the difficulties ahead. These are large enough within the health domain, but outside it there are yet more formidable obstacles.

1.4 Serving the Consumer

As foreshadowed last year, the Charter, in terms of service standards, rather than rights which were unchanged, was extended to family practitioner services. A circular issued in November 1992 (EL(92)88) required all Family Health Services Authorities to set specific standards and targets and 'facilitate the development of charters for primary health care teams.' with effect from 1 April 1993. The features of the new standards are shown in Table 5.

As far as the main features of the Charter are concerned, the task for this year has been to ensure that the rights have been available in practice and the standards met. Last year we reported that some local surveys had suggested that there was confusion about what the Charter meant in practice. Information becoming available during the year showed that authorities were far from achieving what the Charter requires: see Table 6.

While the Charter is the main focus for development, it is only one of several mechanisms which protect users, interests. Another is the Health Service Commissioner and the Select Committee of the House of Commons to which he reports. In a report published in July 1993, the Commissioner indicated that response to complaints was poor.

In response the Government established a committee to come up with suggestions as to how to improve the existing arrangements. Announcing its establishment the Minister said:

> *The health service should actively encourage people,staff and patients to express their views forthrightly. Managers should regard these views as a valuable tool. Far sighted managers can use complaints to review services and improve performance.*

The committee's report is analysed by Michael Solomons elsewhere in this volume. However, the Charter and complaints procedures address only a small part of the larger agenda of making services more responsive to patients' views and needs. The reforms were explicitly aimed at promoting a better match between those needs and services provided. A central way of improving that match is to promote choice.

As we pointed out last year, for choice to be effective, there must be alternatives and people must be genuinely able to choose between them. Last year Anthony Harrison and Sally Prentice drew on the Health Committee report on maternity services which indicated that a significant minority of mothers wanted a form of service not available to them. Following this report which formed the basis of the article on maternity care, the Government set up an expert group to advise on how the recommendations should be implemented.

Table 5: Charter Standards for Primary Care

1. Where a person is not registered with a GP, the FHSA must be able to find a GP for that person within two working days.
2. To help people change doctors easily and quickly, the FHSA must despatch details of how to change doctors and a list of doctors – to anyone who asks – within two working days.
3. FHSAs must co-operate and publish information about local medical services – including the FHSA's own quality standards.
4. FHSAs must transfer medical records quickly when a patient changes doctor.
5. FHSAs must provide a full and open response to any comments, suggestions or complaints that people make about services.
6. FHSAs should in addition work towards the following targets for processing comments, suggestions and complaints.

Acknowledgements

(i) Acknowledge complaints, comments and suggestions about services within two working days of receipt.
(ii) Where it is appropriate, advise the practice or practitioner concerned within two working days of receipt.

Clearance

(iii) Clear complaints made under the informal conciliation procedure within one month of receipt.
(iv) Clear complaints to which service committee procedures apply (up to and including advising the parties of the FHSA's decision) within six months of receipt.
(v) Supply both complainant and practitioner with monthly progress reports until the complaint has been cleared.

Source: EL(92)88

That found that women wanted choice, continuity and control. Their main recommendations reflected those values:

a) the woman (sic) should be able to choose who cares for her during pregnancy and childbirth. This could be a GP, midwife or an obstetrician or a combination of these. Carrying her own notes will be proof that the woman is in charge;

b) she should be able to choose the type of care she wants. This includes choosing to have her baby in hospital or at home;

Table 6: Charter Performance

	A&E % patients assessed immediately	Outpatient clinics % patients seen within 30 mins	% after more than 1 hour	No. of failures to meet standard on cancelled operations
Northern	79	77	5	1
Yorkshire	89	71	9	8
Trent	89	70	9	9
East Anglia	75	77	4	3
NW Thames	74	68	8	49
NE Thames	63	70	9	83
SE Thames	76	71	9	27
SW Thames	56	62	9	63
Wessex	68	78	4	8
Oxford	72	75	6	6
South Western	62	78	5	3
West Midlands	79	83	5	15
Mersey	63	68	9	1
North Western	73	71	9	30
SHAs	95	72	9	30
Average	74.2	72.7	7.5	21.47

c) as far as practicable she should be cared for by the same person, or the same small group of professionals throughout the pregnancy, at the birth and in the early days of pregnancy; and

d) she needs to be fully informed about the options for care available, so that she can with confidence decide what bests suits her including the amount and type of interventions proposed.

Evidence on the actual degree of choices come from work by Ann Mahon and others within the King's Fund programme referred to above. Their main conclusions were as follows:

> *Involvement in choice of hospital and consultant: The level of patient involvement in choice of hospital and consultant was low and there was little change in the reported levels of involvement in the first year of the reforms. Only one in ten patients reported that they had been offered a choice of hospital by their GP (1991 9.9%; 1992 10.9%) and one in twenty said they had asked their GP about other hospitals they could go to (1991 4.7%; 1992 5.4%). The level of involvement in choice of consultant was somewhat lower with only one in twenty patients reporting they had been offered a choice of consultant by their GP (1991 4.9%; 1992 5.5%). It is of note that a considerable proportion of patients did not know to which hospital (1991 24.6%; 1992 28.7%) or to which consultant (1991 67.7%; 1992 66.6%) they had been referred before receiving their appointment letter from the hospital.*

Nevertheless, lack of choice did not trouble most users:

> *Despite the low level of patient involvement in choice, the vast majority were satisfied, with nine out of ten saying they were happy with the way the choice of hospital was made (1991 89.9%; 1992 90.7%). Older patients and those with no further education reported higher levels of satisfaction.*

Other evidence comes from the National Consumer Council's report – *Consumer Concerns 1993*. The Council commissioned MORI to survey consumer opinion on the NHS, including choice of service. In all cases the vast majority of those giving a positive or negative answer were satisfied with the choice available, but sizable minorities were not for some services, 11 per cent in the case of hospital and 14 per cent in respect of GPs

The MORI survey also asked about knowledge of complaints procedures and of the Citizen's Charter. The majority of people surveyed did not know to whom they should complain about their GP or hospital. Of those that claimed they knew, the majority only had a general idea and only very small minorities were aware of their community health councils: see Table 7.

> *Our findings show that consumers are confused about the names and roles of health service agencies. Many re-*

Table 7: Patient Awareness

Recently, the NHS issued a document called the Patient's Charter that sets out patients' rights and the standards of service they should expect.

Have you heard of the Patient's Charter? Have you seen a copy of the Patient's Charter? Have you read any of it?

	Yes	No	Don't Know
Have heard of Patient's Charter	64	35	1
Seen a copy of Patient's Charter	24	38	1
Read Patient's Charter	19	4	*

Source: MORI Survey

> *spondents who say they know where to complain suggest a body that is not responsible for the service in question.*
>
> *Community Health Councils in England and Wales and local health councils in Scotland, for example, provide information and advice on all aspects of local health services, including how to make a complaint. National telephone helplines have been set up to give consumers local information, including details of community health councils and who they need to contact. But community health councils are mentioned by only two per cent in relation to GP complaints and three per cent in relation to hospital complaints.*

Overall, the report is not encouraging for the Government. It concludes:

> *Our evidence show that, far from improving, the scale of the problems which existed in 1979 appear to be getting worse – not only since 1979 but also since 1989. And none is getting any better.*
>
> *For example, the number of people who experience difficulty in arranging appointments or treatment at hospital inpatient departments has doubled since 1989 and increased twelve-fold since 1979. Similar problems at outpatient departments doubled between 1979 and 1989 but have not changed since. In addition, inconvenience caused by having to wait at outpatient departments has increased by around 50 per cent since 1979 and at inpatient departments five times as many people say the waiting time is inconvenient. And there has been no improvement for either department since 1989.*

Whether these reflect real changes in waiting time etc we do not know. It seems a fair assumption however that they reflect changes in people's perception of how things ought to be. Indeed the greater the success of the Patient's Charter, the more acute people's perceptions are likely to be of failings. Similarly, the better complaints procedures, the more complaints there are likely to be. It is therefore inherently difficult to measure 'real' change: the fact that complaints rose sharply in 1993/94 over the previous year could be regarded as a signal that the 'culture of non-complaint' is coming to an end, rather than a deterioration in actual service standards. But it should not, simply for that reason, be dismissed as insignificant: the development of a culture of complaint will make it even more difficult for this or any other government to hold the balance between demand pressures and available resources.

1.5 Overview

The creation of trusts and purchasing agencies and GP fundholders resembles the setting out of the pieces on a chess board: everything turns on the rules determining what the pieces can do and how skilled the players are at exploiting those rules. Now that most of the pieces have been set out, it is on these rules that attention must focus. In fact, as we see later, the rules remain undeveloped in a large number of key areas, so exactly what the game is remains ill-defined.

The developments set out above point in different directions. For example, on the one hand, the Government intervenes to ensure the future of one hospital in inner London and the specialist services that are located in it. On the other, it proposes that elsewhere specialist services should be financed through semi-market processes. It is promoting the introduction of private capital, while emphasising that trusts are part of the NHS.

In justifying the introduction of the 'new' NHS, the Government has persisted in emphasising activity levels – the number of cases treated as inpatients. When the annual activity bulletin for the NHS was issued on 29 November 1993 (93/1090), Tom Sackville, Parliamentary Secretary for Health, announced that the 4.3 per cent increase in general and acute episodes of hospital treatment represented clear evidence of the success of the reforms since the rate of increase had been only 3.3 per cent over the previous ten years.

It is understandable that a Minister aware that the reforms are not universally popular should cling on to one of the few available statistics which appear to justify them, but as we pointed out last year, these numbers are of little value. Numbers were rising before the reforms and numbers alone say nothing about the quality or effectiveness of care, and they may even be a statistical artefact, as stays in hospital can legitimately as well as illegitimately be divided up into statistically distinct episodes. But even if they were sufficient to demonstrate that the new NHS was more efficient at producing health care, that would not in itself be sufficient to justify the reforms, in the terms the Government itself set out in *Working for Patients*. That emphasised other objectives, principally choice and responsiveness to user needs.

The Government itself has not offered an across the board evaluation. In 1992, the NHS Management Executive issued an 'annual report' which it would be kind to describe as inadequate. In 1993, a less glossy and slightly more substantial document was produced.

But with the exception of some figures relating to the Patient's Charter which we have cited already, there is not a single measure, statistical or otherwise, that would help to justify the massive re-organisation that the reforms represent. In the case of GP fundholding for example, the report runs as follows:

> *With the creation of GP fundholders and their ability to buy certain services for patients directly, the influence of general practice within the health service has increased substantially. At the end of March 1993, there were 1,235 practices, with more than 6,000 GPs in the scheme : a significant increase on the figure at the beginning of the year of 580 practices and some 3,000 GPs. Now 12 million patients – nearly a quarter of the population – are looked after by fundholders. During 1992-93 GP fundholders purchased nearly 8 per cent of all elective or planned admissions to hospitals more than twice as much as the previous year.*
>
> *As fundholders savoured their new freedoms, innovation increased. Consultant outpatients clinics were established in surgeries, waiting times reduced and communication with patients improved. Patients also enjoyed better access to services like physiotherapy and counselling.*
>
> *Work has now started on ways to enable smaller practices – particularly those in inner-cities and rural areas – to join the scheme through group or agency arrangements.*

This is PR speak not analysis. No evidence is offered to support any of these statements. For this, the Government has only itself to blame. When the reforms were first being debated, there was a lobby in favour of introducing them on a partial basis, in some parts of the country, in order that they might be tested before their general application. That was rejected by the then Secretary of State Kenneth Clark, as was any attempt to monitor the reforms as a whole. As a result, the most comprehensive attempt to assess them are the studies reported in *Evaluating the NHS Reforms*.

The central conclusion to emerge from these studies is that it is too early to come to a clear view because the degree of change during the first year or so of the new NHS was in fact quite small. This was only to be expected, in part because of the Government's imposition of a steady state in the first year, in part because the players were still getting used to the new game they were in or were preparing for it. The creation of the trust regime for example has absorbed enormous amounts of management time simply to prepare and adjust to the new status.

It is unsurprising therefore that although the Government has claimed that trusts are a success, the evidence for that view is slim. As Julian Le Grand and Will Bartlett point out in their chapter in the book, the first wave of trusts were selected from what was already a self-selected set *ie* those which probably had the best management in place already. It is only to be expected therefore that their activity – the main measure the Government puts forward as an indicator of their success – rose at a higher rate than those units not yet trusts. Now that the trust regime will soon be universal, the comparative test is in any case impractical.

As for GP fundholding, the evidence is clearer but far from complete. The LSE study led by Howard Glennerster into GP fundholding was able to point to a number of effects, mainly favourable as far as the patient is concerned: consultants coming to surgeries for outpatient clinics, speedier turn-round of laboratory tests etc. In all probability it is this research on which the NHS Management Executive relied for the statements quoted above. But neither Glennerster nor the NHS Management Executive has set these benefits against the costs of achieving them. As there is no accepted means of valuing them, that is scarcely surprising but we do not even has a rough balance sheet on which a broad judgement could be made. As we go on to point out in the second part of this review, there is no shared understanding of how it is that many GP fundholders are able to offer their patients quicker access to hospital.

However, it would be wrong to conclude from these modest findings that the reforms do not represent a major and potentially beneficial change. While it is hard to point to the kind of results the Government would like to see – a higher rate of cost reduction for example – there is little doubt that the freedoms that have been created are leading to innovation and experiment on a wide scale. For example free-standing community trusts are now much freer than they were when community units to enter into new markets by providing services directly competitive with hospitals or long term care for social services authorities. Purchasers are, if slowly, beginning to shift resources to new services, even where budgets are not increasing. In the past, new services typically had to wait for 'growth' money. As Gordon Best and others put it (British Medical Journal 308 pps 842-845):

> *Our impression . . . is of a momentum for change generated by the 1991 reforms which has yet to realise the full potential generated by the separation of purchasers and providers. This momentum is, however, accompanied by concern about a widening gulf between the centre . . . and those who actually provide or purchase local services.*

They go to make a series of recommendations designed to stimulate debate about how that gap should be bridged and thereby create an environment in which change can take place. But change will bring 'crises' in its wake, for which, at present, there is no provision.

The creation of 'crises' is one cost of change. But there are others. One is the actual cost of introducing the reforms. The official figures cited last year amount to some £750 million but this is a fraction of their real cost. It is impossible to cost all the time and other resources involved in establishing the new regime and no serious attempt has been made, but it could easily run to many times that figure. On the other hand, as we have already pointed out, much of the new activity, *eg* needs assessment, does not derive solely from the changes introduced by the 1990 Act.

Other prices are still harder to quantify, stemming as they do from changes in attitudes and behaviour. We pointed last year to the readiness of some GPs to use fundholding to their own financial advantage, using loop-holes in the rules which have now been closed. Other examples of 'opportunistic' behaviour which arose before 1991 are discussed in Part 2. The question which they raise is: will such occurrences become more common in an environment explicitly designed to present opportunities for innovation and independent action? Finally, there may be a price to pay in terms of equity, which we also consider below.

PART 2: COMMENTARY

In this part of the Review, we take first issues relating to efficiency and finance, the main battle-ground of the reforms. Next, we consider accountability, developing Bill New's analysis last year in the light of events during this. Finally, we turn to equity, taking as our starting point the allegation that GP fundholding has led to a two-tier service.

2.1 Efficiency and Finance

In 1988, when the Review leading to the new NHS was set up, there was a general perception that, and not for the first time, there was a funding crisis. The immediate source of that concern, an autumn round of bed closures, was itself not new. However, the Review led to the 1990 Act, not to a re-think about how the NHS as a whole should be financed.

In last year's Policy Review, we noted that the Government was threatening a fundamental review of spending programmes, but this did not appear to bite directly on the NHS; rather it was social security that appeared most threatened. In one area at the margin of the health sector, the invalidity benefit, measures were announced designed to reduce eligibility and hence make a substantial reduction in public commitments.

But the basic financial framework for the NHS itself remained unchanged and not effectively challenged. Nevertheless, tensions remain between an open-ended commitment to care on the one hand and a limited budget on the other, which were reflected in publications from a wide range of bodies, including the Institute of Health Services Management, the British Medical Association, the European Policy Forum and the Institute of Economic Affairs, discussing alternatives to the current system of finance. The Government, however, showed no interest in considering any of them. Instead, it continued to press as it has done for the last decade for 'more care per pound'.

Last year we noted record increases for the NHS in the pre-election public spending settlement. This year's settlement has taken place against a background of a record borrowing requirement and a tough spending round. The Chancellor, despite low interest rates and high unemployment, indicated that expenditure control would be the key to reducing the deficit in the public finances. As far as the public sector itself is concerned, that implied a pay freeze: pay could only be increased if costs were reduced through efficiency gains.

Nevertheless, the Government claimed (PN 93/1083) that real resources would increase by 1.6 per cent while efficiency improvements would be worth at least another 2.25 per cent. Overall, according to the Government, that would allow some 4 per cent more patients to be treated. That calculation assumed a zero increase in the wage bill. However, at the beginning of February 1994, the Pay Review Bodies for Doctors and Dentists and for Nurses, Midwives and Professions Allied to Medicine recommended increases of 3 per cent, slightly higher than increases in the private sector at the time. These recommendations were accepted by the Government in full, but no extra funds were made available to finance them. In the words of the Secretary of State:

> *... we look to the NHS to fund this award through improved efficiency and productivity, allowing extra money for the NHS in the budget to go directly into patient services.*

The four per cent target remains unchanged, even though the pay award of three per cent exceeded the efficiency target of 2.25 per cent.

If the Government is able to 'produce' 4 per cent more patient care, that will make it easier to continue to postpone either fundamental choices on finance or on the scope of NHS provision. But it is questionable whether the required increase in productivity can be attained. As the figures we have just quoted indicate, the Government is relying for the bulk of extra treatment to be 'financed' from efficiency savings. In its annual report 1992/93, the Management Executive reported that all but one Region met the 2 per cent efficiency index, which measures the relative improvement in activity against the increase in spending on patient care and this continued to be the aim.

As an analysis by Peter Cutler, an Economic Adviser in the Department of Health (Health Economics 1993 pp 65-75), showed, the hospital sector has been able to produce productivity gains throughout the 1980s of just under 2 per cent a year, but the rate of increase was slower towards the end of the 1980s than it had been in the middle. As medical technology continues to develop, there seems no reason why such increases should not continue. Lengths of stay seem set to continue to fall and rates of day surgery rise. The Management Executive Task Force on Day Surgery added its weight to the case for dramatically increasing its share and most purchasers are setting contracts which require higher proportions of surgical work to be carried out in this way.

But hospitals absorb only just over half of the total NHS budget: elsewhere, it is harder to see how costs will be reduced without loss of quality. In some areas, such as support services, savings may be feasible: EL (93) 55 set out the new regime for contracting out or market testing as it is now called. The circular states that market testing 'is now considered an integral part of the management process.' But it only 'encourages' health service agencies to test a wider range of services, and does not as in 1983 introduce a compulsory list of services for which tenders must be sought. In principle of course the pressure of competition should provide the active encouragement. But competition is far from being an effective spur as yet for most clinical services and in many areas, particularly community based nursing care for the elderly, mentally ill or learning disabled, all of which are highly labour-intensive, the scope for productivity gains seems slight: the Audit Commission report on community nursing, *Homeward Bound*, was remarkably short on specific proposals for efficiency improvement.

Futhermore, the value of a pre-set level for efficiency improvements depends critically on the way the required gain is measured and how it is 'extracted' from providers. Its calculation is inevitably rough and ready, relying as it does on measures of activity such as bed days, contracts or episodes which only crudely measure what the NHS does. The danger therefore is that activity will be distorted in order to meet the target. In part, it is a question of the scope providers have for massaging the figures by 'creating' extra episodes through suitable changes in recording. In part, it is a question of the incentive structure which targets create; for example, a target set in terms of contacts provides community services with a strong incentive to reduce care for frail elderly and relatively dependent people, previously the group which on other grounds they should be focussing on.

'Massaging the figures' is irksome for senior managers attempting to monitor performance but not in itself a serious cause for concern if the underlying pattern of care does not change. The introduction of perverse incentives is a more serious matter for it would mean that while measured productivity was rising, performance was falling. Furthermore, since the pressure for greater measured activity is transfered to providers from purchasers, purchasing choices themselves could be distorted if purchasers chose to go for services where it was easier to score 'efficiency' gains.

There is a double irony: just as Eastern Europe and elsewhere is rejecting the managed command economy the NHS is simultaneously introducing what is termed a market system and strengthening its central command system. The reason the Executive is backing both a failed horse and an untried one is quite simple: it must show results quickly, or the reforms will appear to have failed if they are shown to have failed to produce 'more care per pound'. If the Government survives and returns to its low tax policies, then the kites flown during the year will have to be re-examined.

Cutting Back

While emphasis on efficiency gains continues, the Government has made no explicit move on the scope of the NHS, apart from drugs, where again the limited list was extended. But the salami slice approach was again apparent with regard to dental care, long term care and self-care. In each case the Government appeared to be redefining where the line should be between the (free) NHS and either private payment or other public services for which charges are made. We look first at events in these three areas and then attempt to find a rationale for these areas being treated as 'marginal' to the 'core' NHS.

Dental Services: In response to difficulties over the dentists' contract which emerged during 1992, the Government set up a committee under Sir Kenneth Bloomfield whose report was published at the end of that year. The contractual difficulties continued however and in many parts of the country dentists ceased to work within the NHS or ceased to take on new NHS patients. The National Consumer Council survey quoted earlier found that 28 per cent of those who had sought dentists had found it difficult to find one within the NHS, a third received private treatment and a further third did not see a dentist at all.

The survey would suggest that the NHS is withdrawing from dental care – a result confirmed by the regular surveys by the British Dental Association which found that while groups entitled to free treatment within the NHS continued to enjoy it, there was a drift to private care among those liable to charges. They also found in surveys carried out during 1993 that three in five dentists were seeking to extend their private practice and one quarter were 'doing all they could' to reduce dependence on NHS patients – in mid 1992 however when dissatisfaction with their contracts was extreme, the figure was 46 per cent.

Answering the National Consumer Council charges that patients could not register with dentists, Dr Mawhinney said (H93/1080):

> *We are committed to an effective and accessible NHS general service. Therefore, we monitor closely the provision of services. At 30 June 1993, 15,569 dentists were*

> *practising in England – the highest June figure ever. In the 15 months to 30 September 1993, the number of adults registered as NHS general dental patients rose by 950,000. NHS dental treatment continues to be widely available and those people who do need assistance with finding a dentist should contact their local FHSA.*

That statement did not begin to address the wider issues raise by Sir Kenneth. His report, although not explicitly called on to do so, considered how, if resources were limited for dental care, that amount should be best used. The issues are the same here as for other parts of the NHS: how do we define a core service; does it matter if there is a two tier service and can financial contributions be increased and exemptions reduced?

Sir Kenneth Bloomfield was asked to conduct a 'Fundamental Review of Dental Remuneration' which would among other things 'provide a proper framework for financial control'. It was not a far step from this to consider the broader question: if there is clear control, and hence a set limit to what can be spent on the dental service, how should that amount be best spent? That led Sir Kenneth to consider the question of how a principled view might be reached on what a core service might include. Subsequently, the House of Commons Health Committee and the profession itself added their views.

In the extracts which follow below, we see two broad principles at work: the first setting limits in terms of services, the second by reference to categories of people. As far as the latter are concerned, only pregnant women appear contentious: children and adults exempt from charges are both supported, even though the underlying objectives are not the same.

The issue of a service definition proved more contentious, as the following extract from Sir Kenneth's report indicates:

> *It is, moreover, easier to talk of a "core service" than to define what it ought to be. At one end of the scale, treatments compatible with the current emphasis on prevention and the maintenance of decent standards of oral health should certainly be inside and purely cosmetic treatments should certainly be outside the range of a "core service". Yet what is "purely cosmetic"? As in the case of plastic surgery, this is a field with many grey areas. Defects in appearance can affect self esteem to a degree which has psychological or even physical consequences. Nevertheless it is striking how high is the percentage of fees earned for items of service now paid out, for example, for crowns and bridges. It should not be impossible to arrive at a categorisation of treatments which would focus on health gain and would identify the separate categories of treatments normally available, treatments available only under strict control and criteria, and treatments not to be offered under the NHS at all.*
>
> *It can, of course, be argued that this would introduce an undesirable element of "two-tier dentistry", in that those willing and able to pay for private treatment would continue to have access to the widest range of dental care, while those unable to look outside the NHS would be unable to receive certain sorts of treatment now available to them. It could, however, be argued that it would be better for the patients to aim at a high standard of care across public and private sectors of dentistry in key areas of education, inspection, prevention and treatment rather than aspire to a "Rolls-Royce" service for all which the State is unable to fund adequately. Concentration could permit more effective targeting to advance key health objectives and to respond to need rather than demand.*
>
> *There would, of course, be another way of "concentrating" the GDS. This would be by confining the available service, whether the present fuller range or a more limited "core service", to categories afforded high priority on social, economic and/or health grounds and those unable to pay or make any substantial contribution toward the cost of treatment. In my own view the only category of patients exempt from making a contribution which is questionable is that of pregnant women/nursing mothers. It is not easy to see on what grounds a woman well able to make a contribution to, or indeed pay the full cost of, a dental treatment should receive privileged treatment over what, in a not inconsiderable number of cases, must be in aggregate a period of years. It would hardly be surprising if those able to benefit from this exemption did not on occasion make a point of bringing forward complex and expensive treatment demands during the qualifying period. No doubt it could also be argued that in better-off families, parents could well afford to make some contribution towards the cost of dental treatment for their children, but in this case there seems to be an overwhelming national interest in setting all the children of the country on a sound dental path.*

Use of the 'national interest' clouds rather than clarifies what the issues are. Dentistry is not like, for example, education which the child must experience directly: the value of dental check-ups is something parents might be assumed to recognise on their children's behalf.

The Select Committee, which held its own enquiry into dental services during 1993, commented on the case for subsidising the group which Sir Kenneth found hardest to justify.

> *Sir Kenneth Bloomfield considered the current identification of exempt groups as satisfactory in terms of priorities for ensuring access to dental care with the exception of pregnant women and nursing mothers. In oral evidence to this Committee he resiled somewhat from this exclusion. He explained that his advice had been that there were no remaining medical grounds for this exemption in the 1990s. However we heard in evidence from the Chairman of the General Dental Services Committee that:*

> *Oestrogen and progesterone which are increased in amounts during pregnancy and lactation are actually mimicking, as far as bacteroides gingivalis is concerned, napthoquinone which is the thing which makes them grow like mad. So they think it is napthoquinone, they grow like mad and produce inflammation.*
>
> *There are also grounds for the exemption that might be seen as a dental public health factor or a dental health justification at one remove. Setting the nation's children on the road to oral health has been identified unanimously by our witnesses as a top priority and with that judgement we firmly agree. A logical corollary of this might be enabling the nation's children's mothers to gain access to dental care with as few obstacles as possible so that the awareness of oral health care can be emphasised to those with the task of bringing up the next generation. Furthermore, there may well be social grounds for the exemption that are not accounted for by other qualifications. Pregnant women and nursing mothers often suffer in financial terms because of the time away from work and the increased expenditure that pregnancy and babies necessitate. We recommend that pregnant women and nursing mothers should remain a priority group as far as the provision of dental services is concerned.*

The General Dental Services Committee in its response to Sir Kenneth's report emphasised different points:

> *The vast majority of dentists support a fully comprehensive National Health Dental Service available to all. The view of dentists at meetings around the country is that as Government will not fund a truly comprehensive service, it should at least indicate where its resources are to be targeted. This core service could be based on designated types of patients who would be entitled to full care and treatment; a restricted range of treatments for all patients; or a combination of the two.*
>
> *In line with the Committee's priorities identified in the introduction, the patients included in a core service would be children and exempt adults. Additionally, the current subsidy to charge paying adults could be used to provide access to dental care by means of free registration and diagnosis . . . Fees for all other treatments for this group would be determined by the market.*
>
> *There seems to be less support amongst dentists for a core service based on treatments essentially because it would deprive some patients of necessary care. There certainly has been no support for limiting treatments available to children and little support for restricting what is available to exempt adults.*

Thus, the 'service' approach did not attract support; as a result, the task of defining a core service is turned into the task of defining who should benefit from subsidy. The attraction of this approach is that it enables the risk of a two-tier service to be avoided - but only if funds are available to allow all those exempt from charges to enjoy a full service.

By the end of March 1994, the substantial points made by those reports we have discussed remained unanswered. Although the Government, in reply to the Committee, agreed that an oral health strategy was required and said that it would produce one, it had not done so by that time.

Long term care: Previous editions of *Health Care UK* as well as Melanie Henwood's King's Fund Institute research paper, *Through a Glass Darkly* have pointed to the decline in the role of the NHS as provider of long term care. Further evidence of that emerged during the year. For example the Alzheimer's Disease Society published a report on NHS psychogeriatric continuing care beds in December 1993. The situation identified was mixed, with some authorities actually increasing their provision while others were reducing it: the average decline for those authorities reducing provision was 35 per cent since 1990 despite the fact that the numbers affected by Alzheimer's is expected to rise as the population continues to age.

The report concludes that: 'An open and far-sighted debate is needed if the ever increasing numbers of people with dementia are to receive the care they need.' A special report by the Health Service Commissioner, (February 1994) provided the focus for one.

We noted in our review of 1991 that the Health Service Commissioner had investigated a number of cases where health authorities had discharged people to nursing homes leaving them or their relatives to meet the cost. In February 1994 he issued a special report on a case in Leeds where a patient had been discharged to a nursing home and the authority had ceased to accept financial responsibility. This case was not dissimilar to those on which the Commissioner had reported earlier but perhaps aware of the general uncertainty about the NHS role in long term care, he chose to give particular prominence to this one by devoting a special report to it. The main findings are set out in **Boundary Case**, which is a shortened revision of the conclusion from Commissioner's own report.

The implications of this ruling, if accepted as establishing a wider precedent, are far-reaching. According to a survey of nursing homes produced for the Association of County Councils by Jennifer Henry and others at the University of Aberdeen, 39 per cent of residents had some form of private finance, 34 per cent were solely financed in that way. Although their share decreased, their total numbers rose. Of the residents admitted from hospital, 28 per cent were privately financed. According to *Laing's Review of Private Health Care 1993*, the total turnover of nursing homes is about £2.5 billion, a sizeable sum for the NHS to take over.

However, the impact could be much greater than these figures suggest, since the availability of 'free' nursing home care would radically alter a number of incentive patterns, particularly the balance of

Boundary Case

A man suffered a brain haemorrhage and was admitted to a neuro-surgical ward in the General Infirmary in Leeds. He received surgery but did not fully recover. After 20 months in hospital he was in a stable condition but still required fulltime nursing care. Since nothing more could be done, the consultant decided that he should no longer stay in the ward. The man's wife was told that he would be discharged and that she should find a suitable nursing home for his future needs. Despite her misgivings she agreed to the discharge and he moved to a local nursing home in September 1991. The next year the man's wife – with assistance from her local community health council – complained to Leeds Health Authority (the body responsible for purchasing health care for Leeds residents) that they had not met their responsibilities towards her husband. Despite further correspondence and a meeting no resolution was found, and the woman complained to me in 1993. The complaint which I investigated was that the woman had been obliged to pay for her husband's continuing nursing care, which should have been provided through Leeds Health Authority free of charge under the NHS.

The chief executive of the NHS Management Executive has stated that the NHS has a duty to provide care without charge where a doctor judges such care to be necessary on clinical grounds. He qualifies that by saying that there is an overriding duty to determine priorities within the financial resources available, and that consideration of clinical priority may mean that a particular patient needing inpatient nursing care may never have it provided. How should I regard Leeds Health Authority's position in the light of that guidance and the circumstances of this particular case? The patient had been in the care of the Infirmary for over eighteen months under a contract made by Leeds Health Authority. No one disputes that by August 1991 his condition had reached the stage where active treatment was no longer required but that he was still in need of substantial nursing care, which could not be provided at home and which would continue to be needed for the rest of his life. Where was he to go? Leeds Health Authority's policy, as explained by their chief executive, was (and still is) to make no provision for continuing care at NHS expense either in hospital or in private nursing homes. In particular I note that the contract for neurosurgical services make no reference to continuing institutional care. This patient was a highly dependent patient in hospital under a contract made with the Infirmary by Leeds Health Authority; and yet, when he no longer needed care in an acute ward but manifestly still needed what the National Health Service is there to provide, they regarded themselves as having no scope for continuing to discharge their responsibilities to him because their policy was to make no provision for continuing care. The policy also had the effect of excluding an option whereby he might have the cost of his continuing care met by the NHS. In my opinion the failure to make available long-term care within the NHS for this patient was unreasonable and constitutes a failure in the service provided by the Health Authority. I uphold the complaint.

Source: Health Services Commissioner, Second Report for Session 1993/94

advantage to individuals and their carers of remaining at home or going into care.

The ruling poses the Government a dilemma. The central difficulty is that although the Government has committed itself on several occasions to the NHS maintaining a long term care role, in practice it has opted out but, as the report just cited indicates, in a patchy manner. In Scotland (Health Services Journal, 2 December 1993) the Scottish Management Executive instructed Health Boards to reduce the number of long stay beds (higher than in England) saying they should be used for people 'requiring continuing medical and nursing care'. In England there has been no such directive, so in practice therefore, there is no policy. The Patient's Charter does not apply to long term care: people do not know what to expect and hence cannot make any sensible provision for themselves. In responding to the Health Service Commissioner's report, Baroness Cumberlege continued to be imprecise about where the boundary of NHS responsibility lies, simply acknowledging that the NHS did have a responsibility for looking after the 'seriously ill'.

The Government responded to these findings by asking the NHS Executive to carry out an inquiry in to those authorities reported as having no psychogeriatric care beds. In a letter to the Alzheimer's Disease Society, the Parliamentary Under-Secretary for Health, John Bowis, said that there 'should be no doubt about the overall responsibility of the NHS to secure long term care for those who need it for reasons of ill-health'.

William Laing in *Financing Long Term Care: the crucial debate*, published by Age Concern in 1993 attempts to provide the basis for a debate on the underlying issues. The central question he raises, as did our Policy Review last year, is: is long term care a risk that the state should cover? As we argued then, the insurance approach is a useful way of identifying the core issues. Laing's answer is yes, specifically for carers:

> *Heavily involved carers are.. severely disadvantaged: they are denied significant protection from the state and have no realistic insurance alternative. Of all the gaps in the welfare state's arrangements for covering long term care risks, this appears to merit the most urgent review on grounds of equity.*

As far as users themselves are concerned he points out that a number of arrangements are feasible. The one he puts forward is a mixed model, comprising state support for care, but not for 'living' except for those on very low incomes who are eligible for full income support now. The central point, raised in last year's review, is that the risks to both carers and those needing care are not well understood and are difficult to plan for. While it is reasonable to expect people to plan for their retirement, is it reasonable to expect that Alzheimers will be curable in 20 years time, or not?

Drugs: As in previous years, the Government added to the limited prescribing list and put up prescription charges by 50 pence. Sixty-two items mainly anti-rheumatic preparations and 500 foods, toiletries and nicotine replacement patches will no longer be available on prescription.

As the Parliamentary Secretary for Health put it:

> *The NHS should not be paying for items which have no therapeutic or clinical value. Items such as mineral water, cakes, lip salves and face powder cannot be classified as medicines and I have accepted the advice of the Independent Advisory Committee on Borderline Substances that they have no clinical value and GPs should not be prescribing them. The NHS cannot be expected to supply dietary supplements which can be bought over the counter in health food shops, and currently costing the NHS over £60,000 a month.*

From the Government's viewpoint, the drugs bill represents its most challenging control target. Between 1992 and 1993, spending rose by 9.6 per cent in real terms – numbers of prescriptions rose by about half that. Spending by fundholders grew at a slower rate than that of non-fundholders. According to the Minister for Health:

> *An increase in the drugs bill of 9.6 per cent in real terms cannot be sustained. While it is of primary importance to ensure that patients receive the medicines they need, more has to be done to eliminate uneconomic prescribing.*
>
> *GP fundholders are showing that economic prescribing and good health care are not incompatible. In 1992-93 fundholders' spending on drugs grew by some four per cent less than that of non-fundholders. We will be watching closely to see if this trend continues and what lessons can be learned.*

Further encouragement to the view that the drugs bill was too high came in a report from the Audit Commission on GP prescribing, which set out a number of measures designed to make prescribing more efficient – in some cases, it should be noted that means prescribing more.

These recommendations lie within familiar Audit Commission territory. There were signs, however, of the Government adopting an alternative approach focussed on users, rather than doctors. Speaking at the Annual Pharmaceutical Conference in November, the Minister for Health put the case for self-medication and over-the-counter medicine:

> *A number of factors have come together to make the encouragement of self-medication increasingly attractive to a wide range of interested parties – not just here but throughout the European Community. Governments, manufacturers, health care professionals and the public are all exploring the contribution which self-medication can make to the challenge of improving health care within budgets that are necessarily limited.*
>
> *The Health of the Nation White Paper stated quite clearly that health is not just a matter for governments, doctors and drugs companies. It recognised the importance of fostering and sustaining individual responsibility for health.*
>
> *Self-medication sits well with this philosophy:*
>
> - *it encourages people to be more interested in and committed to their own health;*
> - *it empowers individuals with greater freedom to determine for themselves what medicines they will use;*
> - *it makes the most of the wealth of professional expertise which is on hand in over 10,000 community pharmacies in England;*
> - *it helps family doctors to use their time and money more effectively;*
> - *it provides manufacturers with new markets as products approach patent expiry and governments look to measures of various kinds to reduce the rate of growth of the drugs bill.*

He then went on to indicate how the Government was proposing to encourage over-the-counter products:

> *There is a widely held misconception that a GP's terms of service in the NHS prevents him or her from recommending an over the counter product to a patient. This misconception arose from the wording of the terms of service which appears to say that where a GP believes a particular drug is required for the treatment of a patient the doctor shall issue an NHS prescription for it.*
>
> *That apparent requirement needs to be seen in the broader context of the relationship between the patient and the family doctor. GPs' obligations are in all cases dependent on the consent of the patient. What is important is that patients be offered the choice between a prescription under the NHS and a recommendation to purchase a product over the counter.*
>
> *Many people are exempt from prescription charges and a GP could be regarded as in breach of his terms of service if this point was overlooked.*

> *Many would like to see a wider range of medicines available over the counter without prescription. We welcome such requests to change the legal classification of medicines, provided that there is evidence that the move from prescription control is safe.*
>
> *The industry, the Proprietary Association of Great Britain and the Royal Pharmaceutical Society of Great Britain have been working successfully with the Medicines Control Agency on streamlining the reclassification procedures. So I am pleased to say that procedures for moving medicines from prescription control are now much quicker and much easier to follow and work continues to see what further improvements can be made.*

In the three areas we have reviewed, the Government is clearly unwilling to acknowledge a universal commitment to free care. Can any rationale be found for these areas falling 'on the margin' and perhaps being pushed outside it?

One way of trying to understand these developments is to ask whether or not the condition in question displays certain characteristics which set health apart from other goods and services, and which have encouraged governments to intervene in its finance and delivery in most developed nations. To do so, it is worth revisiting an old debate on what makes health and health care 'special'. Kenneth Arrow, in a seminal article thirty years ago, isolated unpredictability and information imbalance – summarised as uncertainty – as the key characteristics of health or ill-health which made it largely unsuitable for market exchange. Information imbalance – the lack of knowledge of what is in our best interests – make it particularly difficult for consumers of health care to make private markets work in their favour. Moral philosophers, for their part, emphasise the fundamental nature of good health to all other forms of fulfilment, and the lack of responsibility (in general) which we have for our ill-health. Taken together, these characteristics – unpredictability, information imbalance and 'fundamental importance' - give health its 'special' nature: it is the combination of characteristics which is decisive in heeding to state intervention, not any one on its own.

But if these three characteristics 'define' health's special nature, what about those specific instances of ill-health which only satisfy one or two, or satisfy all three but not clearly, or do not 'fit' in some other way? Should these services qualify for state support – in the UK, should the NHS provide? The three services mentioned above – dentistry, long-term care and medicines – which events over the previous year have indicated lie on the 'boundary', each illustrate how their individual characteristics make the answer less than clear cut.

In the case of dental health, it might be argued that people's knowledge is adequate for the market to function properly; if there is any doubt about people's knowledge, public resources should be devoted to ensuring that it is adequate, through concentrating on young people, free checks and general health promotion, supported by quality controls on the dentists themselves. If in spite of that people suffer from bad dental health, the consequences are painful but not disastrous and the pain itself prompts the need for treatment. In the case of long term care, the 'risk' of a long life is obvious to everyone and hence there is no reason why they should not provide for it. Furthermore, the individual in need of care is very often in the best position to know the kind of care they need. But the risk of particular eventualities, such as a partner developing Alzheimer's, is another matter: there is no way of predicting these risks decades ahead and, as we have pointed out, the consequences are disastrous: Laing's argument is therefore cogent.

In the case of over-the-counter medicines, there is a balance to be struck between risk and personal responsibility. In some cases, such as cough medicine, people can be left to make their own choices. In others, there are risks of dangerous self-prescribing and here too the consequences can be disastrous. People can be informed of the risks, by appropriate labelling and advice, and some may decide to accept them. The question that poses for government is whether the consequences, if they prove disastrous, will be seen as the 'fault' of the individual, or the 'fault' of a government which failed to protect people from themselves.

The implication of this discussion is that the boundary of health care is inherently fluid and to a large degree a matter of political judgement. In **Rationing and Justice in Clinton's America**, we set out two approaches to defining it: one the highly pragmatic one of the new health legislation, the second a philosophical attempt by Ronald Dworkin.

While pruning of the scope of the NHS is inherently controversial, another kind of pruning the elimination of treatments that do not work, or which are not 'value for money' – is not. It is a commonplace that only a fraction of treatments have been formally evaluated for their effectiveness, yet the Government has been slow to move, reluctant no doubt to get entangled in the domain of clinical discretion. In the speech just cited, Dr Mawhinney went on to address the value for money theme, as follows.

> *Probably the main issue that these discussions need to address is that of value for money.*
>
> *It would be too easy for a government to argue simply that costs are too high, and to demand that they are cut. We want a vigorous industry which can continue to develop new and better medicines for patients. So we must look deeper than just costs, mainly at the causes in the rise of drug bills, and at just how much value for money the taxpayer is actually getting. That is why so many people in both government and the industry are now talking about economic evaluation.*

Rationing and Justice in Clinton's America

President Clinton's most audacious election pledge was to reform the American' health care system. Although such a proposal had by no means universal support, there was a growing consensus that high and growing health care expenditure by international standards, coupled with gross inequality in its provision, was unsustainable economically and morally. After a year of intense deliberation, the US government, under the guidance of Hilary Clinton, proposed the Health Security Act (what in the UK would be called a Bill). If passed, the Act would require every resident of the US to participate in some form of health plan. The national government would subsidise the cost of these plans for those self-employed or unemployed who could not afford them. For the remainder of the population, employers would pay 80 per cent of the cost.

Each plan would have to provide a basic health care coverage which the Act defines as the '-comprehensive benefits package'. Unlike UK health care provision, the Act makes specific exclusions from what must be provided:

- custodial care (except in the case of hospice care);
- cosmetic surgery (other than to correct congenital anomalies or following an accident or disease);
- hearing aids;
- eyeglasses and contact lenses for individuals 18 years of age and older;
- in vitro fertilisation services;
- sex change and related services;
- private duty nursing;
- personal comfort items (except in the case of hospice care);
- orthodontol and other dental procedures other than those described elsewhere in the Act.

The Act also excludes those 'items or services that are not medically necessary or appropriate' as regulated by a new National Health Board. So although the US proposals go some way towards defining the boundary of public health care provision, the door is left open for further exclusions of expensive or experimental procedures if these are considered inappropriate.

Such a strategy has gained the approval of one eminent American thinker, Ronald Dworkin. He proposes that a 'prudent insurance' principle should replace what he terms the 'rescue' principle which has traditionally operated in US health care. This latter principle, operating within a predominantly private health care market, encourages expenditure and provision well beyond what prudent people would choose if they had full knowledge of the costs and benefits of their expenditure. Every dollar must be spent, under the rescue principle, no matter how small or unlikely the benefit. Neither does the principle, as operated in the US, address the gross inequality in provision which characterises US health care.

The prudent insurance principle imagines what health care provision would look like in a free-market if three conditions were satisfied, conditions whose absence prevents reasonable and fair decisions being made. These conditions are: equal distribution of income and wealth, perfect knowledge as to the costs and benefits of all medical interventions, and no information (particularly for insurance companies) as to individuals' actuarial likelihood of contracting ill-health. Dworkin believes that under these circumstances, prudent people would not spend large amounts of money on insurance for care which is extremely unlikely to benefit them. They would rather spend that money on goods and services (including health care) which have a more realistic chance of benefiting them. One example of an excluded intervention would be life support for persistent vegetative state patients: who, Dworkin argues, would choose to pay high insurance premiums in order ensure that they were treated under such circumstances? He argues that the National Health Board should be guided by his principle when deciding what care is 'appropriate'.

Philosophical 'thought experiments' such as this cannot provide precise answers to the question of what can and cannot be provided within a national health system. And it, like other 'contractarian' theories of justice, is always open to the criticism that the psychological motivations of the individuals in the imagined circumstances are not as the author believes. Nevertheless, such theories, if they can capture a sense of shared values on issues of justice, can guide decision-makers. The NHS, too, appears in growing need of such guidance as it grapples with the consequences of the explicit admission that it cannot do all things for all people.

This is one of the most important issues facing the industry. There are limits to what governments can afford, in all countries. The industry cannot present governments with ever increasing bills – even for research and development. The industry has got to be able to show governments that all of the public expenditure being paid out is cost effective, and that the bills are worth paying.

This issue will not go away, and we can only resolve it together.

On 21 December 1993, the Government announced a development programme for the use of clinical guidelines. Purchasers are requested – gentle word – to use at least one in their 1994/95 contracts from a list including radiology, asthma, diabetes, heart disease, leg ulcers, neonatal respiratory distress and head injuries.

Speaking at a conference in February 1994, the Secretary of State argued that clinical work should be driven 'by fact not fashion' and set out three ways in which clinical effectiveness could be raised:

- using research to find out what works and to evaluate costs;
- using education, clinical guidelines and contracts between purchasers and providers to promote what works;
- using clinical audit to assess the effectiveness of what is done;

In EL(94)20, the Executive followed up an earlier letter (93)94 which set out the role of clinical audit in improving the standards of health care. The February letter refers to 'a fundamental culture change which would need substantial time to bring about'. As it recognises, the process is just beginning. The Research and Development Strategy first announced in 1992 is nowunderway. Working groups have defined programmes of work for which researchers are being sought. But by its nature this process will take time to produce usable results.

Offloading Finance: The NHS capital budget, running at over £1 billion, is much smaller than the revenue account but it is here the main policy initiative designed to replace public with private funding occurred during the year. In the last Autumn Statement the Chancellor indicated that the rules governing the use of private capital in the public sector were to be relaxed: see **Autumn Statement and Private Finance**. In September 1993, the Parliamentary Secretary for Health told a conference on the NHS and the private sector that consideration of private finance should be a standard option for all new developments.

On 1 November, on the occasion of the issue of an information pack *Public Service, Private Finance . . . putting private capital to work for the NHS*, the Parliamentary Secretary for Health reiterated the point:

> *We want the option of using private finance to become a commonplace in the NHS. We want it to be considered for every capital project which is good enough to merit detailed evaluation for public funding. In other words it is intended that private finance should be 'the standard option.'*

Since the publication of the 1992 Autumn Statement, a number of changes have been introduced to make private finance more attractive, which are listed below:

- private sector is encouraged to lead joint ventures, provided control is with private partner. NHS does not have to compare joint venture with wholly NHS-funded option of same scale;
- provided contracts are made on a commercial basis NHS comparator only required if this would be a realistic alternative on a similar time-scale;
- value of leased asset not counted against EFL if great majority of risk stays with private sector;
- forward sale of land may be approved of if it transfers substantial risks to private sector and cost of risk transfer worthwhile.

Autumn Statement and Private Finance

Changes have been made to the arrangements for privately raised finance. The objective is to find new ways of mobilising the private sector to meet needs which have traditionally only been met by the public sector. The new arrangements are based on risk, which needs genuinely to be borne by the private sector.

In future, if the private sector is wholly responsible for a project which needs Government approval and can recoup all its costs by charges (to private sector customers) at the point of use, comparison with a public sector alternative will not be needed. Such a project will normally be put to competition. Under the current rules a comparison has generally been required if a project is one which the Government itself might have undertaken.

Secondly, the government will actively encourage the private sector to take the lead in joint ventures. Participation by the private sector will be let by competition. The Government will specify its contribution in terms of money and risk. It is willing to consider debt and grant finance for such projects. If it takes an equity stake it will not be a controlling one.

Thirdly, the public sector will have greater opportunity to use leases where they offer best value for money. The capital value of leased assets apart from property is at present usually offset against spending allocations unless the lease meets only a short term need. In the future, the criterion will in all cases be based on risk, which is also the principle underlying the relevant accounting standard.

Departments and nationalised industries will be able to enter into operating leases and count only the leasing payment against their provision, provided the great majority of risk stays with the private sector.

In addition, the Government will be looking for further opportunities for the private sector to provide services for which the public sector is responsible, and in which the greater part of the cost involves capital.

Under the new arrangements, privately financed spending will be additional to public provision. The spending which is financed by Government will come out of departmental spending allocations. This is consistent with the principle that the control total should cover the spending which the public sector undertakes, or which it controls.

(Extract from printed Autumn Statement, 18 November 1992)

The stated goals of the private finance initiative are:

- to achieve service objectives and delivery more effectively;
- to achieve a greater working partnership between the private and public sectors;
- to use public money more efficiently;
- to be receptive to private sector ideas;

In the words of the Minister for Health, speaking at a Conference in October 1993:

> *The Private Finance Initiative is about value for money, flexible thinking and open attitudes towards skills and efficient working practices developed outside the NHS. Ultimately, the only criterion for who provides a service should be what is best for the patient. We need to involve the private sector in our service planning and encourage them to come up with innovative ideas to meet our needs. If they can bring new solutions to long-standing problems, that can only be of benefit to patients.*
>
> *Involving the private sector can help us reduce costs. If we lower costs, that means we can buy more patient care for our money. The NHS is constantly striving to improve the quality of service it offers to patients. We need to be open to what the private sector can teach us about achieving consistent high standards, drawing on the way similar services are provided in other walks of life. Better risk management could be obtained by sharing risk with the private sector, and by using their expertise to put a price on risk and negotiate contract incentives to minimise risk.*

The implications of this development could be far-reaching. While it may appear to be simply a new management mechanism, it also represents one more step in the direction of privatisation of supply. At present, private finance is being promoted for specific, fairly small-scale projects, such as the lease of scanners, waste incineration plants, satellite renal dialysis units and long-stay facilities. But it is not a great leap to apply it to all forms of provision including clinical care: indeed, in March it was announced that the second cardiac centre in Wales, at Morriston Hospital, would be put out to tender. The way, it would seem, is open for major changes in the way health capital assets are financed and managed.

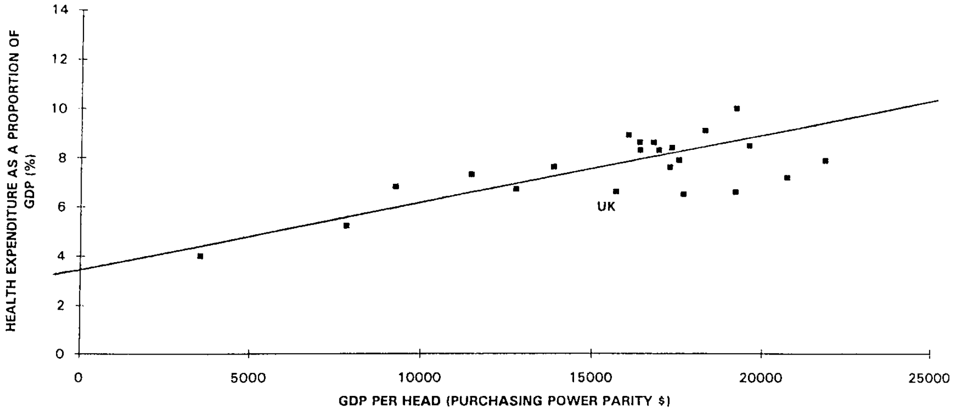
Overall Budget; the starting point for this part of the Review was the assumption that health needs were outstripping the ability of the public sector to finance them. But even in the US where expenditure is vastly greater, the same tension exists. Just what counts as 'enough?'

During the 1980s the case for more spending was regularly made by making a calculation based on demographic change, the impact of medical technology and efficiency changes. That approach of course implied that the base level had some validity, *ie* that at some stage enough was being spent. Recognising this difficulty, another common approach has been to look at health spending in other countries to derive a baseline through comparison. By that standard, the UK always looks a poor performer.

Diagram 3 compares health spending in OECD countries, plotting the share of GDP devoted to health with GDP itself. A strong relationship with GDP emerges: the UK is 'below the line;' *ie* given its income level, it is spending 'too little'.

But why should other countries be the norm? The UK, it might be argued is the only one in step: its highly developed system of primary care, which avoids expensive hospital services for many and its centralised control over the budget, represents the best form of health delivery system in terms of getting value for money.

Diagram 3: Relationship between national income and expenditure on health as a proportion of national income in 24 OECD countries (1991)



Source: OECD, Health Systems Computer Package 1993.

Furthermore, if we compare Diagram 3 with the same analysis but 20 years earlier we find that, the US apart, there has been a strong tendency for countries to come 'into line'. The UK was then, and is now below the line, but the highest spenders in relation to GDP such as Germany and Sweden are now moving towards the 'norm'.

Another and more cynical approach is to regard use of the private sector as an indicator of the adequacy of NHS finance: if enough people vote with their feet and use private medicine, then there is a clear implication that at least for some, the service is not good enough: furthermore a general defection from the NHS would represent a failure of a more general kind – an undermining of its universal nature.

On that measure, the budget is adequate. Although the private sector has gained throughout the 1980s and into the 1990s, it remains small relative to the NHS and the rate of defection, no doubt influenced by the recession, just as private education has been, has fallen. On this basis, the Government might well sustain its balancing act between unlimited demands and limited resources .

Behind the Government's unwillingness to define what would constitute enough lies the hard-nosed belief that the NHS does not make good use of the resources it now has and until good management has been demonstrated, it should not get much more than it is now getting – except in election years. As we have seen, the NHS – or at least part of it – has produced more with the resources allocated to it, and is expected to continue doing so.

But the central question – what does all this activity produce? – remains unanswered. *The Health of the Nation,* with its series of targets for reductions in mortality provides a framework for assessing impact in a number of areas but does not in itself help towards disentangling the impact of measures taken by health providers from other influences. In recent years, the number of avoidable deaths, *ie* deaths due to causes the impact of which it is believed could be reduced, have been falling. But no-one knows why, least of all whether the performance of the NHS has anything to do with it.

The Health of the Nation initiative, together with that on purchasing, has strengthened the drive to measure the outcomes of health spending, be it in prevention or treatment. But any comprehensive set of measures is a long way off, so the question-mark over the effectiveness of the NHS will continue for some time. As a consequence, it will remain hard to demonstrate to a Government intent on reducing the share of the GDP absorbed by the public sector that extra spending on the NHS will in fact prove value for money, except of course when the prospect of an election looms and the need to do something about waiting lists becomes evident.

Despite this uncertainty over 'what works', over the last ten years the pattern of resource use has been shifting away from hospital based services towards primary care in the belief that this represents a better use of resources. The share of the acute sector within the NHS has declined, and the decline is even more striking if the total public sector budget going into care services *ie* including local authority spending and the social security budget – is taken into account.

The factors underlying this shift, and the process by which it has come about are not entirely clear. In fact a number of forces have combined to produce this result. In part it reflects changes in the needs for care as a result both of medical advance and demographic change. The typical patient using a hospital is an elderly person suffering from a chronic disease or disability, for which no 'quick fix' is available. Most of their care will be provided by GP or community nurse. But this is not the whole story. The notion of shifting resources from hospital to the community appears to have gained a momentum of its own.

In the case of London, the Government has supported the Tomlinson analysis that the capacity of the acute sector ought to be cut, and that the primary sector ought to be strengthened. Some £170 million has been allocated for investment in capital projects within primary care in London.

However, in London as in the other conurbations, the need to rationalise is occasioned by overcapacity relative to current levels of use, which is in part a legacy of the history of the medical profession and in part the result of demographic shift: all inner cities have lost population this century.

Furthermore, the forces that have allowed increasing productivity have reduced the need for the beds and created need to rationalise while the workings of the internal market have led to a loss of custom to other suppliers. Furthermore the need to strengthen London's primary care – and the same is true of other inner city areas – has been apparent for decades. As a King's Fund Institute study, *Primary Health Care in London*, shows, much of it is provided in poor premises by single-handed GPs.

However, what remains unclear is how far this process ought to go. *The Health of the Nation* reflects a change in philosophy, from sickness to health service. But while this change is right in principle it is harder to see how effective it will be since with a few exceptions, *eg* immunisation and vaccination for children, it is hard to demonstrate the value of many preventive measures. John Butler's classic review some years ago indicated that very few had been subject to proper evaluation, and indeed the latest advice from the Department, following *Health for All Children*, a report by an expert study group led by David Hall, recommends a very modest programme.

Over and above this, it is becoming apparent, through London studies and others, that the present way of using health resources is unlikely to produce the best results for patients. In the case of London, the central recommendations of the London Implementation Group, which was set up early in 1993 to follow through the Tomlinson recommendation, for the rationalisation of capacity in specialties such as cancer and renal care, went beyond mere bed numbers to arguing that some units were too small to provide a proper quality of care. So far it appears that the Government has accepted the need for concentrating services in fewer centres.

But there is evidence that suggests that this approach has a wider relevance. Research during the 1980s in the US in particular has tended to suggest that for a range of activities including most surgical procedures the outcome of treatment is better, the greater the volume of work done. The implication is that the number of hospitals should be reduced and not just the total number of beds. In *Reinventing Health Care,* NAHAT put forward this view strongly suggesting that:

> *The high technology care centres when developed, might, depending on considerations of geography and access, cover populations of up to two million people. They would be characterised by expensive advanced equipment in intensive use and would undertake complex procedures. They might also include teams working in highly specialised areas whose viability could only be sustained within a very large catchment area. In keeping with trends elsewhere, patient stays will be shorter with some patients being treated on a day basis. High technology centres will be linked to one or more trauma units and a postgraduate training centre. The staffing of both types of centre will be consultant-based with support from other professionals.*
>
> *At the same time, it is becoming clearer that many of the functions undertaken in the acute hospital need not be carried out there. Many users of hospital services, particularly outpatients, do not need the special resources of the hospital: studies of diabetics for example have shown that GPs can provide as good a service as hospital based doctors though not necessarily a cheaper one. Similarly, a range of procedures can be carried out in the home, in some cases without medical or nursing supervision.*

However, while the scope for shifts in the locus of care is clear enough, as we showed in last year's edition of *Health Care UK,* the evidence of benefit is thin. Furthermore, as Anthony Harrison and Sally Prentice argue elsewhere in this volume, while there are strong forces making for change in the provision of acute care, here too there is lack of evidence bearing on some of the crucial choices.

2.2 Accountability

The question of how the NHS should be accountable is far from new but the reforms have put pressure on the existing mechanisms and created a demand for new ones. In the 1985 edition of *Health Care UK,* the then editors concluded that the arrangements in force of ensuring that the Service was accountable were weak, and particularly so when compared with the arrangements in place in other parts of the public sector: but as Bill New pointed out in the 1992/93 edition of *Health Care UK,* the new arrangements posed a series of new questions about the accountability of the service.

- 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?
- Are purchasers in a contractual system of service provision now taking explicitly political decisions on the allocation of resources without appropriate checks and controls?
- Can the public be properly accommodated directly in the decision-making process?
- What is the significance of rights, and, in particular, initiatives such as the Patient's Charter, for the accountability of public agencies?
- Can the new market system for delivering health care be used to hold health care agencies to account?

Bill New's analysis, or mapping, of the various ways in which accountability can be ensured, served to bring out its complexity on the one hand but also the range of issues the various sources of accountability had to deal with. Events during the year served to underline the growing task. Foremost among these was a series of financial and clinical scandals.

In Wessex Regional Health Authority, investigation by the Audit Commission and the National Audit Office revealed not only that vast sums had been spent on information technology with no result, but that some very large contracts had gone to a company represented on the regional board. In the West Midlands Regional Health Authority a series of scandals primarily stemming from the contracting out of services to a company established by former employees of the Region, led to the resignation of the regional chairman, Sir James Ackers. The Public Accounts Committee held a series of hearing on both these during 1993: the resulting reports were highly critical both of the Authorities and the Management Executive. In **Unbecoming Conduct**, we have taken what amounts to a few snippets from two very lengthy documents, focussing on the central questions: how did it happen? and: who was to blame?

In response to the concern expressed by the Committee, the Management Executive issued new national guidance on computer and information technology purchasing and on standards of business conduct. Recognising the fundamental nature of the issues, the Executive committed itself to looking at the general issues of corporate governance in the NHS setting up a task force to review existing guidance.

Speaking to a NAHAT conference in September, Sir

Unbecoming Conduct

In January 1994, the Public Accounts Committee took the extraordinary step of issuing *The Proper Conduct of Public Business,* which surveyed and assessed the full range of its area of responsibility.

Its opening paragraph runs as follows:

> *In recent years we have seen and reported on a number of serious failures in administrative and financial systems and controls within departments and other public bodies, which have led to money being wasted or otherwise improperly spent. These failings represent a departure from the standards of public condcut which have mainly been established during the past 140 years. This was the period following the publication of the Northcote and Trevelyan Report which condemned the nepotism, the incompetence and other defects of the Civil Service and brought about fundamental change. It is from that period that we acquired the principles and the standards which have come to be copied by some countries and admired by many more. It is our task to retain those standards.*

Unhappily, the NHS provided two of the main sources of evidence underlying this broad conclusion, West Midlands and Wessex Regional Health Authorities. Both authorities were brought before the Committee during 1993 and their failings revealed in great detail. The resulting reports led more or less directly to the NHS Executive issuing its guidelines on corporate governance. But what exactly did the reports themselves reveal?

Both are long and at times very detailed. In the very brief extracts which follow, we have focused on the obvious and fundamental questions: what went wrong and who was to blame? On the basis of these two reports, the answer would appear to be: everything and everyone.

What went wrong?

The elusiveness of a simple answer to the question: what went wrong? emerges from the following exchange between a member of the Committee and Sir Duncan Nichol:

> I am deeply unhappy, I have to tell you, about some of the answers that I have heard today; there seems to me to be a good deal of confusion about who is responsible for what and what role non-executive directors and executive directors have in terms of disciplining each other. You say you have written to the regional managers. What makes you think that the regional managers are going to behave themselves any better than some have up until now just because you have written to them?
>
> *(Sir Duncan Nichol)* Exactly one of the extra lessons learned. It is clearly not enough simply to talk about systems and to say these are the ones; it is not enough to issue financial management directions. This is why I made the reference to negotiating with the Audit Commission and our auditors to increase the level of probity investigation and audit. I believe that we have to be able to drill down, we have to be able to spot check and I believe we have to do more of that than we are doing in order to be in a better position to avoid these kinds of things happening, for the very reason that it is not enough simply for me to write out.
>
> Were you surprised when you heard Sir James tell us that he might have 10 meetings a week during which he would hear money mentioned and that a meeting during which £1 million was to be paid to a very dubious firm of consultants was not unusual and that £40 million savings was not unusual and that he as the man who should be monitoring all this did not monitor it any further? Were you surprised to hear that?
>
> *(Sir Duncan Nichol)* One has to take into account the size of this region, the complexity of this region and the fact we are talking about a situation that had escaped the net. This was not on the radar screen.
>
> Do you think this was strictly a one off situation?
>
> *(Sir Duncan Nichol)* I do not know; I do not know.

Who was to blame?

In the Wessex case, the Committee noted:

> *... the Regional Health Authority's evidence that the driving force behind this plan was the former Regional General Manager, Mr Hoare, and that, in their view, he carried the main responsibility for what went wrong. The evidence presented to us depicted Mr Hoare as a man with a strong vision, and such a determination not to be deflected off course, that he presided over a series of actions incompatible with the proper handling of public money and without regard to clear evidence that the project was going badly wrong.*

Despite this clear identification of Mr Hoare's responsibility on the part of the Region, the Committee noted that:

> *... under the terms of his employment Mr Hoare was entitled to the severance payment he received of £111,940. In view however of the Regional Health Authority's assessment that Mr Hoare carried the main responsibility for what had gone wrong, we are astonished that no disciplinary action was taken against him; that furthermore he was offered a special assignment on quality assurance, which was expected to continue until October 1992; and that this assignment was not terminated until July 1990. Indeed, we have to say that we regard it as unsatisfactory and surprising that none of the main parties involved in the waste of £20 million has suffered any significant form of disciplinary measure, and it seems to us that there has been a breakdown in the operation of personal responsibilities and accountabilities.*

In the West Midlands, the Regional Chairman did resign, but in the Wessex case only two junior officers were disciplined, as another exchange, this time with the regional general manager, brought out.

What disciplinary action has been taken against the former or current staff involved? Have any people been sacked?

(Mr Jarrold) Yes, indeed they have.

How many?

(Mr Jarrold) Two people have been dismissed for gross misconduct and charges have now been brought against those individuals, charges of fraud.

The Committee Concluded:

> *We note that two junior staff who had made the original miscalculation concerning Mr Watney's settlement have been disciplined, even though they immediately admitted this error made under pressure. We are concerned that, by contrast, of all the senior management and Members of the Authority responsible for the catalogue of mismanagement and lack of control in this case, only the Regional Director of Personnel, Mr Nock, has been the subject of disciplinary proceedings. This lack of evenhandedness seems to reflect a breakdown in the operation of personal responsibilities and accountabilities.*

Could it happen again?
Sir Duncan's frank concluding comments leads directly to the question: could it happen again? In the case of Wessex, the then Chairman Sir Robin Buchanan thought not.

> *The Chairman told us that it would be impossible for the type of problems that had occurred to happen in the revised structure within the Wessex Regional Health Authority. The five new paid non-executive members of the Authority now felt firmly part of the management process and were of the quality to take part in that process.*

But was this enough? The Committee thought otherwise.

> *We note that the Regional Health Authority and the Management Executive have responded to the shortcomings identified, by introducing changes to staff and procedures. We are not convinced, however . . . that the measures taken fully reflect the gravity of what has happened and that they will be sufficient, by themselves, to prevent similar problems recurring (paragraph 60).*

What should be done? In the Wessex case, the Committee concluded:

> *. . . it is not, in our view, more rules that are needed, but a system of control and accountability that focuses on key areas, while avoiding bureaucracy and allowing initiative and enterprise to develop. The present division of responsibilities between the Management Executive and Health Authorities makes this difficult to achieve because there is too much scope for negotiation and argument. What is needed in our view is clearer lines of control and accountability, both at Regional Health Authority level, and between Authorities and the Management Executive, within which Authorities would supervise their staff by concentrating on a small number of key areas, and Regional Health Authority Management would be free to pursue the key targets set for them, in a framework of effective accountability.*

But systems of management are in themselves insufficient. As the Committee investigations show, rules had been flouted. Accordingly, it concluded:

> *It is also important in our view to ensure that all health service staff respect the fundamental principles of public business in this country, and are judged, in their own performance, by the standards of honesty, openness and fair dealing that are expected in public life. Concern for these standards should play a large part in the selection, training and assessment of staff at all levels.*

Why did no-one 'blow the whistle'?
Another exchange with Sir Duncan failed to provide an answer:

Could you remind me. I may be wrong about the National Health Service but I have a vague recollection of something called the Whistleblower's Charter.

(Sir Duncan Nichol) Yes.

Is that not intended to try to encourage people further down the Service to report on areas where they think that money is being wasted?

(Sir Duncan Nichol) We are still consulting on that charter; it went out for consultation. The general gist of it was to say that people have duties, they have duties to speak out. There should not be recrimination against people who do. There is a process for doing it which carries right up to the very top of the organisation and in the final analysis, providing we are not talking about the release of confidential information about patients, they are able to make their views known outside the authority. That is a delicate matter and that is not a first resort, that is a last resort and should be taken on the basis of professional advice that they should secure.

I accept that. What I really asked was whether, if it had been in place on this occasion, you think it would have helped.

(Sir Duncan Nichol) No, I do not think that people felt that there was any capping of people's ability to speak out. I do not believe that was the case.

As we report in the Review, the NHS Executive have taken a number of steps to reduce the chance of 'another Wessex' which take these points on board. But perhaps the most chilling evidence, too long to cite here, comes from that provided by the District Audit Service, in the Wessex case. The watchdog did bark, loudly and in detail: that part of the system protecting the public purse did work. But the message, no doubt unwelcome as it was, took too long to get through.

Duncan Nichol set out four key objectives:

- a national code of NHS ethics and behaviour, together with plans for the declaration of members pecuniary interests;
- making NHS boards more effective through helpful guidance on for example, the role of the company secretary, establishment of audit committees, application of standing orders;
- implementing in the NHS the Government's white paper on open government;
- local action by NHS boards to examine their conduct of business and to make effective corporate governance a reality.

The Task Force report, *Public Enterprise: Governance in the NHS*, made a series of recommendations which were reflected in a letter from the Secretary of State to all trust chairmen (sic), issued in January 1994 and the draft codes of conduct and accountability for NHS Boards and their members. The main features of the codes are:

- clearer definitions of the functions of Chairmen and Non-Executive board members which will form the basis of the appointment and induction processes;
- declaration, by directors of NHS boards, of private interests which are material and relevant to NHS business;
- a requirement on NHS boards to establish audit and remuneration and terms of service committees;
- a requirement that the standing orders of NHS boards should prescribe the terms on which committees and sub-committees of the board may hold delegated functions, including, where adopted, the schedule of decisions reserved for the Board.
- clarification, by the NHS Executive, of the position on all financial constraints which apply to NHS authorities and trusts;
- a new obligation on health authorities to publish at least an annual report on their performance and stewardship of public finances (an annual report is already mandatory for NHS trusts);
- the publication, in annual reports, of the total remuneration from NHS sources of Chairmen, Executive board members and Non-Executive board members.

Table 8 cites some key sections of the proposed code of conduct for NHS Boards:

All these, it might be said, are obvious and reasonable: whether in themselves they are enough to prevent another 'Wessex' is more questionable, particularly when the Government is aiming to instil other values, as the very title of the Task Force Report itself implies. As with the efficiency target, there is a double irony here. The Government has introduced businessmen into the NHS and consciously in this and other ways encouraged managers to behave more entrepreneurially. But in its reaction to the scandals reported on during 1993, its response has been to re-assert 'traditional' values.

Although not designed to deal specifically with the cases considered by the Public Accounts Committee, the restructuring of the regional hierarchy also affects the mechanisms for accountability. As noted already, *Managing the New NHS* effectively deferred consideration of such issues. Accountability for trusts is defined in terms of their financial obligations. But accountability of purchasers 'will be examined in detail before the legislation for abolishing regional health authorities and merging districts with family health service authorities.'

Nevertheless, it goes on:

> *decisions are increasingly being devolved to local level and it is desirable that this should be reflected in formal accountability arrangements. As part of further work on accountability arrangements in the new system, the possibility of extending accounting officer status further down the management chain will be examined.*

But while speaking of devolvement, the vision of accountability this displays is essentially top down: the

Table 8: Extracts From Code Of Conduct For NHS Boards

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct, based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded, it must be accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

There are three crucial public service values which must underpin the work of the health service.

Accountability: everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity: there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness: there should be sufficient transparency about NHS activities to promote confidence between the NHS authority or trust and its staff, patients and the public.

idea of introducing additional accounting officers while presented as a devolvement is in fact the reverse since the accounting officers would report upwards.

However other initiatives do point in the other direction. In October the Secretary of State launched a series of Patients' Perception booklets, containing guidance on what patients perceive as high quality care. Announcing these, she said:

> *It is important that these changes strengthen and improve accountability not only upwards but above all downwards to the local community. Devolved management will lead to stronger health authorities, better able to gain the confidence of and champion local people. But that in itself is not enough. Health authorities and trusts must engage the public's interest in the issues which they face. They must actively encourage public participation in the decision-making process. This is a particularly crucial task for the chairmen and the non-executive members of health authorities and trusts. They are the focus of local accountability. I expect them, and the organisations they run, to be accessible to the public. They must involve the public in establishing priorities and in making the decisions based on them. They must give information and explain. They must carry people with them as they lead the process of change in the Health Service.*

This initiative is aimed at encouraging an informed public. During the year Ministers made several statements urging health authorities and trusts to consult with and involve the public, and their Community Health Councils. For example, in November, the Secretary of State, addressing the Healthcare Financial Management Association Annual Conference, said:

> *The NHS, like any public organisation, must command a high level of confidence among the public. It must be accountable – at both national and local level – to the public it serves and to the taxpayers who fund it. There must be strong and clear processes of both internal and external control. Individuals within the organisation need to be clear about their roles and their responsibilities. Equally important, NHS boards, and ultimately their chairmen, must have a clear sense of their fundamental responsibilities for the decisions that are taken. They provide the focus of accountability for local people on whose behalf they act.*
>
> *We must also ensure that there is an atmosphere of openness in the conduct of the NHS day to day business. It can be to nobody's benefit always to conduct matters behind closed doors, or to allow the decision-making process to rest alone with a small group of individuals. Consultation on major service changes should be genuine and full.*
> *The health service faces significant changes in how care is delivered. There is enormous potential further to improve treatment for patients, and to improve health, by harnessing modern medical techniques. The public, however, have a right to be informed about these issues, to understand why a particular proposal can be in their interest, and to make their contribution to the debate. That is what I mean when I talk about health literacy. It is for all health professionals to play their part in informing that process.*

In January 1994 all health authority chairmen were asked by the Minister for Health to report on:

- what action has been taken to consult the general public and other interested parties such as GPs and CHCs on the health authority's purchasing plans and how this information was used to shape plans;
- what steps were being taken to discuss the detail of contracts with nurses and doctors in hospitals and community units where they intend to place contracts;
- how they intended to consult regularly in their rolling five year strategy for delivering health care.

The National Consumer Council survey cited in Part 1 shows how large the task of involving the public is. In particular it found that only a very small fraction knew anything about their Community Health Council despite its statutory position. This fact should give pause for thought to those who seek to improve the accountability of lower tier health agencies be these purchasers or provider trusts by bringing on to the board people who represent a range of interests.

While these announcements appear to promote accountability in all directions, they do not tackle directly that relating to professional work – which Jane Lightfoot considers elsewhere in this volume. The issue of professional accountability arose as a result of events in Birmingham. Here it became apparent that over a period of years a consultant had misdiagnosed cancers and as a result a large number of people had received inappropriate treatment. It was also clear that colleagues were aware of the situation, particularly medical colleagues. In a number of other areas, large-scale errors in cervical smear tests were reported. Here there are two main avenues for poor performance to be detected: whistleblowing and audit.

Whistleblowing:

The Birmingham experience indicated the reluctance of professionals to 'inform' on their colleagues. Personal loyalty to one side, they have good reason not do so: typically, the bearer of bad news pays a penalty for doing so. They are frequently ostracised and effectively ruin their careers. In June 1993, in EL(93)51, guidance was issued to staff on relations with the public and the media. In the covering letter, the Chief Executive said:

> *It is important that we encourage a climate of openness and dialogue within the NHS where the free expression by staff of their concerns are welcomed by their managers as a contribution towards improving services.*

The main elements of the guidance are in Table 9. While reasonable enough in themselves, they cannot guarantee that whistles will be blown when they should be; that, as the Wessex case illustrates, depends on the general culture within which the NHS operates to which the rules themselves make only a limited, if necessary, contribution.

Audit: The 1990 Act provided for the introduction of a system of medical audit, but it would appear from research carried out at Brunel University by Martin Buxton and his colleagues that it is unlikely to be effective in detecting failures of this kind. That research indicated that while there was value in the new arrangements, they fell far short of being systematic or comprehensive. They do not provide assurance that clinical quality is good, and, if it is not, that the weaknesses will be detected. The cases mentioned here came to light 'by accident' rather than as a result of an established checking process, external or internal.

Unlike areas where management has clear responsibility, there is no external audit on a systematic basis into professional work. The Audit Commission is straying into professional areas but it does not question specific clinical decisions or even classes of clinical decision. There is no audit probe, to use their jargon, for clinical quality. The only such mechanism in England is the annual report of the Royal College of Surgeons Confidential Enquiry into Peri-Operative Deaths. But this is voluntary and applies only to fatalities: its main value is in deriving general conclusions about the organisation of services such as the need for continuous consultant-level cover. Thus unlike the every day operations of the NHS, there is no general and effective checking process on the quality of the service provided- a large gap in the existing structure of accountability.

Table 9: Guidance on dealing with the media

(i) Individual members of staff in the NHS have a right and a duty to raise with their employer any matters of concern they may have about health service issues concerned with the delivery of care or services to a patient or client in their authority, Trust or unit.
(ii) Every NHS manager has a duty to ensure that staff are easily able to express their concerns through all levels of management to the employing authority or Trust. Managers must ensure that any staff concerns are dealt with thoroughly and fairly.
(iii) NHS employers should ensure that local policies and procedures are introduced to allow these rights and duties to be fully and properly met.
(iv) Individual members of staff in the NHS have an obligation to safeguard all confidential information to which they have access: particularly information about individual patients or clients, which is under all circumstances strictly confidential.

2.3 Equity

As Margaret Whitehead demonstrated in her contribution to *Evaluating the NHS Reforms*, the proponents of the new NHS have had little to say about equity. But as she also shows, equity within the NHS has a number of meanings, so it would be perfectly possible for the new arrangements to improve matters on one score while having the opposite effect on another.

The essence of the NHS is perhaps best captured in terms of its commitment to universal provision, free at the point of access, and available according to need. The Patient's Charter states that 'Every citizen has the right to receive health care on the basis of clinical need regardless of ability to pay.'

This principle has been whittled away over the years, with the introduction of charges for certain services and restrictions on the scope of provision, but they still apply to the vast majority of services. Furthermore, a commitment to equality between areas, evidenced in the 1962 Hospital Plan, the aim of which was to ensure that all areas had access to good hospital services, and later in the revision of the funding formula in the mid-1970s as a result of the Resource Allocation Working Party, has remained strong.

The principle of territorial justice however has appeared to be threatened by a number of developments during the year: the impact of GP fundholding, the working of market forces, variations in quality of service and the resource allocation system itself.

Although the Government continued to deny that fundholders' patients were getting better access to hospital services, the evidence accumulated suggesting that they were. In December, the British Medical Association published the results of a survey of 247 acute units. Seventy-three units (42.2% of respondents) indicated that arrangements were offered to fundholders' patients which were not available to those of other purchasers. This proportion varied geographically, ranging from 18% and 23% in North Western Region and South Western Region respectively to 60% in North West Thames and 67% in Wessex: see Table 10.

Thirty units (42% of fast trackers) were employing fast tracking routinely as part of contract negotiations, although 13 of these were also doing so as a result of allocations running out. Seventeen units (23% of fast trackers) were involved solely as a result of running out of funds.

Why should this matter? One answer is that it does not. There have always been differences between areas arising from the fact that some providers were more efficient than others. All indices of comparative performance have shown wide variations between providers in different parts of the country ever since performance indicators became available: every Audit Commission report reveals wide variations between

Table 10: Evidence on Twin Tracking

In your unit are arrangements offered to the patients of GP fundholders which are not available to the patients of other purchasers?

Region	Yes	%
Wessex	4	67
NW Thames	6	60
West Midlands	9	50
Trent	8	50
Oxford	6	50
SW Thames	5	50
East Anglia	2	50
SE Thames	7	41
Mersey	6	40
NE Thames	5	39
Yorkshire	5	36
Northern	5	36
South Western	3	23
North Western	2	18

Source: British Medical Association Press Release

areas. The introduction of competition between providers and between purchasers can be seen as a way of reducing the impact of these differences since the ability of purchasers to bring market pressures to bear should tend to even these out, in the way that effective markets for any good or service tend to even out differences in price and quality. In this way, market processes can be used to serve equitable ends.

However, that will take time. In the short run, the creation of more effective purchasers – GP fundholders or better than average district purchasers – may either create differences or perhaps identify differences of a kind that were latent before. There have never been mechanisms for ensuring that patients registered with different practices receive similar quality care, or even the same range of care. Variations in referral rates have had, as a matter of pragmatism, to be taken as reflecting differences in need, even though it was hard to show they actually did.

But even if we accept that the introduction of fundholding has brought a new kind of difference, analysis of the existing situation is far from straightforward. While, despite government denials, it does appear that GP fundholders have been able to get better deals for their patients in terms of access times for elective surgery. As Howard Glennerster indicates elsewhere in this volume, fundholders have not been systematically favoured. In a few cases, fundholders, like districts, have had to stop non-urgent referrals because of lack of funds.

As the Secretary of State has persistently argued, the moral to draw is that other purchasers should respond not that GP fundholders should be curbed. That is valid as long as the playing fields are level. In general they appear to be, as far as budgets are concerned and if they are not, the means are available to make them so by bringing them in line with what is being spent on non-fundholding patients. On this basis, the argument would be that the introduction of fundholding is leading to temporary advantages partly due to failure to set correct budgets and partly due to the fact that fundholders have been quicker off the mark to exploit their purchasing power and to make savings in areas where districts have been slower to do so.

Some issues must be resolved before it could be agreed that the playing fields are level. First, there is the question of uncertainty. At present, if emergency admissions increase faster than expected, districts have to meet the extra cost, thus reducing their capacity to pay for elective treatments.

Second, it is generally believed that fundholders are able to do more because they are enjoying lower prices than district purchasers. Although in theory providers are supposed to set prices at average costs, they have an incentive to offer fundholders, particularly those on the margin of their area, lower prices and as the concept of average cost for a particular range of procedures is not very precise, it is hard to rule out such behaviour.

Third, there is no check at the moment over quality and access. So far there is no evidence that fundholders are restricting access to hospital in order to save money. But the risk is there.

But even if the playing fields are level, players will perform with different levels of skill. The question then is, what can or should be done to level up performance? One reaction might be that people must take the rough with the smooth. It is quite impossible for such a large service as the NHS to perform everywhere to the same level. Clearly that point has some force: certainly there is no mechanism which could make all GPs equally efficient. The best that can be aimed for is to eliminate the very bad performer.

As far as the rest of the NHS is concerned, in principle a number of mechanisms are in place to even up performance: managerial controls, Health Service Indicators and the work of the Audit Commission and the National Audit Office, all of which contribute to identifying poor performance and bring pressure to bear for removing it.

But what of market forces? In a 'real' market, the main sanction would be loss of profit and potential failure. As we have suggested that force may powerful but it depends on there being actual or potential competition between providers. In many parts of the country alternatives are available; in others not. And where alternatives are available now, some of the trends we describe elsewhere will tend to eliminate choice. The usual expectation would be that prices would be higher where there is only one supplier and hence residents in those areas put at a disadvantage.

Where market pressures are absent, the idea has been floated that poor performers should be fined: some purchasers already do that, *eg* for failure to meet targets. But there is little point in fining organisations since that only reduces the funds available to provide services. A more radical idea would be to set standard prices to which providers had to work, leaving providers to absorb cost differences within their control. That would leave the workforce to absorb in their pay the effects of lower levels of productivity.

A similar issue is raised by the finance of negligence claims which in a case such as that in Birmingham may amount to many millions. In 1990, the Government relieved doctors working in hospitals of the burden of paying for insurance against being sued for negligence, transferring the whole cost to their employers, at that time, health authorities. That switch could be justified on the ground that it simplified things for the claimant. Moreover it created an incentive for the employers to put into place systems to ensure that the costs of such claims were minimised. However, the true bearer of such costs is the local user. The issue then is: is it appropriate for the user in a particular area to 'pay' for the poor performance of a purchasing unit, or should the risks be pooled overall purchasers from that unit, or nationally?

The Government Consultation document issued in March 1994 acknowledges the case for pooling, but also the case for placing the burden locally:

> *the working party felt that incentives would be strengthened if units continued to bear some of the costs of clinical negligence liabilities themselves. A possible formula might be for the units to bear:*
>
> *(i) all the cost up to a lower threshold A*
>
> *(ii) a percentage – say, 20 per cent – of costs between A and an upper threshold B*
>
> *(iii) nil contribution above B.*

There is a clear conflict between efficiency and equity considerations and no clear principle for resolving it. Other events during the year also brought to the surface issues of equity which have been latent within the NHS since its foundation.

The NHS has always been a national service locally delivered. Given its size, a structure of that nature has been inevitable. Furthermore, as our Review emphasised last year, the individual citizen has never had a right to particular treatments: hospital services, accident and emergencies apart, have always been rationed and subject to the discretion of GP and consultant. For, at the heart of the NHS, there exists a compromise between professional independence and its equity objective. GPs are independent contractors: hospital consultants have enjoyed the freedom to determine in large measure their own workload, and also how they carry it out. Their discretion necessarily conflicts with what might seem a basic requirement of equity – that the service is more or less the same, need for need, in all parts of the country.

At present it is not. As the Health Committee argued in relation to dental services, not only are there wide variations between different parts of the country in oral health but the present system of provision is not in itself capable of responding to them. In the course of their investigation, the Committee took up the question of distribution with the Department as follows:

> *32. How does the Department ensure a satisfactory geographical distribution of general dental practitioners?*
>
> *The Department has no legal power to decide where dentists should set up a practice or to restrict them from setting up in any area. Nevertheless, efforts are made to achieve a better distribution of dentists by giving some financial assistance to dentists who decide to set up in areas which are known to be short of dentists. The payments, a maximum of £10,000 paid in two instalments, are possible under a location incentive scheme, set up for the purpose in January 1989.*
>
> *33. What specific mechanisms exist to enable FHSAs to attract GDPs to work in a particular location?*
>
> *– What has been the take-up of such provisions?*
>
> *– What have been the outcomes of such take-up as has occurred?*
>
> *The location incentive scheme, mentioned in answer to Q32, provides the only central mechanism for attracting dentists to a particular location. FHSAs taking part in the scheme advertise it locally and deal with enquiries from dentists, advising them of the areas in their locality which are short of dentists. If a dentist is willing to set up or expand a practice in such an area, he/she will qualify for an allowance which is 20 per cent of the expenses incurred between £10,000 and £50,000, up to a maximum of £10,000.*
>
> *The scheme started in January 1989 with only 3 FHSAs taking part. The number has now increased to include 60 FHSAs. Just over 100 general dental practitioners in England have received an allowance and contributed to improved General Dental Services throughout the country. A review of the scheme is to be undertaken shortly to assess its effectiveness.*

What this demonstrates is a very faint hearted commitment to territorial justice in dental services. The same is true for other parts of the NHS. Standards of care have never, in theory or in practice, been uniform: there has never been a systematic attempt to aim for a set of common standards of care or of service availability. That is true in even some basic areas such as child health surveillance: the nearest approach to a national programme has been that for immunisation and vaccination where the Department does lay down what every child should receive and does monitor the proportions of children who actually do receive it. But in the broader area of child surveillance, no programme is laid down, though very recently a suggested set was put forward, following on the publication of *Health for All Children*, the report of a professional group chaired by David Hall and a subsequent group led by Colin Waine

In other areas, *eg* accident and emergency services, stroke care and so on – it is apparent from a series of reports in recent years not only that standards of care vary a great deal from one area to another but also that there is no framework for ensuring they do not. This reflects the reluctance of government to intervene directly in areas of clinical discretion. Thus in practice, the main active focus of concern about territorial equity has been the allocation of resources to regions for hospital and community services, combined with control, via the Medical Practices Committee of the location of GPs. With a few exceptions, allocations have been in block form, leaving their actual use to lower levels in the hierarchy. As far as primary care is concerned, there are strong reasons for arguing that the present arrangements will never achieve an equitable distribution: more energetic measures are needed.

Thus, inequity in the sense of service quality variation is commonplace. But for the first time the NHS embodies an instrument that can, if used appropriately, actively promote equity between groups, however defined. In particular, equity between territories at aggregate level is a distinct issue, not directly affected by the introduction of the purchaser/provider split, except insofar as the new regime focuses on the purchasing district, whereas the old focussed primarily on the region leaving the subsequent distribution a matter for discretion. In this sense, the new regime, because most finance can pass directly to districts and the government is intending that virtually all will, should be more territorially equitable at least in principle – whether the formula for determining relative needs is adequate, is another matter.

On the other hand, there is no inherent reason why purchasers, be these districts or GPs, should follow the same set of priorities. So even if they are allocated the same volume of resources, relative to need, the results may differ. Does this matter? In some areas of social policy the answer would be clearly positive; social security was 'nationalised' in the inter-war years and now virtually all payments are made on a standard basis. In the case of education, development of the national curriculum can be seen as move in the same direction.

If it were acccepted that people in different areas with similar needs should have similar treatment, then that would require national norms for rates of treatment, for the availability of services and for efficiency and effectiveness on the part of providers. Purchasers would then be accountable for ensuring the norms are met while retaining discretion in other areas. As we have noted already, the centre is beginning to impose itself through clinical guidelines, but this leaves the rate of treatment and also the range of treatment to be determined locally.

But a major move in the direction of setting norms for either would amount in effect to the nationalisation of the service. Such a move is, viewed from the equity angle just set out, entirely logical. But it radically alters the focus of accountability from the local to the national level. In particular, it would open the way to a model of purchasing in which the purchasers were agents of the centre. Such a change would be most marked at GP level. GPs are not subject to any central requirements – at least not in terms of their being required to provide specific treatments – so GPs above all are not accountable for their actions. They have no reporting line for the content of their work. Thus what they do with their budgets is a matter for them provided they are spent on the purchase of health care services or otherwise retained within the practice *eg* used for purchase of better facilities. This freedom could not be maintained if inter-area equity were to be taken seriously but to curb it would be to undermine the essence of the fundholding scheme and possibly the present structures of provision. As for districts, it would mean a less radical change, but an end to much of the current rhetoric about consultation.

Interpersonal equity: if the NHS were like social security, then complete nationalisation would be feasible. But it is not. While a national curriculum approach is imaginable for a range of conditions – indeed the targets set for some operations come near that – it is not for the full range of services that the NHS offers.

The question then is what rules, if any should govern the distribution of funds between competing needs: should such rules be specified nationally, even if their detailed application is local? The starting point is that the NHS has to ration – in the most overt form through waiting lists. As long as waiting lists remain, it is worth asking whether they work according to rules which would command general acceptance. In October, the President of the Royal College of Physicians suggested that they did not necessarily work that way. In response the Government indicated that they were going to have talks with the Royal Colleges to see if the existing guidelines needed to be reviewed. The Colleges were asked to provide examples of conditions which they believe should be given priority: so far, they have not done so.

One possible criterion for rationing, which public opinion surveys suggest would attract a good deal of support, is according to whether or not a condition might be said to be self-induced *eg* through excessive smoking. One particular case attracted attention during 1993, where a patient had his operation postponed on the ground that it was likely to be more successful if he modified his smoking habits in the waiting period.

However he died before the operation could be performed. The logic was essentially one of cost-effectiveness: the chances of success were greater.

Soon after the Secretary of State made the following statement:

> *It is, always has been, and will remain, a matter for the professional judgement of the clinician involved, how and when to treat his or her patient. Clinicians have always taken a variety of factors into account in reaching such judgements. I regard it as particularly important that they share such considerations with the patient in reaching conclusions about how to proceed. It is a fundamental ethical duty of every clinician to provide the treatment for his patient which he considers will produce the most clinically effective outcome. Clinicians need also to have regard for the fact that the NHS is, and must remain, a service available to all solely on the basis of clinical needs.*

In January 1993 the BMA announced guidelines which required doctors not to discriminate on lifestyle grounds. Their statement, issued on 13 January, read as follows:

> *Doctors have always believed that it is unethical to discriminate against any patient on any grounds and the BMA has said consistently that patients should be treated on the sole basis of their clinical needs and their ability to benefit from any particular treatment.*
>
> *It would be wholly wrong for any doctor to allow personal judgements or opinions to influence any decision they make about a patient's treatment. All decisions should be based on sound scientific evidence.*
>
> *Given misleading publicity, it is of paramount importance that patients are not left with any impression that doctors – in advising them, for example, that they must give up smoking – are refusing to treat them.*
>
> *For some conditions giving up smoking can be the best immediate treatment. If patients are suffering from heart disease, for instance, quitting smoking is often essential if they are to be successfully treated.*
>
> *In such cases doctors will endeavour to provide appropriate, alternative treatment whilst ensuring that counselling and support is given to patients to help them, for example, give up smoking, cut down their drinking or lose weight.*
>
> *Since the inception of the NHS, doctors have always placed the interests of the patient as the number one priority and we will continue to do so.*

This statement came in response to one case which attracted widespread media attention. Other evidence reported during the year identified broader groups of people apparently suffering from discrimination. It is frequently argued, as Age Concern did in its evidence to the Health Committee, that older people get poorer care by virtue of their age. Firm evidence is hard to find but a study of coronary care units (Dudley and Burns, Age and Ageing 1992) found that one-fifth of the coronary units survey operated an age related admissions policy and two fifths an age related thrombolysis policy. There were further press reports of such discrimination in April 1994; in these cases, the individuals were refused treatment at particular hospitals. Responding to the resulting media outcry, the Secretary of State said:

> *The founding principle of the National Health Service shines like a beacon in our society. The NHS provides services for everybody, on the basis of their clinical need and regardless of their ability to pay. There are no exceptions to that rule, whatever the age of the patient.*
>
> *This principle is the first, and most important, right set out in the Patient's Charter. It is the rock on which this Government's health policy is built.*
>
> *I deplore any act that gives rise to uncertainty among patients that this principle is not being upheld everywhere in the health service. It is absolutely vital that the public have confidence that the NHS will be there when they need it.*
>
> *It is the duty of all health authorities to ensure that people of all ages have access to acute care, and that specialist care is available for those who suffer with chronic conditions due to the ageing process.*

Another report, in this case by the Public Accounts Committee (HC 538) on services for younger physically disabled people, revealed consistently poor standards of service, reflecting a failure to recognise the specific extra needs that physical disability gives rise to. The only defence of the findings is that other patients were given greater priority: but on what basis?

It is clearly not feasible to calculate a precise formula to which all authorities and clinicians could refer in difficult cases – the experience of Oregon has shown how blunt an instrument that would be. And even that formula did not try and discriminate between individuals waiting for treatment. On the other hand, professional discretion alone working on unstated criteria – 'clinical freedom' – no longer inspires sufficient confidence that decisions are made fairly. A middle way would be to develop a set of criteria which should be taken into account every time choices have to be made between individuals or treatment groups, and a set which should not.

Taking the latter group first, it is not hard to come up with a list of criteria which should be barred. Discriminating between individuals on the basis of race, income or class is clearly inappropriate. Some other criteria are less obviously inappropriate, for example favouritism and scientific interest. Knowledge

Table 11: Summary Statement of Criteria

Not acceptable: class, race, sex, income, clinican preference, (non-educational) interest.

Acceptable (*taken together*): need, effectiveness, cost.

Arguable: age, lifestyle, time waiting, extent of others' dependency, compliance, productive 'importance'.

of the existence of decisions based on such criteria is only anecdotal; nevertheless, candid clinicians admit that it is often tempting to admit the pleasant, affable or attractive patient ahead of the truculent, rude and difficult one. Similarly, it can be tempting to admit a rather 'interesting' case, ahead of those who have complaints more readily treatable. This is clearly inappropriate unless there is some educational benefit to be gained.

Turning to appropriate criteria, two immediately suggest themselves: need (extent of ill-health) and effectiveness. These are largely uncontroversial because they essentially form the basis of good medical practice. A more controversial criterion is cost. The reason for controversy is obvious: how can a national health service refuse a service because it is 'too expensive'? Because, comes the reply, with limited resources unless we do we run the risk of doing less good than we otherwise might.

Perhaps the difficulty with a general acceptance that cost is appropriate is the suspicion that cost alone would be the criterion referred to, even though care is needed and the service is effective. But neither would considering 'need' alone be sensible if the treatment is ineffective and costly. And an effective treatment would not be supported if the patient or clinician decided it was not needed in a particular case. The conclusion must be that it is appropriate for all three criteria to be considered together. Then, at least, we can be sure that clinicians or health authorities have given due consideration to a range of appropriate criteria when making difficult choices. These choices will still have to be made – precise weights cannot be ascribed to the criteria – but decisions would be guided explicitly in a way in which they have not been in the past.

What about other criteria? Whereas there has been an enormous amount of discussion about cost, chiefly in the context of the QALY cost-effectiveness measure, consensus is still far from achieved for other criteria. As we have seen, lifestyle, age and time waiting have created heated discussion during the year; but whether or not, all other things being equal, employment status should be taken into account needs further discussion too. Are QALYs inherently ageist because they count years of life, or is it just commonsense to take into account how long a treatment is beneficial? The cases referred to in CEPOD, where people near death were treated, do suggest a waste of resources: but where should the line be drawn? And should we take account of the number of dependents which a patient may have? Or whether they have demonstrated compliance with the treatment?

The strategy of setting out appropriate and inappropriate criteria, – see Table 11 – avoids many of the drawbacks of alternative strategies. Implicit professional discretion can no longer command the confidence of an increasingly well-informed public. Oregon-type formulae or QALY league tables are too insensitive to accommodate the complex nature of demands on a health care system. Explicit criteria, on the other hand, encourage careful thought in making difficult decisions whilst acknowledging that personal discretion is necessary in individual cases.

2.4 Conclusion

Announcing the fourth wave trusts in February 1994, the Secretary of State claimed that 'Trusts are at the head of an unstoppable tide of health service reform'. She was probably right. Although Labour's policy statement *Health 2000*, also issued in February, was presented as a new approach, by rejecting market language, the key elements – fundholding apart – were retained. Furthermore, in *Financing Infrastructure Investment*, issued in February 1994, Labour showed itself to be 'plus royaliste que le roi' in its support for private finance for public investment.

Last year our overall conclusion was that the NHS had entered a period of continuous change, to which it was hard to set any time limit or indeed any clear idea of what end-state it is moving towards. The events of this year have served only to confirm the sense of that conclusion, and so we conclude this year's review by reaffirming it. That conclusion is reinforced by NAHAT's *The Future Direction of the NHS*, which concludes with 22 'Questions for the Future'. Take together they reaffirm that no steady state is in sight. The management of the NHS , at political and every other level, is facing an expanding universe of issues to resolve.

PART 3: 1993/94 IN BRIEF

April

1 **Blood services:**
National Blood Authority created.

27 **Nursing:**
Vision for the Future: the nursing, midwifery and health visiting contribution to health and health care published.

May

4 **Medical Training:**
Publication of Report of the Working on Specialist Medical Training.

12 **NHS Management:**
Review of NHS structure established.

June

3 **Purchasing:**
Consultation paper on indicators of health outcomes published.

7 **Mental Health:**
Action programme for black and ethnic minorities launched.

5 **Drugs:**
Triazolam withdrawn.

9 Guidance on relations with public and media published.

14 **Health Promotion:**
New payment levels published for GP's health promotion and asthma and diabetes management programmes.

16 **London:**
Minister for Health commits extra funds for improvement of primary care in London.

18 **Complaints:**
Review committee established into NHS complaints procedures.

24 **Market Testing:**
Revised guidance issued.

29 **NHS Management:**
Priorities and planning guidance 1994/95 issued.

July

2 **Purchasing:**
Purchasing for Health: a blueprint for action published.

Clinical Audit:
Policy statement issued on multi-professional audit.

8 **Public health:**
Discussion paper on local target setting issued.

12 **Management:**
Task force on corporate management established.

20 **Performance measures:**
League tables for individual providers proposed.

21 **Purchasing:**
Guidance issued on costing for contracting.

27 **Public Health:**
Establishment of Institute of Environment and Health.

30 **Public Health:**
Additional health warnings on tobacco products and measures to reduce incidence of skin cancer announced.

August

5 **Maternity Care:**
Report of expert group on childbirth published.

12 **Mental Health:**
Ten point plan announced to strengthen community care for the mentally ill.

25 **Trusts:**
Fifth wave launched.

26 **Accountability:**
Review announced of guidance to medical staff on reporting poor performance by colleagues.

September

14 **Staffing:**
Part-time posts for consultants announced.

20 **Surgery:**
Investment in training centres for 'keyhole surgery' announced.

Report of Day Surgery Task Force published.

21 **Finance:**
Parliamentary Secretary for Health affirms that private finance for NHS capital projects should be a standard option.

29 **Mental Health:**
Working group inaugurated for mental health services in London.

October

7 **Trusts:**
Bulk of fourth wave trusts announced.

11 **Prescribing:**
Extensions announced to medicines not available on prescription.

28 **Ethnic Minorities:**
Establishment of ethnic health unit announced.

November

1 **Finance:**
New measures announced to boost private finance for capital projects.

22 **Prescribing:**
Programme of demonstration sites announced.

23 **Specialised services:**
Guidance issued for contracting for specialised services.

Research:
Professor Anthony Culyer appointed to chair NHS Research Task Force.

December

6 **Ethnic Minorities:**
Michael Chan appointed as first director on NHS Ethnic Health Unit.

8 **Junior Doctors' Hours:**
Minister for Health gives commitment to implementation report on specialist medical training and to meet target for reduction in junior doctors' hours by December 1994.

10 **Ethnic Minorities:**
Programme launched designed to achieve equality of opportunity for ethnic minority staff.

21 **Clinical Effectiveness:**
Development programme to improve clinical effectiveness announced.

29 **Health Promotion:**
Health education campaign on smoking launched.

January

20 **A & E:**
Secretary of State calls for reduction in long waits in A & E Departments.

Hospital Discharge:
NHS asked to review adequacy of discharge procedures.

24 **Maternity Care:**
Commitment to giving women greater say in maternity care made by Secretary of State.

25 **Nursing:**
Ten nurse practitioner projects announced.

CHCs:
Guidance issued on operation of community health councils.

26 **Screening:**
Measures announced to improve cervical screening programme.

27 **Trusts:**
Further fourth wave trusts announced.

28 **Clinical Audit:**
Guidance issued on the development of clinical audit.

February

3 **Pay:**
Pay increases of 3 per cent agreed for staff covered by Pay Review Bodies.

4 **Health Promotion:**
National campaign launched to raise awareness of severe meningitis.

7 **Health Promotion:**
Action plan announced to achieve *Health of the Nation* targets on smoking and expert committee on tobacco and health established.

11 **Accountability:**
Report of the Allitt inquiry published.

16 **Mental Health:**
Guidelines published on registers for some discharged psychiatric patients.

17 **Waiting Lists:**
Additional £12 million made available for reduction of waiting lists.

24 **Mental Health:**
New monitoring arrangements announced in response to publication of Ritchie report on Christopher Clunis.

March

10 **Mental Health:**
Mental Health Nursing Review Team makes 42 recommendations to improve mental health nursing.

21 **Trusts:**
Final eight additions made to fourth wave of trusts, including the unification of Charing Cross, Hammersmith, Queen Charlotte's and Acton Hospitals.

24 **Trusts:**
Trusts given freedom over payments for hospital locums engaged through private agencies.

22 **Junior Doctors Hours:**
£50 million extra funding announced for 125 additional consultant posts to allow junior doctors hours to be reduced.

24 **GP Fundholding:**
Review of scheme announced.

24 **Nurse Prescribing:**
Programme of demonstration sites announced.

29 **Health Promotion:**
Nutrition Task Force programme announced for reduction of fat intake and obesity.

THE FUTURE OF FUNDHOLDING

Howard Glennerster

The economic crises of the 1970s and the Conservative Governments of the 1980s shook the traditional welfare state to its foundations. The check to economic growth caused both the Labour and the Conservative Governments of the period to halt the steady incremental growth of state spending on social policy as a share of national production that had gone on for most of the century. This was nowhere more important than in the case of the National Health Service. In the two decades before 1976 NHS expenditure had risen annually at twice the rate of the national income. In the early 1980s spending on the NHS was to rise only half as fast as the national income and more slowly than the demands of an increasingly elderly population. This put increasing pressure on the service and caused political embarrassment as waiting lists grew. Shortages of resources were not the only factor at work, however. Monopolistic forms of provision and the weak position of consumers and patients began to put the service at increasing political disadvantage in a consumerist world.

The Conservative reforms, therefore, had two main objectives:

- to get more health care from the limited budget the Government was prepared to provide *ie* to increase efficiency;
- to increase the responsiveness of the NHS to consumers.

One model of reform, that in which the district health authority became the monopoly purchaser, was essentially concerned to improve the efficiency of the hospital unit and to improve planning. It was not well adapted, by its very nature, to be responsive to consumers. Indeed, by reducing the number of hospitals with which contracts were agreed, this model tended to restrict GPs' freedom to refer where they wanted, or so GPs feared. Furthermore patients had no choice of purchaser.

The GP fundholding model embodied a quite different principle. Patients should be able to choose between those who would purchase services on their behalf, in this case GPs. Competition would be introduced on *both* the purchasing and the providing side of the market. The nearest example of this model at work was the American health maintenance organisation. But they were much larger than any British GP practice and the smaller ones were subject to budget volatility. They also had a tendency to exclude less healthy costly patients in the competition to stay viable. The fundholding scheme was designed to avoid these problems. Only large practices could join and by concentrating on non-emergency, outpatient and pathology services and by restricting the scheme to patient treatment costs below £5,000, later £6,000, it was hoped to avoid budget volatility. The areas targeted for GP purchasing were, however, arguably the most inefficient parts of the NHS: non-emergency care, outpatients and laboratory testing.

The Efficiency Criterion

Efficiency comprises several elements, which we take in turn.

Hospital efficiency and responsiveness: Even if every GP were a fundholder, less than a fifth of hospital expenditure would be purchased by them. Thus their impact on hospitals for good or ill is likely to be limited. However, evidence presented in, for example, *Evaluating the NHS Reforms* suggests that GPs have been more effective contractors than districts for GPs have had the motivation and the information to seek better contracts. They have been able to diversify their providers, bringing to bear a real threat of exit, providing their patients with choice and speedier and better service. This has been achieved for the most part by switching to more effective providers or by improving the performance of the same provider.

A competing system of decentralised purchasing has forced districts to improve their contracting skills and to invent new ways of involving GPs in their contracting process. GPs, being closer to the pains and preferences of patients, have been more likely to reflect these in their contracts. Medical researchers may, understandably, like harder evidence. Are patients more healthy as a result? The problem is that we cannot readily apply randomised control trial methods to this kind of question. The very hypothesis from which the contestable market theory begins is that every doctor will be affected by the introduction of a competitive environment, not just fundholders. Once the pathology monopoly was broken, it affected non-fundholders as well as fundholders.

Allocative efficiency between sectors: A second expectation was that combining primary and secondary care budgets would enable services to shift to the most convenient place of delivery. The removal of budget boundary walls between hospital, practice and community services *has* begun to produce more flexibility and a growth in practice based work. There is no one right balance but discussion about the appropriate balance and the capacity to do something to change it, is evident. Fundholding has been a catalyst. Devolved budget responsibility does indeed seem to release innovation.

In a number of respects the flexibility is still not great enough. There are constraints on the kind of contracts GPs can make with community services. In 1993 the Department of Health effectively put a stop to fundholders contracting services from themselves through the agency of a private company. While some GPs may have abused this approach, it had only grown up in the first place because the fundholding rules had prevented practices from paying themselves to do minor operations and treatments from the fund. There do certainly have to be safeguards and close monitoring of standards and outcomes, but done properly both can be more convenient for patients and usually much quicker. In short, bottom up budget flexibility has worked and should be given the chance to work better.

Practice efficiency: One of the by-products of the additional managerial input needed to run the fund has been improved practice efficiency. The rest of the practices' activities come to be better managed too.

Economy on drugs: Part of the scheme which is often overlooked is the inclusion of an element that covers the cost of drugs prescribed by the GP. If the practice saves money on this budget it can be used in the rest of the fund. This gives a direct incentive to GPs to carefully review their prescribing habits in a way that Government and commentators have been urging. The evidence from our regular interviews was that our sample GPs did devote serious attention to containing their drug budgets. They did so more than non-fundholders who did not face such direct incentives. We did not possess randomised control data to compare our practices' resulting drug spending with non-fundholders. However, we reviewed several studies that do suggest that fundholding GPs have not reduced the costs of their prescribing but *have* increased the costs of their prescribing more *slowly* than non-fundholders. They seem to have done this by using more generic equivalents to brand name drugs and by being more cautious about taking up expensive new treatments.

Administrative costs: The costs of practice-based contracting are clearly higher than district-based contracting. The additional costs are to some extent offset by the clinical advantages that flow from the improved individualised patient information and monitoring of hospital progress that can be undertaken by the practice as a result. GP-based contracting seems to be better but to cost more.

The scale of referrals: One original intention that lay behind the thinking about GP fundholding was to make practices think more about the reasons for referring patients to hospital by facing the GP with the costs of each referral. If every GP were given similar budgets it might in the end reduce the wide and unexplained variability in GPs' referral patterns. In fact, the way the GPs' budgets have been set has not helped to achieve this goal. Since budgets have been set on the basis of GPs' existing referral patterns, GPs have had no reason to revise their habits in this respect. The efficiency case for moving to a capitation based fund allocation for this reason, as well as others, is strong.

Comprehensive planning: Even if there are micro-efficiency gains to be reaped from having competitive purchasers, critics argue, the result is that districts lose their capacity to plan services for their populations. That requires one purchaser for the whole area. GP fundholders have fragmented any capacity to do this. They respond to patients' demands not the population's needs. They are less concerned with meeting the goals of *The Health of the Nation*. There is some truth in these claims, but not much.

First, we have to remind ourselves yet again that, even with the inclusion of community services and 100 per cent coverage, fundholders potentially control no more than a quarter of the combined hospital and community services' budget. In practice they have, in the past two years, only controlled two and now about seven per cent of that budget, and control over the community services element has been minimal. In most areas the argument is about fears not events.

Second, the concept of planning that districts tend to use in this argument is rooted in epidemiology and the past. The task of a district planner is seen to be examining trends in disease and populations at risk. Consumer preferences and patient demand are rude words or, at least, alien concepts. If they are to be used at all they involve patient questionnaires.

Private service organisations, however, have a quite different notion of planning. So, increasingly, do the new `enabling' and contracting Social Services Departments. An organisation like the supermarket chain Sainsbury uses trends in consumer preferences to tell them what consumers want. They also try to create demand and advertise heavily but then so do health promotion agencies! As we saw in several of our case studies, the more advanced districts were using the market choices of their GPs as valuable hard information in planning future services. The more obscurantist view is akin to the head office of Sainsbury responding to a changing pattern of sales by saying, `It's those bloody customers again. They will keep changing their minds.'

This is not to say that epidemiology is not a valuable tool! But health experts' notions of `need' pursued to the exclusion of consumer demand will kill the NHS. Take physiotherapy as an example. Most of our practices had used their fund to employ a physiotherapist for some sessions a week as a response to growing patient demand and minimal supply by community services or hospitals, except for patients recovering from an operation. Why was this service so neglected? The medical evidence shows it does no good, we were told. That was not the patients' view. It was the kind of response that drives people into the private sector. Without a balance of medical need *and* patient demand the service will not survive.

There is, nevertheless, substance in the argument. A clear priority has to be decided between elective and emergency work. GPs' budgets have been based, essentially, on what hospitals had been able to do three years ago, rolled forward. Under much harsher budget pressure and growing emergency work a district might have to cut back its non-emergency cases for its non-fundholding patients. Fundholders' budgets for this kind of treatment were effectively ring fenced because they had been set on historic activity rates. This left a disparity between fundholding and non-fundholding patients' access to non-emergency care. The district could not deliver its priorities throughout its area.

In fact, by accident, fundholding may have been one way of preserving budgets for treatments which relieve pain and disability rather than extend life at high cost. It may have produced a more rational allocation in some peoples' order of priority. Let us, however, assume that a district is right in its chosen balance between elective and non-elective surgery. The reason that there can be a clash is that the implied budgets for non-fundholding and fundholding GPs were set in different ways. If budgets for both sets of GPs were set on a common formula basis they would reflect whatever priority the district, in consultation with GPs, thought should be given to elective surgery. Within that broad heading the choice of *which* operations were given top priority could legitimately vary from one doctor to another each, acting on their presumed knowledge of patients' circumstances.

It must be said that relations between GP fundholders and districts in many areas are poor and this does not make for good long term planning. Districts and fundholders are realising this and joint meetings and planning groups are emerging especially where fundholding has developed most. We discuss this way forward below.

In contrast, we found that fundholding practices were more aware than they used to be of service-wide issues. They were more aware of financial issues and participated more in discussions about local priorities.

The Health of the Nation: Given formula funding, the argument that fundholding interferes with reaching *The Health of the Nation* targets falls away. It is in any case a weak point. It depends on the view that this is a district function. Yet the `key areas' mentioned in that document – coronary heart disease and stroke, cancer, mental illness, HIV/AIDS, accidents and the needs of the elderly, poor and black populations – all have to rely on the GP as the critical link with the public. The more successful the GP fundholder is in reducing the illness of his or her patients, given formula funding, the more money the GP has to go round. That was always one of the main arguments for HMOs on which fundholding was based. Non-fundholders gain less financial advantage from keeping their patients well. So, far from fundholding being at odds with *The Health of the Nation*, it is a necessary adjunct to it. Since 1993, aiming at *The Health of the Nation* goals has been formally part of fundholders' brief. It will be expected to figure in drawing up their business plans that have to be approved each year. Activities will include advice and screening sessions which most of our practices did anyway. These strategies will need to be linked to FHSA and district priorities as the Audit Commission pointed out in *Practices Make Perfect: the Role of the Family Health Service Authority*.

Accountability: We have seen that large sums of public money, potentially much larger than now, will pass through the hands of private partnerships, which is the legal form GPs' `firms' take. The fundholding budgets are formally ring-fenced and held by FHSAs but there are ways in which `leakage' can occur. One much publicised example was the private company. Another is the use of savings from the fund to extend the practice premises. This adds to the capital value of the practice which partners buy into and sell when they move. Ingenious GPs will no doubt find other ways of leaking funds if a careful watch is not kept. In our experience GPs had entered fundholding, with very few exceptions, because they cared about the quality of the service they could offer and were not driven by financial gain. However, accountability rules are for the exceptions and it is important they are tightened and properly implemented as the scheme grows.

Budget volatility: One of the fears expressed before the scheme began was that practices would not be able to keep within their budgets. Emergencies and the random chance of having to meet a lot of high cost patients in one year would, it was suggested, drive them into the red, as had happened to American HMOs. We have shown that this did not happen in the first two years. Practices may face more difficulty as cash limits tighten, but they possess the means to control their spending. The £5,000 limit on practices' liabilities and the non-emergency nature of the categories covered had put fundholding on a much more secure footing than American HMOs.

Some have suggested that the scope of the fund should be extended to cover all hospital care. There are pilots taking place to test this (*Fundholding*, 7 May, 1993). They should be extended. The idea has virtues. It would extend the benefits of bottom up funding to the whole range of hospital activity. It prevents fundholders shifting their patients into categories like emergency care not covered by the fund and it gives the GPs more power. However, the American evidence on budget volatility makes us very cautious about extending the fund outside controllable non-emergency care.

To sum up: Our view is that what we have called bottom up practice-based funding, for the areas of health care now covered by the fund, has provided tangible efficiency gains by the pressure it has exerted on hospitals and the innovation it has stimulated in practices themselves. These gains are counter-balanced by the set of perverse incentives provided by the way the GPs' budgets are set. There is a perfectly feasible answer to this difficulty – the use of a formula based budget allocation.

The Equity Criterion

It is here that the major controversy surrounding fundholding has taken place. The main objection has been that fundholding has created a two-tier service. This is a confused claim that is based on a number of quite distinct propositions. Again some are valid and others not.

More resources: At the heart of this case is the belief that the cash allocated to fundholding practices is greater than that available to similar non-fundholders for the purchase of hospital and other services. The national and some regional comparisons we have seen do not bear this out. They suggest either that in the first two years there was little difference in the resources allocated on a national or regional basis or that some fundholders have probably been given less than a national or regional average allocation would have produced. The application of the national average costs per capita for fundholding procedures suggested practices were getting approximately 15 per cent less than would have been expected. A study in Oxford Region showed a 9 per cent under-allocation. All in all, it is difficult to support the contention that nationally GP fundholders were systematically over funded compared to what a national formula would have given in the early years of the scheme. The impact of some local differential pricing, with trusts charging fundholders higher prices, was a worrying development in 1993 but rules introduced in 1994 should have put a stop to differential pricing.

There can be no doubt that the case for formula funding is powerful on equity grounds as well as in terms of efficiency. It is certainly true that the budgets allocated to different practices of the same size varied considerably. On a per patient basis we found some practices receiving half as much again as another practice. Yet these variations did no more than put a monetary measures on the unequal uses of resources that were already taking place under the old system. By revealing them in economic terms they are made more difficult to sustain. The introduction of formula funding for access to non-emergency care, which is what GP fundholding essentially will do, will be a major step towards greater equity. At least, it will be if the same basis for allocation can be applied to non-fundholding practices.

Better purchasers, better services: We have suggested that fundholders have proved better purchasers than districts in some respects. Practice-based decisions, given the motivation and information base at that level, are simply better. If that is the case, patients of fundholders will get gradually improved services. Some of that advantage will spin off onto non-fundholding practices. But not all. Small non-fundholding practices unable to make the hospitals listen to them, will become even more disadvantaged than they are now. If fundholding is a better way of doing things and not all practices can become fundholders, there will increasingly become a gap between the two kinds of patient. Practices in poor areas with little energy or space to become fundholders were very poorly represented in the first waves.

To argue for the abolition of fundholding on this ground is, however, perverse. It is akin to the view that equality in human needs can best be achieving by starving everyone. Equity is best pursued by seeking to maximise opportunities, not to minimise them – levelling up not down. The conclusion to this logic is that a way has to be found of extending to non-fundholders the benefits of practice-based budgeting.

Cream skimming: Some patients have always been more trouble to GPs than others. Some are a very considerable trouble – the homeless are one category – and GPs do not go out of their way to be welcoming to patients who may upset other patients or be a drain on the partners' time. Thus, to some extent cream skimming is not a new phenomenon. In fact, because fundholders have been funded on an historic cost basis and really expensive patients' costs have been excluded, these fears have not been substantiated to any noticeable extent. At least, there is no hard evidence of cream skimming. Nevertheless, it could become a reality as the Government moves to calculate GPs' budgets on a formula basis. Unless the formula includes factors that compensate for high cost groups of patients, cream skimming may follow. We have demonstrated elsewhere (Journal of Health Economies, 1994) that it is possible and feasible to produce such a formula . If we fail to counteract this incentive, we shall have introduced a fatal virus into the NHS.

To sum up: There are justifiable fears that left to grow as it is and funded in a crude fashion, fundholding could offset its efficiency achievements with equity losses. This is not an inevitable outcome. There are measures that can be taken to spread the benefits of fundholding to all practices and to fund practices in an equitable way that will counteract any likely cream skimming tendencies.

The Way Forward

The existing scheme can be improved in several ways.

Formula funding

A new formula should include risk factors for patients in certain costly categories like diabetics. Practices could return information from their patient records giving details of the number of such patients and receive a higher allocation for them. This information would have to be checked on a sample basis. Some dangers would remain but they do seem less than leaving things as they are.

Extending the Scheme

In North Worcestershire GPs are purchasing the whole range of health services except accident and emergency. This has its attractions but also its dangers. The risk pool has to be large enough and hence GPs must purchase as a group for the most costly and emergency care. The normal fundholding budget could be handled by separate practices as now.

It is also possible to envisage extension to practices not in the scheme. Some small practices may well be able to link up with larger fundholding practices and use their contracting expertise. Others may join a consortium. Many practices are, however, hostile to the whole idea of fundholding. In a number of areas GPs have come together to negotiate with hospitals as a group, with the help of their districts and FHSA, not merely for fundholding procedures but more widely.

This approach has come to be called `locality purchasing'. Districts were originally designed to be the agencies that were responsible for the management of their district general hospital and associated services. Now hospitals are separately managed, districts lose their logic. Contracting skills are scarce and are dissipated in numerous small purchasing areas. There has been an increasing tendency to amalgamate districts and this will go further with the slimming of administrative costs being pressed by government. In an attempt to keep a local input to contracting and to respond to the challenge set by GP fundholding, some of the new larger groupings of district purchasers have introduced a lower local tier. This has taken different forms. In some places this merely amounts to `outposted' district staff being responsible for a small area's needs and local consultation. In others, it amounts to groups of practices coming together to inform the purchasing agency of their purchasing needs. In a few practices may be given a shadow budget rather like a fundholder's but covering most hospital services. The difference is that the GPs do not do the actual purchasing or have to keep within a clear budget limit. These schemes do reflect some aspects of GP fundholding but do not give autonomy or clear financial sanctions and incentives of the kind fundholding does.

Groups of non-fundholding GPs could be allocated a shadow budget equal in size to what they would have received if they had been fundholders. Non-fundholders would then have a collective say in the scale and kind of contracts negotiated by the agency for non-fundholders in each of their localities. The next step would be to delegate to localities a shadow budget for the whole of the acute hospital budget. GPs would then be involved in discussing how much of the budget should go on non-emergency work. Both sets of GPs would get the same split between emergency and fundholding procedures. Fundholders would negotiate on a practice basis for fundholding treatments and non-fundholders would negotiate collectively via the agency. Emergency care contracts would be negotiated collectively for all GPs in a locality.

Our doubts about locality purchasing and budget holding are that localities do not in any real sense exist. GPs in an area have no shared legal responsibility or accountability. Their livelihood is not bound up in the viability of `the locality'. They do not have the same shared responsibility to keep within the set budget. It was precisely these weaknesses that led to the collapse of loose US models of an equivalent kind which tried to act as HMOs without the shared legal responsibility for the budget. The great strength of GP fundholding is that it is building on a well understood legal and social unit – the partnership. Nevertheless, these fears may be groundless. It would bring alternative systems of contracting and groupings into competition. Patients could then choose which kind of purchaser they wished to act on their behalf.

The existence of fundholding has forced districts to come up with alternative systems of contracting. They may hope that it will make fundholding redundant. I doubt it. Many practices will want to preserve their independence. Some will prefer the new agency to do the contracting for them with consultation. Some GPs, of a collectivist frame of mind, will never have any truck with fundholding. So be it. Systems in competition will be good for patients.

The Conservative Government seems to be going down the route of extending GP fundholding and developing viable alternatives for practices who cannot join. The Labour Party is committed to abolishing it – relying instead on some form of locality purchasing. This is likely to be unpopular with many patients and their GPs. It may also encourage GPs to form private fundholding practices charging their patients the relatively low premium it would take. The Labour Party would have then scored three own goals in a row. It would have made a Conservative Government more likely, reduced the Service's capacity to narrow the gap between private health care and long NHS waiting lists and encouraged private care in an area of health care where little exists. The Labour Party will be making the mistake it made with council house sales all over again.

PURCHASING FOR HEALTH: THE DEVELOPMENT OF AN IDEA

Joan Higgins and Jeff Girling

When the white papers, *Working for Patients* and *Caring for People* were published in 1989, the issues which attracted most public and professional attention were almost entirely concerned with the development of the provider market. The debate centred around the establishment of hospital trusts and their status and function in the new NHS. Belatedly, attention turned to the role of community services and to developments in primary care. The introduction of GP fundholding was, of course, prominent but any discussion of the new purchaser role of district health authorities was almost entirely absent. The provider issues did pose real questions about the organisation and delivery of services and about trusts as apparently autonomous units in a fragmenting NHS, but the even larger challenges facing purchasers were barely addressed. Of the seven key changes set out in *Working for Patients*, six were concerned with innovations in service delivery and management, and the seventh with GP fundholding. The main chapters of the white paper, on Self-Governing Hospitals, Funding Hospital Services, The Work of Hospital Consultants, GP Practice Budgets and Managing the Family Practitioner Services reflect this concern with provision rather than purchasing and the only real discussion of district health authorities – in a chapter headed 'Other Issues' – is concerned with the membership rather than the function of the new authorities. Throughout, the focus was upon financing services rather than upon purchasing health care or purchasing for health.

This neglect of purchasing was both a problem and an opportunity. It was a problem for those authorities where there was little enthusiasm for the new role. Some of these authorities were made up of executive and non-executive directors who were left behind when their colleagues moved off to establish trusts. Without a blueprint, they floundered in their attempt to define a role for themselves, when they would really have preferred to be running hospitals. It was a problem, for different reasons, in districts where they were keen to develop purchasing but where they experienced delay in setting up trusts. The continued existence of directly managed units sometimes prevented enthusiastic purchasers from achieving an effective purchaser/provider split in their organisation and set back the progress of purchasing by months if not years.

The lack of direction on purchasing, however, was a real advantage in districts which positively opted for the new role. They were able to use the policy vacuum to define for themselves the key priorities and strategic direction. Some were offered strong support by regional health authorities to develop their role and functions while others suffered benign neglect as regions rushed to encourage provider units towards trust status. Generally speaking, those health authorities which have moved furthest on purchasing and commissioning have been those in which a far-sighted chief executive could see the potential of this new task from the very beginning.

The aim of this article is to determine how purchasing and commissioning became part of the language of the new NHS and what they were intended to achieve. The relative looseness of the concepts has prompted widespread innovation, as GP purchasers and DHA/FHSA purchasers have sought to define for themselves the meaning of the terms and different ways of operationalising them.

Purchasing and Commissioning: the History of an Idea

It is Alain Enthoven, of course, who is normally credited with introducing the notion of a purchaser/provider split to the NHS in a paper published in 1985. What he envisaged, however, is not what finally emerged in the NHS and Community Care Act. His original recommendation was that each district would be given a RAWP-based per capita revenue and capital allocation with which to buy and sell services. The purchaser/provider split did not imply the organisation of provision separate from the district authority. On the contrary, provision was to be kept in-house, although district purchasers would be free to contract with other districts and with the private sector. As Enthoven envisaged it, district purchasing would be about using resources, including staff, more efficiently and with greater flexibility. It was also designed to stimulate the development of improved costing and information systems. Purchasing was not primarily concerned with effectiveness, in the sense of improved clinical outcomes, and it was not oriented, first and foremost, to health gain.

Although Enthoven's notion of an internal market was a radical one for the NHS, it was the basis upon which several advanced health services already organised their business. In North America and in some of the European countries it was the convention that health care was purchased by agencies, such as insurance companies or funds, which were separate in every way from the organisations actually providing health care. In this respect, Enthoven's proposal was more modest recommending, as it did, that both the purchaser and provider function would continue to rest with district health authorities.

As Enthoven observed, the principle of separating purchasing from provision had already been established in 1983 when district health authorities were required to tender for the provision of cleaning, catering and laundry services in the NHS. This process gave every district the experience of drafting contracts and service agreements and of dealing, in a systematic way, with private sector suppliers. Although the majority of contracts were won by in-house bidders, the process of competitive tendering established some important precedents – both in principle and in practice.

Similarly, the idea of GP budgets and GP purchasing had been around for some time before it was embraced by the Prime Minister's Cabinet Committee and incorporated into the legislation. John Butler attributes the earliest reference to the concept to a conference in 1984. Once again, however, the intention was to stimulate the *process* of contracting to improve services and reduce costs, rather than to achieve health gain and better outcomes. Alan Maynard, who was perhaps the greatest advocate of GP budgets in the early 1980s, however, foresaw that GPs who controlled resources could act as patient advocates to purchase more appropriate services. As Butler observes in *Patients, Policies and Politics* (Open University Press, 1992 p 25), whatever the Government's intention, it is interesting in the light of what followed that `the early formulations envisaged GPs, not the health authorities, as the buyers in the market'.

The Implementation of the Idea

When elements of the NHS and Community Care Act were implemented in April 1991, the launch of purchasing and commissioning was accompanied by catchy phrases about `steady state' and `smooth take-off'. The likely impact of total deregulation of purchasing and provision was becoming evident and the emphasis had shifted from one of unfettered market competition to one in which tight controls would be exercised. The potentially damaging effects, upon health services, and politically, of an uncontrolled and uncontrollable market were increasingly evident. As a consequence, many authorities were required to purchase through block contracts which, in most cases, would preserve existing patterns of service provision and would maintain a semblance of stability. The emphasis lay upon developing contracts with existing providers for existing services – a trial run, essentially, for the contracting process rather than for purchasing and commissioning.

In the 1992/93 contracting round the directives loosened up and health authorities were encouraged by the NHSME to take a more adventurous approach to purchasing services. The forward looking authorities took the opportunity to purchase more selectively from a range of providers and began to make significant shifts at the margins. Their aims were various. In part, the shifts were designed to achieve a real change in service provision where local providers were offering poor quality or poor value for money. In other cases the threat of withdrawing contracts was used to force up standards in local hospital and community services. By this stage too some health authorities, especially FHSAs who had little direct purchasing power, were beginning to think not just in terms of purchasing but also in terms of commissioning, where they used their position to achieve, indirectly and through other agencies, desired health outcomes. The more advanced health authorities had also begun to address the question of how to purchase for health gain and how to shift the focus away from processes, such as contracting and costing, to outcomes.

Despite these advances in some areas, there remained many authorities which retained block contracts, where the emphasis was upon a minimalist approach to purchasing and commissioning and where no thought was given to the aims and goals of the purchasing process.

Sharon Redmayne *et al* concluded in their recent review of district purchasing plans for 1993/94 (*Sharing Out Resources: purchasing and priority setting in the NHS*, NAHAT, 1993) that the vast majority of authority purchasers are not yet addressing the question of priority setting and are continuing to contract with existing providers for a similar range of services. 'Incremental, marginal changes in the overall balance of priorities', they conclude, `still appears to be the norm' (p 5). They add, however, that this does not necessarily suggest that purchasers are simply maintaining the *status quo*. While they appear to be committed to current providers and existing patterns of service they are beginning to require major changes to the way in which these services are provided. As Redmayne *et al* conclude:

> *The first goal of most purchasers, it would seem, is to improve the efficiency and effectiveness of existing services – often by making radical changes to the way in which these are organised and delivered – before moving on to the more challenging task of trying to re-shape the inherited pattern of priorities in the NHS. This still appears to be tomorrow's agenda (op cit, p 7)*

The picture on purchaser development, at authority level, remains mixed. The complexity of purchasing and provision and the organisational turbulence since 1991 have made districts cautious in their plans to change priorities and patterns of provision. Uncertainty about the consequences and lack of knowledge about how to purchase effectively for health gain have lead to understandable conservatism. It has been at primary care level, then, (where purchasers are smaller and where the overall consequences of their exercise of choice may be less dramatic) that the greatest innovation and experimentation has been evident. It is at this level too where purchasers have been prepared to explore more imaginatively what the concept of purchasing does, and could mean that the idea has been developed in its most sophisticated form.

Innovation in Principle and Practice

Despite the slow start in the development of purchasing at authority level, there have been notable innovations in primary care purchasing, involving both fundholding and non-fundholding GPs. Indeed, the impact of primary care purchasing, over the longer term, is likely to determine whether purchasing does, in fact, become the main engine of reform in the new NHS or whether the *status quo* is largely maintained. The NHS has always tended towards a conservative, top down, centralist culture. However, the growth of primary care led models of purchasing and commissioning provides an opportunity to shift the focus of stategic decision making towards health gain and greater accountability to local communities. It reflects a more decentralist set of values which challenges conventional models of NHS management.

There can be little doubt that GP fundholding has had a major impact upon the attitudes of health authorities towards primary care. What started out as a marginal, but interesting experiment has radically transformed the agenda. As a result there is probably no health authority in the UK which does not now have a stated commitment to working in a `locally sensitive' way with GPs and in some form of partnership with local communities. Although there are now more options than simply orthodox fundholding, it has certainly provided a powerful catalyst for change.

Because of the diversity of approaches now beginning to flourish, it is important to clarify the terms which are in use and to explore the different models which are evolving. For the sake of the present discussion, *commissioning* is taken to mean the process of getting the right services in place, either by directly purchasing them or by influencing the purchasing decisions of others. *Purchasing* on the other hand is the direct use of a budget to obtain services. There are five broad approaches to locally sensitive purchasing which are currently in use:

First, there are those approaches in which the purchasing decisions are retained by the health commissioning agency, but where geographical localities are used to `sensitise' the centrally made decisions. To sensitise, in this context, means to take account of the views of those who live in or who provide services to the locality. This is *locality sensitive purchasing*. In terms of decentralisation this model is the least radical and marks the least departure from the traditional top down approach to decision making. The major resource allocation decisions are taken by the institutional purchaser, (usually the district), but the intelligence gathering function, which informs decisions, lies at the locality level. However, there is no devolution of budgets or actual purchasing power.

Second, there are those approaches in which the purchasing decisions are retained at health commissioning agency level, but where those decisions are sensitised to the purchasing preferences of general practice. This is *practice sensitive purchasing* and usually culminates in the setting up of notional budgets for general practice. It is also possible to regard this approach as *practice based commissioning*, in that practices indicate their service requirements and the health commissioning agencies act as purchasing brokers on their behalf. In this model the locality plays a minor role and the central relationship is formed between institutional purchasers and GPs. Although the purchasing budget is retained centrally, the revenue costs are notionally disaggregated down to GP practice level. In this way it is possible to track the cost activity within primary care and the costed activity which is triggered by referral to hospital. The organisational and financial responsibility for purchasing and contracting remains with the institutional purchaser but GP preferences can be strongly reflected in the pattern of purchasing.

Third, there are those approaches in which purchasing decisions are taken at locality level. This is *locality based purchasing*. At present there are basically two variants of this model. In one variant the purchasing decisions are made by locality purchasing managers deployed by the health commissioning agency working at geographical locality level. In the other case, the purchasing decisions are made by a consortium of general practices, with the locality equating to the aggregate of the relevant practice populations. In both variants a proportion of the total revenue available to the district is actually devolved to the locality, which essentially becomes a cost centre. Budgets may cover the full range of services, although exceptions are normally made for high cost, low volume services, where the population base would be too small to make meaningful purchasing and planning decisions.

Fourth, there are areas in which the purchasing decisions are ultimately taken at health commissioning agency level (as in locality sensitive purchasing) but where there is also significant commissioning activity undertaken at locality level. This is *locality based com-*

missioning. The difference between locality based commissioning and locally sensitive purchasing is that the former works within, and as part of, the locality in a manner similar to models of community development. The latter, on the other hand, tends to treat the locality essentially as a source of intelligence for purchasing decisions taken elsewhere. In locality based commissioning there is devolution of two key tasks. First, localities take responsibility for service development and, second, they are expected to take a pro-active role in community participation and self help. The local commissioning function is carried out either by a manager or by a small team, working with general practices, health and social care providers, consumer interest groups and local populations to ensure that local services are focused upon local circumstances and local needs.

Fifth, there are those approaches in which purchasing decisions are taken at GP practice level. This is *practice based purchasing*. This approach includes GP fundholding in the conventional sense. It also allows for radical extensions in which practices assume a greater responsibility for directly purchasing a wider range of services for their practice populations and are given a budget (either notional or real) to reflect that extended role.

In this approach the district allocates an actual practice budget on a capitation basis to cover total purchasing requirements. Contracts can be set at practice level as they would be in orthodox fund holding. This approach entails a more strategic approach to needs identification and assessment than is usually the case within general practice. The role of the district is to provide technical support and advice, as required, to develop the purchasing function at this devolved level. The purchasing and contracting infrastructure is based in the practice and discharged by practice employed staff.

There is clearly no single model for devolved purchasing and commissioning and the NHS and Community Care Act has spawned very varied innovations. It is important that lessons are learned from these existing projects, not only to identify the critical success factors but also to anticipate what the next steps might be in the development of primary care purchasing and commissioning. The next section of this article examines two projects at the leading edge of experimentation in primary care and looks ahead to the future of primary care led commissioning.

GP-led Locality Based Purchasing

This form of primary care purchasing and commissioning is currently being developed in West Yorkshire. The Worth Valley Health Consortium, consisting of eight GP practices, has been formed to assume purchasing responsibilities for a locality of around 60,000 residents in the Keighley, Oakworth and Haworth area. In April 1994 the Consortium received a budget for hospital and community health services worth approximately £21 million for 1994/95. Even though the eight practices have all become fundholders, in order to facilitate this development, the scheme goes well beyond conventional fundholding. The Consortium budget is designed to cover a full range of services, other than low volume, high cost services, such as paediatric cardiology. As the Worth Valley project evolves it is likely to promote the following changes:

- a potentially new relationship between general practice and health commissioning agencies, with the Consortium becoming a sub-committee of the agency. GPs would retain their independent contractor status but would be central to the wider debate about service priorities and rationing choices, as full partners with the health agency;
- a potentially new pattern of relationships within general practice. The creation of the Consortium has created the conditions – and indeed the requirement – for collective decision making as against the traditional practice-focused individualism. Independent action is protected, but the creation of the Consortium has required the negotiation of appropriate forms of inter-practice communication and dialogue;
- a potentially new approach to assessing needs from the `bottom up'. Since the introduction of the NHS and Community Care Act, health authorities have been developing tools and methods for this key function. However, few of them yet have a full picture of patterns of need and morbidity at local level, and orthodox fundholding does not provide all the answers in those areas where it has become established. The locality based approach requires practices not only to assess, comprehensively, the needs of their practice populations but it also requires that practices collectively assess the needs of the whole population of the locality. It is possible, in principle, to develop health gain strategies at both the practice and the locality level;
- a potentially new approach to giving local communities a greater voice in the services which are purchased on their behalf. This depends on an informed dialogue between these communities and decision makers in the Consortium;
- a potentially new way of funding primary care. The locality purchasing budget will be allocated on a weighted population basis from within the overall health commissioning agency budget – in other words a `fair share' of purchasing power for the locality;
- a potentially new opportunity to link health and social care commissioning/purchasing at locality level, in which the creation of an actual or notional

`joint account' between the Consortium and the local authority may be a possible future development.

Locality based purchasing opens up a whole new area for the evaluation of the strategic role of general practice within purchasing and commissioning and it challenges assumptions about how best to purchase and commission services at a point closest to the local community. If practice populations become the basic building blocks, aggregated up as appropriate, this form of primary care led purchasing and commissioning marks a significant advance in decentralised decision making.

Of course, any enthusiasm for such models has to be tempered by a recognition of the unresolved issues. Locality purchasing arose, in part, as a response to the bureaucratic, centralist, top down approaches. However, although GPs may be very close to patients and their needs, and although they may be effective and efficient purchasers, they are also providers of services themselves. It may take some time before the full impact of distinguishing between purchasing and provision is recognised at practice level.

Practice-Based Purchasing

This model of purchasing is developing most clearly at Castlefields Health Centre in Runcorn. As with the locality based purchasing project described above, the practice will increasingly have access to a full purchasing budget, as opposed to a notional allocation. The health commissioning agency is considering the allocation of an actual practice budget, on a capitation basis, to cover all hospital and community services requirements. Contracts can then be set at practice level, as they would be in a conventional fundholding practice although the practice will be purchasing a full range of primary and secondary services.

In some ways, the practice based model has some of the qualities of a modified form of an American Health Maintenance Organisation (HMO). HMOs exist to provide integrated service packages to meet the needs of their subscribers. In some fundholding practices, such as Castlefields, the emphasis is upon primary care development and service development as much as it is upon primary care purchasing. The UK HMO would need to have sufficient purchasing power to ensure that their registered patients have access to packages of care, which it would provide itself or which it purchased directly. This model can be extended to cross the primary/secondary care boundary and the health/social care boundary especially if the practice gains access to the necessary resources. At the time of writing the Castlefields practice is exploring the possibility of a notional social care budget which would enable it to become a social care commissioner.

The strength of this model is that it goes well beyond orthodox fundholding in exploring the full potential of practice-based purchasing of both health and social care. It allows practices with a strategic vision to break free from the constraints of existing models of purchasing to experiment with new possibilities in the internal market. However, a practice based approach may reduce the ability of purchasers to engage fully in wider population planning and health needs assessment. The scope for more broadly based work will be limited by the size of the practice population.

These examples demonstrate that, although health authority purchasing may have been slow to develop after 1991, there have been some important innovations in primary care purchasing and commissioning. There are many who would argue that the real future of purchasing and commissioning lies at this level and that it should be a bottom up focus which challenges the traditionally unresponsive centralist approach. Certainly the experience of the last three years has shown that virtually all the more forward looking and imaginative innovations have occurred at the locality or practice level, where purchasers and providers are close to the needs of populations and where their response can be flexible and immediate. There is no reason to think that purchasing and commissioning will not continue along these lines – driven from below, but facilitated from above.

What is Purchasing For?

The discussion above has focused upon the organisational arrangements which have evolved in Britain to meet the requirements of legislation and to promote the purchasing and commissioning functions in the new NHS. These are important in themselves but they beg a really crucial question. What is purchasing for?

The answer to this question was not at all evident in the establishment of the internal market after 1991. There have been a number of *post hoc* rationalisations which have greater and lesser degrees of plausibility. One argument is that the purchasing function was devised as a challenge to the traditional provider dominance of the NHS. It was created to probe and to question the *status quo* and to focus upon what was needed instead of what was provided. It was suggested that it was a way of tackling the `London problem' of an over concentration of hospital services, without the need for overt political intervention. It was argued, also, that its main purpose in a resource starved NHS was to provide a vehicle for a more open rationing process, which would involve the local population as well as health professionals. Others saw it as a more positive move to involve users and carers in decision making about resource allocation and service development. Many saw the real benefits of purchasing and commissioning arising from the obvious need for better costing and information systems in the NHS.

The growth of the purchasing/commissioning function has served all these purposes in the last three years. This is not to say that, originally, there was a grand and coherent plan for purchasing or that this is what it achieves best. On the contrary, the real and potential roles of purchasing and commissioning require greater thought and further experimentation. This is clearly evident in the development of purchasing and commissioning. Unless we are clear about the strategic purpose of purchasing and commissioning, then it is not possible to be properly innovative. As Drucker put it in *Management* (Pen, 1979 p 44), we should not only focus on `doing things right', but also on `doing the right things'. These deeper questions have barely been addressed in the policy documents which have informed the development of purchasing and commissioning thus far. The `seven stepping stones' to successful purchasing which the Minister of Health described in June 1993, for example, identify the processes and structures which may be required but do not confront the key issues of purpose and intent.

Purchasing and Commissioning as Ethical Rationing

The relatively loose understanding of the purchasing and commissioning functions in the NHS has meant that many agencies, especially at the primary care level, have been prescriptive in their interpretation of the terms. There has been no blueprint for purchasing – at most a series of guidelines and targets. We suggest, in this last section, that there can be a coherent framework for purchasing and commissioning, which sets up a series of tests against which purchasing decisions can be measured. It is not a straitjacket or a formula but a clear backdrop against which purchasing and commissioning can evolve in the NHS. We describe this framework as *ethical rationing*.

Rationing has always been a feature of the NHS and, to different degrees, of all other health care systems. Decision making involves choices. It is about judging options against likely outcomes. There are always consequences – either positive or negative. Management decisions are not scientific, but they can be supported by a framework for making appropriate, fair and effective decisions. `Good' decisions and `right' decisions require clear criteria. Such a condition applies to any strategic enterprise. It certainly applies to health commissioning. There are inevitable and unavoidable problems associated with meeting the health needs of local populations. At the heart of the health commissioning function lies the concept of rationing. The challenge for health commissioning agencies is to rescue the concept of rationing from its negative associations with service reductions made in a non-accountable manner and to turn it, instead, into a powerful mechanism for ensuring the efficient and fair distribution of scarce resources.

Moving towards ethical rationing requires a recognition that purchasing and comissioning have not just financial and organisational implications but ethical ones too. We would argue that the internal market should be managed not just to ensure value for money but also to ensure that the arrangements and decision making processes of resource allocation satisfy ethical criteria. For that reason the key issue is `who gets what and why?' An essential step in developing the idea of purchasing and commissioning, therefore, lies in devising a framework for ethical rationing.

A framework for ethical rationing

The starting point for the development of an ethical framework for purchasing/commissioning has to be the identification of the core principles which capture the essence of the basic values of the NHS. This is not without problems. As David Seedhouse recently observed in *Fortress NHS: A philosophical review of the National Health Service*, (Wiley 1994 p 11) the NHS has a `muddy history' and `muddled principles'. He quotes Klein's view expressed in *The Politics of the National Health Service* (Longman, 1989, p 28) that the NHS is `a never-ending attempt to reconcile what may well turn out to be the irreconcilable aims of policy'. Nevertheless, we can turn to a number of policy documents which enshrine a set of values and aspirations which would be likely to command wide support amongst politicians, managers, health professionals and service users. The Royal Commission on the NHS, established by a Labour Government, and reporting in 1979, and *Working for Patients*, the basis for the Conservatives' health changes, shared a similar perspective. It is possible to derive a composite statement of principles of the NHS from those two documents: see Table 1.

These form a backdrop. Against that backdrop two issues need to be addressed.

Table 1: Principles of the NHS

Encouraging and assisting individuals to remain healthy
Equality of entitlement
A broad range of services of high standard
Equality of access
A service free at the time of use
Satisfying reasonable expectations of users
A national service responsive to local needs
Value for money

First, there is the need to test purchasing/commissioning decisions. In other words what are the criteria against which these decisions should be made to ensure that ethical rationing is taking place? Second, what types of organisational arrangements might be most conducive to the development of an ethical rationing approach within the NHS? What qualities would a health commissioning agency require for it to mature into an ethical rationing organisation?

A health commissioning agency wanting to pursue ethical rationing needs to answer three questions in making resource allocaton decisions:

- Will the outcome maximise health gain?
- Will the decision ensure equity?
- Will the decision satisfy the requirement of due process?

There are obvious difficulties in defining concepts such as health gain and equity in ways which allow them to be operationalised. Nevertheless, the *principle* of testing each key decision against the tenets of ethical rationing is relatively simple.

In evaluating the models of purchasing and commissioning which have been discussed in this chapter we need to apply these tests. It is too early to say that one model should be preferred over another on the basis of the information we have so far about their effectiveness. Nevertheless the ethical rationing framework gives us a set of principles against which to measure their contribution. While these principles may not be all encompassing they do, at least, lay down some markers.

Until we respond, quite explicitly, to the challenge of what question we are trying to answer in developing purchasing, we are in danger of spawning a whole series of organisational models all seeking a rationale. We have argued, in this article, that primary care led purchasing is likely to get closer to the ideal of ethical rationing than more centralised, top down, models. Within that `locally sensitive' framework some variants will have more of the qualities of an ethical rationing organisation than others. The next stage in developing purchasing organisations will be the rigorous collection of data which allows us to test both decision making processes and organisational structures against the principles outlined above. In that way we can work towards the creation of commissioning agencies which have a clear purpose, working within a coherent framework of aims and values.

COMMUNITY CARE ONE YEAR ON: AN IMPLEMENTATION DEFICIT?

Bob Hudson

On 1 April 1993, two years later than originally envisaged, the community care reforms were finally required to be implemented in full. Unlike the health care changes, the proposals on community care seemed to be uncontentious, almost apolitical – the War of Jennifer's Ear had no political counterpart in the Battle of Mabel's Domiciliary Support. Political consensus seemed to be matched by professional support; the key issue then became one of policy implementation rather than policy content. The wisdom of such a consensus will probably puzzle future social historians; moreover the implementation issue itself should not be regarded as a straightforward matter.

Academic thinking on policy implementation has fairly rapidly evolved from a starting point in which the implementation of policy into action was seen as being normally unproblematic, towards a recognition that implementation can be blocked or distorted at a number of stages. In effect, this represents a shift from a simple focus upon `top-down' approaches to implementation, to a `bottom-up' perspective which recognises the *de facto* power of what Michael Lipsky calls `street-level bureaucrats'. In thinking about implementation of the community care changes, it will be useful to distinguish between different types of policy objective and the organisations or actors most likely to hold an implementation responsibility for each of them. Although the divisions can never be watertight, a threefold distinction is possible, and this will constitute the framework for this article.

1 Political and Strategic Shifts: the central government agenda.

- new funding arrangements to avoid the `perverse incentive' towards institutional care;
- the promotion of a flourishing independent sector;
- clarification of agency responsibilities.

2 Managerial Shifts: the local policy agenda.

- promoting day, domiciliary and respite care and carer support;
- developing performance measures and quality systems;
- shifting towards the `enabling authority' role.

3 Front-line Practice: the dilemma of the street-level bureaucrat.

- implementing assessment and care management.
- the involvement of users and carers.

Breaking the implementation agenda down in this way makes it possible to put two propositions to the test. First, that implementation becomes more problematic as the agenda moves from category 1 towards category 3. Second, that the aspects of the reforms which have carried the greatest consensus – category 3 – will also prove to be the most difficult to implement.

Political and Strategic Shifts

The need to put a stop to the rapidly rising open-ended budget for independent residential and nursing home care was probably the main imperative behind the community care reforms, yet it was ideologically important to the Government to keep faith with independent sector providers. At the same time there was an acknowledged need to encourage and promote collaboration between health and social care agencies – an objective which seemed to lie uneasily with a market-oriented strategy. The reconciliation of these three objectives constitutes the central government agenda.

New funding arrangements to avoid the `perverse incentive'

In April 1993, the basis of entry into independent sector social care shifted from an unassessed social security subsidy to a professionally assessed discretionary supplement to minimal social security entitlements. Local authorities were to become responsible, in collaboration with health care professionals, for assessing the needs of new applicants for public support and making arrangements to meet the assessed needs. According to the white paper, *Caring for People*, the intention was `to ensure that people enter homes only when a proper assessment of their needs has established that this is the right form of care for them within available resources'.

To enable local authorities to do this, the Government was to transfer to them monies which would otherwise have funded care through social security payments to people in residential and nursing homes.

Reallocating flows of money to secure shifts in configurations of support is a policy activity with a high prospect of successful implementation – the very growth of independent sector institutional care in the 1980s bears testimony to this. The main threat to successful implementation would be an insufficiency of reallocated resources; in fact, disagreement between the Government and the local authority associations over the amount of transferred money – the Special Transitional Grant – characterised the immediate pre-implementation period, as described in Part I of *Health Care UK 1992/93.*

In the event, many local authorities found themselves underspent towards April 1994. Several reasons may account for this – delays in completing assessments, cautiousness in exercising a new responsibility and, most importantly, the rapid influx of entrants just prior to April 1993 in order to benefit from the old rules which resulted in a lower than anticipated demand for care. The national monitoring exercise by the Social Service Inspectorate and Regional Health Authorities *Community Care Monitoring: National Summary,* reported spending below expectations in half of the authorities surveyed and also reported rates of diversion from residential care of about 10 per cent. Since rates for the allocation of domiciliary packages were not correspondingly high, this may suggest that people who might have been offered institutional care in the past have now been found after assessment to have much lower care needs.

The promotion of a flourishing independent sector

The pre-April 1993 arrangements effectively operated a voucher system for people on low incomes who entered independent residential care or nursing homes. By placing local authorities in a gatekeeping role, the Government seemed to be leaving private homeowners in a particularly vulnerable position, especially where they were dealing with local authorities ideologically hostile to the private sector role in social care. To counteract this, the Government laid down a requirement that 85 per cent of the Special Transitional Grant should be spent upon independent sector providers in 1993/94 – a condition which has been retained also for 1994/95. This is a strategy which bears all of the hallmarks of policy-making on the hoof, and as such, it can be expected to face implementational difficulties.

The main problem facing local authorities over the 85 per cent rule has been finding something upon which to spend their money without simply continuing the perverse incentive towards institutional provision. Independent non-institutional care is not widely available and local authorities have a poor record of encouraging it, as we see below. This has meant that the bulk of the transferred money has simply been recycled into existing institutional providers. Indeed, where the demand for such care has been much lower than anticipated, local authorities have found themselves unable to offload their money at all. The national monitoring exercise reported some authorities `seeking additional guidance on legitimate ways of spending the special transitional grant'. Early 1994 was probably a boom time for the supply of mini-buses to voluntary sector organisations! The Government seems to have painted itself into a corner here, and has so far failed to resolve the tension between two of the key elements in its programme.

Clarification of agency responsibilities

One of the key objectives of *Caring for People* was `to clarify the responsibilities of agencies'. An intersection felt to be particularly in need of clarification was that between health and social care. The white paper admitted that the history of joint working was not encouraging, but simply urged local agencies to draw up their own agreements upon the health/social care distinction and impressed upon them the central importance of collaborative activity. The broad aim is to encourage a plurality of providers who will compete for contracts to provide services, thereby freeing managers from day-to-day operational matters and thereby allowing them to focus on strategic and collaborative issues. However, there is clearly a danger that competition among providers in search of `business' may lead to greater fragmentation and create an environment which is even more hostile to joint working.

Monitoring of the early implementation experience reveals a number of weaknesses. The Laming-Langlands Letter of December 1993 [EL(93)119] laying out those elements of the implementation agenda requiring close attention, highlighted several problematic intersections:

- independent sector providers continued to feel excluded from the planning process;
- health authorities had paid insufficient attention to the consequences of community care policy for investment in and management of the community health services. The two needed to keep pace with each other;
- health purchasers need to have a clear view of the implications for both primary health care and community care of the changing pattern of acute health care;
- more generally, the Letter stated:- `We cannot stress too strongly the continued need for collaboration and joint working in all areas' and went on to acknowledge that this could be threatened by current organisational upheavals. It hoped that `internal and personal uncertainties' would not be allowed to inhibit progress – perhaps a recognition of the importance of those with implementational power.

Joint commissioning between health and social care purchasers is increasingly seen as one way of addressing fragmentation, but it is an idea which has yet to be put seriously to the test. Early attempts have been thwarted on legal issues of sovereignty and accountability, and it is difficult to see purchasers easily securing agreement upon shared values, aims, outcomes, strategy, service specifications and monitoring. There is the further difficulty of matching up micro `spot' contracting for social care with macro block contracting for health care. The national monitoring survey found `some evidence of joint commissioning', and felt further development was needed, but this is unlikely to happen without clarification and guidance from the Department of Health.

An alternative to such voluntary collaboration, is for the centre to require evidence of collaborative activity as a condition of access to funding. This is precisely the line which was taken in the community care funding settlement of October 1992, which as a condition of access by local authorities to the special transitional grant, required evidence of local agreements on access to nursing homes and hospital discharge arrangements to be lodged with the Department of Health by the end of 1992. Every locality managed to come up with an agreement, and the national monitoring exercise reported little change in levels of bed-blocking after April 1993 – a finding which has been disputed by a British Medical Association survey (The Guardian 26.11.93). It is unlikely that the lodging of hastily assembled agreements with the Department of Health will equate with the implementation of those agreements. Melanie Henwood and Gerald Wistow (*Hospital Discharge and Community Cares Early Days,* Nuffield Institute 1993) found tensions between health and social definitions of good practice, and the whole field is bedevilled by disagreement and confusion over who holds responsibility for continuing care.

Managerial Shifts

The local managerial agenda is partly about securing ends – promoting non-institutional support – and partly about developing fresh means – developing the tenets of `new public management'. These require not so much a new way of working, but rather what the Audit Commission has described as a `cultural revolution'.

Promotion of domiciliary, day and respite care and carer support

As noted earlier, one of the key objectives of *Caring for People* is the promotion of alternatives to institutional care, and the 85 per cent rule in effect requires the bulk of new development to come from the independent sector. It is not clear how this can be achieved. Private domiciliary care and home nursing for elderly and disabled people has traditionally been a cottage industry with little expectation of big profits. Indeed, many such providers have been able to retain modest charges only by acting as a conventional employment agency, not directly employing staff and not administering PAYE or national insurance contributions. On the other hand, the combination of economies of scale and property appreciation will incline corporate investors towards `continuing care' complexes with day care, sheltered housing, residential and nursing care on the same campus – the very antithesis of the objectives of the white paper.

The broad response from the Department of Health has been modest – the allocation of £6 million to experimental schemes to develop and promote the supply of independent sector home care. Diana Leat in *The Development of Community Care by the Independent Sector* (Policy Studies Institute 1993) casts doubt upon the argument that the availability of money through local authority contracts will create supply; if it does not, this would leave the local authority as purchaser in the position of having to stimulate supply. The national monitoring exercise admitted that little progress had been made on this front, but failed to grasp the link between this fact and the 85 per cent rule, which gives local authorities a continuing incentive to opt for the stable outlet of institutional care. In any case, the capacity of local authorities to divert people from institutional care may have been overestimated. Jonathan Bradshaw and Ian Gibbs in *Needs and Charges; a study of public support for residential care* (Avebury 1988) estimated that only seven per cent of people were unnecessarily in residential care under the old rules, which implies little room to reduce the size of that sector.

The high priority to be given to carers has been left largely at the level of exhortation – carers have no fresh entitlements as a result of the 1990 Act. Where greater attention has been paid to them, there is the danger of equating carer interests with user interests. *Community Care in Transition,* a 1994 study of four local authorities by the School for Advanced Urban Studies at the University of Bristol, reported that social services managers and fieldworkers generally gave priority to the needs of carers over users, with users sometimes pressurised into accepting services they did not wish to receive such as inappropriate day and respite care.

Development of performance measurement and quality systems

Some of the organisational structural obligations under the 1990 Act have actually been in place since April 1991 as part of the first phase of implementation. In particular, inspection units have been established and new complaints procedures put in place. However, even at this early stage, the Department of Health has indicated an unwillingness to leave the inspection units with social services authorities, and there is the prospect of a move to a separate department within an authority or even the creation of a national inspectorate. The actual effectiveness of the units remains open to question. Although such regulatory activity is generally seen as desirable, there remains a concern that there may be little relationship to improved standards. It is arguable that regulation does not represent investment in service improvements so much as an investment in purchaser safety to satisfy a statutory conscience, and this may lead to inspection simply becoming an end in itself. Strictly, the inspection unit remit only runs to residential settings, and the national monitoring exercise reported few instances of attempts to extend into day or domicilary care. Similarly, complaints procedures were found to be little used, with one fifth of authorities recording no complaints at all.

The wider development of a quality infrastructure seems to be emerging painfully slowly. A survey of a dozen local authorities in 1993 by Peat Marwick for the Department of Health, *Informing Users and Carers*, (Department of Health 1994) found very little evidence of strategic thinking about the role quality assurance had to play, with an agenda of issues only now beginning to emerge slowly. This is reflected in the strictures contained in the December 1993 Laming-Langlands Letter on `the widespread need to improve management and financial information systems . . . Present systems make it difficult for authorities to monitor the working of their own arrangements satisfactorily'. Social services departments will face considerable difficulties in developing an appropriate framework for market activity. Unlike the NHS they are virtually starting from scratch in developing performance indicators, standardised data sets, opportunity-cost type initiatives and appropriate information technology. There will have to be a huge investment in the development of `enterprise culture' activities if social service departments are to orchestrate a quasi-market effectively, but few funds have been specifically allocated for this.

The shift towards the `enabling authority'

As I argue in *Making Sense of Markets in Health and Social Care* the concept of the enabling authority is the principal means by which it is intended to construct a market in community care. This requires movement on several fronts – developing a purchaser/provider split, refining a commissioning role, engaging in contracting and stimulating competition. It is not currently evident that any of these tasks are being satisfactorily handled.

The ways in which purchasers are split from providers seems to vary enormously between localities. A 1992 survey by the Association of County Councils found a common response to be one where budgets for in-house providers were held by provider managers, but those for external providers were held by purchasers, giving rise to a concern that dual standards may be applied to internal and external providers respectively. It is a concern which has been echoed in the 1993 national monitoring exercise, which found the majority of local authorities planning to remain significant providers of services. The Laming-Langlands Letter was critical of this position and called for a clearer separation of purchasing and providing roles, greater competition between in-house and independent providers, and a proper comparison of the relative quality, appropriateness and cost-effectiveness of all potential service options.

However, a more distinct purchaser-provider split will be of little avail unless local authorities develop an effective purchasing role. The first logical steps would be to undertake some assessment of the need for social care and then assess the potential of suppliers to meet that need. In evidence to the Health Select Committee enquiry into Community Care, the Audit Commission estimated that only about half of social services departments had made progress on need assessment, and even those who had made progress were unlikely to have linked this work to budget forecasting or a rational allocation of resources across the authority. With such an approach, eligibility criteria for access to care would constitute the encapsulation of purchasing priorities, but in its 1993 review of progress, *Taking Care: Progress with Care in the Community*, the Audit Commission expressed itself to be `somewhat alarmed' that many authorities had yet to set clear criteria for many areas of activity.

Without a clear purchasing vision, contracting can become an aimless activity, yet it seems likely that far more local effort has been put into contracting than commissioning – the means rather than the ends. Both the national monitoring exercise and the Audit Commission survey report that in an attempt to offer choice to service users, most authorities have relied initially upon spot contracts – buying places individually to meet individual needs – or `call-off' contracts – buying individual places as needed within an overall contract which specifies price, terms and conditions, but not the number of places. Indeed, only one authority was found to be relying upon block contracts. However, the Laming-Langlands Letter seemed to suggest that authorities should move more towards block contracting. It noted that purchasers needed `to balance their own need for purchasing flexibility against the providers' need for a degree of stability and volume of business to make the investment worthwhile'. Purchasers have been able to take a strong stand on spot contracting mainly because there has either been a surfeit of providers or providers have had such high occupancy rates that they could afford the occasional spot purchase. Neither condition can be expected to be sustained in the medium term.

Front-Line Practice: the dilemma of the street-level bureaucrat.

The broad implementational problem confronting policy-makers at both central and local level, is that policy is rarely applied directly to the external world, but rather it is mediated through other institutions and actors. Policy implementation is therefore at risk of distortion by these mediators. An important line of inquiry is the behaviour of those workers whom Lipsky calls `street-level bureaucrats' – those who `interact directly with citizens in the course of their jobs and who have substantial discretion in the execution of their work'. Typical street level workers would be social workers, community nurses and care managers. These have the critical task of implementing the community care reforms at the sharp end with users.

Implementing assessment and care management

The requirement upon social service departments to introduce some form of care management with devolved budgeting poses a threat to centralised management relationships. Difficult decisions are being made on the extent of the purchaser-provider split, the development of financial management systems and the financial management skills of front-line staff. The *Manager's Guide* to *Care Management* (Department of Health 1991) takes an equivocal stand. On the one hand it recognises that front-line staff need to be given sufficient purchasing power to engage their enthusiasm; on the other it acknowledges the economies of scale that arise from centralised purchasing. The evidence from the national monitoring exercise, the Audit Commission survey and the Bristol University research suggests, in line with my analysis in *Health Care UK 1991*, that care management still faces a number of teething problems:

- uncertainty over the organisation of care management: authorities seem to be divided between those who see care management in terms of a process which involves a range of staff, and those who see it as a distinct function performed by individual care managers. It is far from clear which of these might be the most effective;
- complex and burdensome assessments: in some areas, assessment is said to be taking over all social work time, especially for hospital social workers. Often this is mostly due to complex assessments, and those deemed to require something less than a complex assessment are being marginalised. However, the effectiveness of this activity again remains unclear. Although some instances of unmanageable assessment schedules are given, many authorities have yet to link their different assessment levels to eligibility criteria. Monitoring of the assessment process is often inadequate or absent and it is not clear how far information arising from the assessment process is used to inform strategic planning;
- the delegation of budgets to care managers: needs-led assessment is of limited value if service responses remain inflexible. The Laming-Langlands Letter is adamant that flexible care packages are most likely to be created where purchasing and providing roles are clearly distinguished and there is a high level of delegated responsibility for accessing resources. The Audit Commission found that nearly all social service departments had established purchasing budgets to some degree, but in just under half it was limited to special transitional grant monies. More than a quarter were still controlling the budget almost exclusively from the centre, but it was acknowledged that this may in part be due to inadequate management and financial information systems;
- integrating care management with health care: the national monitoring exercise still found examples of health staff running duplicate assessment systems alongside the new care management procedures, and this had led to calls for greater integration of social service and NHS activity. One of the main difficulties in doing this is that there is no real equivalent of the care manager in the NHS with the possible exception of GP fundholders. There remains a need to explore new collaborative configurations, such as joint purchasing between care managers and fundholders, or the delegation of budgets to community nurse care managers.

Clearly there are still problems at front-line level in the implementation of care management, but what these top-down monitoring exercises fail to do, is discover the reality of street-level behaviour in daily interactions with service users. An interesting exception to this is the account of the Elderly People in the Community Project in Stirling, Scotland by Harriet Hudson (Health and Social Care in the Community, 1993 pp 115–123). She demonstrates the ways in which both care managers and users attempt to reconcile the dilemma of a needs-lead approach with an insufficiency of time and resources:

- the assessment process tended to be idiosyncratic and its form determined by professional orientation rather than the official assessment form. Care managers preferred to make notes following a visit and use their mental checklist to conduct the assessment. The assessment schedule was seen as a nuisance which got in the way of doing a good assessment;
- care managers found it a struggle to free themselves from a service-led approach to needs; they could not help referring to services in their discussions with users about needs. Users also defined their needs in terms of the services available – what Hudson describes as a `reality rating';
- users lacked knowledge of the services available and tended to define their needs according to a very restrictive definition of what services could be provided. This is related to the low expectations held by users and the limited sense of their own value, opinions and wishes. Any help was gratefully received and there was a reluctance to mention difficulties;
- care managers were reluctant to raise expectations which could not be met and were accordingly reluctant to prompt for unmet need. They also held to a set of implicit rules that determined `deserving' and

`undeserving' needs, with no clear notion of what these categories constituted.

Harriet Hudson's account is a useful illustration of Lipsky's argument that street-level bureaucrats have enormous power which is scarcely acknowledged in the literature on public administration – a power which extends not only to control over users, but also to a considerable autonomy from their employing agency. However, it is significant that the title of Lipsky's book refers not to the power, but to the dilemma, of the street-level bureaucrat. Hudson's findings show how care managers and users are caught up in a situation where demand far exceeds supply, and that street-level bureaucrats therefore end up making policy in circumstances which are not of their own choosing and which impel them to devise strategies to protect their working environment. In this way, Lipsky is addressing the process whereby zeal is eclipsed and idealism corrupted. Top-down monitoring exercises are unlikely to have gleaned the deep level of cynicism and demoralisation which so often seems to characterise those who do the `actual' work of the agency.

User involvement

The involvement, even the empowerment, of service users has been a frequent theme of the new community care arrangements, but since the package of reform rested upon a shift from entitlement to a place in independent institutional care, to discretion, there has never been any good reason to believe that service users will have an effective voice. In effect, a local authority purchases services on behalf of the user, acts as an agent for the user, and by collectivising the purchasing is afforded more buyer power. The danger is that the power may be used more in the interest of the agent than the user and may restrict user choice. The early reviews of structured attempts to involve users in the planning and delivery of services do not suggest that much progress has been made.

The national monitoring exercise reported on some `energetic and innovative campaigns', but found user involvement to be marginal in many areas. The Peat Marwick study of twelve social service departments in June and July of 1993 came to a similar conclusion:

> *Our discussions with users and carers do not suggest they are knowledgeable, well informed and exercising greater choice in the community care process. Indeed we were struck by how little people knew about assessment, charging and care plans.*

And again, the Bristol University research found the ideals of choice and control for users and carers still to be a long way off. In particular, this last study found:

- local authorities had little experience or knowledge of involving users and carers in planning community care services;
- a mixed economy of care is unlikely to replace the `set list' on offer, at least in the short term;
- users and carers have more choice and control over services where they pay the providers directly.

Conclusion

Although the evidence is patchy and the timetable is still at an early stage, there seem sufficient grounds for suggesting that the community care reforms are characterised by an implementation deficit. Even at the level of central government strategy, it has been difficult to achieve broad shifts of direction, and local policy-makers, managers and street-level bureaucrats have reacted to the implementation agenda in varying and idiosyncratic ways. This conclusion is at odds with the official position – the national monitoring exercise reported an `encouraging picture . . . Almost everywhere, basic structures are in place and beginning to work well', while the Audit Commission talked of `cautious but steady progress'.

The truth is that no one really knows what will happen, because the place of quasi-markets in social care remains uncertain and untested. Fresh opportunities for more appropriate configurations of support may well be possible in the right circumstances, but on the other hand, a pattern of hasty and coercive implementation could easily backfire. In a period where private sector models are simplistically assumed to be modern and public sector models portrayed as old-fashioned, it is tempting for public agencies to bend to the debate and seek to change the basis of their legitimacy. However, even leaving aside the desirability of such a shift, there is the likelihood that change will be merely ritualistic and introduced for the purpose of public expression of ideological commitment rather than to solve specific problems. Finally it needs to be emphasised that social science research and literature has played little or no part in the decision to establish a quasi-market in social care. The danger is that faith has replaced evidence and assertion has supplanted explanation. A simplistic attachment to the alleged virtues of the private sector has overwhelmed sophisticated reflection on inter-professional relationships, inter-organisational dynamics, power-dependence relationships and intra-organisational behaviour. Service users could too easily end up bearing the cost.

HEALTH CARE MARKETS: ABSTRACT WISDOM OR PRACTICAL NONSENSE?

Sean Boyle and Adam Darkins

The establishment of a market in health care services was at the heart of the NHS reforms. When these were introduced, however, the question of what form such a market should take if the benefits of organising the public provision of health care within a market system were to be realised was never fully addressed. As a result, the 'internal' market, as it came to be known, can be characterised as a system in which a new organisational structure was clamped on to an existing set of supply and demand relationships, with little effort made to assess how the fundamentals of this reorganisation - the markets - might then function and evolve. The size and scope of trusts and purchasing agencies reflected decisions on the appropriate size of health authorities made decades ago in a world where competition was as yet unheard of. Indeed, on the contrary, health services were largely provided on quite the opposite basis, with each district having its own facilities.

The NHS reforms were themselves a response to an increasing demand for health care resources threatening the constraints on public expenditure which a probity-conscious Government sought to impose. The key assumption determining the direction which *Working for Patients* took, was that a system of planned delivery of public health care would not be able to meet the Government's objectives. This was combined with a belief that a market solution, albeit within the context of some public control of the agents in that market, would:

- reduce inefficiencies in the provision of care;
- target resources more effectively – and equitably – to needs;
- enhance responsiveness to the public, or consumer.

These may have been the objectives of the reforms but subsequent developments probably owe more to the underlying requirement that the new NHS system is capable of allocating public health care resources so as to meet the seemingly impossible task of matching an ever-increasing demand for health care services with a constrained, or capped, public expenditure budget.

This is one important respect in which the NHS market system differs from the more traditional market model observed in the US. A more fundamental difference perhaps is that the NHS is an internal market and as such does not naturally provide the incentives to its agents which a private market system would. In the US it is possible to have competition between providers which will lead to an expansion of the market, a phenomenon which has indeed been observed throughout the 1980's. Pressure to cap health spending has been ineffective, with providers until recently able to price on a cost plus basis. The result has been US provider investment in technological development in an effort to compete in an expanding market environment.

In the UK, on the other hand, with a strict overall system of financial constraint, there is little opportunity for provider-led market expansion. This in itself acts as a disincentive to innovation – the introduction of new products and technologies. Most innovation comes through growth rather than diversion. Providers may eventually see the need to innovate merely to maintain market share, but this is a relatively sophisticated response. To assert that the mere introduction of markets would herald a brave new world of health service development was just that – an assertion.

Much was claimed for the new system. The slogan 'money follows the patient' reflected the Government's view of how consumer-oriented the new NHS might ultimately become. However, such optimism was based more in a belief in the wisdom of market solutions rather than a fundamental understanding of how a market in health care would work, what positive outcomes it was likely to deliver, and what was necessary for such outcomes to occur.

Even when markets in health care exist outside the public sector, if there are high degrees of uncertainty, high transactions costs, an asymmetrical distribution of information, or externalities, then it is well-known that a market solution will not always be optimal. For the public sector, Julian Le Grand and Will Bartlett have also spelled out several conditions for the existence of what they termed quasi-markets, including the existence of traditional market structures, the flow of information, manageable transaction costs and levels of uncertainty, and appropriate motivation of agents.

Given the initial starting point – a pre-reform NHS in which market relationships had been largely suppressed – and despite the two years of preparation, it would have been naive to expect that a series of markets in health care services would spontaneously arise in April 1991. There was not, as it were, an off-the-shelf market model into which the current system could be slotted in such a way that the likely outcomes were predictable and which could confidently be predicted to produce the desired effects. Even if there had been, the complexities are such that the process of development of markets was always likely to be incremental rather than immediate.

However, there is as yet little sign that the Department of Health or the NHS Executive has recognised the need for a conscious development process. The recent report, *The Management of the New NHS*, signally fails to recognise this need. If it did, it would have to consider three basic questions:

- what is the nature of the products in the NHS market?
- how many and what type of agents should be present?
- what are the legitimate objectives of these agents?

A Market for What?

In any market, it is always possible to look at a more general product from which the demand is derived. For example there are a number of markets for motor cars which derive from a demand for transport. However the more general transport product may be satisfied by non-car products such as bicycles and trains. Equally the car may satisfy needs other than just those of transport. It would be foolish for agents to act as if they were in a simple market for a car. The market for cars can be broken up into distinct parts allowing the behaviour of each sub-market to be studied separately. This process can be seen as one of product differentiation, in which suppliers attempt to match particular characteristics of these sub-markets.

In general, the advantage for the supplier of successfully differentiating the product(s) is to increase or maintain overall market share. Sometimes it may also be possible to extract a different price for a similar good from different types of consumer, though this most often occurs in non-competitive situations. This may have been the case with private and public provision by the NHS at one time, though less obviously now.

The same general model is applicable to health care services. However the evidence suggests that it will take some time for agents in the internal market, both on the demand and supply side, to understand this element of the market place in which they now operate. Both purchasers and providers need to be more aware of the complex nature of the products which they are trading and the possibilities for changes in behaviour which may ensue. So far it has proved easier to maintain existing relationships than understand and react to possible market incentives. There have been notable exceptions as described in the next section when the nature of agents in the market is discussed.

Product Characteristics

The characteristics of most goods and services are generally sufficient to define the product. Even then the identity of the supplier may enter the definition thereby producing at least as many goods as there are suppliers. Restaurants are a good example of this phenomenon with each individual outlet trying to establish its own identity. On the other hand, there are restaurant chains such as MacDonalds which make a virtue out of the homogeneity and cheapness of their product. Possible parallels of the first phenomenon in the provision of health care may be found if particular suppliers succeed in establishing themselves as pre-eminent in a particular field: parallels of the second could only occur if some NHS suppliers began to operate, as private suppliers of eye services already do, at a national level. There is no sign of this at the moment.

Apart from its obvious physical characteristics, the health care product is differentiated by:

- where it is delivered;
- who delivers it;
- who receives it;
- what needs it is intended to satisfy.

The example given in **Differentiating the Product** illustrates the breadth of differentiation which can occur in what might be thought of as a relatively simple situation – where a user wishes to have a consultation in a primary care setting. Why should we expect there to be one price for this service? The potential for differentiation becomes more extensive as the locations and agents in the equation are extended.

Linked Products

It follows that there is no one health service market but many, just as there is no one market for restaurant services but a myriad of sub-markets. However, with health care there is an added complication that the product may be viewed as one event, *eg* one visit to the GP, or a series of linked events taking the user right through a particular care process. Thus use of health services may involve a combination of linked products which introduces the concept of the consumption of multiples of products – hence the need for more complex multi-product markets.

There are well-known examples of this outside of the health care field. The travel agent offers travel services, hotel services, excursions, etc, in various combinations. A series of multi-product markets have evolved in this sphere. In the NHS as it now stands, most hospitals offer a variety of services in different bundles, ranging from a single consultation to a long episode of care. However, as suppliers themselves, they are not 'pure' travel agents, *ie* they are not just co-ordinators of other

Differentiating the Product

A consultation in a primary care setting may seem a relatively homogeneous product. However there are potentially many variants. It can take place in the patient's home or in the GP's surgery. Each is a different product, and is marked as such by the different price which the GP receives. Similarly, it is not always necessary to consult with a doctor. The consultation may be with a GP or with a trained practice nurse who is able to deliver essentially the same advice and treatment. However, these are different products, and might, as in some health care systems, command a different price.

The person consulting the GP may be a young and healthy 25 year old male or an aged 85 year old woman. In each case the nature of the consultation will be different and it might be argued that the resource implications of dealing with the elder warrant describing this as a different product. In this case it is unlikely, under the current system, that a different price will be charged although the GP does receive a differential in the fixed element of pay for the elder patient – whether that person consults or not. Finally, the needs of the person presenting for consultation may be substantially different, from a patient with a minor ailment to one in urgent need of hospital admission. The product is different though it is unlikely that this would be recognised by the current pricing system.

suppliers. In its purest sense that role is currently not performed by any actor in the NHS internal market – whether it will be turns on the incentives facing agents, which we turn to below. If a market for the services of purchasers developed then these agents might come closest to fitting this model of provision.

How far should the process go? There is no standard answer, on economic grounds, to what level of product differentiation, and hence market differentiation to expect nor to how far markets of the travel agent type develop. But better targeting of resources and responding to needs will require more clarity about product differentiation, while the often quoted aim of providing seamless care can only happen if there are agents acting as effective co-ordinators.

In the current situation both providers and purchasers have suffered from the failure of participants in the market process to identify and differentiate products. This, combined with the difficulty of evolving markets for multiples of goods and services, means that there are probably too few markets in the current environment for the potential of a market approach to be fully realised.

If this deficiency is to be overcome, agents must look closely at the very nature of the products which they offer to supply or which they demand for their client populations. These products are inherently heterogeneous. The current low levels of differentiation and current market opportunities exist, on balance, because the present arrangements do not encourage risk-taking behaviour. Again we are brought back to the incentives facing participants in the internal market.

Who is in the Market Place?

A fundamental characteristic of a market is the existence of supply-side and demand-side agents who are willing to interact in respect of the goods and services traded in that market. In most production processes the supplier also acts as a demand-side agent in respect of a set of inputs – crudely, labour and capital – and intermediate products. The car manufacturer demands components and in turn the component maker demands steel. While not wishing to introduce the further complication of the health care labour and capital markets in this paper, some discussion of the supplier's demand for intermediate products will be necessary if the workings of the internal market are to be understood. In particular this derived demand is of crucial importance when considering the supplier as an agent bringing together packages for the final consumer.

Disaggregating the Supply Role

To understand the nature of agents in the NHS market we return briefly to the original purpose behind the development of internal markets. In most businesses there will be decisions to be made about the level of disaggregation of the production and marketing process, and how it is to be co-ordinated. The firm can be viewed as the integration of a series of vertical processes each leading to a further intermediate stage of production. Clearly there will be a limit to how disaggregated an approach can be taken which is set by the available technologies: productive, informational and managerial. At each stage the sub-unit will supply a product which can then be sold on, within the internal market, to engage in the next part of the production process. At any stage there is the option to buy and sell 'internally' *ie* within the firm and, provided costs are properly attributed – often an heroic assumption – the efficiency of the organisation of production is maintained, and sloppiness and inefficiencies are eradicated.

An important consideration in applying this model to the NHS is that the final product is not actually sold in any market. At each intermediate point in the process the product may be produced under competitive conditions but the final product – this might be an object as nebulous as the health of the nation – is not sold on. So at this final stage there is no market equilibrium as a reference point.

Viewed as part of a cost minimisation exercise for producing a pre-determined level of final output, then the intermediate products – the consultation with doctors, the operations, the drugs, – are just inputs to the final part of the production process. The question then is: what should the market structure be for the suppliers of those inputs?

The fundamental split in the organisational structure of the NHS introduced by the 1991 reforms was that between providers and purchasers. But within both types of organisation there can be further divisions in the process of production. The use of trading agencies, compulsory competitive tendering and totally independent organisations for functions as diverse as laundry, catering, computing and financial services, most made as a result of various government initiatives over the last ten years, has produced a degree of disaggregation of the production process with, theoretically at least, a market arising at each production stage.

So far however there is little evidence of the development of markets in professional and clinical labour services which are not attached to the physical unit – the hospital. It is true that the use of agency and bank nurses has been extended but such arrangements are not the norm. However, as Anthony Harrison and Sally Prentice point out elsewhere in this volume, there is no reason why, at a specialty level, teams of doctors should not contract out their services to whichever physical site is willing to meet their price. Such an arrangement is implicit in the hub and spoke models set out for specialist service in some of the London Clinical Reviews. Another example, cited in the Policy Review, is the tender for the provision of cardiac services at Morriston hospital. There is no theoretical reason why this could not become the predominant model in the NHS.

What are Purchasers Providing?

It follows from the previous section that the purchaser/provider split is just one of several possible divisions in function, which happens to occur at the final stage of the health care production process. In essence providers produce services whereas purchasers act as agents in supplying the service to the ultimate users – the public. In this sense their role resembles the travel agent function discussed earlier. The hospital, the nurse, the doctor all operate at the level of producing a service and contract with the purchasing agent who then supplies this to a consumer – ignoring the added complication of the GP who acts as a further intermediary between consumer and product. In principle, this final stage could also be subject to market processes – if for example people were free to choose which purchaser to 'subscribe' to. GP purchasing offers some limited opportunities of this kind but on the whole individuals tend to be assigned to purchasers on the basis of geographic location.

The introduction of a market has highlighted the potential for the process of producing and delivering health care to break up into several component parts. A major unresolved issue is not just the best way for this to happen but how these parts are reconstituted into a recognisable – to the consumer – health care product. Health care is essentially a continuous pathway through a system of care rather than a series of unrelated events. An episode of care might be viewed as a series of events, or a multi-product in the language of the previous section, but it is important to acknowledge the link between these events.

It has long been recognised that the integration of services, the so-called seamless episode of care, is of fundamental importance. This becomes even more the case as there are potentially so many different ways of supplying various aspects of the care process. The role of the co-ordinating agency is fundamental to the successful development of an NHS market system for health care. As things now stand, it falls to the purchasing authority to put together the various elements which make up an episode of care, but this is not the only possible integrating device available. The example provided in **Integrating Packages of Care** shows how CELFACS in east London acts as a co-ordinating agency bringing together a package of care consisting of services which it actually produces and

Integrating Packages of Care

It is interesting that much of the innovative activity, not in terms of new techniques of production, but at the level of market behaviour, has been apparent in the community trust sector. City and East London Family and Community Health Services (CELFACS) is a good example of the development of new approaches to marketing health services, where the divide between the demand and supply side has most clearly been challenged. The chief executive of CELFACS, Hilary Scott, has described the role of this provider-side agency in the east end of London as embracing the family practitioner support and development work of the FHSA with the management of community-based services. She has described some of the new ways in which care will be delivered:

> *The changes we are looking for will not come about by re-organising or re-shaping providers of services alone . . . One example might be placing a contract for maternity services with CELFACS which employs and manages midwives and 'buys on' deliveries and neonatal care from acute co-providers. Another might be contracting for children's services from a community-based trust, where the bulk of care will be provided from general practice and by community-based staff, but secondary and tertiary care will be sub-contracted from other providers by the community trust.*

This is an example of one provider of services extending the type of package of care which it can supply to the market by contracting with other providers. There is nothing to stop a third party, the 'travel agent' acting as a co-ordinating agency in exactly the same way where its only product is the co-ordination. Of course there has to be a purchasing agent able to see the potential in such an arrangement and therefore willing to buy such a product. This may explain why so little of such activity has been apparent so far.

ones which it contracts for from other agents.

As long as the purchaser is the prime integrating device there is likely to remain a tension between the old administrative model which brought together the different care products, generally from a few tied providers, and a true market process where agents supply packages of care to meet the requirements of other agents in the market. Purchasing decisions have tended to be based on historic relationships with what are now NHS trusts. An equivalent in the travel industry might be travel agents who are tied to one or two particular airlines.

There is a potential confusion in the role of purchasers between that of representing the interests of the individuals they purchase for – what might be termed their public health function – and that as a co-ordinating agent bringing together packages of services. Both functions are possible within the same organisation but this arrangement may not be the best way to initiate change. If the old administrative model is to be truly abandoned, and the Government has shown extreme reluctance so far to do this, then some other integrating device than the purchasing agent is required.

There is a tension between the notion of competition in the market and the co-operation necessary to bring about a linked, or multi-product episode. Clearly there is a role for a co-ordinating agent who will be able to bring together packages of care from what might be otherwise competing providers. In fact there are already examples of American hospital suppliers, where the co-ordinating agent contracts to supply both its own products as well as those of competitors. Of course, a thin line separates co-operation between providers and collusion which could subvert market solutions.

To take the example of maternity care, from the ante-natal clinic to the health visitor's subsequent monitoring after the birth involves several agents and activities over a period of time. A user would be unlikely to welcome a model of provision which involved a process of negotiation at each stage. One answer is for all the elements to be provided by one supplier. Another is for an intermediate market to develop in service co-ordination. Within this, an agent who could sell the user the full package of care involved would probably be preferred. This might involve a range of possibilities from the pure 'travel agent' model of provision of services, with the 'maternity agent' playing no actual part in the production process other than specification and delivery of the contract, through to the whole service being produced and delivered by one agency.

Too Many Markets or too Few?

At any one time there are several ways of supplying health care to meet the demands of a particular individual or group of individuals, and this leads to there being potentially several agents of supply. However, the nature of the production technologies available, particularly the scale required if a hospital is to act as a viable economic unit, make concentration into larger units more likely. As Anthony Harrison and Sally Prentice point out elsewhere in this volume, the most efficient scale for the delivery of 24-hour A&E services, may be much larger than most hospitals currently provide. This larger scale unit will only be viable if it serves a large catchment population – according to some of the authors they cite, some two million people. If this did prove the most efficient size for this service then the result would be a series of natural monopolies, the scale of investment in the productive unit requiring a large market, or large market share. It would then require regulation of the form currently in operation in the water and electricity supply industries. In **How Might Markets Operate**, some of the features of this essentially non-competitive environment are discussed.

Thus there may be too few providers for markets to work for some health care services. But, drawing on our earlier arguments, competitive market behaviour may still be possible in the supply of parts of the large-scale emergency service. Furthermore, the same factors making for natural monopoly do not apply to all health care services. Much of the US literature in this field has been directed at ways of identifying and dealing with the lack of local competition which can arise in health care markets. Innovations in the delivery and marketing of care can provide a means of extending the range of potential suppliers by introducing new product ranges into the market place. The question is how this innovation is to take place and who innovates, especially in the cash-limited environment of the NHS. One way is by the creation of markets for alternative forms of product – in the ways we have already described. In principle this can lead to a vast number of markets developing.

This potential over-abundance of markets can be handled within the confines of traditional economic theory by assuming, not unreasonably, that it is the characteristics of these services which are demanded, and hence a competitive market in the characteristics of care is possible. Thus the specialist ENT unit may provide a bundle of characteristics which includes a basic level of care as one output. However, there are other characteristics of the specialist service which the consumer is interested in: for example, less of the negative attribute – riskiness, but more of the positive attribute – convenience, and more of the positive attribute – a shorter waiting time. Units may then differentiate their products by offering different bundles of these characteristics. It is for the purchaser to choose based on an assessment of the needs of the population which is being served. It could then be perfectly rational to make contracts with a number of different providers offering different combinations of the characteristics of the ENT product.

How Might Markets Operate?

Theoretically there are a multitude of products and suppliers available to purchasing agents: in practice their choices can be quite limited. Perhaps the most limiting factor is the need to ensure provision of services within a reasonable distance of the population base. As a result, purchasers may in effect re-create the old arrangements whereby each district had its own monopoly supplier.

There are, however, a range of products for which location is not such a crucial factor. In the terminology introduced earlier, location becomes a characteristic upon which a low value is placed. Care must be taken here as the agent's valuation may not correspond with that of the client population, and in the absence of markets for the services of agents this will not be reflected in any market solution. Nevertheless, we would expect more direct competition in product ranges where location is not such an issue – generally a range of elective procedures but health-check products might be included.

A difficulty arises when the link between demands for these services and others which are very much location-dependent is broken. To take a simple example, suppose a simple two-market model of elective and emergency care with eight agents, six of which operate only in the elective market. It may not always be possible to achieve an acceptable equilibrium solution.

A price may be determined in the elective market which results in all agents being willing to supply a quantity of service at that price. Two agents are also supplying the emergency market for which there is a relatively captive demand because of the location factor. Marginal cost pricing might result in a higher price to take account of the riskier nature of the emergency business. The crucial question then is: can either unit obtain a price at which average cost (of both emergency and elective) is covered? In a monopolistic situation, or one where there is collusion, the price in the emergency market can be set so that total costs are covered, including the elective side of the business. However, there is then an incentive to push down the elective price in order to put the other units out of business, at which point prices could be increased to that level where there is no real threat of entry by competitors.

The crucial factor here is the ability of the units supplying both types of care to differentiate the products clearly and impose a price on the market. In practice there have been examples of purchasers buying more emergency care than planned as a tight rein has been imposed on elective provision. This can only happen if the agent is not in full control of what is purchased, which has often been the case so far. In the example given there would be an incentive for the purchaser to 'game' the market by buying cheaper elective services instead of emergency cases, a dangerous alternative to pursue.

If the two-product units were unable to drive prices in the elective market down, for whatever reason, then they may still choose to cover most of their costs through the emergency market. This could potentially result in most of the purchaser's budgets being spent on emergency provision, again driving the other pure elective units out of business. In all of this discussion the assumption of appropriate attribution of costs between different products does not enter as we assume a market situation where the two-product providers are able to determine their most successful pricing policy. This is not the way the market has been intended to work so far. Department of Health guidelines have tried to constrain the pricing behaviour of providers, not always successfully it would appear. As Diane Dawson has pointed out, a normal market would not. In most competitive situations the theoretical solution is broad equivalence of price, marginal cost and average cost. The NHS market is a long way from this.

In a well-developed market such as that for cars, the development of new product ranges clearly depends on devising new combinations of characteristics such as comfort, speed and safety. Innovation in health care products will require equal insight, which can only come with time and above all, appropriate incentives. In a market environment, this requires that satisfactory prices can be earned for each product or service supplied.

Theoretically, if a price for each characteristic can be determined then this will be a determinant of an overall market price for the supplier's products. On the cost side, the agent must be able to cover its average costs if it is to be viable. It is essential if the market solution is to work that the provider attributes costs appropriately throughout the production process so that cross-subsidisation is ruled out.

Product-Specific Purchasing

The purchasing structure introduced in 1991 was 'general purpose' except for GP fundholders. The case for such a purchasing structure rests in the belief that it allows funds to be moved without hindrance to where they can be used most effectively. However, a series of complications arises from specialist care and its associated products, teaching and research. If these are introduced as separate products for some providers, then the problems of appropriate attribution of costs are extended, as these providers tend to operate very much like joint product firms. The teaching, research or care output are not pure joint products in the sense that leather and beef are thought to be, as the cow naturally produces both and cannot produce one without the other. But units may produce different combinations of teaching, research and care and in each case the attribution of costs is problematic.

It is possible to produce care without any teaching or research element, but the opposite is unlikely to be the case. The implication, however, is not that this care product should be free. Where markets exist a non-zero price is still a possible equilibrium solution. However, it may be that the agent who purchases more general forms of health care may not be the appropriate demand-side agent for specialist care products, let alone for teaching and research.

Specialist care tends to be characterised by low patient numbers and the need for specialist clinical expertise. As the Clinical Standards Advisory Group has pointed out, this may lead to problems where the scale of purchasing is relatively small. The transactions costs involved, even with the current expansion of district purchasing agencies, may make it impossible for markets in specialist care to operate, or only to do so inefficiently. For the specialist provider there is the difficulty of co-ordinating so many potential contracts with agencies, given that to be technically viable the provider will require a large geographic catchment area.

Teaching and research also present difficulties from the purchasing point of view. These are not final products in the economic sense that they are ultimately consumed for the benefits which they offer to the user. They are intermediate investment products whose aim is to improve, or allow future production possibilities. Hence the time horizon for the impact of decisions is of its nature different to most purchasing, the benefits of which are, in most cases, immediate.

Thus there are grounds for arguing that different services may require different purchasers. In the case of specialist services, the old 'top-slicing' approach at regional or national level did reflect the fact that the horizons of particular districts were limited: a higher level purchaser could take a wider view.

Similarly, it is not clear that current care purchasers are the natural purchasers of research and teaching. In the sense that teaching provides future labour inputs to productive units then it may seem natural to view this output as an investment in the future by providers. However a provider may not wish to make the level of investment in human capital which it is actually capable of producing. There may be additional scope for specialisation in supply with some units providing all of the teaching output required.

Alternatively the teaching product could be viewed as an investment by an individual in human capital. In this case the traditional economic model would suggest the individual is investing in his or her own human capital in order to realise an increased stream of future incomes – the purchaser is in effect the individual.

Equally, it is not clear who benefits from investment in research. The productive unit will be drawn to those projects which bring about more cost-effective techniques of production, or a larger share of the market. Yet, there may be a more all encompassing objective for society as a whole which needs to be present as an explicit objective for some group of purchasers. If the fruits of research are to become public goods, and this is generally the case with non-pharmaceutical research, then a market solution to the production of research will not generally be feasible.

Buying for What?

In this section we consider the objectives of the various agents involved in the market. A better understanding of those objectives allows a better knowledge of the possible outcomes arising from allowing the market to determine the allocation of health care resources.

As already indicated there are supply-side and demand-side agents for the final health care products, although, as with any particular production process, suppliers also demand intermediate products and inputs. The supply-side encompasses hospital and community units, GPs and other related professions as well as agents putting together packages of care from a number of production sources. There are two types of demand-side agents, district purchasing agencies and GP fundholders. The user is also a demand-side agent although not one that enters currently into the market – except in minor ways. If there were a market for the services of purchasing agencies, with individual users choosing who would purchase (supply) health care for them, then the market analysis could be developed further with district agencies and fundholders becoming just another tier of the supply-side of the market.

Hospitals and community units have remained within public sector control and have been given relatively straightforward objectives by the Government. They are required to stay within external financing limits, ensuring a balance of their income and expenditure while making a return – set at six per cent – on the capital which they use. Other agents, in particular GPs, have a contractual agreement to provide sets of services, theoretically at least without limit on the amount which can be spent on this type of provision. There have been some rather unclear statements about hospitals serving their local communities but this is unlikely to be their prime objective, and quite rightly so if the introduction of the internal market is to have its desired effect. The interests of the local community are clearly intended to be reflected in the decisions of purchasing agents.

District agencies and fundholders differ in scale but we can assume that they have a similar objective which is to provide high quality health care to that part of the population for which they act as agents. As we suggested earlier, this may involve acting as an integrating device in bringing together different packages of care from different provider sources, but it does not have to.

However it is notoriously difficult to pin down this 'public health' objective, and it is variously, and rather nebulously, stated as meeting the needs of the population, responding to the population's demand for health care, or achieving health gain. Perhaps a more clear goal for purchasers, and one which has been stressed by Government, is to achieve 'value for money', one interpretation of which is expressed in terms of achieving a 2.25 per cent increase in their purchaser efficiency index.

Narrow objectives of this kind however do not sit well astride the process of market creation and innovation which we have outlined. In private sector markets, innovative behaviour if successful is rewarded by higher than average returns – in other words, risk-taking is rewarded. No such clear incentives exist within the current arrangements. Furthermore, the creation of trusts more or less as they stood prior to the new regime has in effect created a new set of vested interests in the status quo which lie in the way of developing new markets in the ways set out earlier.

Lessons to be Drawn

This article has highlighted the problems which arise out of an attempt to implant an existing set of supply and demand relationships within a market structure rather than trying to develop the nature of those relationships in ways which can deliver benefits over and above those of which a planned system is capable. If innovation is to occur then there must be a better understanding of the way in which markets in health care operate together with an appropriate incentive structure which will reward some degree of risk-taking on the part of agents.

We have focussed not just on the actions of agents – purchasers and providers primarily – but on what the structure of the market should be in terms of both the purchasing and providing function. It was a mistake to accept a series of relationships which already existed and try to force these somehow into a new market framework. We feel there are clear messages both for the agents in the market, and also for the not so invisible hand of the Department of Health.

First, it is important for purchasers to begin to perceive their contracts in terms of bundles of care characteristics which they are buying. It is only in this way that new health care products – new ways of delivering patient care – will be developed at a pace which some commentators have expected the market to deliver. In this way, also, it will become apparent that not all providers are providing the same product, that there are trade-offs to be made between quality, convenience (or access) and risk, on the one hand, and cost on the other.

This is not just an issue for purchasers. Providers will have to be able to respond to demands for different types of product. New types of provider agents will need to develop, such as we have seen in London, offering a 'travel agent' style complete package of services. There needs to be an explicit recognition of the important role for an integrating device, which exists over and above any purchasing function. Eamonn Butler has recently emphasized the importance of 'purchasers shopping around if they are to maintain competitive pressure on suppliers'. This may still lead to purchasing just more of the same. We suggest that a more fundamental solution might exist in the development of agents in the market who have a pure co-ordinating role.

Second, purchasers will have to develop ways of understanding the needs of their populations in order to ensure that decisions which they make about different ways of meeting health care needs actually correspond to what is demanded. When some forms of care are being ruled out, or switches to different types of supply are contemplated, then it is important to ensure that these will satisfy both the needs and demands of the population. London again provides a good example. There, the switch from hospital to community based care is much lauded by some professionals but it may not be achievable if the residents of London are not convinced that particular packaging of care characteristics will satisfy their needs: at least not without abandoning all notion of links between the objectives of purchasers and their residents.

Third, the Department of Health may have to intervene to ensure either markets are created for all products or pseudo-market solutions are developed in cases where a real market solution cannot be sustained. Put crudely, if a market for research cannot be created then there must be some central planning so that the research output is not lost: unless of course this were regarded as the optimal outcome.

Finally, the Department of Health must be clear about what kind of market it is intending to create. The existing arrangements are not a pure market system and therefore will not act as such, at least not without a little prompting. It is not enough to encourage agents to work within existing structures. Innovation is of its nature often risky; risk-taking will not occur without reward: appropriate incentives must be introduced so that the evolution of new markets and market relationships is encouraged. Otherwise the purpose of introducing the internal market to public health care provision will not be fulfilled.

One option, which has so far been ruled out, would be to go for the full privatisation of supply. However, the tendency for natural monopolies to exist for many health care products makes this undesirable without some significant degree of government intervention – at the very least to ensure the existence of markets for products to which a private supplier would not naturally be attracted. With such a solution there remains the problem of ensuring that public objectives, if these remain, can be accomodated. If privatisation is ruled out, then the existing structure for publicly provided care must be modified so as to allow the kind of market developments which we have discussed.

New agents should be encouraged to enter the market to carry out the key roles of co-ordination and innovation.

While mixed messages are emerging from the Department of Health it is unlikely that a viable market solution will operate. At two extremes lie an unfettered market dominated by private supply and a planned system of provision. A halfway house may produce the worst of both worlds.

A NEW BLUEPRINT FOR HOSPITALS?

Anthony Harrison and Sally Prentice

It is more than 30 years since the Hospital Plan for England and Wales was published. The pattern of hospital provision that we now have is far from conforming to the 1962 blueprint. Nevertheless it succeeded in its central objective of leading to the creation of a network of district general hospitals throughout the country designed to even up the standard of provision if not to the best, at least to an acceptable standard.

Since that time, medical technology and many other factors have changed, so it is only to be expected that some of the assumptions underlying the Plan are out of date. Nevertheless, there has been no central government statement on hospital policy since 1980 in response to these changes. Instead, a number of individuals and organisations have put forward ideas as to how the provision of hospital care should be organised. We summarise a number of these in Table 1. As the Table shows, views differ on what the appropriate scale and structure of hospital provision is. Each view agrees there should be some division of role between different types of hospital, and that hospitals more or less of the type we now have, should continue to play a central role in health care delivery. But different authors divide functions in different ways and at different sizes of hospital.

Table 1 Hospital Hierarchies: Alternative Views

	Catchment Populations (millions)		
	Main	Local	Other
SE Thames	0.3(0.5)	?	Polyclinics Elective Units
Oxford	0.5–0.8	0.050+	
NAHAT	2.0+	0.02–0.1	
Templeton	2.0	0.2–0.3	

Sources: Shaping the Future: a review of acute services, South East Thames Regional Health Authority, 1991; Hospital Services for the 21st Century, P N Dixon and others, Oxford Regional Health Authority, 1992; Re-inventing Health Care, NAHAT 1993; J Templeton, Organising the Management of Life-Threatening Injuries, Journal of Bone and Joint Surgery, (British Volume) 1994, pp 3–5.

Similarly, in the 'real world' different areas have gone their different ways. At one extreme, Powys, an entirely rural area, has no district general hospital: instead it has a network of small hospitals in each population centre; for the services they do not provide it relies on larger hospitals in neighbouring districts. At the other extreme, some medium sized towns rely for nearly all their hospital care on one hospital, sending only a small number of patients out to specialist services elsewhere.

Why do these differences arise and do they matter? Should we regard such variation simply as evidence of sensible adaptation to different circumstances or does it derive from differences of view as to how hospitals are best organised? The answer to both questions is yes: the pattern of hospital provision has adapted to circumstances and geography, but underlying the documents listed and professional opinion more generally do lie differences in view as to what is required to produce good quality hospital care. Quality of course depends on a large range of factors: our focus here is on only some of them – those that depend on the scale and scope of individual hospitals.

In this article we:

- set out some general principles relating to the planning of hospitals;
- present some of the evidence on the current failings of the hospital system and on how improvements might be made in the structure of provision;
- set out other reasons why changes may have to be made and draw out some of the implications for service provision;
- attempt to define an alternative vision to that set out in 1962. This article draws on a larger study which will be published later in 1994 as *Acute Futures: Deconstructing and Reconstructing the Hospital.*

General Principles

Although the various structures set out in Table 1 differ, underlying them are a common set of ideas which also underpinned the 1962 Plan:

- all areas should have reasonable access to most hospital facilities;
- most of these services should be provided on one site *ie* hospitals should be general not specialised;
- the catchment areas for different services differ, so some specialist or referral services will not be found on all sites.

Nevertheless the structures which emerge are very different. These differences stem from differences in view about the advantages of bringing together the full range of services on one site, the weight to be attached to accessibility, and the scope for separating out some services from the main general hospital into other settings, be these local, community or GP run facilities. In other words, they reflect different views as to the trade-offs to be made between clinical quality, cost and accessibility.

How should the merits of these alternatives be assessed? Given that the structure of hospital provision does vary from one part of the country to another, it should be possible to observe the relative effectiveness of different arrangements. If the general tenor of these reports is correct then the standard of care in areas served by larger units should be better than in areas relying on smaller units.

However, no data are available to allow that kind of careful comparison: indeed, even the simplest comparisons *eg* of unit costs between 'small' and 'large' hospitals, are fraught with difficulty. None of these reports contain very detailed evidence even where they are based on extensive professional consultations. But they nevertheless reflect considered responses to changes that are occurring in the way that hospitals are run and to the evidence that is available on what makes for good performance.

That evidence is patchy: while randomised trials have been carried out on particular procedures and particular ways of organising services for small patient groups, they have not been applied to alternative ways of organising services as a whole. There is however a lot of evidence bearing on particular aspects of what hospitals do. In the next section we present briefly some of that evidence which bears on the link between quality of care and the structure of hospital provision together with the arguments that may be used to justify particular hospital configurations.

Evidence on Performance

Within the new NHS, the performance of hospitals is beginning to be assessed from a variety of different angles – cost reductions, day surgery rates, lengths of stay, waiting times etc. Here our focus is clinical quality narrowly defined: in what circumstances is the appropriate intervention likely to be carried out well?

Poor Performance

There is no regular statistical monitoring series nor systematic inspection process that would yield useful evidence on whether hospitals in general, or hospitals of specific types, perform well. The nearest to such a series is the annual confidential and voluntary enquiry into peri-operative deaths, run by the Royal College of Surgeons, known as CEPOD.

Two recent findings are particularly relevant here:

- that poor performance is often associated with decisions being made and treatment given by inexperienced staff;
- that there are unacceptable risks arising from a single team covering at more than one site – a form of working that has arisen because in some parts of the country centralisation of the services to be found in most general hospitals has not occurred.

The general drift of CEPOD has been confirmed in a number of professional reviews. For example, reviews of the performance of accident and emergency services by the Royal College of Surgeons and others have shown there is scope for better performance – in the case of this service, that means saving lives – and argued that performance will improve if decisions on what treatment should be offered are taken by experienced staff.

Size and Performance

The bulk of the work that has been done on the relationship beween size of hospital and performance has been carried out in the US. The evidence has been summarised by Nick Black and Alastair Johnston (Health Services Management Research 1990 pp 108–114) as follows:

> *It appears that hospital volume is associated with the effectiveness of some health services (most surgery, cardiac catheterisation, trauma care) and may be of importance in other areas (neonatal care, coronary care, burn care).*

But they go on say:

> *Some of the limitations of the literature on volume:outcome will be all too apparent. Firstly, it ignores some areas of hospital care because of difficulties in measuring casemix and outcome. Secondly . . (the) review has deliberately been made to assess the impact of volume on the effectiveness of care. No attempt has been made to assess the impact of volume on the humanity, equity or efficiency of services . . . Thirdly, most studies restrict their measure of effectiveness to case-fatality.*

The authors however are not able to cite any evidence relating to the actual volumes achieved in British hospitals. No information of that kind is regularly published, but unpublished analysis carried out for the King's Fund Institute by the National Case-Mix Office does confirm that in most areas of hospital work, there are units operating at very low levels of activity, including those areas where the volume: outcome link is most securely based. Perhaps the most crucial question, which the research evidence does not fully resolve, is whether the link, where demonstrated, between volume and outcome, works through the hospital as a whole, the individual clinician or the team of which the clinician is part – or indeed all of these in varying degrees. Yet the nature of this link is critical to determining the merits of different ways of delivering care: if the link is primarily through the experience of the individual clinician, then the combination of small hospital and peripatetic specialists is likely to be effective. If it is through the facilities and resources of the hospital as a whole, it is not.

Size and Expertise

One implication of the link between volume and outcome is that size helps create expertise because 'practice makes perfect'. However, the link may work in other ways by, for example, ensuring that medical staff see the unusual as well as the typical case and in this way build up their specialist expertise. Alternatively, a hospital can be seen as a cluster of medical skills, which may interact and mutually support each other. The hospital in this sense is a learning institution. Greater size does not guarantee any specific result but it creates the conditions within which learning in the broad sense may take place.

Specialisation and Performance

The hospital is typically regarded as synonymous with specialisation, and the development of hospitals with the development of sub-specialties, as medical knowledge has grown. The more specialised the medical staff of hospitals become, the greater the number needed for all specialties to be represented.

But specialisation in practice is also a matter of working methods. As far as emergency admissions are concerned, hospitals do not currently put their specialist expertise 'in the front line' in accident and emergency nor at nights and weekends on general wards. Furthermore, in the case of emergency admissions, and again practice varies, the admitting physicians may not specialise in the condition the patient suffers from but may nevertheless remain responsible for that patient until discharge, relying on their skills as general physicians or surgeons. In other hospitals, patients will be passed on soon after admission. But specialisation is not just a matter of individual clinicians: it also involves teams of nurses and professions allied to medicine. Many hospitals do not have specialist teams for conditions such as stroke despite their frequency. Some combine general physicians with specialist nurses.

Voices are still raised for the value of the generalist, but typically the value of specialisation is usually taken as self-evident. However, the evidence for links between quality and outcome supports it. Moreover there is evidence from small-scale studies, *eg* of stroke and asthma care, which suggest that patients do fare better when they are treated by professionals specialising in their condition. But while some patients fall neatly into 'disease' categories, others do not. The case for specialties based on age – paediatrics and geriatrics- lies in part on the view that the very young and the very old are better dealt with by clinicians with a broad experience. However, one result of this is the creation of dual specialists *eg* neurosurgeons specialising in operating on children.

Scope and Performance

The critical link between specialisation and the scope of the hospital – *ie* the range of skills it embodies – turns on the importance, to quality of care, of having all specialties on one site, or if not on site, available at short notice. In the case of emergency care, at least at the serious end of the spectrum, the required form of intervention cannot be known in advance. Hence to ensure that the patient's need can be met, a wide range of skills must be available immediately.

Similarly, in the case of elective work, the condition of the patient cannot be known fully in advance, or things may 'go wrong' for other reasons, and the emergency facilities of the acute hospital required.

The argument here turns on unpredictability and risk. But we have very little knowledge of what the risks are: how many patients for example have to be transferred from some of the remaining single specialty hospitals because a situation arises with which they cannot cope: how many patients have to be moved on from less well equipped accident and emergency departments, and with what effect, because they need the facilities of a larger department?

What the 'right' structure of specialisms is, and how the specialist skills available are best deployed has been the subject of very little research. But the general implications of the evidence cited is clear enough: size – *ie* a higher level of activity and hence larger groupings of clinicians and other specialised staff and equipment – increases the chances of better performance for certain areas of hospital work. If the size of clinical teams increases, and if specialisation pushes up the number of separate teams, so does the 'best' size of hospital rise.

However, while the areas of work to which the arguments we have set out apply to some of the central functions of the acute general hospital, particularly those focussed on emergency and inpatient care, they do not relate to many of the other things which hospitals do, especially their role as a diagnostic facility, provider of a range of therapies and other allied services. These are clinically separable *ie* they can be conducted safely and effectively in other settings than an acute general hospital.

There is general acceptance in most of the reports we have listed and elsewhere that many of these activities need not take place in acute general hospitals. The range of activities listed in the Oxford Strategy and shown here in Table 2 are found in acute general hospitals for reasons of history and inertia: the hospital has been the main physical and organisational focus of the health care system for decades, and so it has been natural that functions should accumulate there. Pilot projects and case studies have shown that in nearly every area of hospital work part can be carried out in other settings.

But while the scope for dispersal into other settings is widely recognised, there are dissenters as to whether it is desirable. For example, the clinical advantages of separating a wide range of elective work from other surgical activity are not apparent and some professionals argue that, as no procedure is entirely safe, risks are inherent in any way of working which separates out work into units with less than the full range of support and diagnostic services. Similarly, while in some parts of the country it is common practice to transfer patients to a local hospital after an operation or a period of intensive medical care so they can be nearer home, clinicians in other areas regard such transfers as harmful to the patient, leading to an unnecessary extension of the total length of stay.

Table 2: Local Hospital Services

- casualty services;
- small number of short-stay nursing beds as an extension of primary care;
- radiology facilities for plain and contrast media x-rays and ultrasound;
- pathology facilities providing basic chemical pathology and haematology investigations;
- outpatient consultation and assessment services for all specialties where the number of referrals which can be managed without expensive technology justifies a session at least twice a month: in a moderately large local hospital, these might include general medicine, geriatric medicine, dermatology, paediatrics, psychiatry, general surgery, urology, trauma and orthopaedics, obstetrics and gynaecology, ENT surgery, ophthalmology and oral surgery;
- elective surgery predominantly on a day basis for all specialties and for all categories of procedure generating at least 150 cases a year;
- a small number of low-risk recovery beds for overnight post-surgical stay;
- outpatient physiotherapy, occupational therapy, speech therapy and chiropody services;
- low-risk maternity services;
- the hospital site could also provide a convenient location for a variety of primary and community services and for professional education and training.

Such differences of view in part reflect experiences on the ground, but they also reflect differences in view as to the feasibility of defining in advance what is likely to be a low risk procedure or a low risk patient. The debate, for example, over the proper location of maternity care is essentially about those issues: the central element in the case for all births taking place in hospital is that risks cannot be defined in advance. The case against argues that in the vast majority of cases such predictions are possible and, if things do go wrong, the answer is to provide rapid transport to critical care facilities.

These differences of view in part reflect what is essentially not a clinical matter *ie* differences in view as to what are acceptable risks and the likelihood of legal action in the event of the unexpected occurring. What we do not know is what the risks actually are, where choices present themselves, for the vast majority of hospital work.

Other Considerations

By itself, evidence on quality and scale is insufficient to define the size and structure of hospital services. Other factors need to be taken into account, principally costs and access.

Costs

Most work on the economics of hospitals has focussed on the hospital as a whole. That tends to show that size is not an important determinant of unit costs. However, when thinking about reconfiguring hospital services, overall cost relationships, however accurate, are of only limited help since what may be true of the whole may not be true of particular functions. Thus, emergency and elective work may be subject to different cost relations, or the cost of support and management functions may rise with scale, while the cost of direct services falls. More disaggregated analysis for each part of the work of hospitals is not available.

Moreover the absence of economies of scale does not mean that the work of hospitals can be economically divided up into any number of units. On the contrary, most hospital activities will be subject to thresholds below which provision will either be uneconomic or poor quality. The single most important threshold relates to emergency care both in terms of equipment and manpower. While local studies suggest it is possible economically to separate out provision for some parts of the work of accident and emergency facilities *eg* through nurse-run minor casualty services, the admission of serious casualties requires a substantial fixed resource to ensure continuous 24 hour cover. How substantial turns on the arguments linking volume and quality and on the staffing factors, which we look at below.

Furthermore where workloads are variable as they are in emergency work, size, measured in terms of beds or medical staff, offers advantages. Evidence contained in the London Specialty Review of Children's Services showed how the number of beds needed to provide for emergency admissions needing intensive care rises less rapidly than the number of admissions. The principle holds generally: any variable demand is more efficiently met by pooling it. That applies both to the physical assets of the hospital and its human resources.

These arguments do not bear on the bulk of elective work which by its nature can be planned and hence the need for a contingency reserve is negligible. The cost thresholds here – and hence the minimum efficient size – are therefore much lower. Other hospital activity *eg* outpatient clinics the work of the professions allied to medicine, will each have its own cost relationship. Here the central issue may not be the existence or otherwise of economies of scale but rather what is the best size for the management and professional development of a group of staff. Hospitals, even large ones, use small numbers of people with particular specialist skills. As a few examples have suggested, they may be best managed within a larger staff or service group: the hub and spoke models suggested in a number of the London Specialty Reviews fit that approach.

For these groups, like ancillary workers and other support services, there is no reason why the economics of provision should be linked to the individual hospital or provider unit since they can be contracted for. But, while markets exist for most non-clinical services, and clinical support services such as pathology, those for professional and clinical skills are poorly developed.

Access

Any change in the number of hospitals or the location of hospital services necessarily has implications for those who must travel to hospital for care. But access is important for three different reasons:

Costs: The fewer the number of hospitals, the longer on average journeys will be. Ambulance costs in rural areas are two to three times as high per patient as in urban areas. Most access costs however fall on patients themselves and small-scale studies show that journeys and the attendant waits can be difficult, in terms of inconvenience as well as cost, for some patients.

Utilisation: Whether access difficulties affect levels of use is another matter. It is a commonsense assumption that distance will tend to discourage use of services and there is evidence from a large number of studies that it does. However, that effect appears to be much smaller for inpatient care than for outpatient visits presumably because people attach so much more importance to the former.

Clinical: The question here is whether the time it takes to get to hospital affects the outcome for the patient. Again the commonsense view is that it must do, but detailed evidence is lacking on the precise nature of the relationship for most categories of patient. The so-called golden hour rule, which stresses the need for access within 60 minutes, for example, is founded on judgement rather than research. In fact, it is much more likely that the chances of better outcome fall steadily with lengthening access time. But some data find very little effect of this kind.

As the precise nature of the relationship is not known, the extra risks that arise from having fewer points where accident and emergency facilities are available cannot be estimated nor the value of such high cost measures as air ambulances. More mundanely, the appropriate rules for ambulance crews – *eg* whether they should take patients to the nearest hospital or make a judgement as to what the most appropriate hospital might be – have not been rigorously evaluated.

Overall, it appears that access may impose costs, of these various kinds, for at least some patients. However these costs may be modified by appropriate action:

- special transport can be provided – some waiting list initiatives have involved this – but there is no reason why they should not be considered on a routine basis;
- services, even operating theatres, can be mobile;
- communications can be used *eg* telephone advice from A & E departments to reduce the need for travel.

These are just examples: despite the fact that good access has been an underlying principle for hospital provision, it has not been taken seriously in terms of research and analysis and hence the options have not been systematically evaluated and their costs set against those within the hospital itself.

This is true even in the case of admissions to accident and emergency facilities. For example, the value of immediate treatment by paramedics, though often taken for granted, is not established and some contest it. Apart from situations where patients are trapped, or where as with heart defibrillation, treatment must be virtually immediate, on-site treatment uses time that might be more productive within hospital. Thus the traditional 'scoop and run' may be the best policy, perhaps in combination with effective communications between ambulance staff and accident and emergency departments to help guide the decision as to where they should 'run' to.

Finally, while reducing the number of hospitals necessarily creates some additional access costs, concentration also offers access advantages to some users of hospitals. Many diabetic patients require care from different specialists and professions allied to medicine. They therefore benefit from concentrating those skills onto one site. For other users, dispersal of some services to more accessible locations may be beneficial. But we have found no information which bears on the relative importance of these two types of user.

Changing Environment

Overall, while it is clear that there are cost, quality, and access trade-offs, their precise nature cannot be defined. Furthermore, even if they were well understood, there are factors at work which are tending to change the basic relationships and it is to these we now turn.

Staffing: The central factor determining the size of the general hospital in reports from the 1962 Plan onwards has been the size of the medical staff required to provide the range of services required for acute care. The professional reports we have cited suggest that the number required should rise largely as a result of the development of specialisation. But there are other factors at work, principally the change in junior doctors' hours which in effect reduces the ability of hospitals to rely on them for medical cover at night and at weekends. This is in effect forcing a change that should on quality grounds have been made anyway.

Hospitals have only just begun to respond to the implications of these two influences. To our knowledge only two hospitals, and then only in part, have responded by introducing 24 hour consultant cover 'on the shop floor', *ie* with the consultants actually working not sleeping in or available on call to deal with emergency intake.

The full implications remain to be seen since the need for such cover is not generally accepted, and if and when it is, what kind of rosters it will involve and hence the size of the clinical teams required, is not clear. Put crudely, the more that consultants and other senior staff can be persuaded or induced to provide services outside the 'normal' day, the smaller the clinical teams can be.

But what is clear is that small general hospitals at the lower end of the catchment range, *ie* serving some 150,000 people, will either not be able to provide similar cover or will have to incur extra costs in order to do so. What is not yet clear but may become so shortly, is whether or not the minimum size for a high quality emergency facility is much higher than what is currently available everywhere except in the largest centres.

Technology: Change in medical and other technologies appears unrelenting and the range of possible changes is far too large to review here. The main point which emerges from such reviews is that it is extraordinarily hard to predict the impact of technical change on hospital structure. As David Banta, in his vast review of the technological factors, *Emerging and Future Health Care Technology and the Nature of the Hospital,* puts its:

> *The tension between centralisation and decentralisation seems likely to grow.*

That Delphic conclusion does little to ease the planning task. But it would seem that techological development is creating the opportunity for new patterns of service delivery, new areas of substitution of skills, of location and of delivery methods. This is particularly true of developments in information technology which are allowing expertise in diagnosis to be deployed over wide geographical areas, allowing hospitals in rural areas to consult colleagues in urban teaching hospitals on the basis of shared results of diagnostic tests. In this way, the clinical benefits of physical proximity inherent in the large hospital can be enjoyed more widely.

Organisational: In recent years, the most obvious change in the organisational framework within which hospitals work has been the transition to trust status and the separation of many at that time from their community services. However, the more critical change is in the freedoms that trusts have gained in relation to staffing, in part as a result of their status in part as a result of changes in the market for medical manpower as a whole.

These have yet to be fully exploited but it is apparent from local developments that trusts are beginning to experiment with different recruitment methods and staffing structures. Because of their tentative nature, their full implications are not yet clear, but they point in the direction of greater flexibility. This is likely to be particularly important for the small hospital, making it easier for it to attract specialists on part-time or other flexible terms.

But this could be just the beginning. The clinical labour market remains highly regulated, but developments at European level and indeed the recent GATT round, will tend to open up the UK to wider influences, thereby reducing the role of the existing regulatory institutions, principally the Royal Colleges. Furthermore, as we have already suggested, there are areas where new forms of organisation may emerge, based principally on professional groups or specific services. The pressure from some consultants to 'leave' the NHS and assume the organisation of the legal profession would, if successful, push in this direction.

Threats to the Hospital

If NHS hospitals were in the private sector, they would be hailed as one of the success stories of the 1980s. They have steadily increased activity, raised labour productivity and kept real costs steady. Demand appears to be infinite: the more hospitals do, the longer their waiting lists. The population continues to age and some illnesses of childhood are increasing. Nevertheless the role of the hospital, and hence demand for its services, has come to be challenged on several grounds.

At one extreme are the expectations generated by developments in biotechnology that the current pattern of disease will disappear. But however real those prospects are, it will be some time before they impinge on the workload of acute general hospitals. More pressing are threats from other suppliers of care.

In recent years the belief has become established both that activities can be transfered from hospitals to settings currently not called hospitals – substitution – and that improvements in primary care can reduce the workload on hospitals – diversion. Further threats come from offering patients greater choice over the nature of the care they receive and from an increasing awareness of the need to take a critical attitude to the value of hospital activity

Substitution: There is little doubt that services can be provided in different ways. Evidence is available from a wide range of sources – case studies, theoretical studies and practical examples covering nearly every aspect of hospital work – that a variety of delivery mechanisms are feasible. Increasingly it is being recognised that there are a range of substitution possibilities between capital and labour and between different professional skills as well as between different locations.

In last year's *Health Care UK*, we illustrated this for three important services, maternity, paediatrics and elderly care – drawing on a number of published or specially commissioned reports. These articles made it clear that different patterns of care could be envisaged for broad categories of patient, but they were unable to provide evidence for which was best, because of major gaps in knowledge of costs, comparative clinical effectiveness and patient response.

Diversion: It is commonly argued, in London in particular, that improvement in primary care will reduce the workload of London's hospitals. Given the poor state of primary care in parts of the capital, that may seem a reasonable presumption particularly for services such as A & E, where attendance at hospital departments may well be a sign of poor delivery at primary level. Similarly, studies of asthma patients have suggested that with proper training for both GPs and patients, the need for emergency admissions can be reduced.

Across the whole range of hospital services, however, the effect of improving primary care may well be the reverse. A 'good' primary care service will efficiently identify the need for secondary care or specialist advice and hence increase the workload of the hospital. Analysis of hospital use by Ken Judge and Michaela Benezeval suggests that utilisation of inpatient services is lower in areas where the proportion of GPs who are single-handed is high. There are several reasons why this may be so, but at minimum this finding cautions against the simple view that better primary care will inevitably lead to less demand on hospital inpatient facilities.

Patient Choice: For particular services, patient choice may be decisive. In the case of maternity services, the right of women to choose mode of delivery is now officially accepted. However, hospitals may well adapt by providing more patient-friendly services within the hospital itself and indeed some are doing so. The 'patient-focussed' hospital is one such reaction across a wide range of services.

The question of choice may however give rise to a more fundamental threat if it undermines the case for the kinds of treatments which hospitals are uniquely able to provide. A limited amount of work in the US and this country suggests that where patients are as fully informed as is possible of the characteristics of the treatment options facing them, they tend to prefer delay and less active interventions. At present however such work has been conducted on a very restricted range of conditions, so its potential impact cannot be assessed.

Outcomes: A perhaps more significant threat comes from the development of a more critical attitude to what hospitals do. The lack of outcome measures and uncertainty as to what is or is not clinically effective inevitably means that the value of additional and indeed existing activity can be called into question. We do not know how much of what hospitals do is of little benefit or is positively harmful. CEPOD reports instances of inappropriate surgery on older people and a recent comparative study by RAND of some US and UK hospitals found that both overtreated, in some cases by as much as 50 per cent, even in the UK. But we do not know how general these findings are nor indeed whether other physicians would agree with them since the concept of appropriateness is far from straightforward.

Overall, the striking feature of the demand for hospital services is how little attention has been paid to understanding it. It has been assumed to be there. That is now beginning to change. But as of now, the nature of the factors influencing the workload of hospitals is far from understood. During the last year or so, for example, there has been an increase in emergency admissions in many areas, but there is no good explanation why it is happening.

Implications

The central difficulty in planning hospital services lies in the diversity of what hospitals do: the best arrangement for one specialty or service may not be the best for another. This does not matter where, as with contracted-out services, an individual service is independent of the rest. It does matter where, as with the main medical specialties and support services, co-existence is essential.

This means that over and above the strategic trade-offs between quality, access and cost, there are trade-offs between patients in different categories. For some patients for example, the creation of trauma centres serving two million or so people and containing all the specialties needed to offer clinical care, may be beneficial, but these benefits may be at the expense of other groups of patient whose needs are not so extreme but who would benefit from quicker access.

Over and above this inherent difficulty are two further complicating factors: our knowledge of the key clinical and economic factors is limited: technical and other change is altering the importance of those factors. Out of this mass of uncertainty, a few clear points emerge:

Critical Care: Efficient and effective size here seems set to rise as a result of the economic and cost factors set out above. In these services, acute hospitals do not face a competitive threat except in areas where good primary care and preventive measures can reduce the call on such facilities.

The central question, to which we do not yet have an answer, is what are the benefits from applying and extending the principle of a 24 hour consultant based service to all the specialties required to offer an emergency admissions service, and what is to be gained from providing such facilities on sites where all the relevant specialisms are available? If both elements – 24 hour cover and a full spread of specialisms – proves beneficial, that would underpin the clinical case for the creation of the large specialist institutions proposed by some of the sources listed in Table 1. Whether overall, allowing for the costs of transition and the continuing costs of access, their creation would be justified, is another matter.

Elective Surgery: The options here appear very wide, from specialist centres focussing solely on elective work to a massive dispersal into small hospitals. But we have only limited evidence as to the effectiveness of alternative ways of providing these services. The general presumption that simpler elective surgery can be carried out away from intensive care facilities may well be justified by the level of risk involved particularly where the surgeons are peripatetic and carry their experience with them. But quite where 'simple' stops, and 'more difficult' begins is less clear.

Morever, the full implications of such shifts in the locus of care are not yet fully understood. At present, many hospitals rely on the availability of cold surgical beds to give them a contingency reserve. If that is reduced, the reserves will have to be provided in other ways by, for example, maintaining a larger level of spare capacity within the emergency service. The rapid switch to day surgery will in any case push in that direction.

Other Functions: The main gain from the analysis and debates of the past few years has been recognition of the scope for alternative groupings of activities away from acute general hospitals. However, there is very little hard information that can assist planners as to the best groupings to choose nor what the cost and other implications are of providing such services in different locations. Thus the Oxford Strategy proposes that the list of functions set out in Table 2 should be carried out in local hospitals. But there are no compelling reasons for either grouping them in one place or for delivering them in a more dispersed manner. Just as at the level of the acute general hospital, trade-offs have to be made between quality, access and cost, but the nature of those trade-offs for local facilities remains to be established.

While the scope for dispersal and the nature of the case for greater concentration is clear, though in neither case fully evaluated, the implications for the organisation of services are not. As Sean Boyle and Adam Darkins argues elsewhere in this volume, the creation of the institutions which currently make up the internal market was made 'on the hoof' without analysis of the underlying economic structures. If the case for large concentrations of medical and other staff in emergency centres is made, their catchment areas will be larger than the largest purchasers: except at the margins they will be effective monopolies, the regulation of which has not been addressed.

At the other end of the scale, the scope for dispersal raises questions about the relationship between different providers, continuity of care and the nature of the service being bought. These questions in turn lead in the direction of structures which do not currently exist both on the purchasing and the providing side.

On the providing side, a number of specialty reviews have proposed so-called hub and spoke models, within which a 'large' hospital is linked for the purposes of a particular service with several others. Those links could simply follow the traditional pattern of onward referral from secondary to tertiary centres. But they could develop much further, as some local examples already show, into arrangements whereby the service is contracted for and managed from the 'large' hospital. That in turn could lead to the effective unit of supply, and hence of competition, being the specialist group: the hospital becomes a common user facility with negotiated access.

This possible direction of development is further strengthened by reconsidering what the critical links are between professionals. A central belief underlying the 1962 Plan was that close relationships between clinicians in the same hospital were of central importance to quality of care. Developments in emergency care tend to confirm that belief. But for many patients, particularly the very young, very old and those with chronic conditions, other relationships, involving other professionals, some outside the NHS itself, are more important. Whether these should be managed by market, hierarchical or other relationships, and what importance the physical proximity that hospitals provide has to the effectiveness of those relationships, remains to be determined. But it is arguable that there is no obvious reason why the overall managerial responsibility should lie within the hospital itself.

Conclusion

Those responsible for running hospitals have, since 1962, been flexible in finding local solutions, in the face of severe financial, manpower and physical constraints. In the decades since then, technological, economic and organisational changes have created more scope for flexibility and more delivery options and will continue to do so. The new policy framework introduced in 1991 creates even more scope for diversity.

It follows that we are sceptical of a blueprint approach. The vision of the hospital of the future should not consist of bed norms or staff ratios or any specific set of physical options or sizes. Rather it should focus on the conditions most likely to create good outcomes. These will tend to lead to particular physical and staffing solutions, but it is up to purchasers to determine how to weigh access against extra risks and poorer quality and to decide how much it is worth paying to ensure both. In rural areas and small towns, they may well consider it worthwhile to incur cost penalties to promote access while maintaining quality: in other areas, other trade-offs will present themselves.

In doing so they will need to carry public opinion with them. There are no easy ways of achieving that. Attachment to the local hospital remains strong, in part because its failings are not understood and in part because it is the most evident symbol of the availability of care in general and the NHS in particular. There are no easy ways forward, but the general direction is clear: change must be associated with service improvement not cost cutting. How to present it that way is another matter . . . . .

In her classic review of the American hospital *In Sickness and in Wealth,* Rosemary Stevens states:

> *. . the hospital is not an inevitable institution . . . There is no set design for the hospital's organisational role or for the structure or performance of the hospital system . . . As hospitals move within and affect their intertwining environments – social, cultural, professional, political, technological and economic – the hospital system is constantly reinvented.*

Recognition of the need for that reinvention is now widespread , and the opportunities for doing so opening up. What we lack is the knowledge which would allow confident choices to be made between the options available.

WILL PATIENTS `BE HEARD'?: IMPROVING NHS COMPLAINTS PROCEDURES

Michael Solomon

In May 1994 the review committee on NHS complaints procedures, chaired by Professor Alan Wilson, published its report aptly entitled *Being Heard.* The committee's terms of reference had been:

> *To review the procedures for the making and handling of complaints by NHS patients and their families in the United Kingdom, and the costs and benefits of alternatives to current procedures, and to make recommendations to the Secretary of State for health and other Health Ministers.*

The review had been prompted by widespread concern about the gross deficiencies in the existing system of handling NHS complaints. Problems originally highlighted by the Davies Committee as long ago as 1973 had been publicised once more by numerous criticisms from interested parties and commentators, as well as two critical reports from the House of Commons Select Committee on the Parliamentary Commissioner for Administration or 'Ombudsman', in 1977 and again in 1993. The increasing clamour for change had led the Secretary of State for Health to announce in June 1993 the establishment of a committee to review complaints procedures in the NHS.

The committee used evidence from 271 sources and made a total of 67 recommendations for changes in the way NHS complaints procedures are handled. The major recommendations are briefly summarised in **Review Committee Recommendations.**

Review Committee Recommendations

The committee proposed that a new complaints procedure in the NHS should have the following features:

- A unified system across the whole of the NHS;
- Separation of disciplinary elements from complaints procedures;
- Increased publicity;
- Increased use of informal responses;
- Improved staff training, to ensure support for complainants and respondents;
- Arrangements for both conciliation and investigation;
- Further review of time limits for lodging a complaint;
- Time limit for completion of all stages of the procedure to be three months;
- Complaints records to be kept separate from medical records;
- Further review of the recording system;
- Impartiality to be ensured within the NHS.

The committee then went on to specify the design of the new procedures:

The first stage would be informal and internal, involving an immediate front-line response, conciliation and/or investigation and action taken by a chief executive or equivalent.

For complainants remaining dissatisfied with the first stage, there would be a more formal second stage, involving screening and panels, of an investigatory rather than adversarial nature.

Four options for the ownership of the second stage were presented:

- Chief executives;
- Purchasers;
- Regional offices of the NHS Executive;
- Independent complaints commission.

Further consideration of these options was proposed.

- The Health Service Ombudsman's remit should be extended to include formal complaints about family health services.

The Committee also made recommendations concerning implementation, including: training; auditing and monitoring by purchasers; legislation, regulation and guidance; implementation over two years; an independent annual review of the system.

Before evaluating the committee's recommendations, it is essential to step back from procedural details in order to examine the context in which complaints occur and the processes involved in making and responding to complaints.

We begin by showing why complaints in health care systems are important, and for whom. The perspectives of the different parties involved in the process – personal, professional, organisational and society at large – differ and must be considered separately.

Analysis of these different viewpoints points the way to presenting a set of criteria to be used to evaluate both the existing NHS complaints procedures and the future arrangements proposed by the review committee. These enable the likely benefits of implementing the committee's recommendations to be highlighted. They also allow, in the final section, identification of areas which would still be in need of improvement if they were in fact all implemented.

Why are Complaints Important?

Complaints are important in different ways and from a variety of perspectives. For complainants, whether patients, their relatives or carers, complaints are a way to express opinions through a channel which should guarantee some form of official response. For the health care professions, complaints are an important source of information in the maintenance of professional standards and can be used to provide feedback on the quality of professional education and training. Complaints can also provide important feedback for individual health care professionals. For the organisations responsible for providing care, complaints are a source of information to be used in the maintenance and improvement of standards of service provision. For society as a whole, mechanisms which allow complaints to be expressed are an important way of ensuring professional accountability, upholding a sense of justice, protecting both patients and professionals, and safeguarding standards of service quality.

Therefore a single complaint may simultaneously constitute a demand for an official explanation and apology, a challenge to professional authority, a piece of management information about service quality and a mechanism of ensuring a socially just and accountable health service. By considering the different perspectives in turn, it is possible to identify the aims of any system for dealing with complaints.

The Personal Perspective

Two questions must be asked when considering the complaints process from the complainant's point of view. First, what are the reasons for wanting to make a complaint? Second and conversely, what factors may stop people from complaining?

Why do people complain?

What makes people want to complain? Different people obviously have different motivations, but they usually include at least one of the following:

Information and explanation: People may want to complain in order to find out what happened. The full details of the event(s) may not have been forthcoming at the time, and people may want an official explanation. If such information is provided appropriately, some complainants will be satisfied that their demands have been met.

Acknowledgement and apology: People may want official acknowledgement or recognition of the mistreatment which they or their relative experienced. Some people, therefore, will be content to draw attention to the event(s) and to obtain and to accept an official apology for what happened.

Preventing recurrence: Commonly an important motivation for wanting to make a complaint is to obtain a reassurance that action will be taken by the appropriate authorities to try to ensure that 'it doesn't happen again'. This may be the case particularly for those who envisage that they will require further treatment, and so complainants may be acting in their own longer term self-interest. But some may want such reassurance to protect others.

Blame and disciplinary action: A complainant may want to know whether anyone is to blame, and, if so, what disciplinary action will be taken against the offending party, whether an individual health care professional or an organisation.

Compensation: Another reason for making a complaint is the desire for compensation. This is a relatively rare motivation for complaining, although it is obviously one reason for pursuing a complaint as far as litigation.

'Doing something': People may be motivated to make a formal complaint for their own sense of personal well-being, in order to ease distress and feel better, and to feel that they are 'doing something'. This may well be relevant in many cases involving health services because the patient is often supposed to be just the passive recipient of care, and may also be important for people processing loss if they have been bereaved due to perceived mistreatment. This is the least visible motive for making a complaint.

Overall: There is a range of motives for making a complaint about health care treatment. The three most common reasons, namely wanting information and an explanation, wanting an apology and a reassurance that it won't happen again, are apparently quite modest. Few complainants ostensibly seek compensation. However, grievances can escalate and be compounded if the complaint itself is handled badly. Many of the complaints investigated by the Health Service Commissioner relate to the handling of complaints themselves.

What prevents people from complaining?

It has long been recognised that the numbers of official complaints represent only 'the tip of the iceberg' of people's grievances with the care they receive. This was found to be the case in 1973 for both family practitioners and hospital services, as reported by Rudolf Klein and the Davies Committee respectively. Likewise, in *Grievances, Complaints and Local Government* (Avebury 1992), Peter McCarthy and colleagues published the results of a survey which found that two thirds of grievances did not become formally expressed as complaints. Instead many were resigned to 'lumping' their grievances.

There are a number of possible reasons why people find it difficult or impossible to complain, and remain 'lumping' their grievances instead. These include:

Low expectations of standards: The most basic reason for someone not making a complaint about the service which they have received is that they do not realise that they have been badly treated, since they are ignorant of the standards of care to be expected.

Ignorance of complaints procedures: A more widespread area of ignorance in the NHS concerns the procedures for making a complaint. People may be ignorant of their entitlements to make a complaint, or of the proper procedures which need to be followed in order to claim that entitlement. Without some degree of publicity and visibility, many people will not be aware of what options are open to them. Recent studies have found such ignorance to be widespread.

In *Focus on Health Care* (RIPA/SCPR, 1988), Patricia Prescott-Clarke and colleagues reported that one of the two most common reasons for not complaining about health service treatment was that people did not know how to make a complaint. Over a quarter (27 per cent) of would-be complainants stated that the lack of knowledge of procedures was the reason for not making a complaint. *Consumer Concerns*, a National Consumer Council survey of health service 'consumers' in 1993, found that only one per cent of respondents mentioned a FHSA when asked about their knowledge of how to make a complaint about a GP. Awareness of Community Health Councils was also very low – they were mentioned by just two per cent of respondents.

Inarticulate: People may not be sufficiently articulate to voice their complaints. This may be true of the mentally ill, mentally handicapped, the old and those who do not speak English. Being unable to read or write adequately or to express a problem verbally, or being reluctant to use the telephone are also significant. The importance of the support from a 'significant other', particularly if a patient is seriously ill or has died, is an important factor in determining whether or not a complaint is made. For instance, the lack of support for non-English speakers was highlighted by an Audit Commission report, *What Seems to be the Matter?* in 1993. More generally, a lack of support for complainants, particularly inadequate information, advice and advocacy, is one reason why people do not express their complaints officially.

Feeling uneasy in dealing with authority: People may be put off by the prospect of having to approach officials, particularly if they have had experience of insensitivity and arrogance on the part of professionals. There is also consistent evidence that people do not like to make a fuss. Often people report that they 'don't like to cause bother' and are reluctant to 'trouble' officials.

Pointless: The belief that there is no point in complaining because no one will take any notice is an extremely common reason for not complaining about public services. Prescott-Clarke and colleagues found this to be the most common reason for not complaining about health services, as one third of would-be complainants stated that this was why they had not complained. McCarthy and colleagues found that this reason was particularly common among users of public services in relatively advantaged areas. People tended to be generally cynical, holding the view that 'complaining is just a waste of time' and would not be taken seriously.

Fear of retaliation: People may not make a complaint for fear of retaliation, either while they are currently receiving treatment, or during an envisaged future episode of care. Some may well be reluctant to voice any form of criticism to people who, whether directly or indirectly, will be responsible for their future care. This applies particularly to the most vulnerable as they expect to receive health care treatment in the future. This argument is supported by evidence from patient satisfaction surveys which consistently find that the elderly are far less critical of the health care they receive, the most likely reason being that they fear reprisals from staff and/or institutions on which they have to depend for further care. Fear of retribution or victimisation has been reported specifically as a reason for not making official complaints.

Personal resources: People may be deterred by the amount of personal resources which are consumed during the process of complaining. These include the time involved in making and pursuing a complaint, the emotional energy needed and the strain experienced during the process. McCarthy and colleagues found that: 'It is often felt to be cheaper in terms of time and effort to accept the grievance'.

Gratitude: Feelings of loyalty may override grievances. This is often referred to as the 'gratitude barrier'.

Overall: These barriers have profound implications when considering NHS complaints procedures and the work of organisations which represent patients and of pressure groups. In a way the obstacles outlined here actually define a large part of the work of such bodies. Their aim is to articulate complaints on behalf of patients, to inform people of their rights and of the way to proceed, and to lower the costs of expressing 'voice' by helping people to make and pursue a complaint.

These obstacles are common to any system of making complaints. The aim of any organisation which takes the perspective of the complainant seriously must be to minimise these obstacles. Before turning to how this might be done, we consider the interests of the other parties involved.

The Professional's Perspective

Health care professionals respond to complaints for a variety of reasons, which can be seen as negative or positive. There are, however, a number of factors which may inhibit their responses.

Negative reasons: Health care professionals must reply appropriately to complaints in order to fulfil statutory requirements or their terms of contract or employment. They must also uphold professional standards, and remain accountable to their profession's regulatory body. At the individual level, professionals have an incentive to respond to complaints appropriately in order to avoid damage to their personal reputation and to minimise the personal distress resulting from complaints being made against them.

Positive reasons: Health care professionals can positively accept the legitimacy of lay suggestions, patients' criticisms and complaints as soon as possible in order to address the concerns of people regarding their treatment, or that of a relative. The sooner a complaint is dealt with, the less intense will be the complainant's feelings of frustration and the more likely it is that any escalation of the complaint can be avoided, to the benefit of all concerned, including the practitioner.

Possible inhibitors: There are a number of factors which can inhibit the responsiveness of health care professionals to expressions of patient views in general and complaints in particular.

First, there are frequently socio-cultural differences between patients and professionals which tend to aggravate gaps in understanding. There is a rich literature detailing the substantial imbalances in power in all health care interactions. These imbalances apply particularly in situations where the clinical judgement of professionals is questioned by patients.

Second, there may be perceptions of threat to the professional's authority, especially where the prevailing culture and attitudes guard against any perceived challenge to clinical autonomy. A common response to perceptions of threat is that clinicians may react defensively to criticisms.

When considering complaints within the context of health care generally, it is clear that professional power still far exceeds patient power, in terms of skill, knowledge and other social and economic resources. It is essential for such imbalances to be widely acknowledged and for professional awareness and standards of communication to be improved. This would be welcomed by users of health services and would also benefit professional providers of care. The need for improvement in the quality of communication in health care generally has been widely publicised, for example by the Audit Commission in 1993, in the report already cited.

The Organisation's Perspective

There is no threat of large scale 'consumer exit' from the NHS. Why, therefore, should health service organisations be motivated to respond to complaints? There may be negative and positive reasons.

Negative reasons: Health authorities and service providers are required to fulfil legal and statutory requirements. These constitute a formal mechanism of accountability, in the form of top-down directives, issued as part of the political process. Furthermore, organisations may be motivated to deal with complaints 'properly' in order to avoid adverse publicity.

Positive reasons: Managers or administrators within an organisation can be motivated in all their activities to act justly, out of an ethos of public service. In dealing specifically with complaints, this may include a desire to provide a fair service based on a notion of justice.

Managers should also be interested in complaints for reasons of efficiency and quality assurance. They should want to increase the responsiveness of organisations by acting on the information provided by complainants. They should also want to improve quality generally, since complaints relate to only a small proportion of unsatisfactory experiences of a large public service.

This instrumental role of complaints has become more prominent since the implementation of *Working for Patients* and *Caring for People.* As one feedback measure of quality available to purchasers, there is potential for information about complaints to be considered in the contracting process. If purchasers become aware of poor complaints procedures, they may be less likely to purchase services from the same provider unit again. The importance of complaints in the contracting process is likely to increase with the further development of the internal market within the NHS.

Society's Perspective

What are the interests of society as a whole regarding complaints procedures? Tax-paying citizens and their representatives have an interest in a series of goals being fulfilled by a complaints system.

Justice: The existence of complaints machinery in a state-provided public service ensures some degree of trust and confidence in 'the system', to the extent that it upholds some notion of justice. It is important for members of society to know that people with a legitimate grievance against public servants and services can have access to a formal means of obtaining redress, and equally that professionals can have the opportunity to respond.

Accountability: It is also essential to have some formal mechanism for ensuring professional accountability, and preferably one that goes beyond simple self-regulation. Historically in Britain, however, this has been problematic as the power of the medical profession in particular has successfully resisted attempts by 'the State' to make it more accountable.

Protecting patients: Patients receiving health care are particularly vulnerable and powerless users of a state-provided public service, and so need protection against possible mistreatment.

Protecting professionals: While it is essential to protect powerless patients in their experiences of health care, it is also important for a complaints system to protect health care professionals from unreasonable distress or unwarranted slurs on their reputation.

Safeguarding standards: Complaints procedures can highlight areas in which the delivery of health care is deficient, and hence where society may be able to achieve better value for money. In this way complaints can be another mechanism of public accountability, this time in the form of quality audit and a potential means of ensuring management accountability.

Criteria for Evaluation

By being prescriptive about what an ideal complaints system *should* be like, we can evaluate both the existing and proposed arrangements in terms of the extent to which they fulfil or fall short of the ideal characteristics. The preceding discussion suggests a number of criteria or characteristics which should ideally be embodied in a complaints procedure for the NHS. These are:

- Entitlement to complain
- Visibility of process
- Accessibility
- Flexibility
- Transparency
- Speed of response
- Representation
- Impartiality
- Powers of investigation
- Rights of appeal
- Monitoring of results

Entitlement to complain: All the criteria for evaluating a complaints system are predicated on the assumption that there is an entitlement to complain which may be exercised whenever a person feels inclined to do so. This assumption should not be taken for granted, as spelt out by Diane Longley in *Public Law and Health Service Accountability* (Open University Press 1993):

> *Complaints and their handling are a fundamental aspect of accountability; part of a belief that in a democratic system there must be an opportunity for the public to air and redress their grievances. A lack of effective avenues for complaints resolution is in itself an injustice.*

Visibility of process: There must be publicity about the mechanisms of making complaints and the circumstances in which they can be set in motion. The publicity should appear both within health care units and within the wider community, with the aim of encouraging people with grievances to voice them. The aim should be for a system which is more than simply reactive; the arrangements and the ways in which they are publicised should actively encourage people with grievances to make complaints.

Accessibility: Making a complaint should be simple, straightforward and free. People should not have to bear any financial cost in making a complaint, and the system in place should be easy to understand by any potential complainant.

Flexibility: An ideal system should allow for the variety of purposes which a complainant may intend to have served by using it. The implication is, of course, that the system should regard the aims of the complainant as paramount.

Transparency: While the procedures should be visible to people who may wish to make a complaint, they should also be transparent to the complainant during the process of investigation, once the complaint has been made. The procedure should be clear, and the full details of both its progress and outcome should be given to the complainant.

Speed of response: There should be reasonable, explicit time limits for all stages of the procedure. Complaints should be acknowledged within a matter of days and resolved in a matter of weeks, or at most months. Delays should be minimised, without having time limits which are so stringent that they reduce accessibility.

Representation: In a complex and often technical public service, where there will be an imbalance of relevant knowledge and experience between service providers and users, there should be arrangements for providing support for anyone wishing to make a complaint. In addition, from society's perspective, it is important to have some form of lay involvement in the investigation of complaints in order to ensure the accountability of health care professions.

Impartiality: Complaints procedures must be fair and unbiased. Equally as important, they must be seen to be so. It is not clear whether procedures must be independent to be impartial. There are two main arguments against the complete independence of complaints procedures. First, providers will inevitably always have to have some sort of procedure for handling complaints at an early stage. Second, it is argued that consumers are likely to receive a better service if providers have to resolve the problems they create and take responsibility for their actions.

However, others argue that a system for handling complaints will be fair only if there is a degree of independence in the internal procedures. This would mean the use of complaints officers and investigators who are seen to be impartial, as well as increased lay involvement. It is argued, therefore, that a greater degree of independence in the system will result in greater impartiality – both actual and in appearance.

Powers of investigation: Those conducting the investigation should have access to the information and expertise necessary. They should be able to initiate action to address the complainant's concerns, and have the powers to enforce compliance with any recommendations made.

Rights of appeal: Both complainants and respondents should have the right to appeal to an independent body.

Monitoring of results: Data should be collected, analysed, published and used in order to improve services – both the handling of complaints and the quality of health care itself. They should include at least the nature of the complaint, the time taken to resolve it, the outcome and whether the complainant was satisfied. Only by such monitoring can complaints be used to improve the quality of services and as a means of ensuring public accountability.

An Assessment of Current Procedures

The existing NHS complaints procedures are outlined in **Existing Complaints Procedures.** They have been widely criticised for a series of deficiencies.

Entitlement to complain: There is a range of avenues by which people with grievances about NHS treatment can lodge a complaint. However, in cases where negligence is suspected, people's entitlement to complain may be limited or even withdrawn. There may be bias towards non-disclosure, while in the extreme health authorities may decide to proceed with an investigation only if a complainant has undertaken not to litigate. Thus the non-legal avenue for pursuing complaints is only opened by shutting off the legal avenue. This clearly presents dilemmas for complainants, and compromises many of the goals of the whole system.

Even more disturbing is that this principle has received the support of the Health Service Commissioner. The Commissioner's report for 1988/89 describes an investigation which was halted precisely because negligence had been uncovered and the health authority feared litigation. The decision to abort the investigation received the Commissioner's approval. The dangerous implication of this decision is that the most serious complaints about NHS treatment are handled in the least satisfactory way.

Such restrictions do not apply to 'non-clinical' complaints. Official guidance in Health Circular HC(88)37 states that:

> *The possibility of legal proceedings should not prevent the officer undertaking the investigations necessary to uncover faults in procedures and/or prevent a recurrence.*

There does not appear to be any obvious reason why this principle should not be applied equally to 'clinical' complaints.

Visibility: The widespread ignorance and lack of awareness of complaints procedures was outlined above. The Association of Community Health Councils in England and Wales has called for increased emphasis on easily understood publicity addressing: the patient's right to complain; clear guidance on how, why and where to do so; where to go for further advice; the importance of making an early approach. In the first instance people need to know whom they can approach to establish what they want from the system.

Accessibility: The current procedures are extremely complex and fragmented, with the consequence that

Existing Complaints Procedures

There are a number of different procedures for making a complaint about NHS services.

Family Health Services

Complaints made against family practitioners are investigated by Family Health Service Authorities (FHSAs) through either formal or informal arrangements. When someone informs a FHSA that they wish to make a complaint, they are told about the different procedures, and it is their decision as to which avenue they would like to pursue.

The formal procedure: Complaints made against a family practitioner can only be investigated formally if, in the FHSA's judgment, there is a possibility that the professional's terms of service with the FHSA have been breached. The complaint must be made within 13 weeks of the event giving rise to the complaint, unless the practitioner agrees to a 'late' complaint. If these conditions are satisfied, then the complaint is investigated by a service committee, made up of three lay people and three professionals, plus a chair who is usually lay. The formal procedure consists of three stages.

At the first stage, the complaint is screened by the chair of the service committee, usually accompanied by professional advisors. If, in the Chair's opinion, the complaint does not involve an issue related to the terms of service, then the complainant has 14 days to submit any further information which might change the decision not to investigate the complaint. If the complaint is to be investigated, then the practitioner has four weeks to respond to the service committee, and the complainant has 14 days to respond to the practitioner's comments.

There is a service committee hearing, at which the complainant can be accompanied by a friend or Community Health Council representative. The practitioner may be accompanied by a friend or colleague, usually a member of their Local Professional Committee. In this quasi-judicial setting, neither 'side' can be represented by a lawyer.

The service committee makes recommendations to the FHSA, which then sends a full report to all parties. If the complaint is upheld, the FHSA may reprimand the practitioner by issuing a warning or by withholding a proportion of their remuneration. In serious cases, the matter can be referred to the NHS tribunal, which has the power to remove names from national lists of NHS practitioners. This does not affect a practitioner's right to practise privately.

At the third and final stage, either party can appeal to the Secretary of State via the National Appeals Unit. If an appeal is to be heard, a panel of three sits, consisting of two medical practitioners and a legally qualified chair. Both parties can be legally represented.

The informal procedure: This is an alternative to the formal procedure. It can be used when the complaint concerns a matter either within or outside the practitioner's terms of service, including issues of communication and manners. The FHSA appoints a lay conciliator to attempt to resolve the dispute between the complainant and the practitioner. If the complainant is dissatisfied, they have a right to a formal investigation of their complaints, but only if there is an alleged breach of the practitioner's terms of service.

Hospital and Community Health Services

Each provider unit is required to have a 'designated officer' to handle complaints. In the first instance, this officer has a responsibility to receive each complaint and to instigate either the non-clinical or clinical procedure.

Non-clinical complaints: The designated officer investigates the complaint and sends a report to the complainant. If the complainant remains dissatisfied, the matter can then be referred to the Health Service Commissioner.

Clinical complaints: A complaint can be made either orally or in writing. There is a meeting between the complainant and the consultant responsible for the treatment. The consultant has a responsibility to look into the complaint and to give a written response to the complainant.

If dissatisfied, the complainant can write to the Regional Medical Officer (RMO). The RMO is usually the Director of Public Health in English authorities, in Wales the Medical Officer (Complaints) at the Welsh Office, or the Chief Administrative Medical Officer in Scottish health boards. The RMO meets both the complainant and the consultant, who may also meet each other again. If the matter is still unresolved, the RMO decides whether to move to the third stage of the process, independent professional review.

The procedure of independent professional review is intended for cases which are serious but are unlikely to go to court. The review is carried out by two consultants in a similar specialty, at least one of whom comes from outside the region in which the event(s) occurred. They examine the records, interview the consultant and any other professional staff involved, and interview the complainant, who may be accompanied by a relative or friend. The assessors then make a written report to the RMO. It is then the RMO who gives a written summary reply to the complainant. There is no right of appeal, even to the Health Service Commissioner.

The Health Service Commissioner

The Commissioner can investigate complaints: that a NHS authority has not provided a service which it has a duty to provide; about a failure in a service provided by a NHS authority; about maladministration connected with action taken by, or on behalf of, a NHS authority. This remit includes the handling of NHS complaints themselves. However the remit does not include clinical complaints, formal complaints concerning family practitioners, or cases where legal action might be taken.

A complaint must be made within a year of the matter concerned. If a decision is made not to investigate the complaint, then reasons for the decision must be given to the complainant. If there is an investigation, it can involve interviews with the complainant and all staff involved. A written report is then sent to the complainant, the relevant authority and the staff about whom the complaint was made. If the complaint is upheld, the report describes the remedial action agreed to be taken by the authority. However, the authority is not obliged to act on the Commissioner's findings.

Professional bodies

Allegations of 'serious professional misconduct' can be investigated by the self-regulating bodies of the health care professions, such as the General Medical Council or equivalent. These bodies set standards of professional conduct and have powers of discipline over their members.

Members of the public can complain to these organisations directly. Complaints tend to be screened before being referred to a professional conduct committee. These committees serve a judicial function. Disciplinary action includes the issuing of cautions, the imposition of conditions and restrictions on registration, suspension and striking off (or 'erasure') from the register of qualified professionals.

Litigation

People can sue medical professionals under the law of negligence. Most cases of alleged medical negligence are heard at the High Court. The plaintiff must show that, first, the defendant owed a duty of care; second, the defendant, in breach of that duty, behaved negligently; and finally, the defendant's negligent behaviour caused damage to the plaintiff. Where liability for negligence is established, damages are awarded for monetary and non-monetary loss.

anyone wishing to make a complaint about health services will face a confusing collection of distinct procedures and strange acronyms. It is essential that this complexity is greatly simplified.

The continued separation of complaints procedures for primary and secondary care has been consistently criticised. It may make sense from the professional or administrative perspective, but makes far less sense to NHS patients, particularly if they have received care from a variety of 'sectors'. It is a clear example of the way the collection of procedures has evolved haphazardly, rather than being designed as a coherent system.

There are also substantial difficulties in obtaining support. Very few complainants are aware of Community Health Councils, and consequently they deal with only a fraction of complaints. The number of requests for help they receive is increasing, with little or no matching increase in staffing and/or resources. The increasing pressure on them may have important implications, since they aim to find out what people want from 'the system' before any complaint is formulated. Without this step, the tensions within the complaints machinery may well worsen.

Flexibility: The current arrangements have not been designed from the perspective of those who are potential users of the system. It is assumed that it is possible to separate each complaint into discrete elements to be dealt with via the appropriate channels. However, it is not always possible or even desirable to make distinctions, such as that between clinical and non-clinical matters.

There is clearly a problem of inflexibility inherent in the requirement to 'find fault' in the formal settlement of complaints. The judicial approach of most procedures is far from ideal in providing the majority of complainants with what they want from the system.

Transparency: While some procedures meet this criteria, the process of independent professional review has been widely criticised, since the outcome for the complainant is only a summary report from an officer who did not conduct the investigation. This inevitably reduces the levels of satisfaction with the process.

Speed of response: There are various time limits in force in different procedures. In particular, the current time limit of 13 weeks to lodge complaints against family practitioners is seen by many as an unnecessary and unreasonable obstacle to potential complainants. The hospital procedure does not rely on the same time limit. In its submission to the review committee in 1993 the National Association of Health Authorities and Trusts (NAHAT) proposed that the minimum time limit should be 13 weeks from the time when the complainant first became aware of the matter, rather than from the date of the event, as at present. NAHAT suggested that 'these arrangements apply throughout the NHS'.

In contrast with such constraints, there are no statutory deadlines to be met by those investigating complaints against family practitioners. This is one potential cause of delays in resolving complaints. Delays create an even less attractive picture for potential complainants. They may well also lead to a worsening of situations which are the subjects of complaints, affecting both complainant and respondent. It is in the interests of both complainant and respondent to have a speedy resolution to complaints. Delays benefit no-one.

Representation: Representation is vital in two respects, to support complainants throughout the process, and in providing lay input into the conduct of investigations. In its submission to the review committee in 1993 the British Medical Association argued that both complainants and respondents should have access to representation of equal quality. The Association urged Community Health Councils to train their officers to a standard which is similar to those of secretaries of local professional committees and representatives of medical defence unions. It is hard to dispute these desires, but it seems that the current situation does not reflect this ideal picture. CHC representatives are rarely as experienced in the area of complaints as their local professional committee counterparts.

In its submission to the review committee in 1993, *It's OK to Complain*, the National Consumer Council stated that:

> *Many user groups would argue that a commitment to complaints procedures that does not include meeting consumers' needs for independent representation is no commitment at all.*

One proposal is to permit legal representation for both parties. However, this suggestion is opposed by the British Medical Association, which argues that the involvement of lawyers might hinder moves towards conciliation. This is quite a powerful argument, but the problem remains, therefore, of how to ensure equal representation.

One possibility would be to increase the resources available to CHCs to train staff in this area, to ensure that complainants are accompanied by representatives who are trained to a generally accepted standard which is comparable to that of the respondent's representative. One popular approach is the introduction of joint training initiatives, in which staff from health authorities, provider units, CHCs, FHSAs, local professional committees and other relevant parties receive the same training, in an effort both to promote equal representation and to help the process as a whole run more smoothly. Another possibility might be a lay investigator commissioning an independent professional adviser to provide expert evidence where necessary.

There are also inconsistencies in the degree of lay involvement required in different procedures. While FHSA service committees must have equal numbers of lay and professional members, plus a lay chair, there is no lay involvement in hospital complaints procedures.

Impartiality: The lack of independent investigations of complaints is a common source of criticism of the system in this respect. While defenders of the current arrangements argue that they are impartial, it is clear that at the very least they are not seen to be so. The lack of lay input in the clinical hospital procedure has been particularly criticised. The British Medical Association has argued that clinicians must retain an 'active part' and a 'central role' in a system of dealing with complaints which is fair – to staff as well as complainants. Such involvement would seem to be desirable for all parties, but it is not clear why this should necessarily mean that clinicians should be in overall charge of investigations. The Association's view still seems consistent with the proposal to have independent lay investigators of 'clinical' complaints who can commission clinicians to provide professional expertise and advice as and when it is required. The status of the Health Service Commissioner is an example.

Powers of investigation: There is clearly a mixture of powers, according to procedure. More formal procedures may have greater 'power', but are actually less effective in producing outcomes that are satisfactory to the parties concerned, particularly complainants. More often informal procedures tend to have more scope for addressing the concerns of complainants.

One way of evaluating the effectiveness of complaints procedures is to assess the level of satisfaction which complainants have with the system. One example is the low levels of complainants' satisfaction found by Leeds CHC in 1993. Over half of those advised by the Council were dissatisfied with the result of making their complaint. More damning was a 1993 NHS Management Executive survey of complainants in Scotland, *The Patient's Charter*: *What People Think*, which found that only one out of 36 people surveyed was satisfied with the outcome of the process.

Rights of appeal: It is hard to justify a system for dealing with complaints which does not allow a right to appeal for any party. While this principle has been long-standing policy, and is now enshrined in the Patient's Charter, there are clearly problems with access to the appeal function of the Health Service Commissioner. The major obstacles are the restrictions on the remit of the office, such that clinical complaints and formal complaints against family practitioners are excluded, as well as those complaints where litigation has not been ruled out. Criticism of this limited scope is widespread.

Monitoring of results: A good complaints system must not only deal with grievances which arise, but must also provide information through monitoring concerns in order to improve the service offered. For this to become reality in the NHS, there is a need for systematic methods to be developed for the recording of complaints, and for the provision of feedback to health service staff. In particular, with the move towards increased use of informal approaches for dealing with complaints, it is important that effective recording systems are in place to monitor informal ways of handling grievances.

In 1993 the House of Commons Select Committee on the Ombudsman criticised (HC 33-I) the present position and recognised the need for improvement:

> *Statistical evidence is seriously inadequate ... Existing national statistics about complaints to health authorities are all but useless for the purpose of identifying patient concerns or improving the service ... [the paucity of information] suggests that, despite its pronouncements on the value of complaints, the NHS has yet to turn good intentions into practice. We recommend that the NHS Management Executive gather centrally comprehensive statistics on the workings of the complaints systems within the National Health Service.*

Overall: The criticisms of the present procedures were effectively summarised by NAHAT in their submission to the review committee in 1993, in the following words:

> *There is considerable dissatisfaction within the NHS; amongst the health professions and organisations representing patients and also amongst informed opinion regarding the current arrangements for handling health service complaints. The arrangements are seen as being over complex, failing to be user-friendly, taking too long, often over defensive and often failing to give any satisfactory explanation of the conclusion reached.*

The existing NHS complaints system definitely needs to be changed. Given that realisation, to what extent would the recommendations of the Wilson review committee improve the situation, and to what extent could it be argued that they fall short on certain criteria or omit important issues?

Review Committee Proposals

The review committee explicitly identified nine principles which must be incorporated into any NHS complaints procedure. These are: responsiveness; quality enhancement; cost effectiveness; accessibility; impartiality; simplicity; speed; confidentiality; accountability. Despite some differences, they are very similar to the criteria for an ideal system outlined above and, not surprisingly therefore, several recommendations of the review committee about the features and design of a new complaints system are to be strongly supported, specifically:

- The unification of the complaints system and the emphasis on simplicity, which should lead to a much-needed improvement in accessibility;
- The emphasis on the use of informal processes first, the use of conciliation and the use of investigation which is related to the wants of complainant, which should mean that the system will be flexible enough to address the concerns of complainants;
- The emphasis on publicity which should improve visibility and accessibility;
- The emphasis on staff training and support for complainants and respondents;
- The separation of disciplinary procedures from the complaints system, which should improve the flexibility of the process;
- The recommendation that the whole complaints procedure must be completed within three months, which, if implemented successfully, would greatly increase the speed of the process;
- The recommendation that complaints records be kept separately from medical records, which would improve confidentiality;
- The recommendation to extend the jurisdiction of the Health Service Commissioner to include formal complaints made against family practitioners.

Overall, the report and recommendations of the review committee are to be welcomed. The thoroughness with which the whole issue of complaints has been discussed, and the progressive proposals for change which have emerged, point the way to substantial improvements in the way in which complaints are handled in the NHS. However, it is important to highlight areas where the recommendations fell short of meeting the ideal criteria discussed above, or where important issues from the perspectives of different parties may have been overlooked. We turn to this task in the final section.

Room for Improvement

We can identify four areas where the review committee's recommendations did not go far enough. These can be summarised under the headings of:

- Reducing the barriers to complaining;
- Ensuring impartiality;
- Improving accountability;
- Changing attitudes.

We now set out what additional action is required within each of them.

Reducing the barriers to complaining

Any complaints system needs to reduce the barriers which prevent people from complaining. The 'iceberg' of grievances about the NHS must become more visible by making it easier for people to voice their complaints. There are a number of ways in which the review committee's recommendations could have gone further in reducing the barriers to complaining.

The committee recommends that publicity should be improved. However, there is a need to be far more prescriptive about the way in which any new procedure will be publicised.

- There must be explicit requirements for publicity which is visible and informative in all health care settings, such as hospital wards, waiting rooms, health centres and GPs' surgeries, as well as for information which is given to each patient. The increased publicity must, importantly, serve to encourage complaints, and must concern all parts of the system.

The committee's recommendation for improved confidentiality is certainly to be welcomed. However, it is unlikely to be sufficient to allay people's fears of victimisation, which is a necessary and integral part of improving the accessibility of the system.

- There must be requirements for specific reassurances to be given about the unlikelihood of retaliation against complainants. In particular, would-be complainants who are powerless and vulnerable need safeguarding against the possibility of retaliation, especially as a new complaints system will mean that complaints are handled closer to the point at which they are made.

Far more detail needs to be given about exactly how the wants of the complainant can be ascertained and clarified initially. It is also important to be explicit about how the complainant would be helped to think through and articulate what s/he actually wants.

- The requirements of this preliminary stage, before conciliation is even arranged, need to be made far more explicit.

The importance of patients' friends cannot be overemphasized. While CHCs are mentioned in the committee's report, there is a wide range of potential sources of help for complainants, including patients' representatives and advocates. This is particularly important for people with special needs. While the review committee does mention 'vulnerable groups', no further details are given. One cannot assume that all would-be complainants are equally articulate.

- It is vital to increase people's sense of empowerment in order to overcome barriers to complaining, and to be far more prescriptive about how this can be achieved. The complete range of organisations and schemes on offer needs to be reviewed, publicised, and extended where possible in order to increase the support available for complainants.

The proposed first stage of the procedure could lead to buck-passing, discouraging the pursuit of complaints. It is important for complainants to have to tell their story only once, and not to feel that they must repeat it to a number of officials. A 'single door' approach has received widespread support, both from Community Health Councils and the British Medical Association.

- There needs to be a 'single door' approach to the new arrangements.

Ensuring impartiality

Arrangements for handling complaints must be impartial and must be seen to be so. This is essential if there is to be any hope of overcoming people's cynicism and sense of 'pointlessness' about complaining. The review committee's recommendations could have gone further to improve the impartiality and the perceived impartiality of both the informal and formal stages of the proposed new procedure.

- In the informal stage, the need for conciliators to be seen to be impartial must be stressed.

There are two serious questions about the impartiality of the formal second stage procedure proposed by the review committee. One concerns access to, the other ownership of, the procedure.

The impartiality of the gatekeeping function whereby complaints are screened for consideration is open to serious doubt. First, the decision may well be taken just by one officer. Second, the proposal allows no right of appeal for the complainant. In view of the criteria of accessibility, impartiality, representation and the right to appeal, this situation is far from ideal.

- The complainant should have the right to representation in the decision whether to go to the formal stage, and should certainly have the right to appeal.

The presentation of a menu of options for ownership of the formal second stage procedure is less than wholly satisfactory. It can be argued whether or not all four options would truly ensure impartiality. But what is more important is the appearance of impartiality. A significant barrier and a major cause of complainant dissatisfaction with the existing arrangements is the perception that the procedures are biased against the complainant. Anything other than a truly independent formal investigation of the complaint at the second stage would fail to allay such concerns. The fact is that the perception and appearance of impartiality is more important than the reality in determining people's decisions about whether to make or to pursue a complaint.

- In terms of the review committee's recommendations, therefore, the option of an independent complaints commission must be selected for the new system to be credible and truly user-oriented.
- There must be clear guidance that no investigations should be blocked or aborted if negligence is suspected. The possibility of litigation should in no way prejudice an investigation of a complaint.

Improving accountability

There is one area where the review committee's recommendations lack the precision needed to address this principle, and one issue where they fail to ensure that it is upheld at all.

The review committee recommends that the process of recording and monitoring complaints needs to be improved in order to improve accountability. However, the proposal is that a Task Force be set up to look into this separately. This is unfortunate, since it is important to put into place the recording and monitoring processes at the same time as considering the system as a whole. There is also no mention of what information will need to be collected, and most importantly, why. Serious consideration must be given to the reasons why complaints data are collected. It seems short-sighted to propose a new design for a complaints system without stating what its appropriate outcome measures will be and how they will be recorded and monitored.

- Complaints data should include at least: the nature of the complaint; the length of time taken to resolve it; any resulting action; and complainant satisfaction. Detailed specifications must be incorporated into contracts.

The review committee recommends that the Health Service Commissioner's remit be extended to cover formal complaints about family practitioners, but does not recommend that it should be extended to include matters of clinical judgement, because of 'practical difficulties'. This is not sufficient. The review committee itself has recommended removing the distinction between 'clinical' and 'non-clinical' complaints, yet does not recommend its removal at the appeal stage. The importance of having a comprehensive appeal stage in the system is crucial if public confidence is to be maintained. The increase in the Commissioner's workload will happen anyway if, as is hoped, complaints will be encouraged and will increase. The 'practical difficulty' of separating the offices of the Parliamentary and Health Service Commissioners is inevitable and probably desirable anyway. The inclusion of matters of clinical judgement within the jurisdiction of the Health Service Commissioner was recommended as long ago as 1977 by the House of Commons Select Committee on the Ombudsman.

- The Health Service Commissioner's jurisdiction should be extended to cover complaints which incorporate clinical judgement, in addition to formal complaints against family practitioners.

Furthermore, there is potential for the Health Service Commissioner, on the basis of the expertise developed through experience, to issue some form of 'code of good practice' for handling complaints.

- There should be legislation to grant the Commissioner the power to conduct audits of complaints procedures, as recommended by the House of Commons Select Committee on the Ombudsman in 1993.

Changing attitudes

Ultimately, to be effective, a system for handling complaints must operate in a context where complaints are seen in a positive light. There needs to be a change in both the complaints procedures themselves and in the attitudes of people who must make them work. Expressing grievances must be seen as a constructive act by all parties involved – patients and relatives, health care professionals, administrators and managers, and ultimately society as a whole. There needs to be a 'cultural change' in the way complaints are viewed, so that, in the words of the title of the National Consumer Council submission to the review committee, people feel that *It's OK to Complain*.

There is a fundamental need for major attitude change. There are doubts whether the review committee's recommendation for extra staff training is sufficient to address the issue of changing attitudes.

- Re-training in the areas of complaints and communication generally is essential for health care professionals as well as administrative and managerial staff. The implications for professional education must also be considered and specified.

However, it seems naive to expect such changes to occur without any increase in the need for resources. There will inevitably be greater need for resources, a point that remains unspecified in the report.

- For NHS staff to do their job properly in handling complaints and in making a new system work, whether they work in health authorities, provider units, Community Health Councils or elsewhere, there will need to be extra resources made available.

Fundamentally, we should move beyond thinking solely about 'complaints'. New, positive attitudes and a new organisational framework should enable more positive comments and suggestions to be made by patients and used by NHS staff. Complaints procedures are only one part of a range of mechanisms whereby patients can provide feedback about the treatment which they receive.

- Ultimately consideration should be given to more integrative ways in which people can participate in decisions about health care planning and service delivery.

Conclusion

The need for improved complaints procedures in the NHS is evident. The approach taken by the review committee is to be welcomed, and the recommendations made must not be diluted in the consultation process, as happened with the recommendations of the Davies Committee in 1973, when opposition watered down proposals to make complaints procedures more impartial.

However, there is still 'room for improvement' in the review committee's recommendations. In particular, more needs to be done in order to minimise the obstacles which prevent people from making complaints, to improve the impartiality and the perceived impartiality of the arrangements, to improve accountability and to change attitudes to complaints.

The perspectives of complainants, professionals, organisations and society as a whole must all be considered in the introduction of new complaints procedures. In contrast to the current system, this will mean that greater emphasis must be given to the personal perspective. If the barriers which prevent people from complaining are not reduced, the system will continue to deal with only the 'tip of the iceberg' of all grievances. If so, it will be limited and compromised in its aims to improve the effectiveness, fairness and accountability of the NHS. It does not matter how well complaints procedures are designed if people do not make use of them.

THE ACCOUNTABLE PROFESSIONAL IN THE NHS

Jane Lightfoot

`Accountability is in vogue'. So said Bill New in last year's edition of *Health Care UK* in which he traced the contours of this ambiguous concept in the context of the NHS. Current interest in accountability and its ambiguity stem from the increasing complexity of modern democratic societies. The plethora of public agencies now needed to operate the affairs of state means that effective accountability in the traditional sense – that is direct accountability to `the people' by those in elected office – is increasingly difficult to sustain.

Instead, below this overarching concept of `public' accountability, a broad distinction is now made between `political' and `administrative' (or managerial) accountability. In *Accountabilities: five public services* Pat Day and Rudolf Klein emphasise the notion of contestability in distinguishing between these categories. On the one hand, political accountability is about those with delegated authority giving a `persuasive account' in a realm in which the criteria for judging actions or policies are contestable. On the other hand, administrative accountability, which developed from the need to ensure financial regularity, is regarded as a neutral, technical exercise of policy implementation where the criteria are broadly agreed.

However, much of the current debate fails to consider a further domain of accountability, that of the professional. One reason for the omission seems to be that models of accountability are commonly drawn along classical lines of the relationship between politicians and civil servants. In this model, civil servants are assumed to work in hierarchical, bureaucratic, organisations. It follows that professionals - with their separate codes of behaviour and recourse to horizontal methods of peer review – are something of an anomaly.

While some writers do acknowledge the problem, it is often perceived as a side issue, worthy of comment rather than analysis. Yet it is not simply the fact that traditional ways of looking at accountability have failed to accommodate the existence of professional groups which is important, but that these groups have the potential to undermine the credibility of existing accountability structures. The problem is stated particularly clearly by Pat Day and Rudolph Klein:

> *The debate and developments of the past two decades are, in retrospect, curiously lopsided. They revolve around the role of experts in accountability . . . But they neglect the accountability of experts. For one of the characteristics of service providers . . . is precisely that they tend to regard themselves as accountable to their peers and are thus not linked into the institutionalised system through which political and managerial accountability flow.*
> (*Accountabilities: Five Public Services*, Tavistock, 1987)

At the heart of this dilemma is the issue of professional autonomy. It follows that debates on accountability in the public services arguably need to devote closer attention to the relationship between the domain of professional accountability and control through political and managerial mechanisms.

Accountability and Professionals

The accountability of professionals is especially pertinent in the NHS. Political acceptance of the doctrine of `clinical freedom' has meant that health professionals, particularly doctors, have largely shaped the pattern of health services. However, the extent of professional autonomy is now challenged on two fronts: managerial and consumerist.

In recent years, central government has paid increasing attention to the work of public service professionals and the degree of their apparent autonomy. Essentially, this interest stems from economic pressures, together with an ideological commitment to running public services according to private sector principles. A central plank of this approach, which has come to be termed the `new managerialism', concerns strengthening managerial control within public service organisations. In turn this requires a fundamental change in the approach taken to administrative *ie* managerial accountability, with a new emphasis on efficiency and effectiveness in addition to a continuing interest in regularity.

In the NHS the introduction of general management from the mid-1980s was critical in implementing the new philosophy. Historically, health service administrators occupied what Stephen Harrison terms a `diplomat' role, facilitating and supporting clinical practice in the context of consensus management. Now, with delegated responsibility for efficient and effective execution of policy within centrally determined political priorities, managers have arguably become `agents' of central government with new power to implement their agenda before that of professionals. Indeed, Stephen Harrison and Christopher Pollitt argue in *Controlling Health Professionals*, (OU Press 1994) that control of professionals has been seen as *the* way of solving the management problems of the NHS. It follows that managerial accountability has inevitably gained in importance and been further strengthened since 1991 by the introduction of the NHS internal market.

In an evaluation of new managerialism Pollitt notes in *Managerialism and the Public Services*, (Blackwell 1993) that, given that one could hardly argue *against* the desirability of efficient and effective use of public resources, it is not surprising that the appeal of managerialism has been so strong: "better management" 'sounds sober, neutral, as unopposable as virtue itself'. A corollary of this appeal has been an attack on the extent of professional power in the NHS compared with the private sector:

> *After all, in ICI or Dupont or McDonnell-Douglas there are plenty of professional experts but they are `on tap' for management, not `on top'.*

The injection of private sector ideology into the pubic services has also led to a growing interest in `consumerism'. In turn, this has fuelled criticism of professional power and enhanced the power of the managerialist view, since criticisms of doctors concern not only matters of professional competence, but also poor performance against the principles of good management. In particular, doctors are increasingly cast as careless users of resources.

Accountability and Conflict

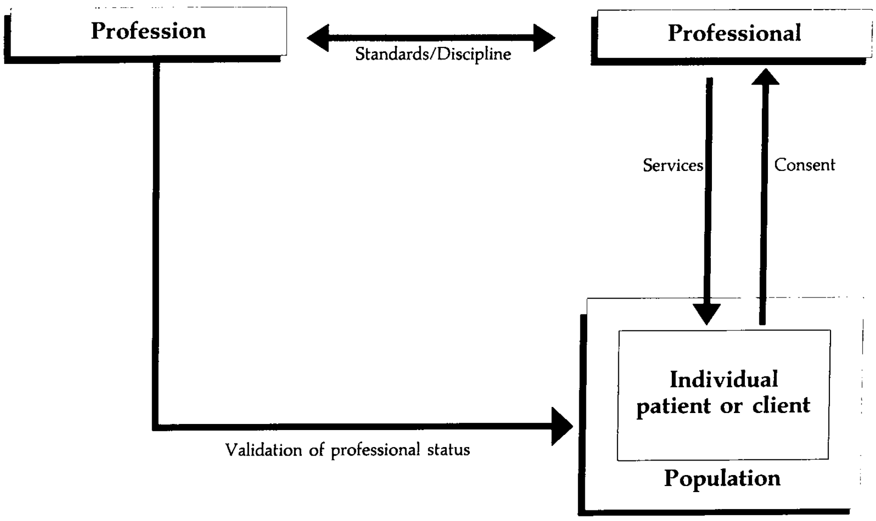
Different forms of accountability need not result in conflict if values are common to all parties. However, in the case of NHS professionals and their general managers this is not likely to be the case. While professional codes of conduct place the relationship between the professional and the individual patient or client at a premium, managers are charged with broader questions of resource allocation.

Accordingly, there is a need for a more sustained examination of the domain of professional accountability and its relationship to managerial and political notions of accountability. What is the nature of professional accountability? Where are the areas of conflict with other domains? How might such conflict be resolved? In attempting to answer these questions, we might be able to move towards harmonising, however tentatively, what appear to be both diverse and incompatible approaches to accountability in respect of professionals working in the NHS.

NHS Professional Accountability

It follows from the discussion so far that we might perceive NHS professionals as subject to three broad domains of accountability; professional, managerial and political. Through professional accountability, the profession itself regulates standards of entry, education and conduct. Figure 1 shows professional accountability in diagrammatic form. The underlying values are broadly applicable across all NHS professions; that is, the importance of the relationship between the profes-

Diagram 1: Professional Accountability



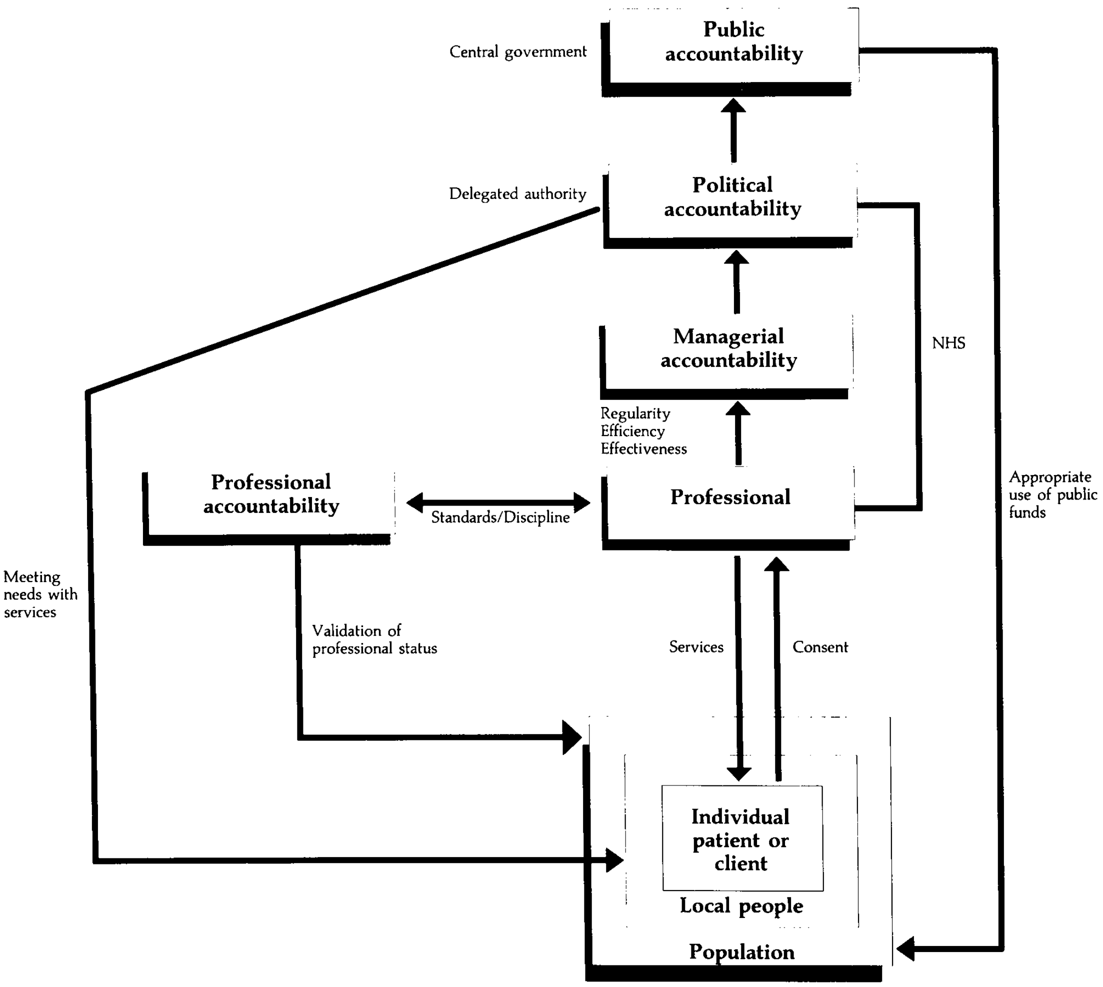
sional and individual patient or client, and the notion of control of standards by peers.

In the case of nursing, for example, responsibility for professional regulation is held by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). Registered nurses are required to abide by is Code of Professional Conduct and the Scope of Professional Practice. While these documents refer to the primacy of the relationship between the nurse and the individual patient/client, they also draw attention to a wider sense of responsibility to `serve the interests of society' and `justify public trust and confidence', thereby appealing to the wider social context upon which depends the status of the profession.

As mechanisms for ensuring professional accountability, however, normative codes such as these are weak. Their emphasis is upon reinforcing the broad philosophy, or culture, of the profession rather than on fixing and monitoring explicit standards. In the case of nursing, compliance with the norms of the profession is secured traditionally largely through a hierarchical system of self-management. In the case of community health care nurses, who work without supervision and might therefore be considered more autonomous, an extra period of education and training preparation is required.

Peer review is underdeveloped in nursing and is a particular problem for community health care nurses, working in isolation. In common with many other professional bodies, the UKCC has developed recently a framework of quality control based on a scheme of post-qualification development. While professional updating is to be mandatory, its content is left largely undefined, thereby threatening the integrity of the scheme. This demonstrates a fundamental problem for the UKCC. Nursing is both a large and broad-based

Diagram 2: Framework of Accountability for NHS Professionals



profession, so proposals for tighter professional accountability must at the same time be capable of professional policing and acceptable to NHS managers in terms of the time and cost required for participation.

The elements of professional accountability are set out in Diagram 1. The key relationships are between the professional and the individual patient on the one hand, and, on the other, between the body responsible for the profession. The latter `disciplines' the individual professional and provides thereby assurance to the user of the quality of care offered. Diagram 2 widens this framework by considering the impact of `third parties', that is, elements which impact on the simple relationship between professional and individual patient or client. Third parties include managers, government and the general public. Accordingly, Diagram 2 shows all three domains of accountability – professional, managerial and political – as they affect professionals in the NHS.

In contrast to the `individual' focus which characterises professional accountability, the emphasis within managerial accountability is upon issues of broad resource allocation, along with economic, efficient and effective delivery of health care. Mechanisms for enhancing this type of accountability in the NHS have proliferated since the early 1980s, for example performance indicators, efficiency savings and resource management. Diagram 2 highlights the resulting dual nature of accountability for individual professionals. The fact that the professional and managerial domains are not directly linked raises the question of how any tension between the two might be reconciled.

Conflict in Practice

Political accountability might be viewed as the context framing debate over service delivery between professionals and their managers. If the core of this debate is the issue of quality, to what extent can professional accountability guarantee delivery of a quality service? This is a stiff challenge to any profession since, as Christopher Pollitt notes (Public Administration, Vol 68 p 435) through control over entry and practice standards, `the control of quality lies at the heart of the notion of professionalism'. However, Pollitt goes on to acknowledged a lack of consensus as to what constitutes quality. Given their preoccupation with resource allocation, managers inevitably place emphasis upon efficiency and effectiveness as components of quality. While professionals may be inclined to trade off these elements for others – by for example, prioritising equity over efficiency, – nevertheless efficiency and effectiveness are also acknowledged by professionals as integral components of a quality service. It follows that it might be productive to explore conflict between professional and managerial notions of accountability around these two themes, examining the impact of the `new managerialism' on professionals.

Most attention has been paid to the impact of managerialism on the medical profession. However, as Day and Klein point out, the extreme characteristics of medicine as a profession such as high social status and esoteric knowledge can lead to an oversimplification of the accountability debate. Here, we will explore some empirical evidence on the impact of the new managerialism on nursing – in particular, district nursing and health visiting. Comparatively under-researched, nursing is a useful focus for examining the impact of managerialism, for at least two reasons; first, its size: nursing is numerically the largest NHS profession, and nursing pay accounts for around 25 per cent of all NHS expenditure. It follows that, if efforts are to be made in matters such as efficiency improvement, nursing is an obvious choice for increased management attention. Second, unlike medicine, nursing had its own strong hierarchical management structure in place before the introduction of general management. This means that the impact of new managerialism on nursing is focused on our prime area of interest – that is, the shift from professional to general management – rather than on a profession coming to terms with hierarchical management *per se*.

Within the profession, community health care nursing is a particularly interesting area for study in relation to accountability. Day and Klein's research suggested that the differential capacity of groups of service providers to make their activities `invisible' to managers was more important than simple status in defining the ability of professionals to influence the `language' of service evaluation. Nurses working in community settings have a relatively high degree of invisibility – and hence autonomy – compared with their acute sector colleagues. Not only does the peripatetic nature of community-based work made managerial supervision difficult, but traditional policy emphasis on the acute sector has arguably reinforced such autonomy through political marginality. Importantly, the work of these nurses is now subject to growing policy and management attention, following national policy shifts in favour of both community-based care and health promotion. According to the NHS Management Executive (*New World, New Opportunities*, 1993) community health care nursing is `at the forefront of a health service revolution'.

Research carried out by the current author, examining how staffing establishments were set for district nursing and health visiting services, provided empirical evidence of conflict between front-line professionals and managers over efficiency and effectiveness. On efficiency grounds, managers were redefining role boundaries and exploring changes in the mix of skills deployed. For example, in the case of role boundary changes, for district nursing this meant re-drawing the boundary between health and social care. Financial pressure and competition had led health and social care agencies to seek to retract to core functions where possible, with home bathing services a prime example of overlapping territory between agencies. District nurses' concerns, raised where health agencies redefined a health bath within a narrow medical model, stemmed from the belief that this approach to efficiency failed to recognise two fundamental values of nursing; first, nursing's holistic approach to the meaning of health care was ignored; second, the question of possible inequity between patients with care supplied from two different types of agency was overlooked.

Skill mix – in this context substitution of lower-skilled for more highly skilled staff – emerged as a key focus for professional/managerial accountability disputes over quality. Reasons for growth in attention to skill mix were firmly rooted in managerial concerns, such as the prospect of policy changes leading to increased demand for services, financial pressures, and a wider search for value for money. The research evidence showed that conflict over skill mix existed at two levels: objectives and methodology. In the case of objectives, was skill mix driven by the need to limit costs – as suspected by nurses – or by a genuine attempt to align district nursing and health visiting skills more closely with the health needs of the local population? Nurses were sceptical of statements made by managers that these two objectives were compatible. The absence of any agreed methodology for implementing skill mix changes was a further source of friction between managers and professional staff. Managers wanted to be `more scientific', but felt hampered by the changing policy context, together with lack of information on needs, activities and outcomes of nursing services – in other words, managers were constrained by the *invisibility* of community health care nursing.

Turning to effectiveness, community health nursing services posed particular problems in terms of developing outcome measures, which constitute a key element in demonstrating effectiveness. Four problems are worth highlighting. First, the concept of a `health outcome', if derived from a narrowly drawn medical model of health, might not recognise interventions of a broader, social type. Historically, community health services were administered by local authorities until 1974. Not only does community health care nursing retain a broad view of the service, but the nature of the work necessitates operating in a pragmatic way at the boundary between health and social care. It follows that differing interpretations between agencies of health need and outcomes are likely to have an impact on what nursing work is considered legitimate for contracting purposes.

Second, the notion of `outcome' is hard to apply to preventive work, which forms the major part of health visiting. Preventive work suffers from the double problem of being a longer term investment, and so not producing immediate gains, and not being readily amenable to the quantitative measurements favoured for contracts. Here, then, is a potential weakness of invisibility.

Third, the effectiveness of community health nursing services is difficult to demonstrate. Unlike their colleagues in hospitals, community-based nurses work amidst a range of additional environmental and social factors, for example, the appropriateness of housing and the availability of informal care, which makes teasing out the effectiveness of the nursing contribution very difficult, if not impossible, in practice.

Finally, a problem which underpins all three discussed above is that of the poor quality of existing information systems. In practice, input and process measures have been used by managers as proxies for outcome, for example activity measured by the total number of individual patient or client contacts. Nurses claimed that such devices restricted professional approaches to quality, for instance overlooking other, more qualitative, domains of care and limiting the development of innovatory practice, such as group work.

Overall, the empirical evidence outlined here suggests that while professionals and managers agree that efficiency and effectiveness are central components of quality, their respective interpretations of these themes are somewhat different. Importantly, the increasingly influential managerial perspective represents a challenge to the validity of traditionally accepted views of professionals.

The Meaning and Control of Quality

There can be no doubt that the `new managerialism' has influenced both the content and pace of the debate about quality in respect of professionals. The evidence outlined here concerning efficiency and effectiveness highlights two dimensions: the meaning and control of quality. The meaning of quality includes issues such as the definition of relevant concepts, for example `health' and `outcome', together with assumptions about the roles of professionals. Quality control, on the other hand, includes deployment issues such as skill mix, questions about attribution of outcomes of nursing activity and the appropriateness of information underpinning decisions about service delivery. How might tensions between professionals and managers over these issues be reconciled?

Future Scenarios

It is possible to envisage at least two broad options for the future; first an *adversarial* model, in which the attitudes of managers and professionals harden, with an increasingly bitter fight for supremacy. Alternatively, a more *conciliatory* approach might develop, with a search for common values. The following paragraphs explore some possibilities under each heading. Given that relationships are still developing, such an exploration is necessarily tentative.

Adversarial Model

This model assumes that the actions of managers will continue to be perceived as an attack on the professions, at least by the latter. Will managers `win'? Currently, the received wisdom is that the odds are stacked in favour of managerialism, assuming general management exists to deliver government objectives through a tight chain of command coupled with practical power through control of resources. While Stephen Harrison notes in *Managing the NHS, Shifting the Frontier*, (Chapman and Hall, 1988) that managers might not yet have achieved total dominance over professionals, this could simply be due to the timescale required and/or that managers have not yet chosen to exercise all the powers at their disposal.

However there is also evidence of weakness in general management. For example, the experience of the Resource Management Initiative has shown that managers currently lack the organisational skills required to reshape health services. Furthermore, as an `implant' from the private sector, the role of general management in a public service organisation such as the NHS remains unclear. For example, one general manager, John Barbour, has mused in public as to what would constitute `success' for NHS general management:

> *It is precisely because the provision of health care remains so fundamentally influenced by the perceptions of politicians, consumers, health care professionals, the media and interest groups in a way that private sector managers must only experience in nightmares that `success' remains such an elusive concept: (Health Services Management Research, 1989 p 53)*

Clearly the picture is somewhat more complicated than simply imposing managerial will on professionals. In practice, managers are required to recognise and negotiate in a context of local circumstances, personalities and power, in which the activities of professionals are critical in turning policy into practice. Indeed, as Harrison and Pollitt point out in a discussion about rationing, managers – like politicians – may in fact see benefits in professionals retaining a degree of autonomy:

> *Such (rationing) decisions are invariably controversial . . . and managers are not spectacularly more willing than politicians to take public and personal responsibility for unpopular choices. A measure of clinical autonomy is therefore protective of managers, as well as of politicians.* (*Controlling Health Professionals*, p 142)

In practice, as Diagram 2 suggests, professionals and managers depend upon each other for successful service delivery. Indeed, it is possible to view this type of conflict in organisations as positive, for example as a stimulus to more effective ways of working. If, as Day and Klein argue, accountability requires an `agreed framework of meaning', then the state of the manager/professional relationship might be an appropriate measure of the `success' of general management. If so, perhaps we should reject the adversarial model in favour of an alternative, more conciliatory, approach.

Conciliatory model

This model concerns the possibility of searching for a common focus, or common values, between managers and professionals. Within this model, it is possible to identify at least two broad approaches; first, a radical approach, in which a different focus is adopted to that normally used by either managers or professionals. Alternatively, a pragmatic approach might be followed, with emphasis on the management of conflict.

Taking the radical approach first, a strong argument exists for looking beyond disputes between managers and professionals to a focus on wider public accountability. If we accept that authority is ultimately derived from `the people' in some way, logic suggests that it is here that we should expect to find binding arbitration. As John Barbour asserts: `increased involvement of the public' is the solution to the problem of `lack of any accepted mechanism for reconciling the allocation of scarce resources with the health care needs and aspirations of society as a whole'. However, it is perhaps not so clear just how such involvement might be best achieved.

At least three levels of public involvement can be differentiated. At the first, most indirect, level, managers and professionals might be exhorted to focus more upon service users. Central government has tended to advocate this approach, for example through the use of Patient Charters. But in terms of public accountability, such an approach is inevitably limited, since without effective censure by the public, both the agenda for consultation and the extent of subsequent action is determined by managers and professionals.

The second level of involvement concerns measures proposed for greater local public accountability as a more direct attempt to secure commitment to local communities. How might this be achieved in practice? While recently central government has proposed delegation of `accounting officer' status to individual health authority and trust chief executives in a bid to improve local financial accountability, there have been calls – from both the political left and right – for greater democratic control of health services through transferring their responsibilities to local government.

The third – and most direct – level of user involvement concerns participation of the public in the design, delivery and evaluation of health services. According to Pollitt, such an approach would constitute `a new and highly legitimate source of opinion on what should be done' (*Managerialism and the Public Services* p 195). While acknowledging that this idea is hardly new, but rather a renewal of traditional ideas about public accountability, Pollitt accepts it as somewhat idealistic today, with few examples to work from in modern societies. Certainly, experiment with user involvement in health service rationing decisions have revealed how difficult it is to put the notion of such involvement into practice, given the varying and changing preferences of individuals and problems of their access to relevant information. Indeed, such an opening-up of the process of decision making could add to, rather than detract from, the potential for conflict between managers and professionals

If a radical, alternative, focus on the public is somewhat idealistic – at least in the short term – what about more pragmatic approaches for easing tension between managers and professionals? Such approaches fall into two categories: first, a search for congruence between managers and professionals; second, mechanisms for practical conflict management.

In support of a search for congruence, several commentators have remarked upon the importance of co-operation between managers and professionals. Bill New talks about the benefits of building a common culture which, as a strategy for securing effective accountability, is both cheap and preventive in terms of avoiding conflict. Is there any evidence of greater congruence between managers and professionals? There are some suggestions that professionals are beginning to adopt the ideology of managerialism. For instance, describing the decentralisation of general management within community health services, Mark Exworthy (Policy and Politics, 1994 pp 17–29) refers to a `compromise' position between professionals and managers. Barbour refers to a `new realism', in which professionals take on, and so legitimate, managerial approaches, such as audit. In the case of nursing, such approaches are spreading; indeed, Wendy King attempts to turn the debate on its head, suggesting that managers have usurped the territory of the nursing profession in their emphasis on setting objectives and evaluating outcomes:

> *This is nothing new to nurses. The fundamental process of nursing is based on assessing need, setting objectives, planning and delivering care, and reviewing its outcome.* (Primary Health Care, 1991, pp 21–22)

At the centre of conflict between professionals and managers is their difference in focus, that is, the professional's emphasis on the individual patient or client versus the collective approach of managers. Even here there are signs of movement by professionals, for example, engaging in the development of clinical protocols. While designed to ensure a consistent approach, protocols inevitably restrict the clinical freedom of individual practitioners. This shift in emphasis suggests that professionals – or at least those who are in a position to influence the content of protocols – are moving to a more collective, standardised, view of quality. A possible corollary of this development may be a need to rethink the shape of professional accountability, moving away from the intensely personal emphasis on the relationship between practitioner and individual patient or client.

Perhaps the most likely scenario for the future of managerial/professional relations is of practical conflict management. Here, the inevitability of some conflict is accepted, with emphasis on practical ways of moving towards a goal of quality services which meet the needs of users efficiently and effectively. At the heart of this approach are mechanisms through which managers can recognise and build upon the contribution which professionals can make to meeting organisational objectives.

In the case of nursing, one approach might be to consider how best to use professional advice. Following a study of the provision of professional nursing advice after the implementation of the Griffiths report, Jane Robinson and Philip Strong recommended (*Professional Nursing Advice After Griffiths*, University of Warwick 1987) `a clearer separation between professional nursing advice and managerial nursing advice (with competition between the two providing a spur to quality)' Such a view both recognises and makes explicit differences between professional and managerial perspectives on quality. However, in separating `professional' from `managerial' nursing advice, the approach is potentially divisive for the profession, reducing its capacity to speak with a united voice on quality issues.

An alternative approach concerns harnessing the knowledge of front-line professionals in meeting managerial objectives, for example in the case of `invisible' community health care nurses, using knowledge gained through local needs profiling activities and defining appropriate data for activity information systems.

Given that managers cannot control professional accountability, but nevertheless require reassurance of its effectiveness, enlightened managers might seek to strengthen the processes of professional accountability, rather than attempt to supplant them with a managerial alternative. For example, Stephen Harrison suggests that managers might improve in-house opportunities for developing peer review. They also might recognise and build upon existing professional quality assurance initiatives. Growing adoption of the traditional management concept of `audit' by professionals, using clinical audit to evaluate professional practice, might be seen as both an indicator of a shift towards congruence and a practical tool for conflict management.

Overall, this final set of ideas – strengthening professional accountability and harnessing its results – probably represents the most realistic way forward, at least in the short term. But matters cannot be left to professionals alone. Also needed are both the political spur which comes, according to Pollitt, from the active involvement of users – currently under-used – and that which comes from the systematic analytical skills of managers – currently under-developed. In other words, we cannot escape the need for a better understanding of the relationship between professional, managerial and wider political/public accountability.

This relationship has two important features. First, it is characterised by a struggle for power over the meaning and control of quality. Traditionally, professional accountability has been assumed to provide quality assurance. However, the interpretation of quality by professions has increasingly been challenged by the rival views of managers and users. Whether these rival views will substitute for, or add to, professional approaches to quality is central to further analysis and debate around the relationship between the different domains of accountability.

The second important feature of this relationship is its practical context. We might expect the balance of influence between the three domains to vary according to factors such as the degree of `invisibility' of the profession; the capacity of managers to impose their vision; the scope of users to express their views. It follows that a deeper understanding of accountability relationships requires not only the development of theory, but also an awareness of the significance of the context in which these relationships are forged and tensions balanced between the three domains.

CHANGING CLINICAL BEHAVIOUR: DO WE KNOW HOW TO DO IT?

Nicholas Mays

There is, currently, a growing interest in the National Health Service in bringing about better care by shifting clinical behaviour towards more cost-effective methods of treatment. This article begins by explaining why efforts directed towards clinical behaviour change are important and necessary, and why the results of research are frequently not translated directly into practice. Before change can be brought about through deliberate interventions, it is helpful to know something about how clinical practice changes normally. This is covered in the second section of the chapter, which concludes by identifying the main barriers to evidence based change. The chapter continues by describing the range of interventions available to change clinical behaviour and how these can be structured and combined. However, the methods produce variable effects. The evidence on the effectiveness of each of the behavioural interventions is briefly summarised. The article concludes with a discussion of how the NHS might make use of the insights derived from the research on changing clinical practice to develop its strategy for improving the fit between the best available evidence and the day-to-day activities of clinicians of all types working in the Service.

Why Is Changing Behaviour Important?

Modern health care is generally regarded as being in a constant state of rapid change generated by political, economic, managerial, consumer, technological and scientific trends. In these circumstances, it is important for clinicians to respond appropriately by modifying what they do in ways which at least do not harm the quality of care and at best improve outcomes. Until recently, it tended to be assumed that health care professionals, particularly doctors, practised scientifically and that advances in knowledge would automatically and quickly be assimilated into their day-to-day practice. It was taken for granted that although some clinical activity was based on custom and practice, wherever evidence from scientific research was available, it fed directly and rapidly into the pattern of clinical activity.

The key objective of clinical triallists and health services researchers was, therefore, to extend the number of rigorous studies of the costs and benefits of new and existing health care procedures. Armed with better knowledge of what works and at what cost, clinicians would be in a position to improve their practice accordingly. In the last 25 years a great deal has been achieved in consolidating the importance of health care evaluation and in generating useful new knowledge on the effectiveness of health care interventions. However, it has become increasingly apparent that generating new 'facts' about effective health care is not enough to ensure that they are taken up and used in practice. As David Eddy, an influential analyst of the variability of clinical practice, pointed out in 1982, 'The profession [of medicine] has placed high value on developing the basic science of medicine, it has not emphasized the process by which the science is translated into practice' (New England Journal of Medicine 1982; 307: pp 343–7). Greater sophistication in the design and analysis of studies had been accompanied by naivety about what makes professionals alter their behaviour towards patterns consistent with the findings of trials and evaluations.

The NHS Research and Development Programme which began in 1991 with the aim of ensuring that NHS decision making, both clinical and managerial, should be based on the best available evidence, focused initially on the generation of new knowledge on the effectiveness and cost of health services. However, the R&D initiative is beginning to give greater emphasis to activities concerned with the *application* of research findings in practice. Implementation of the findings of research is an R&D priority for 1994/95. Greater attention will be given to the synthesis and dissemination of research findings since these activities represent the early stages on a continuum from research to a change in routine clinical practice: see **The R & D Continuum**.

In a recent interview with Richard Smith, editor of the British Medical Journal, the NHS Director of Research and Development, Professor Michael Peckham, described his and his colleagues' task:

> *Ensuring that the results of research and development penetrate into practice is a crucial challenge. Unless research and development are engaged with the cogs of day*

to day work in the NHS *we will not have succeeded* (British Medical Journal *1993; 307: pp 1403-7).*

THE R&D CONTINUUM

Health care
problem

Research/synthesis
of evidence

Diffusion

Distribution — Dissemination phase

Awareness

Acceptance

Development/implementation phase — Adoption

Use of information

Source: Adapted from presentation by Ian Watt, NHS Centre for Reviews and Dissemination, at King's Fund Centre, February 1994

There are numerous topical examples of delay or failure to apply new knowledge in clinical practice which demonstrate the importance of this new phase in the evolution of health services research. Liam Donaldson has recently shown that maternity units in the UK fail routinely to give steroids to women in premature labour despite strong evidence of their beneficial effect on fetal lung surfactant which is crucial for the respiratory health of premature infants, (British Medical Journal 1992; 305: pp 1280-4). One of the most startling examples of the time lag between the production of valid scientific knowledge relevant to practice and its belated use concerns the strange case of thrombolytic treatment. Antman and colleagues traced the 13-year delay between the publication of a cumulative meta-analysis of randomised controlled trials of thrombolysis in patients who had suffered a heart attack which had shown the value of this technique and the appearance in leading medical text books of recommendations to use thrombolytics (Journal of the American Medical Association 1992; 268: pp 240-8). A survey in the Northern Region of the NHS in 1993 suggested that only 30-50 per cent of patients likely to benefit from life-saving thrombolytic therapy were receiving the treatment and that there was still considerable variation among cardiological centres in their rate of use of the therapy among appropriate patients.

Taken together, these accounts of missed opportunities to benefit patients by the application of existing knowledge show clearly why there is growing interest in how clinical behaviour changes and can consciously be changed in directions which are scientifically valid. A number of related initiatives with this aim in mind are already in their early stages as part of the NHS Research and Development Programme, in particular, the UK Cochrane Centre and the Centre for Reviews and Dissemination at the University of York: see **NHS Research and Development Programme Initiatives**. Both centres will attempt to produce and disseminate systematic reviews of the existing evidence on the effectiveness and cost of health care activities. The importance of undertaking reviews as scientifically and systematically as the original research on which they are based has been reiterated tirelessly by Iain Chalmers in the UK who is now the first director of the UK Cochrane Centre. His approach was strongly endorsed by an American epidemiologist, Cindy Mulrow, who undertook a chastening analysis of the scientific standing of medical review articles. She showed that many of them were methodologically flawed and incomplete and, thereby, contained inappropriate recommendations for clinical practice.

Clinicians are one of a number of key groups in the NHS which the NHS R&D Programme wishes to influence. This article will attempt to give an overview of the field of health care professional behaviour change by outlining what is known about how clinical practice changes under 'normal' conditions before turning to the results of experimental studies staged to bring about desired behavioural change.

Understanding Clinical Change

Why does change in clinical practice occur rapidly in some areas and slowly in others? Why does research appear to have a major influence in some developments in practice, but not in others? Barbara Stocking has developed a helpful framework for considering these sorts of questions. She organises her analysis of clinical change by looking at:

- the general environment in which change occurs;
- the characteristics of the change and its consequences;
- the characteristics of the individual health care professionals affected;
- and the local context or organisation in which the change takes place.

Each of these will be considered in turn.

The General Environment

For change to occur, the national and/or international environment has to be broadly favourable. The general climate of opinion and ideas has to be supportive so that a particular change can be perceived as 'ripe'. Some of the elements which can contribute to the climate include the availability of research evidence

NHS Research and Development Programme Initiatives

UK Cochrane Centre, Oxford

In 1979, the British epidemiologist Archie Cochrane wrote:

> *It is surely a great criticism of our profession [medicine] that we have not organised a critical summary, by specialty or subspecialty, adapted periodically, of all relevant randomised controlled trials.*

The Cochrane collaboration came into being to take up Cochrane's challenge.

The UK Cochrane Centre is part of a worldwide collaboration to undertake, disseminate and update systematic reviews and meta-analyses of clinical trials in all fields of health care. It has received funding from the Department of Health and will be producing a series of specialised databases on disk derived from the Cochrane Database of Systematic Reviews.

NHS Centre for Reviews and Dissemination, University of York

While the Cochrane Centre concentrates on randomised clinical trials, the objective of the York Centre, established in 1993, is to carry out and commission reviews of the effectiveness and cost-effectiveness of a wide variety of activities and interventions which are provided in health care systems and then to ensure that the results are widely disseminated and used in practice (*eg* in contracting, in developing clinical guidelines, in professional education and in routine management of the service). The York Centre subsumes the existing programme for producing health care *Effectiveness Bulletins* based on reviewing evidence on clinical effectiveness, cost-effectiveness and patient acceptability. The Centre will not be confining its attention to randomised studies.

A Cochrane Collaboration centred on York has recently been announed to review trials of methods to promote the uptake of research findings. The York Centre aims to develop the skills in the NHS which will help to ensure that research can be used in decision-making. Studies will be undertaken to test the most effective ways of disseminating research reviews in order to change practitioner behaviour.

Getting Research into Purchasing (GRIP), Oxford Region

Like similar initiatives in Northern and North East Thames Regions (Guidelines into contracts), this is a local implementation project funded by the NHS Executive which aims to improve practice in specific areas by using research evidence and clinical opinion leaders to influence the contracting process. A limited number of areas of service delivery were selected for improvement and contract negotiations and audit were linked to evidence of best practice. The four objectives identified for change were to:

- increase the use of steroids in pre-term labour;
- reduce the rate of D&Cs;
- increase the level of co-ordination of stroke rehabilitation services; and
- ensure that grommet insertion for glue ear in children was targetted more appropriately and performed less frequently.

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This outlines the sources of data on effectiveness available to purchasers and encourages them to use this information in the 1994/95 purchasing round. Encouragement is also given to the use of clinical guidelines in local discussions with providers and to restricting the use of new medical technologies until they have been properly evaluated.

supporting change, national consensus statements and other expert views, the promotion of ideas through the mass media, advertising to health care professionals and demand from patients and patient groups. In addition, the financial and legal structures of the health care system can act to facilitate or inhibit particular changes. The institutional and ideological environment performs the role of what psychologists of individual change call a *predisposing* factor – something which is necessary for change to occur, but by no means predicts that it will.

Characteristics and Consequences of Change

Why do some changes occur readily before evidence from clinical trials is available, for example, the adaption of laparoscopic cholycystectomy, while others are more protracted and controversial, for instance, permitting home deliveries for normal pregnancies? A large part of the explanation concerns not the wider climate of opinion, but the characteristics of the change itself.

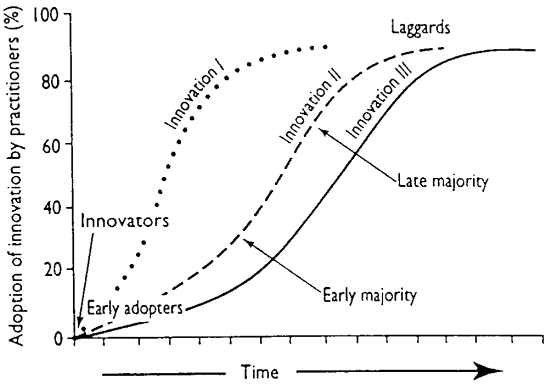
Relative advantage: Potential changes in practice will have costs and benefits for patients which can be compared to the prevailing method of care to provide one estimate of relative advantage. However, changes can also advantage or disadvantage the perceived and actual interests of influential groups involved in bringing about change. An advantage to one group can be a disadvantage to another. The most obvious examples are situations in which one health care professional group is substituted for another in the interests of reducing costs or improving the quality of care.

Compatibility: If a change is not compatible with existing beliefs or working practices it faces a major hurdle if it is to be taken up. Head-on challenges to long held philosophies are most unlikely to be successful without extensive preparation of the ground. This may explain why research frequently plays only a modest part in effecting change directly. It generally acts indirectly by contributing to the shaping of the climate of ideas, making it more favourable to innovation.

Complexity: The more complex the process required to introduce and secure a change the more difficult it will be. For example, changes involving large numbers of people from different backgrounds will necessitate lengthy negotiations and adjustments to working practices in a number of disciplines. It can be argued that efforts to ensure that each patient attending hospital outpatients is given a specific appointment time which is adhered to, represent this type of change. Such a seemingly straightforward change involves clinicians, nursing staff, clerical staff and support services such as diagnostic departments. It has implications for the capacity of outpatient clinics, scheduling and the ability to cope with unexpected patient demand. To work well, it should be accompanied by an audit of the utility of outpatient visits, particularly repeat visits ordered by junior medical staff. One consolation to those attempting to introduce complex clinical changes is the evidence that, once introduced, more complex changes are less likely to be reversed in favour of previous practices.

Observability and trialability: Observability simply means whether the innovation can be seen in operation and trialability whether it can be tested on a pilot basis. Changes involving new pieces of equipment frequently score highly in terms of observability and manufacturers or enthusiasts are often prepared to arrange demonstrations and trial periods. Such activities cannot be guaranteed not to deter some interested parties; for example, seeing a new piece of equipment in action may reveal the true resource costs in terms of supporting activities and staff. But they are more straightforward than efforts to demonstrate changes in the organisation of a service or clinical team. Stocking's work suggests that the twin characteristics of observability and trialability are influential in change, but less important than the characteristics of relative advantage, compatibility and complexity.

Diagram 1: Diffusion of innovations.



Source: Haines A, Jones R, Implementing findings of research, British Medical Journal 1994; 308: pp 1488–92, adapted from Rogers E M. *Diffusion of Innovations*, New York: Free Press, 1983.

Adaptability: Change strategies which can be adapted to local circumstances appear to be more successful than those which are relatively inflexible. Stocking suggests that research findings are frequently seen as an external influence which can be resisted until they are adapted for local use when they become more acceptable and, thereby, more influential.

Characteristics of Health Care Professionals

The uptake of new methods and approaches in clinical care follows the typical S-shaped pattern of diffusion of ideas and innovation which has been identified in many other areas of human activity in which an innovation is communicated through a variety of channels of communication over time to members of a social system and is then taken up, modified, rejected or superseded see Diagram 1.

The diffusion process can be *hierarchical* in which ideas and practices emanate from a larger, more dominant centre downwards to smaller, less dominant places in a formal manner. This is the pattern of diffusion which is assumed in many conventional approaches to the production of guidance on 'good practice' such as the reports of consensus development conferences. Diffusion can occur *spatially* in which ideas and practices are disseminated and taken up from an epicentre radially. Finally, diffusion can occur through a *network* which can be personal, or based on a professional grouping or a social community. Network diffusion operates more informally than hierarchical diffusion and unlike spatial diffusion is not dependent on simple spatial proximity, but on the relationships between people. The evidence from studies of clinical change suggests that network diffusion is the principal means by which actual changes in practice are influenced as opposed to mere awareness of change which can often be generated by more formal, hierarchical means.

Studies of the characteristics and relationships of individuals within the S-shaped pattern of change found in many occupations have shown that the first adopters of new ways of doing things tend to be more in-

Table 1: Characteristics of Different Categories of Adopters of New Forms of Clinical Practice

Category	Characteristics	Values and Relationships	Communication Behaviour
Innovators	High status/ elite position Specialised Cosmopolitan Often young	'Venturesome' Some opinion leadership	Closest contact with scientific evidence Greatest use of impersonal communication channels High attendance at national/ international meetings
Early adopters	High status/ elite position Specialised	'Respected', regarded as role models Influential Greatest opinion leadership	Greatest contact with local change agents* Competent users of mass media
Early majority	Above average status	'Deliberate' - will only consider new ideas after peers have adopted them Some opinion leadership Follow early adopters	Considerable contact with change agents* and early adopters Aware of media messages
Late Majority	Below average status Lower specialisation Lower income	'Sceptical' Overwhelming peer pressure needed for change Little opinion leadership	Interaction with peers who are mainly early or late majority Less use of media
Laggards	Lowest status/ not elite Little specialisation Lowest income Often oldest Smallest practice	'Traditional' Past-orientation Risk avoiders Little opinion leadership Almost socially isolated	Main information source is other laggards Suspicious of change agents*

* *eg* commercial representatives, clinical advisers, reviewers of evidence etc

Source: Adapted from Open University, Decision-making in Britain III, Agriculture, Milton Keynes: Open University Press, 1973, 42, reproduced in Stocking B, Promoting change in clinical care, Quality in Health Care 1992; 1: pp 56-60.

novative and have a more positive attitude to risk than their peers. They may even be seen as deviant by certain of the more conservative members of their profession. Their influence on the principal opinion leaders of the profession through the example of their practice is crucial in ensuring that the majority takes up the change. The so-called laggards are largely untouched for a considerable time after the majority has adopted the new practice. Table 1 summarises a wide range of research on the characteristics of *innovators, early adopters, majority adopters* and *laggards*, much of it undertaken initially among farmers, but subsequently shown to apply to health care professionals, principally in USA.

It shows clearly that as one moves along the continuum from innovators to laggards, so the influence of national and international activities and networks diminishes along with a marked decline in the influence of research evidence and a noticeable increase in the importance of the opinion of immediate peers and local colleagues in determining what is and is not acceptable. The professionals in the early and late majority categories are far more likely to be influenced to change their practice through contact with other people than through reading the literature.

Local Context and Organisation

The vast majority of health care is delivered through organisations comprising professionals with different roles and skills. The pattern of change among clinicians is thus shaped not only by their personal characteristics, but also by the social relations of power and influence which exist in the hospital or the group practice and in the local clinical community. Just as the wider climate of ideas and opinion has to be supportive for changes to percolate from the more adventurous to the early majority, so local opinion leaders can be crucial 'champions of change' for the majority by their ability to keep an issue on the professional agenda and develop local coalitions in favour of change through their good connections within local professional networks. Case studies of innovation show how opinion leaders are also able to shepherd a change through the internal decision making structures of an organisation. Barbara Stocking's detailed analysis of the decision making processes which preceded the setting up of regional secure psychiatric units in the NHS showed how those who believed strongly in the importance of such units gradually built up the support of local clinicians, trade unions and managers at different levels in the Service, thus overcoming substantial opposition.

Overview: the Barriers to Change

The preceding analysis in this section suggests very strongly that clinical change is a social process in which local, personalised influences operating through networks of similarly trained, like-minded professionals are the most potent forces enabling and reinforcing a change among the majority of practitioners. Research evidence appears as one among a number of predisposing factors exerting its influence primarily over the innovators and early, venturesome adopters of changed ways of doing things. For the majority, research evidence is perceived in many cases as coming from a remote and separate professional world, that of the researcher, who appeals to a different audience from the practising clinician. The status of the research evidence appears to be further reduced if it is used to support an exclusively top-down approach to change which hints at the imposition of 'correct' approaches to patient management. Physicians and others tend to oppose changes which are perceived as threatening their livelihood, self-esteem, competence or autonomy from without. Compare the reception accorded to the Government white paper *Working for Patients* with the relatively uncontroversial rolling out of the clinical audit programme which had been developed with the close involvement of the main professional groups such as the Royal Colleges.

The complex pattern of factors which shape clinicians' practice policies and which have been discussed in this section is summarised in Table 2. The combination of local, regional and national sources of influence and the range of methods of influencing clinical behaviour from actions by patients, through educational activities and administrative regulation to economic incentives, yields a considerable number of possible strategies for deliberately modifying clinical behaviour. The next section describes the range of approaches available before going on to consider the evidence of their effectiveness in changing clinical behaviour.

Interventions To Change Clinical Behaviour

The principal types of behaviour-modifying intervention aimed at clinicians which can be separately distinguished are listed in Table 3.

Ten different types of strategy aimed directly at individual clinicians are indicated in the list (educational materials, conferences, outreach visits, local opinion leaders, patient-mediated interventions, audit and feedback, reminders, marketing, local consensus processes and multi-faceted interventions) plus financial incentives or penalties and organisational or administrative interventions which are likely to be targeted on groups of professionals.

In practice, strategies are rarely used in isolation. For example, a strategy based on inducing local consensus and local treatment guidelines is highly likely to be accompanied and reinforced by some form of audit of performance with feedback of information to local participants in the consensus development process.

Table 2: Interacting Factors Influencing Clinicians' Practice Policies

	Source of Influence	
Route of Influence	**National* (predominantly predisposing factors)**	**Local* (predominantly enabling and reinforcing factors)**
Patients	Attitudes to malpractice Population health status	Patient level of knowledge/patient demand Age, sex, socio-economic status of population Health status of population
Education/ Interaction	Scientific literature Official policies Training Licensing requirements Continuing medical education Media Advertising/promotion	Hospital rounds 'Educational influentials'/opinion leaders Colleagues' views Pharmaceutical/other 'detailing'/feedback
Administrative Factor	Organisation/structure of health system Data reporting requirements Limited list legislation etc Drug formularies Disciplinary bodies Rationing rules	Purchaser/provider policies Practice setting (*eg* group, solo) Availability of technology Peer review/audit activities Hospital medical staff organisation Bed capacity Performance indicators/performance data
Economic Factors	Remuneration systems for professionals (*eg* FFS, salary, prospective vs retrospective) Reimbursement systems for provider units Overall budget limits	Resource constraints Physician supply density – competition for patients/income
Physician Factors		Medical school Specialty training Time since graduation Tolerance of uncertainty Attitudes to risk

* national/central initiatives tend to predispose to change without necessarily bringing it about - necessary but not sufficient. Local initiatives enable and reinforce changes as long as not imposed (*eg* strategies to enact national guidance must be set locally).

Source: Adapted from Lomas J, Promoting clinical policy change: using the art to promote the science in medicine. In Andersen T F, Mooney G, eds. The Challenges of Medical Practice Variations, London, Macmillan, 1990, pp 174-91.

Table 3: Means of Promoting Change in Clinical Practice

1. **Information**
    - Research-based (*eg* systematic review of RCTs)
    - To public (media campaigns)
    - Passive feedback on practice (concurrent or retrospective)
    - Expert systems/information transfer
2. **Education**
    - Vocational
    - Continuing
    - Guideline development
    - Conferences (including consensus meetings)
3. **Peer Review and Audit**
    - Active feedback (*ie* commitment to change) usually accompanied by standard setting/guideline development, CME, audit and discussion of practice
4. **Person-to-Person Contact**
    - Change agents, outreach, 'academic detailing' (*eg* drug company representatives)
    - Local opinion leaders, respected colleagues (group or individual contact, formal or informal)
    - Patient mediation, patient demand to change
5. **Decision Aids to Deliver Guidelines/Standards**
    - Manual reminders/prompts (*eg* stickers, inserts in notes, algorithms, test ordering forms)
    - Computerised prompts at time of consultation
    - Computerised decision support systems
    - Remote consultation
6. **Inducing Local Consensus (relates to 3 and 4 above)**
7. **Marketing/Media**
8. **Economic Incentives**
    - Cost controls, budgeting
    - Incentive schemes
    - Penalties
    - Purchaser provider split, purchasing
9. **Administrative Rules**
    - Prior approval, second opinion, prescription review etc
10. **Multi-faceted**

Options for Structuring Interventions

The basic structure of a behaviour-modifying intervention can be thought of by considering the following features, each of which can be varied either singly or in combination to produce a very large number of options for testing in comparison with other single or multi-faceted strategies:

- the behaviour to be altered *eg* prescribing, referral, diagnosis, recording, resource use, etc;
- the health problem or disease concerned;
- the content of the knowledge, advice or skill imparted *eg* overview of results of randomised clinical trials versus clinical consensus;
- the source of the knowledge, advice or skill imparted *eg* external expert, colleague or drug company;
- the intended recipient or target *eg* individuals or groups, specialist or generalist, experienced versus inexperienced;
- the time schedule of the intervention *eg* length and frequency;
- practice setting or clinical context *eg* primary care versus hospital, private versus public sector, solo versus group practice, etc
- the format of presentation or means of delivery *eg* on-screen prompt versus written algorithm.

For example, the focus or target of behaviour change may be the individual clinician, the multi-disciplinary team, the provider institution/organisation, the local peer group or the specialty. Clearly some strategies are more suited to certain foci than others. Strategies involving expensive media campaigns directed at patients and potential patients and occasionally at professionals are far more likely to be aimed at a large and diverse audience.

Nature of Studies of Interventions

The research on ways of altering health care professional behaviour in order to improve the effectiveness or efficiency of services is complex to interpret because of the range of variables which can be manipulated in the design of interventions – *eg* the setting, the target group, the intervention – and the number of studies which involve compound interventions. Furthermore, many studies attempt to compare an experimental intervention to change behaviour with the routine pattern of activity rather than with a different type or design of behavioural intervention. As a result, there is only limited evidence in the English language literature at present on the relative effectiveness of different types of intervention and different designs of the same type of intervention. Most of the published work comes from the USA and Canada and is focused on members of the medical profession rather than other health care workers. There must be some reservations as to how straightforwardly the results of behavioural interventions unlike, say, drug trials, can be generalised from one health system and clinical culture to another.

Another difficulty in providing an unambiguous verdict on the literature is the fact that the methodology of many trials is less than ideal. Trials of behaviour modification suffer more acutely than therapeutic trials from problems of bias, particularly from Hawthorne effects. A Hawthorne effect is a non-specific effect which is said to occur when the participants in an experiment modify their behaviour in response to the novelty of an intervention or the interest and attention of the experimenters, rather than in response to the content of the intervention itself. In these circumstances, it is difficult to be sure whether the intervention will produce any of the observed effects when used routinely. This compounds other interpretive difficulties associated with identifying the contributions of the different components of an intervention to the overall effect. Despite these problems, it is possible to reach some tentative conclusions about what works and what does not.

Evidence of Effectiveness

Andy Oxman's recent review of 102 trials of interventions to help health professionals to change in ways which will improve the effectiveness or efficiency of health services indicates that all the interventions investigated have some effect (Oxman excluded financial strategies and organisational schemes). But even relatively complex and intensive interventions such as outreach visits or the use of opinion leaders were found to have at best a modest effect (*No Magic Bullets: a systematic review of 102 trials of interventions to help health care professionals deliver services more effectively or efficiently*, prepared for the North East Thames RHA R&D Directorate, March 1994). Despite the difficulty of generalising from the results of the trials undertaken to date, it appears that no single strategy is likely to be successful in any particular setting and that compound or multi-method approaches are likely to be the most influential. Approaches generally require a balance to be struck between national, regional and local initiatives which allow individual professionals to participate directly in the design of the behavioural change to be successful. The effectiveness of each of the main approaches is discussed below.

Provision of information: The provision of information and research evidence has been shown to be a necessary, but far from sufficient strategy in itself to bring about desired changes in clinical behaviour. This is particularly the case when the information is not designed with a specific audience in mind. Research evidence can on occasions have a marked and rapid effect on practice patterns when the results are unequivocal and straightforward to implement, but, in general, the results from individual trials, even RCTs, have only a modest impact. Indeed, it cannot be assumed that all health care professionals are entirely supportive of independent trials and formal evaluations of the effectiveness of their practices. For example, the National Perinatal Epidemiology Unit (NPEU) at Oxford has, at various points in its life, encountered major criticism from obstetricians of the rationale and results of individual studies and, on occasion, of its entire *raison d'etre*. In 1993, a survey was undertaken in the NHS to assess diffusion and the extent of use in practice of the NPEU's *Oxford Database of Perinatal Trials*. Obstetric units which did not possess a copy of the database were asked why this was so. One anonymous obstetrician responded on behalf of his/her hospital as follows, 'We are a teaching hospital so we don't need to know what everyone else does' (S Paterson-Brown, N M Fisk, J C Wyatt, *Are clinicians interested in up to date reviews of effective care*? British Medical Journal 1993; 307: pp 1464).

Passive feedback of information *ie*, feedback which is not accompanied by any previously agreed commitment to take action arising from the information either on 'good practice' or on clinicians' past pattern of work, is unlikely to produce sustainable change. Active feedback which links the provision of information to other activities (of the kinds considered below) can be far more successful.

Education: Educational strategies involve some element of traditional didactic activity. The most obvious forms are continuing medical education and attendance at professional and academic conferences. However, there are person-to-person approaches to clinical change such as use of visits to practitioners by outreach workers or by local opinion leaders which rely in part on education, albeit in a personalised way. Educational activities frequently accompany other strategies to behavioural change such as audit and feedback of performance.

Traditional, narrowly focused approaches to education do not appear to be very effective in changing the behaviour of providers of health care, but they may contribute to raising the level of awareness of issues among professionals which, in turn, can provide a more receptive clientele for other approaches (D A Davis, M A Thomson, A D Oxman, R B Haynes. Journal of the American Medical Association 1992; 268: pp 1111-7). In many situations, clinicians possess the necessary knowledge, but lack straightforward means of implementing it in day-to-day practice. Conventional continuing medical education can produce changes if it is focused on very specific forms of behaviour or procedures, but it appears to be less effective than more personalised forms of feedback on performance.

Approaches which incorporate feedback on performance, involvement of learners in setting their own priorities for change or face-to-face encounters between practitioners and an educator may be more effective. These are discussed below.

Guidelines are a specific form of education which

Table 4: Determinants of Success of Introduction of Guidelines*

Probability of Being Effective	Development Strategy	Dissemination Strategy	Implentation Strategy
High	Internal (those directly involved)	Specific educational intervention	Patient-specific reminder at time of consultation
Above average	Intermediate	Continuing education	Patient-specific feedback closely associated with consultation
Below average	External, local	Mailing targeted groups	General feedback
Low	External, national	Publication in journal	General reminder

* Includes educational strategies (*eg* CME), computerised systems of decision support, audit of use of guidelines and face-to-face methods

Source: Grimshaw J, Russell I, Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations, Lancet 1993; 342: pp 1317-22.

have recently attracted considerable attention. They have been defined as 'systematically developed statements to assist practitioner decisions about appropriate health care for specific clinical circumstances' (M J Field, K N Lohr, *Clinical Practice Guidelines: direction of a new program*, Washington DC: National Academy Press, 1990). A systematic review of trials of the effectiveness of guidelines was undertaken by Jeremy Grimshaw and Ian Russell and published in the Lancet in 1993: see Table 4. The review shows that clinical guidelines can be effective in changing behaviour and improving practice in rigorous trial conditions, but that this depends on the specifics of the context, together with the way that the guidelines are developed, disseminated and incorporated into the clinical encounter. In general, guidelines which are generated by those likely to be directly involved in using them, which are based on a specific educational intervention and which can be reinforced by a patient-specific reminder at the time of the consultation, stand the highest chance of being effective in altering behaviour and sustaining change. Patient-specific prompts at the time of consultation, discussed later on, may be the most powerful means of implementing guidelines (see below). Locally-generated guidelines may have the greatest impact, but the process of deriving local guidelines is likely to be expensive and time-consuming. Local groups may lack the clinical, managerial and information-handling skills to develop guidelines without external help.

Peer review and audit: This approach consists of the discussion of summaries of clinical performance with colleagues, frequently in relation to a previously agreed standard or guideline. The simple process of discussing information on performance with peers can produce change in a desired direction at least while the peer review is sustained. However, peer review and audit must be related to clear guidelines for optimal practice and a commitment to change if they are to be successful over longer periods. The most successful trials so far undertaken have been in the fields of diagnostics and prescribing rather than medical and surgical procedures. Even in these fields, the effects seem to be fairly modest, although with expensive drugs the savings can be worthwhile. On the basis of current evidence, albeit imperfect and incomplete, on the possible combinations of interventions, peer review and audit appears to be most effective when linked to some form of individualised person-to-person contact.

Local opinion leaders: This form of personal contact uses providers regarded by their peers as 'educationally influential'. These are respected clinicians rather than innovators. Respected clinicians who have been identified by their colleagues appear to be a key resource for influencing clinical change. Although it can be labour-intensive and expensive to train and enable influential local clinicians to work on their peers, it appears to have positive effects in terms of patterns of patient management. In one study, departmental heads were given literature based guidelines to disseminate in person to their colleagues concerning the use of perioperative antibiotics (D E Everitt, S B Soumerai, J Avorn, H Klapholz, M Wessels, Infection Control and Hospital Epidemiology 1990 11, pp 578-83). Although the heads had not been nominated as influential by their colleagues, their intervention had a major positive effect. In a notable study, Jonathan Lomas and his colleagues from Canada undertook a RCT of audit and feedback of performance in relation to guidelines on hysterectomy versus education by local opinion leaders who had been previously identified by a survey of local obstetricians. Audit and feedback had no effect on rates of trial of labour and vaginal births which were advocated in the guidelines for management of women who had had a previous Caesarian section. By contrast, education by local opinion leaders substantially increased both rates in maternity units where the opinion leaders operated (J Lomas, M Enkin, GM Anderson *et al*, Journal of the American Medical Association 1991, 265: pp 2202-7).

Outreach visits/academic detailing: A variant form of person-to-person contact is the use of a trained person to visit providers in their practice settings to give them up-to-date information on practice and, sometimes, feedback on how their practice compares with others. For example, in the NHS, regional pharmaceutical advisers visit GPs, usually high prescribers, to discuss their prescribing habits and the rationale for their decisions. In the USA this activity is commonly referred to as 'academic detailing'. Pharmacists trained in educational techniques who talk one-to-one with doctors have been shown in American trials to have the ability to improve prescribing decisions (J Avorn and S Soumerai, New England Journal of Medicine 1983; 308: pp 1457-63)

Patient-mediated interventions: This form of person-to-person contact includes activity designed to change the performance of providers by giving information or advice on health care effectiveness directly to patients or by obtaining patients' views on the current pattern of practice and passing them to the provider. The idea is that patient demand will be brought to bear on the professional either directly at the consultation or indirectly by making the professional aware of the aggregated views of patients.

The broad approach appears to have considerable potential, but has been relatively rarely implemented in a systematic way. A number of experiments are underway or in planning in the UK which use interactive videodisks to enable patients facing the prospect of surgery for their symptoms to obtain the best available synthesis of evidence on the pros and cons of the surgery in their particular case together with an estimate of the likelihood of a good or bad outcome. The objective is to see what impact information on the

The Shared Decision Making Program

The Shared Decision-Making Programme (SDP) is an interactive video system which is used to provide patients with detailed, personalised information about their medical conditions and the risks and benefits of the different treatments available.

It was developed in the USA at Dartmouth and Harvard Medical Schools and used filmed interviews with patients and experts to lay out the the nature of the choices facing the patient.

The information on prognosis in the SDP is derived from randomised controlled trials and systematic reviews of evidence of outcome and is updated regularly. Details of the patient's history are entered into a computer linked to the video system which calculates for each patient the likelihood of a range of outcomes based on the best research evidence available. The risks and benefits of each of the treatment options currently available, including the option of 'watchful waiting' (monitoring the patient at intervals without active treatment) are explained using straightforward language, diagrams and cartoons. Patients can interrogate the system for more information on specific aspects of treatment if they want it, using a touch screen. At the end of the video, each patient is given a summary hard copy of their risk/benefit assessment to take home to discuss with their family, friends and doctor. A summary is also prepared for the clinician who made the original referral of the patient. This gives a summary of the information relayed to the patient and is designed to become part of the medical record.

Pilot studies of the feasibility of using the SDP in the UK have been undertaken in patients with benign prostatic hypertrophy referred to hospital for possible surgery and in patients with mild hypertension in a primary care setting who are deciding whether to go on to anti-hypertensive medication. Reports indicate that the vast majority of patients have found the use of the videos a positive and helpful experience.

Randomised trials are being planned to compare the use of interactive video systems with more conventional approaches to giving patients more information in terms of their effects on the pattern of decisions patients make and their eventual health outcomes.

Source: Kasper J, Mulley A, Wennberg J. Developing shared decision-making programs to improve the quality of health care, Quality Review Bulletin 1992; 18: pp 182-90.

potential consequences of the surgery for each patient's quality of life has on the overall pattern of decisions concerning the surgery in question. Will it shift the pattern of surgery towards patients who stand the highest chance of a good outcome? Will use of interactive video technology improve the outcome after surgery?

The technology was first applied to health care in a clinical trial in the USA involving patients who were being offered a prostatectomy for their urinary symptoms. An interactive program known as the Shared Decision Making Program was developed which provided detailed personal information to patients about their condition and the risks and benefits of the different treatments available for prostatism: see **Shared Decision Making Program**. The Program enables the patient to share directly in the decision-making process with the surgeon in the hope that the new information will result in a new pattern of choices and better outcomes.

There is now a need for formal evaluations of such programs in comparison with more traditional means of giving patients and their families information to see which has the more positive effect on decision-making, patient satisfaction and health outcome.

So far there have been very few studies of the effects of any other forms of patient-mediated interventions. One exception is a study from Switzerland in which a public information campaign was mounted in one of the cantons on rates and needs for hysterectomy with the aim of raising awareness of appropriate and inappropriate indications for the procedure to see if this would reduce intervention rates in the experimental canton compared with other parts of the country. The campaign was associated with a 26 per cent drop in the hysterectomy rate within 12 months compared with a 1 per cent increase in areas not subject to the campaign (G Domenighetti, P Luraschi, F Gutzwiller *et al*, Lancet 1988; ii: pp 1470-3).

Reminders: This approach has been discussed in relation to other approaches such as audit and peer review and the use of guidelines. Reminders can be manual or computerised prompts to the health care professional encouraging a particular clinical action. Reminders can be set up to operate at the time of the consultation, *eg* an on-screen reminder to the GP to discuss the patient's smoking or drinking or to test blood pressure, or between visits to prompt appropriate follow-up. The effectiveness of reminders appears to vary depending on the action being prompted and the clinical condition.

Decision aids: An insert in the medical record may be considered the simplest form of decision support system. However, more elaborate research based computer algorithms are being developed to help structure and inform diagnostic and treatment reasoning. For example, there are systems to help clinicians predict outcome after severe head injury which have been developed with a view to determining the appropriate level of care to provide in the intensive care unit. There is some evidence that such systems can improve the technical quality of the care delivered by doctors. It is less clear whether there is any commensurate improvement in patient outcomes.

Grimshaw and Russell's review of the implementation of clinical guidelines indicates that decision aids may have great potential to turn guidelines into practice at the consultation. However, there may be one drawback – computerised decision support systems appear to be more popular in experimental projects than in ordinary day-to-day practice. There are significant numbers of software systems available, but few are widely used.

Marketing: Andy Oxman includes marketing in his list of different types of interventions to change behaviour since marketing techniques can be used to identify the main obstacles to change in the desired direction and, thereby, contribute to the design of an appropriate intervention. Marketing would include the use of surveys, focus groups, etc to elicit professional opinion concerning important clinical difficulties and barriers to overcoming them. Since marketing is strictly a precursor to an intervention, its effectiveness cannot be discussed in isolation.

Local consensus processes: Again Oxman's typology of interventions includes separate reference to local consensus activities, although these are also commonly found as part of the process of developing guidelines which are rooted in the local clinical culture and, thereby, stand a better chance of being implemented. The local consensus process consists of involving relevant local providers in formal discussions to identify the key clinical problems and the appropriate pattern of care to deal with these problems. The latter is the clinical practice guideline or standard of good quality care which is to be implemented. Studies of a variety of behavioural interventions suggest that participation by the professionals likely to use a particular guideline in its origination may increase the likelihood of its being used in practice.

Economic strategies: This broad type of strategy uses financial incentives to change behaviour. The aim of most schemes introduced in health care systems to date has been cost containment or cost reduction. Relatively far fewer schemes have been aimed at improving the effectiveness of care by encouraging only those activities supported by research evidence.

Recent major changes to the NHS, including the introduction of a provider market with a purchaser / provider split can be seen as macro-level interventions to shape clinical behaviour towards cost effective patterns of practice based on economic reasoning. There is little doubt that financial incentives and penalties can be a very powerful determinant of clinical activity. So far most economic strategies introduced in health care have been justified on the basis of micro-economic theory and observational data. There are very few RCTs or trials of any kind of the introduction of different patterns of financial incentives on clinical practice. One problem encountered with a number of initiatives is the difficulty of targeting particular activities. For example, compared with conventional third party payer insurance with fee-for-service payment of providers, health maintenance organisations in the USA appear to have had some success in reducing the cost of health care consumption per enrolled patient. Unfortunately, it appears that these savings are just as likely to be made by a reduction in the use of effective services as by a reduction in the use of ineffective services. Similarly, the use of financial incentives in the form of target payments for achieving specified immunisation and vaccination rates was a feature of the 1990 NHS general practitioner contract. In the same contract, incentives were introduced for GPs to offer health promotion clinics for a wide range of health problems and chronic conditions. It appears that the incentives in operation between 1990 and 1993 altered GP behaviour in favour of a wide range of health promotion activities. Unfortunately, as with many financial incentive schemes, the effect was uniform irrespective of the likely health benefits of the specific activity.

Administrative rules: Procedures such as prior approval from a budget holder before a treatment can be given, *eg* arbitration over extracontractual referrals in the NHS provider market, have been used to shape clinical behaviour. Experience shows that rules and regulations have to be sustained and constantly modified if they are to remain effective in influencing clinical behaviour in the direction originally intended. Clinicians are adept at circumventing rules and maintaining their decision making autonomy. A good example concerned the American Certificate of Need approach to the regulation of new and expensive medical technologies. Under this scheme, designed to curb the purchase of duplicate equipment in hospitals in the same area, each hospital had to make a case to the authorities showing that a particular investment, such as a magnetic resonance imaging device, was in fact needed. If the application was turned down, the machine was simply installed in the office of one of the hospital's specialists away from the hospital campus. The regulations only covered hospital equipment, not equipment in private consulting rooms!

Administrative rules tend to create friction between health care professionals and public authorities because they are based on compulsion rather than collaboration. Some appear to be reasonably effective *eg* prescription review by community pharmacists or redesigning test ordering forms in hospital. Others seem to be ineffective, *eg* utilisation review in the USA, or procedures for obtaining a compulsory second opinion before certain types of surgery.

Conclusions

The determinants of professional behaviour change are complex and so too are the interventions which have been devised to bring change about. Since studies have not yet been undertaken looking at the full range of possible permutations of interventions together with the full range of comparisons between methods, it is not possible to be definitive about what works and what does not, to what degree and in what context. However, it is possible to say that most of the interventions discussed above can bring about positive change in appropriate circumstances, but that the effects are usually moderate. No one approach has been shown to be universally successful. There are no 'quick fixes'.

From what is known to date, it would appear that change strategies which target the multiple determinants of practice style simultaneously, *ie* multifaceted strategies, and operate at a variety of levels between the national level and a personalised, one-to-one interaction, are more likely to be effective than single-facet approaches.

Successful Change Strategies

Returning to Barbara Stocking's framework for understanding 'normal' clinical change (the climate of ideas, the character of the change itself and the local context) helps to provide a structure for describing in more detail the features associated with the most successful strategies for change which have been evaluated to date. Turning first to the wider environment or climate of ideas and opinion, it is apparent that successful change requires there to be clear, high quality evidence of the need for change, together with a climate of professional opinion favourable to change. Sufficient numbers of influential professionals must recognise that current practice needs improvement. Recent work on helping patients to change health-damaging behaviour such as excessive drinking suggests that when patients are approached by their medical adviser and encouraged to cut down, they will be at different points on a continuum of motivational states related to their 'readiness to change'. If people are not ready, they will resist and have to be brought gradually to the point where fundamental change is possible. This analysis of motivation suggests that clinicians may be similarly sensitive to the context and climate of opinion for or against change and engaged in their own personal reappraisals of practice. The provision of information and advice, even from respected sources, is not always sufficient to produce permanent change when it is unsolicited.

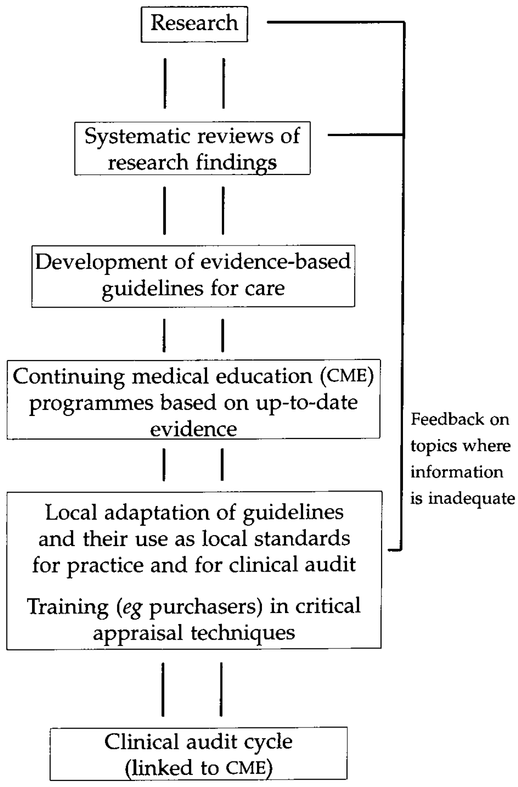
The nature of the change itself is patently related to successful change strategies. A successful change strategy tackles a change which is not too disruptive of previous routines and not too threatening to the interests of infuential groups.

The interventions used should generally combine a number of approaches, such as using opinion leaders to help implement guidelines, and they should be focused, if possible, on specific behavioural changes. The choice of interventions should be related to the supposed barriers to change. If lack of information is not likely to be the reason for resistance to change, but finance is, then an intervention based on incentives is more likely to succeed than one which relies centrally on reminders at the time of the consultation.

The successful change strategy should be sensitive to the local context and seek to involve local clinicians in shaping the change agenda and the guidelines which are to be used. The changes agreed with those who are being encouraged to implement them must be realistic and not too far removed from previous practice to maximise the likelihood of bringing about change.

Where prompts to action are appropriate, these should be made available at the time of the relevant consultations and should be detailed and patient-specific. The best sort of prompts appear to be those which are embedded in the patient's notes or generated automatically by the software used at the consultation.

Diagram 2: Cycle of Activity to Develop an Evidence Based Clinical Culture in the NHS



Source: Adapted from A Haines, R Jones, Implementing findings of research, British Medical Journal 1994; 308: pp 1488-92, Figure 3.

Finally, there are a number of further features of the intervention which will improve the likelihood of success; namely, that the intervention should be sustained over time, that it should be targeted on the correct groups (*eg* it is no good focusing an intervention concerned with the appropriate ordering of routine pre-operative X-rays on senior medical staff if the majority of such requests are made by junior doctors), that any information or guidelines prepared should be well presented and pithy, and, finally, that there should not be any major financial or legal disincentives to compliance with the desired pattern of care.

This is a tall order, although it is worth considering how closely it resembles the way that international drug companies work in their efforts to encourage doctors to prescribe their products. They adopt an integrated approach in which national advertising,

Table 5: Steps in Promoting Change in Clinical Practice

1. **Analyse the Prospective Change**

   Needed?
   Evidence of benefit?
   Obstacles? (straightforward, complex, major, minor)
   Worth effort involved?
   Interests at stake?
   Is change already taking place in the area?

2. **Choose Appropriate Combinations of Approaches**

   Relevant to target groups
   Relevant to cause of problem

3. **Involve Key Stakeholders in Change Process**

   In producing guidelines/protocols (local and attainable)
   Identify and recruit 'opinion leaders' in key stakeholder groups

4. **Train 'Opinion Leaders' and Disseminate Guidelines**

5. **Develop Policy-Related Incentives to Change and a Feedback Mechanism to Participants**

6. **Build Change Into Education System (For Long-Term Change)**

7. **Monitor Effect of Change Initiative and Audit Clinical Performance**

8. **Modify Interventions in Light of Effects and repeat 3-7.**

research, promotion and marketing predispose professionals to change and sustained local and individually targeted visits from representatives, together with company sponsored presentations from local peers enable change to occur. The NHS may be able to learn from the drug companies in developing its own strategies to improve clinical practice by altering behaviour.

What Should Be Done In The NHS?

Andy Haines and Roger Jones, both academic GPs and, presumably, familiar with the *modus operandi* of the drug companies, propose a not dissimilar approach in the NHS to bringing about clinical behaviour change in ways which reflect more accurately than at present the results of research (British Medical Journal 1994; 308: 1488-92). The essence of the plan which they outline comprises getting evidence on effectiveness to purchasers, providers, policy-makers, the public, professional bodies and educational institutions (*eg* through the Cochrane Centre in Oxford and the NHS Centre for Reviews and Dissemination in York), taking national initiatives to develop guidelines and standards and, then, building a large number of local initiatives to develop more locally applicable guidelines. This last step is to ensure local participation in guideline development and local ownership of the ensuing guidance. In these terms, the national work, although probably involving the experts in the field, is no more than the raw material for local activity to change behaviour. Otherwise the message will be interpreted as an imposition and be ignored or resisted. Diagram 2 contains a summary of the cycle of activity which they propose relating to the implementation of research in practice and to changing the culture of the NHS towards a more evaluative one in which research evidence is constructively criticised and then used.

The evolving provider market in the NHS may provide a supportive environment for the implementation of research based behavioural change. Purchasers could help implement the findings of research by incorporating research-based recommendations in contracts, initially on a selective basis. This is the essence of the GRIP project in the Oxford Region. It is possible that in certain areas of health care, consumers and consumer groups may offer the greatest potential. The National Childbirth Trust, for example, has made very effective use of the National Perinatal Epidemiology Unit's publication *Effective Care in Pregnancy and Childbirth* to train its own staff and counsellors. The potential influence of the mass media to inform and, thereby, give greater weight to consumer demand, as the study of an information campaign in Switzerland to reduce hysterectomy rates showed, is great and underexploited.

Professional organisations could also contribute more to behavioural change based on research evidence by the way that postgraduate education, CME, etc is developed. There has been some scepticism among the Royal Colleges about the use of systematic reviews of research evidence as the prime basis for deciding treatment standards, but this appears to be on the wane. The Audit Committee of the Royal College of Obstetrics and Gynaecology recently decided to recognise the updates of *Effective Care in Pregnancy and Childbirth* as an official and, therefore, legitimate source of information on effective treatment in their field.

Professional organisations have a responsibility to identify areas of clinical activity which appear to diverge in important ways from what the research evidence would suggest is the best pattern of care and to work to develop guidelines at national level which can be picked up and used locally as the raw material for local clinical change initiatives. Professional organisations could also explicitly encourage clinicians to participate in trials and cost-effectiveness studies. Clinicians who are regularly involved in trials in the field of cancer have been shown to be more likely to use proven treatments in their day-to-day practice. The more patients a clinician has enrolled in a particular trial, the more likely s/he is to be influenced by the results of the trial when published (R Stephens and D Gibson, Clinical Oncology 1993, 5: pp 211-9).

In the future, as the contracting process is increasingly refined, there should be increasing scope for purchasers to help implement evidence based changes in health care delivery by incorporating research based recommendations into contracts. Innovative projects such as GRIP have begun this process by identifying a short list of priorities for change where the evidence of effectiveness of particular patterns of management is compelling, but current practice is known to diverge significantly from the evidence. One area of care in which GRIP has been successful in changing practice through purchasing is encouraging the prescribing of steroids to women in premature labour in order to reduce the likelihood of respiratory difficulties in the infant.

Finally, any initiatives to change clinical practice have to be carefully selected, clearly thought out and purposefully managed to completion. Table 5 summarises the key steps in implementing an initiative in clinical change. The approach will vary in detail depending whether the intended change concerns a clinical technique, *eg* training for 'key-hole' surgery or the organisation of care, *eg* altering the roles of members of the primary health care team. However, whatever the change, good intelligence is needed on the nature and implications of the intended change and the potential barriers to the change. Key interests which will be affected by the change and the groups which are required to participate directly in changing their behaviour have to be negotiated with and become involved in the change process. The appropriate combination of approaches to change has to be selected which are relevant to the cause of the clinical problem.

Major shifts in clinical practice will require multi-level, multi-faceted approaches sustained over a considerable period of time. Opinion leaders have to be identified and 'trained', guidelines have to be disseminated, incentives constructed where possible and, if long term change is needed, changes must be fed into the training and education of the next generation of professionals.

While initiatives are being pursued, they should be evaluated. More investigations are needed both of why clinicians practise as they do and whether and why certain interventions affect clinical behaviour. Little is known about how long the effects of interventions persist. There is almost no research which systematically varies the main structural features of interventions in order to arrive at the most cost effective designs for shaping clinical activity. Yet some of the most promising methods require substantial resources since they appear to call for local participation and face-to-face contact with influential peers. Issues of cost effective design cannot be ignored if interventions are to be disseminated widely. For example, a very basic question such as the optimal duration of interventions is still unresolved. The research and development task in the field of clinical behavioural change remains an exciting one. Without it, the majority of health services research activity will amount to nothing more than satisfying intellectual curiosity.

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Health Policy Review 1992/93 1

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1.3 Public Health Strategy 16
The Government followed up last year's green paper, *The Health of the Nation*, with a white paper confirming the general approach. It also began a series of measures to realise it. We point out the significant obstacles which remain.

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Services for Elderly People 64
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Elaine Murphy

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The aim of shifting the balance of care for the mentally ill from hospital to community is far from new and the evidence presented here confirm the case for such a shift. But it is more difficult to define, on the basis of existing research, just what the pattern of replacement services should be. Here too there remain substantial obstacles in the way of major change.

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David Hunter

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The NHS: Church or Garage? 136

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Rudolf Klein

Reshaping the NHS: From Radical Reform to Continuous Change 141

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John James

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