UNDERSTANDING THE NHS

a question of incentives

Peter A West

EDWARD'S HOSPITAL FUND FOR LONDON

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To Diane

Preface

Anyone setting out to write a book on the NHS, one of the largest organisations in the world, should beware. It takes more time than you can give and, like Alice, you may end up running pretty fast just to stay in the same place. This book always looked ambitious and may look too ambitious to many. It may reveal as much my ignorance about parts of the NHS as my knowledge. It has taken much longer to write than I hoped and is still under-researched. It has suffered delays as White Papers follow Green Papers and the health service lurches from one crisis to the next.

I have written the book for all those, inside or outside the NHS, who want to understand how it works. But I have not tried to explain all the administrative links in a complicated chain (though there is a diagram on page 175 to help the newcomer). Instead, by concentrating on the incentives of each group in the NHS, I have tried to explain what makes it tick. Recent events suggest it may be ticking because it is a time bomb.

I have spent 16 years working on health service issues and I could furnish further information, published or anecdotal, on everything in this book. But I have not provided large numbers of references to every point. This is partly because it is a personal, rather than an academic, account of what I have seen. It is also because much of the academic literature does not always deal effectively with the practical questions of what really makes things tick.

The NHS is currently run like a charity. It treats many of its patients like poor beggars rather than paying customers. It trades heavily on the commitment of its staff, paying them badly and grinding many down and out of the service. If my comments appear to be cynical or critical of some groups in the

health service, let me make my position clear now. I have the greatest respect for the commitment and service given by many health service staff. But I think that the good service that results is too rare and arises by accident rather than because of sensible planning and incentives. We will always need dedicated people to treat the sick, but calling them 'angels' is not the way to run a modern health service, in their interests or ours.

If you agree or disagree with what you find in this book, please write to me. Apart from the odd reviewer keen to score a few points (and I have scored some myself), an author hears too little from his readers. A few letters in support of some of my articles in the past have been a great boost and even the criticism is worth seeing.

I must acknowledge the help I have had in writing this book. The King's Fund kindly gave me a grant, before I began working for the King's Fund College, which enabled me to buy a computer to help me write this book. I have had helpful comments from Chris Ham, David Towell, Su Kingsley, Kevin West and members of the Health Economists' Study Group – but have not always acted on them. I have also learned a great deal from colleagues and course participants at the College, on whom parts of the argument have been tried out, with mixed reactions, over the last three years. Finally, I must thank my family who have put up with the time I have spent on this book and the mess created by my constant obsession with all the details of the NHS and the collection of paper to match. It has displaced most normal activities from time to time (except Wimbledon FC home games) and it will be nice to get back to them for a while.

Peter A West DPhil

1

Personal and Patient Incentives

INTRODUCTION

This chapter looks at the way we behave when we feel healthy or ill and the incentives that affect our decisions to consume particular products or follow particular treatments. As well as acting as consumers of the NHS and other goods and services, the general public is nominally responsible for the political decisions on the size and allocation of NHS funds and the availability of health-affecting products. However, these decisions are largely taken on behalf of the public by politicians and professional public servants and they are open only to limited control at the ballot box. Therefore this role of the public is considered later in the discussion of the incentives faced by professional and amateur policy-makers and the politics of the NHS, in chapters 5 and 6.

There is no easy and convincing way of separating the sick and the healthy when looking at behaviour in response to incentives. There are large numbers of people at any time with symptoms that some doctors would treat actively. There are also lots of people in hospital at any time who have no medical reason to be there. In view of the difficulty of separating them, the focus of this chapter is not the healthy and the sick but the different consumption decisions taken by individuals for their own satisfaction, decisions which are similar for healthy and sick people.

THE PURSUIT OF WELFARE

Left to their own devices, and with the resources and opportunities available to them, it seems obvious that people will tend to choose goods, services and activities that they feel offer

them the best outcome. This self-interest is the main justification for freedom of choice as a way of allocating goods and services between consumers. There is a sense in which we assume that people try to get the most satisfaction out of life rather than because behaviour has been analysed to prove it. In fairly easy choices, such as the regular purchase of a meal, it is irrational for people to choose food which they really dislike and which offers no other advantages of cost or calories or flavour. Even a gift to charity could be said to be part of the search for satisfaction if the gifts give satisfaction to the givers through their idea of the good they have done.

In practice, individuals are not always left to make their own choices. Advertising and education are the obvious influences but there is a sense in which an independent decision can never be wholly possible. To decide whether to purchase a commodity or undertake an activity, the potential consumer needs an assessment of it. This will normally come from the first exposure to it. Unless the first exposure takes place in a laboratory, it is bound to be affected by the context. A decision to try jogging on a day when it rains heavily will affect the view of jogging. The restaurant and company in which a particular meal is tried for the first time will probably influence its enjoyment. More generally, even if people are born with no tastes or preferences, they are doubtless influenced by the various subtle effects of education, family and society. Short of offering commodities free of all packaging to individuals reared in a laboratory, it is difficult to see how truly independent choices can be made.

If independence cannot be assured, the alternative justification for relying on individuals to choose their own consumption and activities is that, even if they do not know best in every case, there is no strong evidence for believing that anyone else knows better. Even the most dominating governments leave most day-to-day consumer decisions to individuals even if they control many aspects of life or stop the market forces that connect consumers with industry in capitalist economies.

To avoid a difficult theoretical discussion that I could not entirely do justice to, let me say that we are looking at the behaviour of people in contemporary Britain who are assumed,

for much of the time, to be making choices in what they think are their own best interests. By best interests I mean their own welfare or the wellbeing they get from increasing the welfare of their families, friends or anyone else of interest and concern to them.

HEALTH, WELLBEING OR WELFARE

In the analysis of health service use and consumption of commodities which affect health, it is worth looking at how health is linked to welfare or wellbeing. I take the view that physical and mental health have no value other than the opportunities they offer to increase wellbeing by allowing individuals to undertake enjoyable activities. Physical disability prevents some things being done, while mental illness prevents the enjoyment of activities by affecting how they are seen by the consumer (for example, failing to enjoy a good meal due to anxiety). Staying fit to work in order to generate income or to enjoy recreation is using physical fitness as a means to the end of welfare from consumption. The loss of welfare due to a physical or mental problem is then the loss of the preferred activities and the welfare they generate for an individual.

The importance of some abilities for particular activities makes it very difficult to generalise about the effect of illness on individuals. For example, while most of us would probably be unaffected by the loss of use of a little finger, the dedicated pianist, whether earning income or just a great deal of pleasure from music, might suffer greater loss. It is the lost activities rather than the cause of the loss or the physical or mental problem that is the burden of illness. The more the lost activities can be offset or regained, the less the real impact of illness. (I once had this brought home to me during a week of illness when, with symptoms of influenza, I spent a week in a warm bed watching the world snooker championship rather than a week commuting to a cold and wet London to work.)

In order to examine individual behaviour further it is simplest to separate three types of consumption. Consumption of goods and services with no known link to physical or mental health can be ignored for the purposes of this chapter. Consumption of goods and services which have an effect on

health but are a source of satisfaction for other reasons is of interest because in many cases the health effect is bad and is treated by health services. Consumption which has a direct effect on health but no other satisfaction – such as painful surgery (or possibly jogging) – is the type of behaviour most seen in the NHS.

There are many products now on the market and recreational activities undertaken which, apart from giving pleasure, are expected to affect health. Some produce bad effects and others health improvements. There is nothing irrational about the desire of some consumers to choose harmful products. The consumer of a harmful product may of course be unaware of the harm that will result and so a rational decision is based on incomplete information. But the solution to this difficulty is usually to inform and not to forbid. Smokers or drinkers are effectively taking the view that the pleasure they derive from the activity is sufficient to offset the risk of health effects and the future loss of welfare that it will bring. Similarly, those who engage in apparently painful exercise may regard the future health gain, or more correctly the future consumption it will permit, as a fair return for the loss of welfare caused by the painful exercise.

UNHEALTHY CONSUMPTION

Unhealthy consumption activities are a common feature of life in Britain and other developed countries. The widespread use of advertising has led critics to argue that the choice of these products is not the free choice of individuals but manipulated choice controlled by the supplying industries. But it is too simple to suggest that advertising is the main cause of the consumption of these products and others which can damage your health. Harmful products and dangerous activities are found throughout the world in primitive societies and in countries which have no capitalist, profit-seeking industry to promote them. This may reflect the value of mind-bending stimulants and ritual demonstrations of courage in all societies, but also vested industrial interests which are significant even in communist countries. For example, the Chinese have a good record on public health for a country at their stage of industrial

development but they also have a large tobacco industry. It would be foolish to assume that this could be changed at a stroke and the workers painlessly moved to some other crop.

Given the information on the future health risks, consumers can assess for themselves the balance of welfare gain now and loss in the future. Of course, without suffering the pain of later illness the decision can only be based on a guess about the future loss. But there is nothing irrational about running the risk of present or future harm in return for current enjoyment. No one would suggest that a calculation of this kind is behind every consumer decision to buy cigarettes or alcohol. In particular, the addictive nature of these products will play a part in consumption decisions. At the same time it is worth noting that many heavy consumers of such products eventually give up, some after a health scare which changes their view of the risks they run. One explanation is that the heavy user who continues simply does not value the health improvement enough to give up. Even if the urge to go on using the product is related to factors such as stress and the conditions in which individuals live, this is no more than a restatement of the fact that the benefits, including help with coping with stress, outweigh the health damage expected. Indeed the health damage is often deliberately put out of mind.

There are several features of the health damage from harmful products which tend to reduce the impression it makes on consumers. Even evidence of quite severe health damage does not eliminate consumption. Of particular importance are the uncertainty of health damage and the fact that the damage is usually a delayed reaction to the consumption.

THE UNCERTAINTY OF HEALTH DAMAGE

Medical research has shown very clearly that lung cancer is linked to cigarette smoking. Lung cancer is also associated with cigarette smoking in the minds of the general public. Yet lung cancer occurs in only a minority of smokers – the greater risk is from heart and circulatory disease. But even these diseases are not guaranteed to strike in middle age and there are significant numbers of elderly smokers (and drinkers) in the community. Thus, even from a well-established, unhealthy commodity, the

health damage is variable and there are old people around who have survived a long period of unhealthy consumption. George Burns, the American comedian in his 80s summed up these people's experience with his remark: 'If I'd known I was going to live this long, I'd have taken better care of myself'.

The risk rather than the certainty of harm makes it easier for individuals to forget about the health damage from harmful products. Risks are also difficult to understand. I know what it means if a gamble depends on the throw of the dice showing a six. I have a one in six chance of winning and in the long run, if I do not get close to this rate of winning, I will suspect the dice, though it is possible for a fair dice to give no sixes at all in a long series. But what about health damage? What does it mean to say that a heavy smoker has a one in nine chance of contracting lung cancer? Since each of us has only one life to live there is a sense in which the one in nine chance is not possible in the long run. Either the disease strikes or it does not. If it does, there is no sense in which we can be one-ninth dead from it. In consequence, individuals are more likely to view risks as above or below the level on which they act and as important or not. Research on risk suggests that the type of risk, chosen or forced on people, and the type of outcome, nuclear disaster or air pollution, will affect the way risks are seen so that there is often great fear of small risks.

In the particular case of smoking, those who gave up in the face of the health evidence presumably found the level of risk too high. Those who did not, if not entirely addicted, presumably regard the risk as acceptable. Addiction makes it difficult to be sure how smokers see tobacco-related risk. It is also clear that many dangerous sports, with no obvious addictive effects on the body, are enjoyed by some people at great personal risk. (Some might even argue that the obsessional enthusiasm with which some people behave comes close to addiction.) More generally it is clear that risk has only a limited effect on behaviour when individuals are in control of an activity – driving or rock climbing, for example – because whether reckless or not, they are likely to see their activity as more under their control. Because each event is different, the true risks faced are probably unknown. (Due to a problem with my car. I found it one day with the steel ply exposed on

three-quarters of the rim of one front tyre. I would have re-assessed the risks the day before, when I drove on a wet motorway at 70 mph, had I only known. Yet I had survived an apparently high risk activity.)

A final element of health risks is that diseases can and do attack people leading an apparently healthy life. There is no guarantee that by giving up alcohol and tobacco an individual will achieve a longer life. Avoiding risks from harmful consumption still leaves the other risks to be faced. It is easy to see why many people find it possible to reject or ignore the health risks from consumption on the grounds that 'it might not happen to me'.

The health damage from consuming alcohol and tobacco will usually build up over a lifetime. Each single dose of consumption brings immediate and short-lived pleasure and will not usually bring corresponding immediate pain from the health damage. Only in the long run will the full damage show itself in the form of a heart attack, cirrhosis or cancer. The delayed response means that young adults faced with a choice offering immediate pleasure are offered instead the reward of a distant health gain. Usually, the further ahead something is to occur to us, the less importance we attach to it. (Even when there is no inflation there is a rate of interest on loans, reflecting the greater value placed on money now to money in the future. Present satisfaction is more highly valued now than the prospect of future satisfaction.) When the health damage in forty years' time is also difficult to assess accurately, given the risks and health problems that will occur even if healthy consumption is chosen, it is less likely to affect choice. In consequence, longer term health damage is readily discounted and looks less important when set against the short-term pleasure of consumption. The familiar maxim might be rewritten (by those concerned about the prospects for nuclear war for example) as 'eat drink and be merry for there is no guarantee that you will live to suffer the effects of your consumption'.

The argument here does not imply that everyone will reach the same conclusion about unhealthy consumption. Taste, income, stress and other factors will all affect our view of benefits and costs, and produce different responses. Nor does the argument deny the influence of addiction or advertising on

the consumption of unhealthy commodities. But it suggests that the view of health damage and the welfare generated by consumption will influence consumption even when it appears to be unhealthy and risky.

HEALTHY CONSUMPTION

The consumption of products with alleged good effects on health has grown considerably in recent years in the UK. This may reflect a change in information, with consumers now more aware of the links between health and consumption. But there is also a strong fashion component involved. There are, for example, more track suits than regular exercisers in the community. Smoking has become less fashionable in some social groups and it is more fashionable to eat healthy foods. As a result, advertisements push the healthy image of some food products and expand their market share. While much of this change may be linked to the hope for better health, the uncertainties of any health gains in the future will probably limit the continued growth of a healthy lifestyle. If it does not, or if we need further explanation of the current health boom, it might be appropriate to look not at the health gain but at the other characteristics of a healthy life.

The most obvious part of a healthy lifestyle is the shape of our bodies. Holidays in the sun are now a major feature of life in Britain, compared to 30 years ago. The chance to take off most of our clothes once a year is something we choose in great numbers. But who in the free-wheeling beach club wants to look flabby and old? In the long run, whatever their effects on alcohol consumption, I am convinced that package tours will make one of the biggest contributions to public health.

BEHAVIOUR DURING ILLNESS – THE BENEFITS AND COSTS OF PRIMARY HEALTH CARE

Given the basic approach to behaviour described above, where it is argued that individuals respond to what they see as the incentives and disincentives for an action, we can now look at how people behave when ill from the same perspective.

When pain or restriction of activity are first noticed by people

they are likely to respond. The most common response is self-treatment or family treatment, with rest and painkillers from the chemist as the most common treatment. Once illness strikes, the burden to the individual depends on the activities lost and their value. As we noted above, the consequences of a little-finger injury will vary according to the activities individuals undertake. Some will grin and bear it while others will seek medical help at once.

The incentive to get treated is the benefit that is expected to result. For many illnesses this will be small. Treatment may speed up recovery but has only a small effect on the course of an illness such as a cold or influenza. For other symptoms, the individual may be much more unsure of their importance and get medical advice for information as much as direct relief. The greater the benefit in improved recovery of lost health and lost activities or reassurance, the greater the incentive to seek treatment and the more likely that contact with the NHS will occur. While we would therefore predict that the contact with the health service will increase with the seriousness of the problem or, more exactly, the individual's view of its seriousness, it is also common for people with serious problems to put off seeking medical advice because of a fear that the illness will prove serious and potentially life-threatening.

Throughout this book we will encounter behaviour that is stimulated more by the need for reassurance than by the probable direct health improvement. Reassurance may be particularly important when children are involved. Medical opinion or treatment may give the parent confidence in the outcome which they cannot provide for themselves. This may account for much of the use of accident departments and hospitalisation of children for minor conditions or observation. There may also be some misunderstanding of what the health service can provide. A lot of cuts and strains can be treated by bandages, rather than stitches or plaster, and this could have been done at home. But the availability of what is seen as better treatment is attractive and encourages people to use the service. As a result, there is a growing trend to go to hospital accident departments even for very minor conditions (Farmer 1984). More car ownership has made such journeys much easier and helped to increase the demand on such departments.

One further benefit in the past from contact with a doctor was the sick note for time off work. A sickness certificate signed by a doctor is no longer required for a short period of absence from work under the new self-certification arrangements. But it is difficult to assess the effects on sickness absence and consultation rates because the high level of unemployment may itself be affecting sickness absence by increasing fear of dismissal.

Whatever the sources of benefit expected from a consultation, the cost of seeking care will be set against the expected benefit as the individual decides whether to get medical advice. While it is appealing to think of illness as creating a clear need for care, in practice it is more likely that individuals weigh the benefits against the costs before deciding to contact the NHS.

The main cost of getting care from the health service is the time and trouble necessary to see a doctor. This can mean a wait of hours in an accident and emergency department or a shorter wait, often after a few days' delay, in a general practitioner's surgery. For some it may involve a loss of pay, while for others it may simply mean the inconvenient rearrangement of other activities. Individuals differ in the importance they attach to medical advice. Some may be prepared to bear a high inconvenience cost for a relatively simple piece of reassurance about their cold; others will put off a visit to the doctor (and more often the dentist) for almost any alternative activity. At least some of the minor illness contacts will involve people who enjoy ill health and want their illness confirmed, perhaps to reduce their responsibilities at home or at work while their problem lasts.

Distance to the surgery will clearly have some effect, particularly on those without cars. There may be more to this than the simple disincentive of travel time, such as the nearness of the practice to local shops, major roads and public transport. But the evidence is again consistent with the view that the use of the health service involves the balancing of advantages and disadvantages rather than a clear decision that care is necessary.

The extent of disincentives to seek medical advice has been debated fairly recently in Britain as part of the discussion on social class variations in the use of health services (LeGrand 1984). A consultation can take more time and trouble for those

using public transport, except perhaps in central London, and access to a telephone can change the effort required to make an appointment with a GP. Unfortunately the data on disincentives and primary care use tends to be drawn from large and general data collection exercises rather than a detailed local assessment. Thus we cannot be certain how far the various possible factors increase or decrease the incentive to seek care.

The assessment of primary care is further complicated by the fact that much of the illness seen in general practice is medically trivial and will sort itself out without any treatment. The disincentive to seek care for some social groups may therefore not be having a direct effect on their health if, for more serious problems, the incentive of a more significant health gain offsets the disincentive of access costs. More generally the causes of variations in illness and death rates across social groups are still poorly understood and certainly go beyond access and disincentives to seek care (DHSS 1980).

The various costs of getting access to a GP will also give an incentive to some people, particularly those who live or work close to a hospital, to use the accident and emergency department as an alternative source of primary care and not merely for urgent hospital treatment. Although the waiting time in such departments will frequently exceed that in general practice, the patient is virtually assured of medical attention that day rather than with one or more days' delay for a non-emergency general practice consultation. However, it may not be the time to see a doctor that leads to the choice of an accident department but the expected benefit.

Patients may expect a different kind of service from a hospital department, particularly x-rays or active treatment such as bandaging or stitches, which are not part of the current style of general practice. A glance around a GPs surgery rarely reveals patients with obvious injuries, no matter how minor. (The boy with his head in a saucepan is found only in cartoons it seems.) Many patients in an accident department have not contacted their GPs before presenting for treatment as a casualty. They have gone there for a different service based on some assessment of the benefit of hospital care.

To summarise, patients are seen here as choosing their health care in the same way as other commodities, through an

assessment of benefits and costs, but with several crucial differences in the case of primary care. The absence of a money price and the limited choice of suppliers means people may use a service in a way which the doctors and nurses think is inappropriate or unnecessary. The lack of knowledge may also lead to visits for reassurance and information rather than treatment.

Benefit assessment will depend greatly on the individual patient's perception. Hypochondriacs may gain in reassurance, no matter how trivial their illness, while others may put up with a good deal of discomfort when they think it will fade away after a few days of misery and a few aspirins. In general, the more ill a person feels, the more benefit he might expect from medical attention and the more likely he is to visit his doctor. But fear of the outcome may deter those with serious illness nonetheless.

The assessment of costs is based on the time and trouble of attending a general practice or accident department. Money may be indirectly involved in the financial effects of time off work or travel costs but these may often be relatively small elements. In consequence a consultation will never be truly free even when no price is charged.

CONCLUSION

This chapter has argued that the behaviour of healthy and sick people is a response to the various incentives and disincentives, the costs and benefits that they face. There is a sense in which it is bound to be correct because why ever would someone do something if it did not benefit them! But we can never measure directly how much benefit people get from a choice, and often we only measure some of the costs. As a result, the approach remains plausible but not easily turned into scientific fact. Since a lot of behaviour can be predicted from a knowledge of the incentives and disincentives involved, the approach seems to have some use.

When people are healthy they often consume unhealthy goods and services because present pleasure is better than future pain. When they are sick, they respond by looking for treatment. Not everyone gets treatment in the same way, just

as not everyone consumes the same commodities. But there is less scope for shopping around for treatment when ill, particularly an NHS treatment. Consumers may also find it more difficult to judge the product than they do the things they buy in the shops.

Once the decision is made to visit a doctor, many of the other decisions (some have argued too many) are then taken out of the consumers' hands. The chapters that follow look at the incentives for those who work in the different services and levels of the NHS who take these decisions on behalf of patients and the public at large.

2

Primary Care

This chapter examines the incentives and behaviour of those who provide primary care, mainly general practitioners. Primary care is also given by hospital doctors in accident departments and some aspects of their choices are considered here. (Chapter 3 focuses more closely on the behaviour of those working in hospitals.) District nurses, health visitors and practice nurses all give elements of primary care, although district nurses are often providing care for chronic patients rather than health education and primary care for less serious illnesses. Some aspects of their work are covered in this chapter; other aspects are covered in chapter 4 on community care.

THE DOCTOR'S INCENTIVES

When the patient comes for treatment, of the doctor must decide what, if any, medical treatment is required. The decision will depend on two sets of costs and benefits – those of the patient, as judged by the doctor, and those of the doctor personally. These will not always coincide, for example when the GP thinks that hospital treatment is not necessary but the patient thinks a hospital appointment is essential.

General practitioners have no direct financial interest in most patient consultations. GPs are paid a fee for each patient on their list, regardless of the number of times each of them visits the doctor. They are also paid a fee for certain procedures. Some costs, for example the salaries of practice nurses or receptionists, are mainly paid by the family practitioner committee in their area which also pays their capitation and fee income.

These financial arrangements put GPs in an unusual position. Doctors decide how much of their services we need and also supply them. While this is also true for many services too

complex for the layman to understand, there is usually some competition in these services which offers the consumer some protection against exploitation by a supplier who is also an adviser or agent. In the NHS a lazy GP loses no income by cutting down on consultations by telling patients there is no need to return for treatment. In other countries, doctors can increase their income by recommending regular return visits, each for a fee. Either way, because the doctor makes the choice for the patient, the patient loses much of the control we take for granted when buying other things.

The lack of easy and effective customer choice in primary care is very different from other services in the market economy, though the government is aiming to change this (see chapter 7 and *Promoting Better Health*, Parliament 1987). Faced with a limited choice of suppliers, the gain from treatment may be seen by the patient as dependent on the doctor who will be consulted and not just their medical problem. Their own and their friends' experiences will give patients some idea of how far they will get what they want from a consultation with a particular doctor. The number of visits may depend on how far patients can get access to a doctor they think is appropriate for their problem. The easier it is to change GPs, the more people are likely to vote with their feet and go to the GP they think offers a better service for them.

Changing your doctor under the present health service arrangements is difficult for two reasons. First, as there is no fee for every consultation, the doctor gains only a modest capitation fee for taking on a new patient. If patients who want a transfer are unhappy with the services of another GP then they are probably regular and demanding users of the service. The doctor will guess that the patient may be more demanding than average, in the quantity or quality of service expected. The capitation fee is a small reward for the extra work. Second, since their confidential medical records will transfer with them, patients may feel that any disputes about what is really wrong with them ('It's my stomach doctor'; 'No, it's your nerves') will simply be passed on to the new GP and bias the new doctor's view of them. For these reasons, even those who are very unhappy with their care may not try to find a new GP.

On the other hand, the current system protects the patient

from exploitation by an expert who over-supplies services. (How many of us feel car repairs are always necessary up to the level our garage provides?) But there is less protection against a low quality service, or merely a service that does not match the patient's requirements.

Low quality facilities are commonplace in the NHS partly because there is no incentive to provide better waiting rooms. Incompetent or negligent medical advice is more difficult to protect against by direct competition, because of the consumer's difficulty in judging the product. In medicine and most other professional services, quality is examined by a professional body who can strike off an incompetent practitioner. The General Medical Council polices standards of behaviour in general practice. However, the Royal College of General Practitioners has recently proposed that financial incentives also be introduced to maintain quality (RCGP 1985) and the government seems to share this view in its White Paper. This reflects the dissatisfaction with a system that can only stop the worst of bad practice rather than encouraging good practice all round.

Failure to give the patient what is expected is less easy to show than downright bad practice. The core of the problem is the different views of benefit and cost: of patients, of doctors for themselves and as doctors for their patients. Dowie (1983) has shown how patient demands for a referral to hospital may not be seen as a reasonable demand but as an intrusion into the doctor's area of professional skill. Thus the patients as consumers, wanting a hospital referral, have to feel their way through the meeting rather than using the usual power of consumers to buy what they want. If the doctor makes judgments about patients' views of benefits and costs, rather than asking them, there is obviously plenty of scope for dissatisfaction with the service provided.

Four areas of general practice and the incentives that affect them are considered here. These are the surgery visit, prescribing, preventive work in general practice and home visits. In these and in other areas of practice, such as referral of patients to hospital, it is not being suggested that the incentives will lead to the same action by all GPs. We know that GPs vary in their practice in all these areas and differ in the extent to which a particular incentive or disincentive works with their

professional training and standards to produce a course of action. Again we can comment on the direction in which the incentives may push them without suggesting that the same result will occur for every GP.

THE SURGERY VISIT

Considering the complex nature of the human body and the way we live, perhaps the most surprising aspect of the usual GP appointment is how short it is. In five to seven minutes a GP will assess your problem, give you a diagnosis and choose an appropriate drug or further action. Certainly when we pay for professional advice, from a solicitor or some other professional, we expect more time for our fee. There is clearly no financial incentive for the GP to extend the consultation, for example to explore a broader range of social problems beyond the medical condition that the patient suffers. The absence of a direct payment and the lack of easy transfer to other doctors also limit the patient's options as a consumer, even when dissatisfied with a short visit.

If the doctor adopts a narrow, clinical focus, on the grounds that this is what medicine equips doctors to do, benefit to the patient will be seen largely in terms of final changes in health. A problem diagnosed and a prescription rapidly written are efficient routes to the maximum benefit for the patient and can be achieved in a short time. This is, in a narrow technical sense, the best outcome for the patient and also minimises the cost in time spent per consultation for the doctor. While medical teaching has expanded general practice training away from this restricted, clinical approach towards a wider, social one, I certainly know many people who prefer the fast and effective treatment that it offers and do not particularly want a long consultation on their private, social or sex lives. But other patients complain that the short, clinical interview does not give enough time to discuss their real underlying problems and anxieties.

Recent research on consultations has shown that while GPs vary in the length of their consultations with patients, and the hours spent seeing patients, GPs with fewer patients on their lists did not usually have longer consultations (Wilkin and

Metcalfe 1984). GPs are clearly seeing patients quickly in order to meet the demand for appointments. If they cannot or will not expand the total time spent in the surgery each week, an increase in the length of consultations would result in a longer delay before seeing the doctor. In assessing the patient's view of benefits and expectations, the GP must then judge how far patients will accept a delay or a shorter surgery visit. While the patient does not shop around a great deal, there will be a tendency for GPs and patients to expect that the consultation time will not differ too much from those of other GPs. The pressure, without any financial incentive, is to provide an acceptable service that gives enough time for the technical assessment of patients but does not lead to too long a delay for an appointment.

Since there are some patient complaints about short consultations, it is interesting to think about how these might be avoided in future. One solution is to allow the patient to choose the length of time of the first visit. A receptionist might say, 'The doctor normally sees patients for five minutes but if you want a longer consultation, that can be arranged'. My guess, in the absence of research, is that the majority of patients would not want a longer consultation going beyond their immediate clinical problem, while the small number who wanted more time might be more satisfied. There will be abusers, no doubt, but these occur already. So do extra long consultations, and if these are unplanned they also disrupt appointments. It may be more effective to allocate more time to patients who think they need it rather than have to provide it, for whatever reasons, at the time of the consultation. I have not found any evidence that it has been tried but in principle it should reduce the disruption of the appointment schedule.

Although this kind of flexibility looks awkward at first sight, similar approaches mixing open access and booked appointments have been tried with success (Taylor 1984). Doctors may doubt the patient's ability to decide the length of consultation but if a patient thinks that a longer consultation is necessary, there may be a case for meeting the demand, at least the first time, to help educate the patient in the choice of time and to find out what anxieties led to the choice of a longer session.

THE PRESCRIPTION

While prescriptions are a technical answer to a physical or mental problem, they are also a part of the process of the consultation. As such, they can have benefits apart from their direct medical impact. To examine the role of process as opposed to the final change in health, we need to look at the consultation in more detail.

In market transactions, consumers feel that when a service does not come up to the standard expected, complaining or cancelling an order is reasonable behaviour. This comes from their confidence in judging the quality of the standard supplied. The incentive to complain is the return of the cash or a replacement for the commodity. The supplier has a clear financial incentive to avoid disappointing the client while trying to get a good price. A market transaction only goes ahead if both parties are satisfied, or think they will be. A refund can then be requested on the grounds that the satisfaction purchased has not been delivered for some reason.

General practice, in common with many professions, provides services which patients are frequently unable to assess directly. Instead they may focus on parts of the process by which they are treated, as a proxy measure of the outcome or because the process is a source of satisfaction. However, in the NHS patients do not pay to visit the doctor and so a demand for process benefits is less easy to show than in restaurants, for example, where we choose to pay higher prices for better facilities. It is hard for the patient to express a demand for particular parts of the process by choosing a different supplier, given the problems of transferring to another practice. If shopping around is not a readily available option, certainly not more than once or twice in a single neighbourhood, a demand for different characteristics of the service cannot be expressed by using the familiar market choice. Nor can it be expressed in a straight demand to the current GP without challenging the doctor as a supplier of the specialised service (for example, by asking for a prescription), or by asking for something for nothing (for example, an improvement in the waiting room furniture).

The result of the often unspoken emphasis on parts of the

process of primary care may be that some things are done because the doctor thinks that the patient values them rather than because of any direct effect on health. The single most common example of this is the prescription.

The prescription is intended to reassure the patient that the clinical problem has been understood and dealt with by an effective technical intervention. It may be clinically unnecessary, and many such prescriptions were written before the move to the limited drug list in general practice in 1985. But even a useless prescription can have reassurance value. If the patient believes in the medicine as both cure and an indication of successful diagnosis then it has some value. GPs know that the prescription may do little good but no harm and so, guessing the patient's views of the benefit of the consultation, they may provide a prescription even when it is not necessary.

The charge for a prescription will obviously affect the consumption of medicines to some extent. However, the prescription is a curious commodity. The doctor may prescribe it to satisfy what is seen as a demand by the patient. If the patient is in fact less concerned about the prescription than the doctor suspects, the prescription can be thrown away without costing the patient anything. Patient concern, if it exists, can be met without cost by the GP and the patient can then make an assessment about the merits of the medicine compared to the prescription charge. Of course, patients may feel obliged to take what is prescribed or, on the other hand, be forced by their limited income to discard a valuable treatment.

While exemptions of various kinds protect patients receiving large numbers of prescriptions, some infrequent and poor users are probably deterred by the current charge, which has risen dramatically under the Conservative government. There is some evidence suggesting that the prescriptions which go unfilled are not necessarily those for trivial drugs (Rashid 1982).

While excessive prescribing by doctors may lead to a visit from higher authorities, this is generally regarded as a very weak control. And while recent government moves to limit the list of drugs has probably reduced the prescribing of very trivial drugs, there is probably still wide variation in prescribing habits and little direct incentive for further reduction.

PREVENTIVE WORK IN GENERAL PRACTICE

The incentives in general practice, which lead to a large amount of prescription-writing among other things, encourage an acceptable service to patients at minimum cost to the GP. A prescription can offer some process benefits without much effort. Patients may also benefit from a fuller examination or a longer consultation. Many health educators would argue that a better alternative would be a longer discussion of general health, regardless of the reason for a particular consultation. However, preventive activities of this kind, always possible as a way of taking more time in a consultation, raise some incentive problems for the GP and the patient.

GPs currently receive a fee for providing a wide range of specific services: vaccinations, monitoring the progress of pregnancies, cervical cancer screening in women over 35 and night visits to patients' homes. The fee adds to the incentive to perform an activity. In general, for a given fee, the activities that will be undertaken will be those that minimise the cost to the GP and maximise any gains apart from the fee. For vaccination, the additional incentives are the gain in child health and the reduced workload for the GP in future years due to the lower rate of infection (see, for example, Binnie 1984). The vaccination itself takes a very short time and earns the GP £2–£3, so there is a clear incentive (albeit a small one according to Binnie) to undertake this kind of preventive work.

For other areas of prevention, particularly health education, where a specific medical procedure is not called for, the incentives are far less clear. The outcome of twenty minutes' health education for each patient is hard to see. GPs may feel that if they practised health education they would be straying into an area of individual behaviour that is not their general responsibility. (Given the incidence of alcoholism in the profession, the remark 'an alcoholic is a man who drinks more than his GP' is not without its point.)

In the absence of a financial incentive, GPs may be reluctant to find the time for an effective discussion of general health in the face of pressure of demand for consultations. Some GPs have diverted this element of service to their support staff, for example by having well-person clinics run by health visitors or

practice nurses. (A GP can receive 70 per cent of the cost of a practice nurse from the family practitioner committee but must find the rest from the practice income.) The benefits may be an improvement in the status of the practice and the job satisfaction of the support staff, together with any ultimate effect on patient health. And practice staff may help towards the extra cost of their employment by earning fees for procedures such as cervical cancer screening, or by attracting more patients who are relatively healthy and undemanding and take up little of the doctor's time in return for the capitation fee.

For patients, the incentives to seek more preventive advice from their GPs are also limited, as discussed in chapter 1. While the public may be happy to undergo general screening, my guess is that this is for reassurance about their immediate health. And where immediate illness is not life threatening, longer term changes in lifestyle are less likely. The recent White Paper on primary care has proposed that GPs could be paid a fee for screening new patients. This kind of servicing 'once-over' seems an obvious move for GPs taking on new customers. (At the same time the White Paper suggests ending the payment made to dentists and opticians for a screening check. This could push the cost of screening on to the patient and discourage screening. On the other hand, many competitive suppliers of technical services provide estimates before any work starts, without a charge. Greater competition in primary care could lead to the charges for screening being dropped by dentists and opticians as competition increases.)

HOME VISITS

Home visits are relatively common in the NHS compared to other health systems. They are obviously time consuming, to the point where at least one GP has introduced a minibus service to bring patients to the practice. But for many people they represent the commitment to continuing care that is a part of the style of British general practice.

During the day, home visits impose a cost on GPs by taking their time from other activities. While a part of their time will be scheduled for visiting, the fewer visits made the more time saved for another task. There is no financial incentive to make a

daytime visit, apart from some connected with maternity care. Patients face no charge for a home visit but there is frequently some concern among patients to avoid irritating a doctor who will go on treating them. As a result, some people do not like to ask for a home visit unless it is clear that they really cannot travel to the surgery. There are also probably 'abusers' of the system who ignore friction with the doctor and demand and receive numerous visits.

Since the incentives beyond direct patient care and professional standards work against visiting, it is not surprising that many GPs attempt to reassure demanding patients by telephone initially. Even the effects on the patient's health are not certain because the patients most likely to receive a home visit are those with a continuing problem. Their age and condition is unlikely to respond to a single visit. Younger groups will be expected to get to the surgery or bring their children; acute emergencies will be handled by ambulance, though often with some involvement by the GP. But generally a home visit will be for monitoring a continuing or fluctuating condition where little direct change is expected immediately.

Once patients or their families decide they want a home visit, they have effectively made a guess at the result they want and the service that the doctor will provide. It is not surprising that there is some friction between patient and doctor when advice by telephoning is offered instead. Relatives find it particularly difficult to give all the information that might be important and the call for a visit might in part reflect their demand for reassurance and not that of the patient.

Clearly, if the home visit is to stay a major part of general practice, it is worth thinking about the financial incentives necessary to support it. An obvious comparison is the visit to a patient's home after midnight, which presently carries a fee of £17.20. In addition, providing services out of hours brings GPs lump sum and practice payments. While many doctors remain committed to the principle of night visits, the fee, after tax, is seen by many as small reward for the loss of sleep and loss of freedom imposed by night calls. Many readers might not want to lose an hour or more sleep to go out on a winter's night or into a tough, inner city area for an extra £10–£20 of income. People in lower income jobs or without employment might

regard it as a good return for the time involved but it is unlikely to be seen in the same way by a GP who is comfortably off already.

The response of many GPs has been to use deputising services, usually doctors hired to visit several practices' patients with a radio link to the deputising agency. (This has happened widely enough to lead the government to intervene, for reasons discussed below, by introducing tighter control by family practitioner committees.) Since deputising services receive the night visit fee as well as a subscription fee from the GP, it is clear that many GPs value their time more than the night visit fee. The implication is that for activities not covered as part of the package of care funded by the capitation fee, the additional fee necessary to achieve a specific objective must reflect the amount of time and energy required. By comparison with the inconvenience of a night visit, the fees for vaccination, cervical smears and general contraceptive services seem relatively generous (£3, £7 and £33 per year respectively) given that they involve no travel or inconvenience but can be fitted into a normal working week in the surgery. A simple comparison of the time involved in each shows that a night visit of perhaps an hour brings a very low reward.

The use of deputies increases spending by the family practitioner committee because the home visit is almost bound to take place once requested. A deputy is already out and about, probably with a radio link, and so has no problems of broken sleep and inconvenience to prevent a visit. Deputising has also been criticised because it breaks the continuity of care between the patient and the doctor, which is a feature of general practice. However, this overlooks the fact that patients are unlikely to get their own doctor even where no deputies are employed. Night visits are fairly rare and can be easily shared out between a practice or a group of practices. One study found that roughly the same proportion of patients saw their own doctor during a night visit even though the use of deputies differed a great deal between the two areas studied (Simpson 1979). Unless a partner or neighbouring GP is to be expected to find the records of a specific patient before setting out – which will take a lot of time – the continuity of care is likely to be lost whether the visit is done by a deputy or a partner. While a

partner may have some knowledge of a patient from the practice, the case against deputies on the grounds of continuity certainly looks weaker than at first sight.

INCENTIVES, PROFESSIONAL PRACTICE AND QUALITY CONTROL

In each of the areas discussed above, the current incentives do not necessarily lead to what patients, doctors or critics might regard as an ideal service. But it is not so easy to think up other arrangements to encourage change. In particular, if it is difficult for patients to change doctors, because of the administrative arrangements and a reluctance of doctors to compete, patients lack the chance to take their custom elsewhere. (Though many people turn to alternatives ranging from herbs to osteopaths for problems that persist in spite of their doctors' help.) While consumers may be unable to judge the final outcome of their care, their demand for processes such as longer consultations or more prescriptions or home visits will not necessarily make their health worse. More responsive suppliers might make people feel better even if their physical and mental health, as seen by the doctor, was unchanged.

Incentives could include a change in the funding arrangements to fee for service, a change in the fees for particular services, or a change in the standards of the profession and its control over the quality of service.

If funding were to move from capitation fee to fee for service GPs would have a direct financial interest in all patients and their continued use of the service. The fee for a patient visit would then go some way towards encouraging the kind of service that the patient wanted. Other countries have arranged primary care in this way, through public or private insurance and a share of the cost levied on those able to pay. But as soon as the consumer stops paying, the usual operation of the market breaks down and the control of costs by consumers' willingness to pay for a service is lost. Cost control then requires monitoring of practice and of fees to determine what will be covered and at what fee. France, for example, has a formal method of setting the prices that doctors receive for treatments, but negotiations with the medical profession are

some way from the theoretically efficient market place with its competing suppliers. There are also potential problems of excessive treatments or consultations provided to increase fees rather than for any medical need.

Dentistry in Britain is funded by fees for each treatment and the patient bears a growing share of the cost. But there is still concern that overtreatment results and this is always possible when consumers are relatively ignorant of technical standards (DHSS 1986b). Issues of alternative funding are fundamental to incentives and are considered more widely in chapter 7. It is worth noting here that the government supports moves by the medical profession to monitor standards. This kind of audit could provide an effective way of controlling the worst effects of payments for services rather than capitation.

It is possible to argue that medicine and dentistry are so unlike conventional commodities that consumers have little control of the quantity or quality of service. Consumers take what the supplier recommends regardless of who pays what for the process. Yet fees remain within the structure of general practice and are a substantial component of GP income. If they are to stay, it is possible to stimulate activities such as prevention or home visiting by their use (though there is often a problem of monitoring whether a preventive activity took place when there is nothing to show for it.) As long as those taking the decision on fees are satisfied that the current level of provision is too low, there is no real fear that oversupply will result from a gradually increased fee. For consultations, audit by a professional peer group could be a satisfactory method for changing behaviour and reducing unnecessary visits. Alternatively, any fees could be linked to a course of treatment rather than the exact number of visits. There is also scope for a more flexible approach to appointments, with some queueing and some scope for longer appointments where the patient feels this is appropriate.

CONCLUSIONS

Increased fees may provide a partial solution to the underprovision of some services, but more effective competition or monitoring of GPs is also required. The medical profession is

concerned to change its standards by monitoring and general encouragement. Enforcing standards such as automatic home visits would obviously mean profound changes in the basis of the GPs' contract and could lead to a good deal of opting out of part of the package. The alternative favoured by the profession is the monitoring of GPs and a payment system that encourages good practice. While the Royal College of General Practitioners has stimulated the debate, it is too early to say how this monitoring will work. Given the large workforce, the monitoring force would also have to be large to be effective and the standards at which money was deducted could be controversial. How many times would a GP have to fail to be available before losing a bonus? What proportion of patients would be sampled and in what depth?

In the long run, monitoring of the profession, by lay and professional assessors, is an appealing solution and one which should reduce the isolation and low standards of some single-handed GPs. It avoids the creation of incentives to overprovide services and overconsume them. But it will not be easy to introduce and will almost certainly increase the cost of primary care. Of course, the gainers in bonuses could be funded by deductions from the lower quality GPs. But more realistically, bonuses rather than penalties are likely to be sought by the profession and the majority are likely to get the bonus. After all, while doctors may be altruistic in many respects, it is unrealistic to expect them to accept arrangements that reduce their likely income. It will then be a question for the DHSS and society at large to decide how high a priority it gives to improving the quality of primary care. The White Paper suggests that while tightening up on some aspects of primary care – for example, the retirement age of GPs and the conditions required to qualify for basic practice allowances – the government is also prepared to look at other methods, from peer review to incentive payments for health screening for example.

This chapter has examined the incentives to provide primary care and offer a service that responds to patient demands. While it cannot explain every difference in behaviour, the assessment of benefits and costs from each activity seems to go

some way towards explaining behaviour, once the wide range of possible benefits and costs is examined. The same approach is followed in the next chapter which examines issues as they occur in hospitals. The wider debate on how general practice is paid for is one theme of chapter 7 which looks at ways of changing incentives.

3

The Hospital

Once a patient reaches hospital, the decisions and actions of the many staff who work there will set the pattern of care. The medical staff of a hospital choose many of the services for a patient and have been called 'conductors of the therapeutic orchestra'. This chapter looks at the incentives they face. Decisions by other staff groups, in wards, laboratories and kitchens, will also affect the quality of care received. Those who can make a clinical decision on how much care to provide – for example, therapists – can be viewed as having some of the same incentives as doctors. Others – for example, staff in support departments – face many of the same incentives as in other jobs in the economy but with less scope for being rewarded for good performance because of the cash limits on hospitals.

Although they share some common ground, psychiatry and mental handicap treatments differ from general clinical activity in the range of services required. In particular, there has been a strong trend away from hospital care for these groups. For this reason, this chapter concentrates on acute hospital care. It also concentrates mainly on doctors as the key actors in much of hospital care after looking briefly at the incentives that affect hospital staffing. Care for groups such as mentally handicapped people is covered in chapter 4 on community care.

STAFFING HOSPITALS

Finding the staff for hospital work is now a major problem for the NHS, largely because of the pay and career opportunities offered. In this labour market, incentives clearly affect staff fairly directly.

Hospital medical staff in the NHS are organised around individual consultants in teams called 'firms' and into departments

known as 'specialties'. A typical local acute hospital providing emergency cover and general hospital services will have about 40 consultants in 10 specialties, supported by operating theatres, intensive care, x-ray and pathology. The larger specialties, such as general medicine and general surgery, orthopaedics, obstetrics/gynaecology and psychiatry, will usually have several consultants. More complex specialties and those which deal with fewer patients may have only a single consultant firm or a hospital may provide the service for a number of neighbouring districts. Ophthalmology and ear, nose and throat services are often provided in this way. Very specialised work such as neurosurgery and open heart surgery is carried out in smaller numbers of regional referral centres, often in teaching hospitals.

Consultants will normally have a number of beds under their personal control and, for surgery, an allocation of operating theatre time. Each consultant is supported by a registrar or senior registrar and/or a senior house officer. Senior registrars are close to promotion to consultant, having obtained post-graduate qualifications such as membership of the royal college in their medical specialty. A senior registrar with several years in the post will normally be looking for a consultant job. At the other end of the scale, house officers have only recently completed their medical school training.

The staffing and organisation of hospital medicine is now in something of a mess in Britain. A consultant is appointed at the age of 30–35; he or she therefore has 30–35 years of service to retirement. A registrar might expect to spend up to five years in that grade. This means that one consultant will work with as many as six or seven different registrars over a career. But these six or seven can only become consultants if there are six or seven vacancies. Their own consultant will provide only one vacancy at retirement. It follows that without continuous expansion of the consultant grade, the structure cannot continue as at present.

In the past, movement into primary care was much easier and some doctors who were unable to get consultants' jobs moved sideways instead. Now, more training is needed and doctors choose general practice earlier in their careers. The obvious way to resolve the problem of current registrars unable

to find consultant jobs is to expand the consultant grade. But this is not in the interests of current consultants, particularly if it means a cut in the number of junior staff. It will change the way they work and in some cases threaten their income from private practice, as well as pushing up hospital spending by increasing the number of consultants with independent spending power. Some hospitals now have consultant jobs which they cannot fill for financial reasons and so the nominal expansion of posts may not have much effect on careers in the next few years (Levitt and Wall 1984).

Recent proposals show some signs of expansion but probably not fast enough to satisfy the junior doctors completely. (They may also lead to less work by GPs as part-time hospital staff in order to keep the hospital work for hospital consultants.) In the meantime, with such strong competition for jobs, discrimination is always possible, against women and immigrant doctors. Overseas doctors are also concentrated in what are seen as less popular specialties, such as psychiatry, and in less popular parts of the country (House of Commons, Social Services Committee 1981).

Junior medical staffing is easier in specialties where experience is a qualification for general practice. General practice is becoming more popular with medical students, partly because of the career log-jam in hospitals, and so there are more recruits for these specialties. Others, such as orthopaedics, are finding it hard to recruit junior doctors in some parts of the country and services are restricted as a result.

Recruitment to the therapy professions and particularly to nursing now pose major problems in some parts of the country. Also some therapy professions are relatively well paid, within the pay review system; others offer a relatively poor reward for a long training. Nursing has traditionally relied on large numbers of enthusiastic young women who leave as a result of marriage or complaining of disillusionment and poor pay. (It is worth noting that banks apparently have a similar level of staff loss so it may be that money and conditions of employment are less important than the other pressures on female workers – to raise a family, for example.) The falling number of 18 year olds, due to a drop in the birthrate, will make it very difficult to maintain nursing at current levels in many hospitals without

major changes in recruitment and retention of staff. Job share and part-time working are relatively rare at present in nursing, but without an improved incentive to stay at work, some hospital wards may close because of a lack of staff rather than a lack of money.

HOSPITAL DOCTORS' INDEPENDENCE, INCOMES AND INCENTIVES

Hospital consultants have defended their independence to a considerable degree in spite of becoming salaried employees of the service in 1948 rather than independent contractors like GPs. Once appointed, there is little control over a consultant's working practice. Consultants choose the type and quantity of work they will do and may decline to treat one patient group in favour of another. As far as I know, consultant contracts never contain clear guidelines about the exact clinical work that should be done. I have come across cases where individuals appointed to deal with a particular disease have chosen a different one, or where surgeons have not operated on the patients from the waiting list in spite of money being available for these operations. I have heard a consultant refuse to see a particular group of patients who he could have treated on the grounds that they were of no clinical interest. Given the great deal of routine work in medicine, choice of the more interesting work is very predictable. Many consultants do not overlook the less interesting end of medicine – the mass of routine patients – but this is because of their commitment not because of any incentive to do it.

Independence is unrestricted by any direct assessment of the success or failure of particular clinical decisions or styles of practice. It usually comes as a surprise to laymen to discover how little the average NHS consultant knows about the success or failure of treatments given. Detailed follow-up of a sample of patients is limited to occasional research studies, and there is little systematic record keeping to help monitor success. For example, the death of a patient who should have returned for a check-up will be recorded in their hospital notes as a failure to attend for an outpatient appointment if death occurred in another hospital or at home. Even quite simple data on the

number of people who are treated in hospital each year cannot be readily standardised for patients who come in and out several times for the same problem. It is arguable that consultants are too busy and the system as a whole too short of resources for detailed analysis of data on every patient. There is also an element of 'Catch-22'. Until there is some evidence that a treatment is ineffective, it may be difficult to persuade medical staff and others to follow it up. In the treatment of breast cancer, surgical fashions (and given the limited hard data on outcomes it is difficult to find a better term to describe the trends) have varied from radical surgery, including removal of the breast and surrounding tissue, to simple removal of the malignant lump with far less surgical and psychological damage. In the absence of clear standards, a wide range of practice remains possible.

It is interesting to compare doctors with airline pilots. It is widely accepted that planes need a well-trained, independent professional to cope with whatever situation develops. But it is also accepted that the autonomy can be exercised within limits of financial and organisational efficiency set by the airlines. Furthermore, customer safety requires detailed reviews every six months to check on the competence of the pilot in a range of situations.

By comparison, hospital consultants face no outside review, and periodic scandals have shown that sometimes even the most incompetent can carry on for years. Neither has the medical profession developed audit of itself at any great pace, though there are now numerous research studies developing this, most recently in surgery (Buck and others 1987). If our concern is to limit the range of behaviour, for financial reasons and to maintain clinical standards, the independence of doctors will have to be challenged, directly or indirectly. Their reactions to these challenges will decide the success or failure of the management initiatives discussed later in this chapter and elsewhere in the book. Certainly at present there is no direct incentive for a consultant to agree to clinical audit or performance assessment.

There is nothing in the way doctors are paid to give them an incentive to behave differently. Consultants are paid a salary for their services and the few fees for services performed within

the NHS are more like a perk than a major addition to salary. (In some specialties, administrative quirks give some fees for service: for example, for sterilisation in gynaecology, and cremation certificates and coroners' post-mortems in pathology.) Salaries for junior staff are increased by the allowances for emergency on-call duty outside normal working hours. Less popular and less urgent specialties often set up some dubious overtime arrangements to prevent their staff suffering lower pay and their jobs attracting many fewer applicants than surgery.

The major additional item for consultants' pay is a merit or distinction award, awarded for life. These are allocated by a national committee and are not published. The awards are concentrated in the more prestigious specialties, such as surgery and cardiology. A grade 'C' award adds about 17 per cent to the maximum salary, while an 'A+', given less often, adds 90 per cent giving total pay of over £57,000 a year (1986–7 figure). While they are supposed to reward high standards and offset the incentive to go into the private sector or abroad, they are also a sort of bonus payment. Fewer awards are made to doctors who are at arm's length from most patient care, in pathology and x-ray departments, for example. Awards are also said to be made or raised when the consultant is close to retiring age, giving a higher pension worth an enormous amount over the retirement years. It is hard to believe that doctors are still improving at an age when productivity in almost every other field of physical and mental work is falling. On the other hand, the secrecy of the process may encourage suspicion and criticism beyond the real impact.

The absence of a financial connection between doctor and patient has been argued to be a major strength of the NHS. It has been used to explain the fact that the United States has much higher rates for routine non-emergency operations than the UK. There is no incentive to overtreat NHS patients or to perform operations of questionable medical necessity for money. But the lack of a financial link may also slow down the introduction of those which are effective. Competition for patients and income stimulates the introduction of new equipment in other health systems. In the NHS, a consultant has less incentive to learn a new treatment method. (I know of a

hospital where an important and proven treatment of patients' eyes has been taken up by those responsible for the treatment of the disease which causes the eye problems and not by the ophthalmologists in the hospital. For a time at least, the treatment was being provided under the nominal supervision of a consultant ophthalmologist who could not use the equipment.) It might be unfair in the absence of good data to overrate the delays to new techniques, particularly if a shortage of money is also holding them back. But we should beware of being smug about the ability of the NHS to avoid spending on ineffective treatments.

Care without direct payment carries on a tradition from the voluntary hospitals that pre-date the NHS. Doctors gave their time free of charge in these hospitals, hence the name, in return for the chance to practise their skills and train junior doctors. Their income was derived from treating the rich at home (since hospitals were places of infection which the rich avoided 'like the plague') and fees from their students. This charitable background may still be affecting many consultants' attitudes to patients.

While most patients are impressed with the technical quality of care they receive, the attitudes of medical staff do not always receive the same praise. Illness and anxiety lower our self-confidence in hospital. Since patients have no effective purchasing power, merely the right to approach the hospital, they cannot control the transaction in the usual market way. It is uncommon to find patients complaining to the doctors about late appointments or poor facilities, though complaints to clerical and nursing staff are more common. Doctors often discuss proposed treatments with little or no involvement of the patient sitting next to them. Where the patient has a choice of doctors and where an insurance fund will reward doctors for the treatments provided, as in many European countries, there is much more of an incentive to keep the patient happy and informed about the treatment.

Changes in what might seem traditional attitudes are taking place, but they happen very slowly. (It is perhaps worth noting that an influential consultant aged 55, training young doctors today, will have been trained by consultants who entered medicine, and had their attitudes shaped, in the 1920s.) Social

sciences have been incorporated into medical school training since the 1970s but often with limited emphasis in a very crowded training programme. Doctors also come mainly from higher income groups and are chosen for their performance in science exams, not communication. Given their background and incentives, it is not surprising that we find them frequently lacking in the area of customer relations.

Doctors rely for patient care on two sorts of resources in hospital: those whose use they control more or less directly, even when other staff groups are involved, and those where a task is referred to a supplying department that takes it over. It is interesting to look separately at how doctors use these two types of resource since they face different incentives towards over- or under-use of each.

THE CLINICAL FIRM'S RESOURCES

Beds

A clinical firm will usually be allocated a number of inpatient beds with supporting facilities, operating time and related equipment for surgical specialties, and outpatient clinic time. Beds are usually the most important resource because of the way they affect the use of other resources and because of the high cost of nursing. Less frequently, firms will have access to their own special diagnostic facilities such as ultrasound in maternity departments or endoscopy (flexible fibre optic equipment) in gastric medicine or surgery. These resources are more or less directly under the control of the individual consultant, so it is reasonable to expect their use to reflect the incentives and objectives of consultants. However, nurses are directly involved in these areas of hospital activity and the incentives and objectives of senior nurses may also affect the pattern of use of these resources. Nurses can insist on professional standards of care and there are periodic disputes in hospital when medical and nursing policies differ, for example on the timing of a patient's discharge from hospital. As in so much of the NHS, the authority structure does not provide a clear resolution of such problems. Nurses are not usually directly employed or directed by the doctors who use their wards

(though they are told what to do by them from time to time). Indeed many nurses feel that apart from prescribing certain drugs, the doctors should leave decisions on the routine care of the patient firmly in the nurses' hands. In practice, who decides what will happen usually depends on personalities rather than standard policies.

The resources directly controlled by a firm – for example, its beds – are likely to be used in the way the consultant chooses. Hospital beds have a key place in the management and the myth of the NHS. For some consultants, beds are equated with status and their use will not be surrendered to colleagues even when, for clinical or other reasons, their occupancy is falling. (Under-used maternity facilities were a common result of the fall in the birth rate and this effect has moved through paediatrics and other child-related specialties.) In the absence of the right incentives, the choice of how to use beds might not be efficient for the hospital but simply what the consultant chooses. They might keep them full unnecessarily to prevent emergency cases blocking the next day's waiting list admissions, a common problem in winter. While consultants are at times accused of behaving like prima donnas over their beds, many of us would probably feel as bad if we found our place of work taken over by others, leaving no room for doing our own work. On the other hand, a consultant may take no real interest in the management of hospital beds and face few penalties for this lack of interest.

There is wide variation in the length of stay for many conditions treated in hospital and it is tempting to blame the consultants for this. At the same time, it must be recognised that the product of a hospital's clinical firms is patient care. Patients are not commodities who can be sent from the factory as soon as they are finished. Family arrangements, housing and car ownership could all affect the right time to discharge patients who are clinically identical. It would not be surprising to find that a patient with no access to a car and living alone in a tower block had a longer stay in hospital than a similar patient with a car, a spouse and a bungalow. In practice it may be impossible to assess the relative efficiency of different clinical firms from only clinical data.

Before recent developments in computers made it possible

for data to be collected quickly on all aspects of hospital activity, beds were the main focus of management data. In particular, high occupancy rates are seen as a target by management and, increasingly, by consultants. Under-used beds may imply to higher authorities that too many beds are available and, if they are staffed by nurses, budgets may also be queried. Major reductions in the number of hospital beds have taken place without a fall in the number of cases treated and often an increase. But in spite of the availability of data and the clear criteria for what is required, differences in length of stay continue. They reflect different medical policies, different work-rates, different patient populations, and the local balance of facilities and the cases referred to them. John Yates, in a valuable book exploring the use of beds, has shown how the data available can be used to improve practice (Yates 1982). However, it is important not to forget that whatever the formal management arrangements in the NHS, managers are usually negotiating with consultants and not handing down decisions. Whatever the data on bed utilisation show, management cannot immediately proceed to solve any problems in clinical areas by direct action.

Theatres

The use of operating theatres involves some of the same difficulties as hospital beds. The two are related, as a surgical firm needs the right mix of the two to do its work. Changes in surgical technology and fashion and the problems reaching surgeons will alter the right mix of beds and theatre time so at any time it may be out of balance. To achieve a high rate of use of theatres, admissions of waiting list cases must be fitted around any emergencies. Some estimate must also be made of the length of time of each operation so that the session, of about three-and-a-half to four hours, is used as fully as possible.

Unfortunately, theatres, like beds, are not always used effectively and a good deal of frustration results. One cause is the lack of clear management and this may change in the new management structures that are spreading through the NHS from the top down. A senior nurse will usually be in

charge of the staffing and organisation of theatres but consultant surgeons tend to treat the staff and facilities as an extension of their own team. Since the managers have no real control over the consultants, they can only make sure that the theatre is ready to provide the service expected of it. They cannot make the service happen. Theatre users' committees exist, but for these to function effectively a group of consultants may need to challenge a colleague about the use of facilities. Often there is no incentive for them to do this. It is usually the younger surgeons who want more operating time and the older ones who do not want to give it up, even though they are not using it effectively. Perhaps more surprising, there is still relatively little clear planning of how much operating time any surgeon has.

Districts which are achieving a high level of theatre use do so by investing management and medical time and effort. In some hospitals, a patient is booked in for an operation in a diary at an outpatient clinic as soon as the decision is made to operate. Patients then know when to expect to be asked to come to hospital and can choose a time which avoids clashes with family and business plans. Waiting lists are regularly reviewed to keep track of patient addresses and to make sure that patients still want the operation. Many patients will be treated in a single day, avoiding unnecessary stays in hospital before and after treatment. In some of the worst run hospitals, patients are selected by a junior doctor at short notice without detailed discussion with the consultant. Their names are drawn from badly kept waiting lists which have out-of-date addresses and include patients who do not want the operation. As many as one-third of the patients on some hospital waiting lists have been deleted following a review of the list, cutting the queue dramatically without a single operation! Even when patients reach hospital the disruption continues. The order of cases through the theatre can affect the pace of work, particularly if an infected case is treated and the theatre cleaned before the next case. Consultants may change the order to meet a personal timetable and disrupt the work further as patients are then brought from or returned to the wards unexpectedly. A glance at a much-amended operating list, where the order of patients has been changed several times, does not give the impression of a well-planned working period.

The operating theatres will probably not be used for every available minute, however, even in efficient hospitals (National Audit Office 1987). It is difficult to predict exactly how long an operation will take, beyond the simplest procedure. The age and weight of the patient, the design of the theatres and the organisation of the transport of patients from the wards all affect sessional time used. Operations can be cancelled because of pressure on beds from emergency cases. Even when all the patients attend there will be a natural caution to over-estimate the time that each will require. The cost of under-use is negligible to the consultant surgeon, whereas over-use will provoke irritation in theatre staff and any surgical colleagues kept waiting. Eighty per cent utilisation of theatre session time, or an average of more than three hours use for every four hour session, is a high average to maintain and indicates relatively well run facilities.

It is alleged from time to time that consultants keep long waiting lists to help their private practice. There is an obvious incentive to do so but rarely any hard evidence to prove it. A more fundamental problem is the mismatch between the rate of detection of problems by GPs, confirmation by the consultant at outpatients clinics, and final treatment. A patient may be diagnosed in minutes for a condition that will take hours of direct treatment and days of hospital stay. As a result, a waiting list will start to build up for either inpatient treatment or outpatient clinics. In business terms, sales have got ahead of production because the inpatient and outpatient time of the consultant are not coordinated so that the rate of treatments per week matches the new cases found each week.

Apart from professional pride and a commitment to treat as many patients as possible (both of which are strong, positive incentives throughout the hospital system), there is no direct incentive to ensure efficient use of theatres. It would be unfair to give the impression that all these problems occur frequently and across large numbers of hospitals. But it would be misleading to pretend that the best management is widespread and, more important, there is no real incentive to improve performance.

By allocating beds, theatres and other facilities to individual consultants, the system effectively allows them a private choice

about their use of resources. While the results of this choice may be clear for all to see, colleagues may have little incentive to attempt to wrest control back again by asking a senior colleague for the use of unoccupied theatre time or requesting a colleague to discharge patients earlier. Nor do managers have a clear incentive to increase performance: even if the number of patients treated increases, the income of the hospital does not.

THE USE OF OTHERS' RESOURCES

If we were to add up the resources used for patients lying in beds and being treated in theatres, we would find that most of a large general hospital's costs went directly or indirectly to those areas. Nursing and medical staff alone account for nearly half the cost, and the hotel services provided to inpatients – laundry, catering and cleaning – add a further 10 per cent or so. It follows that a much smaller range of resources are called upon to provide the rest of the care for the patient. But these resources are not under the direct control of consultants and their junior staff. Using these resources for one case does not affect the firm's decision about another case as it does with their own resources. The service is apparently free to them. As a result, there is more scope for demands which managers regard as inefficient. While it is not necessarily a symptom of inefficiency, the continuing growth of diagnostic testing suggests that there may be some unnecessary use.

Incentives for defensive medicine

One source of over-use of the resources of support departments, particularly diagnostic services, is defensive medicine. The doctor's professional ethic is to do the best possible for the patient. Just what is the best and what services it is or is not reasonable to provide have been the focus of many court cases in recent years and have led to the practice of defensive medicine.

Defensive medicine is medicine practised to avoid criticism or legal action and usually implies doing everything in detail, even when the clinical gain is small or non-existent. In the US doctors are sued more often and American surgeons pay

thousands of dollars to insure against negligence claims. In Britain, partly because lawyers cannot work for a share of any damages, court cases are less common. But UK rates for this insurance are rising faster than inflation, from a level, comparatively recently, of only a few hundred pounds a year. This indicates that claims and damages are on the increase, and some consultants in less risky specialties have asked for a differential insurance rate. But this in turn raises questions of pay and responsibility that could undermine the position of consultants not directly responsible for patient care, such as radiologists and pathologists, compared to those at high risk, mainly surgeons and anaesthetists.

Defensive medicine is likely to lead to excessive use of investigations. Every headache could be a major brain problem but the vast majority are not. Defensive medicine encourages the use of diagnostic tests to turn high probabilities into virtual certainties. When these tests have no harmful effects, they may be widely undertaken to reassure the doctor that the diagnosis is correct. Defensive medicine in the use of beds is less often practised, though it is quite common in paediatric care. Faced with anxious parents and a baby unable to explain the extent of the symptoms, there is a tendency to admit the child to hospital for a period of observation.

A second source of over-use might be called professional defensive medicine. This is practised by junior hospital doctors to defend themselves against criticism by their consultants. In particular, junior doctors may tend to over-use routine diagnostic services, such as x-ray and pathology, in order to avoid criticism for their failure to pursue a particular diagnosis thoroughly. Medical teaching of these qualified but inexperienced doctors is often conducted in a dialogue between junior and consultant in which the junior feels under pressure to demonstrate that all the right steps have been taken. Unnecessary test results can be held in reserve but a decision not to do a test is asking for trouble. Tests done by technicians at night are also a source of overtime pay and so technicians may be less critical of doctors' apparent misuse of their services.

Similarly, junior doctors are reluctant to take the initiative of discharging completely an outpatient returning for a check-up (Dowie 1983). They are much more likely than the consultant to

recommend a return visit in six months or so, blocking up outpatient clinics with as many as four or five times more returning patients than new ones. As consultants cannot see every patient at every clinic it is possible for this situation to continue for years with no effective change in the treatment of the patient's problem. I know of one case where this cycle continued for 14 years before being resolved by a GP who requested a consultant review of the patient's case. The patient was discharged back to the GP!

A third cause of over-use of diagnostic services may be the need to demonstrate concern or to reassure the patient that the problem is receiving attention and is under control (much like the prescription is used in primary care). I have heard doctors talk of x-rays as 'excludograms', by which they mean an x-ray where the negative result was strongly expected but the examination was requested to rule out definitely a particular diagnosis. Patient reassurance should not be underrated, as many people have a high level of anxiety about their health and will go for repeated tests without any symptoms to provoke their concern.

Finally, whatever the extent of defensive medicine, we should not lose sight of the fact that doctors are motivated to help people and may push this to the limit where they think it is worth trying. Cardiac arrests in hospital usually provoke a rush of medical staff down the corridor to attempt resuscitation. Yet only a small minority of those on whom resuscitation is attempted will leave hospital alive. Their poor physical condition will deteriorate sooner or later and death will follow. But there is clearly a moral and professional pressure to try to prevent the death of a patient. This leads to action first and foremost, not a debate about the quality of the patient's life. Indeed, faced with a file showing vast expenditure with little effect on patient health, it would be difficult, if not impossible, to know whether the doctors involved were highly motivated junior staff in the NHS or profit-oriented and highly cynical physicians in a fee-for-service system.

FINDING EFFICIENCY

As a result of the incentives that face doctors, resources may be used in ways that economists and others term 'inefficient'.

Every use of a service or drug in hospital denies the use to someone else because the hospital budget is fixed. If the extra benefit to one patient is small or non-existent then resources that could have been well-used on the next patient are being misplaced. But this raises questions about the right use of resources that are often not answered in medicine. While everyone agrees that 'waste' is a bad thing, there is frequently no general agreement on the right clinical regime for a given patient with a given disorder. (I know of one disease, regularly treated in hospitals, where a national group of specialists were unable to agree on the nature of the disease or whether treatment was at all effective. Sitting in on such debates gives the layman considerable pause for thought.) Research conducted by pathologists, with the obvious advantage of hindsight, suggests that many clinical problems are not correctly identified or treated in hospital (Cameron and McGoogan 1981). With all this uncertainty, it is probably wiser to think of improving hospital efficiency by eliminating obviously wasteful activities rather than trying to get medical consistency on patterns of resource use when there is no consensus on the right treatment. This approach is discussed further below.

In the absence of a clear guideline on what is the right treatment for a patient, the incentives towards inefficiency lead to heavy loads on service departments. There is no cost to the junior doctor who orders a diagnostic test, and the only benefit may be in avoiding criticism from senior doctors. Routine tests are over-ordered and unnecessary x-rays and drugs are used. But it is not easy to create incentives to offset such high use because of the organisation of hospital resources and finance. In order to examine these we need to consider the incentives and pressures on the supplying departments and the scope for management action.

INCENTIVES FOR OTHER DEPARTMENTS

Departments providing a service to other groups in the hospital have a range of equipment and an establishment of staff at their disposal. The managers of these departments are usually specialists trained primarily in the discipline of the department rather than in management. Faced with a rising demand they

can either try to increase output from the resources available, claim more resources to meet demand at the current level of efficiency, or restrict the growth of demand. In practice we might expect to find combinations of all three responses.

Increasing output by making everyone work harder is not popular and may be resisted by managers who have a loyalty to the service they manage. When the fuss has died down, it is they who must continue to work with their staff and see that their service is provided to patients, not the higher levels of hospital management. And they cannot usually pay staff more for working harder. It is likely that tighter management will not be the most popular answer or the first reaction to pressure of demand on the available supply. Nonetheless, it may occur under pressure or be encouraged by rewards such as promises of additional equipment to help meet part of the demand.

It is usually easier to pursue efficiency in the non-clinical support services where there is no direct question of a threat to health from reductions in staffing. In catering and cleaning in the NHS new working practices have been brought in by competitive tendering. Private firms, whose managers may have a much clearer incentive structure, now provide catering and cleaning in some hospitals. Putting in a new team of managers can also overcome existing loyalties even when some of the same staff are retained.

It has been suggested that privatisation could be used to produce savings in services such as pathology where technology has dramatically changed the need for skilled staff for some tests. But these areas are more difficult because of concern about clinical standards. Indeed the track record of some private contractors has damaged confidence in the areas of activity already open to tendering.

Pressure for more resources in the NHS is applied upwards from wards to managers or from districts to regions, while pressure for restraint is applied to the demands from below. Enoch Powell, in his perceptive book on the health service, contrasts the pride with which an individual part of the health service will display itself during a ministerial meeting with the letters claiming that the service is breaking down and more resources are needed (Powell 1976). While the resources for growth have become tighter in recent years, there is no doubt

that claiming that a crisis exists is a good strategy for getting more, whatever the actual position.

Reducing or controlling demand is increasingly being seen as an alternative way to cut expenditure within hospitals. These methods are considered in the section that follows.

MODIFYING INCENTIVES IN HOSPITALS – BUDGETING AND AUDIT

There is now a great deal of interest in the NHS in controlling hospital expenditure and removing perverse incentives by introducing budgeting. This is, in part, a result of the Griffiths inquiry into health service management (DHSS 1983). If incentives are to be changed in hospital, why not make those responsible bear the costs of inefficiency? This section compares budgeting with a less ambitious approach. I have characterised the two as the 'technical efficiency' approach and the 'elimination of whims' approach, a phrase I have stolen from a professor of pharmacology. In the former, the emphasis is on detailed monitoring to shift resource use closer to some technical standard, while the latter does not accept the existence of a single standard but tries to get rid of the obviously wasteful.

Technical efficiency

In the case of clinical firms, the prime decision-makers, interest in the technical efficiency approach has led to a great deal of support for the introduction of clinical budgeting (see, for example, Wickings and Coles 1985). Under clinical budgeting in its full-blown form, clinical firms receive a budget against which every use of a resource under their direct or indirect control is charged. The budget is based on projected activities and their expected cost. Changes in practice such as the use of relatively expensive drugs or diagnostic tests impose a heavier cost on the budget and lead to overspending that will be challenged by management or may prevent some patients being treated at the end of the financial year. The restriction in activity is the price to be paid for inefficiency. On the other hand, savings from more prudent use of resources, previously absorbed elsewhere in the system, can be retained in part or

whole to fund other developments. There is then an incentive not to make wasteful demands on other services and to save resources to develop new treatments.

The budgeting process is most easily seen in a department like the pharmacy where materials are a major cost. Every drug prescribed has a direct cost to the hospital and so reductions in prescribing will release money for other purposes. If there is more economical prescribing, with the budgeted number of cases treated, clinical firms can use the money saved to buy new drugs or other services elsewhere in the hospital.

The logic of clinical budgeting is obvious. Those who take the decisions become aware of their cost and can then weigh these against the benefits and the alternative benefits of other uses of the same funds. But it is naive to move from this simple and appealing idea to an ideal and efficient reality. A major weakness is the failure to see that in the market place, where consumers pay the price of their choices, we see widely different behaviour according to incomes and preferences. As long as the consumer is prepared to pay the price for each service, the market will supply it. In consequence, while it is often claimed that many doctors must be inefficient, because they differ in the treatment of a given patient, this is precisely the kind of variation that we take for granted from consumers, even though they choose within a budget. Consultants may differ in the aspects of care they think are important (for example, a more expensive hip joint versus a better rehabilitation regime), in the size of their budgets or in number of the patients that must be treated from that budget. For all these reasons, we should not expect a consistent and efficient result from a budgeting system for consultants.

Clinical budgeting in practice

Practical difficulties arise with respect to budget setting, budget monitoring and the control of the resources involved.

Setting the budget for a clinical firm is difficult because it is hard to start other than from current practice. An analysis of current activities and costs provides a baseline for future budgets. But if this is the starting line for the budget, then those who were high spenders at the start will receive higher

budgets, whatever the clinical justification. This rewards waste, at least at the start of the budgeting process, and may undermine confidence in it by consultants who thought themselves to be efficient already.

Inflation will affect different clinical firms differently and may shift actual expenditure well away from the planned level. If this happens, a decision is needed on whether to find additional resources from other budgets or to make the clinical firm live with the extra, unforecast inflation. Without a complex price index reflecting the mix of activities in each specialty, some firms may be particularly hard hit – by their reliance on high cost drugs, for example. But taking money from the budgets of other firms will damage their commitment to the budgeting process as they will lose some or all the gain from their efforts. Where inflation is lower than forecast, there are difficulties in the handling of unplanned savings made by the firm. Typically these are likely to be left with the firm in the short run to avoid giving it an incentive to go on an end-of-year spending spree – a common feature in the public sector.

Costing activities to charge against budgets poses a number of further problems. Costs are not easy to measure in hospitals. (An example from the home may help to make this clear. What did it cost you to sleep in your own bed last night? Very little, if we count only the direct cost, since the bedroom is usually being paid for whether in use or not. But what about the contribution of a night in bed to the heating bill, the laundry bill and so on? If we add up all these costs, the average cost of a night in bed is quite high. But the decision to stay or use a hotel is based on the marginal cost, the cost of a night at home, once all the overheads have been paid.) In hospitals, most of the costs are an overhead and will be incurred whether the hospital is relatively busy or relatively quiet on a particular day. Charging the average cost per activity to clinical budgets gives misleading signals to consultants about where resources are saved. But charging only the extra (or marginal) cost and only giving them a small budget to meet these costs leaves most of the hospital outside the budgeting system.

Costing is particularly problematic in departments which have a greater reliance on staff than on materials. If staff are hired for full-time or substantial part-time work, staffing can

only change in relatively large chunks. For example, a department with ten staff requires a 5 or 10 per cent fall in work before staff can be reduced. In consequence the marginal cost, the cost of an extra unit of demand, may be very small. Once the x-ray department is staffed, a single x-ray costs only the price of the film. If this low cost is charged to clinical budgets it will offer relatively little incentive to save. It is tempting therefore to use the average cost, including staff and overheads, to represent the cost of a single x-ray. But this has the weakness that if x-ray demand is reduced by less than the minimum amount necessary to save staff (5 to 10 per cent), little will actually be saved. There is then a possibility that clinical firms promised a chance to spend some or all of their 'savings' will try to spend resources that have not been saved in the first place. The result may be extra spending for the firm rather than redeployment of a constant amount of resource.

A further problem can arise due to variations in the efficiency of the various service departments. The budget information shows doctors what they have to spend and the price of different services. They may act like the consumers discussed in chapter 1, balancing costs against benefits for different services. But unlike the usual consumption decision, they have little choice. If their x-ray department is the most expensive in the country (and is inefficient rather than well-equipped), the price of x-rays will be much higher than elsewhere. If this distorts the pattern of care away from the use of x-rays, it may adversely affect patient care for reasons that lie outside the control of the firm. Alternatively, if they continue to use x-rays at a clinically reasonable rate, then they will be penalised by reduced purchasing power in other areas of the budget. The problem is that without effective competition, who is to bear the cost of inefficient departments – the hospital centrally or the individual clinical firms?

Inflexible costing that does not take account of these subtle variations can bring the budgeting process into disrepute. For example, I encountered a budget system that costed pathology tests by dividing the cost of the department by the number of tests performed (setting aside the more detailed costing of individual tests). During one month there was a strike in the sterile services department of the hospital. This prevented

some operations and so pathology requests by the surgeons fell. The budget system then divided the cost of the laboratories by a smaller number of tests and came up with a much increased cost per test. This was then charged to budgets with the result that medical firms, who had continued their work largely unaffected, had a big increase in spending on their budgets. But they had not changed their behaviour. The system had arbitrarily changed what they were charged for in its haste to cover all costs. If this sounds messy, so too is the alternative – charging the surgeons for a part of the cost of pathology, whether they used it or not.

These difficulties arise wherever budgeting is undertaken and are not restricted to the public sector. It is difficult, for example, to apportion the time of factory maintenance teams between activities and to find out if the time spent was legitimate or not. But the key difference is that in factories most staff and resources are directly linked to activities as part of the division of labour. In hospitals, almost every department makes a contribution to the care of patients and there is less dedication of staff to one diagnostic group of patients. Departments are an overhead facility, used when necessary or thought appropriate rather than clearly linked to a particular group of patients. Hospitals are more like families than factories, with competing pressures on the available time and a moral obligation to do all kinds of things to help out. If families have not adopted complex data collection and time management to solve this problem, perhaps hospitals should look elsewhere too.

In hospitals a great deal of data must be collected on activities which are each of very little importance in cost if full budgeting is to be applied. A patient might have part of the care package provided by the clinical firm, anaesthetists, nurses, physiotherapists, pharmacists, radiographers and radiologists, laboratory technicians and pathologists, theatre nurses and porters, clerical officers, cooks and cleaners. A glance at medical records shows a bulging file for even a short stay in hospital, reflecting the large amounts of paper that follow from all the interactions of patient and services. The complexity of hospitals means that considerable investments in manpower and computer hardware are required to get the system off the ground. So far there is relatively little convincing evidence that the health districts

leading the way on budgeting of this kind have been particularly successful. Interpreting the printout is also far from easy, and some budgeting schemes run the risk of sinking their users in a sea of paper.

A final difficulty concerns the financial climate in which budgeting is introduced. At its worst, this has involved budgeting as a technical device intended to save money. Data collection and cost reporting has gone ahead without first clearly establishing with consultants the framework within which it will be used. In districts where success seems more likely, budgeting has started with debate with consultant firms aimed at setting target levels of future work. The resource implications of the planned levels of activity are the cornerstone of the budgeting scheme, and the emphasis is on the behavioural aspects rather than the techniques of data collection (Wickings and others 1985). Cost information given to doctors is also limited to the areas of expenditure that they directly influence and not to overhead and staff costs that cannot be influenced by current clinical choices.

By generating new data on the resources going into treatments givenby similar specialties, budgeting may encourage and improve audit of clinical services so that we know which treatments are the most effective and not just which are the most expensive. But cost data, with all the quirks of local costs and efficiencies, may merely obscure the picture. Even more detailed costings (for example, diagnostic related groups – the basis for payment by insurers to American hospitals) will suffer from this drawback. The diversity of hospital inpatient care is such that in a single month only a small number of cases of a particular type will have been treated. Random variations in their characteristics will alter the resources used to treat them efficiently, but the naive reader of the data may conclude that there is inefficient use of resources. The unreliability of data on small numbers of patients can be overcome by using longer periods to look at costs or by using comparative costs from other hospitals. The weakness is that data rapidly become out of date and it is difficult to answer questions about why costs varied without yet more enquiries about small numbers of patients. Data drawn from other hospitals may help, but as this data will include all the quirks of costs in a particular hospital,

comparisons are actually misleading. Whatever its detailed data base, the technical efficiency approach means that the right level of spending on each case, or at least a narrow range of cases, needs to be achieved. But this overlooks the many differences between patients and the lack of clear technical standards for treatment of many diseases.

Finally, in a climate where pay awards and prices are not fully funded in most hospitals, a major problem for any budgeting system is to get agreement between consultants competing for resources on who will reduce activity to cover the funding gap. There is no real harmony of interest between different consultants and a political fight is more likely than a rational debate on budget data when all budgets are effectively being reduced.

Eliminating whims

The elimination of whims approach, which is a weaker version of clinical audit, starts from much lower expectations of success in achieving efficiency. In pharmacies, most hospitals have made some steps towards this by introducing formularies (a shopping list of acceptable drugs) which exclude the whimsical use of expensive but similar alternatives and rely on generic drugs as much as possible rather than on brand-name drugs.

In some other departments, particularly diagnostic ones, the list of procedures is already set by the facilities available. If there is no body scanner than a body scan cannot be provided locally. The purchase of scans from the private sector would generate a bill, and the interest of the management would quickly follow, given the cost of scans per patient. The whimsical use of unnecessary tests and excessive defensive medicine could be countered by the monitoring of demand, by rationing, by education or by the introduction of clear guidelines. Monitoring of demand is difficult if a medical review is required for each test. Some departments require consultant approval for particular procedures, and expensive procedures are often more tightly controlled anyway because they involve senior staff time. Monitoring every chest x-ray request would be tedious and expensive.

A much tougher solution to the problem of rising and

unchecked demand is direct rationing of services. This has been tried in at least one x-ray department which imposes quotas on the clinical firms that use it. If they exceed their quota for urgent examinations then their allocation of non-urgent examinations is reduced and waiting lists for their outpatients get longer. The waiting list, and its public and political sensitivity, provide the balancing mechanism. This approach is not always popular and may be difficult to enforce in an environment where diagnostic department doctors do not command the same status as those with greater patient care responsibilities. But it remains an attractive solution, since it rests on relatively simple data collection and reporting and encourages a direct dialogue between clinical and diagnostic parts of the hospital without involving finance and management staff. It can also directly reflect the physical constraints on a department when budgeting suggests much greater flexibility than is actually possible.

Education of junior doctors, continuing education of GPs, and written guidelines for the use of other departments, offer perhaps the best chance of eliminating whimsical demands without too many cumbersome systems (Fowkes 1986). (I know one x-ray department which requires GPs to attend its education sessions regularly if they are to go on having their requests dealt with.) Stamps can be given out, to be stuck on each test request, on the understanding that more stamps can be obtained by a junior doctor each month by coming to talk to the consultant in charge of the diagnostic department. Written guidelines, extending to computerised advice on pathology tests, have been tried in a number of hospitals. The frustration of the outsider is based on the lack of a systematic scheme for every hospital. This in turn is linked to the wider problem of audit which, if properly conducted everywhere, would effectively reduce the whimsical use of resources.

An alternative is a more systematic audit, perhaps by outside clinical inspectors (discussed further in chapter 7), by pairing or rotating consultants through each other's departments to check that treatment methods and case selection fall within broadly acceptable guidelines. We know that the greatest variation in practice occurs in private, at times behind the closed doors of long-stay institutions. What we must do, by systematic audit,

is break down the professional privacy that surrounds the use of resources by consultants, even when their whimsical use can be clearly seen by the staff around them. Staff on wards and in other parts of the hospital must be given the managerial responsibility to discuss and sometimes challenge what they see as inappropriate use of their resources.

CONCLUSION

Elimination of obvious inefficiencies and whimsical demands would make a contribution to the resources of the NHS. More sophisticated methods, such as budgeting, may contribute even more, particularly when they are linked to plans about the service, the behavioural aspects of budgeting, and where there is scope for income to increase with efficiency. But budgeting is far more costly to introduce and, within a cash limited NHS, looks more like a gamble. But whatever the techniques used, it remains the case that clinical autonomy, the cornerstone of consultant contracts and practice, will limit what can be achieved in places where greater efficiency is most needed.

Although consultants and their staff are employed by the NHS, their contractual position, together with custom and practice, does not make it easy to dictate clinical policy to them. Doctors, like many other professions, defend their independence and their discretion. They are held responsible for the care of the patients they treat and must be free to choose what is best for their patients. This poses difficulties for management for two reasons. First, the consultants are likely to be hostile to any management initiatives which encroach on their freedom of action. Since consultants are not typically disciplined or dismissed for disagreeing with management or writing hostile letters to the press, it is difficult for management to enforce its initiatives without negotiation and a mixture of carrot and stick. Second, and more fundamentally, there is only limited agreement on what the right treatment for a group of patients is. In some cases, such as breast cancer, there is almost no real agreement. Indeed clinical differences can extend to such basic things as the way in which a patient is sewn up after surgery. There are at least two accepted ways to stitch an abdomen!

Without agreed policies that can be readily identified and

enforced by lay managers, it is difficult to see how efficiency can be improved by management action, even with the new management arrangements for the NHS (discussed in chapter 5). Indeed, as in many large organisations, it may not pay management to get tough on one issue when it needs cooperation on others.

To return to the airline analogy, it is clear that laymen cannot and should not fly airliners. But the financial and planning staff of the airlines can legitimately lay down the routes and schedules for pilots to follow. What we need in the NHS are approaches which retain much of the freedom of action of consultants but prevent the most serious and inefficient actions that result. Given the lack of effective use of much of the available data, it seems unlikely that this will be achieved by yet more detailed data generation. The search for the right bit of data to control hospital costs is rather like peeling an onion. There is always another layer inside and after a while you start to cry! What is needed instead is an approach to management which takes account of how little we know and how few right answers there are rather than one which continues to foster the idea of technical efficiency.

In our current funding system (see chapter 7), even a major effort to break down the isolation and whimsical practices of individual consultants may be defeated because of the pressure on resources. Budgeting may be the solution. But I would rather put my efforts into the audit and education of staff, encouraging commitment to the hospital, and devolved management to make it happen. It might achieve only limited changes but my suspicion is that budgeting, after all the computers have been bought and the accounting staff paid, will do no better at a much higher cost. If I am proved wrong then I will welcome the benefit to the NHS no less for that.

4

Community Health Services

INTRODUCTION

Community services are provided for people with a wide range of problems: elderly people, people with physical or mental handicaps and people with chronic mental illness. It is impossible to look at all the subtle differences of each type of care in just one chapter, so community services are viewed here as a whole. While this may overlook some important differences there are enough common features, in my view, to make it worthwhile.

The term 'community services' tells us more about the place of care than the services provided. It is important not to overlook the fact that almost any type of care can be provided in a patient's home. Peterborough has piloted a scheme to take hospital services out to the community, for example. Kidney dialysis is often provided in a patient's house in a room resembling a small hospital unit. The main practical limitations on community services are the physical limits of a normal house and the dilution of staff and specialised support services when patients are spread throughout the community. But, as the examples above illustrate, where these can be coped with, quite complex services can be provided at home. As a result, there is a wide range of services in the community, depending on attitudes and costs rather than on measurable, practical standards. Indeed, the measurability of costs and the lack of a clear measure of the additional benefits of community care over institutional or hospital care has meant that costs have dominated much of the debate on community services. The reader should beware throughout this chapter of the dangers of considering costs without a satisfactory measure of benefit to set against them.

In this chapter, the incentive problems for the community services are assessed. These stem from the lack of clarity over who does what, how much it is appropriate for them to do, what this will cost and the lack of flexibility in the use of different agency resources. Each of these areas is examined here followed by a look at more flexible approaches using different carers or cash instead of care. By way of background, I will first examine the motives for the movement towards more community care.

COMMUNITY SERVICES AND THE ESCAPE FROM INSTITUTIONS

Community care has received a good deal of emphasis in plans and policies for health and social services over the last ten years. This can give the impression that it is something wholly new and different. In fact, the majority of the elderly and a proportion of other groups in need of care rather than cure have always been looked after in the community – by family and friends and by themselves. What is new is the extent of the emphasis on continuing community services for groups of mentally ill and handicapped people, particularly those who have in the past been housed in large rural hospitals, isolated from family and friends.

Large asylums on the outskirts of towns were a feature of Victorian health care policy. While they offered food and shelter to disabled and disturbed people they also used their labour on farms or in factories. More important, they encouraged an 'out of sight, out of mind' attitude in the rest of society, keeping psychiatric patients away from the community even when they posed no threat to the general public or themselves.

By the early 1960s, policy was shifting against long-stay asylums. The trend towards community care received a very public push from Enoch Powell's address to the conference of the National Association for Mental Health. He referred to the long-stay asylums as 'isolated, majestic, imperious, brooded over by the gigantic water tower and chimney combined, rising unmistakable and daunting out of the countryside' (National Association for Mental Health 1961, quoted by Jones 1972). This pressure was reinforced by enquiries into low standards in

a number of mental illness and mental handicap hospitals during the 1960s and 70s (see Martin (1984) for a catalogue of these scandals). Apart from evidence of abuse, it also became clear that quite able patients had been made totally dependent on an institution when they could have managed their own lives in the community with only limited help from health and social services.

Two other things apart from the low standards of hospitals encouraged the move towards community care. One was the growing range of social security benefits available to people who, because of mental and physical problems, had no wages or pensions from employment. The other was the development of drugs that enabled a wide range of mental disorders to be treated in the community. Indeed, the 1960s was the decade when the use of such drugs took off. As a result of these trends there was a general agreement on the policy to run down large long-stay hospitals by ending admissions and, where possible, by returning the existing patients to the community. But complete closure had to wait for the development of appropriate community services, and in some parts of the country this has been a long wait indeed. For example, Powick Hospital in Worcester was earmarked for closure as a special project and yet it remained in use ten years later.

The concern for better long-term care for physically and mentally ill patients led to the label 'priority services' being given to this part of the health service, particularly after DHSS policy statements. The 1976 policy document *Priorities for Health and Personal Social Services in England* (DHSS 1976a) accepted the need for a better environment for long-term care of mentally handicapped people and the need to avoid unnecessary segregation.

Policies developed from these general principles have been taken up by health authorities throughout the country, both to move patients to the community and to raise standards in long-stay hospitals. (Yates and Vickerstaff (1982) have shown that many of the scandals were predictable from the low level of staffing in some long-stay hospitals.) As a result, staffing in the priority services of care of the elderly, the mentally handicapped and the mentally ill, has grown appreciably since the 1960s, though only a little faster than in acute hospitals more

recently. However, the recent limits on growth in the total NHS budget have made it necessary for districts to consider withdrawing money from acute hospitals to meet their priority plans. Obviously this is much more difficult and sensitive than the allocation of new money. As a result a stronger political will to improve services for priority groups is now required to continue the switch of services towards the community.

A different pressure to run down long-stay hospitals came from the view within parts of the NHS and political circles that community services would save money or at least offer a better service at little extra cost. The priorities document emphasises low cost solutions for the care of mentally ill people, and its sequel, *The Way Forward* (DHSS 1977), says that it is not only undesirable but often more expensive to admit patients to hospital rather than care for them in the community. Faced with growing demands on virtually all services, the obvious financial incentive, if the over-simple view of cost is accepted, is to switch care to the community. This would increase the amount of care to be provided by other agencies or families but potentially cut the burden on the NHS. It is not easy to find published statements that savings would accrue, probably because this would imply withdrawing money from the groups established as priorities. But the perception continues, in spite of counter-evidence, and is a frequent feature of behind-the-scenes discussions in the NHS. 'Expensive' long-stay hospitals are still seen by some as the resource that will fund community services. As noted earlier, looking too much at cost ignores the question of benefits. And it does not take enough account of the costs falling on other members of the community as costs are saved by the NHS.

The effect of increased interest in community services for groups previously in hospital has been to make it seem like a major new area for health and social services. This has led to changes in management arrangements, focusing on groups of patients or clients rather than institutions. Twenty years ago, psychiatric services in an area were often provided by a separate district hospital group from that providing the main acute services. Managerial separation continues but now the services fall under 'priority care' or 'community' units with less emphasis on buildings and more on the client group to be cared for.

WHAT IS COMMUNITY CARE?

It is probably easiest to define community care by saying what it is not. It is not care provided for patients in hospitals but for people who live mainly or wholly outside large, formal institutions. This tells us more about the place where care is provided than the type or amount of care to be provided. Community care may describe health or local authority care provided in the home or in a small, residential-style institution. But the way in which care is provided and the extent to which it is in the local community may be as important as the building where care is provided. A small, residential home may be just as much an institution as a large hospital if it operates without much contact with the local community and with methods that stop clients being independent.

It is simpler to see community services as care aimed at maintaining the level of independence of patients and clients in the community. One standard frequently cited is that care should enable individuals '. . . to lead as normal an existence as possible given their particular disabilities and to minimise the disruption of life within their community' (House of Commons, Social Services Committee 1985). This emphasises self-reliance and care to help the client continue to cope with the day-to-day problems of living. This care may be provided in the home, in day hospitals or lunch clubs, sheltered housing or hostels. While it includes more technical medical tasks, much of it is focused on general care for clients, through the provision of services and social contact and assistance with activities that patients or clients cannot do on their own.

There are two big problems that dominate community services for all kinds of clients. The first is the large number of suppliers. This complicates the management of services and the incentives for each agency. The second problem is the lack of a clear standard of care. Community care is often general 'looking-after' for a client rather than performing well-defined technical tasks with a clear time commitment. There is no easy standard to decide the service that an individual should receive.

WHO DOES WHAT?

The whole emphasis of the movement to more community care is based on the importance of encouraging people to look after themselves as a way of living a more normal life. Where extra help is needed, the following agencies may all be involved:

families and spouses;
neighbours;
health authority community services, mainly district nurses;
health authority hospital services (providing home visits and day hospital facilities);
general practitioners;
local authority social services departments;
local authority housing departments;
voluntary agencies (WRVS, Help the Aged, Alms Houses, and so on;
social security officers;
private sector homes and carers;
employers offering modified employment;
education and recreation services.

These groups, with perhaps more than one person involved from each group, will not all be involved in all community care. But they have overlapping interests and will at times be acting independently for the same client. A client could come home from hospital to be met by eight different agency workers all eager to offer their services. Yet many people with problems get no help. Too much and too little help are both the result of uncoordinated agencies sometimes assuming that someone else is dealing with the problem.

Community service workers have a range of different skills, ranging from those without formal training such as families and neighbours to doctors with many years of professional training. The NHS clearly dominates at this end of the spectrum, with consultants and GPs the most highly trained. But it employs other skills too. District nurses have additional training after qualifying as nurses as do community psychiatric nurses. Health visitors, though often more concerned with preventive care in the community for mothers and young children, have extended their role in some parts of the country

to preventive care for the elderly. They too have a college training programme after nurse training. Specialists such as occupational therapists, speech therapists and chiropodists may be organised partly or wholly to provide a community service. Finally, those with least formal training from the health service include care attendants with perhaps only a matter of weeks in work-experience training.

The social services department of a local authority employs social workers to coordinate the services received by its clients. Some social workers are based in hospitals to improve communications and contact but they are still employed by the local authority. The other major group employed by social services departments is home helps who assist with house cleaning, cooking and similar tasks. Unlike health services, there may be a charge for a part of the cost of their services. Local authorities also employ some specialists – for example, occupational therapists who advise on adaptations and aids for clients' homes.

Local authority housing departments have in the past provided residential support through sheltered housing, with adapted homes and resident wardens. Social services departments have funded residential homes for less independent clients, particularly the elderly but also children with handicaps or social problems. Some of the provision for the elderly has changed dramatically in the recent past because of private sector competition. Changes in the arrangements for fixing weekly charges for clients receiving social security and paid for by the DHSS have led to a big expansion in private residential homes, particularly in retirement areas such as the south coast. The role of state funding through pensions and benefits rather than direct care (as noted earlier) is a major feature of recent developments and is examined at the end of this chapter.

It is virtually impossible to do justice to the full range of voluntary services for different client groups in the community. They vary from major national bodies such as MIND, MENCAP and Age Concern, to local charities, some dating back to the middle ages with eligibility linked to ancient boundaries. Newer agencies have grown up, often as pressure groups high-lighting an identified deficiency in local health and social services. Some then become providers, either

spending their own money or working with health and local authorities.

The wide range of agencies involved in dealing with community services is a major problem for the allocation of the services available (a view confirmed by Sir Roy Griffiths in his recent review of community care). Of course, many different parts of a hospital may be involved in the treatment of inpatients, and while coordination in hospital is limited by professional and managerial divisions, it has a greater coherence than community services because of the role of doctors as prescribers of the pattern of care. In the community, no one can prescribe for services from another agency. Instead, each agency refers clients to another for an assessment. Depending on the amount of resources available, and the competing demands, a pattern of service will then be decided by that agency. As a result, while social workers, GPs or others may coordinate services for clients, variations in policies, approaches and funding between agencies is much more likely to lead to different services for similar clients.

Since the home element of community care takes place in private houses, it may be hard to ensure the same standard of care as a client would receive in an institution where standards can be seen directly. Staff have a clear incentive to spend more time with clients they get on well with or who are less demanding, which can be in conflict with their professional responsibility. There is a second conflict between the clients' demands for help and those that the staff are trained to provide. For example, I have encountered health service managers concerned about district nurses fetching prescriptions or shopping for their clients, tasks beyond their formal nursing responsibility and considered a waste of time by some managers. If this is what the client wants, refusal may damage the relationship between the client and the staff. This does not mean that trained nurses should do such work but rather, where no other help exists, that the range of tasks expected from a skilled carer may often be much simpler than their training would expect. Most of the data collected on community nursing and other services is provided by the staff involved. This makes it difficult to use it to show that the wrong service is being provided. Staff may simply not report the activities that they are not supposed to provide.

There are a number of formal statements of policy about what activities each agency covers (only the family being expected to do almost everything). Some of these statements relate to the specialised tasks of a group: GPs can prescribe pills or aids; a GP or nurse can give injections; a bathing attendant can wash feet but cannot offer all the services of the community chiropodist. Housing departments provide sheltered housing but are also now in the business of taking the shelter, in the form of employed wardens, to the clients in their own homes. General tasks, such as doing the shopping or making the beds, may be done by one or other group, though usually the more skilled the workers the less likely they are to do such work officially. There are also a number of statutory requirements that services be available, but most of the services will depend on the budget set for community care by local health authorities, local government and local volunteers and charities.

For any particular client, who ends up doing what for them will depend on the other local agencies, the extent of their services and the demands from other clients. Introducing a service to a client may change his use of other services, even if this is not the intended effect, and it may lead to greater reliance on the new supplier. For example, giving a client a high-technology emergency phone link with a mobile warden, activated by a wrist button, may mean that demands for other services are channelled through the warden. For smaller tasks, a warden is likely to find it easier to do it himself, rather than spend time contacting those who should provide the service, and so the burden of care is shifted by the technology. Similarly, when a client gets a home help from the local authority, it would not be surprising to find that family or other agencies reduce their own contribution, on the grounds that social contact as well as services are now being provided by the home help.

Where policies differ, agencies may be involved in disputes about the the right service mix to provide for clients. For example, a local authority social services department may take the view that heavily dependent clients, with little ability to do things for themselves, should be helped to stay in the community as long as possible. This policy may be linked to the client's age and mental ability. For young, road accident

victims with neck and back injuries, there may be pressure to help them stay at home even though they have almost no ability to move their bodies. If NHS staff feel that, beyond a certain level of physical problem, hospital is the right place for a patient then they may use their services as a lever to bring this about. Their view may be the result of too many pressures on their time or a genuinely held view of the appropriate style of care. Either way, the threat of withdrawal of services may be used to push the client and social services agencies to accept institutional care.

Conflict between the NHS and clients' demands for care can also stem from the lack of charges for health care. Some district nurses feel that their service is abused because local authority and voluntary agencies often make a charge towards the cost of care at home but the NHS does not. This gives clients an obvious incentive to press for more nurse visits, if possible, to do some of the tasks which home helps might provide.

It would be unfair to suggest that the health service will always push what might be termed 'marginal' clients towards hospital care. But equally, because nurses are more hospital oriented, they may sometimes channel too many clients towards hospital. Certainly these conflicts do happen from time to time over disabled long-term patients. They revolve around the question of how much society is prepared to pay to take services to where clients prefer to live rather than bringing clients together in an institution. Once staffing levels for each service have been fixed, any refusal of a client by hospitals, community health services, local authority or voluntary agencies may appear to those taking on the extra work as 'passing the buck'.

HOW MUCH CARE SHOULD BE PROVIDED?

The large number of caring agencies complicates the allocation of services to clients. A close look at the care provided to similar people receiving 'community services' would almost certainly show a wide range of services provided across the country and even within a single administrative area. This variation has recently been heavily criticised by the Audit Commission (1985). Its study found big differences in the types of client in different

types of accommodation; less seriously restricted clients were at times in more supportive institutions while more seriously restricted elderly people were being turned away for lack of space. Similarly, they found that in some areas half the home help service was devoted to the less restricted clients. In general, the report is very critical of the lack of a clear division of responsibility for different services by each agency and the lack of clear objectives. These findings confirm the results of other studies which have demonstrated the lack of any pattern or plan in the allocation of community services.

It is easy to see that the responsibilities of each agency are not very clear, as anyone who has been involved in arranging care for themselves or their relatives will know. But it is not certain that clearer objectives and regulations will change the mix of services provided. The Audit Commission, in common with other critics, has misunderstood the major problems of community services. There is no 'right' level of service for each client and no single focus for inter-agency agreements. Even if there were, the way in which clients receive services will not usually lead to an ideal allocation of the services available.

It is particularly difficult for the agencies involved in community services to use fixed standards about the level of service that clients should receive in order to share services between competing clients. The aim of care, to maintain normal living for disabled people, sounds ideal. Unfortunately, however, a closer look shows some difficulties. What we regard as normal existence may depend on more than the individual's health.

Elderly and disabled people of all kinds often have lower incomes than the rest of us. As a result, they may not be able to enjoy what many of us would regard as a normal life, because the problems of income and disability combine to lower their quality of life. Equally, since reduced activity is a natural result of growing old, the normal life of elderly people is usually different from that of young people. Given these problems, it is difficult to set out exactly the services that would restore 'normal' life. Should we be trying to restore life by offsetting only physical problems or by offsetting physical and financial problems? And what comparison group is to be used to decide when we have raised a client's standard of living to the appropriate average? If life with a partner is normal should we

provide a partner for single people? My own father was disabled. Should my brothers and I have received extra sports coaching as compensation?

If the quality of life will be affected by a wide range of services, it can go on rising as more resources are provided. There are few technical limits on what can be provided and no limit on what it would cost if all demands were met. But it is not easy to take services away when clients regain the ability to look after themselves because the various caring and support services are valuable to them even when their physical or mental problem is over. For example, people usually want to leave hospital when they have recovered from a short illness, but they may still want to retain home help and meals on wheels services as these are still worth having when well. In the upper income groups, help in the home is purchased privately and take-away meals can be delivered to the door. Both services are so valued that people will pay for them. It is not surprising that people try to hang on to such services even when they are over the initial problem that justified them (particularly when they are also free of charge).

The kind of caring person who ends up having to allocate scarce community resources is not likely to find the allocation decisions easy. Health workers of all kinds are often biased towards current recipients rather than trying to be fair across existing and future clients. They will usually find it easier to water down the service provided rather than withdraw it completely. As a result, some applicants get nothing, while some current clients who have less need of services continue to receive them. While this may not be the most 'efficient' use of available services, it is likely to fit in with the caring attitudes of staff and lessen the amount of aggravation in their job by reducing the need to withdraw services from clients. Saying 'no' to a new client on the grounds of lack of staff may be easier than taking a service away from a long-standing client. Either way, it is hard not to sympathise with those forced by limited budgets to make the decisions.

The same problems of standards, costs and allocation can be extended right across community services. Services are a means of redistributing wellbeing to those who are worse off due to health problems or general aging. To set an objective is

like saying, 'How long is a piece of string?'. My own standard, for example, is that we will know when the services we provide for the disabled are good enough when we find the able-bodied getting into wheelchairs in order to enjoy them! If there is no right level of redistribution, those involved at all levels of the allocation process will use their views and the resources they have to meet their own equity standards. Centralised objectives are largely unenforceable because of the multiple dimensions that contribute to wellbeing and the desire by those involved in the allocation to retain some freedom to deal with their clients as they think best. As with doctors, community care staff often see a key part of their jobs as their professional discretion to spend their time and resources as they think best.

As there are no clear standards, it is easy to understand the differences in services across the country and across clients. It is hard for the agencies to press a case for a specific amount of money in the way, say, that a cardiac surgery team can. Such a team cannot work without all the right members present – surgeons, anaesthetists, perfusionists controlling the heart-lung machine, and so on. Community agencies could, and often do, begin a service with a single part-time worker because a little is a bit better than nothing. By contrast, a cardiac surgeon without a support team is no use at all.

Norms are widely used to get some level of service or defend a largely arbitrary one. But their lack of any clear base means that they are frequently not met when local resources are more limited than the average. Take a simple activity like having a bath. Old and handicapped people often find this a problem. What level of support should society provide to restore this activity? An ideal standard would be that everyone should have the right to take a bath when they feel like it, just like people without any restrictions. But for those without families, this could mean round the clock shifts of helpers to help with bathing. In fact, where a bathing attendant service is provided, it usually means that the client has to have a bath at a time of day that is convenient for the helper rather than when he wants to bath. Bathing attendants may be hired using a norm per head of elderly population rather than on any assessment of who needs the service and to what extent. Indeed, the main theme of my argument is that such questions cannot really be

answered, once we have decided not to provide a bathing service 'on tap'.

COSTS, INCENTIVES AND THE ALLOCATION OF SERVICES

Before discussing aspects of the cost of community services, the problems of looking at costs alone must not be overlooked. As noted earlier, costs, particularly the direct financial cost to the agencies providing services, are easily measured. Benefits are not so easy to assess, much less so than in curative health services. But without a measure of benefit we are in danger of considering only half the story. A more expensive service will not necessarily be better, but we should beware of the probability that a cheaper service will be worse.

For more dependent patients no longer housed in long-stay hospitals, community costs will depend on the level of service offered. The potential maximum is very high where round-the-clock care is needed. But costs are also high because of the nature of the service. When clients or patients are grouped together, a small group of staff may be able to care for a number of patients, albeit with a lower standard of care at times. It is quite possible to monitor all the patients in a ward while directly caring for one patient. But when clients are dispersed through the community, a lot of staff time is used up in travel and only one client can be seen at a time. Although the NHS may no longer bear all the costs for community cases, services such as meals and laundry for a large group of people in a single place will usually be cheaper than for the same group scattered through the community. (Institutions, however, often provide these services for clients who could do them for themselves, so some of their costs may be unnecessary. Moving such clients to the community may offer legitimate savings in these areas of personal care.)

Costs can be cut by shifting some of the responsibility on to another agency or clients' families rather than because a technically more efficient method has been adopted. In studies which have counted the opportunity cost of carers' time (that is, the lost opportunities for work or recreation), community services invariably cost more because it is cheaper to cook and clean for a group of people than for a lot of individuals. Costs can also be

cut by providing a lower standard of service, and this is always a risk without a clear measure of benefits and standards and when budgets are limited.

Another, quite legitimate pressure on costs, is the effort of those staffing a new development (a small residential facility, for example) to begin with high standards. Acting as advocates on their clients' behalf, they are likely to argue for something better than the services offered by long-stay hospitals. (Indeed it must seem ironic to those involved in community services that pressure to close such hospitals because of low standards and 'cheap and nasty' care has been associated with a desire by some to reduce the cost of care for the clients involved as these 'expensive' large hospitals close.) Here again the lack of a clear measure of quality undermines the comparison of costs alone.

As a result of these pressures, it has become clear that good community services are often not a cheap option. While it is difficult to standardise cost comparisons for the types of client involved, one study of residential facilities has found that they cost between 20 and 50 per cent more per client than a long-stay hospital (Wright and Haycox 1985). But are they better and worth every penny or merely a drain on the public purse with no service improvements? Research cannot say.

If services are in short supply, because the demand is open-ended and the resources limited, each agency will have to ration its services. It will have its own views about fairness which will decide how the services are distributed. There is also an incentive to save resources wherever possible (to be used for other clients) by shifting responsibility to others. Shifting responsibility to the families or to local authorities will relieve the health service of some of its pressure. Equally, the family and the local authority may resist the pressure since each has the same incentive to get as much as possible from the others.

The family is the obvious target, however, because family members are likely to feel the greatest responsibility for the client. Families with elderly relatives often find themselves under considerable pressure from a health or local government agency to look after their disabled or elderly relatives. It is not unknown for quite bitter rows to develop over the future care of a client, with a family under the opposing pressures of guilt

and the strain of caring. While there are some social security payments for relatives, for example constant attendance allowance when care is needed round the clock, there is little financial reward for most family carers. Such payments are very small compared to the opportunity cost of the time given up in care, if this is costed at the average wage. Women are the traditional carers in society and may find themselves unfairly pressured into taking on the care of their relatives, particularly if they do not work. It is clearly for social policy generally to determine how far and for how long this bias will go on. A recent decision in the European Court suggests its days may be numbered as the court gave women equal rights to some social security benefits when caring for relatives.

A second shifting of responsibility goes on between health and local authorities. Since 1976, some funds have been made available under an earmarked allocation called 'joint finance' to pay for initiatives which would keep patients out of hospital or encourage the transfer of patients to the community. However, the scale of the expenditure is small compared to the total cost of the health and social services – less than one per cent of health authority budgets or less than £500,000, on average, for each health district.

Health and local authorities both provide some institutional care: the health authority through hospitals and, more recently, home-style care for the disabled; the local authority through sheltered housing and residential homes. The placement of a person in one or the other may be determined not only by their needs, however measured, but also the alternatives available. Research suggests that clients are frequently in a place that is unsuitable for their characteristics and that an exchange of clients between agencies, moving the most dependent into a geriatric hospital and the less dependent into residential care, would be beneficial (Fordyce and others 1981). But we must beware of the danger of ignoring the fact that clients are people. They may wish to stay in their homes for a much longer period than the model of staged care suggests. Indeed, there are many cases of old people, largely unable to take good care of themselves, preferring to stay at home in poor surroundings rather than go into an institution. Since we are concerned with the client's wellbeing, it is hard to ignore

their own assessment that wellbeing is greatest when they live where they want to.

It is also difficult to avoid random factors affecting the allocation of services or residential places. Take the case of an increasingly dependent elderly man or woman who has been cared for by a daughter and her family for a number of years. A severe winter cold, with related chest problems, or a fracture on an icy pavement may lead to a hospital admission. Once recovery is complete, they may be less dependent on support and care than most patients in a geriatric ward. But the family may feel that they have carried the burden of care long enough and want a residential place. Several factors may prevent the transfer: there may be no free residential places available; or, if the old person is well-adjusted to the geriatric hospital environment (and some have attractive and well-planned facilities enjoyed and valued by their patients) he may not wish to move. Discussions of the ideal place for a particular patient or client with a particular set of problems frequently overlook the fact that we are talking about a person's life and that where you live is a major factor in life. Old people should not be subjected to regular moves if it can be avoided, and residential services should be more integrated to prevent this from happening.

In Canada a number of large facilities for elderly people are able to offer a wide range of services – from residential support to quite high levels of care towards the end of residents' lives. It is also worth noting that the Canadian climate may encourage the model of providing everything on one site because the winter weather makes journeys outside quite hazardous. The facilities are sometimes so large that they provide their own community. But they are open to the criticism that they isolate old people from the rest of society, offering an environment that may be more comfortable than a long-stay hospital but remains an institution. Having visited some of these facilities, I must say that I prefer them to many institutions I have seen in England offering care for the same age group. But this is probably due to the higher standards offered by the greater affluence of Canadians.

The large numbers of elderly people living alone or with families in the community puts enormous pressure on the limited residential facilities available. Even with some rules

about the type of patients or clients who are admitted, it will be difficult for an agency to keep some of its places empty when they are wanted for slightly less serious cases. Once a client is admitted, the need for stability in their accommodation will make it less likely that they will leave until they are sufficiently ill to need the next stage in the progression to greater and greater dependency – a nursing home or hospital. Residential homes simply cannot reassess existing and proposed residents every week to decide an ideal use of the places and discharge those who do not meet this week's entry standard. When viewed by a naive observer, the use of facilities might appear inefficient or inappropriate, but the random influences and the need for a stable residential environment probably make it inevitable.

High costs, fixed budgets and vague standards all force agencies to ration their service. The need to ration the available resources can lead the agencies involved in community services into the kind of disputes about clients and allegations of passing the buck noted earlier. What is really happening is that each agency is trying to call on some of the resources of the others. Faced with a queue of clients who cannot all be given what is seen as the ideal service, and a professional motivation to do the best for the clients, an agency will try to get someone else to do some of the caring for them, particularly as this costs the agency nothing. And there is no doubt that such efforts are better for the client than a straight refusal. But the negotiation process causes a good deal of friction, particularly when the family is the agency expected to take on more of the care.

Shifting of costs has been particularly important in the transfer of people from large hospitals to community care. Local authorities may find themselves bearing a much higher cost or, if the budget is inflexible, facing much greater pressure of demand. The ideal is for costs to shift to an open-ended budget. Then sums of money not previously available can be used to provide additional services.

This ideal has been realised recently for some clients transferring to the community from long-stay hospitals. Once living in the community, they are eligible for a range of social security payments that they are denied in hospital. Indeed, one of the ironies of the NHS is that only long-stay patients with low

incomes bear any cost for hospital care – their old age or other pensions are reduced on the grounds that the state is directly providing the basics of food and shelter. Social security payments can be used to pay the rent on sheltered housing or to help pay for care assistants working in residential homes. But shifting the problem from service provision to income support does not solve all the allocation questions, as we will see later.

The core of the allocation problem for community services agencies (and social security) is the question of equity. It is difficult to resolve two equity issues, what economists in other fields call vertical and horizontal equity.

Vertical equity refers to the fairness with which different people are treated differently. Different services are obviously given to people with different problems, but the way in which services differ between clients may be hard to decide. Usually, the more seriously disabled a person is, the more services we might think it right to provide them with. But how many more? If we are trying to raise their level of wellbeing, should we give them all the services available until they reach the level of the next worst off? In other words, should we concentrate all the services on those in greatest need and do nothing for the rest? Or do we want to share out the resources so that we do more for the worst off but still do something for others?

Horizontal equity refers to the problem of treating similar cases similarly. In community care, this comes down to the question of how similar two cases are. Are rich and poor disabled people with the same disability to be treated equally? Are those with families around them to be treated the same as those without? In both these cases many people would feel that limited resources should be shared out in favour of the isolated and the poorer individuals. But this can discriminate against caring families who find that by taking on responsibility for care, they are expected to bear it indefinitely by an agency trying to spread its resources around.

Even if we could set some standards for each level of disability – for example, specifying the type of client eligible for each type of residential care (extensive support at home, sheltered housing, nursing home or geriatric hospital care), we cannot allocate services in a rational way so that every place is filled only by the 'right' type of client. Services are not used by

people in a planned way to make life easy for the providers. Services are provided in response to random fluctuations in the health and wellbeing of the person concerned and cannot then be reallocated by some formal mechanism.

We are left with a picture of community services in which ideal standards are largely unachievable and in which the limited resources must be spread around many competing and worthy claimants who will remain clients for much of their life. The difficulty of this distribution is the key question of who bears which costs. Responsibility will often be passed by one agency to another in order to save some resources for use elsewhere. The diversity of different groups involved makes this cost shifting complicated and also makes it difficult to assess how much care is provided.

TOWARDS A FLEXIBLE SOLUTION

At present, the diversity of agencies at times hinders the allocation of resources by giving each agency limited but overlapping responsibilities. Two approaches have been developed to increase the flexibility of community services and to reduce the extent of any mismatch between what clients want and what they get.

The first source of flexibility is the use of staff who are not limited to a specific type of service. Professional boundaries at present mean that a client is in touch with several agencies at a time, each of which provides a narrow service. Care attendants, able to perform most routine caring tasks and with limited training in simple nursing techniques, are an alternative workforce who can offer a wider range of help in a single visit and maintain continuity with the client. This avoids disputes about what is or is not within the activities of one staff group and allows the client to use the helper flexibly. The smaller number of helpers involved with a single client can also reduce significantly the staff time lost in travel between clients. But even with flexible helpers, there is still the question of how much help each client receives in cash and in services.

A solution tried in several experimental areas, and now operating in one form or another in several parts of Britain, is to provide either the individual client or a social worker with a

budget to buy the services needed (Challis and Davies 1980). For example, a client eligible for home help might prefer some other service that is less readily available. By providing social workers with a budget for each client, their preferences can be taken into account so that they get more of the services they want. The client can choose whether to have a service directly given, to rent some equipment such as a washing machine to provide the service, or to go without the service in order to increase some other element of care. Usually there will be some limit to the budget available for community services. In some cases, some proportion of the cost of residential care will be the ceiling on expenditure on the grounds that community care is preventing a residential stay and will be cost-effective if it can be provided more cheaply.

The extent to which the client can make choices from the budget will depend on their problems. In some cases a social worker or other helper may be needed. But where clients are disabled but mentally alert they may be able to take full control of the budget themselves. This comes close to the economist's view that individuals are generally the best judge of their own wellbeing and that as far as possible individuals should make their own choices between different goods or services. It is worth noting, however, that some agencies are likely to stop short of handing over the cash instead of services. If the client is seen to want to buy services, such as home help, then the agency will probably have no objections. But problems start if the cash is used to pay for smoking, drinking, holidays or other luxury goods that were not the intention of those providing the service. Personally, if someone prefers more consumption to more domestic cleaning then that is fine with me. But in tax-financed and charitable agencies there will often be some concern on the part of those bearing the costs that only 'proper' goods or services should be bought. Only rarely will an agency give a person receiving community services the right to spend their budget as they wish, though this is partly on the grounds that some of the recipients of community services may have difficulties coping with the budget, perhaps because of psychiatric problems.

One difficulty remains with the budget approach, however. The budget for each client still has to be set. This will require

eligibility rules to relate health, age and income to the final benefit to be paid. Such rules are used currently to allocate social security benefits. But the result of these rules, under which all who qualify receive the stated amount of money, is to make the total cost of these benefits open-ended. Typically the agencies involved will want to prevent this happening and will look instead for a method of allocating a fixed cake. But this flies in the face of the eligibility rules, as the amount received may vary with pressure of demand and clients may face fluctuating budgets for services. In the light of the earlier discussion, we should also not overlook the great problems that would arise in setting the budget for any particular client according to some eligibility rules.

One solution is to limit the community services expenditure to a proportion of the cost of residential care. But this is arguably too narrow a view of community care. Is community care being provided because it is cheaper or better? If it is better and if clients prefer it there is a case for spending more than the cost of residential care to provide it. Only if community services are seen as a method of preventing admissions to residential facilities will the cost of those facilities be a good guide to how much to spend in the community. (More realistically, the cost of residential care provides a standard which has no real basis in principle but is a convenient average from which to start any comparison of costs.)

Social security benefits are a source of cash for community services, as noted earlier. There are a large number of different benefits available for different types or sources of problems. Those injured in wartime military service, for example, have traditionally been eligible for a greater range of services than those handicapped for other reasons. Some of these financial benefits – for example, the constant care allowance – are payable to family members who are bearing the cost of care instead of the health or social services.

However, it is important not to overlook two problems in shifting costs to social security budgets. The first is that they produce unplanned growth in public spending and may provoke further policy changes which threaten the services based upon them. The second is that the assessment of these benefits may be no easier than the assessment of the right level of

community services of other kinds. Mobility allowance is payable to those who are virtually unable to walk, but in practice there is a good deal of confusion about this standard. What distance, time, effort or pain threshold is to be used to decide that walking is almost impossible? Given the need to consider aspects other than physical health – the local geography of an area, for example – an inexact and narrow medical standard is in danger of becoming a nonsense.

Not surprisingly those who apply for such benefits think themselves eligible; and those who allocate them by medical or social inquiry are often seen as restricting access. A further complication is that the personalities involved can alter the apparently objective medical assessment. I have seen it demonstrated on video recordings of consultations for back pain that the attitude and personality of the doctor can affect whether people with back problems manage to touch their toes as part of the examination. The same patient can be pushed to a much higher level of apparent fitness by a more forceful or less sympathetic doctor. If this is an indication of a general problem, that the personalities are as important as the medical problem, then we may have to accept that the assessment of clients for benefits can be affected by much more than their physical illness.

Apart from some budget flexibility for clients, more radical changes to the community sector have recently been proposed to reduce the extent of conflict between agencies. In particular, there are suggestions from the Select Committee that, for some groups of clients, health and social services in the community should be integrated under local government control. This is the classic solution to shared responsibility for costs, since putting everything on the same budget reduces the scope for passing the buck from one agency to another. (In practice, separate departments are likely to have some of the same problems.) This will anger those keen to retain the strongest links possible with the hospital service. But it is arguable that much of the problem of long-stay care has come from the over-medicalisation of the client's difficulties. Mentally handicapped people are not in direct need of medical help for much of the time, unless they have an associated physical illness. Once a long-term illness has been stabilised there is no need

for anything more than occasional medical monitoring so the weakening of links with the hospital service may not be such a serious problem. Much will depend on local circumstances and the extent to which an integrated service already exists.

One disadvantage of local authority control would be that there may be variation in standards. Political parties dominate local authority decisions; health authorities are nominally apolitical, even though governments have exercised a strong hand in appointing chairmen to them from time to time. Local authority standards of provision vary widely as a result of political decisions whereas there is greater reliance on the use of norms to set standards for community health services. In a real sense, the decision on future control is like that on care itself: 'You pay your money and you take your choice'.

CONCLUSION

In the meantime, the management of community services in the NHS is beginning to go down the same road as in hospitals, seeking to set budgets for units or services and then monitor the use of those budgets against activity data. For the reasons already discussed in chapter 3, I have serious doubts about the ability of accounting or activity data to solve the basic problem of sharing out a service when much of the care is personal rather than technical and standards cannot be set or monitored easily, if at all.

Community care at its best is almost certainly a better way of caring for people who are not acutely ill but in need of support. At its worst, it has led to the discharge of people from hospitals into an environment which they cannot cope with and without the support that they need. As the number of psychiatric beds falls, some people will probably wind up on the streets or in unpopular housing without visitors or care. There is now some medical concern that a proportion of the mentally ill patients no longer admitted to hospital are institutionalised in prison. The best service is an ideal that will be expensive to achieve. If only limited money is available, there will be a temptation to favour institutions or low standards of community service. But if the move to community care is to mean anything, it should mean a better life for those with long-term problems and a social

commitment to provide the resources necessary to make this possible. This will still always leave the fundamental problem, even more than in hospital medicine, that there are no right answers to the question of standards and costs.

The Social Services Committee has noted that with the right level of resources, severely handicapped people can be cared for in the community. But they also note that the burning question is whether society is prepared to pay more than at present to give severely handicapped people the closest possible approximation to normal life. My suspicion is that many millions more should be spent on community services of all kinds. But that will still leave much to be done to give a better life to more people with chronic physical and mental problems. In these circumstances, perhaps the most important commitment we should make as a society is to raise standards constantly and not become tied to minimum standards and norms which have no technical basis and which are mainly intended to control costs rather than provide good services.

5

Management and Authority

INTRODUCTION

Earlier chapters have looked at the incentives and actions of different parts of the NHS. This chapter examines the same issues for those responsible for managing and directing the service. While each of the components of the health service has its own managers – for example, an x-ray department superintendent or consultant radiologist, a ward sister, a consultant running a firm – the resources they are given are set by those in control of the service locally. The 191 district health authorities in England and similar bodies in Wales and Scotland are responsible for deciding how much money and manpower each part of the service will get from the budget provided to the district. There are also higher authorities, the 14 regional health authorities in England, which receive an allocation from the DHSS and in turn allocate the money to the districts. They also coordinate overlapping district services and plan major hospital developments and specialist services across more than one district.

Local authority social services (home helps, meals on wheels, social workers and residential homes) and general practice fall outside the control of health authorities in England. (In Scotland the health boards combine the role of family practitioner committees and health authorities, while in Northern Ireland they provide social services as well as hospital and community care. This may be a planned experiment but looks like historical accident.)

The 1974 reorganisation of the NHS set up area health authorities with the same boundaries as local government to improve coordination of services which meet a similar need from health and local authority budgets. But the areas were abolished in

1982 because three tiers of administration were seen as too much bureaucracy. As a result, districts may now deal with several local authorities when organising services. This can get particularly difficult when the local authorities are controlled by different political parties.

Family practitioner committees deal with GPs. But the way in which general practice gets its money makes them more like a handling agent than a manager of the service provided. However, they do have some powers to manage or control aspects of the service, for example by checking on the extent to which deputies are used to make night calls. The emphasis on a more competitive style of primary care in the recent White Paper (see chapter 7) suggests that the government is looking to the market to monitor standards for primary care. In view of their greater direct responsibility for health care, this chapter concentrates on district health authorities.

District health authorities provide hospital and community services in their area. They are made up of appointed individuals, some representing local bodies such as the local authority and others drawn from the reserve army of men and women of good will prepared to spare some time for 'the public good'. The chairman is appointed by the Secretary of State for Health and Social Security and receives a part-time salary. As discussed later in this chapter, the composition of health authorities does not help when it comes to setting objectives for a district, though the political selection of chairmen may provide a stronger sense of direction.

The management of the district work for the authority and report to it, usually at monthly public meetings. The public are usually excluded for some of the discussion. Research suggests that health authorities differ in the sort of business they discuss and the extent to which they do so privately. While some personnel matters – for example, the short list for a management job – will usually be in the private part of the meeting, in some districts wider policy questions such as possible hospital closures are discussed in private. Health authorities also use subcommittees of members to discuss issues without the public present. At these the staff have much more to say. In some districts these groups are the place where influential members are 'sold' the management line which the members

then present to the full health authority. But in other districts they are a genuine exchange of views leading to a compromise that is acceptable to members and achievable by the managers. (For an extensive study of health authorities at work, see Ham 1986.)

The later sections of this chapter will look at the effectiveness of health authorities, but there is little doubt that the regular monthly meeting forces the pace of work in the management of the health service. Indeed, pressure to get the papers ready for the health authority may often prevent a clearer and more thoughtful approach to managerial problems.

MANAGEMENT IN A NEW CLIMATE

Health service management has received a great deal of attention in the past few years following the Griffiths report (DHSS 1983). Roy Griffiths was a successful businessman from a leading supermarket chain and was asked to advise on alternatives to the consensus management of the service at that time. Under consensus management, a key idea since the 1974 reorganisation of the NHS, the district's management team took collective decisions. No single member of the team – nurses, finance officers, administrators, hospital doctors, GPs, and other representatives (for example, medical school staff in a teaching hospital) – had executive control. While in practice some teams were more strongly led than others, the principle was that responsibility was shared. This style of working was intended to mirror the shared responsibility of different groups for the care of patients. A successful treatment needs many different staff groups and no single group can take over care completely.

Responsibility for putting the decisions of consensus teams into practice lay with the district administrator, the head of the administrative side of a district. In many districts it often appeared that the district administrator was already a chief executive. Administrators with a strong personality effectively steered the team to its consensus. In other districts a different member of the team was the real leader, though the health authority would still expect the district administrator to report on policy and action. While management responsibility

appeared to be rather looser than that in industry, in some districts it was very close to a personal leadership style.

Griffiths recommended much more clearly identified managers for the service on the grounds that the floating responsibility of consensus led to delays on difficult issues. In Griffiths's view, since no one personally took responsibility for a course of action, it could sometimes be allowed to grind to a halt on the first obstacle from another department or district. Regions and districts have now appointed the new breed of managers and they in turn have appointed managers for sub-divisions of their districts, such as hospitals or community units. While ministers apparently hoped that the initiative would attract outside management into the NHS, the vast majority of the district managers' jobs have gone to the former district administrators, though with some 'musical chairs' in some regions. At the next level, the unit, more nurses, doctors and other professionals have secured jobs, but again the former administrators are the dominant group and the number of managers from industry is still small.

It is also striking that a growing number of managers from outside the health service, from the armed forces and industry, have left before the end of their contracts, some complaining about the complex political problems of the NHS, others about their inability to get on and manage because of interference from the health authority or ministers. The most senior of these was the first Chief Executive of the new Management Board at the centre of the health service. Victor Paige felt that ministers and civil servants played too large a part in policy and the setting of priorities. However, outsiders are not the only ones to suffer in the new managerial climate. A number of insider managers, with previous health service experience, have also faced an early end to their contracts.

Nurses felt particularly hard done by under the Griffiths management changes. As the biggest workforce in the hospital and community health services, they were upset at the appointment of others to manage nurses and the elimination of many senior nursing posts in the process. In early 1986 the Royal College of Nursing launched a major campaign against the Griffiths changes. The RCN complained at the way in which nurse managers, previously quite a large group in hospital

and community services, had been sidestepped, weakening nursing advice and management in some districts.

Some of this cut in nurse managers was predictable, however. Following the report of the Salmon committee (Ministry of Health 1966), a large number of extra nurse management jobs were set up. Many administrators, speaking off the record, have suggested that this sudden growth of nurse managers led to the promotion of too many nurses unskilled in the management aspects of their jobs. Some of these nurses then suffered a further loss of support from their nursing staff. And because they dressed in business clothes rather than nursing uniform, they were seen by managers and nurses as too distant from ward nursing and therefore out of touch with the 'shop floor'. In consequence, in some districts nurse managers have had serious problems finding a new role after Griffiths (though others have followed success in nurse management with a move to general management).

Doctors were appointed to some of the management posts, as were former finance staff. In some districts, doctors' involvement in management is seen as the cornerstone of the new system. Clearly doctors are potentially well-equipped to understand and communicate with other doctors, the key users of the resources available. But many of those appointed are relative amateurs as managers. Some have been given administrators to guide and brief them, and this has been a cause of resentment to those who feel that administrators could do the job and are indeed doing much of it without the pay and responsibility to match.

The new post-Griffiths managers are on fixed term contracts, ranging from three to five years. The change in the contracts of health service managers has created a different set of incentives. It is rather early to try to assess these from observations of behaviour because as yet they have had little time to behave. On the other hand, since their contracts are short, there is limited time for them to achieve an impact and so quick results are certainly being expected by some political observers of the NHS.

In order to look at management and authority in more detail, we need to separate the part each plays in the management and decision-making of health districts. This is most easily done by

separating operational management, the day-to-day running of hospitals and other services, from strategic management, the big decisions that will affect the service over years rather than days.

OPERATIONAL MANAGEMENT

Operational management is controlled by the manager rather than by the health authority members. Although members may visit hospitals to look at standards or sit on subcommittees, they usually leave day-to-day running of the hospital to managers. Following the Griffiths proposals, hospitals now have a unit general manager. But it should be clear to the reader that the control of these managers is different from that of managers in other organisations.

British Rail, for example, has a network of stations of varying sizes, grouped into areas and regions. Managers operate at every level in a single chain. But in the health service, the management chain is not continuous in this way. Only for a few services are there junior managers in charge who then report to more senior managers. For example, portering staff, transport and patient complaints are usually the responsibility of management staff.

Hospital wards, clinical firms, and departments such as x-ray or pathology, have their own management arrangements. They operate on the principle that those who work in the department can develop through their careers to run some or all aspects of the department. There is frequent tension between doctors and scientific staff in departments such as x-ray and pathology; the doctors interpret the technical results and are a separate 'officer' class as their clinical training places them above senior technicians. In clinical or technical support areas, management by a group of junior or middle managers does not usually happen. Instead, managers must liaise with other professional groups and coordinate activities from outside. At this level, the impact of Griffiths is likely to be limited because of the key role of the professional staff, unless the professionals can become more involved in general management. However, there are a few hospitals where a clearer management line has reached the technical and professional areas. Some junior

managers now directly manage nurses or professional staff. The success or failure of these initiatives cannot be judged yet but they are the test of what Griffiths really intended for general management. But it remains the case in almost every hospital or community unit that the professional staff still take many of the decisions on the work that is done each day. The large number of separate decision-makers in the professions is what separates health care from most industrial and service industries.

It is too early to say how unit general managers will cope with the more typical lack of a single, effective management chain throughout the organisation. Some districts have attempted to get the professionals to join in management by becoming responsible for their own colleagues as part of the management structure. A manager of diagnostic services, for example, might be recruited from the consultant radiologists and pathologists and senior radiographers and technicians. They might be full or part-time in the management job with responsibility for the services provided by their colleagues. But this may be quite different from management by an identified group of managers. A great deal will depend on the extent to which managers at each level have some financial independence. (For example, I recently studied a unit which had to obtain central permission to spend a few pounds on a hose pipe for the patients' allotment.) Equally important is the extent to which such managers see themselves as part of the hospital management or, first and foremost, as part of their own department.

Hospital management is really the art of juggling and rationing the available services to meet the constant pressures from patients, doctors and other staff. The NHS does not control doctors' and nurses' pay. Pay rises above the level provided in the annual cash limit, as well as the pressure of demand, mean that a great deal of management time is now taken up to avoid overspending. In the recent past it has also been used to manage the privatisation of the cleaning and catering services in hospitals. Apart from that, health service management is like the day-to-day administration of any large organisation; juggling the parking spaces, planning the repainting or the new extension, dealing with press queries and patient complaints,

or coping with a bed shortage when admissions rise in winter. The key difference remains the lack of a clear management chain down the organisation, even after Griffiths. As a result there is much more emphasis on local consultation and negotiation with a large number of individuals and interest groups and not just a number of trade unions.

In spite of claims by the media of too much bureaucracy, British hospitals still have very few managers designated and trained for that role. Many of them are young and relatively poorly paid compared to managers in other industries. Much of the growth in administrative staff has been in secretarial and clerical areas designed to increase the efficiency of clinical services. A hospital of about 500 beds may have only three or four administrative and management staff ultimately responsible for coordinating activities. There are the specialised managers of each component of the service, but they are usually competitors for resources, not allies of the general managers of the hospital.

The need for a small management group to work hard to get the job done and the need to consult and negotiate are often in conflict. This can lead to frequent arguments over management proposals. Management will often use the available data selectively to try to justify its case. But the lack of a tight audit of data in the health service means that data often have missing items or errors and are always out of date. Doctors or professional staff then respond by challenging the numbers and making the proposal seem inappropriate. A lack of openness in the early stages and a reliance on data to prove a point that can never be fully proved leads to the lack of trust that is the cause of the numbers game. But it is also partly a result of the lack of a clear common interest in hospitals. The physicians, surgeons and psychiatrists will all have their own plans and patients and few common interests. For example, two of the three groups might want money for new diagnostic equipment, but only one group has an interest in the theatres. As a result, managers face different coalitions each pursuing its own objectives while management tries to control the budget and manage the direction of new developments.

WHAT ARE OPERATIONAL MANAGERS TRYING TO ACHIEVE?

We could effectively side-step this question by putting in an answer which, like motherhood or apple-pie, is universally popular. A recent recruitment brochure for junior managers suggests that the manager's job is '... to make a hospital achieve its objective [health care] ... and to manage the organisation so that [doctors' and nurses'] commitment has a chance of succeeding'. But while these views are commendable, they do not tell us much about the day-to-day practice of management. More important, they overlook the fact that, while everyone may want to provide more and better care for every patient, this will usually not be possible within a tight cash limit. When money is available, in periods of growth or when opening new facilities, management is much easier. While it still needs a great deal of work, it is essentially about organising and coordinating activities so that it all happens as planned. But when the system is not growing, as recently in many districts, managers face difficult decisions about priorities and spending.

My view, based on observations and conversations with managers, is that managers are trying to reconcile competing pressures so that the hospital runs as well as possible while avoiding major conflicts and serious overspending. In order to resolve conflicts in operational management, they may have to find compromises which favour one vested interest over another. It may also be easier at times to do nothing about a problem, particularly if focusing attention on it may lead to more expenditure. Perversely, while managers may know that a consultant is not working hard, it may be better, judged by the unit's financial target, to take no action because less work also means less expenditure. The hospital budget is the same, no matter how much work is done.

Keeping the confidence of the doctors is crucial for the more senior operational managers. To do this they need to avoid disputes over issues which, although important, may generate bad feelings and stop managers getting their way on more important issues. For example, I know of a district where one health service hospital was buying body scanning for individual patients from a private hospital while the other NHS

hospital, about half a mile away, was taking in private work to help pay for its scanner. The price of the private scans bought by one hospital was greater than the fee charged at the other. In other words, getting one NHS hospital to use the other NHS hospital's scanner would have been cheaper, by £50 to £100 per scan and many thousands of pounds a year. To make this happen, however, managers would have had to overcome hostility and friction between the hospitals and between consultants, the result of traditional and personality differences. Given the sums of money involved, managers perhaps reckoned that the fight was not worth it at a time when medical cooperation was needed on wholesale rationalisation of the district to meet a falling budget.

Similar behaviour occurs in another area. Patient complaints are usually handled in a way designed to protect the hospital rather than to root out those responsible for a poor service as quickly as possible. The delaying tactics of a number of hospitals have been the focus of serious criticism from the Health Service Commissioner, the health 'ombudsman'. But tough pursuit of a complaint by managers would probably offend medical staff threatened by the enquiry and so, to avoid additional friction, delaying tactics may be tolerated by managers. After all, it is the consultants, not the patients, who will have most influence on the success of the managers.

To succeed in operational management in the health service, junior and middle managers must demonstrate above all else a solid reliability. Their senior managers will expect them to cope with problems without upsetting medical or other key staff groups and to cope without constantly referring back to higher levels of management for guidance. Turning up at meetings out of office hours, coping with periods of on-call work, and so on, are all part of the demonstration of workrate that the NHS expects from its managers.

Since output in health improvement is not directly measurable, the ability of managers is likely to be judged by the absence of a financial or service problem rather than by a balance sheet of health gains. Although there are fewer clear objectives for the NHS manager than private sector counterparts (discussed further below), the day-to-day work of operational management has many similarities with management anywhere (Mintzberg 1973).

The NHS also expects loyalty from its managers. Again in common with many large organisations, the management of one part will secure the support and confidence of its staff by sticking up for them in any struggle for more resources. As a result, it is not uncommon in the NHS to find staff writing papers which present a selective case for their unit getting more resources from the district, or putting forward their district's case by undermining the case of other districts, by implication if not direct criticism. (This is particularly the case where RAWP, the method used for sharing money between districts, is concerned. I will return to this in the next chapter.) Within this system of loyalty there may not be much room for objectivity or honesty.

It is also worth noting the style of management in the NHS. Because so much of the senior management task is negotiation with key groups rather than day-to-day control of individual departments, managers spend most of their time in meetings. There is much less of a tradition of walking about the shop floor than in productive or service industries, reflecting the passing of much of the direct control to senior staff in the separate professions. It will be interesting to see if the Griffiths approach changes this. I have certainly met a number of unit managers who intend to adopt 'management by walking about' for a substantial part of the working week.

MANAGERIAL INCENTIVES AND MANAGEMENT BEHAVIOUR

The main incentive for managers interested in a continuing health service career is, in the end, to get through the work to their boss's satisfaction and get a reputation as a reliable assistant who can cope with issues, use initiative and deliver the necessary report or coordination on time. There is usually so much work being generated by all the different interest groups among the staff and by patient administration and complaints that there is no need to look for work. Hospitals generate vast amounts of paper or computerised data which must be organised into sensible statistics. Medicine generates constant demands for more clinical services and equipment. Patients and staff generate all the usual hassles of large groups of people, while the public expects more and more from the service.

No one looking for a quiet life should go into health service management.

As a result of the Griffiths proposals, managers from the top of the system downwards are gradually being appointed on fixed term contracts. The effect of this is to simplify the firing of staff since a contract can merely end, whereas before it was necessary to prove incompetence. Given the lack of detailed objectives and management control, demonstrating that a manager was ineffective was quite difficult. Now there is no need to produce the evidence of inefficiency.

To keep their jobs, or ensure promotion, managers may have to carry out unpopular decisions, for example on privatising services, with more enthusiasm than in the past. In the current financial climate many decisions are part of the control of overspending by their units. Overspending is possible because of the fixing of doctors' and nurses' pay in the middle of the financial year, but also because the power to spend money is not solely in the managers' hands. Pharmacies may overspend due to a change in drug prices or the type of drugs used. Nursing may overspend because of the need for sickness cover or a change in patients or patterns of care. Laboratories may overspread because of additional night calls for tests by doctors. None of these can be directly controlled by the managers and not every change can be budgeted for at the start of the financial year.

Managers may be given a clear directive to prevent overspending in order to keep their contracts, but in practice it will be difficult for them to be certain of achieving the magic financial target. Since money is not supposed to be central to the business of the NHS, as it is in commercial companies, it is also difficult at times to get staff to face up to financial problems or, indeed, to admit in public that financial rather than service factors are the main reasons for change. However, the continuing tight limits on NHS funding and the need to generate some growth from internal savings has brought into the open in many districts the true financial pressure to make changes.

As a last resort, hospital management may have to close a ward to save money, once the porters' bonus schemes and the cleaning contracts have been thoroughly squeezed. This problem is becoming more common as hospitals increase the

pace of work by better organisation and shorter patient stays. Much of the cost of a hospital depends on staff numbers but some cost items, notably drugs and disposables, increase with the amount of work done. Several efficient hospitals are now faced with temporary closures because they have provided a year's service in ten months. Any additional work done will not alter their budget for the year but simply lead to overspending. It is also worth noting that as services are contracted out, managers may lose their flexibility to make savings from a service. For example, when wards are closed at short notice the domestic staff might in the past have been expected to make some economies. But now, whatever savings were made when the contract was set, it is likely to be more difficult to reduce payments to contractors at short notice when the area to be cleaned is cut back. The key contracts that are unwritten, those between the service and its professional staff and patients, are the ones which can be changed at short notice to find savings.

Closure can also be used as a threat to try to influence the clinical decision-makers, but they are a large group, subject to regular change because of junior doctor training. Fortunately for managers, the physical condition of many hospitals makes closure for repair or renovation a familiar problem. Such closures can sometimes be manipulated so that they move from temporary to permanent as the financial problem develops.

With no clear outcome measures and limited lines of control there is no obvious activity measure by which to assess health service managers. The real goal is the avoidance of negative events like conflict and overspending. But these cannot be readily used as a reason for action because both seem less legitimate goals for a health service than patient care. Plans and proposals produced by health service managers are therefore usually written in terms of patient care. Savings are put forward as a means of improving care for another patient group or funding a new support service. The real reasons for action may be well known but, because they are not central to the caring role of the NHS, they are often kept below the surface (though I know of one district where they appear on the cover of the annual report). In other words, managers have an incentive to be fairly covert when justifying changes which are in practice a result of financial or political pressure.

As a result, the NHS often appears in its public statements to be very unpolitical. An operational manager may manage the pressures from national political decisions on funding and policy by essentially political means. Managers look for compromises to buy off one group or another and put more pressure on those most easily pushed around rather than on those that are the biggest problem. But none of this may show in the written record. It appears in some places more like a script from 'Yes, Minister', sidestepping the real issues in favour of cosmetics. For example, a district with a growing financial problem because of RAWP or pay awards may see the closure of some of its facilities as the only solution. But it is relatively unlikely to go to the health authority with a document that identifies the cost of different parts of the service and invite the authority to choose its savings.

Instead, a case for closure will be developed on grounds of the apparent inefficiency of one or other unit or the benefits offered by greater clinical integration. The reality is that the closure will probably be based partly on these factors but mainly on its achievability compared to other possible economy measures. Since efficiency and clinical benefits are not readily measured in all their complex detail, it is usually possible to put forward a case for closure that is not easily proved wrong. Better still for a unit seeking economy measures is a view from the medical royal colleges or nursing's English National Board that facilities are unsuitable for modern patient care and the training of junior doctors or student nurses. In these cases, closure becomes a technical matter that managers must accept because of the loss of junior staff.

Consider, for example, the changes in maternity practice, recently highlighted by the conflicts in the Wendy Savage case. On the one hand, many women are pressing for lower technology births, sometimes at home and without too much medical intervention. But under professional advice, health authorities are closing small maternity facilities in order to put everything into a general hospital unit run by a consultant. While this may offer the best chance of survival in the event of problems, for the average normal birth there may be few advantages, at least for mothers who prefer an alternative approach; there may even be disadvantages such as longer journeys for care. For

normal births, care will be the same, managed mainly by a midwife. Neither managers nor authorities, faced with strong recommendations from regional and national committees that births should take place in a centralised hospital unit, can easily say in public that they wish to operate facilities which will put a small number of women and babies at higher risk in order to give more choice. Instead they have little choice but to follow the advice of the influential royal colleges.

More often, the relative benefits to patients of alternative services cannot be assessed at all. Therefore, alleged benefits of service integration and economies of scale are used as arguments which cannot be proved. Managers in financially pressed districts are really trying to find a reorganisation of services that will be agreed by as many as possible of the various interest groups. Having found a compromise, managers will then try to sell it to higher levels of management, the health authority and the public, with some spurious data on services and savings. The incentives of these district managers and authority members are central to an assessment of their reactions and these are discussed in the next section.

To summarise, the incentives for operational managers are to keep the organisation going to the satisfaction of their superiors. While this is probably true for all managers, those in the health service have little in the way of performance measures to demonstrate their worth when their contract expires. They may have been set specific tasks, but there are usually many in the health service who can resist change even when it is directed by very competent managers. As a result there are often no clear criteria for assessment in managers' contracts. Individual performance review has been introduced to the NHS to aid the assessment of managers, but it is too early to say whether this will help to clarify the inevitably vague question of management performance. Only finance is measured in a clear enough way to be regarded as objective, and so finance may come to dominate discussions about performance that would do better to look at patient care and its standards. Aside from finance, the main thing senior staff will expect is to avoid major conflicts and disasters. Keeping the lid on things, whatever the actual service to patients, will probably be a pretty effective strategy for an ambitious young manager.

The new titles and contracts have given managers a clearer responsibility and, as a result, may have given them the authority to get more work or higher standards from other parts of the organisation. While the same sort of people may be working with each other much the same as before the Griffiths changes, the fact that one of them is now the manager may change the way in which instructions or suggestions are passed on. Certainly I know some managers who, in spite of staying in virtually the same job, now find it easier to challenge other departments about the service provided. At this level, general management is seen as taking more responsibility and having the authority to get operational issues sorted out. But there is still little real control of nursing staff or clinical activity by general managers. While a little control may come as management arrangements work down from districts – for example, when theatre managers or diagnostic service managers are appointed – the contractual and professional position of doctors and nurses still makes real management control difficult.

MANAGERS, AUTHORITIES AND OBJECTIVES

While operational management is the preserve of the junior manager and the clinical and support services managers, strategic management is the responsibility of the district general manager (though DGMs also find themselves doing a fair amount of presidential work such as attending opening ceremonies or saying farewell to long-serving staff). Strategic decisions are the main concern of health authorities, so senior managers are likely to spend a lot of time preparing plans for the health authority and discussing them in subcommittees and with the full authority in public session.

In principle, the district health authority is formally responsible for the services provided by its hospitals and community care staff, though the interference of the DHSS in its decisions is not unknown, particularly on political initiatives such as privatisation. When things go wrong the district can be sued and when a difficult decision is required, for example on a hospital closure, it is the DHA which takes it. Obviously for the more routine issues, such as the organisation of temporary services during rebuilding, the managers will largely have

a free hand. They may report formally to the authority rather than expecting the authority members to sort through the detail.

The health authority is, at first sight, rather like the board of a company, but with members of the public instead of representatives of shareholders. In addition, the public has a say in decisions through community health councils. Under the three tier system of regions, areas and districts up to 1982, the public authority taking decisions was at area level. CHCs were introduced as part of this structure to give local district people a way of commenting on health service plans. Now that authority has passed to district level, the CHC and the district health authority are often made up of similar groups of people representing the same district population. In districts forced to cut services, the CHC has become the vocal opposition. Like the Parliamentary opposition, the CHC has few resources to help it, only one or two full-time staff compared to the health authority supported by professional planners and managers. Because CHCs lack the legal powers of the health authority (having mainly the power to oppose changes formally with the Secretary of State), they receive little attention from managers in many districts and are seen as a vocal nuisance but not a major obstacle. In other districts, where money is more readily available, there is less for the CHC to complain about.

To understand health authorities we need to understand where their objectives come from. These can be most readily seen by comparing health authorities with commercial firms and local councils.

COMMERCE, LOCAL AUTHORITIES AND HEALTH AUTHORITIES

For a business, the objectives of board members are fairly clear. If the board is to avoid being challenged by unhappy shareholders it must make sure that the management deliver a reasonable rate of profit now, plan for future market changes to maintain profits, avoid very risky investments where possible, and prevent damage to the general company image. Management knows more or less what is expected of it, though not necessarily the easiest way to achieve it, and a serious failure in

any of the major objectives can lead to dismissal. But if there is more than one objective held by board members then managers may not be so readily assessed; they may satisfy some of the board but not others. When there is a single dominant objective against which performance is measured, management is easily judged by the board.

An extreme example of management with a single objective is the professional sports team, of which English soccer provides a convenient case-study. The directors of a football club can see its performance by glancing at a Sunday newspaper. In some cases a relatively small change in performance by a team is enough to generate pressure on the manager from board members. When a team fails to perform on the pitch it is quite common to see managers fired at short notice.

Larger private sector firms of the size of health districts have more objectives and, even when profit is dominant, it is less easy for it to be assessed in a very short time. Studies of management suggest that private sector managers have some of the same problems as health service managers, such as vague objectives and constant pressure of big and small items of work. Many do not have a direct profit target, for example. However, the overall financial targets of the firm and their direct measurability make it possible to produce some measures of performance for groups of managers. While it may not be possible to say who contributed what to the final profit, a group assessment can be made.

Private sector managers usually have to negotiate with trade unions but can command the professional staff since that group is more directly dependent on management for its employment. Certainly managers can limit the freedom of other staff. Only management signs the contracts with customers and suppliers in a well-run company.

When the board of a company accepts management explanations of poor performance, there is a further set of critics who can act: these are the competitors who think they could do better with the company's assets. In the recent past in Britain, take-overs have become common and the assessment of management by the market is now much more short term than a board of directors might operate. (There has even been a whiff

of the same approach in the NHS with several district mergers taking place recently.)

Local councils arguably have one overriding goal, to be returned to power at the next election. But there is no single change which, if achieved, will ensure that they are returned. Since the electorate has many objectives, some in direct competition with others (for example, employment versus the environment, educational facilities versus lower rates) the council has to juggle priorities and policies to seek as much support as possible. Political parties have their own committed policies and receive advice from party headquarters. But while these may indicate where the council stands on some issues, for many others the national party does not have a clear view. National policies change in the light of electoral opinion, and so local objectives may change relatively quickly for some services (for example, the sale of council housing by Labour councils). As a result, local authorities often have to seek a compromise within the majority party in order to get a policy agreed.

The council has officers who manage each service and whose job is to carry out its policies. But it is much more difficult to monitor the process in local government when there is no indicator as clear as profit. Plans are usually less specific than profit targets and it is not easy for council members to know how far the officers are resisting their policies by inertia. Nor is it easy for senior officials to be fired by councils, again because of the problem of demonstrating poor management with hard data. Board members of a company may be just as badly informed, but in the last analysis, the dividends are the data they rely on, even if they use that data to judge managers unfairly. By comparison, councillors receive a good deal of much softer information from their staff and can never be wholly certain how well informed they are. Although other councils can provide a comparison – for example, on the cost of a service such as refuse collection and the cost savings of privatisation – the council still has a local monopoly and it is impossible to know how well others would have done in the same circumstances. Indeed, monopoly is a key feature of the assessment of performance. Even in the private sector, managers of a monopoly concern may have much less incentive to improve efficiency when the customer is more or less bound to pay whatever the

charge imposed. If the performance of competitors is a yardstick for performance measurement, having no competitors means having no yardstick.

By comparison with company boards and local councillors, health authorities appear to be in an even weaker position to set objectives and monitor them. For all the restrictions on them, council members in the majority party have policies which are open to some monitoring and which give a clear direction to policy. But health authority members are appointed, not elected. They come and go, often with no clear idea of their precise role and usually receive little advice or education on what they are supposed to do. Rather, in the classic style of the British amateur, many of them are expected to pick things up as they go along. Indeed, even authority members who have a detailed knowledge of the service often find the role of a member to be a frustrating one. It is almost impossible for them to get direct access to all the information they might need on an issue of interest. Instead they are always in the hands of their officers who can reveal more or less of a story according to their own objectives.

Authority chairmen are usually more sophisticated and are paid to work about two days a week. Often they have a local political background. Because they are around more, and because they will decide on the reappointment of their managers, they may be better informed. But they may still not get the full story. This is largely because an agreed policy in the face of competing pressures may rest on compromises that would cause trouble if revealed in public. Recent events have shown how much covert activity there is in the commercial world. The main difference is that the health service is expected to reveal all every month to a public meeting at which their own senior staff – the consultants – are represented on the authority and usually feel able to speak freely.

Secrecy surrounds issues, both large and small. The reason is that solving the problem is what makes the managers' jobs interesting. The more they involve and inform others, the less control they may have to fix things themselves. The fastest way to work is to solve the problem and 'sell' the solution to the health authority. While involving the health authority and other groups would be a more democratic approach

and perhaps generate wider support for any solutions put forward, it also conflicts with some interpretations of general management.

Some general managers feel it is their job to get things sorted out, by direct management action if appropriate, while health authority members keep to very long-term strategic questions. But authority members are also formally in charge. Doctors or other groups can get directly in touch with the problem. It is not uncommon to find authority members raising problems of day-to-day management at the request of a professional group or an individual consultant when management thought it had already solved them. Health authority members often like to discuss day-to-day issues – the pay of medical secretaries or the condition of the hospital roof for example – because they can understand them, even though such issues are most appropriately dealt with by managers. Long-term questions of medical strategy – should we get an additional neurologist or an ophthalmologist – are less easy for them to understand fully because of the many medical and technical issues involved.

Given the pressure on funding at present, control of information may be vital if the financial effects of a scheme are not to prevent it going ahead. For example, I have seen one district where a new building was wanted by almost all the managerial and medical staff. While it might improve the service, the main reason for bidding for the money to build it was to sweeten the bitter pill of service reductions elsewhere in the district. A new building is fun for everyone to work on (and dream about) and provides interest and optimism which have been sadly lacking in many districts recently. In this particular district, the financial information in support of the new building was adjusted to give the most favourable picture possible. Savings from transferring services to it and from other sites were over-estimated. An alternative approach, which looked almost as good on paper and was more feasible on the ground, was removed from the relevant paper before it was presented to health authority members and the regional health authority.

But even if a health authority was given more information from managers, our ability to measure in a meaningful way what the health service does for health is so limited that data offer little help. Health service data cannot be combined into

a single measure such as profit. Instead, the many different activities are separately reported and can sink the health authority in a sea of detail. For example, health authorities often send out over 100 pages of reports at short notice for members to try to digest.

The health authority's role in a district with a growing budget is typically easier than in districts with a falling budget. Their main task is to decide how the growth will be used. In principle, they also control the existing budget and so they could propose changes in that. But in practice altering an existing service is usually controversial and there is little enthusiasm for such changes (Charlton and others 1981).

Each part of the service usually has a reputation, and clients or patients who like it or who think they need it, will argue for its retention. Even a service that has been shown to be of limited clinical effectiveness may be retained for a time because it offers reassurance or convenience to its users or, more simply, because keeping it avoids a decision. An obvious example is the Mass Miniature X-Ray Service. By the early 1970s it was clear that the detection of TB and other diseases in the general population by mobile vans was extremely low in most parts of the country. The screening service became relatively ineffective (Pole 1972). But instead of deciding that resources should go to a higher priority, the tendency in the areas I have examined was for the service to wither away slowly, as vehicles wore out and consultant staff came to retirement. The service, even when finding few cases, continued to offer reassurance to some and avoided a hospital x-ray visit for others. Faced with consumer resistance, health authorities appear to have avoided a difficult decision and left it to the aging of men and machines to end the service.

Allocating the growth money requires a health authority to have a set of priorities for service development. To some extent this is difficult because of the lack of clear and consistent policies by the majority of members and the lack of clear data on health outcomes. By comparison, the political slant of a local authority may cut down the list of potential policies to be adopted. Health authorities are made up of individuals with their own points of view, even though they are drawn from a fairly narrow range of the population – mainly professional people

(see, for example, Ham 1986). While one member may favour cardiac surgery, another may favour mental handicap services. There is no easy way to resolve the conflict between these two, and less scope for appeal to wider goals such as the next election in local government. Although local councillors are appointed to the health authority, they are in the minority, and even if they agree on priorities on party lines they may not be able to control decisions.

One answer to the health authority's problem of choice is to get someone else to set the priorities. We have seen in chapter 4 that government policy for a number of years, and from both major political parties, has been to shift care for the long-term mentally ill and mentally handicapped out of big hospitals and into the community. Regional health authorities have endorsed this policy and passed it on to districts. It is then a district's responsibility, with regional help to carry it out. A part of a district priority plan for spending is effectively decided by others.

More recently, problems of national concern have been declared as government priorities – for example, AIDS and drug abuse – with some money allocated for health authorities to spend on them. These central priorities often remove some of the flexibility of local health authorities, but at the same time they avoid difficult decisions. Similarly, authorities have been almost ordered to put support services out for tender and privatisation. These directives from the centre reduce the freedom of districts. But given the 'National' aspect of the NHS, it is not clear how much freedom health authorities should have if they are supposed to provide a service to national standards. In practice these standards do not exist in any detail but tend to be built into planning norms which say something about the mixture of inputs but not the potential outputs.

Norms dominate much of health service planning, covering such things as the number of nurses per bed or the number of beds of a particular type for a given population. These norms are usually developed by the regional health authorities and form the basis of their advice to districts. A district uncertain what to do with growth money can look at the extent to which its services fall short of one norm or another. It might decide from the norms which services are most 'deficient' and should be expanded first.

But this does not mean that the DHSS and the regional health authorities control the districts through national policies and norms. These can provide an answer when officers and authority members have no alternative priorities or agree with the general drift of priorities from above. When the district officers or members develop an independent position on services, regions and the DHSS have limited control. Only overspending or a failure to carry out a particular instruction are likely to lead to the replacement of an authority or its managers. Developing a different style of service is acceptable as long as it falls within the budget. However, these differences are just as likely to stem from historical accident or local politics as from a careful assessment of health needs or outcomes.

In the situation where authorities are unclear of their role or direction, the task of district managers is to develop a strategy for the use of different sites and services with few clear objectives. Like their junior staff, they have a clear incentive to show those who hire them that they are doing a good job. The relationship between a district general manager and the district chairman is crucial, but apart from overspending, it is not easy for chairmen to assess their general managers. Instead of a bottom line they face many separate statistics and impressions of the district's performance which cannot be combined. Since the district is a local monopoly, it is not possible to disprove claims that no one could do better with the resources and staff available. Nor is it easy for chairmen to develop a clear idea, with or without the authority members, of where they want the service to go. A district deciding what services it wants to provide in ten years' time may face a range of possible services. Usually none of these can be shown to be obviously better or worse. Most will fit in to a degree with regional and national policy but that still leaves a range of options open. As a result, just like lower level managers, the district general manager and the chairman are likely to try to manage the local politics to achieve a compromise that works rather than one that is best. However, the district manager is concerned with the big strategic questions and so more people are usually affected by a decision. A compromise may be that much harder to achieve.

For example, I know of one district which has three hospitals, one of which is relatively modern but for historical and

geographical reasons is under-used. Its long-term financial position and the need to reorganise services to meet royal college and regional advice means that the district might operate better with two sites rather than three. The district general manager attempted to achieve this in the face of opposition from some of the clinical and other staff who would have to be relocated. The final solution proposed had the sort of logic that a private sector company would immediately recognise. But the local reaction to closure of one hospital was so hostile, particularly from some of the local consultants, that the proposal was overturned by local and national political pressure. (It is interesting that the particular focus of opposition in this case was a specialised unit that offered little in the way of service to the local population. They were fiercely loyal to it, partly because of fund-raising in the past, and would accept no relocation of a service they would probably never use.) The plan was technically a reasonable solution but was blocked by the local politics of the NHS. When the chairman of this district comes to assess the manager for a new contract, will the failure to achieve the original plan be held against him? Can managers be held responsible for sparking off major disputes with what on the face of it are sensible proposals to all but the immediate losers?

The scenario above is fairly common in districts faced with a stock of sites and buildings that do not match future budgets and service plans. The general public will almost always defend a local hospital, no matter how small the advantages in access or other things that it offers. Medical and other staff will resist disruptive moves, particularly if they expect to lose status in any departmental amalgamations. Maximising the general good (where it can be judged) is the broad aim of many health authorities, but it is an ineffective strategy when those who lose in the interests of the majority are too powerful or too vocal to be beaten. In some cases, this can work to the advantage of a district. If a plan is rejected by higher authorities, then the managers can claim, with some justification, that later problems were not of their making. The rejection of the plan to rationalise for political reasons can be used instead to get regions or the DHSS to pay for the extra services retained.

There are good reasons for believing that manipulation of

this sort now plays a major part in the funding of London hospitals where a consistent policy of resource transfers to the rest of England has led to hospital closures to help bring London into line with the service elsewhere. When the hospitals closing were small, unpopular with clinical staff and less important to managers they have closed, though sometimes with an occupation by local staff and members of the public. But when there is a threat to one of the famous London hospitals, the political fighting starts. While the financial projections for London make it look as if a major teaching hospital will have to close and not just relocate, political pressure is likely to rescue any famous hospital that is threatened. (The teaching hospital which now provides a medical screening service to members of parliament has surely not decided to offer this by chance!) As a result, there are perhaps four or five separate strategic documents for London districts, compiled over the last ten years and all now gathering dust. Each was designed to overcome the problems of falling resources due to redistribution and each has been rejected by political pressure. Yet the problem of falling resources goes on and many of these districts are forced to close wards intermittently to make ends meet. Instead of a direct managerial response, as in industry, the politics of the NHS makes piecemeal saving and the avoidance of a strategic decision the only viable approach. Big decisions provoke a big reaction and possible stalemate, so small cuts and small disputes are the continuing story throughout London (see King's Fund 1987).

Although much of the politics of bureaucracy appears from time to time in the writings of politicians and civil servants, the political nature of the NHS is less often revealed by those who work in it. I suspect that this is because the true picture would be very unpopular. It would show that many of the decisions made are not based on a careful assessment of health outcomes, on which almost no good data exist, but on a local deal. In these deals managers often appear to be indifferent to patient health. In fact, I believe that they become worn down by constant claims that one decision or another is bad for patients. In other words, since they know that whatever they do, some suffering will be said to occur, they assume that much of the suffering cancels out and that one local compromise is as

good as another. Fixing a deal within the organisation is an inevitable result of the style of management, the lack of public accountability, and the tough choices that senior managers face. They should not be blamed for their response to a difficult environment. Most came into the NHS with very high motivation and are frustrated by the way the financial situation has changed their work.

Having worked with a variety of districts, I know of some where a more open approach to management with the authority has been tried. In one district, management and the authority consulted the local community on a strategic plan, as they are legally obliged to do. But it was done in a much more open way than happens in most authorities, and the district was prepared to consider the alternative proposals put forward. The situation was settled happily because additional finance was made available for expansion on one site. More important, since there was no reason why management should have its way in choosing between options whose outcomes were largely unknown, letting the public influence the choice was not seen as a setback.

This is the core of the problem between health authorities and managers, and also accounts for the poor relations between managers and community health councils in many districts. If managers enjoy controlling things and making the decisions then they will find it hard to open issues for genuine debate. This debate also slows things down and reduces the extent to which managers can show real changes when on a short contract. If, on the other hand, managers see their role as to coordinate a set of activities that are relatively confused, and with few clear objectives or measurable outcomes, then a more open style can work. It is not the achievement of a task but the process that becomes central. Having a local health service which has the support of the health authority and many of its own staff may be better, and not obviously worse, than having a health service that operates at minimum cost per unit and has a name for tough decision-making, conflict, lack of shared commitment and regular disputes. While the choice is less clear cut than this, and while parts of the two approaches can go together, the problem for managers is to decide how they are being judged. For authority members, the problem is how to

judge the alternatives available and the managers' success in assessing and implementing them. These are extremely difficult tasks and no simple solution is possible. Personally I am convinced that a more open and honest approach will produce a better situation, but there are many in the health service and other (small 'p') political organisations who would accuse me of being naive.

Certainly it is far from clear what effect the Griffiths proposals for general managers throughout the NHS will have on these processes. General managers are appointed on short-term contracts, managerial performance is assessed annually by individual performance reviews and managers can receive performance-related pay. It is possible that these contracts and incentives will increase their accountability. Getting it wrong, as judged by higher levels of management or the health authority, could mean facing unemployment at the end of a three-year contract. But at least one critic has suggested that these contracts will increase the affability of managers more than anything (Gourlay 1985). Whether the chairman likes you may be as important as whether you do a good job, because a good job cannot be directly measured.

The lack of clear objectives undermines the whole accountability review process in the NHS. This process started before the Griffiths enquiry but Griffiths encouraged its wider use. Each level of the organisation is called to account once a year. DHSS and ministers meet the regions, the regions review the districts, and the districts review their units. Each asks searching questions about aspects of the service and success or failure to resolve issues from last year. Where the issue under scrutiny is relatively clear cut, this can obviously work fairly easily. A district either has or has not put its catering and cleaning out to tender. If this is a priority of the government, then it can ask regions how their districts have performed and districts can pass the pressure on. Continued delay may be possible in districts where the authority does not like the idea of private sector contractors, but managers faced with the possibility of non-renewal of contracts may feel more able to push the idea than in the past.

The great difficulty with the review process comes when an issue either does not have a clear objective or where the

management's control is limited. In the former case, lack of clarity undermines the question of whether something has been achieved or not. Nurse educaton, for example, is an extensive and expensive part of the NHS. Central government is concerned that it may be too expensive, while professional bodies are concerned that the training should shift to colleges and that the falling numbers of eighteen-year-olds will frustrate recruitment at current salaries. In the absence of clear data on such questions as, 'How many nurses will the service need in five years?' and 'How many will it be able to recruit?', there are no easy answers. As a substitute for tackling the difficult questions, authorities often fall back on a paper solution. A report is written to satisfy the review process but no one expects to act on it afterwards. The safest approach is to model your report on that of other regions that have been accepted rather than risk a new approach.

Where management control is limited, it is difficult to blame management for failure to achieve a change. There are so many different groups to be satisfied in the NHS that delay is almost inevitable. Money for new buildings is so tight, and often cut back due to financial problems, that it can take ten years to build a hospital. The budget for running costs depends on national politics and pay awards and many districts do not know whether to plan for expansion or contraction. This is true of industry, but industry has much greater flexibility to change when it becomes necessary.

The proposals to shift long-stay psychiatric care to the community, for example, were led by a development project in one district. Patient admissions ended in 1978, but the hospital was still open in 1986 and its remaining patients are the oldest, most dependent and most difficult to relocate. In spite of a great deal of effort, the closure is simply not that easy. Other agencies' cooperation is not enough if resources are not available on a scale that will permit the immediate provision of a 'Rolls Royce' service in the community.

CONCLUSION

The main conclusion is that, given the limited public control of health services through authorities and the many pressures on

managers, the style of management in the parts of the health service under financial pressure is a reasonable response to the climate. Compromise is a sensible strategy, whatever the actual outcome, if a manager wishes to avoid conflict and to impress senior staff. A more open system of collaboration and consultation will probably be slower and, on many controversial issues, will not generate an agreed solution. I, for one, would still prefer it mainly because the NHS is so often out of touch with its own staff and local community. This leads to a poor relationship in which staff and community do not feel ownership and pride in their health service but resentment and lack of involvement.

Greater local accountability at district level through elected authorities has been suggested by some critics of the current system. I am unsure how much an election of members to health authorities would interest voters enough to get a good turn out. Equally, I am unhappy that the present system of contracts provides central government with a strong hold over the health service. In my view a change in the funding of the health service is needed to make districts and their managers more responsive to the public and its health problems. This is developed in chapter 7.

6

Central Government and the NHS

INTRODUCTION

The National Health Service has occupied a place close to the top of political agendas since it started in 1948. In spite of wide differences in standards of buildings, staffing and service quality, health care without any charge at the time of use has proved to be popular. The service and changes to it attract a great deal of public interest. Politicians must respond to this public concern if they are to show that they are looking after a key public service to the public's satisfaction. Failure to convince the public could lead to election losses (though the 1987 election did not show much effect, given the complaints about financial limits on the NHS under the Conservative government.)

When looking at how the health service is changed by governments, it is worth noting that the government has much more control over the support services and administration than over care itself. Governments have frequently reorganised the administration of the health service and, recently, privatised some support services. But a direct change in the pattern of care, for example the imposition of a limited list of drugs for general practice, is very uncommon. This is because of the independence of the medical and other professions. They are able to limit changes in ways which administrators, managers and manual workers cannot. Cutting administration or the laundry bill and spending the savings on patient care is also an appealing policy for a government concerned to control the growth of public spending.

This chapter examines the incentives for governments and looks at the overall level of health service expenditure and government policies in each of the areas covered by earlier chapters.

KEEPING THE HEALTH SERVICE HEALTHY: SPENDING AND SAVING

More staff and buildings and higher expenditure on patient care are the main factors likely to affect the service and improve public opinion of the NHS. The incentive for governments to spend more on the health service is obvious. It shifts money to one of the most popular areas of the public sector. Successive governments have claimed that they do indeed spend more on the NHS, though recently the Conservative government has not found it easy to convince its critics that this is true.

It is very difficult to decide by how much the health service has grown for two main reasons. First, the resources used by the service change in price each year. In order to standardise wage and price rises a price index is needed and there will always be arguments about how this is calculated. For example, at a time of low inflation a high pay award to doctors and nurses increases health spending by more than general inflation. But if the same number of staff is employed after the pay award the service cannot have increased in the way that the spending figures suggest. These comparisons become even more difficult when there is a change in the hours worked by staff, because then more staff are needed to provide the same number of hours of care. The same level of service is bound to cost more.

The second difficulty is that the level of service we 'ought' to provide is not easy to quantify. If the service has grown this is all to the good, but if it grows more slowly than the demands on it then the overall service may get worse. The main sources of growing demands on the health service are the higher numbers of elderly people, the heaviest users of the NHS, and changes in medical technology. Technology can affect spending in two ways. More advanced and more costly drugs or appliances may increase the cost of treating a disease. For example, new cancer drugs containing platinum are now on the market at high prices. New technology can also open up areas of care for diseases which were previously untreated or relieved by painkillers. For example, intensive care for small babies, treatment for infertility (*in vitro* fertilisation) and, on a wider scale, hip replacement, have expanded

what medicine can do into new areas and increased the resources required to deal in new ways with the same range of problems.

A new treatment always poses problems for the NHS. It will almost certainly have to be funded partly or fully from the costs of other treatments. The NHS does not receive an increase in its budget every time technology finds a new treatment. But most current treatments have not been systematically evaluated to the point where we can describe their outcomes for different types of patient. There is little hard evidence to help judge which treatments should stop to pay for the new treatment. The result is the kind of arguing and bargaining that leads to the compromises discussed in chapter 5.

The recent debate on total national spending on the NHS has tended to oversimplify the effects of an ageing population and new technology. Since we cannot specify a technically correct level of health funding, because the budget will always be less than that required to pay for every possible caring and curing service, we cannot find the growth required to extend this correct service to an older population. A simple calculation based on the growing numbers of elderly people implies that their individual health needs are constant and that current standards are the right ones. Certainly for geriatric care there are many in the service and outside it who would challenge this.

Technology is even more difficult to assess. It advances in fits and starts. For diseases treated by drugs it may produce massive cost increases in a short time when a new drug hits the market. For other diagnostic and treatment facilities, a great deal will depend on the speed at which the innovations spread. As we noted earlier, this may depend on the interests of individual doctors and local fund raising rather than some national plan, and so the rate of change is hard to predict.

If the right rate of expenditure growth cannot be found, the alternative is to pick a target. This has been done in the recent debate in which the British Medical Association, the Royal College of Nursing and the Institute of Health Services Management have challenged the Conservative government's record on NHS spending. The main focus of what has at times been called the 'two per cent' debate is a calculation that this

level of real growth in the NHS is necessary to keep pace with the rising numbers of elderly people and changes in medical technology.

However, the three national groups involved have recently tried to break away from the tedious argument about whether 1.8 per cent or 2.2 per cent was a reasonable rate of growth, when the calculations were largely educated guesses. Instead they have asked for a commitment to a rate of growth linked to that for the economy as a whole. The intention is that rising standards of living should be reflected in rising standards in the health service, at an affordable pace (O'Higgins 1987).

Since the NHS budget has been growing slowly, other sources of funding for patient care have been found by changing the mix of expenditure on different parts of the service. The Conservative government has put great emphasis on changing the balance between support service costs and direct patient care. This source of saving, restricted to hospital and health authority care, is discussed below.

SHARING A LIMITED BUDGET

Aside from the growth in the budget, the way in which it is used has obvious political implications. RAWP (from the Resource Allocation Working Party, DHSS 1976b) is the policy of allocating budgets to regions on the basis of their populations and a crude assessment of health needs. It has been a feature of all governments' health policies for the last 12 years. (There are other formulae in Wales, Scotland and Northern Ireland with some technical differences. Northern Ireland and, to a lesser extent, Scotland enjoy higher funding than the rest of the UK for health care, but the health needs of these countries are also different to some extent.) The shift of emphasis from hospital to community care for many chronic patients is also shared by all political parties. However, the effects of these policies on voters may be quite different.

RAWP is a mechanism for sharing a budget, no matter how big or small that budget. Target budgets for the 14 regional health authorities are based on a calculation of what they would require to provide the national average service to their populations, adjusted for any above or below average illness

levels in the region. (This is done using statistics on the number of deaths in a region and has proved very controversial in some regions, notably those with lower death rates which lose money as a result.) No allowance is currently made for urban deprivation or the level of primary care provided by general practitioners in each regional health authority.

The actual cash allocation to a region under RAWP depends on two things. First, it depends on the total cash limit set by the government for health authority services: that is, the size of the cake to be shared by the RAWP method. Second, it depends on an estimate of the ability of regions to cope with change. When RAWP first began in 1977, some regions were as much as 15 per cent from their calculated target budget. Since a region could not manage this level of change in a single year (and since a big cut in a region's health services in one year would be very controversial) the pace of movement towards the target was slowed down. Regions calculated to have too high or too low a budget were to move towards their target over a number of years.

When the total national budget was growing significantly, it was possible to raise all regions' budgets, giving a little growth to regions which for historical reasons had too high a share of the budget and greater growth to those with too low a share. This made RAWP appear more like a catching-up exercise in which there were gainers but no losers. (In practice, because the historical inequalities were much greater at district level, some districts were bound to face a falling budget even when their region was enjoying some growth.) However, it is now clear that RAWP can only operate within the current growth rates of the total health service budget by either cutting some regional budgets or offering very slow growth to the regions below target.

The regions most restricted by RAWP are those in the south east of England. The districts which face the biggest reductions are in turn concentrated in central London, though suburban London and the centres of other big cities also face some reductions. As a result, the reductions in the health service have a much higher political profile. London news is often national news and parliament is itself only a stone's throw from two major hospitals, both of which face a difficult financial future.

Although many of the London districts are dominated by Labour, there are still large numbers of Conservative voters in inner London and their concern over the state of the health service has led to calls for a change in RAWP. Such manipulation has been a common feature of the rate support grant for local authority services. For local authority grants there are strong signs that governments have juggled the calculations to reward their own political territories more than their opponents'.

RAWP could be revised to take account of urban deprivation to shift resources back to the inner cities and some London health authorities have pressed for this. But funding for deprivation would raise other problems for the government. Using this approach to shift money to inner London would mean penalising outer suburbs and the home counties. But these districts are still more dominated by Conservatives, as are rural and suburban districts elsewhere in the country. These districts are often below their target allocation of funds because of rapid population growth and a low level of services in the past in rural communities. Many of these districts are affluent, growing communities where RAWP is not keeping pace with population growth. To avoid the problem of penalising Conservative areas in order to help London, RAWP would have to be revised in a way which shifted the balance between north and south. This would reinforce the two-nation criticism of the Conservatives and would be politically controversial.

Nor is it clear that an urban deprivation element in budget setting would help London and the south east particularly. While there are clear pockets of deprivation in London, there is also a great deal in the major cities of the midlands and the north. It is too simplistic to expect a major change in the balance between north and south from any extension of RAWP to include deprivation, and so the government's dilemma is likely to remain in the long term. The NHS Management Board's review of RAWP in the autumn of 1986 concluded with a policy of no real change in the absence of hard alternative data for resource allocation (NHS Management Board 1986) but a further review is due to appear in 1988.

In November 1986, the government announced some additional funding for the Thames regions to assist in the transition to rationalised services. This was potentially a one-off exercise

in the run-up to an election since the review of RAWP has made no longer term changes. But following a good deal of media criticism and complaints by the royal colleges in December 1987, a further increase in funding was offered by the government. It may be that an annual political fight, particularly over the full funding of pay awards, will be a feature of health service budgets for the next few years.

PUBLIC HEALTH AND HEALTH PROMOTION

The government has wide responsibility for public health and health promotion. But in choosing its policies it has to balance a range of interest groups. Industry expects to avoid heavy costs for reducing environmental damage or heavy taxation on unhealthy products. The public expects to consume unhealthy products if its prefers them. In these areas a policy designed to improve health will not always have the same support as an improvement in the health service.

The government is also caught up in the wider economic implications of any action against industry for health reasons. For example, cigarettes and alcohol provide a substantial part of indirect taxation. The government can use its concern with the health effects of these products to increase their prices with taxes and duties which discourage consumption to some extent. But too much discouragement will reduce the taxes raised on them. The government has a financial incentive not to restrict consumption to the point where it has to raise other taxes.

Governments are similarly slow to cut pollution. There has been gradual progress towards reduced lead levels in petrol and less air pollution by industry. But where these measures increase costs, every country has an incentive to go slowly in order to avoid any price disadvantage or inflation. Since it is usually difficult to prove cause and effect for any specific illness due to general pollution, it is also difficult to sue individual polluters for the damage they do. The effects of living in a polluted environment are the result of a whole series of factors, such as lifestyle, work place and genetic make-up. When an individual dies as a result of the long-term effects of pollution, the death cannot usually be blamed on a single pollutant.

Indeed, we still have only a relatively poor idea of the reasons for the different death rates from some diseases across the country.

When a public health disaster occurs, governments are much more likely to react with a policy because the public expects some action. As a result, policy may move in fits and starts, lurching forward rather following a planned path. For example, the growth of AIDS and heroin abuse has led to the allocation of considerable sums for public awareness advertising. Yet the health damage of alcohol and tobacco far outweigh these two (though AIDS has the potential for rapid growth). Perhaps we can conclude that in a democracy the government is forced to limit its controls on popular vices while taking a tax rake-off nonetheless.

The current government clearly see interference with personal choice as an infringement of the rights of the consumer. It has frequently been at odds with the Health Education Council over this and other issues such as diet and fat consumption. The HEC's criticism has not been shared by the government, and the conflict was finally ended when the HEC was wound up and replaced by the Health Education Authority which is directly accountable to ministers and with a new team of senior staff. The incentive to place this activity under direct control was clearly the reduction in the scope for embarrassing the government when other departments were supporting policies which the HEC saw as bad for health. It is too early to say how much independence the new HEA will be able to exercise without facing government interference.

One final area of concern is the general social conditions in which individuals live. Health surveys of the population often show up bad housing as a major factor in concerns about health. And unemployment is likely to increase family and psychiatric problems, whether or not it causes the deaths that some have alleged. Critics of government policy in these and related areas often refer to the NHS as a 'national sickness service' since it is unable to tackle causes of illness at their social source. A doctor can increase the points needed by his patient to get to the front of a housing waiting list (by advising the housing authority that the present housing conditions affect his patient's health) but he cannot directly change the home

environment. Yet their own social conditions are the biggest day-to-day health worry of low income families. Society has largely stamped out the simple medical problems associated with poverty, such as the spread of infectious diseases caused by overcrowding and poor water supplies. But this still leaves the social and environmental problems of bad housing, dirty streets and the stress of unemployment.

A major initiative to improve the housing conditions of deprived and rundown areas would be very expensive. Governments of either main political party face the usual disincentive that taxation is never popular. In housing spending, they face the further problem that the aid is very narrowly spent. Health service spending, particularly in general hospitals, is of potential benefit to almost everyone. But only those in poor housing are likely to gain from a major housing programme, and there will always be others who oppose this redistribution. The issue of redistribution also affects the health service itself as we will see below.

PRIMARY CARE

The relationship between GPs and the health service started as a compromise in 1948. Independence was highly valued by the profession and direct, salaried employment by the NHS was unpopular. As a result, governments have never had strong and direct controls over primary care. The government may set up incentive payments to get GPs to work in unpopular areas, a feature of the latest White Paper (Parliament 1987), but they cannot directly set up primary care in an area that is not well provided with it – for example, by paying health authorities to offer primary care clinics with salaried medical staff. This would involve a much bigger change in the conditions for general practice and would lead to a major row with the British Medical Association.

Similarly, where the link between GPs and district nurses does not work well, or where different GP practices have patients living in the same areas, nurses attached to different practices visit the same street. This is obviously inefficient. But the government cannot easily change it. Rather, it has been encouraged by the Cumberlege report (DHSS 1986) to set up a

parallel system for organising care; but some GPs see this as a solution to a problem posed by some of their colleagues and not by themselves. Since the government cannot intervene to make some GPs work more closely with district nurses, its only direct solution would be to set up a whole new system which cuts across the good cooperation between some GPs and their attached district nurses. The White Paper suggests that the government would like to see more team care in general practice, but still built around GPs and not a separate network.

The other key feature of the Cumberlege report is its proposed improvement in the status and independence of nurses. For example, it recommends limited prescribing rights for nurses. As the falling number of 18-year-olds in the population cuts the numbers of new nurses, the nursing profession will be ideally placed to improve its status and independence. The shortage will force government and the NHS to pay more attention to the improvements needed to keep nurses in the system. However, the British Medical Association is less enthusiastic about a greater role for nurses because it threatens its own control and independence.

The current Conservative government's main (but usually unstated) concern about primary care has been the lack of clear cost control. Many prescribed drugs and fee for service items in general practice are paid for from an open-ended budget that meets the cost, whatever the level of demand and provision. Although the government takes credit for the growth in health service spending, it is estimated that about one-third of the growth under the Conservatives has come from largely unplanned increases in expenditure on general practice (House of Commons, Social Services Committee 1986).

The incentive to increase control is the obvious one of preventing extra spending beyond the planned amount. One direct measure to reduce the cost of primary care was the imposition of a limited range of drugs on general practice. At the same time, since the government has a general agreement on profits and prices with the drug companies, it has been able to negotiate profit reductions and lower prices. Here, however, its incentive to cut costs is opposed by the economic and trading incentives to avoid undue damage to the industry, a major exporter. There has recently been an increase in the profit

levels allowed after claims by the industry that jobs have been lost and investment transferred to other countries.

Conservative policy towards primary care is influenced by right wing economic thinking which is inclined to be against the professions. Professions are seen as white collar trade unions which have too much control over themselves and the market. They use this control to protect themselves from competition. The government has taken up this idea most noticeably in the changes it has made to opticians' services (and outside the health service, to conveyancing). Moves to a simple voucher system and changes in the regulations about how glasses are sold have led to much advertising and price competition. It is also much easier now to get an eye test, and glasses are often provided on the day of ordering. The primary care White Paper suggests some further competition – for example, by allowing doctors to publicise the services they offer and by making it easier to change doctors.

Competition may be encouraged in dentistry, particularly as the effects of fluoridation lead to a fall in simple dental work. The White Paper shows that the government is prepared to put more of the cost of services, including dental inspections, on to patients. (In practice, competition might encourage free examinations even when the government stops paying for them.) Competition of this kind is much less likely in general medical practice. Here the White Paper suggests that more information is needed for consumers and that minimum standards should be maintained. Some services, vaccination for example, may also have a performance target built into the payment system to encourage GPs to offer the service to more of their patients. GPs will also find it more difficult to operate a skeleton service with a small number of patients. A better service will have to be provided by doctors before they qualify for the practice allowances.

Competition in primary care is complicated by the way doctors see the incentives to expand. A larger list size brings more income. But the only way to meet patients' expectations is to hire more medical staff. Unlike a service such as hairdressing, which can expand on the reputation of the boss but hire less experienced and lower paid staff to do some of the work, GPs are not readily able to use different types of staff for the

basic patient contacts. Although a nurse may assist with some patients, most will probably expect to see a doctor, at least on their first visit. A larger list then means either more work or more medical partners, who must have the same salary after a trial period. As a result, many of the potential gains are lost.

More patients may also mean more problems; and the fee is the same no matter how demanding the patient. The patients who want to change doctors may be more demanding than those who accept unsatisfactory treatment, and so may generate more work in return for a relatively small annual fee.

HOSPITALS

Hospitals and related services are the biggest component of the health budget. They have therefore been the main areas of concern for government policies on overall spending and greater efficiency in the NHS.

The government gave health authorities extra funds in 1986 and 1987, mainly for hospitals, to show that the most sensitive part of the health service is being well looked after. December 1987 saw the strongest criticism yet of government funding for hospitals, partly because of a few sad children waiting for operations, and the government could not resist calls for extra money. This pressure tends to occur in winter due to the extra demands on the service and the approach of the end of the financial year in March. The extra money on offer in the winter of 1987, around £86 million, was a relatively small sum when split between 191 authorities. It is unlikely to prevent over-spending in many authorities. If that overspending is then carried forward to the next financial year, the problem could be worse in 1989.

In the past, only the districts facing a significant cut in their budget due to RAWP and the effects of pay awards had major financial problems. Recently, however, the pay award problem and the slow rate of growth of the total budget has led to financial problems for more authorities. London, the area facing the biggest reductions in funding due to RAWP, has received special help in the recent past. The incentive for the government to avoid too many disputed hospital closures in London is that London hospitals are the most prestigious in the

country and also the closest to the national media. While a large number of beds have closed in London, this has concentrated doctors and patients rather than reduced their numbers. But without a reduction, the costs of the service fall only slowly, if at all, because the same work is being done faster in most hospitals.

Special attention to London is one feature of recent government action on the hospital service. Others include a determination to get greater efficiency. Targets for efficiency have mainly been in support services but, more recently, they have been in clinical areas such as waiting lists. Clinical performance is now monitored in great detail, but it is not clear that the performance indicators actually lead to changes in services.

Within the cash limit available, the government would clearly like to show the best and most efficient service to the public. In its calculations of the growth money available to the health service, the government includes savings from improved efficiency. Savings have been put at £86 million a year (1986/7) by the government but this is contested by its critics. The main source of this money, the cleaning and catering services of hospitals, have been put out to tender to increase efficiency and lower costs.

The savings from privatisaton and other efficiencies are expected by government to release half of one per cent of the budget each year for use in patient care. This is a small contribution, though it can add up to a significant extra source of money over a number of years. Even small savings are worth having if they also improve public opinion by showing that the health service is tightening up on support services to improve patient care. The government's direct control of health authority chairmen's appointments and of their manager's contracts has made it much better placed to enforce privatisation in the face of resistance by some health authorities.

One surprise is that privatisation of some services has caused very little industrial action. There are at least two reasons for this. One is obviously the climate of unemployment in which union power has generally been reduced. But a second is the low wages of many support service staff. Faced with a cut in wages or hours of work and the offer of a redundancy

payment, many may be as well off receiving unemployment or supplementary benefit. Certainly the financial rewards for a hospital cleaner defending a job are dramatically different from those in the printing or mining industries where long, but unsuccessful, industrial action has occurred under the Conservative government.

Waiting lists are another area where governments have tried to show that the service is getting better in spite of financial pressures. Governments like to use the figures to score political points. When the list is going down, largely for unknown reasons, the government of the day likes to take the credit. When the lists are rising, the opposition will jeer and the government may feel obliged to act. Earmarking extra funds was an initiative tried in the build up to the 1987 election and continued into 1988. Districts receive a fixed sum for each extra case treated from the waiting list.

In practice, waiting list initiatives may be doomed to failure. It is not clear whether governments do not understand waiting lists or simply do not want the public to understand them. No one knows exactly how many ill people there are in the country so the potential demand for hospital care cannot be assessed. What is clear is that we know very little of how patients, GPs and hospital doctors behave when faced with each type of illness. (For example, it is not generally known whether a consultant surgeon regularly finds more cases to treat in a single week's outpatient clinics than he can treat in a single week's inpatient operating theatre time.) The organisation of hospital work, together with the uncertainties of behaviour in the community, can mean that extra consultants in a district might increase the waiting list as all the different factors change. The data are extremely suspect, not least because as many as a third of people on a long waiting list may no longer want the operation. (See Yates 1987 for a full review of waiting list problems.)

Performance indicators, a set of data comparing hospitals and health districts in detail, are prepared and sent to health districts each year. Because hospitals are the part of the service where the most complex activities take place, they are covered by a much wider range of detailed indicators. The incentive for government is to identify the inefficient and to use the data to

criticise and pressurise health authorities in the annual review. The review itself is a further method of pushing for greater efficiency. The problem with management by data, however, is that the activities of hospitals are so complex that even a great deal of data still gives a poor picture. In particular there is virtually no standardisation of data for the type of case treated, its severity or its outcome. Trying to include this data would probably make the whole exercise completely unmanageable. Already there are doubts about the extent to which managers actually look at the clinical performance data. As we saw in chapter 3, this is the area where they have least control of performance.

Finally, it is worth noting that in one area of hospital work, nursing, government policy seems very thin. The shortage of nurses as a result of changes in the birthrate 15–20 years ago is well known and predictable. In a few districts, the shortage is already so bad that districts have saved money because they are unable to find the nurses to staff their wards. But apart from short-term promises to review the pay of some nurse groups, following press criticism of hospital services in December 1987, there is no clear policy from the government or the Health Service Management Board on nursing. This may reflect the famous quote that 'a week is a long time in politics' and that a much longer term problem can only be dealt with when it turns into a short-term crisis.

COMMUNITY CARE

In community care, the government's problems again centre on resources. Much of the early pressure for community care as a better way of caring for people took place in a financial vacuum. We saw in chapter 4 that in some cases savings were expected from the transfer of patients to the community. Certainly there is little or no clear financial data to assess how far the budget of a major psychiatric hospital could pay for an acceptable community service. In the absence of special budgets for psychiatric services, the speed of transfer of patients to the community depends on the local health authority. Decisions to reduce the acute hospital service in order to expand community care are not likely to be easily taken because of the

way in which the public sees the health services it uses. My own view is that the public's expectations of the health service can be explained partly by a concept used elsewhere in political theory – 'the veil of ignorance'.

The political philosopher John Rawls argued that society would choose a fairer distribution of income if individuals did not know their own place in society. By the time we reach voting age we have a good idea of our likely income, based on education, family income and wealth. Rawls argues that if voters were behind a 'veil of ignorance', where they were voting without knowing their own position in society, they would tend to choose a fairer distribution of income. This would protect them from the effects of being among the poorest. That is, if you know you will do well in an unequal society, inequality is not a worry. If you do not know, inequality is more of a threat and many would vote for greater equality (Rawls 1972).

Rawls's approach seems to fit the health service well. Individuals are effectively behind a veil of ignorance where their personal health is concerned. Any one of us may suffer a heart attack or other serious illness in the near future which will damage our health and cost a great deal to treat. Evidence on risk factors for different diseases will not let us predict our own personal date of serious illness or death. Major accidents are even less predictable. Effectively we are behind a veil of ignorance and choose a health service that protects the worse off, the most seriously ill, since each of us may become seriously ill in the near future.

By comparison my suspicion is that people feel they are much less at risk of mental illness or mental handicap than acute illness. As a result, inequalities which result in poorer care for these patients are more easily accepted by the rest of us. Care of the elderly is less of a concern because we discount future problems (as discussed in chapter 1). As a result, the public is likely to be biased in favour of acute medicine. Therefore, the closure of a small accident department can provoke public anger. (But people can also be angry when a psychiatric service is moving into their neighbourhood – because they do not want it near them.)

If the public is concerned to defend acute hospitals then the

government must show that it is doing its best to provide a good service, particularly in those areas where resources are growing under the redistribution formula. Unfortunately it faces a further problem. Because of the difficulty of publicly ending a particular health service, health authorities tend to present optimistic plans that include developments for almost every service. But changes in the budget available or the wages of staff mean that optimistic targets cannot be achieved. Developments are then put off, even in districts with a growing budget, and the impression of cuts in the service is reinforced.

One way of achieving the changes required for community care without cutting acute hospital services has been to release extra money. Long-term residents in hospital have part of their pension or benefit taken away, on the grounds that the public sector should not pay for their food and feed them in hospital. When these patients are discharged from hospital, the reverse may happen. In the community they are eligible for a range of additional social security benefits to cover the cost of housing and other essentials. We have seen in chapter 4 how these funds have been used to obtain more services for patients receiving care in the community. But this funding has been more of an accident than a government policy.

When the various rules for social security were set, no one anticipated the extent to which health authorities with a tight cash limit would move patients and increase their benefits so that much of their accommodation or services could be paid for from a social security budget without a cash limit. But the government faces a dilemma in deciding how to respond. If it cuts the benefits it will need to fund the long-standing commitment by all parties to move patients from unsuitable long-stay hospitals. If it does not, a part of the social security budget is likely to go on growing for some time. Perhaps the most obvious incentive to delay a major change was the threat of lost votes in the run up to the 1987 election. The decision to ask Sir Roy Griffiths to have a further look at community care, announced in late 1986, was a predictable delaying tactic (used by the last Labour government when it set up the Royal Commission on the NHS after disputes over private beds and other aspects of the health service). Griffiths's conclusions, particularly a greater role for local authorities

in community care, do not appear to be popular with the government.

MANAGEMENT AND AUTHORITY

Successive governments have changed the bureaucracy of the NHS three times in 12 years. This shows the importance of the NHS to governments. But it also shows their lack of control over the biggest part of it – the service given by the clinical professionals. Senior managers and authority members are directly or indirectly appointed by ministers, so there is no great difficulty in changing this part of the service at a reorganisation or, following Griffiths, at three-yearly intervals as contracts expire. The Griffiths initiative to bring in general managers to hospital and community health services was due to a desire to bring more commercial principles to the public sector, as with privatisation. The tension between efficiency and caring, the key role of the NHS and the core of this book, is a real and continuing one.

The management of the system is regarded as an irrelevance by many who work in the service and by almost all consumers. So there is much less public criticism of moves to 'cut bureaucracy' or 'streamline the management', though the other staff in the NHS have complained loudly about the threats from a new management style. As already stated, there have been three reorganisations of the NHS since the early 1970s but little change in the independence of the health service professionals that managers are supposed to manage. In common with education, the government offers greater local responsibility to managers and authorities but at the same time wants to impose national standards of what should be done. In the meantime, doctors and teachers largely do the things they choose, at least when not under direct observation!

There is no doubt that whatever the savings from reorganisations, their effect has been to strengthen government control of the health service. Senior managers in the health service are on short-term contracts; health district chairmen are on short-term appointments; and both groups are likely to be judged fairly toughly by government. Appearing to do as you are told has become a common type of behaviour. Managers who have

doubts about the use to them of national initiatives – for example, the Körner proposals to collect a great deal of data to monitor performance – usually feel unable to criticise such initiatives in public. Instead, they reluctantly carry out the task, not with any enthusiasm but at least as fast as their neighbours in other districts.

CONCLUSIONS

The main incentive to any government to show it is providing a good health service is the electoral and public opinion response. This has been harder for the recent Conservative government because of its aim to reduce public spending, of which health spending is a major part. But all governments face problems of waiting lists and the rise of new health threats such as AIDS and heroin addiction.

The Conservative government has responded to these incentives by tightening its grip on the health service, particularly district health authorities. Through the Griffiths proposals, and through its power to appoint health authority chairmen, it can now enforce policies such as privatisation more effectively, at least those policies which the managers and authorities can directly control. Changing clinical practice or professional standards is not so easy.

The distribution of money across the country has remained relatively even-handed over the last ten years and it is to the credit of those responsible that, whatever the limits of RAWP, it has not become a political football like the rate support grant.

In general practice, government control is much weaker. Having largely lost a fight with GPs over deputising services, it then imposed a limited drug list, one of the elements it controls directly. Other government proposals are to continue the gradual introduction of competition to parts of the primary care service which began with significant changes to opticians' services. In community care, the government may well have no clear policy. It cannot turn back the clock and avoid the accidents of funding and eligibility that have led to the current situation. Nor can it easily put more long-stay patients on to the streets. But it would clearly like to avoid the current situation where some of the cost of community care is falling on

budgets (social security, for example) which are open-ended and were not set up for that purpose.

Finally, the real challenge for all governments should not be overlooked. This is that as patients we are more demanding than our taxes will allow. The health service involves considerable transfers of resources from those of working age to the old and the young and also, within the working age group, to many who will never work again. Ultimately it is the willingness of the tax paying public to encourage this distribution (in the hope that they themselves might benefit but often for the clear benefit of others) that will decide the size of the NHS under current policies. The alternative is a new method of funding the NHS, discussed in chapter 7.

7

Future Alternatives

INTRODUCTION

The earlier chapters of this book have shown the limited and often unhelpful incentives that operate in the NHS. This chapter sets out some possible changes that would move the NHS a little closer to the national health insurance systems of Europe and Canada. It is clear that a tax-funded national health service is very cost effective in raising revenue and distributing it without a large administrative system to monitor every payment. But it is useful to separate how we raise the money from how we spend it. Tax funding need not mean public sector provision. The NHS is close to the hearts of the British people but there is still a case for change.

The primary objective of the NHS is to treat or prevent illness as effectively and as fairly as possible, across the country and across income groups. It cannot avoid problems of priorities, and political compromises will always settle some decisions. But under stringent cash limits it has become unresponsive to demands. While all demands cannot be met, the current system needs to become more flexible if it is to provide an acceptable service. The case for higher standards, particularly of buildings, is clear and there would, I believe, be public support for a larger health budget. But an enlarged health service would be partly providing comfort, care and a demonstration of concern for patients. It would probably not lead to a dramatic increase in health or life expectancy, but rather some increases in the quality of life for patients, their families or carers. Spending money on relatively ineffective health procedures may be an apparent waste, but in affluent societies it may be of no less benefit than some of the other goods and services on offer. In some cases it could be of much greater

benefit because of the redistribution of welfare that the NHS provides, to the sicker and worse off members of society.

The section that follows examines the case for leaving the health service alone on the grounds that it has had too much change too quickly. Instead it concentrates on changes in the approach of the current service. Later sections look at some of the features of the NHS which would justify greater change in the long run. The proposed alternative is a method of funding in which incentives of one form or another play a bigger role. In particular, the proposals strengthen the links between activity and rewards, not necessarily for individuals but for hospitals or health centres.

My own position should be clear to the reader who might otherwise infer something about my personal philosophy and politics. I firmly support protection of low income families by social security. If redistribution of income to the poor was increased, the idea of charging for some elements of health care is less harmful. Without that redistribution, I am less sure of the merits of charges for health care. Charging would be one feature of a health system modelled on European or Canadian lines. But even without the introduction of more charges, there is a case for rethinking our attitude to the National Health Service. As a nation we have separated health care from other issues of welfare and cling to the idea that for health itself, at least, we are a fair society. Much of the concern with the equality of the NHS is a token response in a society with considerable inequalities in living standards and prospects. Indeed, concern with equality is a part of the almost charitable behaviour of the NHS, rationing out its medical care to patients who do not feel able to behave like consumers in spite of paying for the service indirectly.

TURBULENCE AND CHANGE – SHOULD WE LEAVE THE NHS ALONE?

Before examining the proposals in detail, the timing of any changes is worth thinking about. The NHS was reorganised in 1974, again in 1982, and effectively again in 1984 by the Griffiths changes to the management arrangements. Griffiths has also recommended another round of changes in the

organisation of community care. Given the poor condition of many of its buildings, there is a case for putting our money into capital investment and leaving the organisation unchanged. However, three factors are continuing to cause upheaval in the NHS and it may be that stability in the organisation and funding will not alter them. The three problems are the cash-limited funding of the service below the level of health care cost inflation, the pressure for further privatisation and the instability of management.

Annual cash limits are not meeting the rises in pay and prices that the NHS faces. Many districts are forced to make short-term closures to meet their financial target. A partial solution would be for the government to end its assumption that health authorities can go on taking 0.5 per cent out of their service costs each year through efficiency savings. But, more importantly, health authorities must be given a real stake in the pay review system or, if it remains independent, be given the means to meet pay awards fixed by others.

The privatisation of pathology and, perhaps, of management is beginning to be openly discussed. There is no doubt that privatisation would provide the chance to challenge some working practices that, because of new technology, are no longer justified. But it would be all too easy for privatisation to be used as an excuse to cut wages and conditions of service and to ignore the effects on the unmeasured quality of care. While it may save money in the short term, in the longer term there may be a price to pay in higher staff turnover and lower motivation.

Privatisation of management is perhaps worth an experiment. But it would be interesting to see which private companies would be prepared to manage hospitals within the constraints of cash limits and the contracts of professional staff. It is worth remembering that the private sector enjoys the flexibility of employing almost no doctors! Privatisation could further damage the continuity of management, which is already turning over too fast in some districts. Contracting out can also limit the flexibility of managers as it gives 'one-off' savings but no scope for further savings later in the contract. In the past, support services and administration provided many of the short-term savings at the end of the financial year. If these are

subject to contracting out, short-term savings might be found instead in the clinical areas where neither doctors nor patients have a clear contract showing what the service will provide for them. Some of the recent frictions between doctors and managers may be due to this increased pressure on uncontracted areas of hospital work.

The final source of turbulence is management itself. Faced with fixed term contracts, managers have taken on some of the mobility of footballers and their managers. For example, one major city hospital group in Britain is now on its third general manager since 1983 and numerous districts are on their second general manager. It is scarcely credible that managers can influence major organisations in such a short time. Nor are frequent changes of manager likely to produce stable management with a commitment to long-term change. The health service now needs contracts and pay for managers that will give greater stability within a planned career. This might ensure that they did not chase every promotion regardless of the number of changes of job it required. Some progress is being made towards this planned career development of the kind that is common in large companies and the civil service. But it will only succeed if managemnt in the separate areas of hospitals and health districts is seen as a unified group. There are so few administrators in the NHS that if managers are restricted to what used to be administrative jobs, districts with annual budgets of as much as £30 or £40 million may not be able to offer a good career to managers. Certainly in the short term a cultural change will be needed to move health service managers away from a 'survival of the fastest' approach that rewards those who move frequently rather than those who stay in one place to achieve a planned set of changes.

SOME SHORT-TERM IMPROVEMENTS

In addition to action to reduce financial instability in the NHS and improve its buildings, other short-term improvements are worth considering. The primary change would be attitudes, of managers to their staff and of staff to patients. Too many health service managers cannot find the time to consult and involve their staff. As a result of this, and their relatively low pay, staff

in the NHS are frequently demotivated and uninterested in patients and relatives. Indeed, all things considered, we are lucky to get as good a service as we do from the NHS, and trade too much on the good will of many staff. A major shift in attitudes towards greater focus on the consumers is needed, but this will need a big investment of time in staff training to achieve it. This need not be expensive if it becomes part of the job of managers at every level, not only to develop internal methods of training but also to emphasise good communications with staff and patients at all levels.

The focus on consumers should be carried further to involve them in planning decisions. Too often people hear about changes in their health service at the last minute when managers divorced from direct use of the service announce their plans. While other services rely on sales as an indication of consumer reactions, the NHS relies on silence. In community care particularly there is a key role for consumers, whether patients and clients or carers. Only by finding out what people want and what they need can the service provide a useful and well-used service. General practitioners might follow similar lines of consultation – by some market research, open evenings or annual practice meetings for example.

Unfortunately, the current method of funding the NHS, in which activities and income to fund them are largely separate, does not encourage consultation with staff or patients. Arbitrary (and quick) decisions are needed each year to keep within the cash limit in a way which no commercial company would accept. Financial problems occur in some places because of the success of the service in treating more patients rather than because of any management failure. There are not sufficient incentives in the current system to make it responsive and flexible, and there are too many central initiatives which force managers to spend large amounts of time on information collection.

A final area for action is the audit of services at all levels. A great deal of the work of the NHS is carried out by professionals largely working on their own or in very small teams. Indeed, the essence of professional work is that the individual has discretion to adjust the work to the situation and to have independence of action when required. But independence can

lead to isolation and it certainly does not encourage a wider team approach within a profession. The isolated individual can begin to depart from the standards of colleagues or be left behind by technical improvements. Every professional in the NHS should be paired with a colleague from time to time and share their working style, not in a spirit of criticism and attack but of support and advice. We demand that airline pilots be scrupulously checked every six months. Is the work of health service professionals any less important?

There has been a good deal of progress, but the audit of services remains fairly unusual. I would be reluctant to see it enforced because this would lead to a climate of suspicion rather than cooperation. I believe that responsibility should fall on managers and the natural clinical leaders in the NHS to be more open about their work and to lead by example. Audit might also be influenced by the introduction of accreditation schemes examining hospitals' systems and procedures. Such a system, used in Canada for example, would be designed to assess hospitals with the results being published. We have this system already for the priority services through the Health Advisory Service and the National Development Team for Mental Handicap. Recent work to study deaths shortly after operations is an example of what can be done in acute hospitals, and deserves to be taken further (Buck and others 1987). But it may also be necessary to change incentives and funding to bring about the change in attitudes towards audit. Taking collective responsibility for work should lead to collective rewards.

A final area for possible short-term change is the structure of the health service, from the management board to the district health authority. Readers may have noticed the scant mention of the NHS Management Board in chapters 5 and 6. This reflects the lack of clarity about its role as an independent group rather than as a part of the DHSS. Victor Paige, its first chief executive, resigned for this reason. It is hard to see any success achieved by the Management Board that justifies its formal role as a separate body, and the case is strong for reabsorbing its functions back into the DHSS.

There have been a number of calls for members to be elected to health authorities to try to increase the representativeness.

At present many do not feel that they have a clear constituency for which they speak or a power base from which to challenge managers and chairmen. One difficulty is that elections would probably lead to domination by the local political power. Labour health authorities with elected status might find it difficult to conform to central government decisions on funding or service priorities. In the short term, I would not expect any great improvements to come from poorly supported elections of health authority members.

THE NHS FOR EVER?

If changes in attitude and management could occur in the short run, could the NHS continue as it is? Certainly there would be a great deal of support for a policy of 'no change'. The lack of payment at the time of use is a major and popular feature of the NHS. But its popularity has blinkered us to changes.

In the eyes of central government, control of health service spending is the key function of the NHS. The NHS is no longer simply about improving health or providing care. It is also, perhaps more so, an instrument of macro-economic policy. As a major component of public spending, the NHS must deal with inflation if it is to serve governments. Underfunding of pay and prices in a sector that consumes about 6–7 per cent of the Gross National Product is a major contribution to monetarist control of the economy. Restriction of expenditure, regardless of demand and technology, helps achieve monetary targets and keeps down taxes. (Recent Labour governments, as well as the current Conservative one, have been unable to resist this lever of public expenditure control.)

The result of the macro-economic function of the NHS is a service which fails to satisfy either providers or consumers. Patients may now wait many months for treatment in a hospital building in such poor condition that if it were a restaurant, cafe or pub, they would not enter it. Nursing staff have been cut back and, coupled with demographic changes, have now reached very low levels in some hospitals. This has the effect of limiting expenditure as unstaffed wards close.

The failure of the NHS to meet public and professional hopes can continue because of the relative ineffectiveness of the

electoral system. There are too many issues involved in an election for the public to express a clear view on one service or another.

Although it is difficult to assess public opinion without bias due to loaded questions, there can be little doubt that health services remain a popular area of public spending. One concern preventing pressure for further health spending may be that people are unsure what is in it for them. Voting for a bigger NHS will not offer any personal protection; they may still end up with a low priority illness or be at the end of a long waiting list. The national aspect of the NHS weakens the connection between what we pay and what we get in order to achieve equality. There is no doubt in my mind that a more locally organised health service, in which communities felt greater local ownership for their hospitals and funds were mainly raised locally, would be well supported and popular. But this would lead to unacceptable inequalities in services between rich and poor areas, as well as probably distorting priorities towards the acute hospital service.

Alternatively, it may be that we are not sick often enough to have the NHS at the top of the agenda in an election. While we use general practice more often, there is much less dissatisfaction with the service compared to hospitals. Over five million people are discharged from hospital each year, but this is still a small minority of the population. For most of their working lives, except for child bearing, the great majority of the working population do not go into hospital very often. Only one in 20 men aged 15 to 44 goes into hospital for an acute illness each year – often after an emergency or accident that leads to rapid treatment – and one in ten men aged 45 to 64. Child bearing increases hospitalisation to around one in ten for all adult women. So while most people like the idea of an effective health service, they do not press for more to be spent on it because they make such limited use of it. Only when people make frequent use of the NHS, predominantly in old age, do they discover lower standards and longer waits than expected. To a degree the government is trading on the ignorance of voters about when they will be ill. When they are healthy they accept, as voters, a smaller level of health spending than they would like to enjoy when sick.

The problem of public expectations and reluctance to pay its cost is present in any public service. But public collection of the funds for health care is the most cost-effective way to pay for a health system and achieve a fair service across the country. Given public funding, however, there is no reason for the current inflexible methods of spending the money to be retained. Within an agreed annual ceiling for growth, we could allow some element of payment for service in hospitals or primary care, not necessarily payment by patients, to strengthen the links between work and income. Simply setting the same ceiling on NHS growth and keeping current funding arrangements would not deal with the incentive problems of the service.

The proposals below also have some macro-economic consequences that are worth looking at. Health care is a service industry which makes a relatively high demand on labour. As a result, increased spending on health leads to more jobs rather than more imports. With current levels of unemployment in Britain, the scope for expanding the health service is considerable and savings in social security payments would be substantial. We can afford as a nation to spend more on health care and, by better management and more incentives, increase the cost-effectiveness of what is, compared to other countries, a cost-effective service. It seems regrettable that we use control of doctors' and nurses' pay to have a cheaper rather than a better system compared to Europe.

THE ALTERNATIVE: A MOVE TOWARDS NATIONAL HEALTH INSURANCE?

The NHS is at one extreme of the range of systems found in developed countries. This section examines the benefits of a move towards those closest to it, the social insurance schemes of Europe and Canada. The hypothetical system below would involve changes in the way we collect the money for health care and pay for hospital care in particular. The possible use of charges is also considered. Since any moves in this direction would cause some upheaval, there is a case for piloting them in one region for perhaps three to five years before adopting them nationally. They should also be seen as proposals for the long term.

I would be opposed to more radical change in favour of greater reliance on private health insurance. It is impossible to avoid serious inequalities in privately financed health systems, between rich and poor, young and old, sick and healthy. Allowing the healthy to pay less of the cost of health services by giving them lower premiums when they are healthy is again trading on the ignorance of the healthy about their future sickness. In the two-tier system that would result, with a lower level of service for the publicly-paid poor, the elderly and the chronic sick, I would not like to be in the position of losing income, employment or private health insurance cover because of serious illness.

The main features of an NHS moving towards a European model of national health insurance would be:

A separation of health service funding from government in a health insurance agency, with compulsory membership, subsidised for low income groups.

More independence for district health authorities which would have responsibility for overseeing the local health service and monitoring standards and so on. Associated with this role would be a substantial investment in medical and professional audit.

Payment for hospitals based on a combination of block grant and payment for service increases at marginal cost. Continued employment of doctors and nurses by hospitals as salaried employees with a pay review system to monitor pay rises.

Payment for GPs based on a mixture of capitation and fee per consultation.

Payment for chronic care based on individual and social security payments for residential care and home support.

Separate equalisation funds to achieve a fairer service across the country, on the lines of the current RAWP approach.

These proposals are designed to increase the amount spent on health care, to make this increase more acceptable through earmarked collection of revenue through the health insurance fund, and to spend it in a way which provides incentives and flexibility.

Each of these features is presented below.

A national health insurance agency?

The model for this agency would be the European and Canadian insurance funds run by Quangos or by provincial or central government. Subscriptions could be indexed to income. Alternatively, if subscriptions were constant across income groups, beyond a minimum threshold, the tax system could be adjusted to offset the effects of the change on low income families. There would be universal membership of the scheme and no inspection of membership before receiving services. Subscriptions would be deducted by employers (or paid by social security for those not in employment) and paid to the health insurance fund.

It is arguable that a move to a separate agency would be largely cosmetic and would incur the costs of a further administration. Critics on the political right might prefer a more radical shift to more private insurance. But the great weakness of private insurance is that it is only prepared to insure against certain risks and for certain periods of time. Even the United States has a very substantial public budget for subsidised health care.

A change towards a national health insurance fund would clearly not take the politics out of health spending. The intention of separately identifying the health component of public spending would be partly to focus attention more clearly on it and to liberate some of the public good will towards health services. The consumer may pay something called a premium more readily than a tax. But in countries which have this system, the annual rate of increase of the premium is a political problem that is bound to reflect the views of government and not merely an independent Quango. In view of the size of health spending, it is likely that governments would exert quite a lot of influence over the average rate of growth.

A further disadvantage of raising the money for health care outside the tax system is that it creates a whole new bureaucracy. While this could be used to create additional jobs in depressed areas, this might be an unconvincing argument to some politicians or voters to justify the duplication of effort. However, it

might be less costly if the bureaucracy to administer national health insurance was built on to or replaced the present system for collecting national insurance. The location of major national insurance offices in unemployment centres such as the north east is one reason for supporting the Quango model. The proposed change would give the national insurance bureaucracy a wider role.

However, it is important to bear in mind that however we raise the money for the NHS, we can still change the way we pay for the services provided. It may be that the limited advantages of a Quango NHI system are enough to rule it out. But we can still use taxation to fund the health service in different ways.

The role of health authorities

The district health authority would monitor and control services by, for example, limiting the development of facilities and monitoring standards of care. DHAs would also have a major role in developing medical and other service audits. They would play a central part in negotiations with hospitals on the block grant element of funding for facilities, discussed in detail below. They would agree a level of workload in line with any direct block grant funding. These proposals parallel those of Enthoven (1985) for competition between hospitals for health authority contracts and on a smaller scale the PACTS work of Wickings (1985). They might also coordinate the supply of information such as waiting times and facilities available in competing hospitals.

DHAs would encourage hospital management to be more independent, and private hospitals might in the long-term provide some services or manage some public hospitals under contract to the DHA. Private hospitals, NHS community hospitals or groups of GPs might tender to provide day surgery in a district whose acute hospitals had dragged their feet in introducing it. (Acute hospitals might also go into primary care more formally through designated clinics in their accident departments.) DHAs would retain ownership of hospitals for the foreseeable future. Since having competing facilities would mean having competing buildings and equipment under-used

most of the time, changing incentives and sometimes management is arguably the cheapest way to achieve competition. (I have no objections to greater efficiency but I would want restrictions on pay and conditions of service to ensure that lower priced contractors were more efficient rather than just paying lower wages.)

District health authorities or CHCs would also have a key role in developing the audit of all services, perhaps through accreditation on Canadian lines. Hospitals would receive regular visits from an accreditation team to check that the various administrative, financial and clinical systems were up to the required standard. As noted above, there is no clear reason why audit should not be widely adopted within the current NHS with current funding arrangements. But in a health service funded by NHI, there would be more scope for monitoring procedures and checking on audit systems in return for accreditation. Apart from having status in its own right, accreditation would be a sign that the hospital met the procedures laid down by the health authority and was eligible for the payments at the margin for the workload-related element of funding.

It would also be interesting to see more experiments by DHAs on standard setting. One of the frustrations under the NHS is that the patient is in principle entitled to every possible medical treatment but in practice has no clear idea of what will be provided or when it will be provided. No health authority can guarantee to treat all patients tomorrow but it would be worthwhile to experiment with standards – for example, no more than ten per cent of a patient group to wait more than six months for surgery – to see if they were at all feasible or enforcible. One possibility is that after a certain wait, patients' names could be passed to alternative hospitals with a request that they provide the service.

Regional health authorities would have a reduced role in a more flexible system, perhaps retaining a watching brief on facilities which were intended to serve wider populations but playing a much smaller part in local planning. They would have a key role, as now, in controlling medical manpower if we are to avoid a situation in which successful hospitals or health services in a district were able to attract more doctors. While

there may be also a place for incentive payments to increase the attraction of some jobs, signs of expansion in the health service could reduce the pessimism around some medical specialties where the wait for a consultant post is very long.

Regions might also have a role in monitoring progress towards greater geographical equality. Block grants would be allocated on the lines of the RAWP formula to make sure that districts with a lower level of service had the facilities to improve and expand them. There might also be greater financial flexibility within this allocation. Districts below target might be allowed to borrow capital to increase the building programme, meeting interest payments from their increasing block grant. However, in the longer term, as hospitals take on greater independence, they would make their own investment decisions based on estimates of income from block grants and fee for service income from the NHI.

Paying for general practice

In an NHS closer to European NHI systems, GPs would be paid by a mixture of the current capitation fee and a fee linked to consultations. They are already paid in this way, but the main change would be a payment for each consultation or course of treatment from the insurance fund, possibly with a payment by the patient. Payment for courses of treatment has the advantage that it avoids the incentive for GPs to encourage unnecessary repeat consultations, a criticism of practice in countries where a fee is paid for every visit. On the other hand, capitation fees do not encourage the availability or range of services provided by GPs.

I would be reluctant to see greater emphasis on capitation charges in the payment of GPs. Paying for the number of people on the list encourages GPs to recruit patients but not to treat them. While only a minority of GPs are guilty of this, the separation of practice income and activity is unlikely to promote higher standards. GPs may also be more inclined to refuse patients who make relatively high demands on their time and wish to transfer from other GPs who have not met their needs. In common with hospitals, controls on the annual increase in practice income could be used to limit the rate of

growth of expenditure and the pay review body could adjust fees in line with the national workload of practices.

I can see a place for direct payment by patients, initially on an experimental basis. A small payment would be used to focus both doctor and patient on the idea of the patient as a consumer. These charges might be levied on patients for the first visit only or as a single payment at the end of a course of treatment and not directly related to the cost. GPs might also be allowed to compete with hospitals for block grants from health authorities for some minor hospital services – for example, treating minor injuries and day surgery. This might encourage GPs to obtain x-ray and other diagnostic equipment to extend their services. In the longer term this could increase the range and job satisfaction of general practice for the expanding numbers of medical graduates keen to enter it.

Charging is a very sensitive issue in health care and the possible use of charges for primary and hospital care is likely to provoke a good deal of controversy. I am very sympathetic to the argument that charges are a deterrent to the use of a service and may put off some people from using the service, even when faced with the early stages of a serious illness. But I am also dissatisfied with the lack of a consumer response from the NHS. There is an air of charity about some parts of the NHS, where the consumer is made to feel unworthy for demanding additional services or more convenient appointments.

Although charges pose problems of deterrence or, if we have exemptions for low income groups, of the social stigma of being a welfare patient, I would like to see at least some pilot studies of their effects. A part of these experiments would be to audit the service provided to patients in different charging groups to ensure that those with exemptions were not over-treated to increase the incomes of those providing the service. In an ideal world, even low income families would have the means to pay the modest charges that I would regard as high enough to make us feel like consumers but low enough (or repayable from public funds) to prevent hardship. But the stigma of welfare exemptions, the effects of exemptions on the poverty trap, and the possible cost of collecton, lead me to put patient charges lower down the agenda for reform.

In common with recent government proposals in the primary

care White Paper, I would like to see GPs offer preventive services such as checkups, not only when a new patient joins their list but also every two or three years. Checkups play only a limited part in the prevention of disease in the longer term, but even if the effects on mortality are not dramatic, I think it is worth encouraging greater health consciousness among the public at large through preventive measures. Since checkups are not part of the current NHS GP service, I would support a centrally-paid fee to pay for them, possibly with some patient charges, particularly as GPs do not have the same incentives as dentists and opticians to look for directly remedial problems. Much of the most serious illness is passed to hospitals for major treatments, so GPs are not able to screen patients as a method of identifying future work which they could perform.

Abolition of a payment by the NHS to dentists and opticians for dental checks and eye tests was also proposed in the recent White Paper. This has proved controversial but may not have the predicted effect. In a more competitive environment, the lack of a government fee for screening may not mean that providers make charges. Instead screening might be provided free (as estimates for all kinds of work are provided) by dentists or opticians competing for patients' business. However, for dentistry, rising standards of dental health will mean that more and more patients will only need inspections and some oral hygiene work. Therefore, as dental health rises in the community we will need to be aware of the incentives to overtreat healthy mouths. Where health is relatively good and where the risks of non-treatment are less severe, the NHS might move to a salaried service for dentistry. Alternatively, we might set up dental maintenance organisations, on the lines of the United State's health maintenance organisations, through capitation fees paid by the public sector or partly by patients.

Patients could be given an opportunity, say once a year, to register with a new GP or stay with their current practice. To simplify transfers patients would hold their own records or an edited version of them. Technology now makes it feasible for such records to held on a 'smart' credit card, which can be read by a computer. Copies of records would be held by GPs to protect against accidental loss. I can see no justification for the current secrecy surrounding patients' notes. As an adult I

expect to see all the facts relevant to my health for the next three to five years, though some of them may need to be broken to me humanely. Competition would be stimulated by advertising the facilities that a practice offered, the times of surgeries, and so on. Practices might also hold regular open evenings with groups of their patients to air views on new services (screening, treatment for sports injuries, arthritic drugs) and provide some information on new medical developments and the practice attitude to them. At present, we receive most of our informaton from the media, rather than being kept informed by our medical advisers. Similarly we read in the press about possible changes in the local health service with no idea of what our GPs think. It may be that there would be little local interest in such events, but there is still scope for more imaginative presentation of information and health education than in the past. No doubt some practices are already doing this and many more would try it when faced with a little more competition.

GPs would retain their role as the first check on non-emergency patients needing more complex hospital care. They would have the freedom to refer patients to the hospital of their choice, but the wider publicising of standards of service offered by health authorities should increase the patient's interest in a referral to one facility or another. Again, it would be misleading to pretend that patients will be able to assess directly the best place for the next stage of their care, but greater knowledge of what is on offer would be an improvement. Hospitals would be encouraged to hold education and awareness events, but it is to be hoped that these did not turn into 'free lunches' designed to stimulate business!

The central pay review body would remain as a control on the incomes of GPs. As currently happens with doctors' pay, and to a greater extent dentists', the fees for items of service would be set to reflect the average doctor's workload and a target annual (or weekly or hourly) income for GPs. A sudden increase in activity by all GPs to increase their incomes would be offset by a change in the fees for consultations. Extremely high earners would be scrutinised from time to time for fraud or overtreatment of patients.

GPs, like hospitals, would be covered by a system of audit to

maintain standards. Single-handed practitioners would get particular support through group visits and contact with other doctors as part of a commitment to shared audit. But there might also be some financial penalties for failure to join such schemes. The profession itself will develop this without such added pressure, on the lines already developed by the Royal College of General Practitioners (see chapter 2).

In the longer term I find it difficult to see clear reasons for continuing the separation of family practitioner committees from district health authorities. The arrangements in the NHS currently reflect a messy political compromise in 1948. With changing medical attitudes and increased interest in general practice among medical students, the time may be right in the coming years to begin increasing the powers of the health authorities to use a block grant system to plan and monitor general practice. This could begin to reduce the worst aspects of independence of the contractor while encouraging competition for health authority contracts. The introduction of salaried GPs using health authority facilities in some inner city areas might be one result. Again, the growing number of medical applicants for general practice might make this possible. It may also be hard for the medical profession to defend some of the more extreme results of independence when faced with the third term of a Conservative government committed to cutting down restrictive practices by all groups, whether white collar or blue collar workers.

The objective in any reform of payment for general practice must be to end the current situation where GPs often have little interest in the quality of premises or some aspects of their service because competition, planning and control are relatively weak. In my last neighbourhood, my GP's surgery was less comfortable than the local pub. I was not treated like a paying customer, but as someone fitted in at the organisation's convenience, usually by joining a queue at 8.00 in the morning. I approached the practice as a supplicant and not a customer, uncertain of what if any demands I could make. But when I took my prescription to one of the three local chemists, I became a customer again. If they could not fill the prescription when it suited me, I went elsewhere. The two elements of payment and ability to transfer are crucial to this change in

behaviour. Even if only a token payment is used, it might focus the minds of suppliers on the patient as a consumer with consumers' rights.

Paying for hospitals

Hospitals would receive a block grant for facilities and planned services, agreed with their local DHA. Funding would be calculated on the basis of about 75 per cent block grant and 25 per cent service-related payment linked to activity. This performance payment would probably start at a lower level and be phased in over several years. We know the level of work done by a hospital in previous years. From this we can estimate crudely the cost this year of providing a constant level of service. A limit on the level of growth in the budget each year would prevent the galloping inflation of the US health expenditure. Payment in this way is much closer to the NHI systems of other countries. However, since the ceiling on growth can be fixed in advance, there is no reason why it should not be used to reward some hospitals within a tax-funded system with an upper limit on real expenditure.

Clearly, the payments for additional cases would be based on some estimate of a reasonable level of performance. The least efficient hospital in the country would need to improve its performance in order to earn its target income. Failure to do so would undoubtedly cause a good deal of local concern. Indeed, a central problem for the health service is the difficulty of punishing poor performance without also punishing the local patients who rely on that service, whatever its faults. On the other hand, there are currently few incentives to improve the efficiency of hospitals and there is a case for offering incentives to the least efficient in an effort to make them improve their performance.

Each case type would be classified into one of three groups and each group would attract a fee per case treated, roughly equal to 25 per cent of its cost. The figure of 25 per cent is fairly arbitrary but comes close to the non-staff costs of hospitals. Many of the staff of a hospital are effectively an overhead cost, and much of the materials a cost directly linked to patient care. The intention is that the payment of a 25 per cent fee should go towards meeting the marginal costs of additional cases.

There would clearly need to be research to support the categories of patients and fees. There would be occasional changes of category – for example, if a treatment changed from inpatient to day patient – but I would be opposed to massive data collection and an attempt to cost everything that moves. As should be clear from chapter 3, the cost of a case in hospital depends on too many other factors to be reliably measured.

If a hospital treated the same number of cases as in previous years, it would earn the necessary 25 per cent of its income from these fees to raise its block grant income to the level needed to cover costs. If it exceeded its planned service level then it would get more, rewarding its extra efforts. Some hospitals would undoubtedly make a fuss about the categories, but unless a hospital had a very large number of an unusual type of case – for example, a minor surgical case which for technical reasons was very expensive to treat – the crude averaging should not be too much of a disadvantage to any hospital. Creating more data on each case type and its costs has often widened the range of arguments rather than resolved them.

Fees for the 25 per cent of costs would normally be paid by the district health authority from its tax or insurance fund allocation. For minor hospital admissions or outpatients, it might be possible in an insurance-style system for the individual to pay directly and receive an adjustment to the monthly deduction by the employer, or for employers to pay directly. For people in regular employment, any fee up to the monthly contributions could be handled fairly simply by this method, perhaps with some discount to encourage individuals and firms to minimise the work of the central bureaucracy.

As in primary care, there are elements of hospital care where patients accept low standards because they do not feel like consumers. One possibility would be to introduce a modest co-payment – that is, the part of the fee not met by the tax or insurance system to be paid by the patient. This would not be a major source of income for hospitals but would be intended to make the patient feel and act more like a consumer. For example, a payment of 20 per cent of the marginal fee would be equivalent to 5 per cent of the cost of hospitalisation – less than £10 per day in most hospitals and closer to £5 in some. This

co-payment could be limited to a maximum number of days so that the financial burden would be small, except for those on very low incomes. Its function would be to make people feel like consumers and begin to act like them in demanding choice and better standards, but also to think a little more about whether their visit is necessary. A large number of trivial attendances at accident departments might be thought about first if there was even a small fee.

Ideally, and optimistically, no one would be too poor to afford the low level of charges I envisage. Alternatively, social security payments or exemptions could be used to prevent a financial burden on low income families. We should not overlook the fact that long-stay patients currently have their social security benefits reduced and are the only ones to pay for some of their hospital care in the NHS. But I would prefer to see low incomes raised so that £5 a day was not a great burden, through, for example, additional sick pay for those with low incomes who are not covered by occupational sickness schemes. It is also possible to take out insurance against such payments under hospital income plans, but these are less likely to help those on low incomes.

One difficulty with co-payments is that many hospital patients would be likely to fall into exemption categories (because they were over 65, for example – though not all the elderly are without the means to pay such charges). For admissions beyond a few days we might find ways through social security to fund the payment on discharge, but I regard it as very important that the money pass through the patient's hands. Paying your way is an important feature of most aspects of life in market economies and charges are worth looking at further, even if we eventually abandon them in favour of free care. At the very least, a charging system might tighten up admission and discharge procedures in many hospitals to give a clearer idea of who was in hospital at any time.

Under a system which paid a fee to hospitals for each case treated, hospitals would not be allowed to discriminate against relatively costly patients within any category if they had the facilities to treat them. This practice, known as 'skimming', is a predictable response and one which is alleged to occur in profit-making hospitals in the USA. By choosing the simpler

cases a hospital can get the maximum fee for the minimum outlay. Since the fee income would only be a part of the payment to hospitals, the incentive to 'skim' would be reduced. But health authorities would need to be aware that if they contract with small public or private hospitals for simple waiting list surgery, they may need to run an emergency acute hospital that is half empty some of the time if they are to have a service that can cope with unpredictable peaks in activity. This will affect the block grant set for such hospitals and the savings from contracting out all the easy work are likely to be smaller as a result.

It is also worth noting here that 'skimming' probably occurs already in the NHS. Many hospitals have restricted the number of cases treated by some high cost specialties. Treating simpler cases to stay within a cash limit is an obvious response to the current financing of hospitals. Restrictions on particular patient numbers for dialysis, for example, are common and hospitals often negotiate over the price tag to accompany a particular transferred service. Debates between hospitals on who does what and for what financial return are more common in the NHS than we may like to think.

The funding arrangements proposed could mean that hospitals which increased activity by 10 per cent in a single year would earn an extra 2.5 per cent of their budget. Hospitals which fell in activity due to inefficiency in the delivery of services would suffer a financial penalty of a similar size. Neither change would be so large as to alter massively the way the hospital worked. The additional income would provide an incentive for better performance which does not currently exist. Hospitals would be allowed to keep any surpluses to fund developments. It is important that surpluses are generated since these are the incentive for efficiency. Fee funding might need to change, as a percentage of total costs, to ensure the right level of surplus which should be high enough to encourage growth but within the limit of acceptable growth rates.

The ability to earn extra income might also be a useful lever for the introduction of audit in hospitals. If the extra income was earned by departments rather than individual firms, they would have an incentive to improve coordination and overall activity. If an efficient surgeon sees a less effective colleague as

a limit on the development of the specialty rather than merely a silent partner, this might be a spur to greater interest in improving specialty performance rather than personal performance. Surplus income when additional work was performed also moves hospitals away from the restrictions of current attempts at clinical budgeting. These attempt to fix resources and workload for consultants, but the consultants have only limited control over workload. At present such budgets penalise extra work instead of rewarding it.

To prevent the disruption caused by unfunded pay awards, hospitals need to negotiate pay. They will need a national body to avoid being divided by effective trade union power in the professions. But again we need to escape the stranglehold of a single bureaucracy in which a hospital can be short of a particular group of staff, have the money to pay them the national rate or above, and yet be unable to get them. Hospitals function as teams, and without some members – for example, intensive care nurses – the whole team stops. When hospitals receive income in return for a part of their work, the flexibility to pay more to some key groups will begin to develop.

Paying for the care of the chronic sick

Care for the chronic sick suffers from several weaknesses. The first is that many long-term patients or clients are still housed in inadequate accommodation in long-stay hospitals. The second is that a large number of agencies are separately involved in care in the community. There is no clear responsibility on any one group or individual to shape the services into a mix that meets the client's needs. At least some of the problems have been solved for clients able to obtain social security, personal or family funding for residential care because they can now act more like consumers. However, the accidents of legislation which have increased social security funding and produced a boom in residential homes have a major disadvantage, that of institutionalising the elderly. For clients who wish to stay at home, there is a jumble of social security legislation to decide how much money they and their carers should receive. But this can be resolved primarily by financing rather than organising services. Growing old is the main cause of chronic problems,

and for those with enough money the home support can be found. We could similarly solve the problems of people in need of chronic care by giving them the resources to obtain it.

One appealing change in chronic care services is for a unified social security system to fund individuals according to their personal, family and environmental needs and resources. (This is not to deny that a lot of practical complications will make this a difficult task.) Individuals on low incomes should be given the financial support necessary to stay in their own homes even after the level of dependency that would at the moment require care in a residential facility because the cost of home care exceeded some guideline. The level at which the ceiling for home care would be set would rise over time in line with living standards. It is difficult to know at what figure to start the care for different groups of patients, but the current cost of residential care, met from social security, would provide a good deal of home care. This could be increased by funding from health and social services which currently provide services rather than the means to purchase them. It should be the client's choice whether to obtain meals-on-wheels or a microwave oven when conventional cooking becomes too much of a burden.

It is also important that when planning community care we get away from the idea that old people must move regularly to institutions offering more and more services as they grow more dependent. I would like to find a resting place in old age and, if the cost of staying at home is too high, know that once I had moved I would not have to move again. Canada has many examples of residential facilities that contain a few hospital services to help clients end their days with some of the benefits of modern medicine but without the need to be moved to a hospital. Too many people die in hospital, and we must find a funding system which re-emphasises the fact that old people are not chess pieces to be moved to the square which best suits those playing the funding game.

Local authorities and health authorities would be able to sell their services to the public or close them as other suppliers took their place. (A range of imaginative schemes can be found in the King's Fund Institute Briefing Paper No 3 (Hunter 1987).) Neighbourhood nursing agencies might develop around GP practices or separately on the lines proposed in the Cumberlege

report (DHSS 1986). GPs would prescribe some therapeutic nursing paid for by the national health insurance fund, and subject to the same audit, but the majority of general care and support would be funded through the social security payments. Since most chronic care is long term, it is possible to plan and set up the finances for an individual in line with their income and other characteristics and prevent low income families being unable to buy the services they wanted for any length of time.

I am particularly attracted by the idea of a care manager who is responsible for named clients and helps them get the mix of services they want. In many cases the effective care manager might be a family member, but a patch-based care management programme would still be appropriate, accepting that some clients would need little time from the care managers. There might also be scope for involving the local community in many areas by the use of local residents as part-time care managers, though it would be important to avoid problems of confidentiality in very small communities if the care manager was given access to too much personal information.

It is difficult to predict the cost of a universal benefit system for the old and those in need of continuing care for a chronic condition. In particular, since many new jobs would be created, it is difficult to assess the amount of money now paid to the unemployed which would switch to the care of the chronically ill. But even if we cannot give every patient all the home care he or she needs, we must have it as our goal to develop this focus of care further and faster with the resources to match its growth.

What are the objections to these proposals? They broadly fall under two familiar economic headings, equity and efficiency.

EQUITY AND NATIONAL HEALTH INSURANCE

A major concern among many critics of alternative methods of funding the health service is fairness or equity. It is argued that only a wholly free system with open access can protect the poor. Other systems which move away from progressive income tax as the main source of revenue are likely to discriminate against the poor.

Even in a scheme with 'insurance' in its title, national funding and universal coverage would eliminate the need to check benefit contributions and discriminate against patients at the time of treatment. (Some self-employed people may get services for nothing by avoiding their contributions but this is no different from tax evasion. Tax evaders are not currently refused hospital treatment.) When attending for treatment, rich and poor should receive the same service. In practice this does not happen now because of the ability of some to get a better service. This difference may be less if patients felt more like consumers, but this raises the question of the co-payment which poor people might be unable to find.

When looking at alternatives to the current funding of the NHS, we should look beyond its ideal to its current practice. While some low income groups obtain good care, others – for example, ethnic minority groups with limited spoken English – may obtain a poor service as there are relatively few interpreters in the NHS. Interpreters make it easier for some patients to use the NHS but the NHS has a cash limit and a backlog of demand. Attracting more patients is not a priority. If more patients meant more income for hospitals, this could provide an incentive to employ interpreters. Without such incentives, increasingly tight cash limits may lead to rationing in which the middle classes use their skills to get a better deal.

As noted above, the biggest difficulty for low income patients is any charge or co-payment. But some sort of charge is vital if patients are to feel like consumers, but it may be impossible to introduce without putting the poor at a disadvantage. The alternative is to rely on competition to generate a more customer-oriented service. This appears to have happened to a degree to maternity services in London where some women shop around for the style of delivery they prefer and some hospitals now advertise their services. It might be more prudent to experiment with competition and other changes before introducing charges for health care. And we should not expect too dramatic a change from competition. It will only work in the big cities where there are enough hospitals for effective competition.

In spite of their disadvantages, charges may help to make the service more customer responsive. I would like to see patients signing the bill to be sent to the DHA or insurance system to

agree that their treatment has been completed to their satisfaction before hospitals or GPs could claim. Better still would be a charge which patients could reclaim, in part or in full, from tax or insurance funds.

Geographical inequity would be dealt with by giving disadvantaged health authorities an increasing block grant, to be used flexibly to fund capital or revenue. Hospitals and other services would bid for an expansion of their service in return for a larger block grant. Districts currently well above their financial target might face a reduction in their block allocation but would retain the fee per case if they treated extra patients. This could offset some of the discouraging effects of continuing cutbacks and political fights to save wards from closure. Equality of funding, as defined by RAWP, would be gradually approached but those who lived in an area with efficient hospitals would get a better service. This happens now but the difference is that there is little incentive for relatively inefficient hospitals to improve their service.

EFFICIENCY AND NATIONAL HEALTH INSURANCE

The typical efficiency argument against insurance for health care is that since the consumer is ignorant of what is needed and does not bear much if any of the cost, exploitation by doctors will occur. More operations take place in America and some critics argue that this has more to do with money-making by doctors than illness among patients. Similar criticisms have been made of British dentists. However, the proposals above provide only an indirect incentive to overtreat hospital patients because doctors' incomes are not directly linked to activity. If the rate of growth of cases each year is limited to a maximum figure for each hospital it should be possible to prevent an explosion of 'unnecessary' surgery. Similarly, although general practitioners will have an incentive to increase the number of consultations for patients, a payment system which rewards courses of treatment rather than every consultation might encourage a good service with less scope for exploitation. Exploitation would also be limited by the pay review system.

Setting the fee to be paid to hospitals or GPs for any treatment is likely to cause many arguments about the right level of

fee for different types of work. As discussed in chapter 3, the urge to quantify in great detail has led to massive investment in information collection in the NHS. But there is a danger that in trying to set the exact fee for each piece of work, we overinvest in the data collection system. It seems surprising that the NHS is prepared to take on whatever work comes its way, given the way it is funded (the capitation system) and its cash limits, yet as soon as a fee per treatment is discussed, the exact fee for every different type of work is demanded. We should accept that perfect matching of costs and treatment will never happen in health care and instead settle for a broad banding of fees.

Inefficiency due to medical exploitation is often said to lead to a demand for extra operations. Under a system where hospitals would benefit rather than surgeons personally, and in a situation where current waiting lists are a major area of criticism, this seems less likely to be a problem. Wider use of audit would also help prevent unreasonably high levels of operating on patients who do not need an operation. However, we should not forget that, even without direct payment to surgeons, Britain did not escape the fashion for some surgical operations – delivering babies by Caesarean section for example.

In some parts of the country it would be possible for hospitals to compete for the block grant. For example, in London hospital capacity has fallen but expenditure is still well above the financial targets for the next five years. Under current NHS funding, every district will face reductions. We may already have enough closed wards in different hospitals, for part or all the year, to equal one or two whole hospital closures. Districts might find it easier to defend a decision to shop elsewhere when the financial implications of holding on to too many hospitals are clearer. Alternatively, hospitals which increase their workrate may be able to maintain services in spite of a falling block grant under reallocation. While competition could increase the efficiency of services in London, we might have to accept that in small towns the existing hospital will continue to be the main supplier of acute care. However, over the longer term, it would be more feasible for other hospitals or agencies to begin to provide some of the services and to break up the complete and sometimes inefficient monopoly of the main general hospital.

Medical and nursing manpower problems could limit the efficiency of some agencies. One solution is more coercion of staff; another is to find other means of improving services in less popular areas and making posts more attractive. Certainly this is a problem which the NHS has not fully resolved and it would be unfair to imply that it is a problem of insurance funding. As noted earlier, the agencies providing care will eventually have to have a greater say in what staff get paid and introduce skill and area flexibility if the service is to be staffed appropriately. As well as pay flexibility, contract flexibility will also need to develop so that, together with audit and earning power, the providing agencies can tackle inefficiency by terminating contracts.

The proposed workload, grant funding and limited charges would not turn patients into highly skilled consumers pursuing efficient suppliers. There will always be an imbalance of knowledge between professionals and patients, but I believe we can still restore a little of the feeling of being a consumer to the patient. It is sometimes possible for NHS patients to choose, for example, a quiet coastal hospital in winter for minor surgery to avoid the waiting list in the city. All I am seeking is to increase these kinds of opportunities and widen public awareness and choice. Choice will mean asking if something is appropriate rather than demanding it, but that is an improvement on current arrangements.

One danger, very visible in current NHS data collection, is that efficiency would measure throughput or activity but not quality. Health authorities would need to be sure that they were getting a good standard of care for their money. Making patients feel like consumers and a major investment in regular service audits should help this. A second difficulty is that there would be a good deal of political pressure on health authorities to buy services from their traditional suppliers. However, a growing feeling of consumerism and the threat of transfer elsewhere might do something to increase the pace of change. Hospitals which have two of everything might be forced to rationalise and use their resources more effectively. This might mean a loss of jobs in some parts of the country, but to criticise the proposals for this is to miss the point. Overall, if a change in funding led to more money for health care there would be

more rather than less health service jobs. Jobs lost in London, where other work can be found, may be the price we pay for a faster rate of job creation in the north of England.

Finally, the key question is what the various changes will cost. From what we know of other countries, we might guess that the cost of moving towards an insurance-based system, while retaining many of the cost controls we currently hold, could in the long term be several per cent of gross national product. But this increase in cost would take a long time and would be at a controlled rate of growth.

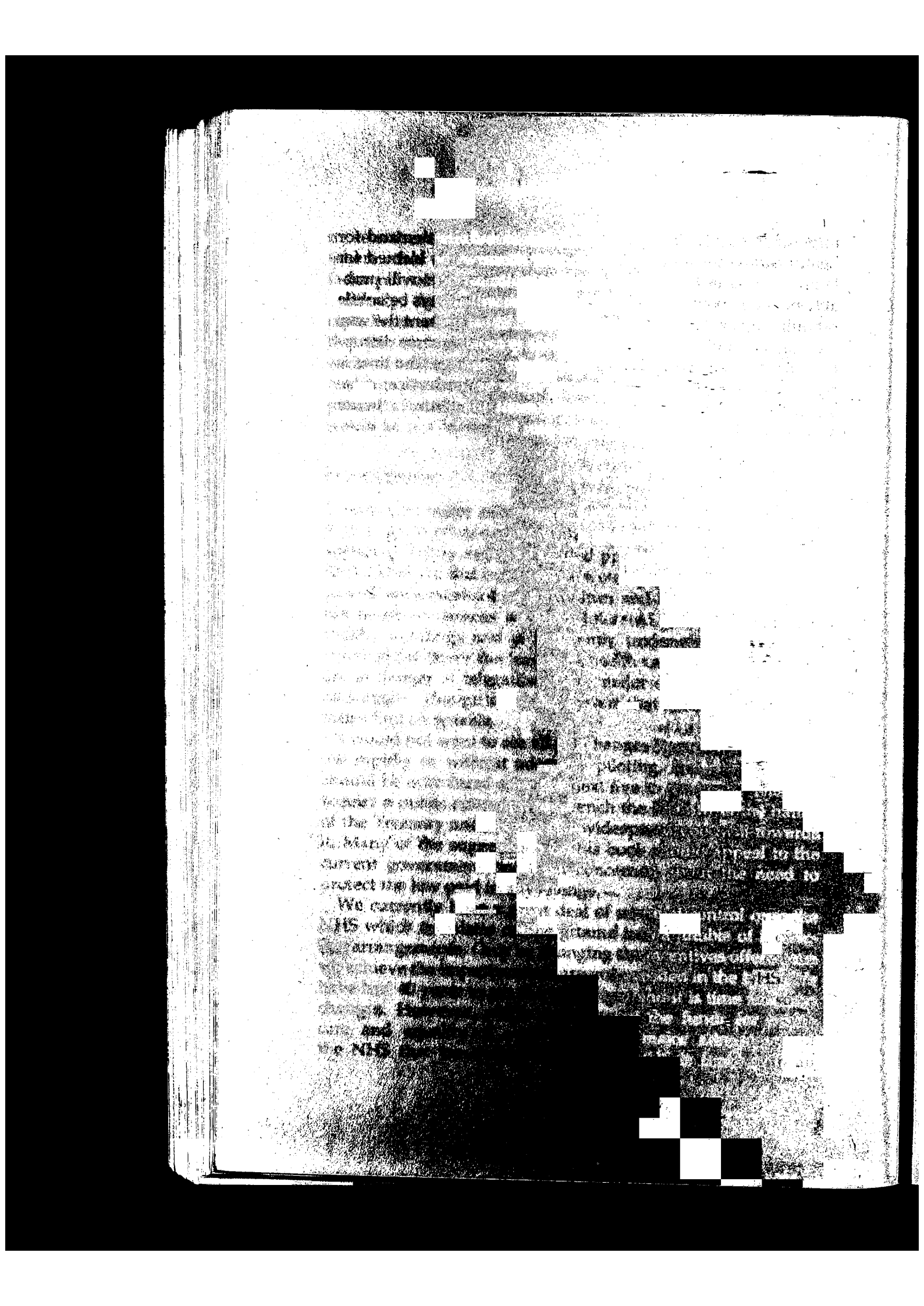
CONCLUSION

Overall, the major advantage of an insurance-based system is that it would release some of the goodwill towards health care spending that is currently bottled up by tax funding and cash limits. I believe that most people would prefer a growing health service with more job opportunities and higher standards. In the name of fairness we have tolerated an NHS which has shabby buildings and is frequently under-staffed. We have fallen so far down the league of health care spenders that we are in danger of relegation. Only major change will bring us back again – change towards a system that other liberal democracies find acceptable.

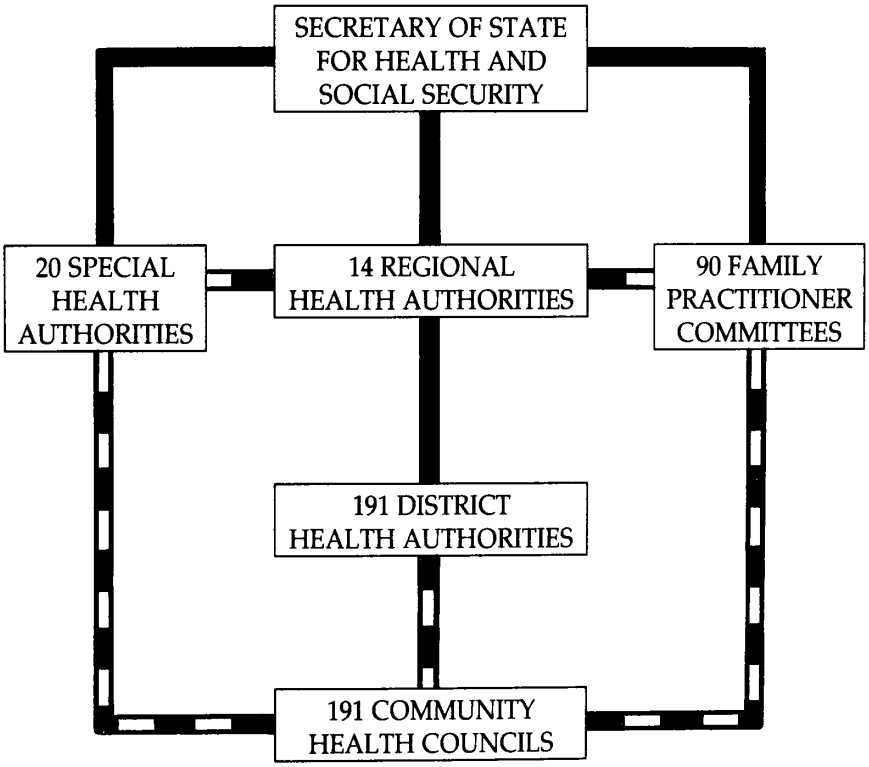
I would not want to see all the changes I propose introduced too rapidly or without adequate piloting. But I believe they should be introduced over the next five to ten years. This will require a public campaign to wrench the NHS from the hands of the Treasury and liberate the widespread goodwill towards it. Many of the suggestions in this book should appeal to the current government but I am concerned about the need to protect the low paid in any change.

We currently have a great deal of nominal control over the NHS which translates on the ground into a jumble of ineffective arrangements. Only by changing the incentives offered can we achieve the improvements urgently needed in the NHS. We have had 40 years to get the NHS right and it is time for some changes. However, public collection of the funds for health care and equality of access are two major advantages of the NHS that we should retain. The NHS is faced with an

impossible task. It is expected to treat an infinite demand for health care with finite resources, and it cannot be blamed for failing in this task. Explicit rationing of its services will probably never be politically feasible and there will always be subtle rationing by doctors and other care staff. But at present the way we organise and pay the health service is causing more disruption than advantage in many parts of the country. The time is ripe for some changes: more money for a better service; more incentives to achieve it; and more audit to ensure a better service is delivered.



The National Health Service in England



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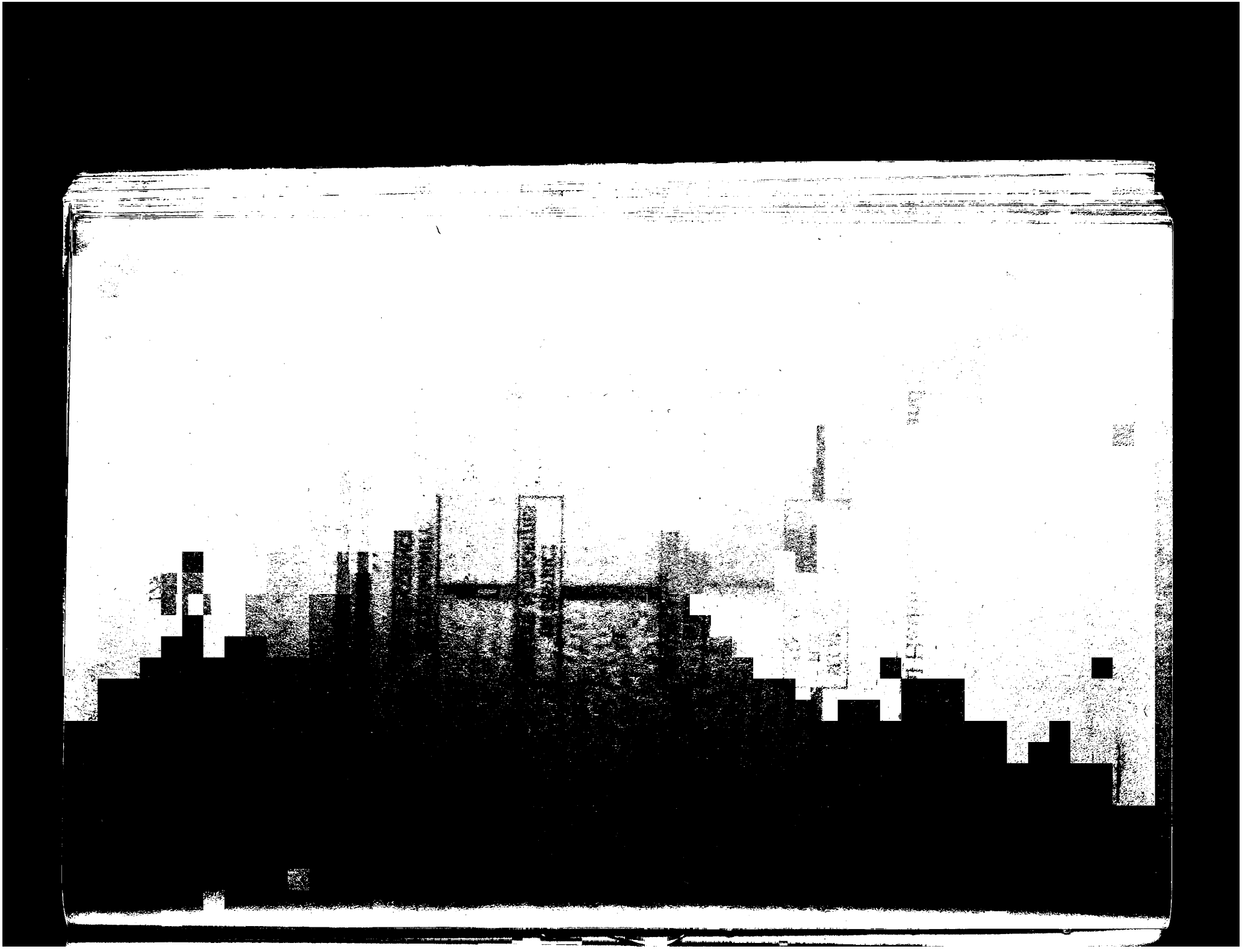

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UNDERSTANDING THE NHS:
A Question of Incentives

Peter A West

The NHS is a vast and complex organisation, never out of the public eye and now the focus of major political argument. Peter West examines the way the NHS works and the incentives that motivate everyone concerned – the general public, the health professionals and managers, and the government. There are too many perverse incentives in the NHS (the fact that hospitals which treat more patients receive no additional cash and risk overspending, for example) and the final chapter proposes a new structure with different incentives which would make the NHS more flexible and more responsive to its users. A new system would have its costs, compared to the current tight control by the Treasury, but the costs are arguably worth bearing if a better service results.

The book, an honest look at what makes the service tick, should interest the general public as well as health service staff. It was written while the author was a Fellow of the King's Fund College, London. He is now a management consultant.

Peter West trained as an economist at York University and has spent 17 years working on, in and with the health service. He is the joint author of a standard textbook on health economics and has written numerous research and consultancy papers on the NHS. He has also been a regular TV and radio commentator on the funding crisis in the NHS.

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