King's Fund

Health Care UK 1995/96

An annual review of health care policy

demographic shift

community care

trust governance

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Health Care UK 1995/96

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An annual review of health care policy

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Health Policy Review 1995/96

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Part I

Main Events

In 1991, the first King's Fund Review of Health Policy focused on the implementation of the National Health Service and Community Care Act 1990. Strictly, it was the start of that process: the community care provisions were delayed for two years, while it was envisaged at the time that the process of Trust creation as well as the development of GP fundholding would be a gradual one. The district level of purchasing was created 'at a stroke' but in the first year they were enjoined by the NHS Executive to maintain a 'steady state' so no immediate changes were made here either.

Each year since, successive Reviews have recorded the stages by which the 'new' NHS has been developed through successive waves of trust creation and GP fundholding. These, along with the other main elements of the Government's health policy, *The Patient's Charter* and *The Health of the Nation* initiative and, when the relevant provisions began to take effect, Community Care, have provided the structure for our commentary. These make up three of the four so-called strategic policies set out in the 1996/97 Planning and Priorities Guidance for the NHS set out in the Box overleaf.

However, the emphasis apparent in the early 1990s on changes to the structure of the NHS has disappeared. In the words of the Guidance, there is a need:

> *to shift the focus away from questions of organisational structure to improving health and the quality of care.*

The development of GP fundholding no longer appears in its own right but as part of the fourth strategic objective – the promotion of 'a primary care led NHS' – designed to ensure that 'decisions are taken as close to patients as possible.'

The definition of a primary-care-led NHS has changed over the years. In the 1994/95 planning guidelines it appeared in the form of a general statement that:

> *Primary health care will have a major role in delivering the objectives set out earlier.*

Subsequently, it appeared in a different form. In the 1995/96 guidelines the emphasis was on institutional change – the extension of GP fundholding and the creation of the new health authorities, as well as co-operative relationships between these and GPs. In the 1996/97 guidelines, its scope was broadened yet further:

> *There should be demonstrable progress in developing partnerships between health authorities and GPs, particularly through implementation of the national framework for GP fundholder accountability and development programmes for primary health care teams and health authority staff.*
>
> *Each Health Authority should have secured agreement to a local strategy for health and service improvement reflecting the objectives of The Health of the Nation, developed in partnership with GPs locally, other agencies and through consultation with local people.*

NHS Strategic Priorities

The Health of the Nation remains the central plank of government policy for the NHS and forms the main context for NHS planning for 1996/97. It provides a strategic approach to improving the overall health of the population, setting targets for improving health in five Key Areas and emphasising disease prevention and health promotion. Much progress has been achieved both in embedding *The Health of the Nation* within the NHS and pursuing its objectives across the community in partnership with other agencies, but much more remains to be done.

Three other strategic Government policies remain of central importance to the NHS, as vehicles for delivering the NHS purpose and for obtaining the benefits of greater equity, efficiency and responsiveness:

Community Care (Caring for People): The Community Care reforms aim to allow vulnerable people to live as independently as possible in their own homes or in a homely setting in the community. The emphasis is on releasing resources from institutional care to fund more flexible and appropriate care for patients within their local community.

Patient's Charter: The *Patient's Charter* initiative aims to put patients first, providing services which meet clearly defined national and local standards and responding to people's views and needs.

A Primary-Care-Led NHS: In a primary-care-led NHS decisions about health care are taken as close to patients as possible, with a greater voice for patients and their carers in such decisions. To achieve this, GPs and their teams are being given a wider scope of influence in the purchasing and provision of health care, within agreed public health priorities.

Source: *1996/97 Planning and Priorities Guidance for the NHS*

> *There should be measurable progress in reshaping traditional patterns of service to achieve an appropriate balance between hospital and community provision, reflecting both patients' preference to be treated at home or in their own community, and the need for certain services to be concentrated to secure effective clinical outcomes.*
>
> *Each Health Authority should have demonstrated a significant increase in the numbers of GPs directly involved in purchasing, particularly through the expanded fundholding options.*

This definition encompasses themes already covered in the Review. One new theme to emerge over the period is that of clinical effectiveness. Although it does not feature as one of the four strategic policies, it appears as one of six medium-term priorities:

> *Improve the cost effectiveness of services throughout the NHS, and thereby secure the greatest health gain from the resources available, through formulating decisions on the basis of appropriate evidence about clinical effectiveness.*

In a lecture given at the Harvard Medical School in May 1995, the then Secretary of State, Virginia Bottomley, made knowledge-based care, a term often used interchangeably with clinical effectiveness, the fourth element of her health policy, with the triumphant but justified words:

> *This is a pioneering programme. I am not aware of anything as comprehensive or as advanced anywhere else in the world. (p 9)*

The antecedents of this development can be traced back to the end of the 1980s when a House of Lords committee reported on medical research. Subsequently the publication in 1993 of *Research for Health* laid the foundations for an NHS Research and Development policy designed to produce knowledge directly relevant to the work of the NHS.

As the Secretary of State pointed out in her Harvard lecture, it is not just a matter of commissioning new research: it is also a matter of making use of what already exists and that entails not only assessing the evidence, but also disseminating the results of that assessment and hence in turn influencing practice. In all these areas measures have been taken in previous years but during 1995/96 the theme emerged ever more strongly. Policy developments relating to all these stages therefore now enjoy a section of their own in the first part of the Review.

The second part of the review follows the established pattern, looking in turn at efficiency and finance, equity and accountability.

1.1 Creating the new NHS

Although changes in organisational structure may no longer appear as one of the NHS' main priorities, the process of transforming the 'old' NHS continued during 1995/96. The year saw the virtual completion of the transmutation, begun in 1991, of provider units into trusts. Long before this process was complete, however, its conclusion was already anticipated. The alternative regime – the directly managed unit – was never a rival, once the process of gaining trust status took off in the second wave of trust creation which took effect in April 1992.

But while the trust regime is now virtually universal, the structure of the trusts themselves, in terms of the range of services they comprise, varies. The working paper which originally set out the nature of trust status was concerned mainly with organisational issues rather than with groups of services. It was only later that a decision was taken to support the separation of community from hospital services. Consequently, the service structure of trusts reflects a variety of local and specific factors rather than a clear view of what would be most effective.

In service terms, the structure of NHS providers of hospital and community services is diverse. There are just over 100 'pure' acute hospital trusts, about 30 'pure' ambulance trusts and a smaller number of 'pure' mental illness and learning disability trusts, plus a handful of stand-alone tertiary centres. The majority comprise different combinations of these elements. Furthermore they vary considerably in size. While some city hospital trusts have turnovers in excess of £200 million, there are 20 with less than £10 million, with the rest strung out between these extremes: see Table 1.

Table 1 Trust budget sizes

Range (£m)	No.
0-10	20
10-20	50
20-30	60
30-40	62
40-50	53
50-60	57
60-70	32
70-80	20
80-90	19
90-100	12
100-150	27
150-200	4
200+	3

Source: *NHS Executive, Management Costs in NHS Trusts 1994-95*

On the purchaser side, the process of transformation continues and is far from complete. Health authority purchasers were created overnight and closely reflected the original district structure. Since then, there have been a large number of mergers and also changes of boundary. As a result, the structure of district purchasing, in terms of the populations and budgets for which they are responsible varies considerably: see Table 2.

The range here is not as large, in proportionate terms, as for trusts, and the role of district purchasers is virtually identical from area to area. But the spread of fundholding has created diversity in terms both of budget and role. The smallest, community fundholders, may control only a few thousand pounds and a

Table 2 Health authority population and budget sizes

Population	**No.**	**%**
800,000 and above	4	3.7
700,000 - 799,999	6	5.6
600,000 - 699,999	9	8.4
500,000 - 599,999	18	16.8
400,000 - 499,999	23	22.4
300,000 - 399,999	19	17.8
200,000 - 299,999	21	19.6
Below 200,000	6	5.6

Budget (£m)	**No.**	**%**
350 and above	2	2
200-349	4	3.9
250-399	10	9.8
200-249	18	17.6
150-199	23	22.5
100-149	27	26.5
Below 100	18	17.6

Source: *Health Services Yearbook 1995*

narrow range of service: at the other end of the scale, the largest district purchaser buys the full range of health care and spends several hundred million pounds.

Like trust creation, the development of GP fundholding began on a small scale but rapidly gained momentum. At the beginning of April 1995, the number of patients within fundholding practices rose to about two out of five. In August 1995, the sixth wave of fundholders was announced. According to Gerry Malone, Minister for Health:

> *The number of applications to join the GP fundholding scheme has been the highest ever. Applications were received from over 3,000 GPs in more than 1,200 practices, serving 12 per cent of the population. (PR95/417)*

As from April 1996, the number of patients in fundholding practices rose to one in two. The proportion varies considerably from one part of the country to another, from 4 per cent in Camden and Islington to 84 per cent in Derbyshire, Kingston and Richmond and the Isle of Wight.

However, many of the new fundholders – about 35 per cent – came into the community category which only offers control over a limited range of services: staff, drugs and most community health services but not acute hospital treatments: see Table 3.

On the other hand, the range of standard fundholding was extended to include smaller practices. Furthermore, towards the end of 1995, the Government announced that a number of

Table 3 Applications for the sixth wave of fundholding

	Standard Fundholding		**Community Fundholding**	
Region	**Funds**	**Populations Served (%)**	**Funds**	**Populations Served (%)**
Northern & Yorkshire	85	9	65	5
Trent	35	5	48	5
Anglia & Oxford	48	7	22	2.5
North Thames	153	12	33	2
South Thames	74	8	21	1
South & West	78	9	53	5
West Midlands	72	9	23	2
North West	100	11	106	7.5
Total	645	9	371	4

Source: *Regional offices*

practices, originally around 50 but later raised to about 60, would pilot total fundholding, ie these practices would become responsible for the full range of hospital and community health services. Unlike the early stages of fundholding, it also announced that the pilot would be evaluated in a two-year research programme – subsequently increased to three – covering all the sites and a further wave of about 35 sites was announced in March 1996.

Another experiment was announced in July 1995: six fundholding practices are to pilot the purchasing of maternity services, hitherto excluded from the standard purchasing scheme. In February 1996 yet another variant was announced in relation to mental health. Standard fundholders purchase community mental health and outpatient services and, as from 1 April 1996, day attendances as well. The experiment extends their role to inpatient services: comprising 27 practices, it will be evaluated over a two-year period. In April 1996 it was announced that 28 fundholding practices were to test the possibility of buying the services of osteopaths and chiropractors.

Over and above the differences arising from the scope of GP fundholding, a range of structures are developing involving varying degrees of co-operation between practices. These developments largely reflect local initiatives rather than central policy directives. In some cases fundholders are entering into purchasing consortia with districts to buy high cost treatments such as CABG, partly to increase bargaining power, partly because in this way they can reduce fluctuations in the demands placed on their budgets. In other cases, fundholders are forming groups – multi-practice funds, consortia and multi-funds – which have different legal structures and imply different degrees of co-operation and integration.

Furthermore, in areas where fundholding is less developed, many district purchasers have created structures within which GPs are consulted about purchasing priorities. These developments confirm the expectation, expressed in the 1994/95 Review, that the structure of purchasing will vary from one part of the country to another.

In *Purchaser Plurality in UK Health Care* (King's Fund forthcoming) Nicholas Mays and Jennifer Dixon suggest that:

> *Each district now has its near unique blend of purchasing carried out by the health authority at district level, by standard fundholders and community fundholders, by multi-funds and other constellations of fundholding practices, through locality commissioning organisations and GP commissioning below the district level on behalf of non-fundholder and sometimes standard fundholder patients and, now, increasingly through the pilot extensions of standard fundholders and the total purchasing initiative which is expanding rapidly both through the national scheme organised by the NHS, and through a number of local experiments. In each district, the number of schemes, their share of the population and range of services purchased varies and, so too, do the levels of transaction costs generated for the health authorities and providers.*

This growing complexity is expensive to manage. As Nick Goodwin notes below, the emergence of a large number of small purchasers imposes costs on providers, in addition to those already arising from their dealings with district purchasers. The result has been an increase in the number of managers and others not engaged in frontline care. As noted last year, how much of the increase apparent in NHS workforce figures is real and how much results from changes in definition is hard to say. Nevertheless the Government launched what it described as a blitz on paperwork in November 1995, setting up a scrutiny team 'to take a rigorous look at bureaucracy in NHS trusts and health authorities' with the following terms of reference:

- identify achievable reductions in the administrative burdens associated with the work of NHS Trusts and health authorities, and recommend action which will eliminate unnecessary bureaucracy, consistent with the objective of improving the efficiency, effectiveness and responsiveness of patient services;

- examine the traffic in guidance and information that flows between the Department of Health (including the NHS Executive and Regional Health Authorities), and Trusts and health authorities, and make recommendations that will reduce the burden on the NHS while retaining the information necessary for effective management of the service.

This followed a report from the efficiency scrutiny into general practice, which began in late 1994 and reported in full in July 1995. Its final report contained 65 recommendations which in themselves will require a considerable bureaucratic effort to implement. In October the Government announced a series of measures to reduce the costs of running the new arrangements bearing on both purchasers and providers:

- health authority administration costs to be cut by 5 cent in cash terms in 1996/97;
- trusts to be required to publish figures showing their total spending on management and non-clinical administration. These figures also to be cut by 5 per cent in cash terms. The total to be cut includes the salaries of all managers, excluding those who are primarily clinicians, earning over £20,000 a year, those in a few specified posts regardless of salary, the salaries of all other staff working in corporate functions and the cost of management consultancy;
- reduction in the number of forms to be completed by GPs. In July, the Secretary of State claimed that as from April 1996, 15 million forms could be torn up following from a report *Patients not Paper*, the efficiency scrutiny set up at the end of 1994;
- fundholders to be allowed to use savings in administrative cost allowances for patient care;
- an efficiency scrutiny to take effect on paperwork in hospitals and health authorities.

Speaking to the Trust Federation Conference in September, the Secretary of State argued that:

> *Over the past ten years we have been through a phase of building up the management function, correcting a historical problem that the NHS did not devote enough resources to proper and disciplined management and to deciding its priorities.*
>
> *What we must now do is to tighten up the management function. That means insisting that managers themselves are subject to the same pressure to improve efficiency as they, quite rightly, impose on others in the health service.*
>
> *It also means looking critically at the process of management, and tightening that up. It is not enough simply to reduce the number of managers without addressing the question of whether the processes of management are as efficient as they can be.* (PR 95/437)

While these phrases are unexceptionable, what they actually mean in terms of reducing jobs is hard to determine. Underlying both the Government measures and the Federation's proposals lies a lack of knowledge on both sides of what management should cost. A report from the Audit Commission, *A Price on Their Heads: measuring management costs in NHS Trusts* published in June 1995 showed that overall management costs account for only 4 per cent of the NHS budget but there are considerable variations round this figure.

Some differences are readily explained: for example, very small trusts tend to have a high proportion of management costs since some, such as the cost of chief executives and other senior officers, are 'indivisible'. The same is true of purchasing by fundholders but in neither case can it be presumed that high costs represent inefficiency. The Audit Commission in its review of fundholding suggested that more rather than less management was required if its potential benefits were to be realised.

However, both Government and trusts are agreed that the burden of bureaucracy could be reduced. The NHS Trust Federation concluded on the basis of a survey of its members:

> *Our findings demonstrate just how much work still needs to be done to relieve Trusts of some of the mountain of red tape they have to labour under. We have welcomed the Secretary of State's declared intentions to reduce bureaucracy, but have made it clear that this can only be achieved by first reducing the increasing administrative burdens placed upon Trusts.* (PR 11 Jan 1996)

Some of these so-called burdens rise from the continuation of controls, eg over medical staffing, which it might be imagined, wrongly, the creation of trust status was designed to remove. Others arise from the new NHS itself, in particular the contracting process which trusts in particular are beginning to find onerous.

The Trust Federation put out a set of guidelines for NHS contracting designed to make the process of agreeing and implementing contracts simpler. Too detailed to set out here, their central theme is the desirability of purchasers and providers working collaboratively, both in relation to long-term planning and to day-to-day sharing of information.

One of the iron laws of bureaucracy, best represented in Parkinson's observation that as the size of the navy declines, so does the number of admirals rise, is that when cut backs are made, the periphery suffers while the centre is spared. The 'new' NHS however has showed itself in this respect to be genuinely innovatory: with the abolition of Regions and slimming down of the Department of Health and the NHS Executive, cost savings of some £200 million in 1997/98 are expected to ensue. Whether they will or not, taking the NHS as a whole, is another matter since many of the functions which Regions performed must continue to be done. For example, in the past, NHS Regions played an important role in supporting regional level specialties. That role has still to be carried out.

In January 1996, a new organisation was announced to advise on the purchasing of specialised services – the National Specialist Commissioning Advisory Group – whose task it is to:

> *advise the Secretary of State, through the NHS Executive Board, on:*
>
> *a) the identification and funding of services under the supra-regional services arrangements;*
>
> *b) the identification and funding of specialised services not qualifying for supra-regional service designation, but where there is economic and/or clinical justification for contracting centrally for their delivery;*
>
> *c) the commissioning of purchaser guidelines for specialised services where purchasing is best arranged through local purchasers by means of lead purchaser or purchaser consortium arrangements;*
>
> *d) funding the service costs of new developments, in those services for which it is likely to become the purchaser, to enable full evaluation to take place.* (PR 96/20)

In the case of cancer care the Government began implementing the recommendations of its expert committee which set out a national framework for the service which entailed a division of roles between hospitals to allow specialisation between them. This top-down approach may be a better way of proceeding than allowing each region to make an independent review of what the pattern should be and hence there may be a genuine cost saving. But in other fields former regional functions will have to be replaced in ways which may prove more expensive, eg those relating to information and analysis of trends and other developments significant for service planning.

The measures designed to reduce the costs of the Department of Health and the NHS

Executive were described last year but because they involved the abolition of regional health authorities, which required legislation, they did not formally come into effect until April 1996. At the same time, the 'new' health authorities, which combined the functions of districts and FHSAs, were also formally created. Thus in terms of structure, a comparison of the situation in April 1996 with that six years earlier, reveals what can only be described as a transformation. But to what effect?

From the Government's viewpoint, the rapid emergence of a new pattern of provision and purchasing would seem to count as a success. According to Gerry Malone, investment in trusts has produced a massive return on the considerable investment made in them – the direct costs are said to amount to £109 million.

> *The creation of NHS Trusts has been a huge organisational change that has brought very tangible benefits to patients. Trusts are now treating more patients - over 20 per cent more than before the NHS reforms, they are treating them faster and they are treating them to ever higher standards of care.* (PR 95/223)

On the purchasing side, Ministers have said little about the performance of district purchasers but have continued to emphasise the advantages of fundholding:

> *Fundholding is one of the great success stories of the new NHS. As independent studies have consistently shown, fundholding allows those who best know their patient's need to manage resources most effectively in order to meet those needs. It brings about improvements in the quality of patient care and enables services to be provided in the community, closer to the patient.* (PR 95/254)

Last year's review suggested that the 'new' NHS is best seen as a command rather than a market system, driven by centrally determined requirements for efficiency gains, set at 3 per cent for the current year, and for reductions in waiting times. Of the six baseline requirements for purchasers set out in the Priorities and Planning Guidance, four are concerned with these and three of the four are concerned with activity levels. Not surprisingly, therefore, Tom Sackville, Parliamentary Secretary at the Department of Health, yet again greeted the latest issue of *Hospital Episode Statistics* in May 1995 as a sign that the 'NHS is forging ahead, carrying out more operations and improving the lives of ever more patients.' (PR 95/226).

At the same time, Ministers were also able to claim that waiting times had continued to fall. In July 1995, the Minister for Health announced that while total numbers waiting had fallen slightly, the numbers waiting for more than a year had fallen dramatically. As a result, the average time waiting had fallen sharply. Furthermore, for the first time detailed information about waiting times for first outpatient referrals became available in August. This revealed that 95 per cent of people in the first quarter of 1995 had been seen within 26 weeks and 82 per cent within 13 weeks.

There is little doubt that the pressure to improve performance in terms both of activity and waiting times has been centrally driven, through the requirements placed on purchasers to extract efficiency gains from providers and through the waiting times initiative with its earmarked funds targeted on reducing long waits.

None of the six baseline requirements within the 1996/97 Priorities and Planning Guidance concern use of the new structure of the NHS to promote efficiency gains, eg through competitive tendering. Evidence of market behaviour among district level purchasers is very limited. *Testing the Market*, a NAHAT report on the tendering of clinical services by purchasers, found only a small number of examples of such services being put out to tender. The reasons reported in the NAHAT paper for this slow growth in tendering for clinical services are also unsurprising:

- the process is time-consuming and expensive in terms of management time;
- access issues often rule out competition;

- change could be pursued in other ways;
- co-operative working was productive, but that involved commitment and stability. Purchasers did not have the clinical knowledge to challenge providers.

The report goes on to cite evidence that most purchasers and trusts were seeking guidance as to how to proceed, in several areas:

> *Most health authorities and Trusts felt that there was a need for central guidance on the 'rules of engagement' in market testing. While some districts saw a need for fairly detailed guidance on all aspects of the tendering process, most were keen for more general support on specific issues and some pointers on the basic ground rules for tendering. No authority or provider wanted overly-prescriptive directives about market testing. (p20)*

A number of specific suggestions were made, including:

- *basic standards to include in specifications*
- *financial arrangements (including an indication of the proportion of any one provider's income that could be put at risk by a single tendering exercise)*
- *ground rules on the consistent and fair application of tendering*
- *a 'dos and don'ts' checklist*
- *a good practice guide on the use and application of evaluation criteria*
- *legal aspects of tendering (particularly concerning contracts with the private sector).* (p20)

The striking thing about these items is how elementary they are. It is rather surprising to find points of this kind being raised some four years after purchasing was introduced. It is less surprising to find that:

> *The issue of independent medical advice is an important one, which was raised by a number of authorities when asked about problems they had experienced with tendering. The complaint by purchasers that providers tend to have (or at least, are perceived to have) a monopoly on clinical knowledge is not uncommon and it is not restricted to the market testing process.* (p21)

The need for purchasers to be well informed in clinical terms was recognised from the start of the new NHS. A series of central purchasing initiatives, eight in all, were announced in 1991, which were designed to assist in the process of determining priorities and value for money but their impact appears to be limited. The NHS report from 1994/95 sets out several key issues in respect of the development of effective purchasing, but no achievements. Similarly it is clear from the NAHAT report that the impact of purchasing has been disappointing. It provides little evidence that district purchasers have been able to assert themselves over the way that the resources placed at their disposal are used.

Not surprisingly, the overall conclusion of the Policy Institute study of the impact of the reforms *(The Working for Patients Reforms: a balance sheet),* in relation to district purchasing runs as follows:

> *If the purpose of the 1990 Act was for health authorities to assess the health needs of the population and to purchase services to meet those needs, existing research does little to determine whether these original aims are being met.*

In contrast, as noted last year, GP fundholders have been able to demonstrate achievements to the satisfaction of both academic researchers and the National Audit Office. But whether the achievements justify the costs incurred in bringing them about is another matter. Asked to justify the costs of introducing fundholding – £99 million for management allowances up to end of 1993/94 – the NHS chief executive was hard put to do so when cross-examined by the Public Accounts Committee. (27 February 1995)

> *But those [the £99m] are public resources that could have been used to treat patients are they not?*
>
> *[Mr Langlands] They are, but the improvements in the drugs bill are the reverse side of the coin.*

Unfortunately, it is not clear what the improvements in the drugs bill are. Mr Langlands managed to suggest a level of savings without actually doing so:

> *You list a number of kinds of improvements in patient health care that you get from fundholding, for example, waiting times, better consultation, lower bills for drugs and so forth. In which area has there been the greatest improvement? I know it is bound to be rather impressive but which area has been the biggest source of improvement?*
>
> *[Mr. Langlands] It is very difficult to be precise but just in monetary terms a 1 per cent improvement on the drugs bill represents a £30 million saving for the NHS. That has to be significant. The other issues, as the Chairman suggested at the beginning, are less easy to measure. I am sure, in terms of patient benefits, reduced waiting times and the broader range of services that are now provided in general practice represent the biggest gain.*

Although the Government did not set up any research to monitor the impact of fundholding, a large number of studies have appeared which bear on particular aspects of it. As Nick Goodwin shows below, much of this evidence is unreliable or hard to interpret. Where fundholders have achieved worthwhile changes, it is hard to be confident that the benefits stem from fundholding or from the nature of fundholding practices. In other words, the perceived benefits may simply reflect the fact that many of the more innovative GPs became fundholders.

Furthermore, in some cases, non-fundholders have been able to match or exceed the achievements of fundholders. Goodwin concludes that:

> *The nature of the evidence on GP fundholding leads to the conclusion that both a robust defence of, and a vitriolic attack on, the scheme are possible.*

He goes on to argue that:

> *The evidence to assess the true impact on transaction costs, equity and quality of case is very poor.*

The Audit Commission's review of fundholding, *What the Doctor Ordered*, confirms these sceptical conclusions. While it acknowledges that there are genuine achievements, most practices achieve very little. It found that while a few had achieved a great deal, most had realised only a fraction of the benefits potentially available.

In response to the report, the Secretary of State suggested that:

> *If the rest were as good as the best there would be huge benefits to patients.* (The Times 22 May 1995)

Unfortunately there is no reason to assume that any such levelling-up process can actually be achieved. Studies of comparative efficiency in any activity invariably show wide and persistent variations between the best and the worst reflecting differences in ability and motivation, which are likely to resist attempts to eliminate them.

The fundholding scheme has attracted more research than any other aspects of the new NHS. There has been very little research on health authorities as purchasers. Consequently, it is not possible to come to a firm conclusion as to their impact. Overall, the Institute study concludes:

> *It appears that developments in purchasing have allowed the support mechanisms for improving health to be put in place but the evidence has yet to show whether this*

> *improvement has actually occurred or not. More importantly, if the structures that were put in place have had a positive impact on both the service and the health of the population, it is not clear from the evidence reviewed here whether the heart of the reforms – the internal market – is still required to maintain the most beneficial effects especially since we have a service increasingly dominated by the centre with a rising number of 'top down' demands.*

A judgement on provider trusts proves just as difficult to reach. The original expectations were that giving trusts a greater range of freedoms would lead to:

- a stronger sense of local ownership and pride
- encouragement of local initiative
- an increase in choice
- greater competition
- improved quality of service
- increased efficiency.

In the event, trusts have not achieved the freedoms originally envisaged. As noted below, local pay bargaining is not yet fully established and access to capital, never freed up anyway, has become more rather than less complicated through the imposition of the Private Finance Initiative. Inevitably therefore, trusts have gained only limited freedom in relation to their external environment: on the other hand, they have enjoyed greater freedom to manage their internal affairs.

The volume of evidence bearing on the hoped-for benefits is extremely limited. Again, no central research was commissioned, and, as with health authorities, there has been virtually no independent research either. Studies of the first wave trusts suggested that in some respects they performed better than what were then directly managed units, but again this could arise from 'self-selection rather than trust status'. On the other hand, the Clinical Standards Advisory Group report, *Urgent and Emergency Admissions to Hospital*, found that trusts admitted patients slightly more slowly than directly managed units. But there is little reason to infer from the report that this difference arose because of differences in status. Those now managing trusts appear to prefer their present status since they undoubtedly do enjoy greater freedom to determine their internal policies than they previously did and they would clearly like more. But it is not possible, on the basis of the evidence available, to relate such perceptions to the original aims of the reforms.

It would be wrong to infer from these agnostic conclusions that anyone would wish to go back to the old NHS: even the Government's sternest critics do not want a total reversal. The Government itself appears unwilling to envisage any further structural change, arguing that the reforms are 'complete': whether that is justified is considered in Part 3.

London

In May 1995, the Government won the vote in the House of Commons against the opposition of some of its own backbenchers in support of its proposals for the closure of some of London hospitals. In the following month, Marmaduke Hussey, chairman of the London Commission established by the King's Fund whose report, published in 1992, had supported hospital closures, announced that the Commission would be reconvened:

> *Much has happened in the last three years and it is time to have another look, as before, with a long term perspective.*

The second London Commission formally began work in December 1995 and is due to report in Spring 1997.

In fact, many of the changes suggested by the Tomlinson Committee have yet to occur and some appear unlikely to take place: for example, the pattern of rationalisation of cardiac services is unlikely to follow the pattern proposed in the

Committee's report, but it looks as though a similar reduction in the number of centres will emerge. The closure of whole hospitals however still remains on the horizon. While Bart's has lost its A & E department, it has not yet closed for other services.

Almost at the same time that the King's Fund's announcement was made, Gerald Malone, the Minister for Health, said, at a primary care conference organised by the Lambeth, Southwark and Lewisham Health Commission, that:

> *We now have a policy that has put an end to uncertainty. It sets a clear strategic direction for London's health service – a better balanced service, not one dominated by large acute hospitals.* (PR 95/285)

The Minister's confidence rested largely on the belief that primary and community health care services required improvement, irrespective of the impact of such improvement on the demands for hospital services. To that end, a primary care development programme was launched within the London Initiative Zone, and bids encouraged for projects designed to improve services. Table 4, derived from unpublished data, shows that 59 per cent of the budget during 1995/96 has gone into improving infrastructure and the rest spread between a wide range of projects.

However, there were signs that London was finding it hard to recruit and retain GPs. In October 1994, a number of measures had been announced designed to improve GP training. These were followed up in November 1995 by a series of financial measures designed to encourage them to stay in the capital:

- *an Initial Practice Allowance (£10,000 per annum per GP) which will support the recruitment of GPs into advertised practice vacancies;*
- *a Collaborative Working Allowance (£5,000 per annum per GP) to encourage GP principals in single-handed practices and partnerships of two doctors, who often suffer isolation in their professional lives, to meet to work together on the development of primary care services;*
- *London Implementation Zone Associate Doctor Payments (£7,500 per annum per GP) and Assistant Scheme (£15,000 per annum per GP) designed to introduce new GPs in the Zone and*

Table 4 London Initiative Zone primary care development 1995/96

	Projects		**Budget**	
	No.	**%**	**£000**	**%**
Improving basic infrastructure	265	30	57,794	59
Extending primary care services	211	24	13,880	14
Widening access to primary care	60	7	2,051	2
Emergency primary care	34	4	2,949	3
Managing care across the interface	47	5	2,436	2
Intermediate models of secondary care	67	8	9,891	10
Evaluation, research and development	60	7	1,780	2
Project management support	59	7	2,637	3
Professional development	73	8	3,577	4
Miscellaneous	4	0	490	1
Unclassifiable	4	0	235	0
TOTAL	884	100	97,721	100

Source: *Policy Institute*

> *to create capacity for practice improvement and collaborative working among small practices.* (PR95/109)

The London Commission's lack of confidence that things were moving in the right direction rested largely on the view that it was hard to be sure that the various elements making up London's health care system were changing in a manner which ensured they are mutually consistent with each other. Furthermore, with the demise of the London Implementation Group at the beginning of 1995, there was no longer a single official body in a position to take a view about London as a whole.

As the King's Fund *London Monitor,* published in January 1996, revealed, it remains hard for any non-official body to do so. The extent to which primary care has developed as a result of the Government's substantial injection of capital funds and of the work of the Primary Care Task Force, has not been systematically monitored – indeed it is doubtful whether the tools to do it exist – so that although the inauguration of particular facilities such as new GP premises and new services such as paediatric community care can be identified, the overall picture is hard to make out.

Moreover, since the finance supporting many of these initiatives is limited in duration, how long they will persist is unclear, as the pressures on hospital services show no signs of diminishing. Although some of the development in primary and community services may reduce them, others will not. Furthermore the signs continue to emerge that demand for hospital services is increasing.

As in other parts of the country, London's hospitals have been reporting rises in emergency admissions with consequent delays for some patients in getting a bed. Most are running at very high levels of capacity, with little margin to deal with unexpected variations in demand. In these circumstances it is not surprising that reports of long delays in getting admissions for emergency medical patients continue.

Some of the pressure however stems from the discharge rather than the admission end: London continues to have a deficit of 'step down' facilities into which patients can be discharged from acute care and the process of assessing people for community care is not always working as it should.

The interface between social and health care services is particularly important for mentally ill people. Here too the familiar issues continued to emerge. Although the Mental Health Task Force London Project follow-up report suggested that progress was being made, monitoring of the situation during the course of the year suggested that serious problems remains. According to Robin Powell and colleague (Crisis in Admission Beds, *British Journal of Psychiatry* 1995 pp 765–769):

> *On more than 49 per cent of occasions in Inner London (and over 39 per cent for greater London), the beds in some individual districts were over 100 per cent occupied.*

In the *London Monitor* Richard Duffett and Paul Lelliot concluded in respect of mental health services that:

> *Integration between health and social services, and between secondary and primary care, remains an aspiration rather than reality. For patients, carers and front-line clinicians, miscommunications, bureaucratic referral and assessment procedures and duplication of effort remain the common experience.* (p 79)

These are no different in nature, though perhaps in degree, to other parts of the country. However, as a result of changes to the national formula for allocating finance for hospital and community health services, many purchasers are facing budget reductions. In the words of the *London Monitor*:

> *In a period of rapid transformation in health service provision it will be even tougher for London health authorities to achieve the changes which are being sought.* (p 35)

1.2 Community care

Unlike the NHS part of the 1990 Act, the objectives of community care have not aroused major political controversy nor have the main mechanisms introduced to promote those objectives. Nevertheless the task of the making the mechanisms work effectively has proved an enormous one, requiring a complete restructuring of service provision and a re-thinking of the role of service management. The decision to defer the introduction of the community care part of the Act rested in part on the belief that such major changes could not be implemented without more time for preparation.

Nevertheless, monitoring by local authorities, the Audit Commission and the NHS Executive of the progress made in implementing the community care provisions of the 1990 Act, has generally found, in the words used last year, that disaster had been avoided. A further round of monitoring by the Audit Commission *Balancing the Care Equation: Community Care Bulletin 3* confirmed that conclusion but found that:

> *Progress with the implementation of the community care changes continues but varies widely. Authorities differ significantly in the proportion of people they assess, the eligibility criteria they apply, and the local arrangements they put in place to implement the changes, with different mechanisms used for devolving budgets and contracting for services.* (p 33)

In July 1995, the Department of Health issued a consultation paper, *Community Care Development Programme*, 'to focus and encourage work where it is most needed'. As the paper puts it, 'the overwhelming impression [is] of steady progress'. However it lists a number of so-called pressure points, 14 in all, where more work is required. Taken together, they add up to a considerable amount of 'unfinished business'.

The progress noted in the consultation document concerns mechanisms rather than objectives. While the available data suggest that the community care reforms have changed the pattern of care in some respects, in others, the evidence continues to come in that the fundamental weaknesses that were identified long before the 1990 Act was passed still remain; specifically, failure to provide a seamless service across the administrative boundary between the NHS and local authority services and also between different local authority services. That this is an area of continuing concern is reflected in the fact that the NHS Executive has made the interface between NHS services and those provided by local authorities and others one of its six medium-term priorities.

To illustrate this continuity of concern, this section looks briefly at three areas: discharge from hospital, housing, and community care and mental health, in all of which evidence emerged during the year bearing on the links between services.

Table 5 Community care pressure points

- Needs-led outcomes for users
- Sound financial control
- Carer recognition and flexible support
- Consistency and equity in assessment
- Refinement of eligibility criteria for care management
- Care management for people with fluctuating needs
- Greater involvement of GPs
- Better joint working with housing authorities
- Agreements on continuing care
- Effective diversification of local markets
- Unit costing/cost-effective provision
- Coordinated hospital discharge interface
- Need for sound information management
- Importance of effective information systems

Source: *Community Care Development Programme, Department of Health Consultation Paper, 1995, Annex B, p 25*

Discharge from Hospital: the NHS Report for 1994/95 refers to the results of a survey which revealed that:

> *... the NHS, working with other agencies, needs to keep hospital admission and discharge procedures under review. On the day of the survey in March 1995, of all patients aged 75+*

> *occupying a hospital bed, 20 per cent were waiting to be discharged. Of these, a third were awaiting placement in a residential or nursing home.* (p 15)

Similar reports emerged from individual hospitals during early 1996. Although many hospital trusts attributed bed shortages to the usual winter rise in emergency medical admissions, others placed more emphasis on difficulties in discharging elderly patients to other settings. However, work by the Audit Commission suggested that discharge arrangements were poor on a continuing basis and could not simply be attributed to failure by local authorities to make funds available for nursing home places. *United They Stand,* the Audit Commission's report on co-ordinating care for elderly patients with hip fracture, found that discharge performance from hospitals was often poor, for reasons that are only too familiar. In the words of the report:

> *Hospitals have been required since 1989 to establish and set out clear procedures for discharge and make these known to staff. All hospitals visited had policies, but staff rarely referred to them. In some hospitals, social workers were unfamiliar with the standards and triggers for referral to social services, social workers did not routinely attend ward round meetings on orthopaedic wards at any of the hospitals visited during the study, although most did attend multidisciplinary meetings on elderly care wards.*
>
> *Perhaps more significantly, there appeared to be few attempts to estimate the resource consequences of hospital policies. Social services assessors reported difficulties in arranging complex care packages for hospital patients because of a shortage of resources. The requirements to clarify NHS responsibilities for meeting continuing health care needs should start to quantify some of these needs and resource requirements, confronting policymakers with the financial consequences of current arrangements.*
>
> *This lack of common understanding causes major problems in planning rehabilitation and discharge. Hospital staff are under constant pressure to discharge patients; the decision to discharge may be made during a ward round and the patient is expected to go home the same day. Social services assessors, on the other hand, are under pressure to tailor individual care packages and to remain within limited budgets. This takes time.* (p 49)

These findings were confirmed by a report from the Social Services Inspectorate, *Moving on: a further year*. This found that although there were

Collaboration and integrated services

Priority E runs as follows:

ensure, in collaboration with local authorities and other organisations, that integrated services are in place to meet needs for continuing health care and to allow elderly, disabled or vulnerable people to be supported in the community.

- Policies and eligibility criteria, agreed with local authorities and meeting the full range of conditions set out in HSG(95)8, should be published and operational from April 1996.
- Procedures for reviewing decisions about eligibility for NHS continuing care should be operating efficiently and effectively.
- Readmission rates and audits of hospital discharges should demonstrate falling numbers of inappropriate discharges and effective arrangements for rehabilitation and recovery.
- Rates for readmissions, emergency admissions and for delayed discharge days should demonstrate effective arrangements, agreed with local authorities, for supporting elderly, disabled or vulnerable people in the community.

Source: *Priorities & Planning Guidance for the NHS: 1996/97* improvements in procedures relative to the previous year, the interfaces between hospital and community continued to give difficulty:

> *Not surprisingly, with a year having passed, there was evidence that assessment procedures and practices were getting better. Although there were continuing reports of staff pre-judging assessment outcomes, this seemed to be diminishing. Since the early days most social services departments had reviewed their assessment procedures and in response to pressure from practitioners a number had revised and simplified their assessment documentation.*
>
> *These inspections confirmed general weaknesses in recording the contributions of others to the assessment process. In addition we found some evidence that assessments in hospitals were primarily informed by hospital – based professionals and did not always include information from community – based health staff. Conversely, in the community, practitioners reported finding it more difficult to 'network' hospital-based therapy services.* (p 17)

However, these difficulties did not derive simply from failures in relationships or from poor procedures: they also reflected the pattern of provision:

> *We also found continuing concern about fitness for assessment. In one authority, pressure to release hospital beds had led to assessments being made before the patient had recovered and rehabilitation had been completed. In some areas these problems were exacerbated by a low level of NHS continuing care provision, particularly that relating to rehabilitation/recovery.* (p 18)

The issue here is more fundamental than administrative failure: what is at stake is the effectiveness of the health care system as a whole in restoring elderly people to a level of physical and psychological fitness sufficient to allow them to return home rather than to institutional care. The pressure on acute hospitals to increase turnover of beds directly militates against this, unless suitable rehabilitation facilities are available elsewhere. This point is further developed in section 2.1 below.

Housing: Housing policy is central to the realisation of the objectives of the community care reform, since the range of housing types available and conditions of access to them play an important role in enabling people to continue to live independently. But the links between housing policy and social care policy continue to be weak. *Moving Obstacles*, a report from the Joseph Rowntree Foundation by Judith Hudson, Lynn Watson and Graham Allan, argues that this central point is typically overlooked.

> *The idea of independent living is strongly promoted in the policy guidance on community care and yet assisting people to move to alternative accommodation, unless it is to a residential home or nursing home, is not seen by policy makers as central to the community care task. At the same time, local housing authorities are often culturally ill-equipped to deal with the particularities of housing applications which demand more than a straightforward offer of the right size of property in the preferred location. People who are looking for both housing and support services may therefore face considerable obstacles, arising from both the shortage of appropriate provision and the economic marginality which prevents many from buying their way into the housing market and organising their own support.* (p 1)

Their main conclusion is:

> *The research findings reveal certain patterns, both in the channels people use to obtain suitable accommodation and support and in the obstacles they encounter along the way. Most striking of all is the sheer length of time it usually takes to achieve appropriate housing.* (p 38)

Further evidence of failure to ensure that housing and social services mesh properly together emerged from other research supported by the Joseph Rowntree Foundation. In *Health and Housing: working together?*, Sue Goss and Chris Kent note that:

> *Inter-agency working between health and housing has been surprisingly poor, given the strong evidence that housing problems are an important contributor to poor health.* (p 12)

They continue, echoing conclusions from research cited in *Health Care UK 1992/93*, that:

> *Even where good practice can be identified, it is clear that important gaps remain in joint working. For example, joint working can be very effective between front-line staff, but less effective at the level of service management, or strategy. In many instances, joint working is underway at the planning or purchasing stage, but without any clear agreement about goals or outcomes. Sometimes joint working is effective at the top and the bottom, but not at the middle of organisations – creating real problems of internal communication and policy implementations.* (p 13)

They go on to point to a number of factors which militate against joint working:

- *the tension between policy and reality*
- *pressures on efficiency savings*
- *different criteria for good care*
- *the tension between different systems of needs assessment*
- *the organisational impact of restructuring*
- *the impact of the purchaser/provider split.* (p 16/7)

The authors conducted interviews in 11 areas, covering both health and housing authorities as well as voluntary agencies. They found a lot of evidence of working links between them but in response to a question about the impact of changes in health service organisation, the study found that:

> *Housing agencies were almost universal in their negativity towards the impact of organisational reform in the health service. Particular concern was expressed in relation to:*
>
> - *continual restructuring – leading to problems with continuity, and a constant sense of 'information lag' because of an inability to keep pace with the volume of change;*
> - *changes in personnel – creating practical difficulties in developing relationships and maintaining credibility with the wider community;*
> - *a general sense of confusion about what was happening and who was leading the change. Some concern was also expressed about a loss of sensitivity to local issues and concerns because of a preoccupation with internal matters.* (p 21/22)

The discouraging point to emerge from this work is that while some of the factors, such as different professional cultures, stem from long-standing differences in the statutory and financial framework within which housing and health authorities work, some such as the purchaser/provider split, stem from factors peculiar to the post 1990-NHS. Goss and Kent underline this as follows:

> *The problem of fragmentation has hitherto been seen as a problem within the housing and voluntary sector agencies. However, new developments within the NHS mean that fragmentation of health purchasing will become a very real issue in the next few years. The increasing emphasis on primary care as the most important of the health settings will limit the extent to which health purchasers can speak on behalf of the rest of the health agencies. Individual GPs will play a larger and larger role in health purchasing and planning, and, therefore, in any inter-agency working. New*

> *developments, such as GP consortia, locality planning and primary care centres will accelerate this trend. However, the links between primary care and housing are the weakest of all. Traditionally, GPs do not understand housing systems well and, understandably, fears are being expressed that the switch to primary care will reduce joint working between health and housing.* (p 19)

What should be done? Part of the answer may lie in the place that housing policy has been given in discussions of community care. A report from the Chartered Institute of Housing, *Homes for Independent Living* by Lynn Watson, argues that housing has been treated too peripherally in most discussions of community care, implicitly requiring housing to adapt to the needs of social care rather than vice versa.

> *. . . the strategic role of local housing authorities; a role which, in relation to community care, is still largely unexplored by the authorities themselves and often insufficiently acknowledged by the other key statutory agencies. This can be explained in part by the knowledge that the Social Services Department is the lead agency for community care and the perception that health and social services authorities have historically had a special relationship with regard to joint planning in this field. In addition, housing solutions have traditionally been seen in terms of discrete schemes or projects set up and managed by organisations geared up to this particular task. These assumptions reflect old ideas and are no longer sufficient, given the radical shifts in funding mechanisms for housing and support services and the need to be more imaginative in drawing in resources of capital, property and revenue finance at a time when traditional sources of funding are increasingly stretched.* (p 2/3)

As the Audit Commission's *Community Care Bulletin 3* confirms, current policy does not properly take into account this broader framework. As a result, authorities are faced with perverse incentives: while the overall aim of community care policy is to support people in their own homes, local authorities may find it cheaper to place them in residential care. Whether this is true or not depends both on the circumstances of the individual and the costs facing the local authority. But the Audit Commission found that out of 11 authorities it studied, for ten the net cost to the local authority was higher for home care for someone on basic income support. This point is also considered in section 2.1 below.

Mental Health: Last year's Review drew on a series of reports which suggested that mental health services were not working well. Further evidence emerged during the year reinforcing this conclusion. A wider ranging report from the Clinical Standards Advisory Group, *Schizophrenia*, based on a study of 11 districts found some good practice in all areas, although some services were of poor overall standard. Furthermore:

> *Joint commissioning of mental health services, whether between district and GP fundholders or district and social services, was conspicuous by its absence. The care provided for the severely mentally ill by the primary and secondary health services and the social services, particularly in the eight English districts, is far from seamless. However it was not possible within the timescale to visit GP practices or to interview any GP fundholders and our comments about, for example, the priority GPs allocated to severely ill people are mainly from the perspective of those in the Secondary Sector.*
>
> *Collaboration with Social Services was tenuous in most districts . . . the philosophy of care often differed from that in the health services. Users and carers complained that they were allowed no influence on planning and management, and felt frustrated by the token nature of the few contacts they did have. Seamlessness should be for their benefit but if it is lacking they feel the lack most.* (p 42)

Gerald Malone, Minister for Health, wrote to all

NHS chairs in August 1995 reiterating the importance attached to planning and delivering better mental health services. Regional directors were subsequently asked to discuss plans with purchasers and to report back in three months as to whether districts had developed plans consistent with policy and reflecting local circumstances and whether those plans are practicable and deliverable.

In November 1995, the Health Minister John Bowis launched *Building Bridges*, described as 'comprehensive guidance to strengthen co-ordination of mental health services', with the words:

> *Many different agencies, including health and social services and the voluntary and independent sectors, are involved in providing care for mentally ill people. Severely mentally ill people in particular may be receiving services from a number of different organisations.*
>
> *With a number of different agencies involved in a patient's care, it is vital that they work closely together so that the patient receives effective, efficient and appropriate services of a high quality. Sometimes in the past agencies have not worked well together, on a few occasions with tragic consequences. (PR 95/504)*

Finally in February 1996, the Secretary of State issued a new statement which set out a draft set of rights to mental health patients and introduced the terms 'spectrum of care' to replace 'care in the community', a term which appeared to have become tarnished by association with its failures rather than its successes. As the Secretary of State commented at the time:

> *The phrase 'care in the community' has too often been taken to mean the abandonment of residential care for mentally ill people. This is not, and never has been, our policy. That is why I am today publishing a document entitled The Spectrum of Care, which sets out in clear language the range of services which constitute a modern mental health service.* (PR 96/9)

The statement listed those authorities which had not been able to demonstrate that they had effective mental health care strategies in place putting them on notice that improvements were expected. It also called for the provision of 24-hour nursing care for people with severe and enduring mental illness. According to the accompanying Guidance (HSG (96) 6):

> *Mental health planning has by and large been reasonably successful in providing accommodation and rehabilitation for the old, long-stay clients emerging from the old, large institutions. However, few health authorities have made adequate provision for new long-stay clients with severe and enduring mental illness who may never have been in a large institution, but who will require daily supervision of medication and daily monitoring of their mental state for many years.*

This idea has been floated by the Department as long ago as 1991, but according to the Mental Health Act Commission Sixth Biennial Report, progress in implementing it had been slow. The Commission also report an imbalance in the nature of the facilities available:

> *Whilst many long-stay elderly mentally ill patients have been successfully relocated into community settings, there remains a core of patients who are unable to make the transition and for whom Community Care is arguably the least preferred option. This reality can become lost in the pressure for, and process of, change in each locality.*
>
> *For many people with enduring mental illness/severe mental illness the acute ward environment is disturbing, which in turn results in increased ward management and nursing problems. Long term rehabilitation and resettlement cannot easily be achieved within the confines of present day acute wards with high bed occupancy rates, high percentages of detained patients and increasing numbers of patients manifesting difficult to manage behaviour. As a result many units have a*

> *significant proportion of patients staying in hospital as long as 6 months and often over 12 months, all awaiting transfer to the community, delayed by lack of access to rehabilitation units or supported accommodation.*
>
> *For some patients undergoing rehabilitation, return to the community is prematurely enforced by the need to discharge in order to free up beds. The result of such unplanned discharge is often early return into hospital and the creation of a 'revolving door' situation.* (p 134)

In part as a result, occupancy levels in acute wards were found to be extremely high:

> *The Commission's concern for the welfare of detained patients who have to be admitted to and treated in over-full admission wards was highlighted in its last Biennial Report. These concerns have persisted over the last two years and are not confined to London or other urban areas. These continued pressures on acute hospital beds cause additional strains upon the services which can be provided, on staff and on staff morale. Occupancy levels of 100% and above have been reported in areas of Devon, East Anglia and Cheshire as well as all the main conurbations.* (p 97)

The continuing difficulty in getting satisfactory mental health services in place naturally raises questions about the adequacy of the resources available. However, it is clear from the reports which were produced on Christopher Clunis, Jonathan Newby and others that there are persistent weaknesses which do not stem directly from lack of resources: for example, most reports into specific incidents suggest that record keeping is poor – records are typically incomplete and inaccurate, and often lost. After-care arrangements are fragmented partly because of the complexity of relationships between the various services involved and partly because of the failure to define responsibilities, e.g. between mental health services and the criminal justice system. In many cases, community and hospital teams have incompatible information systems: joint systems across all agencies do not exist. *Inner City Mental Health*, a report prepared for the NHS Trust Federation, asserts:

> *Information systems are generally haphazard, and it is rare that the duty psychiatrist or A&E department has any relevant information on a patient in crisis at the time that they present. It is common practice that admissions out of hours are dealt with by (often agency and unfamiliar with the patients) nurses and a duty doctor who can only gain access to any useful, and often critical information the following working day from the medical records department. This is despite the fact that the patient might have had numerous admissions and be well known to the community team.* (p 7)

If these basic requirements are not met, then it is scarcely surprising that 'system failures' occur.

Although further serious incidents occurred during the year, in fact, the risks appear not have risen in recent years: the *Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People* from the Royal College of Psychiatrists, based on 39 cases of homicide and 240 cases of suicide involving people who were mentally ill, showed that neither is increasing.

On the basis of this report, John Bowis argued:

> *There is no evidence that either homicides or suicides involving mentally ill people are increasing. Indeed we have seen a fall in the percentage of homicides committed by mentally ill people. Severely mentally ill people are more likely to harm themselves than they are to harm others and our policies are geared to the reduction of harm and the improvement of safety for people with mental health problems and the public as a whole.* (PR 96/9)

Nevertheless the Government has felt obliged to respond to public concern with the Mental Health (Patients in the Community) Act, which came into force from 1 April 1996. This provides for a health authority to require a patient to reside at a specific place, to attend for treatment education, occupation or training. If the patient does not cooperate, then the supervisor has been given the power to convey the patient to such a place. However, the Act does not provide for compulsory treatment even though it is failure to adhere to treatment especially medication which typically leads to recurrence of severe illness and subsequent readmission. Whether these new powers will produce the results intended may therefore be doubted.

According to the *Confidential Inquiry*:

> *Probably the most commonly stated cause of failure of continuing care was that treatment had been offered, but not accepted or continued. This applied both to the offer of care and follow up by a staff member and the prescription of medication. In some cases poor compliance could be blamed upon the underlying psychopathology, but in others there were extrinsic factors amenable to correction.* (p 65)

To sum up: in all three areas – links between hospital and community, housing and social care and mental health policy – there is evidence of failure of different agencies to work effectively together.

At one level, the Government cannot be accused of neglecting the difficulties reported here. *Building Bridges* emphasises the need for working together and in May 1995, the Department of Health issued *Practical Guidance on Joint Commissioning*. At the time of publication, the two Ministers most concerned emphasised the need to ensure effective links between services:

> Health Minister John Bowis: *The people being helped by community care are some of the most vulnerable in society. This guidance should ensure that health authorities, housing and social services work together to ensure seamless provision. The coordination of purchasing power will lead to better services for people needing them and improved efficiency and value for money for those providing them.*
>
> Environment Minister Robert Jones: *Delivering quality community care requires the active participation of housing authorities and other housing agencies. The essence of the policy is that most people requiring care services should be able to live in the community. Housing services, such as providing sheltered housing and adapting existing homes, have a key role to play in community care.* (PR 95/237)

The Guidance itself begins by recognising weaknesses of the kind described earlier:

> *Health, social services, housing and other agencies are there to deploy resources as effectively as possible to address the needs of users and carers. Yet the organisational divisions between these agencies can get in the way of addressing these needs in the most effective, efficient and integrated manner. Users and carers may have to approach a series of different agencies in order to gain access to the range of services they need. At a strategic level, this can mean uncoordinated expenditure. Independent decisions by different agencies lead to some services overlapping, while other needs are not addressed at all.* (p 3)

Joint commissioning itself is described as:

> *. . . a tool for tackling such barriers and so improving the way in which single agencies could otherwise respond to need. It can operate at a strategic level, or at the level of individuals and their needs, or at the level of a particular patch service or user group.*
>
> *There is no blueprint for joint commissioning, nor should it be seen as a bureaucratic or administrative process. It is a way of helping agencies to overcome organisational divides so that they can focus on meeting people's needs in the most appropriate and efficient manner. (p 3)*

The question is whether there is any reason to expect that these initiatives will have any effect in the face of what appears to be intractable obstacles. Richard Poxton considers this question below.

If public agencies find it so difficult to work together, despite many years of effort devoted to ensuring that they do, are there alternative ways of co-ordinating the care and other services people require? Research cited in *Health Care UK 1992/93* suggested that many of those receiving care in the community would welcome the chance to become their own care managers and to do that they would require control over the services their require by being given the cash needed to pay for them. A study carried out for the British Council of Organisations for Disabled People (*Cashing in on Independence*, Gerry Zarb and Pamela Nadash) found that 60 per cent of the authorities which responded to the survey already operated payments schemes, although most were of an indirect kind which avoided the current legal restrictions. The Report found that:

> *People receiving direct or indirect payments have markedly high levels of overall satisfaction with their support arrangements than service users.* (p iii)

Moreover the costs of services under direct or indirect payment schemes are lower since administration of payment schemes was found to be lower than for services.

In 1994, the Secretary of State indicated that she was ready to accept this approach: a year later, in November, the Community Care (Direct Payments) Bill was published. The first clause offers local authorities in England and Wales the power to make direct payments to someone they have assessed as needing community care services. It allows the local authority to take into account the individual's financial circumstances when calculating the level of a direct payment. However, the Government appeared reluctant to spread the benefits of the cash alternative as widely as it could, proposing to phase in the introduction of the scheme by applying it at first only to physically disabled adults under 65.

Despite the difficulties and obstacles identified, Government commitment to the local authority role in community care remains strong. Over and above the extra resources allocated to mental health care, the 1995 public expenditure settlement provided for an extra £481 million, an increase of 7 per cent on the previous year. As Table 6 shows, overall spending on personal social services has risen by more than three-quarters in England as a whole over the ten-year period from 1984/85 to 1994/95.

Table 6 Net current expenditure on personal social services: 1984–85 to 1994–95

	real terms growth %
Shire Counties	101.4
Metropolitan Districts	65.4
Inner London Boroughs	35.0
Outer London Boroughs	66.9
England	77.8

Source: *House of Commons Health Committee, Public Expenditure on Health and Personal Social Services, session 1995/96*

Despite this increase, local authorities continue to feel under pressure. *Who Gets Care?*, a report from the Association of Metropolitan Authorities, found that many authorities were hard pressed to meet the demands placed upon them. As the extracts in the Box opposite show, people are being refused care who appear to have obvious care needs. It also found that a large number of people were having very small amounts of money spent on them, including people who appeared to have significant needs. However, according to the Department of Health *Statistical Bulletin 96/5*, resources are being concentrated on fewer people.

> *There appears to be an increased targeting of services provided to those people most in need. Whilst the amount of service provided increased in 1995 for all services covered by this bulletin, the numbers receiving home help/care or meals fell.* (p 2)

Whether this concentration reflects need must, on

Not in need of care?

Who Gets Care? contains some real case profiles and records both what happened in practice, and how the authorities responding to the survey indicated they would have responded to the information provided. Three profiles are set out below, where care was in fact refused.

- Mrs P aged 87 lives alone. Newly discharged from hospital after a fall. Is increasingly frail and is having difficulty walking because of severe arthritis. She manages most household tasks for herself but was having difficulty with lifting and carrying. She needs help with cleaning and laundry.
- Mr G aged 81 lives alone. Is visited regularly by a niece but she also has care responsibilities for her mother who is 85 and very frail with arthritis. Mr G has just been discharged from a lengthy stay in hospital. He is in the early stages of dementia and is incontinent.
- Mr F aged 91. Lives with his daughter aged 55 who is in full-time work. Mr F has diabetes and a history of heart problems. He is increasingly immobile and very breathless. He needs help during the day when his daughter is at work. He needs help to dress, to get a daily meal, to bathe and to get into bed at night. He does not want to go out during the day.

Source: *Who Gets Care? Association of Metropolitan Authorities, case profiles 2, 3, 9*

the basis of these figures, remain pure conjecture. Analysis of the performance indicators for social services published by the Audit Commission suggested however, that local policies vary widely: while a large number of authorities appear to be increasing the number of people given an intensive service, i.e. those receiving help six or more times a week, others were not: see Table 7.

Table 7 Intensive Care Packages: 1993/4 to 1994/5

Change in % in receipt	No. of authorities
Decreases	
20	2
10–20	3
0–10	11
Increases	
0–10	77
11+20	17
20+	5

Source: *Audit Commission, Local Authority Performance Indicators 1994/95*

Further evidence of rationing in practice comes from *Stuck on the Waiting List: older people and equipment for independent living* (Age Concern, 1996). While many people have to wait a long time, there are no published waiting lists. A 1991 Department of Health study found that the average waiting time for an occupational assessment was 11 months. Times now appear to be shorter – on average 13 weeks. But no figures are published which show how many are waiting and for how long. However one of the Audit Commission's performance indicators record the speed with which authorities respond to requests for items of equipment costing less than £1,000. As Table 8 shows, most authorities succeed in responding quickly to requests for cheaper items of equipment, but a number do not.

Table 8 Local authority response times

% Requests supplied within three weeks	Nos
0-10	1
11-20	0
21-30	1
31-40	4
41-50	2
51-60	7
61-70	8
71-80	20
81-90	28
91-100	39

Source: *as for Table 7*

Given the pressure on resources, it is scarcely surprising that the National Consumer Council report *Charging Consumers for Social Services* found that:

> *People with chronic illness or disability increasingly find they are being charged for the care services arranged by their local authority social services department. More and more charging schemes are being introduced for services like home care, day centre care, transport to and from day care, and sitting services, sometimes on top of flat-rate charges for meals, for instance, or orange badge parking schemes.* (p 1)

One of the key aims of the community care reforms was to eliminate the so-called perverse incentive presented by the availability of social security funding for residential care. Evidence to the Health Select Committee from the Department shows that authorities have been able to reduce the numbers of placements to nursing and residential care.

> *It was assumed, on the basis of historic trends, that the number of claimants in independent homes in Great Britain would continue to grow by 30,000 per year if the old funding system continued. This provided the basis for the client number projections for what would have happened had the old system continued, only what has actually [sic] happened.* (p 102)

A comparison of estimated numbers and actual numbers available is given in Table 9.

Table 9 Numbers supported in residential care

	Estimated	**Actual**
March 1993	294,000	289,000
Mid 1993-94	309,000	279,000
Mid 1994-95	339,000	280,000

Source: as for table 6

The official evidence goes on:

> *These results suggest that the number of publicly funded residents in independent homes in mid 1993-94 and mid 1994-95 has proved lower than estimated (i.e., the growth in the number of new cases with the Residential Allowance has been lower than the growth in numbers which was expected to have occurred if the old scheme had continued). One reason for the difference is that some people who would have entered residential care under the old scheme are being offered non-residential care under the new arrangements.* (p 102)

As noted already however, this does not always lead to lower local authority costs.

To sum up: there is some evidence that the mix of services being provided is changing and that the proportion of people being helped to continue living in their own homes has increased. But evidence on the impact on people's lives remains thin. Individual pieces of research suggest that benefits have resulted. For example, *Inside Residential Care*, by Geoff Shepperd and others from the Sainsbury Centre for Mental Health reports, that:

> *In hospital, residents were unable to influence when, where, what, or with whom they would eat. It was common for there to be no facilities to make tea or a snack and, where these were present, access to them was often limited. Indeed, in some cases, access to rooms and personal possessions was controlled by staff. These practices were much less common in the community. These findings are consistent with earlier research which indicates a relatively high degree of restrictiveness in hospital settings.* (p 21)

In contrast:

> *The central findings are that long-stay patients who are resettled into a variety of community accommodation show fewer 'negative' symptoms, experience better social integration, and report higher levels of satisfaction compared with matched groups who remain in hospital.* (p 9)

Evidence such as this supports the general concept of community care but it represents only a fraction of the evidence required to demonstrate success over the broad spectrum of services which make up community care. No national-level attempt has yet been made to assess the impact on people's lives. The vast majority of the effort that has gone into implementing the community care part of the 1990 Act has gone into shaping the way care is delivered rather than estimating its impact.

As Melanie Henwood and colleagues argue (*Social Policy and Administration*, March 1996), it was initially:

> *... necessary and appropriate to ensure both that the smooth transition objective was realized and also that all localities had established the basic building blocks of the new arrangements for delivering better quality community care services: assessment and care management systems; a purchaser/provider separation; and enhanced capacities for inter-agency working. Such arrangements are, however, merely means for achieving the user outcomes specified in Caring for People. In the short term, it may have been legitimate to see their establishment as proxies for progress towards delivering user-centred services. However, monitoring and evaluation should now be increasingly oriented towards ensuring that they are, in fact, producing the desired service outputs and user outcomes.* (p 49/50)

The Department of Health report *Building Partnerships for Success*, published in September 1995, recognises the challenge:

> *During the past two and half years the major structural change of the introduction of the community care reforms made it necessary to spend a lot of time concentrating on processes and systems. It is now time to move on, and consciously to remind ourselves that processes and systems are not an end in themselves, but only a means to achieving our objective. That objective must be to secure at a local level the best achievable practice to ensure the most positive outcome for users and carers. Focusing on this objective, keeping it at the centre of what we are doing, will affect and improve the way in which services are planned, commissioned and delivered.* (p 5)

To do this however represents a daunting task, on which a start has yet to be seriously made.

1.3 Public health strategy

The 1996/97 Priorities and Planning Guidelines claims that *The Health of the Nation* remains the central plank of government policy for the NHS and forms the main context for NHS planning for 1996/97. In the light of the critique offered by Mark McCarthy in *Health Care UK 1994/95*, that may seem to overstate the priority which in practice it attracts. The emphasis on activity levels and reducing waiting lists elsewhere in the Guidance suggests that in practice it is care rather than disease prevention and health promotion which occupies central place in the minds of purchasers and providers. Nevertheless, *Fit for the Future*, the second progress report on *The Health of the Nation*, published in July 1995, asserts that:

> *The concepts set out in the White Paper have become accepted as a central part of health strategy: health is no longer seen as the exclusive property of health professionals, hospitals, the NHS and the Department of Health. Instead those important players have gained powerful and innovative partners. Departments across Government and many other agencies and organisations outside Government, are contributing to the improvement of health across the nation, concentrating on the five key areas where challenging targets have been set.* (p 7)

It sums up progress so far in the following terms:

> *In general, progress towards* The Health of the Nation *targets has been encouraging. For most of the targets for which monitoring information is available, progress to date has been in the right direction. The health strategy is still in its early stages, but we can already*

> *see how the targets are acting as they were intended to, as an effective tool to focus attention where it is needed.* (p 8)

However, it goes on to acknowledge that some of the risk factors for ill health are moving the wrong way, making it harder to achieve the targets set:

> *Our regular monitoring shows that there are three targets which present particular challenges. The prevalence of smoking among schoolchildren has increased since the baseline year of 1988, and the target for 1994 has not been met. This is disappointing, and a wide range of actions is being taken to address this problem. Obesity has been increasing among men and women since the mid 1980s. Obesity increases the risk of coronary heart disease and stroke. The actions to address this would be expected to take some years to show any effect; this target had therefore been set for the year 2005, by when any results of these policies should be apparent. It is also worth noting that the latest figures for lung cancer mortality among females aged under 75 show a small increase, after allowing for the effects of coding changes. However, it is hoped that the fall in smoking levels among adult females will lead to a reduction in female lung cancer rates in future years.* (p 8/9)

Health Related Behaviour, a report from the Department of the Health's central monitoring unit, also found a number of encouraging changes, *eg,* the sharing of injecting equipment among drug misusers has declined since 1987, and fatalities in fires decreased between 1983 and 1993. But it too found that those in the younger age groups tend to engage in health damaging behaviours to a greater extent than others.

The point is underlined by a survey of children's health assembled by OPCS, *The Health of Our Children,* which remarks that young people are aware of the risks of smoking but appear to accept them.

> *The Health Education Authority survey of 9-15-years-olds suggests that there is a high awareness of risks of smoking (both active and passive) but that awareness of risk is not always a deterrent against smoking. Recent theories to explain health behaviour recognise that other influences operate in addition to the acquisition of knowledge, although there is no unifying theory. The achievement of change through health education may therefore be limited, and social and political solutions are also required. Many behaviours examined here show marked differences between social groups. Early socioeconomic and cultural forces are likely to extend beyond childhood, contributing to life-time habits and later health.* (p 57)

In line with the OPCS conclusions, in *Health of the Young Nation* the Government recognised the importance of focusing on young people:

> *The Chief Medical Officer highlighted the importance of young people's health issues in his 1993 report. The first step towards our goals is to bring young people on board, and all those who work with young people to establish what works. We need to use messages and media which appeal to young people and which get them thinking about their own health at a time of their lives when they are establishing a pattern for the future. There is a three-fold advantage in focusing on young people:*

- *immediate benefits – for example, reducing the numbers of accidents and suicides;*
- *long-term benefits in establishing healthy lifestyles;*
- *healthy habits developed when young carried on into adult life.* (PR 95/342)

In the case of obesity, the report recognises that the *Health of the Nation* targets are unlikely to be achieved. And also that, even though it seems clear what is required – more physical activity and a lower fat content in the diet – the appropriate ways of influencing behaviour are unclear, and hence more research needs to be carried out. *Eat Well II,* a progress report from the Nutrition Task Force, records a fall in dietary fat, though whether or not that is due to its efforts remains unclear. Nevertheless it recommends a series of measures designed to ensure that the impetus and cooperation already achieved will continue. It concludes by suggesting that a formal evaluation of the programme should take place in five years' time – an indication in itself of their modest expectations about the likely speed of change.

A report from the Nutrition and Physical Activity Task Forces, *Obesity: reversing the increasing problem of obesity in England,* by its very title makes the point that this risk factor is moving the wrong way as Table 10 brings out.

The Table suggests that the proportion of the male and female population who are seriously overweight has doubled since 1980. The Nutrition Task Force is developing a policy for obesity but it had not yet appeared at the time of writing. In July 1995 however, the Task Force issued a national food guide, *The Balance of Good Health.*

Another initiative, aimed at all ages, *More People, More Active, More Often,* a consultation paper from the Physical Activity Task Force, sets out the health benefits from physical activity and suggested a strategy – *Active for Life* – aimed at raising the intensity and duration of physical activity. The justification for this new approach was set out in a *Strategy Statement on Physical Activity* from the Department of Health. Subsequently, in March 1996, the Health Education Authority launched a campaign, *Active for Life,* described as the most wide-ranging of its kind in the world. Although based on the belief that exercise has health benefits particularly in relation to heart disease, it proposes a change in the form of exercise.

> *Moderate activity forms the basis of this physical activity strategy because it offers the potential of the greatest health gains for the majority of the population, particularly the sedentary and those who have low activity levels. Vigorous activity does convey the maximum benefit for heart health and remains an important objective for those able and willing to undertake this level of activity, but this is an unrealistic goal for the majority of the population.*
>
> *No more than moderate activity is needed for weight control as this depends on the total amount of energy spent, which relates to the length of time spent exercising as well as intensity.*
>
> *The objective therefore is to:*

Table 10 The proportion of adult men and women who are overweight and obese in England as monitored in different surveys over 13 years

Year	**1980**	**1986/7**	**1991/2**	**1993**
Men				
Mean BMI	24.3	25.0	25.7	25.9
Overweight (BMI 25-30) (%)	33	38	42	44
Obese (BMI >30) (%)	6	7	12	13
Total (BMI > 25) (%)	39	45	54	57
Women				
Mean BMI	23.9	24.7	25.4	25.7
Overweight (BMI 25-30) (%)	24	24	29	32
Obese (BMI >30) (%)	8	12	16	16
Total (BMI > 25) (%)	32	36	45	48

Source: *Obesity: reversing the increasing problem of obesity in England, Department of Health 1994.*
Note: BMI = Body Mass Index

- *promote the value of moderate activity on a regular basis for sedentary people;*

- *inform people of the value of maintaining 30 minutes of moderate activity on at least 5 days a week for those who already take some moderate activity; and*

- *advocate, for those already taking some vigorous activity, the maintenance of a total of three periods of vigorous activity of 20 minutes a week.*

This advice is intended for the population at large and it needs no stressing how large a task it will be to persuade them of its merit. The task of persuading health care professionals to take it seriously might seem a great deal easier. But here too the obstacles appear to be severe.

In *Dear to Our Hearts: commissioning services for the treatment and prevention of coronary heart disease*, the Audit Commission argued that 8,000 premature deaths could be avoided if resources were devoted to health promotion and prevention. Despite the apparent evidence of benefit, it found that:

> *Clearly identifiable health authority spending on primary prevention is low. Despite national policies such as those in* The Health of the Nation *programme, the commissioning of services aimed at primary prevention is sometimes seen as an unimportant, low status, aspect of health authorities' work.*

This is explained by the fact that:

> *Some chief executives and other senior health authority managers are deeply cynical about primary prevention and the objectives that underlie policies such as those in* The Health of the Nation *programme.*
>
> *At worse this means that the commissioning of primary prevention services is a relatively neglected and low status activity, despite lip service being paid to it in public by senior health authority staff. In such cases, too little effort is put into the development of robust and coherent district health promotion strategies, and poor management systems and contracting arrangements are permitted to pass unchallenged. Poor working relationships between Health Promotion Unit staff and clinicians working elsewhere in the NHS may also be accepted, along with destructive conflicts between one-sided advocates of primary as opposed to secondary prevention. These can undermine awareness that both primary and secondary prevention require a balance of social and medical inputs, which should serve to complement each other.* (p 25)

The risk factors considered here have been documented in research studies throughout the world. So too have the links between health and socio-economic factors. In October 1995, the Department of Health published *Variations in Health*, the report of a sub-group of the chief medical officer's *Health of the Nation* working group. The *Health of the Nation* White Paper had noted public health strategies ought to be sensitive to variations in health and the *1994/95 NHS Priorities and Planning Guidance* asked purchasers to address variations between regions and social groups. The 1996/67 Guidance recognises that equity is central to the purpose of the NHS and that requires targeting resources where needs are greatest. The Health Service Guideline (95/54) which accompanied publication of the report, 'invites' NHS purchasers and trusts to draw on the report in 'taking forward work to reduce variations in health'. It then goes on:

> *Purchasers are asked particularly to note the report's recommendations about the importance of evaluating the effectiveness of interventions designed to reduce variations in health.*

It is of course perfectly valid to suggest that public health strategy, like clinical practice, should rest on evidence linking intervention to its effects. Inevitably judgements have to be made on the evidence available at the time which may later turn out to be misleading. That point was illustrated during the year in relation to the official advice offered to the general public on safe levels of drinking.

Last year's Review noted that evidence had emerged from a number of sources that suggested moderate drinking had a beneficial effect on health. That evidence was assessed by a Department of Health group which concluded that:

- Current scientific knowledge supports the conclusion that drinking one to two units a day gives a significant health benefit in reducing coronary heart disease for men over 40 and post-menopausal women.

- There are situations where people should not drink at all for their own or other people's safety – for example, before or during driving, before using machinery or electrical equipment.

- It is more helpful for people to think of a daily benchmark than a number of units per week.

- Men who drink three to four units a day and women who drink two to three units do not face a significant health risk.

- However consistently drinking four or more units a day (men) and three or more units a day (women) is not advisable because of the increasing health risk it carries.

- Advice given is only in the form of benchmarks because individuals' reaction to alcohol vary.

- The benchmark for women is set lower than those for men because of physical differences such as generally lower average weight.

- More attention should be paid to the short-term effects of drinking too much, or at the wrong time, or in the wrong place. Excessive alcohol consumption is a danger to individuals and to society generally.

- Children under 16 who drink alcohol, and young people are mentioned as particular causes for concern.

- Women who are pregnant should not drink more than one or two units once or twice a week and should avoid getting drunk.

The report found that there are identifiable benefits from the recommended level of alcohol consumption in regard to ischaemic stroke and to the accumulation of gall stones, as well as coronary heart disease. As a result, the Secretary of State announced increases in the limits, or benchmarks, as they are now described.

While this new advice published just before Christmas was widely criticised for appearing to encourage drinking and hence drink-driving, the reaction was nothing to the storm provoked by the announcement in March by the Spongiform Encephalogy Advisory Committee (SEAC) that while there is no direct evidence of link between BSE – mad cow disease – and Creuzfeld-Jacob disease, on the balance of evidence available, a number of recent cases of a new form of the disease were best explained by the assumption that they had been caused by contact with diseased animals.

In a formal statement, the Chief Medical Officer stated:

> *These new findings suggest that there may have been an association between eating bovine products, which may have been contaminated by infected brain and spinal cord, and a risk of developing CJD before the introduction of measures in 1989.*
>
> *There remains, however, no scientific evidence that BSE can be transmitted to man by beef. However, risk analysis suggests that even the likelihood of the extremely small risk of transmission increases when non-muscle parts from older cattle are eaten. It is essential therefore that the source and quality of beef is clear and that the public can be assured of these measures.*

> *Current measures must be rigorously enforced. This is at the heart of the issue. SEAC will recommend that effective training measures should be introduced and consider this further.*
>
> *Further research is urgently required and this will be funded.* (PR 96/86)

Unfortunately, this statement together with those made by Ministers was ineffective in allaying public disquiet. Because the Government had insisted for so long that there was no link between the bovine and the human form of the disease, its assertion that the risks were now small, however well founded in the available evidence, was not believed, neither in the UK nor abroad. The EU Commission imposed a world-wide ban on the export of beef. According to Coopers & Lybrands, the result would be a loss of 28,000 jobs in the first year and £550 million in compensation, plus other significant effects to the public finances and the balance of payments.

But what the health benefits would be remain unclear. Estimates of the number of deaths that might occur ranged from zero – on the assumption that there was no link between beef-eating and the new form of CJD – to two or more millions on the assumption that there was a link and current measures were not enough to eliminate it.

In the face of such uncertainty, the Government was unable to develop a principled response. Relying on the support of its scientific advisers, it argued that continuing to eat beef was safe, in the everyday sense of the term, ie there was no guarantee that there was no risk. But if those scientists who took a different view were right, or only partly right, then its advice should have been quite the reverse and the slaughter programme of older animals introduced in May 1996 quite inadequate. If the probability of an event is low, but its occurrence absolutely disastrous, then radical action – in this case the virtual elimination of beef production in the UK – would be justified.

In another policy field, control over air pollution, the Government also had to proceed with imperfect knowledge but in this case it took the view that even though the risks to health were small, further action should be taken. *Asthma and Air Pollution*, a report from the Committee on the Medical Effects of Air Pollutants, concluded that:

- *initiation of asthma – most of the available evidence does not support a causative role for outdoor air pollution. (This excludes possible effects of biological pollutants such as pollen and fungal spores.)*
- *worsening of symptoms or provocation of asthmatic attacks – most asthmatic patients should be unaffected by exposure to such levels of non-biological air pollutants as commonly occur in the UK. A small proportion of patients may experience clinically significant effects which may require an increase in medication or attention by a doctor.*
- *factors other than air pollution are influential with regard to the initiation and provocation of asthma and are much more important than air pollution in both respects.*
- *asthma has increased in the UK over the past 30 years but this is unlikely to be the result of changes in air pollution.* (PR 95/488)

A further report, *Non-biological Particles and Health*, concluded that:

- *there is no evidence that health individuals are likely to experience acute effects from exposure to concentrations of particles found in ambient air in the UK;*
- *there is, however, evidence of an association between levels of particles such as those encountered in the UK and acute effects on people with respiratory and cardiac disease, ranging from exacerbated symptoms to earlier death;*
- *the epidemiological studies have demonstrated associations between effects on health and particles from a wide range of sources – there is no*

evidence that particles from any one individual source are solely responsible for the effects on some people's health;

- *there is no established mechanism of action which explains how airborne particles are having these effects; and*
- *evidence regarding the chronic effects of long-term exposure to particles on health is less well-developed and confidence in the accuracy of any predictions is less than for the acute effects.* (PR 95/517)

Current policy offers 'the assurance that any health risk will be steadily reduced'. But the Government decided in November to go further by announcing its intention to bring about further reductions in small particles in the atmosphere. The statement announcing these proposals does not offer any estimate of the health benefits, but in its preliminary response the Government accepted that it was appropriate to take action in the absence of clearcut evidence:

> *COMEAP [Committee on the Medical Effects of Air Pollutants] acknowledge the lack of any established mechanism of action but advise that 'it would be imprudent not to regard the link as causal'.*
>
> *The Committee is not able to calculate the numbers of people who are likely to be affected in the absence of specific research, but they refer to published studies of exposure-response relationships, with the warning that estimates based on these studies are likely to provide only a first approximation to the actual effect.*
>
> *With regard to long term exposure to particles the Committee also conclude that although the evidence is limited 'it would be prudent to consider these associations between long term exposure to particles and chronic effects as causal'. In addition the Committee reported that the presence of genotoxic carcinogens in particles means that a contribution to the burden of cancer in the United Kingdom cannot be ruled out, though it is likely to be very small.*
>
> *It is clear therefore that the potential effects of particles on human health must be taken seriously.*

However, indoor pollution ie in people's homes may be important. A report from the Building Research Establishment, *Indoor Air Quality in Homes,* suggested there may be risks to children from nitrogen dioxide from gas cookers and from dust mites to people with asthma. But monitoring and even more the control of the home environment present serious difficulties.

In some areas, prevention programmes are well established. Nevertheless, as earlier Reviews have noted, there have been concerns about their implementation. *Health Care UK 1994/95* presented National Audit Office findings on the way that the major preventive programmes bearing on the health of women were working. There was a sharp contrast between the nationally organised breast screening programmes and that for cervical cancer, which led to control for the latter being passed to the national co-ordinating team for breast screening.

The need for better control was reinforced by further examples emerging of smears being improperly taken or misdiagnosed – 70,000 smears had to be re-examined in Kent during 1995 – but perhaps more significant – figures were published for the first time in February 1996 which revealed the wide variation in rates at which early warning signs of cancer were diagnosed: see Table 11.

The variations between particular laboratories was greater still, ranging from 2 to 56 per cent. In response to these findings, it was announced in March 1996 that a series of measures would be taken to improve the quality of the programme. *Quality Assurance Guidelines* were issued for the programme as a whole and standards set for particular procedures within it: a national co-ordinator was appointed for each part of the UK.

The breast screening programme has not

Table 11 Variations in Detection Rates: cervical cancer screening

Highest	%	Lowest	%
Huntingdon	10.9	Hillingdon	1.8
Isle of Wight	10.0	East Kent	2.4
Manchester	9.5	Oxfordshire	2.4
St Helens & Knowsley	8.9	Southern Derbyshire	2.4
Stockport	8.8	North West Herts	2.5
Croydon	8.5	Barking & Havering	2.5
Doncaster	8.2	Worthing	2.5
Coventry	8.0	South West Herts	2.6
Grimsby and Scunthorpe	7.9	East & North Herts	3.0
Exeter & N Devon	7.8	Buckinghamshire	3.0

Source: *The Times*

suffered from the same lack of quality control. However, the Health Committee in its report *Breast Cancer Services* concluded that the programme ought to be extended to women aged 65 or over. Other women can request screening but very few do so. According to an Age Concern Survey (*Not at my Age*):

> *In reality few older women actually do request screening. Less than half a per cent of women aged 65 or over are screened on request in one year. Government figures show that in 1992/93 only 0.33 per cent of women aged 65 or over were screened as a result of self or GP referral; in 1993/94 there was a fractional increase to 0.44 per cent. According to Government figures, it is estimated that in 1993/94 in England about £1.4 million – only 5 per cent of the total breast screening budget – was spent on testing women aged 65 or over for breast cancer.*

Older women had originally been excluded because:

- there would be a 'poor response rate' to invitations for screening by older women;
- there was an increasing chance of older women dying of diseases other than breast cancer;
- breast cancer diagnosed in older women 'appears to run a less aggressive course than when diagnosed in younger women'.

However, as the Age Concern paper argues:

> *There is a good deal of research evidence supporting the likely benefits of screening for older women, and it is estimated that as many as 2,000 older women's lives could be saved every year if they were routinely invited for screening. Many of the assertions about older women made in the Forrest Report, on which the present system was modelled, do not stand up in the face of evidence.*

The Select Committee, drawing on evidence from Sweden, recommended that the age up to which women are invited for screening should be raised to 69. The Government was not entirely persuaded, but did agree, in its response to the Committee's report, to two pilot schemes which would run for about three years. Commenting on these in the House of Lords, Baroness Cumberlege said:

> *We have already consulted the independent Advisory Committee on Breast Cancer Screening on whether routine screening should be extended to include women up to the age of*

> *69. We accept their advice that further research is needed.*
>
> *The pilot studies proposed are to evaluate the likely take up and effectiveness of screening women in this age group. They will be run closely together to ensure shared aims and evaluations, and will be undertaken in South Thames and the Northern and Yorkshire Regions. Work is in hand to agree the necessary clinical, financial, logistical and evaluation details and a further announcement will be made soon.* (PR 95/486)

She went on to say:

> *. . . . [extending the screening programme to women aged over 64] is a very expensive process to introduce nationwide. We do not know at the moment how many women would take up this opportunity. We do not know what the costs would be in terms of the detection of cancers.* (Hansard Col. 1575 – November 1995)

This is as clear an example of rationing on cost grounds as might be found. Not surprisingly Age Concern comments:

> *Age Concern would be appalled if the cost of treating the breast cancer which screening would detect in this age group was ever used as a reason to deny older women the chance of early detection of their cancers. They deserve the same chances and opportunities to safeguard their health as younger women.*

The Health of the Nation set itself targets specific to the key areas it focuses on but its general aim, like that of the health care services which absorb most of NHS expenditure, is 'to secure through the resources available the greatest possible improvement to the physical and mental of the people of England'. The Guidance in which these words appear does not propose an indicator, or set of indicators by which any such improvement might be measured. However the Department of Health supported work by Margaret Bone and others, reported in *Health Expectancy and its Use* (HMSO 1995), designed to help it decide whether such an indicator might be both valuable and feasible.

The report points out in its conclusion that:

> *. . . health expectancy is a necessary tool for accurate monitoring of* The Health of the Nation. (p 78)

and makes a number of recommendations to that end. Using the data already available it draws a number of conclusions about the overall health of the population as a whole and particular parts of it.

> *[it] would seem to be that future gains in life expectancy among elderly people may well be accompanied by a rise in the amount of chronic disability, particularly at lower levels of disability and/or self-perceived health status.* (p 33)

Whether this is correct or not remains open to debate since not all the available evidence points the same way. Recent research in the USA by Kenneth Manton, reported in the *New Scientist* (16 March 1996), suggests for example that people are living longer in better health. There is no comparable data for this country but as Margaret Bone has shown (*Trends in dependency among older people in England*, OPCS 1996):

> *Despite the growth in the numbers and proportion of the oldest old, it appears from measures based on the General Household Survey that there was no change in the prevalence of dependency of any degree among older residents of private households in the 1980s.* [see Table 12] (p 14)

These findings are based on self-reported data and are not linked to use of health services. Without those links being clear, health expectancy cannot be used as evidence of success since any change may be due to factors outside Government influence. But it remains nevertheless a valuable indicator of changes in health status.

Table 12 Dependency of persons aged 65 and over, percentage at each dependency level in 1980, 1985 and 1991, England

Dependency level		**1980** **%**	**1985** **%**	**1991** **%**
Independent	1	76	73	77
Least Independent	2	16	19	18
	3	5	6	3
	4	1	1	1
	5	1	1	0
	6	0	0	0
Base = 100%		3,803	3,155	3,201

Source: *M Bone, Trends in Dependency among Older People in England, OPCS 1996*

Currently there is no means of distinguishing between the effect of policy and of other influences. Thus despite the apparent clarity created by *The Health of the Nation*, the framework within which health policies work remains poorly defined both within the NHS and outside it.

The obstacles are of course severe, given the complexity of the links between the environment and health, and there is no administrative framework which brings them routinely together across central government as a whole. However, in EL 95 (135), the Department of Health issued *Policy Appraisal and Health*, which sets out a method to be used throughout the public sector for the appraisal of the health impact of public policies.

> *All policy, programme and project options in the public sector should be systematically appraised. This means identifying and weighing up all important costs and benefits. Health is important and is affected by many different areas of public administration. Health impacts should therefore be fully considered. Responsibility for this rests with those who will take the final decision as well as all those who contribute advice. This guide, though not mandatory, gives advice on how to appraise health effects, and should be carefully studied by anyone who will be called upon to carry out such an appraisal.*

If the Ministry of Agriculture, Fisheries and Food had made such an appraisal in 1989, what exactly would have been done differently?

1.4 Serving the consumer

Responsiveness to users is the third criterion against which the Planning Priority Guidelines state the NHS should be judged. Several strands of policy bear on it: *The Patient's Charter*, which the Planning Guidance treats as a baseline requirement, the concept of a primary-care-led NHS, the aims set out under medium-term priority D, empowerment – see Box opposite – which relates to the role of patient or user in influencing the content and manner of their care, and complaints procedures. This section considers each of these and then briefly considers some other related initiatives.

Of these four strands, the *Charter* is the most specific in its requirements. Since its inception, the Government has considerably expanded its scope and put sustained pressure on providers to meet the standards set.

As noted last year, a revised and expanded *Patient's Charter* was launched in January 1995. Three elements came into effect immediately and the rest from the beginning of April. Subsequently, a more rigorous standard was set for emergency admissions that patients should be given a bed within two hours, as opposed to

Empowerment

Health authorities should have a strategic plan for, and should be engaged in, systematic and continuing communication and consultation with local people, representative and voluntary groups (particularly Community Health Councils) in respect of the development of local services, purchasing plans, specific health issues and health promotion as appropriate. Particular attention should have been paid to addressing the concerns of those with special needs.

Health authorities and providers should be able to demonstrate how consultation and dialogue with GPs and local people or groups, including those with special needs, has influenced the development, planning and purchasing of services; and feedback to local people and groups on the outcome of consultation.

Purchasers and providers should be able to demonstrate that they have a systematic programme in place aimed at achieving active partnership with individual patients in their own care, in particular seeking to improve the quantity and quality of information given to enable patient choice about treatment options.

Purchasers and providers should have complaints systems in place which reflect the revised procedures stemming from the Government's response to the Wilson Complaints Review *Acting on Complaints.*

Source: *Planning and Priority Guidelines for the NHS 1996/97*

Children's Charter standards

- parent-held child health records;
- prompt and appropriate information for parents about the names and how to contact the health visitor, school nurse and children's nurse (in both the hospital and community);
- children suffering from asthma to have access to their inhaler at school;
- help with equipment loan when caring for a sick child;
- a separate area for children in A&E departments;

from April 1996, for non consultant-led outpatient services

- local Charter standards to be set for the maximum waiting time for first appointment following GP referral;
- the address and telephone number of the service to be given to parents so that advice can be sought prior to the appointment;

In hospital

- children to see the children's ward they are to be admitted to beforehand, and adolescents to be asked if they want to go into the children's or adult ward;
- parents to be encouraged to stay in hospital with their child and be involved in their care;
- information about pain relief for children;
- choice of children's menus;
- breastfeeding facilities for nursing mothers;
- children to wear their own clothes and be able to have some of their own things with them; and
- full opportunity for play and, when appropriate, education.

three to four, to come into effect as from April 1996. In March 1996 a *Children's Charter* – see Box – was launched.

The Review noted last year that not all providers were able to meet the requirements of the *Charter* as it then stood: sometimes performance fell far short of it and other agreed standards. In respect of children for example, the Department of Health set a target in 1991 of having a registered children's nurse on duty at all times in A&E departments. However, a report from the Audit Commission, *By Accident or Design,* found none of the departments it studied came close to that standard. Furthermore, it identified a range of other weaknesses which the new standards do not bear on.

In April 1995, however, a report from the National Audit Office, *Outpatient Services in England and Wales,* showed that the NHS was at last improving its performance in respect of outpatient services, which, over the years, have given rise to more patient dissatisfaction than other main services. An earlier report, published in 1991, found that about only half of patients were seen within half an hour of their appointment time. In contrast, the 1995 report found:

> *National data on performance against that standard show that 86 per cent of patients in England, and 84 per cent in Wales, were seen within 30 minutes of their appointment time during the quarter to 31 December 1994. At the hospitals visited, performance against the standard in 1993-94 ranged from 71 per cent to 86 per cent. This performance represents an improvement over the findings at the time of my previous report, when 53 per cent of patients in the clinics surveyed were seen within 30 minutes. And patients interviewed for the National Audit Office research among outpatients generally expressed a high level of satisfaction with waiting times, with many waiting for less time than they had expected.* (p 2)

The Government was also able to announce a further improvement to waiting times for elective operations. The numbers waiting for long periods continue to fall, although overall the number on waiting lists have changed only slightly.

Between March 1988 and September 1994, mean waiting times more than halved, from 9.24 to 4.59 months. Change in the median wait has been much less marked. As more recent figures indicate – see Table 13 – long waits have continued to fall, so the mean wait has continued to decline.

In the past, assessment of the figures for waiting times has had to be qualified because of the possibility that patients have had to wait longer for an appointment with a hospital consultant. Data on waiting times at this stage began to be collected at the end of 1994 and the results started to become available during 1995: see Table 14.

In July 1995, the second annual set of NHS performance 'league' tables was published, covering the same areas as last year but also including the new information on the time taken to get an outpatient appointment with a consultant and on the number of family doctor practices which have developed their own patient's charters. The overall summary showed improvements across the board:

Table 13 Waiting times: March 1996 and % change since December 1995

	0-11 months		12-17 months		18 + months	Total list	
Region	**No**	**Change (%)**	**No**	**Change (%)**	**No**	**No**	**Change (%)**
Northern & Yorks	144,077	0.7	127	-96.2	0	144,206	-1.4
Trent	95,970	2.0	2,108	-19.0	0	98,078	1.4
Anglia & Oxford	109,768	1.1	746	-65.5	0	110,514	-0.2
North Thames	155,745	-1.2	934	-88.3	0	156,679	-5.4
South Thames	152,238	2.8	33	-99.2	0	152,271	0
South & West	124,170	2.8	394	-33.7	0	124,564	2.6
West Midlands	82,330	-5.9	39	-17.0	0	82,369	-5.9
North West	173,041	0.6	0	ERR	0	173,041	0.6
All Regions	1,037,339	0.6	4,381	-79.0	0	1,041,720	-1.0
SHAs	1,913	-4.6	2	-77.8	0	1,915	-4.9
Total	1,039,252	0.5	4,383	-79.0	0	1,043,635	-1.0

Source: *PR 96/121*

Table 14 Waiting times from GP referral to outpatient consultation: quarter 2 1995/96 – England

Specialty	**Waiting time (%)** **Under 13 weeks**	 **13 to under 26 weeks**
General Surgery	91	8
Urology	77	18
Trauma and Orthopaedics	73	21
Ear, Nose and Throat	75	21
Ophthalmology	74	22
Oral Surgery	83	14
Plastic Surgery	74	18
General Medicine	88	11
Dermatology	78	18
Gynaecology	88	11
All Specialties	83	14

Source: *NHS Quarterly Review*

- *93 per cent patients assessed with 5 minutes in A & E departments – it was 88 per cent in the previous year;*
- *88 per cent of patients are seen within 30 minutes of their appointment time – it was 84 per cent in the previous year;*
- *73 per cent of Trusts had three or fewer failures in meeting the cancelled operation standard, of which 54 per cent met it in full;*
- *over half of hospitals admitted 95 per cent or more of patients in the eight main surgical specialties within 12 months of going on to a waiting list;*
- *95 per cent or more of patients in the general surgery, urology and gynaecology specialties were admitted within a year;*
- *nationally for all specialities, 82 per cent of patients were seen within 13 weeks of referral and 95 per cent of patients were seen within 26 weeks of referral;*
- *now more than 60 per cent of family doctor practices have developed their own charters, setting out their standards of service for patients.* (PR 95/345)

While the Government could take some satisfaction with these results, the weight to be attached to some of these success measures is open to criticism. In respect of the triage target for example, a survey of A&E departments (June A Edhouse and Jim Wardrope, *Do the national performance tables really indicate the performance of accident and emergency departments?*, Journal of Accident and Emergency Medicine 1996, pp 123-126) discovered that the guidelines for collecting the information were frequently not followed and that 'a high star rating' reflected the speed rather than the quality of the assessment. In their words:

> *In some departments the pressure to score a high star rating is interfering with their well established advanced triage systems. Some departments are now running formal triage in parallel with an immediate assessment system. The nurse performing immediate assessment literally greets the patient, eyeballing their condition, and thus satisfies the Patient's Charter standard. Then, aware that this is an inadequate fore of assessment, a second nurse performs formal triage in an unhurried way.* (p 126)

They conclude:

> *The star rating system provides no useful information; it does not truly reflect the quality of care and is misleading if used to compare performance between departments. The measurement of time to immediate assessment could be refined, but this would require the investment of significant amounts of time and money. Better indicators of performance of A&E departments do exist, and the necessary data are already routinely being collected. The new standard of waiting time for a hospital bed is welcomed, but unless data are collected in a standardised way the national performance figures will continue to be uninterpretable.* (p 126)

The Public Accounts Committee *(National Health Service: outpatient services in England and Wales)* added to the scepticism with which some indicators are regarded by concluding that some of the improvement to outpatients waiting times had been achieved by using a nurse to see patients before the consultation proper began: in the words of the report:

> *We note the NHS Executive's view that there have been significant improvements in the accuracy of data available to monitor performance against Patient's Charter standards and look to the NHS Executive to ensure that satisfactory arrangements are maintained to collect accurate data on performance against Patient's Charter standards and to avoid manipulation of data through procedural devices.* (p xiv)

Further developments during the year suggested that the benefits of reducing waiting times might be being won at too high a price. The Government has focused on reductions in waiting times, because they appeared to epitomise the failings of a strictly cash limited service: in international comparisons, long waiting lists have appeared to be the price paid for spending a small proportion of GDP on health.

To cut back on the numbers waiting for long periods of time has required injections of money, initially through the nationally led waiting times initiative and then subsequently through local action. But for several reasons the significance of this objective may be questioned. First, throughout the country, there were signs that the pursuit of shorter waiting times has been given too much weight relative to the need to meet the other main demand on the hospital service, emergency care. Hospitals throughout the country have, at various times, had to refuse admission to patients requiring urgent care. As a result, it is arguable that the lives of a number of patients have been put at risk.

Second, the precise link between extra expenditure devoted to reducing lists and numbers waiting remains unclear. A University of York Study *(Modelling Waiting Times for Elective Surgery)* by Stephen Martin and Peter Smith concluded that:

> *Our results contradict some of the received wisdom about waiting lists in the NHS. For example, they refute the claim that any increase in provision of surgical beds will necessarily result in increased demand, and therefore bring about little consequent improvement in waiting times.* (p 23)

Another study (John H Newton and others, *BMJ* 23 September 1995) covering the Oxford Region found, however, that increases in admissions did improve waiting times, but did not reduce list size because of further additions to the list. This effect is apparent at national level: despite year on year increases in admissions, the total numbers waiting show very little change at around one million. The Oxford study also showed that extra spending was associated with shorter lists but not greater activity – which suggested that it had been used to prune existing lists of those no longer requiring care, rather than reduce the numbers 'really' waiting. Finally, the benefits of reduction in the waiting times are far from clear. As a recent analysis by David Naylor and colleagues (*Quality in Health Care* 1994, pp 221-224) put it:

> *Queues may promote healing by tincture of time, since patients with less severe conditions tend to be put off the longest. For example, one study from Oxford's Radcliffe Infirmary found that 20 per cent of children and 8 per cent of adults on the waiting list for tonsillectomy improved sufficiently to decide against surgery. On the other hand, comparisons between private and NHS care . . . suggest that more rapid referrals to private coronary surgery led to fewer deaths in the queue.* (p 221/2)

The significant implication is that the single-minded pursuit of shorter waiting times across the board cannot be justified. Waiting lists are better seen as providing a stock of potential demand for hospital care which requires further analysis to determine the clinical importance of the range of needs identified. As Harry Hemingway and Bobbie Jacobson (*BMJ*, 1 April 1995) have argued:

> *The assumption that waiting lists reflect need (that is, ability to benefit) may be tested by considering the indications for various procedures. Increasingly, systematic reviews and techniques for identifying consensus have been used to set criteria of appropriateness for clinical procedures. There seems, however, to have been little interest in using this work to tackle waiting lists. The appropriateness of some procedures may be questioned regardless of the clinical indications (for example, dilatation and curettage in women under 40), but for most procedures for which there is a waiting list, the situation is far more complex. The intended procedure, the precise indication for that procedure (the condition and its severity), and any comorbidity must be assessed. These factors could be used to generate an appropriateness rating.* (p 818)

The need for such a rating grows ever more urgent. In the past 5 years, the number of elective operations per year has grown by some 2.5 million, or more than twice the length of the waiting list. Yet there has been no official, published analysis of what the nature of this extra activity is.

Primary-care-led NHS: The concept of a primary care led service is intended to allow decisions:

> *to be taken as close to patients as possible, with a greater voice for patients and their carers in such decisions. To achieve this, GPs and their teams are being given a wider scope of influence in the purchasing and provision of health care, within agreed public health priorities.*

What exactly is meant by a primary-care-led service is, however, far from clear – a confusion to which Ministers have added by defining it in terms which are different from the Planning and Priorities Guidance and which vary from speech to speech. Like 'the shift from hospital to community', it is a piece of policy rhetoric that has come into common use without any detailed justification. In an article elsewhere in this volume, Peter Holland sets out a more appropriate agenda for the reform of primary care.

Enpowerment: The third strand is labelled 'empowerment' in the Priorities and Planning Guidance but it is now termed 'patient partnership' – apparently a phrase less threatening to professionals. The Department of Health's 1996 report describes what this strand involves. In its words:

> *Traditionally, however, it was assumed that the doctor or nurse knew what was best for the individual patient and that the wider health service knew best how health services should develop. These attitudes have been slowly changing. Accelerating the pace of that change and achieving active partnership with patients and the wider community is now a major challenge for the NHS.* (p 73)

It goes on to explain that 'Patient Partnership' works at two levels:

Individual level

- *to promote user involvement in their own care, as active partners with professionals; and*
- *to enable them to become informed about their treatment and care and to make informed decisions and choices about it if they wish.*

Community level

- *to contribute to the quality of health services by making them more responsive to the needs and preferences of users; and*
- *to ensure that users have the knowledge, skills and support to enable them to influence NHS service policy and planning.* (p 128)

These goals are to be achieved through work in four areas:

- *consumer change, amongst health professionals about patient partnership and amongst health service staff more generally in user involvement in service development;*

- *the production and dissemination of information for health service users and their representatives;*

- *structural, organisational and resourcing requirements for helping patients generally and their representative organizations play a fuller part in the NHS; and*

- *research and evaluation of how best to involve patients in their own care and wider service issues.* (p 129)

The report gives no details of what is involved in these four areas, nor of how success or otherwise would be demonstrated. It remains an area of experiment rather than routine application.

Complaints procedures: In contrast, complaints from patients are a matter of routine, but one which does not work well. The weaknesses in existing complaints procedures were exposed by the Wilson Committee report *Being Heard* and were further exposed in July 1995, when the Health Service Ombudsman published a report highly critical of the way that complaints were treated. The Executive responded with a letter to all chief executives which identified the key areas of weakness and followed that up in October with *Interim Guidance on Implementation of the NHS Complaints Procedure*. The final guidance was issued in March 1996 and requires that all trusts and health authorities should have a written complaints procedure and a designated manager.

The new procedure has two main features:

- ***Local resolution*** *– a quick and informal way to complain direct to the provider of the service, under which the NHS Trust, GP practice, dentist, pharmacist or optician will respond to the complainant and try to provide an answer which satisfies the patient.*

- ***Independent review*** *– under which complainants can ask for a further review, which may involve establishing an independent panel under an independent lay chairman, and with a majority of members independent from the provider of the service. Independent clinical advisers will provide advice in appropriate cases. The decision to convene a panel will be taken by a non-executive member of an NHS Trust or, in cases involving primary care services, by a non-executive from the relevant health authority, in both cases in consultation with an independent lay chairman.* (PR 96/75)

At the same time as these changes were made, the Health Service Commissioner's powers were extended to include clinical matters, thus allowing patients a further channel to pursue complaints.

Another way of making services responsive to patients is to create genuine options. With *Changing Childbirth*, the Government took the fundamental approach of aiming to provide the conditions required for women to exercise choice of the mode and manner of delivery. In the first year of that initiative a large number of projects were supported from central funds and a further tranche gained support during 1995. The projects announced in July 1995 supported a very diverse set of projects, including training and education, as well as new forms of care delivery. Their very range emphasises the complexity of putting the policy into effect. In January, Baroness Cumberlege launched *Informed Choice in Maternity Care*, which has the following objectives:

- *to enable childbearing women to exercise informed choice by making explicit the choices available*

- *to empower consumers by providing them with information on which practices are known to be safe and effective and which are not*

- *to improve the quality of maternity care by providing professionals with succinct, evidence-based information related to good practice*

- *to enable purchasing authorities to fulfil their target of ensuring that consumers are able to exercise informed choice cost effectively and thoroughly*
- *to enable midwives to offer non-directive support to women who are making their own informed choices.*

These objectives are being pursued through the preparation of leaflets 'in pairs', each pair containing one written for users and one for the professionals. Both are based on whatever evidence is available; the latter in particular are clear about the areas where research evidence is weak; for example while there is strong evidence that women benefit from continuous support while in labour, how that support should be best offered and by whom is not established.

However, the process of creating choice is far from straightforward. According to *Availability of Home Birth*, a 1995 report from the National Childbirth Trust, some women are being struck off GP lists if they request a home birth and in some areas it was hard or impossible to obtain one. In response to doctors' fears of being sued if a home pregnancy goes wrong, the BMA issued guidelines recommending that GPs wishing to provide maternity services should do so on a separate contract. The number of home births is still so small as to be almost invisible in national statistics.

The approach adopted in *Changing Childbirth* is of wider application. The King's Fund programme *Promoting Patient Choice* is building on earlier work in the USA covering prostate conditions, which found that watchful waiting was often preferred to active intervention when patients understood the implications of the alternatives. The Fund programme covers a number of additional clinical conditions:

- Incontinence
- Colorectal Cancer
- Inflammatory Bowel Disease
- Childhood Nocturnal Enuresis
- Post-Operative Pain Control
- Hormone Replacement Therapy
- Anxiety and Depression
- Menorrhagia

Finally, the Government has begun to argue that the consumer with rights is also a citizen with responsibilities. In February 1996 it launched a campaign to persuade patients to 'think more about how they use family doctor services'. In particular:

- *help patients think more about how they use the family doctor service;*
- *give patients more information to make better judgements about their health; and*
- *help patients take more responsibility for their own health;*

> *The Doctor Patient Partnership Campaign* [not to be confused with the quite distinct initiative already referred to] *aims to foster partnership and cooperation between patient and doctor. For this to work well, patients need to think about their responsibilities as well as their rights.* (PR 96/60)

The prime beneficiary of this campaign appears to be GPs irritated by night calls for non-urgent matters who might well support more 'patient responsibility'. But if the potential for patients to become 'responsible' is large, it is as demanding of the doctor as the patient. It will also require a sustained development effort, as the King's Fund programme shows.

The need for this has been recognised. In August 1995, Michael Peckham announced that an advisory group would be established within the framework of the R&D initiative to identify priorities on cost-effective methods of obtaining and using consumer views in decisions about

NHS R&D programme on consumer issues: terms of reference

i) To review the ways in which consumer views have been addressed in all stages of the NHS R&D programme to date.

ii) On the basis of the information gained in this review, to make recommendations on how consumer involvement could be enhanced in each stage of the R&D process. This would include:
- advising on priorities to be addressed in new research within the NHS R&D programme;
- agreeing the methodologies to be used to address these priorities;
- commissioning and managing the conduct of research;
- reporting on completed research; in association with the NHS Patient Partnership Initiative, disseminating and using the results of research to help consumers reach informed decisions about their own clinical treatment;

iii) To monitor arrangements for consumer involvement in the wider work of the CRDC and its sub committees.

iv) To advise on priorities for a programme of commissioned research into consumers' involvement in the NHS R&D programme

v) To report regularly to the CRDC.

the provision and delivery of health care. Its terms of reference are set out in the Box.

At a general level and subject to the reservations already expressed, the initiatives recorded here appear to be pushing the NHS in a direction which most would favour. However, although they all promote responsiveness, they do so in different ways which to some degree conflict. At the broadest level for example it is arguable that the very existence of *The Patient's Charter* has helped to give rise to some of the pressures that GPs and A&E departments have been experiencing. More specifically, the requirements of the *Charter* are set centrally, on the implicit assumption that 'everyone' would want to see them met. That may be so, but the more detailed they become, the greater the likelihood that they will conflict with locally or even individually expressed views. For example the American work referred to above, suggests that many patients would prefer 'watchful waiting' to immediate surgery, at least for prostate conditions. For those taking this view at least, longer waiting lists may be a sign of improvement rather than the reverse. These conflicts are some way in the future but is only a matter of time before they emerge.

1.5 Clinical knowledge

As the Secretary of State's speech cited at the beginning of this Review indicated, clinical knowledge emerged during a year as the fourth arm of the Government's policy towards the NHS. In November Stephen Dorrell followed his predecessor by arguing that:

> *It is by concentrating on increasing the effectiveness of clinical interventions that we are most likely to find the solutions to the dilemmas posed when rising demand and rising expectations meet the inevitable constraint of limited resources.* (PR 95/522)

With this statement, the significant link was drawn not only between clinical practice and the quality of care offered to patients, but the underlying theme of health care policy for over 40 years, cost containment. Two months later, in January 1996, the retiring Chief Medical Officer suggested in an interview reported in *The Independent* of 2 January 1996 that £1 billion might be saved out of current expenditure if ineffective treatments were eliminated. Not surprisingly, therefore, clinical effectiveness features as one of the six medium-term priorities in the Planning and Priorities Guidelines – see Box.

Knowledge-based care requires the generation of relevant knowledge, assessment of its

Clinical effectiveness

Improve the cost effectiveness of services throughout the NHS, and thereby secure the greatest health gain from the resources available, through formulating decisions on the basis of appropriate evidence about clinical effectiveness.

Building on the programme of action under G.1 of *EL(94)55*, the circular which purchasers should have developed and are implementing (sic), in partnership with providers and their clinicians and with primary health care teams, strategies to secure sustained and comprehensive improvements in clinical effectiveness, which demonstrate:

- the use of evidence of clinical outcomes and the results of clinical audit to influence changes in services;
- their sources and use of information to judge the effectiveness of services or interventions;
- how patients are being informed about evidence of effectiveness related to their treatment.

Purchasers should be able to demonstrate a significant change in the level of investment in an agreed range of primary, secondary and continuing care interventions as a result of applying available evidence of cost effectiveness, in particular within the key areas of *The Health of the Nation* strategy. This change should involve a shift in investment from less effective interventions towards investment in treatments shown to be effective.

Purchasers should develop plans for commissioning Cancer Services based on the Expert Advisory Group Committee report and the guidance on site-specific cancer types which will be produced over the next two years. For the less common cancers, this will be achieved in collaboration with other purchasers.

Source: *Planning and Priority Guidelines for the NHS 1996/97*

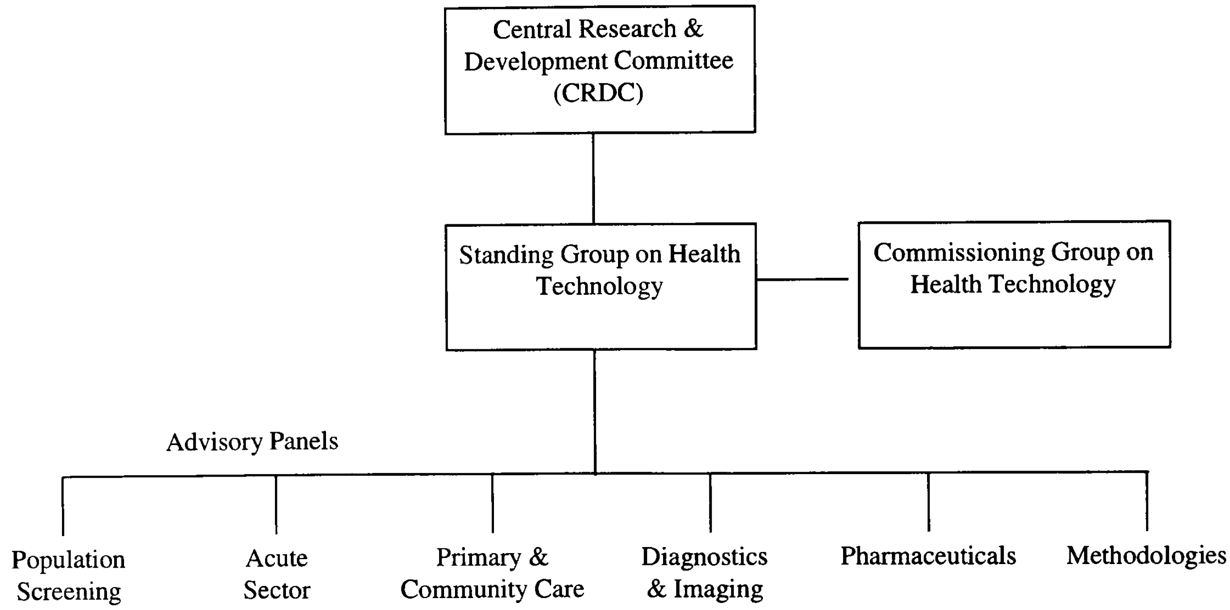
significance, dissemination of the results of that assessment, and finally application to clinical practice. We look briefly at developments in these successive stages.

Prior to the NHS and Community Act, a Committee of the House of Lords had reported on the state of medical research. In the words of a later Lords' Select Committee on Science and Technology which reported in 1995:

> *The Committee found UK medical research in a condition of despondency and low morale. Inadequate funding left many good research proposals unsupported; career prospects for clinical researchers were poor, particularly by comparison with medical staff engaged solely in clinical practice; clinical research was under pressure from the demands of clinical service; and above all, the NHS was run with little awareness of the needs of research or what it had to offer.* (p 5)

The 1988 Report made a series of recommendations designed to address these weaknesses to which the Government replied in 1989. While not all accepting all of them, it did accept the case for a Chief (later Director) of Research and Development, a post to which Michael Peckham was appointed. In 1991 he published *Research for Health*, the first step in the process of developing a programme of research and development, the composition of which was determined by the needs of its users, the NHS, as opposed to the interests of the researchers themselves. In addition, the intention was to transform, in Peckham's words, the NHS from 'a passive recipient of new technologies to a service with a research competence'.

To achieve that, a new structure had to be created, which could identify the areas where research was required and to ensure that it was commissioned. The main elements of that structure are shown in Figure 1. The process is overseen by a Central Research and Development Committee, chaired by the Director, which is supported by a series of other groups or committees. Some of these are standing bodies, but in order to define research priorities, a number of time-limited groups have been assembled, some disease-related, others



Source: *Report of the NHS Health Technology Assessment Programme 1995*

Figure 1 Structure of the Health Technology Assessment Programme

covering specific issues or clients. Angela Coulter's article in *Health Care UK 1994/95* listed the areas covered by these groups.

How much effort should be devoted to each and how large the R&D programme as a whole should be, was and remains, hard to determine. Giving oral evidence to the House of Lords Select Committee on Science and Technology, Professor Peckham said:

> *. . . when the programme started in 1991 it seemed to me very important to establish the principle of a percentage commitment of funds to R&D and that we would not, on a year by year basis, have to negotiate a sum. So we see that as being absolutely crucial. How to fix a percentage, well it was difficult because there was no detailed knowledge of the amount of NHS funding spent on research and indeed that remains the case in part. We estimated that if one took the service support funds into account together with other expenditures about 0.9 per cent of the NHS budget could broadly be said to be spent on research and the support of research. We saw that it needed to increase to cover the areas that we saw as important and we then made, if you like, an empirical decision based on the usual R&D expenditure of service industries which is between one and two per cent and set the target figure of 1.5 per cent. I think that has been a very useful target which we have worked towards but as the recommendations of the Culyer report are implemented we will no longer need to be enslaved by it.* (p 31)

The Culyer report was the work of a Task Force under Professor Anthony Culyer, which published *Supporting Research and Development* in 1994. The main recommendations of this report were accepted by the Government as set out in a circular issued in December 1994, *Supporting R&D in the NHS: implementation* EL(94)96. This proposed:

- *there should be a radical new 'single stream' funding mechanism for NHS R&D;*

- *R&D funds should be raised by a levy on purchasers of health care;*
- *an extra £8 million in 1995/96 for research commissioned by the NHS;*
- *a new role for the CRDC advising the NHS how to invest its R&D funds;*
- *the creation of a National Forum* [see Box] *to bring together the major health-related research funders to provide advice to NHS and the Government.* (PR 94/589)

The most immediate impact of the Culyer proposals was a requirement for all NHS bodies to identify the research currently underway. That process was still being carried out at the time of writing.

Most research funded through the R&D initiative is being carried out within Universities rather than the NHS itself, but much of the research relevant to the way care is provided comes from a vast range of sources, worldwide. The NHS therefore requires a means of assessing the evidence emerging from research wherever it is carried out and of the merits of new forms of treatment wherever they are identified. Thus while there may be a risk that technologies will fail to be exploited because their relevance to health care provision is not appreciated, there is a risk that new technologies will be introduced before their likely impact has been assessed.

As EL95(105) *Improving the Effectiveness of Clinical Services* notes:

> *Sometimes new health technologies become available before we have a complete picture of their application and cost effectiveness.*

It then goes on to set out a list of services where:

> *Any further investment . . . should be in the context of . . . recognised assessments, and not as part of routine care.*

National Forum terms of reference

To advise the Director of R&D, and through the Director of R&D, the Secretary of State for Health, on:

- current national and international strategic issues relating to R&D of importance to the NHS;
- advances in science and technology which may impact on health;
- technology transfer, covering links between basic science, applied research and health services;
- the development of coordinated systems for information derived from and about research;
- the capacity, and ways to increase the capacity, for undertaking R&D, including health services research, needed by the NHS;
- any other matters relating to R&D remitted to the forum by the Director of R&D.

With a view to setting a strategic framework for the CRDC, to advise the Director of R&D, and through Director of R&D the NHS Executive Board, on:

- the overall pattern of funding for R&D, and the plans and priorities of individual research funding agencies;
- the needs for NHS support for externally sponsored R&D within the NHS;
- progress on the establishment and operation of new systems for funding and supporting R&D in the NHS.

Those identified in the Circular are listed in Table 15. Many of these technologies come from outside traditional areas of medical research. As Michael Peckham put it (*Health Policy and Technological Innovation,* edited by J Newsom-Davis and D J Weatherall):

> *We can anticipate an increasing flow of technologies into health from research outside the conventional field of medical research. For example, noninvasive monitoring of cerebral oxygenation in neonates using near infrared*

Table 15 Health technology assessment: ongoing assessment

Population screening
- Screening for colorectal cancer by once only flexible sigmoidoscopy
- Antenatal screening for HIV
- Screening for Down's syndrome, using ultrasound measurement of nuchal translucency
- Screening for fragile X
- Neonatal screening for inborn errors of metabolism, including use of tandem mass-spectrometry and DNA analysis
- Screening for abdominal aortic aneurysm
- Screening for ovarian cancer
- Breast cancer screening from age 40
- Yearly breast screening
- Identifying and monitoring osteoporosis, featuring use of:
  - dual-energy X-ray absorptiometry
  - low frequency ultrasound
  - biochemical markers

Cancer services
- Laparoscopic surgery for colorectal cancer
- Specialist genetic assessment service for familial breast cancer

Cardiovascular services
- Transmyocardial revascularisation (TMR) as treatment for intractable angina
- Trail of bezafibrate for lower extremity arterial disease
- Carotid artery surgery for asymptomatic patients with carotid artery stenosis

Diagnostic and imaging services
- Evaluation of Picture Archiving and Communication Systems (PACS)
- Digital imaging techniques for screening for diabetic retinopathy
- PET scanning: particularly for epilepsy and lung cancer

Other services
- New treatments for low back pain surgery, including laser disc surgery and ligament procedures
- New and unevaluated treatments for benign prostatic hyperplasia, such as dilators, microwaves or lasers
- Use of lithotripsy to treat small asymptomatic renal calculi
- Radiotherapy for age-related macular degeneration of the eye

Results expected
- Results from the following assessments, some of which featured in previous ELs, will shortly be available:
  - Use of neonatal extracorporeal membrane oxygenation (ECMO)
  - Trial of Continuous Hyperfractionated Accelerated Radiotherapy Trial (CHART) versus conventional radiotherapy for:
  - non-small cell carcinoma of the bronchus
  - head and neck cancer
  - UKCCCR trial of two-view mammography for screening
  - Trial of faecal occult blood screening for colorectal cancer
  - The use of PSA to screen for prostatic carcinoma
  - Evaluations of interactive videos for informing patients on therapies

Source: *EL95(105)*

> *light makes use of technology from cruise missile guidance systems, the remote sensing of ballistic missiles, high-speed optoelectronics from telecommunications and naval research on techniques of underwater visualization (Delpy, personal communication). Another example is the Science and Engineering Research Council's Interdisciplinary Research Centre in Biomaterials which assembles diverse scientific disciplines and technical approaches to focus on the development of implants, including materials science, mechanical engineering, polymer chemistry, ceramic technology, protein and molecular biology, orthopaedics, pathology and dentistry. Research is directed towards the development of materials that are biological in concept, and materials that provide a stable interface with implants. An interesting example of cross-sector flow within the programme is the application to prostheses of approaches developed by the aerospace industry to the lifetime prediction of airframe materials.* (p 148)

He goes on to add:

> *This rich scenario offers a wide diversity of opportunities for the creation of new health technologies. But these fundamental advances pose the challenge of how to judge the value of new developments flowing from research and to make use of them in order to secure improvements in health. Considering the huge global investment in health-related science and technology, and the remarkable advances that have been achieved, the issues involved in harnessing inventions arising from health research have received scant attention.* (p 148)

In 1993 the Standing Group on Health Technology was established whose task it is to advise on national priorities for health technology assessment. Its tasks are:

- identifying technologies in need of assessment;
- advising where there is a particular need to control diffusion of a technology;
- identifying emerging technologies likely to have major implications for the NHS; and
- identifying and prioritising the need for R&D in methods used for health technology assessment.

In practice the role of assessment merges into dissemination. The need to disseminate to purchasers information derived from a proper assessment of all the information available about what is or is not clinically effective was recognised in the early days of the new NHS with the establishment of *Effective Health Care Bulletins*, and the series of epidemiologically based needs assessments and its importance reaffirmed in subsequent circulars. In 1993 the advice to purchasers was reaffirmed and strengthened in *Improving Clinical Effectiveness* EL (93/115).

During 1995/96 a series of events strengthened the Government's commitment to assessment and dissemination. In April 1995, the Minister for Health Gerry Malone formally launched the Cochrane Database of Systematic Reviews and in November, Lady Cumberlege, Parliamentary Secretary at the Department of Health, opened the National Centre for Evidence-Based Child Health, which is based in the Department of Paediatric Epidemiology at the Institute of Child Health, the research arm of Great Ormond Street Children's Hospital. The Centre is the second of a network of centres each with a different specialty interest. The first is sited at the John Radcliffe Hospital in Oxford and has the general remit of promoting the teaching, learning and evaluation of evidence-based medicine and health care, and of creating a graduate programme to train researchers to perform randomised trials and systematic reviews.

In the same month, the first international conference on the scientific basis of health services was held in London. In his opening address, the Secretary of State asserted that:

> *Five years on, a new programme is in place designed to create an effective link between the*

> *NHS and the methods and the products of science. I believe it has the potential to make the single biggest contribution to patient care in this country as we approach the next century.*
>
> *The task for health services is to take advantage of the burgeoning progress of science both to advance the treatment of disease and to devise realistic approaches to its prevention. If that commitment is to be delivered, health services need to invest in research and development.*
>
> *It is no longer sufficient to rely on clinicians reading articles in learned journals. They need to make a serious commitment to ensure that the results of modern medical science are made easily available to practising clinicians.* (PR 95/460)

As previous articles in *Health Care UK* have shown, there are major obstacles to be overcome if clinical knowledge is to be applied in practice. In the 1993/94 edition Nicholas Mays identified a large number of difficulties in the process of actually making use of the knowledge that exists. Last year Angela Coulter identified a number of areas which might hinder the effective implementation of the R&D initiative.

In October 1995, the Department of Health published *Methods to Promote the Implementation of Research Findings in the NHS – Priorities for Evaluation,* which identified 20 possible methods for improving the way in which evidence arising from research might be incorporated into clinical practice and proposed a programme of research into each of them. In November 1995, the Secretary of State urged that clinicians should be fully involved in health authority purchasing decisions so as to:

> *. . . ensure that they can play a full role in encouraging Trusts to apply the latest medical knowledge to the benefit of their patients. Only then can we be sure that advances in clinical practice, effectiveness and latest research evidence are being rapidly reflected in patient care.* (PR 95/522)

In December 1995, the NHS Executive issued *Improving the effectiveness of clinical services* (EL(95)105) which signalled its intention to make clinical and cost effectiveness of services a part of the routine management of the NHS. In particular it asserts that:

> *Enough good quality information is available now to support local strategies to promote clinical effectiveness. Managers and clinicians in primary and secondary care can do this in a way which focuses on patient care and involves patients in decisions about services. These local strategies should demonstrate:*
>
> - *the use of clinical outcomes and clinical audit to influence changes in services;*
> - *the sources and use of information to judge the effectiveness of services;*
> - *how patients are being informed about effectiveness related to their treatment.*
>
> *Purchasers can then begin to demonstrate a significant change in the level of investment in an agreed range of primary, secondary and continuing care services, from less effective towards investment in interventions shown to be more effective.* (PR 95/105)

In January 1996, the Secretary of State launched *Promoting Clinical Effectiveness* which 'sets out a framework for action throughout the NHS and provides information and guidance to promote implementation at local level.' It includes:

- *a plan for a formulary of clinical effectiveness giving summaries of the latest clinical information;*
- *a compendium of existing advice to health authorities and GP fundholders on clinical issues;*
- *a review of health authorities investment in promoting cost effective clinical practice;*
- *a requirement for health authorities to promote at least two interventions shown to be effective and*

work to reduce the use of at least two known to be less so);

- *issue more guidelines on clinical effectiveness for local decision makers;*
- *consulting on the value of more research based evidence information for GPs on common illnesses such as sore throats, coughs and tiredness;*
- *a plan for a series of 'Choice Leaflets' for patients from the Centre for Research and Dissemination showing the benefits and limitations of various treatments, like antibiotics for 'flu;*
- *a programme to measure and demonstrate the health benefit of more effective treatments.* (PR 95/460)

A large number of organisations or *ad hoc* groups are already at work throughout the NHS attempting to modify clinical practice in the light of the available evidence. For example the King's Fund programme *Promoting Action on Clinical Effectiveness* (PACE) operates on 16 sites throughout England.

The elevation of clinical effectiveness to form a central plank in the Government's health policy may seem uncontentious. The development of the hospital in the 20th century, government funding through the Medical Research Council and other channels could with justification be seen as the antecedents of such a policy. In other words, modern medical practice has always rested on a body of explicit knowledge – or what was taken to be knowledge – and politicians and the professions have, since the foundation of the NHS, been concerned, in a broad sense, with the quality of care it provides. A great deal of the informal regulatory structure within the NHS which emanates largely from the Royal Colleges over staffing levels, training programmes and appropriate configurations of hospital services has been designed to that end.

However, it was only with the 1990 Act that medical, later clinical, audit, became a general requirement throughout the NHS. Last year's Review drew on evidence presented to the Committee on the implementation of medical audit in Scotland which revealed how slow the process had been. A report from CASPE Research, *Provider Audit in England: a review of 29 programmes*, concluded that:

- *the monitoring of the progress of programmes was difficult due to a general lack of well focused objectives and low quality data being reported;*
- *attendance at audit meetings was generally high, but further participation in clinical audit was at a rather lower level. Providers believed, however, that commitment had grown in the three year period;*
- *the nature of changes reported as arising from clinical audit was diverse, although relatively few directly affected the quality of health care delivered to patients. Most changes focused on the health care delivery process which could be expected to affect patients indirectly.* (p 25)

A further CASPE report: *The audit activities of the medical royal colleges and their faculties in England*, concluded that the colleges had had a significant role in promoting clinical audit within the medical professions during the early days of development, and that the programmes were generally successful. The NHS Management Executive had, however, adopted a non-prescriptive approach to this professional area of audit that had led to programmes which were uncoordinated and priorities which were self-selected rather than national in nature; and there was little possibility of evaluation since the objectives of the programmes were often poorly defined. It also noted that there had been little formal evaluation of the outcome of college clinical audit activities.

A National Audit Office report, *Clinical Audit in England*, included some case studies where audit was perceived to have produced a beneficial effect, eg:

- *one general practice increased the number of appointments available for patients by 15 per cent;*

- *a fixed time has been set aside each day for a general practitioner to be available to speak to patients on the telephone where an immediate appointment is not possible;*
- *a practice charter has been introduced;*
- *'repeat' appointments have been reduced to make more 'new' appointments available; and*
- *an initiative has been introduced to reduce the number of patients who fail to attend for their appointments.* (p 23)

These may be worthwhile if meagre returns.

A further CASPE report, *Nursing And Therapy Audit* by Judy Foster and others, found that although there was evidence of audit having a beneficial effect on patient care, there were serious shortcomings.

> *The experience of others, both within and outside healthcare, suggests that establishing a successful quality improvement programme demands a substantial and continuing investment in training and education, to raise awareness of audit, to generate and maintain positive attitudes towards audit, to provide participants in the audit process with the necessary skills, and to build teams and organisational support structures. However in the nursing and therapy audit programme, it was noticeable that very few resources had been committed to training and education for clinical professionals, many of who were encountering audit for the first time. The expectation that staff would already have the necessary skills was unrealistic and many clinical professionals had to learn while undertaking audit projects and initiatives.* (p 100)

As the range of the initiatives described here indicates, devising and implementing a programme for the generation and application of knowledge represent a massive task. One measure of that task, suggested in the report of the Standing Group on Health Technology (p 1), is that over one million interventions are in everyday use.

Of those, only a small fraction, usually quoted as 15 per cent, have been evaluated by the so-called gold standard of the randomised control trial, and most of these have been pharmacological ones. However, as David Sackett, Professor of Evidence-Based Medicine at Oxford, has pointed out, most patients have common conditions and the common treatments have largely been validated. Moreover, many life-saving interventions, such as blood transfusion or appendicectomy in the case of acute appendicitis, have never been and never will be validated though no one doubts their effectiveness.

Nevertheless, a NAHAT study, *Acting on the Evidence*, points out:

> *Although it may seem as if there is a massive amount of information on effectiveness available, it still covers only a very small proportion of healthcare activity. There are many important gaps, which have yet to be addressed. For example, over 70 per cent of the items listed relate to treatments which form part of acute care, with far fewer items covering healthcare interventions in mental health, learning difficulties or the community. Needless to say, this distribution of clinical and cost effectiveness evidence does not reflect the relative spending or activity in these healthcare sectors. The largest single group of items of information deals with pharmaceutical interventions, which is not surprising given the longer history of RCTs and similar evaluations of new drugs.*
>
> *Perhaps most tellingly, the great majority of items listed (79%) relate to activities undertaken by the medical profession, and very few concern the work of nurses, physiotherapists, and other clinical professionals. In short, the available evidence is biased towards acute care, drug therapy, and the work of doctors – to the detriment of other equally important healthcare interventions. The analysis by diagnostic group* [see Table 16] *demonstrates that there are many important areas of medicine which evidence-based medicine*

Table 16 Coverage of information on clinical effectiveness

Factor	Category	Number	Percent
Health-care sector to which item relates	Acute	71	71
	Community	19	19
	Mental health and mental handicap	10	10
Intervention type described by item	Drugs	34	35
	Surgical procedures	24	25
	Therapeutic/interpersonal	12	12
	Screening/diagnostic tests	8	8
	Aids and adaptations	3	3
	Other/miscellaneous	16	16
Professions involved in area covered by item	Medical	83	79
	Nursing	16	15
	Paramedical	6	6
Major diagnostic group of patients or conditions covered by item (based on ICD chapter headings)	Infectious diseases	0	0
	Neoplasms	4	5
	Endocrine, metabolic and nutrition	5	6
	Blood/blood forming organs	2	2
	Mental disorders	8	9
	Nervous system and sense organs	1	1
	Eye	2	2
	Ear	2	2
	Circulatory system	13	15
	Respiratory system	4	5
	Digestive system	5	6
	Genitourinary system	9	10
	Pregnancy and childbirth	5	6
	Skin	4	5
	Musculoskeletal system	9	10
	Congenital abnormalities/disorders	4	5
	Other	10	11

Note: some items of information were assigned to multiple categories for some factors, so totals for different factors vary, and exceed the number of items listed in the Appendix. Percentages may not sum to 100 due to rounding.

Source: John Appleby, Kieran Walsh and Chris Ham, *Acting on the Evidence*, NAHAT 1995.

> *has yet to reach. In important specialties, such as haematology, otolaryngology and neurology there are just one or two items of clinical and cost effectiveness information currently available.* (p 26)

The gaps are particularly significant for service planning where clinical and other forms of knowledge need to be combined. As the Audit Commission report, *By Accident or Design*, commented in relation to A&E services:

> . . . *fundamental data on which to base decisions about the future of emergency services*

> *are still lacking. To date, there has been little evaluation following A&E closures or amalgamations, so the effects on the local population, on waiting times for treatment, or on total NHS costs remain unclear.* (p 72)

Similar conclusions could be drawn for other fields of care: as Anthony Harrison and Sally Prentice in *Acute Futures* (King's Fund 1996) have brought out, knowledge of many of the key factors relevant to determining the best pattern of hospital services is weak.

While the various initiatives described here have succeeded in putting clinical knowledge on the political as well as the professional agenda, *Promoting Clinical Effectiveness* acknowledges that there is little information which will assist in demonstrating whether or not treatments offer 'value for money'.

The elimination of treatments on grounds of ineffectiveness alone is likely to be a slow process. The £1 billion Sir Michael Peckham suggested might be saved through evidence-based medicine is roughly equivalent to the volume of resources assumed to be 'saved' in less than two years of efficiency savings. But it may be misleading to think in terms of savings. The return is much more likely to take the form of greater health gain through better targeted and more appropriate intervention, rather than outright cost reduction through complete elimination of treatment.

Part 2

Commentary

As in previous years the second part of our Policy Review assesses developments within three broad headings, Efficiency and Finance, Equity, and Accountability. The Priorities and Planning Guidance puts it rather differently, preferring Responsiveness to Accountability. However desirable responsiveness may be, the needs of 'upwards' accountability to Ministers, Parliament and ultimately to taxpayers and the electorate at large remain.

2.1 Efficiency and finance

In the November Budget Statement, the Government announced increases in spending that maintain its election pledge to make an increasing level of real resources available to the NHS. The total for current spending was forecast to increase by £1.3 billion or 1.6 per cent in real terms, provided that wages and salaries did not rise more than the 3 per cent assumed. Within that total, spending on family health services was set to grow by 3.9 per cent and hospital and community services by 1.1 per cent, while additional resources were made available for research and development, education and training, and mental health services in the form of the Mental Health Challenge Fund.

In respect of capital however, a substantial cut was announced, indicating the Government's determination to apply the Private Finance Initiative to mainstream NHS projects, raising the total to be financed privately to £165 million.

Last year's Review noted that private finance had been confined to small-scale projects, not involving clinical services. The first contracts for main hospital services were announced during the year. These include a £59 million project at St James's Hospital in Leeds which will provide a new paediatric wing, a patient hotel for low dependency patients, a medical science part for research and bio-technology activities and parking facilities, a £90 million scheme for rebuilding Swindon's Princess Margaret Hospital and a £170 million scheme for a new hospital in Norwich. According to John Horam, the Parliamentary Secretary for Health,

> *Improvements to services can be achieved more quickly through the PFI than through the traditional public sector route.* (PR 96/23)

There must be few within or without the NHS who would share that view. Far from speeding up capital schemes, the reverse appears to be true, given the complexity of the processes involved in agreeing the respective roles of public and private interests. The private sector itself also appears to be less than enthusiastic. According to a survey by the Computer Services and Software Association (*The Health Business Summary* January 1996):

> *Many in the IT industry are concerned that the cost of bidding – high enough already – has gone up. Some of the smaller PFI projects are costing more to tender than the actual project they set out to procure. Buying cycles are now*

> *often 18 months rather than 6-12 months. Business cases are often sent back and resubmitted several times, further delaying the operation. There seem to be very limited resources available within the approval process to complete and assess the business cases presented.* (p 2)

Similar evidence was submitted to the Treasury Committee's inquiry into the Initiative. The Committee welcomed the Initiative in principle but concluded that its benefits had not yet been demonstrated. They therefore proposed that the Treasury should demonstrate at some future date that higher financing costs had been more than offset by efficiency gains.

As in previous years, the increase in NHS finance was accompanied by the clearly stated expectation that activity at least in hospital and community services would increase at a greater rate than resources, ie 3 per cent over and above the 1.1 increase for this part of the NHS budget. Announcing the allocations, the Secretary of State said:

> *For 1996/97 I am again setting health authorities a challenging target for efficiency savings of 3 per cent – equivalent to £650 million – which will be ploughed back into the service in line with our past pledges. An important contribution to this will be the planned savings of some £130 million – 8 per cent in real terms – from a reduction in the management costs of NHS trusts and the costs of running health authorities.* (PR 95/542)

For more than ten years the Government has been explicitly aiming to make the resources available to the NHS more productive. The only way in which such productivity is routinely monitored, the cost-weighted activity index, continues to suggest that it has been successful and that the rate of improvement has not diminished. Overall, hospital and community health services appear to have succeeded in offsetting a relatively high rate of inflation by achieving more 'output per person employed': see Table 17.

Table 17 Hospital and community health services: expenditure and productivity trends

	HCHS Cost Weighted Activity Index	Expenditure adjusted for changes in input unit costs	Expenditure in real terms
		1983-84=100	
1983-84	100.0	100.0	100.0
1984-85	103.0	100.1	100.8
1985-86	105.7	100.2	100.4
1986-87	107.3	100.6	104.7
1987-88	109.1	101.3	108.6
1988-89	110.0	102.1	113.4
1989-90	112.4	103.8	114.7
1990-91	113.9	106.8	116.5
1991-92	119.8	107.5	123.8
1992-93	123.6	111.1	131.2
1993-94	128.5	112.7	133.8

Note: 1993-94 figures are provisional.
Source: As for Table 6

Despite the continuing increases in measurable levels of activity, there were a number of incidents during the year which suggested that hospital capacity was insufficient to deal with the demands being placed upon it. Most centred on the provision of emergency care. Some hospitals had to refuse admission to patients because they had no available beds or to make them wait for substantial periods of time before being admitted. At various times during the year, A&E departments in a number of hospitals had to temporarily close because of staff shortage and in some cases GPs have been brought in for overnight work.

In January 1996 the British Medical Association Council passed a motion pressing the Government for action to 'rectify the severe and prolonged bed crisis in the acute sector'. It claimed that the:

> *Contract system seems close to collapse in some areas with Trusts short of money as contracts run out nine months into the financial year.*

The pressures on beds were most effectively highlighted by a series of cases where patients were passed from hospital to hospital or transferred over long distances by air ambulance before they could be admitted to an intensive care bed. For example, Nicholas Geldard, a Stockport boy, was transferred between four hospitals, including a trip across the Pennines, to Leeds where he was found to be dead.

A telephone survey by the Labour Party (necessary because of the lack of any official statistics of admissions to hospitals over the winter months) found that over a four-month period children had been turned away from intensive care units on 300 occasions – with what ultimate effect on their health was not established.

In the face of the pressures arising from this and other similar incidents, the Government issued a wide-ranging statement on emergency care:

> *In the short term they [hospitals] will need to show how resources will be managed to meet short term fluctuations in the workload; they will need to consider the use of admission wards; they will need to consider improving access for patients in the A&E department to hospital diagnostic facilities; they will need to consider the relationship with local social service departments, and a number of other issues that have been shown to contribute to the efficient running of emergency services.*
>
> *There are also a number of longer term issues which health authorities need to address:*
>
> - *firstly, they need to consider how they intend to strengthen the purchasing function in emergency care in order to bring a clearer focus on patients' expectations for these services.*
> - *secondly, there is still a considerable amount of work to be done in workforce planning for A&E services.*
> - *thirdly, I have asked the Chief Medical Officer to undertake a review of emergency care services outside hospital. It is important that health authorities plan for a full range of service, and do not rely only on hospital A&E departments.* (PR 96/95)

In addition, the Secretary of State announced measures to improve the availability of intensive care beds and drew Trusts' attention to examples of good practice, see Box overleaf.

Within general practice, the demand for urgent care also appeared to be rising. In April 1995, the Government produced a new package of measures designed to relieve the pressure on family doctors providing services outside normal surgery hours. The proposals included:

- a change to the GP's terms of service to allow a doctor to transfer his or her out-of-hours responsibility to another GP;
- changes to the rules which would allow Family Health Service Authorities to use their

Good practice

- Education and Training: the majority of units with the most severe recruitment problems are those where educational opportunities are poor and/or the workload interferes with SHO training. This can be helped by the employment of a clinical assistant, GP or staff grade doctor.
- Rotations which include A&E: these offer SHOs the opportunity of a year long post, ie February to February, linked to other inpatient specialities.
- Review of Work Patterns in A&E Departments: this would include reducing the number of steps patients go through when they attended A&E, ie patients with clear-cut diagnoses going directly to the relevant team; patients known to the hospital being admitted directly; patients sent in by GPs being admitted directly by the appropriate team.
- Effective use of Clinical Staff: many simple actions can be taken to improve the working capacity of the SHO including providing dictaphones, secretarial support; reducing non-clinical/admin tasks and arranging for other appropriate staff to arrange discharge and follow-up.
- Review of Duty Rosters: to ensure that junior and senior doctors as well as available nurses are best deployed in relation to patient flows through A&E departments. This would include transferring to non-medical staff as much as possible of the administrative workload of senior doctors and readjusting clinical practice to avoid non-clinical activity being done at peak patient attendance times.
- Junior Doctors' Hours: the working arrangements of junior A&E doctors should ensure that their availability is maximised, within the limits on contracted hours, hours of work and appropriate rest periods required by the New Deal.
- Recruitment from within and outside the EEC: trusts with recruitment difficulties should seek guidance from trusts with established links overseas.

Source: EL (96) 3

cash-limited funds to help doctors find appropriate local solutions to their out-of-hours commitment through the development of co-operatives, for example;

- an additional £15 million to support the development of GP co-operatives, and for meeting the needs of those very rural GPs who cannot organise locally;

- a patient information campaign to help patients make the most appropriate and sensible use of their doctor's emergency service.

Pressures on services were also evident in other ways. In a number of clinical disciplines staff shortages were reported, particularly in psychiatry, anaesthetics, A&E, paediatrics and orthopaedics. A NAHAT medical recuitment survey confirmed that a majority of trusts were finding recruitment of consultants to be difficult. It also found high drop-out rates at both senior and junior levels.

Difficulties were also reported within general practice. The Medical Practices Committee 1995 Recruitment Survey found that:

> *As in 1994 the general thrust of replies was that there was a recruitment problem, with fewer applicants than previous years. It was perceived that the quality of applicants was poorer, nevertheless there were still good candidates to be appointed.* (p iii)

In February 1996, a Task Force set up by the BMA on the medical workforce concluded that there were insufficient doctors to meet the increasing demand and the change in the role and responsibilities of general practitioners working in the NHS.

The report points to the fall of 15 per cent in GP registrars, the rising proportion of women seeking a career in general practice and the virtual drying-up on recruitment from overseas into general practice. It made a large number of recommendations designed to improve the situation but concluded that the demand for medical staff was imperfectly understood.

> *Studies must be funded to identify recruitment trends, participation rates, retirements patterns and 'missing doctors.'*

These recommendations reflect a perception that the nature of the medical profession is changing, away from life-long commitment towards the more flexible and varied careers paths that typify other professions. The change made in 1990 to allow part-time GP practice and job-sharing, measures designed largely to allow more women to practise, indicate that the medical labour market is becoming more like any other labour market, subject to the forces of supply and demand and not, as implicitly assumed in planning for the future supply of doctors, a sector largely immune from market pressures.

The apparent shortage of medical staff led to a number of responses. In February 1996 the Government made £5.7 million available to create at least 300 new trainee consultant posts.

> *We have worked with the profession and managers to identify the specialties where there are difficulties in recruiting to consultant posts. The new system means that we can tackle these problems directly by giving priority to those specialties where the need is greatest; these include paediatrics, anaesthetics (these two will have the largest increases), accident and emergency, trauma and orthopaedic surgery, and mental illness. Substantial increases will also be achieved in most other specialties. These will underpin the implementation of the Chief Medical Officer's reforms of medical training, which will lead to a consultant-based hospital service.* (PR 96/46)

Responding to the second report from the Medical Workforce Standing Advisory Committee, the Government announced that the numbers of doctors in training would be increased.

> *The Government accepts the Committee's main recommendation of a gradual increase in the UK target medical school intake from 4,470 to 4,970 by the year 2000. We will be discussing its implementation with interested parties.* (PR 95/323)

In March the recommendations of the Specialist Workforce Advisory Group (SWAG) were published. The main recommendations, set out in EL(96)8, were:

> *Available resources should be targeted in such a way that gives priority to particular specialties with major recruitment problems. The following specialties are those which are currently showing evidence of recruitment difficulty at consultant level. Deans will be expected to achieve full implementation of their targets in these priority specialties:*
>
> - *accident & emergency medicine*
> - *anaesthetics*
> - *diagnostic radiology*
> - *forensic psychiatry*
> - *general surgery*
> - *medical oncology*
> - *obstetrics & gynaecology*
> - *old age psychiatry*
> - *ophthalmology*
> - *orthopaedic surgery*
> - *paediatrics*
> - *palliative medicine*
> - *psychiatry (mental illness)*
> - *radiotherapy (clinical oncology)*
> - *urology.*

Shortages were not confined to the medical profession. Incomes Data Services conducted a Labour Market Survey in October 1995 which found that skill shortages had got worse, with the most persistent shortages in the professions allied to medicine as Table 18 shows.

Whatever the merits of the decision to increase the number of doctors in training, it could have no impact on the current situation. To ease the situation in A&E departments the Government relaxed the rules relating to the structure of medical staffing, allowing trusts to recruit extra staff even if that meant exceeding the nationally agreed ratio of staff grades to consultants of 10 to 1. A number of trusts took matters into their own hand, by recruiting to senior medical posts from other countries to meet pressing shortages and others begun the process of assessing the extent to which nurses or others could do the work currently being done by doctors.

A number of small-scale studies have been carried out of nurses taking on medical roles within hospitals, largely stimulated by the reduction of hours worked by junior doctors. In 1991, under the so-called New Deal, the Government agreed that as of the end of 1996, no junior doctor or dentists should be contracted for over 72 hours a week. By September 1995, there remained 1719 posts in England contracted for more than this.

The need to reduce junior doctors' hours stems in part from the changing nature of the hospital service: shorter lengths of stay and an increase in day surgery mean that a higher proportion of those in hospital need medical care. But the Government's success in bringing their contracted hours down has in turn made it harder to staff and run hospitals. The shortage reported in A&E departments is one sign of this but the implications go much wider. In many hospitals, reductions in the effective availability of junior doctors combined with the changes being brought about in medical training to bring the UK system closer to the EU – usually referred to cryptically as Calman – are compelling changes in the way that services are provided.

Such changes were arguably necessary in any case. Early in 1995 the Audit Commission published *The Doctor's Tale*, which concluded that doctors' working arrangements have not adapted fast enough to the rapidly changing environment in which they work.

The apparent crisis in hospital staffing is beginning to lead to new thinking. In January 1995, the BMA published *Towards Tomorrow*, a report from its central consultants and specialists committee, the origins of which lie primarily in the changes required in the training of junior doctors but also in broader changes which appear to be required in the structure of health care delivery. Among its recommendations was that the role of the non-medical workforce should be extended:

Table 18 NHS Shortage Groups

	No. of organisations
Professions allied to medicine:	
Physiotherapists	22
Occupational therapists	14
Psychologists	13
Speech therapists	5
PAMs generally	14
Nursing & midwifery:	
Children's nurses	6
Mental health nurses	6
ICU nurses	3
Specialist nurses generally	8
Qualified nurses generally	8
Health visitors	3
Medical:	
Junior doctors	7
Consultant psychiatrists	5
Consultant anaesthetists	4
Consultants generally	6
Medical staff generally	12
Other:	
Medical secretaries	7
Ancillary staff	4
Technical staff	3

Source: *Incomes Data Services, Pay in the Public Services, p131*

> *The possibilities for delegating medical procedures to non-medically qualified staff will depend upon the specialty of the team. In all specialties there are certain medical procedures which should only be undertaken by a doctor, but these will clearly vary between specialties.*
>
> *Diagnosis: In some specialties non-medically qualified staff already have some responsibility in the diagnostic process. There is scope for increased involvement of non-medically qualified staff in the diagnostic and treatment process but only within the parameters of individual protocols. For example, although Clinical Nurse Practitioners (CNPs) can fulfil a useful 'screening' diagnostic role, this is necessarily less complex than that allowed by a medical training.*
>
> *Prescribing: Some non-medically qualified staff can already prescribe from a limited list of drugs. This could be extended within limits set by the consultant.*
>
> *Surgical procedures: Some non-medically qualified staff already carry out surgical procedures (for example cardiac surgeons' assistants) and it should be possible to extend this practice, for example by nurses acting as first assistants in theatre.* (p 11)

Furthermore the Royal College of Physicians of London and the Royal College of Nursing published a joint statement on skill-sharing (*Journal of the Royal College of Physicians of London* January/February 1996):

> *For a number of years there has been a trend towards the sharing of skills, with their transfer from one group with which they have been traditionally associated to another within the health care professions. Examples in medicine include nurses delivering care to patients with diabetes mellitus, carrying out gastrointestinal endoscopy, administering intravenous chemotherapy to patients with cancer, and contributing to the management of patients myocardial infarction and with asthma; opticians are employed in the screening of patients for glaucoma and diabetic retinopathy; and physiotherapy and radiography grew out of nursing. This movement is seen to be advantageous for patient care in that it extends the range and numbers of personnel.*

In the same vein, the NHS Chief Executive told the Committee of Public Accounts (17 May 1995) that:

> *We might well consider that people in the medical profession will have rather more flexible careers in the future and may be required at different times in their career to top up their training or sometimes to retrain . . . some specialties, I think that the relationship between the medical profession and other professions has to be explored and there is very good evidence now in accident and emergency departments and intensive care units that nurse practitioners can often substitute for shortages or the requirement to maximise the use of highly specialised medical skills. We need to be much more imaginative in our whole approach to work force planning and the speed of change, not demography as your hip replacement example implies, because that is controllable and is predictable, but the speed of change, particularly in relation to science and technology and maybe also social expectations, is now happening at a pace we have never experienced before.* (p 8)

The Medical Workforce Standing Advisory Committee's 1995 report *Planning the Medical Workforce* had drawn, for the first time, on a wider-ranging analysis of future economic prospects and it also looked explicitly at the scope for changing the balance of the workforce. It concluded:

> *Skill mix appears to be an essential mechanism to help manage changes of the scale and complexity currently underway in the NHS. We suggest that skill mix changes are a means of augmenting the efforts of the existing medical workforce, without which maintenance*

> *of services to patients would be difficult. We consider purchasers and trusts must take responsibility for developing and supporting further changes to the skill mix, which reflect their own local needs and priorities for services, to improve the overall quality of patient care and the morale and efficiency of the workforce.*
>
> *As with other issues considered in this report, the consequences of changing the skill mix on the future requirement for doctors are not clearcut. At present we cannot judge the future need for doctors should there be widespread substitution of significant tranches of medical work by other health professionals. We do not know the acceptability of such a move to patients, purchasers and the professions involved. We do not know the extent to which substitution is feasible in terms of standards of care, costs, training requirements and recruitment into the various professions.* (p 65)

When last year's Review went to press, the Government still had not concluded last year's pay round. In the event, it did not manage to do so until the Autumn, by which time the next round was underway. The drawn-out nature of the negotiations reflects, on the one hand, the Government's insistence on local pay and, on the other, the workforce's strong opposition to it, reflected most clearly in the vote in May by the Royal College of Nursing to allow their members to take limited industrial action.

In the end, the result was a formula which represents a compromise between the two positions: local negotiations went ahead, but in the knowledge that in the following year an adjustment would be made to pay levels where settlements had been reached below the national average. The main features of this framework are set out in the Box opposite.

The RCN were not party to this agreement although subsequently these terms were accepted by staff side nursing and midwifery representatives. However, as the Pay Review Body for Nursing Staff notes, staff resistance to local pay remains strong:

> *The arguments in favour of local pay determination in trusts remain unchanged. The issues and possible risks relate largely to how the process is handled and here management bears the main responsibility. We believe that trusts should set out to allay the fears of staff that local pay will lead to lower levels of pay and conditions. The perception that staff could only lose out through local pay determination was a striking feature of our visits. The experience of other industries, and our reading of the limited evidence so far available about trust contracts, suggest that local terms and conditions as a whole are unlikely to be less favourable than those embodied in national agreements, and may in some respects be more favourable. Local pay can be expected to lead to new pay structures and working arrangements but we do not see it as a 'low pay' agenda.* (p 8)

The Government insisted in the *Planning and Priorities Guidance* that:

> *Significant progress should be demonstrated by employers in the development of local contracts and reward packages.*

But the national position made it hard for trusts to decide what to do. Incomes Data Services in early 1995 found that half of trusts had attached strings to their offer, including the following:

- *acceptance of trust contracts (ie those who retained Whitley conditions would not get a local increase)*
- *meeting of trust financial or performance targets*
- *meeting targets on sickness absence rates*
- *conversion of two extra-statutory holidays into annual leave (resulting in a loss of earnings as trusts no longer pay premium rates for those two days)*
- *consolidation of allowances into national rates*

Extract from the national framework agreement on pay

The Review Body for Nursing Staff, Midwives and Health Visitors (NPRB) and the Nursing and Midwifery Staffs Negotiating Council (NMNC) will continue to provide the machinery by which local pay is developed within a national framework;

New 'national' rates of pay effective from 1 April 1995 form the initial base against which further increases resulting from local negotiations will be monitored;

Information will be collected, in respect of the various staff groups subject to 'national' terms, on the levels of settlements reached locally - the accuracy of the information being subject to agreement locally before being provided; precise details of information to be collected will be a matter for agreement nationally in the NMNC in conjunction with the NPRB and their results will be shared between the two Sides; information will also be collected about the numbers of staff employed exclusively on local terms and conditions; in subsequent years this process will take place from April and will normally be concluded by August;

From this information the NMNC will - in respect of the staff within their remit - establish the range of levels of increases and, having regard to certain guiding principles and parameters set out in the paragraph (e) below, seek to reach agreement on the levels of increases to be consolidated in the future national agreements; in subsequent years this will take place in August/September.

Source: *Incomes Data Services*

- *agreement to co-operate with a job evaluation exercise*
- *move to monthly pay.* (Pay in the Public Service, p 80)

Subsequently however, it appears that a number of the strings had been withdrawn, partly as a result of statements from the Executive suggesting they were inappropriate.

Most trusts have been putting new employees on trust contracts, along with those who change jobs or are promoted. These have largely mirrored the national terms particularly with respect to basic pay. Only a small number of trusts have introduced their own structures and the confusion at national level appears to have slowed progress in this direction down, even though according to Incomes Data Services, the majority of trusts are planning to move away from national conditions.

The next pay round was beginning before the previous one was completed. The guidance on local pay issued in February 1996 in EL(96)9, recognised the difficulties but urged trusts to press ahead:

> *1995 was a difficult year with protracted pay negotiations at national and local level but the result was that around 93 per cent of NHS staff had part of their pay determined locally, resulting in fair and affordable increases. It is important to build on this in 1996, with local pay forming part of trusts' strategies for delivering high quality patient services through a well motivated workforce. Purchasers should support trusts as employers in developing their management approach to pay, and other human resource policies, and should not carry out their financial and contracting responsibilities in a way which implies that local pay means low awards which might be held to be unfair by both staff and the public.*

Not surprisingly, despite the framework agreement, the various participants in the 1996 pay round wanted different things: the Department looked for a small national increase to be supplemented by local negotiation; the staff side, a national pay rise and no local element; the employers side, no national element, leaving all negotiations to be local. In the event no side was satisfied by the Review Bodies' recommendations.

The report of staff shortages naturally reappeared in the evidence prepared by staff representatives for the Pay Review Bodies. However, the Review Body for Nursing Staff, Midwives Health Visitors and the Professions Allied to Medicine in its 1996 Report did not accept that there was a national shortage of nursing staff and saw local pay as part of the solution to local difficulties.

> *We have carefully weighed all the evidence presented to us and we are not persuaded that there is a general nationwide shortage of nursing staff at the moment. There are clearly local difficulties and problems with particular specialties, and we believe that local pay may be part of the solution to these problems. We recognise, however, that other factors such as the design of individual jobs that take account of the needs of potential employees, and the procedures for facilitating the return to the workforce of qualified nursing staff, are also very important. Nevertheless, we also believe that there are some signs that more general shortages may emerge in the future. We believe that it is essential for national monitoring of the vacancy position to continue and be strengthened where necessary so as to provide a comprehensive and agreed basis on which to plan.* (p 18)

However, it recommended a national increase of 2 per cent, leaving little leeway for local bargaining if the assumptions in the Government's spending plans for the NHS are to be realised. The Government nevertheless regarded the recommendation as confirmation of the principle of local pay.

As far as doctors and dentists were concerned, their Review Body proposed an award of 3.8 per cent with higher increases for registrars (4.3 per cent) and house officers (5.8 per cent with a further 1 per cent to come). The Government accepted these awards though staged part of that to doctors and dentists until December 1996 'to avoid damaging patient care.' (PR 96/36).

The union reaction to this was to formulate a claim, based on the award to junior doctors, for a 6.45 per cent award for employees on both national and trust contracts. Obviously, an award at this level would be totally incompatible with the assumptions made in the public expenditure round.

The signs of stress in day-to-day service provision were to a lesser degree mirrored in financial strains within health authorities. Cambridgeshire Health Authority's refusal to pay for treatment for Jamie Bowen known as 'Child B' who suffered from a form of leukaemia, although justified in clinical terms appeared as a financial decision. Berkshire Health's announcement that it did not intend to support a range of services appeared to represent, perhaps because it coincided with reports of pressures on beds, evidence of a general failure to cope with the pressures of demand. In fact, a number of other purchasers have declined to pay for these treatments in previous years. Nevertheless, the Secretary of State was quick to issue a statement saying that no treatments were outside the NHS provided they were of clinical value, in the following words:

> *There should be no clinically effective treatment which a health authority decides as a matter of principle should not be provided; there will always be the exceptional case where treatment is clinically justified. To ban treatment in such circumstances would be inconsistent with the principles on which the NHS is established.* (PR 96/4)

This statement on the scope of the NHS appeared to rule out any reduction in the scope of NHS provision as a response to the pressures upon it. However, as noted in earlier Reviews, the scope of free provision has in fact been reduced in a number of areas. Before reviewing these, it is worth mentioning one area where the NHS took a small step in the other direction in the provision of wheelchairs. In February 1996, John Bowis announced that powered wheelchairs would be available within the NHS at a cost of £50 million. The new policy comprises:

- powered indoor/outdoor wheelchairs for severely disabled people
- a new voucher schemes allowing wheelchair users more choice and financial support if they choose a wheelchair provided by a private company.

Examples of services being improved are not rare: what is rare is the identification of an explicit sum to finance this particular one.

Sight Tests: There was no policy change towards eye services during the year, but further data became available on the public's response to the introduction of fees for sight tests. On the introduction of charges, numbers of tests fell dramatically and subsequently began to rise. As Table 19 shows, that rise has continued, but the level is still much below the previous figures.

Drugs: Prescription charges were increased as from April 1995 by 25p to £5.50. In January 1996 the Government announced a different approach to reducing prescribing costs in the form of pilot projects to test whether allowing pharmacists to dispense prescriptions in instalments can reduce the amount of medicines which never get taken. The aim here was to reduce waste:

> *There are many reasons why medicines are wasted; patients may start a medicine and find it disagrees with them; they may obtain several months' supply of their usual medicine but need to change to a different drug part way through; their illness may get better more quickly than expected; a GP may sometimes prescribe larger quantities than patients immediately need to save them making another appointment.*
>
> *The pilot projects for repeat and instalment dispensing will explore the benefits of GPs being able to write repeat prescriptions which would authorise a pharmacist to dispense repeat items on a number of separate occasions so that patients would not have to ask their GPs for a fresh prescription every time they needed further supplies.* (PR 96/22)

A measure such as this may be useful 'housekeeping' but cannot be expected to have a large impact on the drugs budget as a whole. One single drug, beta interferon, which appears to reduce the impact of multiple sclerosis, could do just that. During the year knowledge of its availability in the USA led to pressure for its use in the UK, where it is not yet licensed. At a cost of around £10,000 per person per year, it could on its own absorb a significant share of national spending on drugs. In this case, sufficient doubts were raised about its efficacy that the issue did not have to be grasped in practice. But it will not go away.

At present UK licensing is based on three criteria: efficacy, safety and quality of manufacture. Cost cannot, by law, be taken into account, leaving judgements on its cost effectiveness in particular applications to individual clinicians. Karen Bloor and colleagues argue below that this has got to change if the drugs bill is to be controlled.

Table 19 NHS eyesight tests paid for by family health services authorities: England

	Millions
1978-79	7.894
1979-80	8.331
1980-81	8.332
1981-82	8.469
1982-83	8.678
1983-84	9.266
1984-85	9.882
1985-86	10.246
1986-87	10.615
1987-88	11.695
1988-89	12.493
1989-90	5.280
1990-91	4.154
1991-92	4.979
1992-93	5.528
1993-94	5.935
1994-95	6.383

Source: House of Commons, Written Answers, 30 January 1996

Dental care: The policies announced last year confirmed the Government's commitment to maintaining dentistry within the NHS. But there were signs during the year that they were finding it difficult to do so in practice as dentists appear to have reacted to the new contract terms by withdrawing from NHS commitments except for those groups of the population such as children who receive free service.

Precise figures are hard to obtain for most dentists continue to do some NHS work, but there were signs from a number of areas that new patients were finding it difficult to get NHS treatment. No regular statistical series are available on the numbers of dentists continuing to work within the NHS nor of the type and number of patients they treat – many have been declining to take on new patients within the NHS or have decided only to treat fully exempt patients. The only way to get at the numbers of people finding it difficult to find an NHS dentist is through survey. According to a Harris Poll carried out for the British Dental Association, one in three people claim to find it difficult over the country as a whole but in the South East the figure was one in two; see Table 20.

A British Dental Association survey of 160 MPs discovered that constituents complained about difficulty in finding an NHS dentist as often as they did about local water companies. In a drought year such as 1995 that could be taken as strong evidence of a concern which was shared by both Government supporters and the Opposition.

Table 20 People finding it difficult to find an NHS dentist in their area (%)

North	19
Yorkshire and Humbershire	21
East Midlands	26
East Anglia	48
South East	52
London	33
South West	47
Wales	44
West Midlands	39
North West	27
Scotland	16

Source: British Dental Association

To help maintain an NHS dentistry service the Welsh Office offered grants of up to £50,000 to relocating practices and according to a report in *The Guardian* (13 December 1995), had succeeded in attracting 18 new recruitments over a period of two months.

Measures such as these would appear to suggest that it was proving hard to maintain an NHS dental service. However, the Doctors and Dentists Review Body was not inclined to see a crisis:

> *For our part we do not believe that a convincing case has been made by the profession for any of the forms of payment or restructuring referred to in the previous paragraph. Neither have we seen any data to suggest that NHS dentistry is in a state of crisis as the professions' representatives would have us believe, although we recognise that patients in some localities are having difficulty in accessing NHS treatment. Nevertheless we are concerned about dentists' perceptions of their remuneration system and the uncertainties about the future stemming from developments following the new contract which we have described in paragraphs 7.1-7.5. We believe dentists' morale to be generally low as a consequence. Moreover, we believe some action is now needed by us to demonstrate to dental practitioners that we have some concern about the recent shift to private practice which we believe to have been reinforced by the perverse effects of the TANI system and in particular the large cut in fees imposed by the Government in 1992-93 when we had recommended an 8.5 per cent increase in TANI (target earnings).* (p 51)

Nevertheless it did recommend that local packages should be developed:

> *Our first suggestion is that the Government should make available sums of money to the local health commissions and boards in order*

> *that incentives might be developed and offered locally according to patient need and dentists' circumstances to secure full availability of GDS treatment. As we record in Chapter 6, the Government has introduced a package of financial incentives to encourage workforce flexibility for general medical practitioners in the London Initiative Zone with resources being made available of £10 million, £15 million and £20 million in the years 1994-95, 1995-96 and 1996-97 respectively. We would like to see similar sums of money injected into the GDS to alleviate the growing problem of shortages of NHS dentists by encouraging dentists to enter the GDS and by rewarding those with a continuing commitment to the NHS. We would like to see incentives being made available to dentists during 1996–97, perhaps initially on a pilot basis in selected areas of the country.* (p 51)

As Jonathan Shepherd and his colleagues point out (*BMJ* 14 April 1996), dentistry represents, for the UK, a privatisation experiment, but not one that has either been properly structured or monitored. The 1998 dental survey will detect whether low income but not exempt families are receiving less dental care than before, but there is no systematic monitoring of the impact on other parts of the health service – community dental clinics, GPs, A&E departments and dental hospitals, of the changes that have been made. What is happening in dental care as a whole therefore remains unknown.

Long Term Care: Following on from the Guidance issued in early 1995 on the role of the NHS in continuing care, the Department of Health took a series of steps to ensure its implementation on the ground.

Priority E of the Priorities and Planning Guidance states that health authorities should:

> *Ensure, in collaboration with local authorities and other organisations, that integrated services are in place to meet need for continuing health care and to allow elderly, disabled or vulnerable people to be supported in the community.*

To back this up the Department of Health issued a checklist for purchasers to assist them in reviewing current practice and developing their own policies. Health authorities were required to develop plans for their areas and to state the criteria they intended to use by the end of September 1995. In HSG(95)39, the Department set out its proposals for reviewing decisions on eligibility for NHS continuing inpatient care: these require the establishment of review panels with an independent chair by each health authority. In EL(95)88 it set out proposals for monitoring how health authorities were responding and only a short time before the new arrangement were due to come into effect, it issued a further circular, EL(96)8, which drew authorities, attention to what it saw as emerging issues: health authority/local authority joint working, application of eligibility criteria and future priorities.

In November 1995, the House of Commons Health Select Committee published the results of the first phase of its study of long-term care. Much of the evidence presented to the Committee concerned two related issues: how to divide health from social care and how to define satisfactory criteria for determining the issue in practice. Obviously if the line was clear, the issue of definition would not arise. If the line cannot be pinned down, how can the individual understand what they may reasonably expect? The answer offered boils down to clinical judgement on a case-by-case basis as Alan Langlands explained to the Committee:

> *The point at which you translate to very specific circumstances is the point of interface between the doctor and the patient. That is where it is explained and it will not be explained in terms of our criteria, it will be explained in terms of how someone is feeling, what complications they have, what the aggregate position is and it will be explained one to one and evidence decisions taken about the best way forward.* (p 31)

If a line has to be drawn, is there a principled way of doing so? The Department and most of those giving evidence sought to define a line in terms of skill. Thus medical care is clearly part of the NHS, but nursing care, in the view of the department, could be divided into specialised and non-specialist. As nursing representatives pointed out, another skill line could be drawn between the trained nursed and the social care assistance in a nursing home. But why in either case skill level should be the relevant criterion was not discussed.

Another way of defining the line between health and social care lies in the nature of health care itself. Bill New and Julian Le Grand (*Rationing in the NHS*, King's Fund, 1996) attempt to define criteria which could be used to determine what should and what should not be included in a 'free' NHS. As they point out it is hard to observe any consistent criteria behind the exclusions that have taken place:

> *What, indeed, have tattoo removal and nursing care got in common that they are increasingly excluded from universal provision?*

They therefore consider the issue the other way round: what has the bunch of services making up publicly funded health care got in common? They suggest that health care has three special characteristics:

- the need for it is unpredictable
- there is an information imbalance between providers and users
- it is of fundamental importance.

The general nature of these criteria means that judgement will still be needed in their application both for particular services and for particular people. But using them, they reach a different set of exclusions and inclusions to those the Government has introduced: see Table 21.

Another, pragmatic rather than principled way of determining what should be included or excluded is to consider the implications of drawing a line at a particular interface. The issue here is one of efficiency rather than source of finance, as Professor Millard explained to the Health Select Committee:

> *Long-term care may be cheap per day but it is not the cost per day which is important in the running of health care for older people, it is the cost per case. The cost per case of everybody who goes into a nursing home who should not go and lives there on average three years, whoever is paying the budget, is £500 multiplied by 52, multiplied by three and that is a lot of money . . . I have absolutely no doubt that the correct way of controlling this is by controlling it by defensive thresholds, by rehabilitation, community care and state responsibility for the payment of long-term care*

Table 21 Examples of services which should be 'outside' NHS responsibilities, and those which should be 'inside'

'Out'	'In'
• Residential care for elderly people • Routine nursing home care for elderly • Cosmetic dental treatment; provision of spectacles and hearing aids • Cosmetic surgery (enhancement) • Medicines for non-complex conditions (eg headaches, hay fever)	• Continuing medical care • Medical or specialist nursing services for those in residential care • Curative dental treatment (including restorative work such as fillings); preventive dental and sight check-ups • Cosmetic surgery (reconstructive) • Fertility treatments

Source: Bill New and Julian Le Grand, *Rationing in the NHS*, King's Fund 1996 (p53)

> *however that is done because it is in the state's interest.* (p 48)

Following that argument to its logical conclusion, Professor Millard concluded that the boundary should be drawn so as to include social care within the health service: see Box.

As things stand, spending within the NHS may save money within the public sector as a whole. Hence redrawing the boundary and off-loading NHS responsibilities may not be quite as good a bargain for the public finances as it may at first sight appear: whether it is depends critically on how people respond to the financial incentives facing them.

The Select Committee inquiry has been part of a wider public debate about long-term care to which a number of organisations have contributed. In response to public concern, the Chancellor announced in the Autumn Budget Statement that the rules governing the use of assets to finance long-term care would be relaxed, allowing those forced to finance their own care to retain more capital than hitherto

A comprehensive service?

(Mr Congdon) Can I ask Professor Millard a question? In your evidence you claim that the requirement to have a registered nurse in nursing homes implies that the people in these homes have ongoing health care needs and therefore argue that nursing home care cannot be classified as social care. Are you arguing therefore that all nursing homes, in other words all nursing home care, should be the responsibility of the NHS? Do you make any differentiation between social care and health care needs?

(Professor Millard) The British Geriatrics Society argues that there should be a combined medical and social service throughout the country which is knowledge based, driven by standards and with universal quality of delivery of care. As a more rehabilitative approach was introduced into this country, into the current people or the future people going into residential care, as these guidelines begin to take action and the number of people in nursing homes and rest homes begins to be controlled then the people inside, coupled with the ageing of the population, will become progressively more dependent.

(Mr Congdon) That has not fully answered the point. I want to be very precise on this. We know we have a lot of nursing homes and from the discussion just now with Christine Hancock the argument was being advanced that in fact you could argue for a nursing presence in all homes. I would not particularly argue about that; I might argue about the scale and the level of skills in those homes. However, what I want to press you on is if in fact that is the case and therefore we have lots of elderly people who will need nursing home care or homes where there will be nurses present, the question is who should be responsible for that, who would be responsible for funding it?

(Professor Millard) Take the funding away. The responsibility for the home should be the responsibility of the people who make the decision that the person should go there. In other words a long-term responsibility for who is in a home should be the people who are running the service decisions that the person should go there. That is why I believe and the Society believes that there should be seamless acute rehabilitative long-term care service. The decision made as to who goes into a residential and nursing home, having failed a rehabilitative package, should be ongoingly reviewed by the physicians, the therapists, to see whether this decision was correct.

(Mr Congdon) Can we be a little more precise because we are in danger of being too vague on this? The inference, I would have to say from what you are saying, is that you would switch the current situation where effectively the community care package is determined by social services, switch it to health authorities or trusts, the health service. Is that what you are saying?

(Professor Millard) Yes.

Source: House of Commons Health Committee, Long Term Care, Vol II, Evidence, p51 was allowed. The upper limited, where people cease to get any help, was raised from £8,000 to £16,000 and the lower limit below which people do not have to contribute at all from £3 to £10,000

In May 1996 the Government published a consultation paper, *A New Partnership for Care in Old Age*, which aims to:

- *promote greater understanding of current arrangements for long-term care, so that people are aware of the costs they may face;*
- *encourage people to plan for the possible costs of their long-term care needs;*
- *stimulate the financial services industry to offer attractive, reliable products which will make provision easy and affordable.*

Nick Morris and Tim Wilsdon examine these claims elsewhere in this volume.

Overall

The pressures described here coincided with the publication of a number of discussion documents about the future of the NHS. In *UK Health and Healthcare Services*, for example, Health Care 2000, an *ad hoc* group set up with support from the pharmaceutical industry, concluded that:

> . . . *there appears to be a gap between resources and demand and the prognosis is that, without radical action, that gap will widen.* (p 44)

The difficult question is to determine whether the pressures observed during 1995/96 are simply a repeat of earlier situations, or whether they signal an entirely new situation. In its response to the apparent crisis in emergency care, the Government, much to the disappointment of the medical profession, declined to offer any more resources. Implicitly, it accused the BMA and others of shroudwaving.

On the other hand, the crisis may to some extent have been of the Government's own making. It has both increased the pressure on the acute hospital sector to produce more care episodes through the purchaser efficiency index and made it harder, through changes in medical staffing for them to do so. In several ways, as Anthony Harrison argued last year, current policies may be inconsistent. For example, developments in primary care, particularly those arising from the 1990 contract, and rising expectations fuelled in part by *The Patient's Charter*, may be contributing to the pressure on hospitals if GPs, as many allege, are seeking to off-load some of their work. If that is so, then the perception of pressure may be relieved by better management at national, rather than local level. There were signs during early 1996 that the NHS Executive was aware of the need to adjust the incentives and pressures bearing on trusts and the 1997/98 Planning Guidance recognised for the first time the need to provide a satisfactory level of emergency care. But this appeared as an *ad hoc* response, to specific pressures, rather than an appraisal of the situation as a whole.

2.2 Equity

The 1996/97 Priorities and Planning Guidance defines the equity objective for the NHS as:

> *improving the health of the population as a whole and reducing variations in health status by targeting resources where needs are greatest.*

The first part of this *improving the health of the population as a whole* can be interpreted to mean, as an equity objective, that everyone should have access to the services that the NHS provide – that no group or section of the population should be excluded. It also contains the implication that services should only be provided where they are effective – there is no justification on equity grounds for directing resources where they cannot 'improve' health. But the second part *targeting resources where needs are greatest* specifies the basis on which these resources are to be distributed, and this is 'need'.

No other criteria are deemed relevant.

'Need' of course has to be defined in operational terms. Over the past 20 years, financial resources have been allocated to different parts of England by an explicit formula. This, and its counterparts in other parts of the UK, have been designed to reflect relative needs and, by allowing for cost differences, to put all areas on an equal footing. Recent developments in this area are considered in the first part of this section.

Equity between regions or districts – 'territorial equity'– has been an explicit part of NHS policymaking for 20 years and it is this we consider first. Equity between individuals has been largely left to individual decisions by clinicians faced with an evident need to ration use of the resources at their disposal. But a number of recent events have pushed equity at this level to the fore: how it may be achieved and whether the 'need' criterion is adequate are considered in the second part of this section.

Territorial equity

Territorial equity has been pursued since the 1970s by attempting to ensure that the financial resources available to different parts of the country are the same, relative to need and allowing for variations in the cost of those resources. However, the most that such an approach can achieve is potential equality of access to services, unless it is accompanied by explicit definitions of the range of services which health authorities should provide and the volume and quality in which they are made available to individuals. Thus, there are at least four different ways of assessing whether resources are indeed being allocated equitably relative to need: purchasing power, availability, activity and quality. We look at these in turn.

Purchasing power: The RAWP formula, implemented during the late 1970s, introduced demographic, mortality and relative cost indicators into the formula used for allocating resources between regions so as to relate the volume of resources regions had at their disposal to the extent of ill health and not simply the size of the population, or the historical pattern of provision. This 'weighted capitation' approach has been widely accepted in principle ever since. The series of revisions during recent years as a result of reviews within the NHS or, as in the most recent changes which took effect in 1996/97, research carried out at the University of York, have been aimed at devising better measures of need and of cost differences.

Despite the apparent technical nature of these objectives, their pursuit has in practice proved controversial. The Department of Health modified the formula suggested by the original York work by distributing expenditure relating to community health services on an unweighted basis, ie a constant amount per head. That had the effect, relative to the 'pure' York formula of shifting resources to areas in the South-East outside London and away from other inner city areas.

Contesting this judgement, Mary Brennan, and Roy Carr-Hill argue that the services making up this group, which account for just under a quarter of the hospital and community services budget overall, should be distributed according to needs variables of the type used in the rest of the formula. The original York study was not able to demonstrate a satisfactory statistical link between need indicators and actual spending. That allowed the Department to exercise its own judgement as to how finance for these services should be allocated. Breen and Carr-Hill reach their position by taking each of the services in the community group and looking at the evidence which indicates the circumstances of people who benefit from them. As Table 22 shows, for some parts of the country, the difference between the two formulae is significant.

Thus despite 20 years' acceptance of the need for an equity-based formula for distributing finance to different parts of the country, the search for a satisfactory formula continues. Unless data sources are improved, that search will continue indefinitely. One way forward may be a National Cohort Study which would link service use to personal characteristics, and hence

Table 22 Gains from chosen Department of Health formula relative to an evidence-based allocation of the community spend

10 Highest Gainers	Gain %	10 Greatest Losers	Loss %
W Surrey & North East Hants	7.27	Lewisham and N Southwark	-6.87
Wycombe	7.11	Newham	-7.03
Basingstoke	7.03	West Birmingham	-7.04
Huntingdon	7.01	Tower Hamlets	-7.78
South West Surrey	6.82	West Lambeth	-7.78
Mid Essex	6.20	Camberwell	-8.28
East Hertfordshire	6.13	Bloomsbury & Islington	-8.84
Winchester	6.11	City and Hackney	-8.90
Tunbridge Wells	6.08	North Manchester	-9.78
West Berkshire	6.01	Central Manchester	-10.89

Source: M Brennan and R Carr-Hill, *No Need to Weight Community Health Programmes for Resource Allocation?* Table 1a, Discussion Paper 146, University of York 1995

provide data for monitoring health policy in a wider sense as well. However, the scope of the existing formula might be changed on the basis of data already available.

Currently, the resource allocation formulae and their equivalents in Scotland, Wales and Northern Ireland only focus on hospital and community health services, and are not used to allocate primary health care resources. This seems on the face of it to be clearly inconsistent: why should access to a GP not be decided on the same basis as access to hospital services?

Karen Bloor and Alan Maynard have analysed what would have happened to Regional Health Authority allocations if some form of RAWP approach had been applied to family health services. Some of their results are summarised in Table 23.

If the methodology used by the authors is accepted, then these data clearly demonstrate that the current allocation of primary health care resources to the old Regional Health Authorities of England would be significantly changed if some RAWP-like measure of need were taken into account. Furthermore, analysis by Michaela Benzeval and Ken Judge at the FHSA level suggests there is a systematic bias in the current arrangements against urban areas in favour of rural ones, as Table 24 shows.

If these results are accepted, what should follow? There are substantial practical obstacles to achieving a rapid evening out of the availability of GPs: practices cannot simply be uprooted and moved around. Furthermore, the differences in availability arise despite the efforts of the Medical Practices Committee over many years to influence where GPs work. Bloor and Maynard recognise that change must be slow, but nevertheless put forward a radical option in the form of a new GP contract in the form of an *'agreed national contract for primary care let by competitive tender and with clear performance targets'*. As they remark, both the contract and the tendering process would be hard to define but the proposals put forward in June 1996 in *Primary Care: the future* point in this direction.

Availability: If the allocation of resources were based on a universally accepted formula that would in itself not ensure that people in different parts of the country had the same range of services available to them. The scope of the NHS has never been defined in terms of rights to specific ranges and levels of service except in the limited number of areas codified within *The Patient's Charter*. This has been left to local choice but as events during the year indicated, there are pressures which are pushing the NHS in this direction.

Table 23 Implications of an equitable distribution of GPs, by Region

Region	Gain/loss (% of national expenditure) according to York calculations	% of current allocation of GPs above or below target based on York calculations
Northern	0.64	-13.31
Yorkshire	0.23	-4.47
Trent	0.41	-7.71
E Anglian	-0.31	7.29
NW Thames	-0.64	15.11
NE Thames	-0.30	5.21
SE Thames	-0.15	1.33
SW Thames	-0.16	5.53
Wessex	-0.17	6.07
Oxford	-0.12	8.98
S Western	-1.05	15.34
W Midlands	0.74	-5.94
Mersey	0.15	-11.28
N Western	0.72	-18.26

Source: K Bloor and A Maynard, *Equity in Primary Care*, Table 1 Discussion Paper 141, University of York, Centre for Health Economics

Table 24 Difference between actual and needed no. of GPs

		Above Need
1	Cornwall and Isles of Scilly	-17.45
2	Gloucestershire	-16.31
3	North Yorkshire	-15.75
4	Dorset	-14.81
5	Buckinghamshire	-14.42
6	Isle of Wight	-14.39
7	Hertfordshire	-13.93
8	Devon	-13.85
9	Cumbria	-13.45
10	Oxfordshire	-12.98
		Below Need
11	Wolverhampton	21.16
12	Sandwell	21.38
13	Liverpool	24.18
14	Oldham	26.58
15	Tameside	26.70
16	Barnsley	27.75
17	S Tyneside	31.76
18	Wigan	33.43
19	Sunderland	34.25
20	Rotherham	36.40

Source: *Journal of Public Health Medicine* 1996 pp33-40

The most explicit attempt to ensure equity in terms of availability has been in relation to continuing care where it had became clear that different parts of the NHS had pursued quite different policies. The Government responded with draft criteria, described by Gerald Wistow in *Health Care UK 1994/95*, which were then re-issued in response to the criticisms made of them. The central theme of most critics of the Government's approach is that it will lead to inequities between people in different parts of the country.

As noted above, partly in response to the Department of Health's guidance on eligibility criteria for continuing health care needs, the Commons Health Select Committee published the first volume of their report on long-term care. Many of the submissions to the Committee broadly supported the Department of Health's move to spell out in greater detail what could be expected from the NHS, but felt that they should go further. The main principle of the Departmental guidance was that eligibility criteria should continue to be set locally; however, it was the Committee's view that although:

> *the final guidance . . . goes some way towards meeting the concerns of those who felt that the original draft guidelines failed in their principal objectives of clarifying the responsibilities of the NHS .. [it] promoted, rather than removed, geographical variations in the availability of NHS services* (our emphasis) (p. xviii).

The Committee stated that:

> *on the grounds of equity, we believe the nationally set framework should include the eligibility criteria for long-term care to define what the NHS as a national service will always provide.* (p. xviii)

The concern of many of those who submitted evidence to the Committee was that unless more specific and detailed criteria were set by the centre, certain parts of the country would continue to fail to provide any long-term care, whilst other parts would provide a substantial service, thereby reducing access to NHS long-term care to a 'lottery' dependent on where one lived. An example of a case in the former category, arising from an investigation by the Health Service Commissioner is in the Box.

The Commissioner made his judgement in this case with reference to the passage in the 1977 Act which requires the provision of 'such facilities for... the after-care of persons who have suffered illness...', but only to the extent that the Secretary of State 'considers are appropriate as part of the health service'. Furthermore, it is generally accepted that legal precedent has established that this duty can only be discharged within the resources available, and that therefore prioritisation is inevitable. In the light of this it is conceivable that the Health Authority could have argued that they *had* discharged their responsibility by providing 24 long-stay beds, even though they were insufficient to meet all needs. That they did not is probably a reflection of their respect for the Health Commissioner's opinion rather than an acceptance of a point of law. Notwithstanding this case, local discretion still rules, and it is this discretion which many of those submitting to the Committee objected to. The National Consumer Council in its evidence to the Health Committee, put it this way:

On the Borderline

- A 55 year old man admitted to Alexandra Hospital, Redditch on 8 September 1992, after suffering a cerebro-vascular accident was later transferred to the stroke unit at the Princess of Wales Hospital, Bromsgrove, which at the time was managed by North Worcestershire Health Authority. Since 1 April 1993 it has been the responsibility of North East Worcestershire Community Health Care NHS Trust. On 25 March 1993 the man was discharged to a private nursing home. The Health authority declined to meet the cost of his continuing care.
- The consultant at the stroke unit decided in march 1993 that the man no longer needed treatment as a hospital inpatient. That decision, made in the exercise of clinical judgement, was not open to question by me. The man was highly dependent and could not be nursed at home. As the Health Authority had decided, as a matter of policy, not to contract for private nursing home places, and as they had only 24 long stay beds which they admitted were insufficient to meet the need, their policy excluded NHS funding for the continuing care of younger, highly dependent patients not in need of hospital inpatient treatment. I found that to be a failure to provide a service which it was a function of the Health Authority to provide.
- The Health Authority agreed to make an ex *gratia* payment of £5,000 and took over the cost of the man's continuing care.

Source: Health Service Commissioner: selected investigations, April to September 1995 p 9

> *While it may be difficult to determine national criteria for access to NHS long term care, that does not mean it is impossible. We feel it is important for people to be very clear about what their entitlements are and where they can have free care and where they cannot [. . .] we suggest a relatively straightforward criterion for eligibility. That is that entitlement for NHS nursing care . . . comes about if nursing care is needed and nursing care could be defined broadly to include all diagnostic, monitoring, palliative procedures normally carried out by trained nursing staff in hospitals.* (Evidence p 183).

In November the Association of Directors of Social Services reported the results of a survey of the eligibility criteria drawn up by districts: it found that in many cases they contained very general statements and omitted some categories of service, particularly community-based ones, suggesting the risk of variation is considerable.

The Government have made some steps in the direction of making the criteria clearer since the first attempts in August 1994 but they are clearly extremely unwilling to take matters one step further and effectively 'nationalise' decision-making. Alan Langlands claimed in cross-examination that the new arrangement would be more equitable. When asked if the new rules would mean people with the same needs may be paying in one part of the country and not paying in another, he replied:

> *I think my only response would be that that is a little less likely under the new arrangement in the sense there is now at least a national framework which I think is more explicit than it has ever been before. As the Minister has explained, there have always been variations, variations in supply and variations in demand, and that could lead to the phenomenon you describe.* [Evidence p20]

Furthermore, according to Harold Laming, head of the Social Services Inspectorate:

> *I think this is a major step forward in practice. It is not about shifting the boundary but about good practice, about trying to make sure there is a partnership between the user of services and the provider of services and arrangements which are made are best suited to the individual.* [Evidence p23]

What neither explained, however, is what the advantage in terms of equity would be from not having one set of criteria nationally determined. Much attention will now focus on whether the new guidelines manage to reduce variation in availability.

Long-term care was by no means the only service where 'equal' availability was at stake. The restriction of acute procedures, as in recent years, again provoked controversy. In August, Berkshire Health Authority caused a furore when a document was leaked which apparently suggested that a number of treatments – such as the insertion of grommets, D&Cs for women under 40 and a range of cosmetic surgery – 'should not be purchased'. Berkshire were by no means alone. Contrary to recent research by the University of Bath conducted over the last three years, which found only ten or so authorities explicitly refusing to purchase certain procedures, a survey by Yorkshire consultancy Blackwell Masters found that 40 of the then 129 health authorities had stopped buying certain types of care and were limiting others. Furthermore, North and Mid-Hampshire Health Commission told its GPs in October that free abortions to under 18s would no longer be automatically provided for the rest of the period covered by the contract, due to the fact that the provider had been 'over-performing'. And GP fundholding has caused its own version of service availability scandal: in October it was announced that Salisbury Health Care Trust had cancelled all non-emergency operations for non-fundholding GPs.

These examples of services being removed, permanently or temporarily from NHS provision now represent the generally accepted meaning of the term 'rationing', in contrast to economists' understanding which is of any activity involving the allocation of scarce resources. Rationing, to the British media, increasingly means the withholding of a service in its entirety. But whatever the terminology, such actions clearly represent something of a break with traditional NHS practice as far as the general public are concerned, and these events all caused much commotion in the media. So much so, in fact, that the health commissions and GPs involved very quickly 'clarified' their positions. Services were not being 'banned' in Berkshire, merely ineffective treatments limited; in North and Mid-Hants and Salisbury the difficulties arose from authorities running out of money early in the year, partly in turn due to providers being 'too efficient' in achieving contract specifications. Meanwhile, the Government repeated its claim that all this was a legitimate manifestation of local decision-making.

There was no doubt a certain degree of *naïveté* in the actions of those concerned – if all they were trying to do was avoid purchasing ineffective procedures, why was this not made more clear at the outset? But if health authorities are going to continue be largely free to decide on local priorities, then such events will recur as purchasers continue to try and find ways of making their budgets go further. Although the Government has so far refused to be drawn on the issue, it will find it increasingly hard to do so as further examples present themselves.

Activity: If the availability of services is a relatively new concern, variation in activity levels has been the subject of research for some time. Most analysts of variations in intervention rates between different parts of the country and between different countries have concluded that in large measure they reflect uncertainties in clinical practice. However, not all such variation can be explained in this way.

An Audit Commission report, *Dear to Our Hearts?*, published in December 1995, claimed that heart disease still causes up to twice as many premature deaths among men in England

Problems for healthcare commissioners: heart disease

Limited data on patterns of service provision

- This apples particularly to the co-ordination of different forms of care delivered in separate hospital, general practice and other settings. NHS information about community health service activity and performance levels is particularly weak.

Limited data on service user needs and priorities

- Even in authorities which have invested in studies of service user experiences and preferences, there are difficulties in drawing together information from various departments and using it to guide commissioning/contracting.

Limited evidence on the effectiveness of prevention and treatment

- Many forms of care are not fully evaluated. Even where overall effectiveness evidence is available, it is often impossible to apply it appropriately to individual cases.

Conflicts between 'top-down' priorities and those of devolved 'primary care-led' decision-making systems

- Commissioners with limited resources may have to balance investments in service improvements desired by local practitioners and their patients with those aimed at meeting national performance targets.

The inherent difficulty in promoting good clinical practice

- Only limited knowledge is available about how best to change clinical behaviour. The attainment of district service goals of this type is likely to require a range of marketing, pubic affairs, leadership and quality management skills which most health authorities do not as yet fully possess.

Source: Audit Commission, *Dear To Our Hearts*.

and Wales as in many other western nations. One of the reasons for this could be the absence of standard levels of provision across the country for treatments such as coronary artery bypass grafts (CABG) and coronary angioplasty (PTCA). The Audit Commission noted that:

> *the NHS in England and Wales will supply approximately 400 CABGs per million population . . . The private sector probably adds a further 10-20 per cent to that figure. Yet [this] total [is] still well short of the annual targets such as the 600 CABGs per million . . . suggested by the British Cardiac Society* (p20).

The report noted how this discrepancy is accentuated in some areas by the 'substantial variations in local NHS intervention rates'. It recommended that districts and localities with unusually low revascularisation rates should consider, as a matter of priority, the case for improving supply. But such exhortations will inevitably run up against the fact that still very little is known about how effective these treatments are in preventing premature mortality. And these unknowns are even more severe when primary preventive care is under consideration.

With the move toward evidence-based medicine, the centre may wish to exert a significant degree of control over the introduction of new techniques, or the removal of others; they will be inhibited, yet again, by their reluctance to move away from a locally driven system toward a national one. That reluctance may well find a rationale in recognition of the uncertainty which will continue to attach to clinical effectiveness.

In *Dear to Our Hearts* the Audit Commission set out – a series of obstacles to ensuring a satisfactory level of service in relation to heart disease. These reveal how hard it would be to provide a precise specification of what should be done – see Box opposite.

However, even if there is a standard, inequity may still arise if it is unevenly applied. Last year Michaela Benzeval pointed to the need for equity audits. The Audit Commission also proposed in relation to heart treatment that provision should be systematically monitored.

As well as the difficulties of establishing robust evidence of effectiveness for treatments, and the implementation of such evidence, there remains the question of variations caused by the dynamics of the system. This is not just the result of the 1990 reforms; any system capable of development will throw up innovation in treatment and practice, and therefore variations. The reforms may promote such innovation if purchasers become more attuned to looking for providers offering good value for money. But even so, some variation will be inevitable in a dynamic system and indeed is being encouraged by fundholding and the Government's proposals for primary care.

Quality: The fourth way to assess whether territorial equity is being achieved is to look at the quality of service provision. The Labour Party released figures during December which claimed to show wide variations in death rates from breast cancer, with some districts reporting mortality rates 40 per cent above average, and others 50 per cent below. This may be the result of variations in activity, such as screening or CABG rates, or in population risk factors, but it could be that the quality of care varies – in this case access to specialist care.

In another development, a Royal College of Radiologists 1996 report *Guidance on the Structure and Function of Cancer Centres*, claimed that many of the most fundamental questions about the best way to treat breast cancer remained unanswered – individual centres are free to do what they think is best, leaving patients irradiated in different positions and with different doses. It was feared that in the past approximately 1 per cent of women had been harmed due to a lack of knowledge of best practice. RAGE, an action group set up to speak for those who have suffered the consequences of radiation treatment, gave evidence to the Health Select Committee investigation into breast cancer services and argued that there was now a case for a national standard – but this is next to impossible before there is agreement whether a standard could be formulated.

However, in the case of cancer services as a whole, the Government has accepted the case made by an expert committee for a network of cancer services, which does represent an attempt to ensure that quality standards for this service are evened up. No specific resources were made available and no new mechanisms to implement the new system: furthermore, evidence emerged during the year that different purchasers were pursuing different policies: while some were supporting access to existing specialist centres, others were not and as a result patients in the same centres were being treated differently. Availability alone in other words is not enough to ensure equality of access; whether this is a matter of concern on equity grounds turns on whether local variations are justifiable. In the case of cancer care, the grounds for local variation would be hard to find.

Variations in outcome for infertility treatment were also reported by the Human Fertilisation and Embryology Authority in *The Patients' Guide to DI and IVF Clinics.* IVF live birth rates were claimed to vary from 0 to 20 per cent between districts, direct insemination rates from 0 to 43 per cent. Criticism of these figures – that they ignored other relevant factors – perhaps predictably came from the medical profession, since it is the consistency of the quality of their care which is in part being questioned. But further criticism drew attention to the possibility that such figures would discourage districts from undertaking research into new techniques in favour of the 'tried and tested' which would be popular with purchasers, suggesting that market arrangements could actually stifle innovation.

The issue of quality of care is particularly problematic for policy makers. If outcome depends in part on the arrangements of service delivery – how inputs are distributed around the country, with fewer specialist centres providing high standards of excellence, for example – then attempts by the centre to influence quality may have implications for access: it is not possible to equalise access – in the sense of the personal cost to individuals of presenting for treatment – for everyone to a relatively small number of centres.

To some degree, access to health care is inevitably different according to location. The difficult question is whether or not such differences should be compensated and if so how. In some instances it is possible to do so by providing services at higher cost in areas where access is relatively poor but the more widespread that became, the stronger the case for some explicit recognition in the resource allocation formula. As things stand, access in this particular sense is not officially recognised as an appropriate criterion for allocating resources.

Health status: How have these attempts to implement equity in resource allocation impacted on health, and variations in health? This is, after all, the ultimate objective as specified in the opening statement from the Priorities and Planning Guidance. If resources are properly focused on need, then, in principle, variations should diminish: areas currently allocated more because of their higher needs should move towards the average as a result.

The same should be true of the long-standing differences between the health status of different socio-economic groups. Variations in health status due to variations in socio-economic circumstances finally received acknowledgement by the Government this year with the publication of *Health variations: what can the Department of Health and the NHS do?* Standardised mortality ratios (SMRs) for coronary heart disease and stroke are chosen by the Working Group which produced the report, to demonstrate how the likelihood of death from these causes increases with worsening material conditions; they could have chosen many more. Also included were the SMRs for breast cancer which show the reverse trend, perhaps to emphasise that the question is not quite as straightforward as many imply. The report does not try and dodge the responsibility of the NHS in addressing these matters, even if many of the strategies will involve other agencies in other areas of social policy:

> *Given the many and complex factors which contribute to variations in health, the importance of alliances, at both national and local level, cannot be overstated . . . The Department of Health and the NHS have a particular responsibility in drawing attention to the need for such alliances and providing leadership and support.* (p2)

Some of the specific recommendations are as follows:

- health authorities and GP purchasers should have a plan for identifying and tackling variations and for evaluating interventions;
- the plan should include provision for working in alliance with other relevant bodies;
- health authorities, GP purchasers and trusts should take steps to monitor access to services to safeguard equitable access.

The remainder of the recommendations related principally to research, both into effectiveness of interventions, and into the effectiveness of measures to mitigate variations. All this may seem rather bland, and indeed the report claims that what is needed is not a new strategy but a much more explicit targeting of the issue within existing policies and activities. Others do not share this view. A report from the King's Fund, *Tackling Inequalities in Health,* recommended that, 'substantial resources need to be top-sliced for local health authorities to enable them to take the broad population approach' and that 'the NHS needs to make much greater efforts to assess whether it is achieving equal access for equal need for all social groups'.

Of course simply linking resources to 'need', or ensuring equal access for equal need however these may be defined, will not necessarily result in equity of health status, even if variations in activity and quality are resolved. By no means all forms of ill health are treatable, and many which are can only hope for marginal improvements. Attempts to genuinely 'equalise' health status across regions could imply vastly unequal distributions of resources, with certain regions having resources poured in due to the high incidence of conditions which are only marginally responsive to health interventions.

The alternative is to focus on the causes of ill health, and these go far beyond the departmental boundaries of the Department of Health. The King's Fund report mentioned the following: housing, working conditions, pollution; (low) income and wealth, levels of unemployment, and the quality of social relationships; and insufficient education and childcare. If this range of policies is to form part of health policy, inter-departmental co-operation is vital. But at present, despite the report's recognition of its importance, there is no sign of any serious attempt to ensure it across all these areas.

Choosing between people

The question of whether to focus resources on need regardless of the possibility of benefit when allocating resources between regions is simply an aggregated version of one of the basic conundrums facing the NHS as it faces up to growing public awareness that it must choose between those waiting for health care: should limited resources be used where they can achieve the greatest health gain, or should they be focused where there exists the greatest 'need' defined in terms of 'poor health'? As we have seen, at the geographical level, need in this latter sense is deemed to be the only relevant criterion, though it might be argued that the existence of (relatively) poor health as evidenced by below-average SMRs is *prima facie* evidence of the scope for health gain.

At the individual level, because more information is available, it becomes possible to institute criteria such as cost-effectiveness: not 'is this individual in need because their health is poor,' but 'is the amount of benefit they can enjoy worth the cost of benefit forgone for others?'. And what other factors can or ought to be taken into account: time waiting, age, the existence of dependants?

The principal event of the year involved what seems to be relatively clear-cut choice between using resources where they were needed and where they were likely to do the most good. Jaymee Bowen, or Child 'B' as she was known until the legal proceedings were resolved, had been refused further treatment for a rare form of leukaemia – after an initial bone marrow transplant – by Cambridge and Huntingdon Health Authority, on the grounds that the likelihood of success was negligible and that significant distress would be involved. Jaymee's father challenged this judgement in the courts but, as with virtually all previous attempts to reverse decisions not to fund treatment, the judges found in favour of the health authority, although only on appeal. The reasoning, as ever, was that the Secretary of State, and the health authorities under her, were responsible for providing health care only within the resources available, and that how to best use these resources was a clinical decision on which the courts could not rule. In order to find for the plaintiff the court would have to be satisfied that the decision had been highly unreasonable. As one account of the case put it (*Rationing Health Care,* ed. Robert Maxwell, Churchill Livingstone 1995)

> *[The appeal court] overturned Mr Justice Laws' decision, essentially on the grounds that the health authority had to take its decisions within resource limits: 'the courts are not arbitrators to the merits of cases of this kind'.* (p 163)

However, in this case the matter did not stop there as others had in the past. It became apparent that there was a new experimental treatment available. With the help of an anonymous benefactor, Jaymee received this treatment through the private sector – the health authority continued to refuse payment for it. She survived for over a year, but eventually died in May 1996. Nevertheless, it appeared for a while that the possibility of significant health benefit to an individual was forgone by clinicians and other decision-makers in the NHS. Health authority managers continued to state that they believed, on medical advice, that further treatment would not be effective and would cause distress to Jaymee. However, they could not entirely escape the accusation that they would have made a different decision if the treatment had cost only a penny. The cost of the treatment *was* a factor.

Two points are worth making about this episode. In the first place, the courts would be highly unlikely to make a different judgement in the future on the basis of this case, since the original judgement was explicitly based on precedents relating to making the best use of limited resources; and second, the NHS doctors' decision would be strongly supported by many as an ethical decision given the small chance of benefit and the benefit forgone to other cancer patients who may have a claim on these resources.

But, the Jaymee Bowen case is nevertheless significant because it dramatically and publicly demonstrated that the NHS will not do everything possible for someone if the cost is high enough and the prospect of benefit low. In this sense, the case was perhaps unique, at least in terms of the publicity it generated, and may represent a watershed in the loss of the public's innocence over how the NHS provides health care.

If the Jaymee Bowen case demonstrated that there is still a lack of consensus in the public mind over the degree to which need, regardless of cost, should be taken into account, then discussion about other potential criteria also continued to rumble on. The General Medical Council's new guidelines *Duties of a doctor,* published during 1995, for example, specifically include an obligation on doctors not to judge patients' 'lifestyles' and therefore discriminate against smokers:

> *you must not allow your views about a patient's lifestyle, culture, beliefs, race, colour, sex, sexuality, age, social status or perceived economic worth to prejudice the treatment you give or arrange.* (p 5)

But the 'discrimination' against, Harry Elphick who was refused admission in 1993 for CABG until he gave up smoking, and who later died, was justified on the ground that the procedure would have been significantly less effective if conducted on a smoker. In other words, his lifestyle was taken into account, and rightly so, in the opinion of the clinicians, because otherwise the treatment might have been used on someone for whom it could do little good. The Council's guidance has not clarified or made reference to this issue: is it reasonable to take account of the factors listed above when they are a useful proxy for the ability to benefit from treatment?

Whether or not age should be a relevant criterion also remains controversial: while many reject it, it seems nevertheless to be taken into account in practice. According to the British Regional Heart Study, among smokers, 1.03 per 1,000 men aged 40-59 receive a bypass operation, while for non-smokers the rate is 1.45. In *An Audit of Cardiac Rehabilitation Services in England and Wales* (University of Hull 1996), David Thompson and Gerald Bowman conclude from a review of the literature relating to cardiac rehabilitation that there is general reluctance to offer older patients cardiological services and treatments. Their survey of services currently on offer in England and Wales showed that while cardiac rehabilitation services were widespread, their organisation and content varied a great deal and there were no generally accepted criteria for admission. The age of the oldest patients varied from 65 to 83, which would at minimum suggest that different criteria were in operation and that some services did not accept older patients. The report itself concludes that nine centres out of the 25 visited discriminated against older people. The reasons why are not made clear.

Health Care UK 1993/94 suggested that further debate was necessary to establish which criteria were and which were not suitable for choosing between those waiting for treatment. It proposed that three – need, effectiveness and cost – were, when taken together, defensible and that there were signs that a degree of consensus amongst commentators was developing on the need to take them into account, if not on the weighting between them. However, two years later this conclusion is beginning to look rather optimistic. The case of Jaymee Bowen has shown that as far as the public are concerned, we are a long way from consensus on the place of financial considerations in the NHS. It is clear that significant sections of the population believe that taking account of money when lives are at stake has no place in the NHS. According to a MORI survey carried out in association with the BMA and the King's Fund, about half the general public thought the NHS should have unlimited funding (*Rationing in Action* BMJ Press 1993, p145)

As for other criteria, such as lifestyle, age, time waiting and dependency, very little progress has been made even amongst academic commentators, and there is little evidence that the public realise that such criteria are relevant, or of the complexities involved in adopting them explicitly. In fact, it is becoming increasingly clear that there is never likely to be sufficient consensus on the appropriate principles to be used: they are ultimately matters of personal value judgement about which rational discourse can make only painfully slow progress. Decisions in the NHS will always be political in this sense; a more productive way forward might be to involve the public in the debate more closely and attempt by doing so to raise its standard. As matters stand, public debate in the media is characterised by melodrama and caricature, with very little demonstration that even fundamental facts of public life, such as the limited nature of resources, are properly understood.

2.3 Accountability

The *Priorities and Planning Guidance* does not refer to accountability, but its requirements continue to impose themselves. Last year's review recorded a number of initiatives relating to corporate government designed to improve the accountability of NHS trusts and district purchasers. This year saw their detailed implementation taken a stage further, while the abolition of Regional Health Authorities created a more direct line of accountability both for providers and for purchasers.

With this new framework in place, the Executive may well feel that it has done nearly enough to ensure the probity of the NHS as an organisation. However, some steps remained to be taken. In March 1996, a new Prescription Fraud Squad was established, in line with a recommendation made in an Audit Commission report, *Ensuring Probity in the NHS*. This recommended that the Prescription Pricing Authority should provide expertise in the detection and investigation of fraud in pharmaceutical services, which is estimated to cost taxpayers some £30 million a year.

While this problem was peculiar to the NHS, the public sector as a whole has been under scrutiny by a Committee on Standard in Public Life, chaired by Lord Nolan. Its first report (Cm 2850-I) covered NHS bodies along with others. It concluded that the Government ought to produce a consistent legal framework for public bodies, including those forming the NHS and that a number of other changes should be made in relation to disciplinary procedures for board members and the role of NHS accounting officers. A new code for the latter came into effect in April 1995.

The Government reply confirmed a standard of best practice for openness for Executive Non-Departmental Public Bodies and NHS bodies, which is cited below, and also accepted the Committee's statement of Seven Principles of Public Life: see Box on p. 83.

Subsequently the Government published a consultation paper *Spending Public Money: Governance and Audit Issues* (Cm 3179) but as far as the NHS is concerned, largely confirmed the measures already taken. However in December 1995, the post of Commissioner for Public Appointments was created, following a Nolan Committee recommendation, whose job it is to monitor, regulate and provide advice on appointments procedures for a wide range of government bodies, including the NHS. In April 1996, the first commissioner, Sir Len Peach, published a code of practice on appointments and, simultaneously, guidance for departments on appointments to NHS bodies. Sir Len reports to the Public Service Committee of the House of Commons, whose first report, *The Code of Practice for Public Appointments*, endorsed these.

While the Nolan proposals have proved largely uncontroversial, other areas of

Responsiveness

D1 Health authorities should have a strategic plan for, and should be engaged in, systematic and continuing communication and consultation with local people, representative and voluntary groups (particularly Community Health Councils) in respect of the development of local services, purchasing plans, specific health issues and health promotion as appropriate. Particular attention should have been paid to addressing the concerns of those with special needs.

D2 Health authorities and providers should be able to demonstrate how consultation and dialogue with GPs and local people or groups, including those with special needs, has influenced the development, planning and purchasing of services; and feedback to local people and groups on the outcome of consultation.

D3 Purchasers and providers should be able to demonstrate that they have a systematic programme in place aimed at achieving active partnership with individual patents in their own care, in particular seeking to improve the quantity and quality of information given to enable patient choice about treatment options.

D4 Purchasers and providers should have complaints systems in place which reflect the revised procedures stemming from the Government's response to the Wilson Complaints Review, Acting on Complaints.

Source: *Priorities and Planning Guidance 1996/97* accountability within the NHS continue to give rise to concern and controversy. In December 1995, a doctor was taken to court by a woman who claimed that he had undertaken an abortion whilst performing a hysterectomy without first seeking her consent. She had provided consent only to the hysterectomy, and the doctor was charged under a little-used 19th century statute outlawing back-street abortions. However, if the abortion is necessary to save life or preserve health, then under the emergency provisions of the Abortion Act 1967 the doctor will be entitled to dispense with the requirement to obtain consent. And so the court found in this case: the doctor argued that he had acted in the best interests of the mental health of the patient, who had a history of mental illness which he judged would be exacerbated by the knowledge of a pregnancy.

The case revealed the continuing reluctance of the judicial system to become involved in matters of clinical judgement. Such reluctance may increasingly strain the public's tolerance. Patients are becoming less acquiescent as they become more knowledgeable and better informed; their willingness to accept doctors' judgement is weakening. Where things go wrong they are increasingly wanting to know why.

Doctors, however, like other professionals, predominantly hold themselves to account through mechanisms of peer review and professional sanction. It is a form of 'normative' accountability – emphasising moral responsibilities – based in professional ethics. The need for this form of accountability stems from the fact that professionals have a monopoly of knowledge necessary to make informed judgements on their colleagues' conduct.

But the suspicion has grown that professions sometimes abuse this power to protect poor performers and that patients have insufficient recourse when they feel they have been wronged. Nevertheless, the most likely source of control over poor performers remains professional colleagues. Speaking out over perceived poor standards of care – or 'whistleblowing' – has received a good deal of attention since the case of Graham Pink, a nurse

The Seven Principles of Public Life

Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.
Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness: Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty: Holders of public office have a duty to declare any private interests relating to their pubic duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office should promote and support these principles by leadership and example.

These principles apply to all aspects of public life. The Committee has set them out here for the benefit of all who serve the public in any way.

Source: *Committee on Standards in Public Life, First Report. 1995* who spoke publicly about poor patient care and was subsequently disciplined by his employers. Some time afterwards, in an unconnected case, concerns were raised about pathology services in South Birmingham when it was revealed that a doctor's diagnostic judgement was seriously impaired by illness, but colleagues who were aware of the risk of this misdiagnosis failed to act on their suspicions.

Partly in response to the events in South Birmingham, a review group was set up in 1993 and its report, *Maintaining Medical Excellence,* published in August 1995. It made a number of recommendations for encouraging doctors to exercise the professional responsibility, including widening the General Medical Council's ability to notify employers of allegations of poor performance, and the setting-up of a national helpline to provide confidential advice. But it also suggested that:

> *there is a need for action to establish a culture and a climate of opinion within the NHS which is sympathetic to the problems of doctors whose practice standards are poor, to encourage colleagues to take appropriate action before patients suffer or extreme sanctions are needed . . . [One way] this may be achieved [would be] specific reference to such a duty within the terms and conditions of service issued by employing authorities.* (p3)

However, this recommendation has proved controversial, since there is now the possibility that two sets of conflicting terms could co-exist within a single contract: one requiring the doctor to inform on poor standards, and another requiring confidentiality.

This possible conflict has its origins in the NHS and Community Care Act 1990 which provides the basis for the operation of trusts. Before the introduction of these reforms, employment contracts used by all health authorities provided that they should be free without the consent of the authority to publish or speak on any topic whatsoever. But with the institution of market arrangements came the issue of commercial confidentiality – trusts would need to protect their commercial position in the market. Accordingly, under the 1990 Act, trusts are free to set such terms and conditions as they see fit. In a recent book on the law and the NHS, *Who Should We Treat* (Oxford 1995), Christopher Newdick describes how this has led to the possibility of over-sensitivity about commercial viability:

> *Concern has been expressed as to the use of 'gagging' or confidentiality clauses designed to prevent hospital employees from bringing to the notice of the public matters of management or policy. Some have introduced clauses which restrict freedom of speech previously enjoyed under the old regulations.* (p252)

If these clauses were to apply to clinicians' speaking out over poor standards amongst their colleagues, then there could clearly be a contradiction in many contracts. It may be that simply imposing conditions on trust employees is in any case misguided; what is needed instead is the development from the 'bottom up' of a culture in which clinicians and others can readily accept constructive criticism and work toward improving their practices – obviously rather more easily said than done.

Poor clinical standards will also, from 1996, become more open to scrutiny from outside the NHS. As reported last year, in March the Government proposed a number of changes to complaints procedures in *Acting on Complaints,* the response to the report of the review committee on NHS complaints procedures. One of these proposals moved closer to reality with the announcement in the November Queen's speech that the Health Service Commissioner (Amendment) Bill would be placed before Parliament during the 1995/96 session. Currently the commissioner's jurisdiction covers hospital complaints, excluding matters concerning the exercise of clinical judgement, and Family Health Service Authorities, but not the conduct of GPs. When the Bill became law in March 1996, these restrictions were removed.

The exclusion of clinical matters has severely hampered the commissioner in his work in the past. On the face of it, it seems sensible to restrict a non-professional scrutineer to non-professional matters, but in practice this restriction has meant that hospital authorities have been able to manipulate the nature of patient complaints so as to assume the guise of 'professional judgement'. The following example is taken from the latest edition of *Selected investigations of the health service commissioner April to September 1995.* The complaint was in part concerned with the fact that an elderly woman had been left on a mattress on the floor when she had become agitated:

> *St. Mary's NHS Trust, Paddington, which manage the services involved, said that placing a patient's mattress on the floor was not normal procedure but the staff did so to maintain a safe environment. The nurses had used their professional judgement to respond to a difficult decision, and their decision was therefore outside my jurisdiction.* (p10)

Regardless of whether the nurses were acting properly or not in this particular case, the commissioner was often left with no authority to pursue complaints which seem, *prima facie,* to have some justification.

The Act brings about a fundamental shift in the role of the commissioner, and, though small in scale – the commissioner only undertakes about 150 complaints a year of which a much smaller proportion will be of a clinical nature – it also represents another important weakening in the ability of the medical profession to police itself. The new role will not be easy for the commissioner and, as the Government noted in *Acting on Complaints*:

> *he will need access to appropriate medical advice in undertaking these new responsibilities.* (p7)

This is to say the very least. But the nature of this professional advice will not make it easy for him to uphold complaints, if the experience of the courts is any guide. The judicial system has consistently felt unable to challenge professional opinion, taking the view that a clinical decision is not negligent if a 'responsible body of medical men' would consider such a practice proper (the *Bolam* test), or in the case of managing scarce resources, if the decision was not unreasonable (the *Wednesbury* test), that is unless no reasonable person would have taken the same decision in the same circumstances.

The commissioner does not have the same authority as the courts, and so he will be able to pronounce under less strict conditions; he will also presumably not be investigating cases of negligence, but less serious clinical judgements, such as whether a certain procedure was appropriate in a certain individual's case. But nevertheless he may find his new role rather more frustrating than his current one.

The developments briefly described here should strengthen the position of the individual patient. But none bear on what was seen from the beginning of the new NHS as the most serious area of concern, the position of the health authorities.

The Priorities and Planning Guidance sets out four areas of action relating to 'Responsiveness'. Action relating to D3 and D4 has already been discussed in Part 1. As far as the first two are concerned, the central issue is: how can appointees gain the support of the local communities they serve when making tough political decisions about how to use scarce resources, when those communities do not have any direct electoral sanction over the individuals concerned? Many of the initiatives reported in last year's review – the new accountability framework for GP fundholders and the new codes of practice on accountability and openness, for example – fail to grasp firmly the basic fact that decisions about how to use public resources are more than simply questions of financial or managerial probity: they are political decisions based on value judgements. As such, so the argument goes, reinforcing lines of accountability upward to the minister in Parliament or making public employees marginally more open in how they work, do not measure up to the issues at stake.

Handing the role now undertaken by health authorities to local authorities has often been suggested as the appropriate response. By so doing, a number of benefits would accrue, as David Hunter (*British Journal of Health Care Management* 1995, pp78-81) has argued:

- *Democratic accountability: the elective principle would give citizens more direct influence over the workings of the NHS;*
- *Legitimacy: improved accountability would bring greater legitimacy;*
- *Co-ordination and regulation: bringing the NHS into local government would establish greater linkage with other public services.*

Simply positioning the purchasing function within an electoral framework is not, however, the same thing as improving accountability. Local government authorities are themselves notoriously 'undemocratic': political parties often have a virtually permanent hold on power in certain areas of the country, with this power based in the main on a very small proportion of the popular vote – hardly the recipe for giving citizens more influence over the workings of a health care system.

Funding would also be highly problematic: if it were locally based one would expect increasingly wide variations in purchasing power with funding based on political will rather than need; if it were centrally controlled and distributed, as now, then an important element of local accountability would be lost. And, however funded, the understanding as to what the NHS ought to provide – particularly the range of services provided free – would become even less clear than it already is, since one would no longer be able to state that what the NHS does is provided free or at universal subsidy: local authorities provide too many services which are means-tested.

Hunter is well aware of these difficulties and proposes significant reforms:

> *[There is no] assumption that local government would remain unchanged. Far from it. The emergence of a renewed commitment to local governance requires the creation of a new integrated organisation in which the local political element of strategic management through election would be complemented by a variety of other measures directed towards making local government in its reinvented form more user-sensitive, and at enabling the public to be more involved in helping shape local strategies for health in its broadest sense.* (p80)

What this would mean in practice is hard to say: sufficient to note here that it confirms that existing institutions do not provide a ready answer to the democratic deficit. Not surprisingly, therefore, new ideas are emerging which bypass them. The Institute for Public Policy Research published *Voices Off: Tackling the democratic deficit in health* during 1995 in which a number of ways of improving democratic structures were suggested:

- Citizens' Juries
- Electronic democracy
- Open governance

The third of these is already on the political agenda government-wide. Last year's Review noted the publication of the *Code of Practice on Openness.* In the NHS Annual Report 1994/95, the key points were stated as follows:

- access to available information about the services provided by the NHS, the cost of these services, quality standards and performance against targets;
- explanations should be provided about proposed changes, and people should have an opportunity to influence decisions on such changes;
- patients should be aware of the reasons for decisions and actions affecting their own treatment;

- people should know what information is available and where they can get hold of it.

The critical question is: what does this amount to in practice? In fact, much information has become harder to get on the grounds that it is 'commercially sensitive'. As the King's Fund 1996 *London Monitor* remarks:

> *A starting point . . . would be for the full business cases, upon which so much of the decision making in London and elsewhere depends, to be subject to a degree of public scrutiny . . . This issue, when touched upon by the Health Committee of the House of Commons . . . met with a somewhat reticent response from politicians and health service managers.* (p36)

Furthermore, even when the system drastically fails as in the case of Nicholas Geldard, the Stockport boy taken to several hospitals before he eventually died in Leeds, and a subsequent inquiry identifies the circumstances giving rise to that failure, no person or agency can be found to be responsible. In a case like this individuals and individual organisations may act appropriately, but the system as a whole does not. This issue is discussed by Seán Boyle and Anthony Harrison elsewhere in this volume.

The increased availability of telecommunication technologies – in short, the ability to send text, audio and moving images via electronic cable – opens up the possibility for faster, more interactive and direct forms of democracy. At the least ambitious end, this would simply allow improved ability to question those in power about how they exercise it. Rather more fundamental would be the increased opportunity for direct voting on a whole range of questions, with authority vested in the outcome of tele-referenda.

Unfortunately, technological advance comes with subtle dangers depending on the degree to which direct forms of democracy supplant representative ones. Improving people's ability to question their representatives, to debate issues, and to acquire information, if properly organised, is relatively unproblematic in principle; the same cannot be said for developments in direct democracy. Any form of direct democracy runs the risk of unaccountable decision-making simply because those voting do not have to reflect on the issues at stake, do not have to defend their position, nor have to deal with unforeseen consequences.

Such concerns, not dissimilar to those voiced over proposals to extend the franchise during the 19th century and, during the 20th, in the votes for women campaign, may simply reflect a nervousness about the new and untried or they may reflect legitimate worries over the consequences of a fundamental break with representative democracy. Citizens' juries are however coming into use, drawing on experience from other countries, particularly Germany and the USA.

The idea is that small groups of citizens – representative of the whole community, not particular interests – should gather together over a number of days to deliberate on matters of policy. They take evidence on a particular question, cross-examine witnesses, and then deliver their verdict, although they are not isolated from the community as are legal juries. The thinking behind these juries derives from an attempt to reverse the passivity which traditional representative democracy encourages, and to promote participation in the democratic process, By widening involvement in the decision-making process, it is hoped that the alienation which results from a clear separation of the governors and the governed will be mitigated.

This problem is becoming particularly acute in the increasingly technically complex world. Many issues are considered too difficult for 'ordinary' people. In health care the obvious example is that of rationing: how health authorisation and clinicians allocate resources is often considered a technical job, but in reality it is a political one. Citizens juries could have a number of advantages: first, they would be able to play a part in resisting policies which do not make sense to them, thereby forcing policy makers to develop policy in ways that are acceptable, and therefore more legitimate.

Second, the level of public debate and understanding would be improved by a more realistic participation in the debate. Finally, the health of the democratic system in general could be improved.

There are obvious difficulties, the most important of which is the question of how much real authority and power the jury could have. Would they ever be able to veto the decision of an elected or appointed body? And, typically, a small number of people would be involved, probably only looking at a small number of issues.

In Germany these juries have been used to assist with planning decisions, including architectural and environmental questions, at the local level. They have also considered more technical issues such as the most appropriate form of energy production, coal, nuclear, or gas, for example. In the USA, juries have considered social issues – such as the reasons for problems amongst young people, and Clinton's health care reform proposals – as well as questions concerning the US federal budget. In the USA juries have at present no direct influence on decision-making; they are purely voluntary, private initiatives. In Germany juries are commissioned by a government body, and the deliberations of the jury must, by the terms of the contract, be taken into account when a decision is finally taken.

Citizens' juries seem to offer some hope for an improvement in both the quality of decision-making in the health policy arena and an improvement in the level of public debate. Some pilot studies have already taken place: see Box.

Citizens' juries

The first Citizens' Jury in the UK took place in March 1996 at the Cambridge and Huntingdon Health Authority. Professional recruiters were given a demographic breakdown of the Cambridge and Huntingdon area, and 16 people were selected by stratified random sampling to represent their community. The Jury sat for four days, and during this time they were presented with information to help them to reach a number of decisions. Jurors were asked to consider ho priorities for purchasing health care should be set, according to what criteria, and what role, if any, the public should have in these decisions. Expert witnesses gave evidence, and jurors were given the opportunity to question them before debating the issues amongst themselves.

The Jury provided the organisers with a number of 'decisions' in response to a wide range of questions on priority-setting, based on recordings of the Jury proceedings and questionnaires filled in by jurors. First, the Jury tended to favour 'quantity' rather than 'quality' in the context of a finite budget, and that priority should be given to effective treatments for minor conditions rather than treatments of unproven effectiveness for life threatening conditions. However, they were keen to retain funding of treatments of unproven value in the interests of medical research and progress.

Second, the Jury gave support for some kind of national 'council' for priority setting, as a means of addressing variations between health authorities in the principles and practice of priority-setting. The majority of the jurors felt that this body should only set guidelines, but a couple of the jurors felt it should be prescriptive. There was a strong feeling that the body should not be political, a point reinforced by the fact that whereas most jurors thought that doctors, ethicists, health economists, lay people and health service managers should sit on it, nobody voted for the involvement of politicians.

Finally, a majority of the jurors felt that there was a role for the public in the setting of priorities, although they were clear that this should only be as one input alongside other interests. They all pointed out that if the public were to be more involved in the decision-making process, then they would need a lot more information about the issues concerned.

This pilot Jury was also concerned with evaluating issues of process: how did the Jury cope with the question; how were its deliberations managed; how much information should be provided; and how should jurors be recruited and reimbursed? The answers to these questions reveal that the decisions which the Jury came to must be interpreted with some caution.

The crucial issue is what kind of issue the Jury should address. In Huntingdon, the Jury was given a broad set of questions concerning how decisions relating to priority-setting in the NHS should be made. Initially, the jurors found this difficult: it was hard for them to assimilate all the information necessary to address these issues, and they were not clear what, precisely, they were required to answer. One interesting aspect of the jurors reaction was their nervousness about whether, in this context, they ought to be involved in public policy decision-making. They asked why the elected/appointed bodies were not making these decisions, and whether the public were competent, technically or otherwise, to do so in their place.

Another important issue was the organisation of the Jury's deliberations. The central problem was one of group-dynamics: how might the moderators ensure that all the members of the Jury have adequate opportunity to express their opinions? Not surprisingly, some jurors were more articulate, confident, experienced and better educated. They tended to dominate the discussions where all the jurors were present. To address this issue, the Jury was split into two smaller groups, one of men and one of women. As a simple expedient, this worked well – those who were quieter in whole-group sessions gained confidence in a smaller group, although other methods of organising small group discussions need to be explored.

In managing the Jury's deliberations, the role of the moderator is crucial. The moderator acts as a kind of chair-person, ensuring that discussions run on time, that all jurors have a chance to participate, and that witnesses keep to their brief and answer questions which are put to them. Moderators also need to ensure that the discussion stays on the chosen topic, whilst at the same time allowing opportunities for jurors to suggest their own witnesses and questions. Clearly this is a skilled job: the approach in Huntingdon was to use individuals with no experience or knowledge of the subject matter; an alternative would be to employ a neutral 'expert'. The problem with the former strategy is that witnesses may be able to manipulate the Jury by using their specialist knowledge; with the latter, the danger is that bias may creep into the proceedings.

How much background information should be provided, and who should respond to 'questions of fact'? Jurors felt they would have benefited from background briefings, both relating to the overall question and the individual witnesses' presentations. There may be a case for supplying the Jury with a briefing paper from a neutral expert before the Jury convenes, and encouraging witnesses to supply a one page summary of their argument, also in advance. The difficulty is ensuring that this information is neutral. Clarifying questions from jurors about 'points of fact' is even more problematic. There could be an expert on hand to provide this information, but no individual is all-knowledgeable, and having a single person undertaking the role might introduce bias.

The jurors were selected at random to represent the socio-demographic characteristics of their community. Although this did not present problems in Huntingdon, in other areas there may be a need to resolve difficulties for jurors for whom English is not their first language. 16 jurors were recruited and it was felt that significantly more would have made the sessions hard to manage; however, more experience is needed of other Jury sizes. To retain impartiality it may also be necessary to vet jurors to ensure none has a vested interest: for example, should a clinician be allowed to take part in a Jury which is to deliberate issues of priority-setting, when he or she might stand to benefit from a particular decision?

Jurors were reimbursed with £250 for the four days. They seemed satisfied with this payment – no juror dropped out and attendance was almost 100 per cent over the period the Jury sat.

In conclusion, there may be two models for citizens' juries in the UK: a 'deliberative' model involving broad, open-ended questions where the Jury is engaged in a process of guiding policy-makers, and offering feedback and opinion from the local community; and a 'decision-making' model, where the Jury is engaged to adjudicate on an 'live' issue, involving a set of clear options, and where a statutory body has found it difficult to reach a decision using standard procedures. Both models could improve the democratic process; the latter might also improve the legitimacy with which controversial decisions are made.

Part 3

Overview

The central theme of successive Health Policy Reviews has been change. They have recorded not only the changes brought about by the implementation of the 1990 Act but a range of other policy responses to new issues such as the need to improve corporate accountability and most recently the identification of the effective application of clinical knowledge as a key policy objective.

The need to make such changes can in turn be traced back to the wider context within which the NHS and Department of Health policy-making both operate, specifically the need to justify their ever-increasing claims on the public purse in line with the commitment made by the Government before the last election, in terms of greater efficiency in the use of the resources at their disposal. While a Labour Government, had one been elected in 1992, might not have taken the same track as the Conservatives, it too would have had to respond in some way to the pressures on the NHS which gave rise to the 1990 Act.

As this year's Review makes clear, the pressure on services continues, while the evidence presented in Section 1.1 of the Health Policy Review suggests that the 1990 system has not had a great impact. Although there has been an apparent rise in activity, it is easier to attribute it to central direction rather than the new structure of purchasing and provision. If the pressure of demography, technology and rising public expectations continues, does that mean another round of structural reform is required?

Government policy statements during 1995/96 have suggested the answer is no. As the Secretary of State put it:

> *April 1 1996 marks the end of the process of institutional upheaval we launched in the early 1990s which was designed to ensure that the health services was more efficiently and more responsively run. The issue now is how we use the structures we have in place to deliver the health service we want – to move the argument off managerialism on to questions of quality of service and the changing shape of healthcare delivery. (Guardian* 13 April 1996)

In the more arid terms of the Priorities and Planning Guidance in selecting (the) medium term priorities, two important themes have emerged:

> *the need to shift the focus away from questions of organisational structure to improving health and the quality of care;*
> *the need to reinforce and realise the commitment in the NHS to partnership, collaboration and teamwork.*

It is hard to disagree with these motherhood and apple pie sentiments. That may, from the politician's standpoint be their main merit, helping to cool down public debate about the NHS. From the manager and clinician's viewpoint, a period of consolidation may also seem attractive after five years of constant change. The true costs of these changes are as elusive as their benefits but there is little doubt that they have absorbed a vast amount of effort in whatever terms they are measured in. Thus from a political, clinical or managerial perspective, further changes in organisation would seem hard to justify: health policy insofar as it is concerned with the organisation of health care delivery into trusts and GP practices and purchasing in districts and fundholders would seem to be complete.

Leaving the pressures of cost containment and the need to improve efficiency to one side, if the present organisational structures were those which offered the best chance of achieving better quality care, better health, and more teamwork, then this conclusion might be justfied. But do they?

As we go on to argue, the answer must be no. But before moving on, we should first consider what the merits of the current structure are. Although the 1990 reforms were justified at the time in terms of broad policy objectives, the evidence presented in Section 1.1 and in more detail in *Working for Patients Reforms: a balance sheet* suggests that they have not justified themselves in those terms. This is in part because those objectives were set and the structures devised separately from the objectives that they have in practice been required to pursue and in part because they were not founded on any analysis either of the changes that were likely to be needed in the way that health care was organised or of the best way of achieving those changes.

Their main merit, it might be argued, is that they have proved to be more flexible instrument, than those which preceded them, allowing new ways of working to develop and also new ways of organising services. Although the extent of change, as revealed for example in the Audit Commission's review of fundholding, is modest, that may simply reflect a general cultural conservatism among both GPs as purchasers and among their current or potential providers. Slowly these barriers may erode and more change ensue.

The flexibility of the new arrangements is readily apparent as far as purchasing structures are concerned. A variety of forms have emerged, much greater than the two-model approach with which the reforms began. Indeed, it appears that a Darwinian process is underway, much of it without the explicit blessing of Government, allowing in Nick Mays and Jennifer Dixon's words, a 'purchaser plurality' to develop.

If there is a high degree of uncertainty as to what the future pattern of health care delivery should be, as Anthony Harrison and Sally Prentice have argued in *Acute Futures*, (King's Fund 1996) then flexibility is a very considerable merit and one worth preserving. However the process remains limited: for example, no 'firms' have emerged which specialise in the purchasing role in particular fields, the kind of intermediaries suggested by Seán Boyle and Adam Darkins in *Health Care UK 1993/94*. Freedoms to develop new forms of purchasing at district level remain very limited although as Carol Propper pointed out last year, further change here could be envisaged, so as to introduce some degree of contestability.

As far as providing is concerned, the degree of flexibility has been very limited and the case for the present structure is harder to make in these terms. The changes that have taken place since the trust regime came in, have been relatively small and largely defensive, such as trust mergers. There is a variety of structures, but there has been virtually no evaluation of these differences. Is the free-standing mental health trust a better form of provision than a service forming part of a large community or community and acute trust? If it is, would the same logic apply to other services? The question has attracted virtually no attention let alone research. Furthermore new types of provider based on a specialist service or skill have been slow to emerge, and there has been no direct encouragement for them to do so.

While trusts appear to offer a more attractive regime for those running them, their wider advantages are less apparent, in large measure because they have not been allowed to develop in the way the early rhetoric might have suggested was likely. While many trusts have developed new services and changed their ways of working, it is impossible to link such changes to their new status.

Moreover it can be argued that in some respects the existing structures hinder rather than promote service development. While changes in clinical technology tend to promote variety and alternative ways of care delivery, e.g. through telemedicine or hospital at home, existing financial and organisational structures often get in the way. This is particularly true of services which straddle the hospital/community/primary boundaries. In one or two areas, services within some hospitals are managed by outside organisation, e.g. community trusts, as part of an integrated service for a specific client group, or other hospitals on the hub and spoke model. In this way, the service rather than the trust becomes the key organisational unit. But such examples are rare: moreover that form of service integration cannot be carried through into general practice, i.e. it is not possible to create a unified geriatric or paediatric service across all care providers although of course links can be made short of full organisational integration.

Furthermore the pressures on hospital trusts from centrally imposed targets appear to have reduced rather than increased the scope for innovation where this involves cross-boundary connections or the transfer of work to other providers. Moreover, the financial regime under which all trusts operate makes it hard to absorb the impact of loss of contract income.

Thus existing organisational structures allow some changes in service responsibilities and for new services to develop but inhibit others, particularly where these run across the hospital and community boundary. But do the present arrangements provide the right kind of structure if the NHS is going to continue to develop and improve the quality of its services? Whether they do or not depends on what view is taken of the process of innovation and the areas where it is most likely to take place. If quality improvement is best pursued piecemeal, locally and on an experimental basis, then the approach represented by fundholding is appropriate. That provides scope for innovation without being directive about the form it should take. The proposals for dentistry involving local experiment and the recent proposals for primary care are in the same mould.

If in contrast the best way is a top-down approach, the very variety of purchasing structures may make it harder to effect change. In many parts of the health care delivery system, it is arguable that the existing organisations are too small rather than too large. The best current examples are cancer, A&E and emergency care in general. The quality arguments here push in directions which run counter to existing trust and purchaser responsibilities either because they cut across existing boundaries or, as Seán Boyle and Anthony Harrison argue elsewhere in this volume, because the appropriate scale of service planning may be much larger than the individual trust or purchaser.

In the case of cancer care, the Executive is trying to achieve within the existing structure a change which cuts across the interests of some trusts. The same would be true of accident and emergency care, if the recommendations made by the Audit Commission in *By Accident and Design* were adopted. In the case of paediatric intensive care the Department has not only made a specific intervention in response to a perceived crisis, but has begun a programme of work to fund a long-term solution. To go down this path consistently however would require a reversal of the policies of the past five years which has culminated in a virtual elimination of the regional capacity to take a considered view of how services should be developed. Furthermore it would mean that much of the rhetoric relating to trust independence and much of their genuine independence would be elimated, along with that of district purchasers and fundholders.

In summary: the existing structures will allow progress to be made in certain directions, even if that means using them for roles for which they were not originally intended. However if the local incremental approach is the right one, then it might be pushed further than is currently envisaged. In fact, local discretion remains subject to a large number of national rules, e.g on the boundary between health and social care, on payments systems for primary care, on the structure of fundholding and the nature of general practice. Relaxation of rules such as these could lead to a whole host of 'natural experiments'.

If the knowledge gained from local experiment was to be widely exploited, that would pose considerable difficulties purely on technical grounds. However carefully subsequent monitoring or evaluative research is planned, it may not be possible to remove confounding effects and hence to identify the benefits from innovation.

But it would also raise fundamental policy issues: is it possible to envisage the deliberate creation of different national health and local social services by abandoning those national rules which do exist and even allowing local versions of the purchaser/provider split? Of course there have always been differences, between different parts of the country but these have happened implicitly rather than, except in a few instances such as the London Implementation Zone, as deliberate acts of policy.

If variation were actively pursued, a host of new questions would emerge: what broad criteria would each area be required to meet in terms of equity, clinical effectiveness, efficiency and responsiveness? How would failure be detected and what would the sanctions be? A quite different agenda would emerge from that which currently concerns the NHS Executive but no less a demanding one.

But in those services where both experience and evidence suggest major restructuring is required, change can only be made in ways the existing purchasing and providing structures were not designed for. Over and above the quality arguments pushing in this direction, there are also political ones arising on the one hand from media attention to cases such as Jaymee Bowen and on the other from the work of national level organisations such as the Audit Commission which put the spotlight on variation in performance. The Government has managed to hold the 'local choice' line in relation to long-term care, but for how long? If , for whatever reason, the national agenda grows, then this too will have implications for the central role. In some ways the new regional office structure will make it easier for the centre to impose whatever policies it decides: the line of command is short and direct. The main question mark, as Seán Boyle and Anthony Harrison argue below, lies over the capacity of centre or region to handle the more demanding role that such centralisation would imply.

Which way to go? The answer inevitably involves political judgement about the nature of a national health service, and what features can be allowed to vary within it. Those considerations to one side, the key factor is the future shape of health service delivery. The 1990 reforms implicitly assumed that local choice on purchasing and providing were appropriate and the incremental approach set out here can be seen as a further development of that policy. But that assumption has been rejected for cancer and intensive care on the grounds that the centre knows best and has sufficient knowledge to devise a solution of its own. That would suggest that contrary to the Secretary of State's expressed hopes, health policy in the sense of structural reform of the pattern of purchasing and provision remains on the agenda.

Part 4

Calendar of Events

April

4 **London hospitals:** Secretary of State announces decisions on rationalisation and development of London hospitals.

5 **Dentistry:** plans for changes to NHS dentistry made public.

6 **General Practice:** proposals published for out-of-hours work.

7 **Community Health Councils:** consultation documents on future arrangements for community health councils and a code of conduct for members published.

20 **Medical Staffing:** concultation paper issued on proposals to change specialist medical training, thereby implementing several recommendations made in the Calman report.

24 **Cancer Care:** new framework for cancer services announced following the report of the expert advisory group *A Policy Framework for Commissioning Cancer Services.*

24 **Clinical Knowledge:** Cochrane Database of Systematic Reviews launched.

26 **Health Inequalities:** Government responds to King's Fund Report *Tackling Inequalities in Health.*

27 **Fundholding:** accountability framework for fundholders published.

May

12 **Community Care:** publication of *Practical Guidance on Joint Commissioning.*

17 **Health of the Nation:** Consultation Paper *More People, More Active, More Often* published by Physical Activity Task Force.

18 **Medical Staffing:** further consultation papers published on specialist medical training.

24 **Medical Staffing:** medical undergraduates to receive more training in general practice.

NHS: Secretary of State sets out goals for the next three years and announced changes to the overall management of the NHS.

June

1 **Accountability:** new Code of Practice on Openness published.

6 **Management Costs:** Audit Commission

report *A Price on their Heads: measuring management costs in NHS trusts* published: trusts now to be obliged to publish information about management costs in annual reports.

8 **General Practices:** GPs reject Government proposals on out-of-hours work.

Pay: Ken Jarrold issues statement on local pay, affirming Government's commitment.

9 **Clinical Knowledge:** first National Centre for Primary Care Research and development opened at University of Manchester.

14 **Medical Staffing:** career guidance booklet *Making Your Career in Medicine* issued to help increase percentage of women consultants and increase number of consultants in surgical specialties.

20 **NHS:** Secretary of State issues statement setting out a long term view of the NHS.

Medical Staffing: the intake of medical students to increase by over 10 percent to nearly 5,000 a year by turn of century.

28 **NHS Organisation:** Health Authorities Bill receives Royal Assent.

July

4 **NHS:** second set of annual NHS performance tables published.

5 **NHS:** Stephen Dorrell appointed Secretary of State for Health.

12 **Mental Health:** research initiative into mental health launched at a cost of £2.4m.

Complaints: Alan Langlands responds to criticisms made in Health Service Commissioner reports.

14 **Medical Staffing:** measures announced to deal with poor performance by doctors.

16 **Pay:** Secretary of State asserts commitment to local pay.

18 **Public Health:** report of Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship published.

19 **Fundholding:** maternity pilot sites announced.

Health of the Nation: second progress report published.

26 **Medical Pay:** changes to consultants' distinction awards announced, designed to make the system fairer and more open.

Maternity Care: a further £1 million announced for *Changing Childbirth* projects.

31 **NHS Organisation:** *Patients not Paper*, a report on paperwork in general practice published.

August

7 **Medical Standards:** *Maintaining Medical Excellence* published, recommending that doctors take responsibility for monitoring colleagues' performance.

10 **NHS:** Secretary of States issued statement on the agenda for the future NHS.

Training: joint declaration of principles between NHS Executive and the Committee of Vice Chancellors and Principals bearing on agreement of training contracts.

17 **Long Term Care:** arrangements announced for monitoring NHS responsibilities.

30 **Outpatient services:** first information on waiting times for first appointments published.

September

5 **Pay:** agreement reached between NHS

Executive, employers' organisations, Unions and professional bodies.

October

2 **Rsearch & Development:** Professor John Swales appointed as Director of Research and Development as from 1 January 1996.

3 **Medical and Dental Education:** new arrangements announced following recommendations by the Advisory Group on the Service Increment for Teaching.

10 **Mental Health:** Ray Rowden appointed as first director of commissioning for high security patients.

11 **NHS organisation:** Secretary of State announces cuts in health authority spending on administration and imposes publication requirements on trusts.

17 **Health of the Nation:** joint report of the Nutrition and Physical Activity Task Forces, *Reversing the increasing problem of obesity in England*, published.

18 **Fundholding:** increase in number of total purchasing pilot sites announced.

Public Health: proposals for new breast screening pilot sites announced.

19 **Medical Training:** new measures announced including introduction of new specialist registrar grade, Specialist Training Authority and Specialist Register.

Public Health: Committee on the Medical Effects of Air Pollutants issues report on *Asthma and Outdoor Air Pollution* which concludes that the effect of air pollution is small relative to infections and allergens.

20 **Prescription Charges:** exemptions equalised as between men and women following European Court ruling.

23 **Health Inequalities:** Department of Health publishes *Variations in Health: what can the Department of Health and the NHS d?*

30 **Compensation:** NHS Litigation Authority established to assist with clinical negligence scheme for trusts.

November

2 **NHS:** annual report 1994/95 published.

8 **Public Health:** Committee on the Medical effects of Air Pollutants publishes *Non-biological particles and health* which suggests that air pollution episodes are unlikely to affect healthy people. Nevertheless stricter standards were announced.

Medical Care: Medical (Professional Performance) Bill receives royal assent.

9 **NHS organisation:** efficiency scrutiny announced within trusts and health authorities.

10 **Clinical Knowledge:** first National centre for Evidence-Based Child Health opened at Great Ormond Street.

19 **Community Care:** Direct Payments Bill published.

22 **Complaints:** NHS chief executive responds to further reports from Health Service Commissioner.

23 **Long-Term Care:** House of Commons Select Committee first report into long term care published.

28 **Blood:** National Blood Authority proposals for the blood service in England published.

Finance: first major private finance initiative scheme announced, involving new hospital buildings at High Wycombe and Amersham.

December

1 **Health Service Commissioners (Amendment) Bill** published, extending remit to care and treatment.

12 **Public Health:** revised levels for safe drinking announced.

January

8 **Hospitals:** Secretary of States asserts value of small hospitals, following publication of *Maintaining High Quality Care in Smaller Units,* by Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee.

NHS: Secretary of State sets out challenges for the future.

10 **Clinical Knowledge:** *Promoting Clinical Effectiveness,* a framework for promoting evidence-based medicine published.

11 **Emergency Care:** trusts granted freedom to make staff grade appointments to A&E departments.

18 **Nurse Prescribing:** extensions for pilot scheme announced.

23 **Long-Term Care:** Department of Health publishes response to Select Committee report.

25 **Specialist services:** National Specialist Commissioning Advisory Group announced.

Prescribing: pilot projects announced for repeat and instalment dispensing.

29 **Finance:** £50 million project at Leeds announced under private finance initiative.

February

8 **Pay:** Review Body reports published.

Charges: new prescription and other charges announced.

13 **General Practice:** Gerry Malone Minister for Health begins 'Listening Tour'.

Medical Staffing: 5.7 million allocated to help create new trainee consultant posts.

19 **Mental Health:** draft Patient's Charter for mental health users published.

20 **Mental Health:** £95 million extra announced for mental health and *Spectrum of Care* booklet published.

23 **Community Care:** new scheme for NHS wheelchairs announced.

Fundholding: some fundholders to pilot purchase of mental health inpatient services.

28 **Patient education:** doctur/patient partnership announced.

March

5 **Long-Term Care:** extra funds spending on continuing care announced.

6 **Emergency Care:** action plan for emergency care announced.

12 **Fraud:** new unit set up to reduce prescription fraud.

13 **Fundholding:** second wave of total purchasing sites announced.

14 **Complaints:** final guidance on new procedures published.

15 **Cancer Care:** health authorities set time limit for implementing new framework for cancer services.

18 **Public Health:** new guidelines on cervical screening launched.

19 **Public Health:** Active for Life campaign launched.

20 **Patient's Charter:** *The Patient's Charter* and *Services for Children and Young People* announced.

CJD: Chief Medical Officer and Secretary of States issue statements after report by the Spongiform Encephalopathy Advisory Committee.

22 **Complaints:** Health Service Commissioners (Amendment) Bill gets royal assent.

Pay: national payscale increases announced for 90 percent of non-medical and non-dental staff.

25 **CJD:** Chief Medical Officer and Secretary of State issue statement on CJD and children.

27 **CJD:** Secretary of Statement issues statement at joint meeting of House of Commons Agriculture and Health Select Committees.

[illegible] mental health and Spectrum of C[illegible]
[illegible] published

[illegible] Community Care: new scheme for NHS [illegible] has [illegible] announced.

[illegible] Fundholding: some fundholders to pilot purchase of mental health inpatient services

[illegible] Patient education: doctor/patient partnership announced.

[illegible] Care: extra funds spending for [illegible] care announced

[illegible] Care: action plan for emergency [illegible] announced

13 Fu[illegible] up to reduce [illegible]

[illegible] second wave of total [illegible] announced

[illegible] guidance on new [illegible] published

[illegible] Care: health authorities set time [illegible] implementing new framework for [illegible] services

[illegible] Public Health: new guidelines on cervical screening launched

[illegible] Term Care, Employment [illegible]

[illegible] reports published

Analysis

UK health and health care in an international context

Ken Judge and Bill New

For most of the 1990s analysis and debate about the organisation, financing and performance of the NHS has focused almost exclusively on domestic issues related to the changes set in chain after the publication of the White Paper, *Working for Patients*, in 1989. This is hardly surprising because, despite the introduction of the most fundamental changes to the NHS since it was created in 1948, there continues to be a widespread perception of 'unmanageable' pressure on NHS resources. This feeling that the NHS is in 'crisis' fuels fierce political controversy about whether or not the broad direction of recent changes has been for the best. Unfortunately, good evidence to evaluate the competing claims is in short supply.

It is five years since the first of the substantial proposals in *Working for Patients* began to be implemented. So it is now timely to look at the longer-term trends in the UK health care system and at the way they compare with those taking place in other similar countries. Using data collected by the OECD the aim of this short article is to highlight some of the most significant trends in the UK and to compare them with rich industrialised countries in Europe and elsewhere.

Such an analysis cannot contribute directly to an evaluation of the *Working for Patients* reforms, but it does show that the seeds of contemporary pressure on the NHS have been sown for the best part of a generation. Looking back to 1960 it seems reasonably clear that much of the crisis management within the NHS of the mid-1990s has its origins in the extent to which physical and human resources have been squeezed over a long period in response to relatively poor economic performance and the earlier impact of an ageing population in the UK than in most other countries.

The basic methods, coverage and format of the comparative analysis are described in the Box overleaf and the main trends are discussed under five main headings:

- the economic background
- demographic trends
- health spending
- medical services
- population health

The overall message of the analysis is that

Scope, method and definitions

The analysis focuses on a comparison of the UK with other OECD (Organization for Economic Co-operation and Development) countries for a variety of health and health care variables. There are three 'cases' for presentational purposes: the UK, European OECD countries, and all OECD countries. In the last two categories, unweighted means are used as comparators. Creating a European mean allows analysis of trends unaffected by the influence of the USA, often seen as something of a special case internationally. However, by and large the European and OECD means do not differ significantly.

The countries included in our analysis only comprise members of the OECD, the organisation of relatively rich, industrialised nations. There are 25 countries in the OECD from which we have excluded four at the outset,except where noted in the text:

Included	Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, UK, USA
Excluded	Iceland, Luxembourg, Mexico, Turkey

The reasons for these exclusions relate to population size and data availability. Ideally, weighted means should be calculated for groups of countries to take account of different population sizes. This proved impractical, but to avoid the worst consequences of unweighted means, Iceland and Luxembourg were excluded as their populations are extremely small and therefore liable to have a highly disproportionate effect on the overall mean. Mexico and Turkey are excluded because there is insufficient data available for these countries for most of the variables. In many specific instances, individual countries do not have data available – these are noted at the bottom of the relevant chart and are not included in the mean values for that variable.

For many of the expenditure variables, 'TDE' is used as the denominator. This is 'Total Domestic Expenditure' and is used by the OECD as the most appropriate measure of national income for health expenditure calculations. It is not significantly different from GDP (Gross Domestic Product) which is used to measure overall economic growth rates.

We chose ten variables to be represented graphically, and these are highlighted in bold in the text. Other variables were also analysed, but for reasons of space we only make reference to the main findings from these supplementary indicators. In general, variables were chosen on the basis of the quality of the data availability, both across a wide spectrum of countries and through time.

Definitions were not always unambiguous, in part because of difficulties relating to statistical comparability between countries. The following offers further explanation of what some of the variables were attempting to measure; in other cases definitions are largely self-explanatory.

• total domestic expenditure (TDE)	a measure of national income preferred by the OECD for comparative purposes
• dependency ratio	the number of people aged less than 20 and more than 65, as a proportion of the 20-65 age group
• public expenditure per capita	'public expenditure' includes all state subsidies, spending by government-managed social security schemes, compulsory private schemes, the cost of guaranteeing private health care institutions against bankruptcy, etc. It is net of all charges and co-payments.
• health expenditure at constant health care prices	the growth in the quantity of resource inputs available for providing health care (ie. 'volume growth': spending adjusted for what the OECD term 'medical specific inflation').
• in-patient admissions	the number of persons admitted to all in-patient care institutions as a % of the population ('in-patient' includes psychiatric institutions; day cases not included except for UK);
• in-patient beds	the mean daily census or mid-year estimates, all in-patient institutions;
• in-patient length-of-stay	the mean patient days per admission to in-patient care institutions;
• physician numbers	number of practising ('active') physicians, mid-year estimates.
• standard mortality rates (SMR)	deaths per 1000 population, adjusted for age and sex;
• infant mortality	deaths per 100 live births;
• potential years of life lost	rate per 100,000, from avoidable causes of death, ages 0-64.

Source: All data are taken from *OECD Health Data* (1995), Paris and are available in digital format on computer diskette.

during the past generation the position of the UK has changed relative to many other countries that in 1960 had less well-developed economies and health care systems. However, the relative deterioration in population health, for example, is not as great as might have been predicted by poor economic performance alone, perhaps because resources have been used more efficiently in the UK than elsewhere.

The economic background

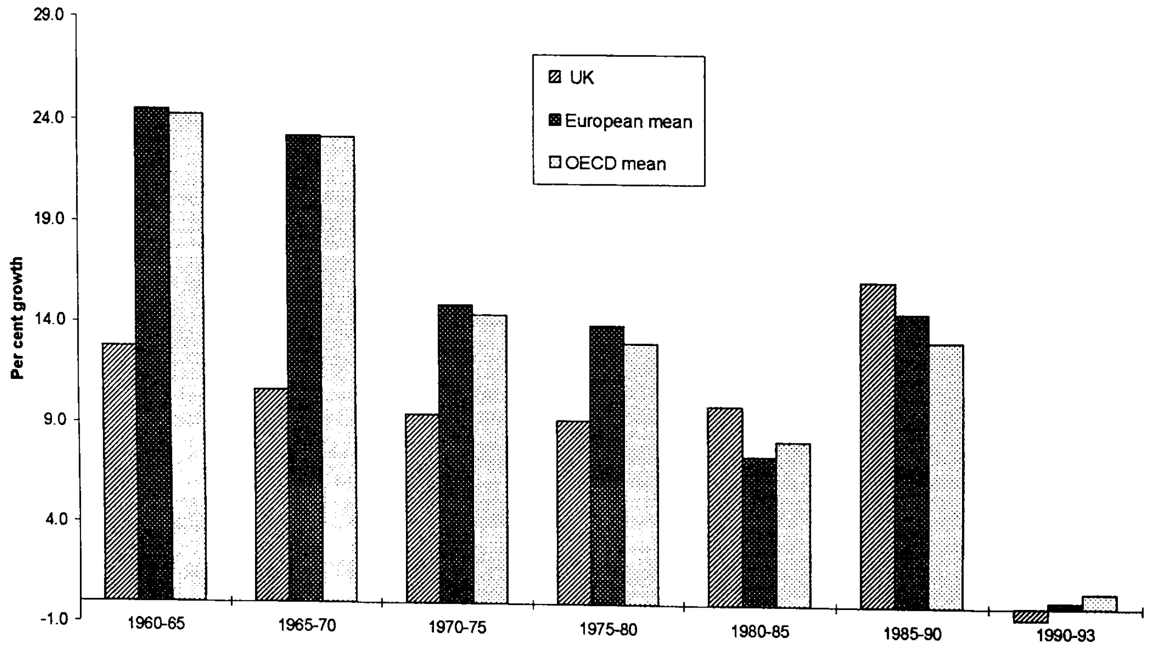
OECD countries are significantly wealthier now than in 1960. Between 1960 and 1993, the **national income (GDP)** of OECD countries had risen, on average, in all of the seven time periods shown in Figure 1. This also true for the European countries, and for the UK except for the period 1990-1993 when it was in recession.

The rate of growth of national income has not been constant. Overall, the OECD has grown at a decreasing rate in each of the seven time periods, with the exception of 1985-90; European countries followed a similar trend. The UK's growth rate has followed a more variable pattern, starting at a lower level of growth (12 per cent) than the average, rising to above average rates during the 1980s, before falling into recession in the 1990s.

Over the entire period, the UK's economy grew by 89 per cent compared with 150 per cent for both Europe and OECD. Relatively, the UK has become a poorer country than its economic partners, falling to 15th position in the league table of 24 OECD countries (excluding only Luxembourg) in 1993, from 6th position in 1960.

Demographic trends

Figure 2 shows the **dependency ratio** – a measure of those not of working age as a proportion of those who are. This ratio has decreased significantly between 1960 and 1989. The OECD average peaked at just over 80 per cent in the mid-1960s and has fallen steadily

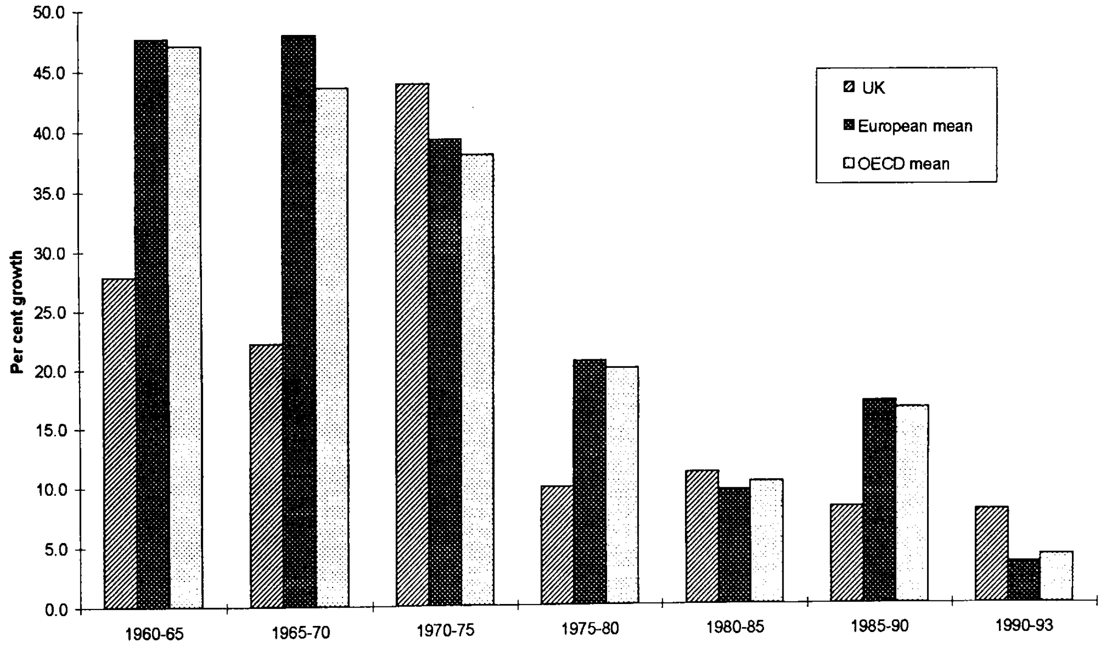


Note: national currency units, 1990 prices

Figure 1 Growth in GDP per capita at constant prices, 1960–1993

Note: Data not available for Denmark and Portugal

Figure 2 Dependency ratio, 1960–1989



Note: national currency units, 1990 prices; data not available for New Zealand and Portugal

Figure 3 Growth in total health expenditure at constant health care prices, 1960–65 to 1990–93 since then to just under 70 per cent in 1989. The UK trend has followed a similar pattern, peaking a little later than the average in the mid-1970s at just over 80 per cent. However, the relative position of the UK has worsened, with a dependency ratio well below the average in 1960 and significantly above in 1989.

There has been a significant 'ageing' of the population in the OECD – the average number of people aged 75 or above has grown from approximately 3.5 per cent of the population in 1960 to almost 6 per cent in 1990. The UK's proportion has remained significantly above this average over the entire period, and its relative position has not changed substantially.

The source of improvements in the dependency ratio is clearly not the older sections of the population and must therefore come from younger age groups. Although the data is poor for this variable, the proportion of the population aged under 20 has fallen substantially, from 38 per cent to 29 per cent between 1960 and 1990 in the ten countries which did provide data.

The impact of these changes in population structure on health care systems depends on how much is spent on the various age groups as well as the overall dependency ratio. So, since expenditure on elderly people is far greater per head than on young people, a shrinking dependency ratio coupled with increasing proportions of elderly people could nevertheless be associated with significantly greater pressures on spending.

Health expenditure

Total

In the league table of OECD countries ranked by total expenditure on health per capita in 1960, the UK was ranked 8th out of 20 (excluding Portugal, Turkey, Mexico, Luxembourg and Iceland). How has the UK fared in comparison with its OECD partners in the intervening period?

Growth in total health care expenditure at constant health care prices – volume growth – is shown in Figure 3. Growth has been positive for all the time periods, though the rate of increase has been falling. Overall, the average growth rate in the OECD fell in each successive period in Figure 3 except for the period 1985-90 – from 47 per cent between 1960-65, to 4 per cent between 1990-93. European countries followed a similar trend; the UK, however, followed a more erratic pattern with early high rates of growth between 1960 and 1975 of between 20 and 45 per cent over five-year periods, slowing to a more consistent growth rate of around 10 per cent for the five-year periods between 1975 and 1990, and 8 per cent between 1990 and 1993. The UK's growth rates were significantly below the average in the 1960s, and above average between 1990-93.

Overall, expenditure grew by 386 per cent on average for all OECD countries between 1960 and 1993. The equivalent figures for Europe and the UK are 391 per cent and 220 per cent respectively. The UK's position in the OECD league table has fallen from 8th in 1960 to 16th in 1993, although it appears this relative decline may now have been halted, at least during the early 1990s.

Share

The share of national income taken both by total and by publicly financed health expenditure has grown steadily in OECD countries between 1960 and 1993. Total expenditure accounted for approximately 4 per cent of national income in OECD countries in 1960, rising to nearly 9 per cent in 1993. A similar trend can be seen for **public expenditure:** see Figure 4. Although the UK share has grown as in other OECD countries, it has done so at a slower rate. For both measures, the UK was above the average for all OECD countries in 1960 and was well below the average by 1993. This relative change is more marked in publicly financed health expenditure, where the UK was over 140 per cent of the OECD average in 1960, falling to 90 per cent by 1993.

The share of public expenditure as a proportion of total expenditure on health for all

OECD countries rose on average from 63 per cent in 1960 to 78 per cent in 1980, and thereafter declined to just over 75 per cent in 1993. The UK has followed a similar trend, though at a consistently higher proportion than the OECD average over the same period. However, the differential has narrowed: the UK was 135 per cent of the overall average in 1960, and 110 per cent in 1993.

Health expenditure and national income

By 1993, whatever the measure of health expenditure – total or public expenditure per capita, total or public expenditure as a proportion of national income – the UK occupied a position towards the bottom of the 'league table' whereas in 1960 it had been near the top. This matches the relative decline in overall economic performance outlined above – although in the case of health expenditure, such a decline is not necessarily unwelcome if there is no noticeable impact on health. In fact, a **relationship between national income and spending on health care** was found as far back as 1960. As Figure 5 shows, it continues to hold and, with the exception of the USA, most countries are very close to the regression line.

Clearly, overall economic performance is the major determinant of levels of health care expenditure. Nevertheless, certain countries appear to be significantly 'below the line' – spending less than their level of national income would suggest on the basis of other countries' expenditures. In particular, the UK, Denmark and Japan fit into this category. Other factors, such as the particular type of health care system, need to be taken into account when assessing variations in health spending.

The USA is the most significant 'above the line' spender. In fact, it is such an outlier that it might be supposed that it would skew the position of the trend line to such an extent that the 'below the line' position of the UK is exaggerated. However, if the USA is removed from the scatterplot the relative position of the UK is largely unchanged.

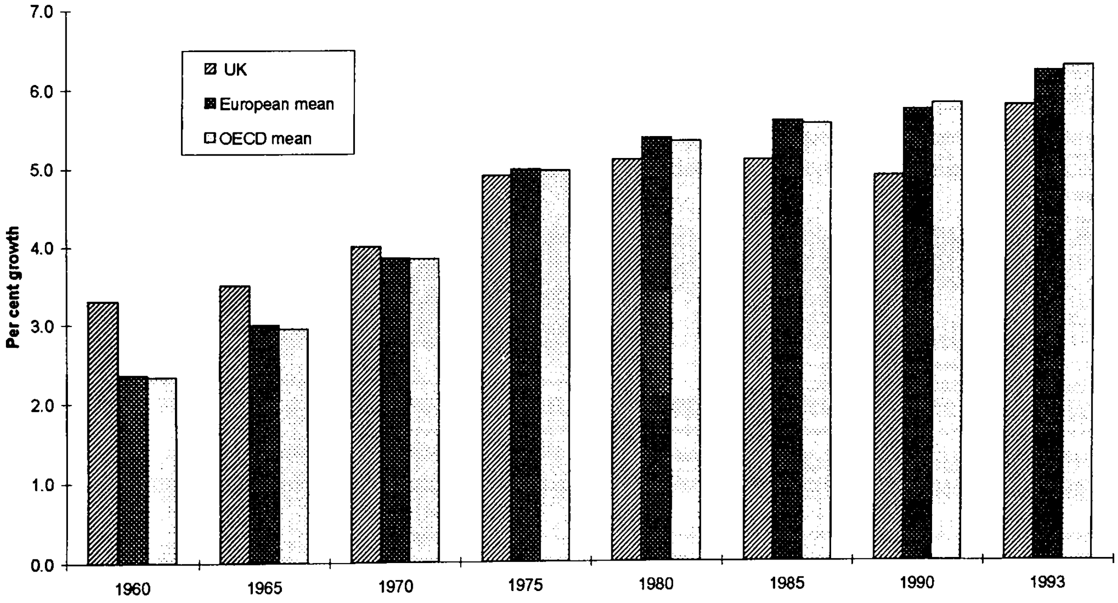
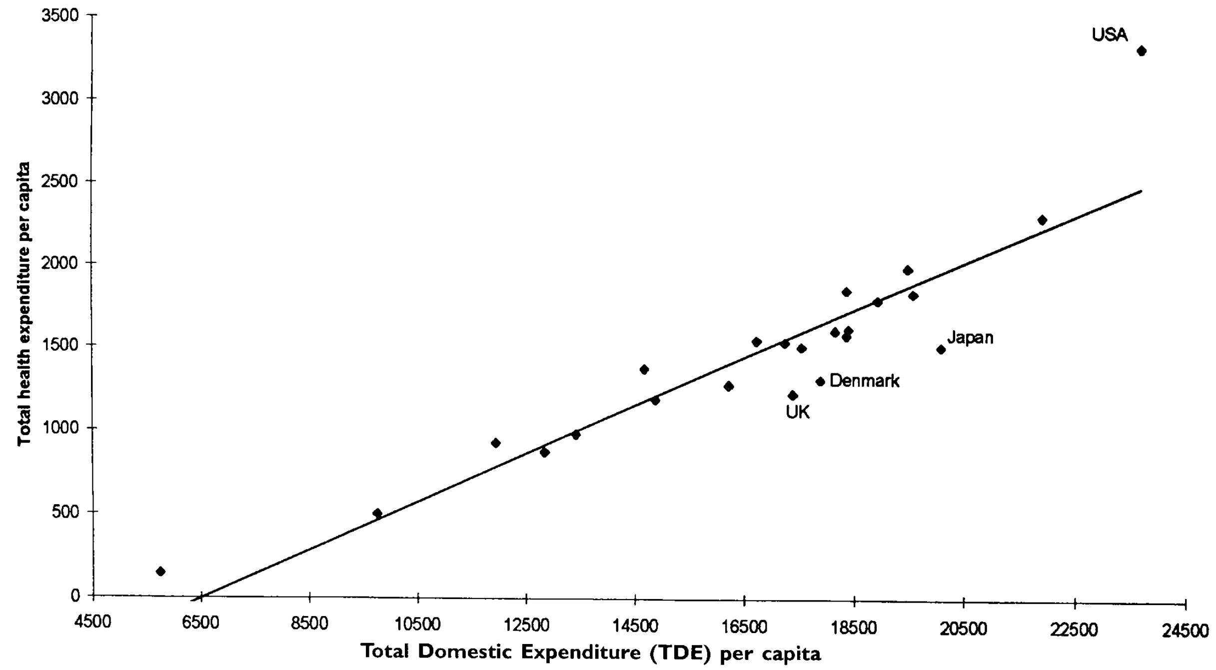


Figure 4 Public expenditure on health as share of TDE, 1960–1993



Note: all OECD countries included except Mexico for which data not available

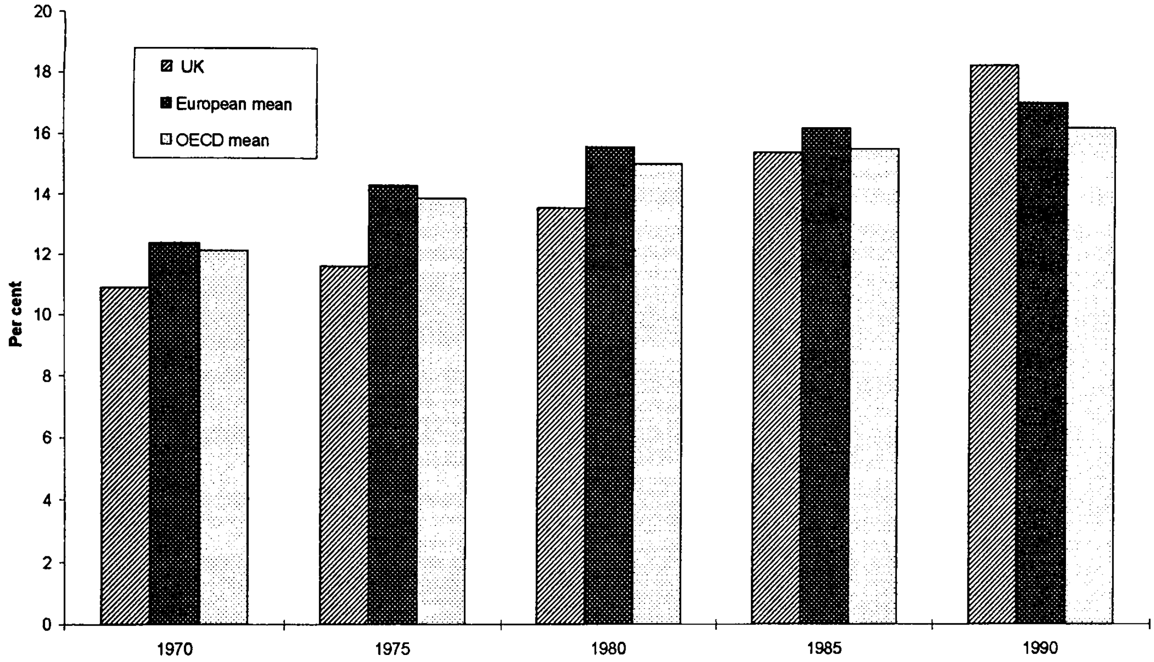
Figure 5 Correlation between total health expenditure and TDE, 1993 (correlation coefficient = 0.916)

Medical services

Inpatient admissions expressed as a proportion of the population have grown steadily on average for OECD countries as a whole: Figure 6 shows an increase from 12 per cent in 1970 to just over 16 per cent in 1990. The UK has followed a similar trend, although its increase has been significantly faster – from 11 per cent in 1970 to over 18 per cent in 1990. The UK has also moved from a position below the OECD average in 1970 to one significantly above it in 1990. In general, day cases are not included as part of admissions data by the OECD, although direct communication from OECD indicated that they are included in the UK's data. This would go some way to explaining the high rate of increase in admission rates displayed by the UK.

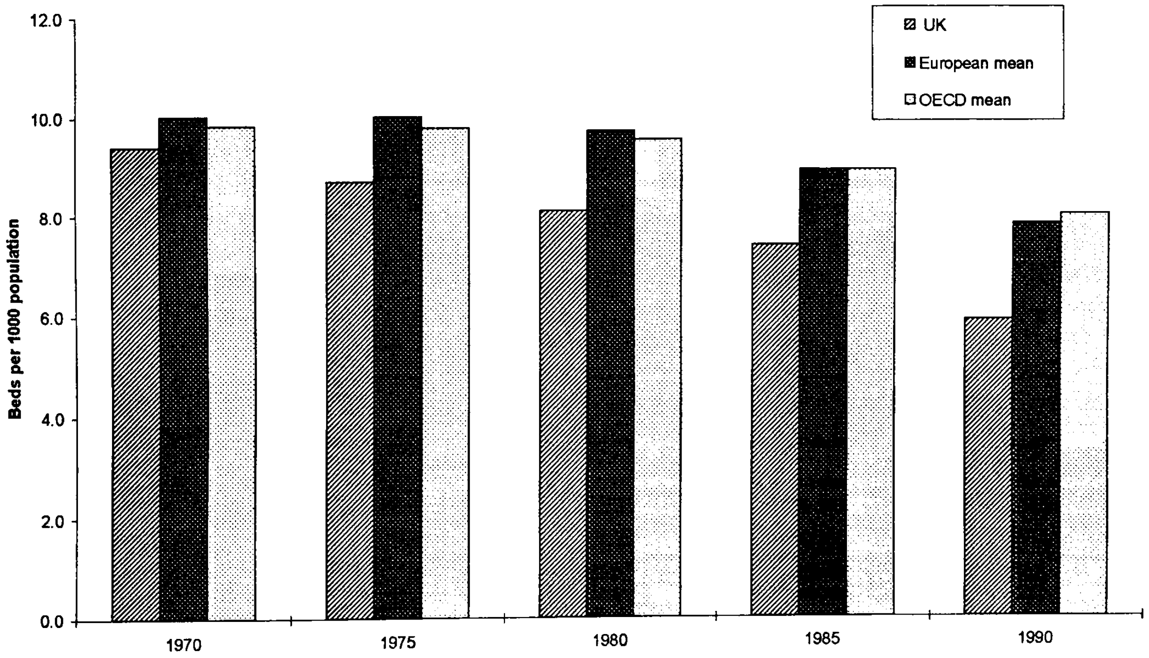
The number of **inpatient beds** has fallen on average in OECD countries from nearly 10 per 1000 population in 1970 to 8 per 1000 in 1990: see Figure 7. The UK has again followed the trend, but at a faster rate – it was 96 per cent of the average in 1970 and 70 per cent by 1990. *Prima facie*, the combined effects of greater admissions and fewer beds would suggest either, or both, shorter lengths of stay and greater day-case admission rates. And where these changes in admission rates and bed numbers have been most marked – as they have been in the UK – one would expect changes in lengths of stay and day-case admissions to be most marked too.

Certainly, as Figure 8 reveals, **average lengths of stay** have fallen across the OECD, but have fallen more sharply in the UK, from over 25 days in 1970 to 14 in 1990. The UK has also moved from being significantly above the OECD average in 1970 – 111 per cent – to significantly below it in 1990 – 87 per cent. So this analysis supports the perception that pressure on bed use in the UK has been severe in comparison with our OECD partners, and that the current difficulties and 'pressure points' intermittently experienced in the NHS are the consequence of long-term international trends which have been



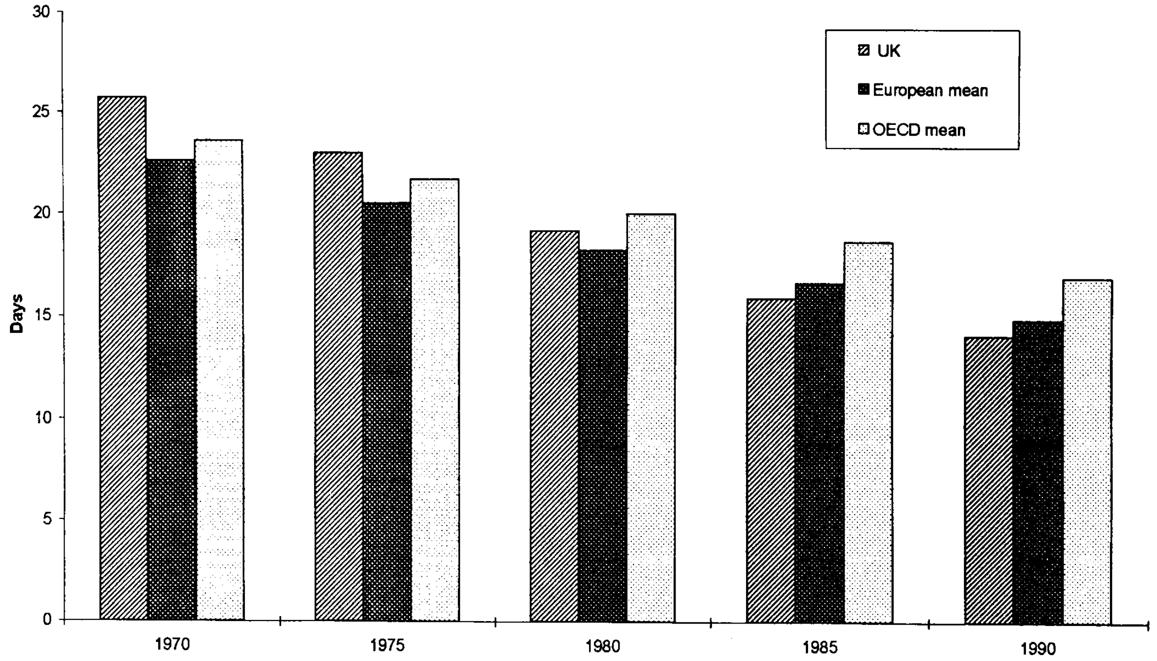
Note: data not available for Australia, Canada, New Zealand, Norway, Spain; data include readmissions

Figure 6 Inpatient admissions as proportion of population, 1970–1990



Note: data not available for Australia, France, Norway, Switzerland

Figure 7 Inpatient beds per 1000 population, 1970–1990



Note: data not available for Australia, Belgium, New Zealand, Norway, Spain, Switzerland

Figure 8 Inpatient average length of stay, days, 1970–1990

particularly keenly felt in the UK. However, as noted above, the effect of including day-case data on admission rates in the UK exaggerates the severity of this pressure on bed use.

Finally, the total active physician-to-population ratio has been steadily increasing on average across OECD countries, from just over 1 per 1000 in 1960 to more than 2.5 per 1000 in 1990. Data from the UK is not available before 1980, but it is clear that although the UK's proportion is also increasing, the overall proportion is well below average – 56 per cent of the OECD mean in 1990. It could be that the UK makes relatively greater use of nursing staff. Unfortunately, OECD data is poor for this variable. But what evidence there is does not support this hypothesis. In 1985 – the most recent year for which data exists for the UK – certified nurses constituted 4.1 per 1000 of the population, compared with an OECD average of nearly 6 per 1000.[1] This is not as small a proportion of the mean as that for physicians, but it is still low: only Spain, Portugal and Greece have a lower proportion of nurses relative to population.

Health status

Standardised death rates per 1000 population on average in the OECD have fallen steadily, from just over 11 per 1000 in 1960 to just under 8 per 1000 in 1989. The UK's rate has also fallen over the same period, though not as fast: in 1960 it was at the OECD average level, whereas in 1989 it was at 110 per cent of the overall average.

Data for potential years of life lost reveal a similar story for men and women between 1960 and 1990 in all OECD countries: a reduction from over 9000 to just over 3000 years lost for women, and from nearly 13000 to 5500 for men. The UK has followed a similar trend, although for both men and women it was well below the OECD average in 1960, but by 1990 the UK was marginally above the OECD average for women, and only slightly below for men.

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[1] Countries included in nursing staff: Belgium, Canada, Denmark, Finland, France, Germany, Greece, Italy, Norway, Austria, Portugal, Spain, Sweden, UK, USA.

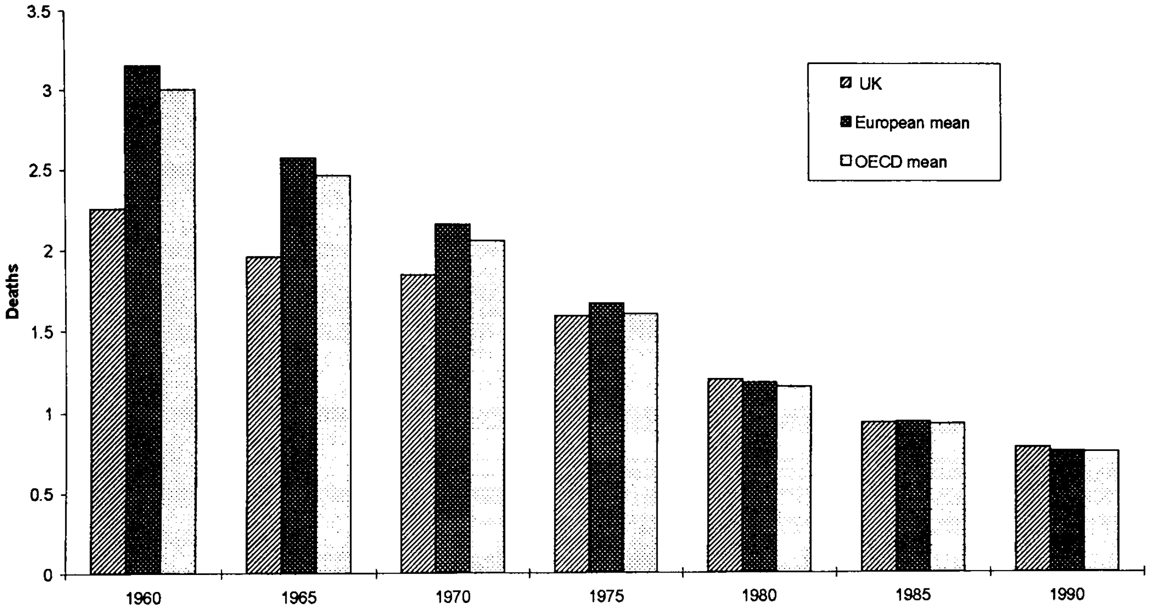


Figure 9 Infant mortality, death rate per 100 live births, 1960–1990

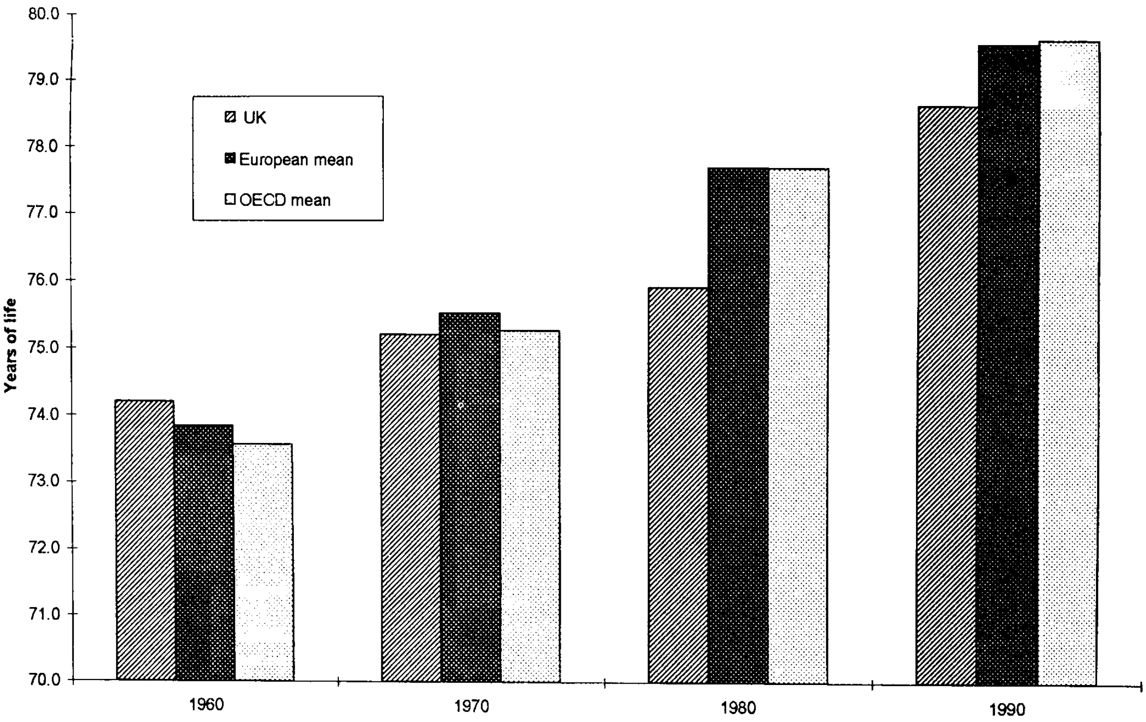
Again, a similar story emerges for **infant mortality**, shown in Figure 9. Death rates have fallen steadily in OECD counties between 1960 and 1990, from 3 per 100 live births to 0.9. As above, the UK has followed a similar trend, but starting from a lower point of 2.25 in 1960. Both infant and adult mortality are subject to certain biological constraints on possible improvements, and so it is perhaps not surprising that there appears to be convergence amongst OECD countries. Clearly those countries which had rather poorer records in previous years have been able to make improvements at a faster rate than countries such as the UK which already had relatively good outcomes.

Life expectancy for men has improved in the OECD as a whole from 67.5 years in 1960 to 72.7 years in 1990. The position of the UK has also improved over the period, starting and finishing at the overall OECD average level. However, during the 1960s and 1970s the UK dropped well below the average rate before recovering during the 1980s. **Life expectancy for women**, shown in Figure 10, reveals a similar overall trend – increasing from an average of 72.6 to 79.2 – although the relative position of the UK has worsened. In 1960 the UK was 102 per cent of the OECD average but by 1990 it had fallen to 99 per cent. This variable is tending to converge for all countries as improvements become harder to achieve; nevertheless, the UK's position relative to the average for women has worsened to some degree.

Discussion

The UK's position has, for many of the indicators outlined above, changed significantly with respect to the OECD mean. It is not possible in every case to say that this constitutes a deterioration, but in many cases the UK does appear to have moved from an advantageous position relative to the mean, to one which is less advantageous or represents greater pressure on health care resources than that experienced by our OECD partners.

The variables which show the most marked change relate to: national income, the dependency ratio, health expenditure at constant prices, health (total and public) expenditure as a



Note: data not available for Canada, Finland, Greece, Italy, Portugal

Figure 10 Life expectancy at birth, females, 1960–1990

share of national income, inpatient admissions, length-of-stay and potential years of life lost for women. A few of these changes unequivocally represent a 'worsening' in our position relative to our partners – those relating to national income and potential years of life lost, for example. Others represent increased pressure, whether one considers them welcome or not. For example, lower relative health expenditures, coupled with increased admissions and shorter length-of-stays together represent an increase in the pressure on the UK's health care system relative to our international competitors. This may, of course, also represent a more efficient use of resources than that abroad. In fact, many would argue that these changes indicate a system adapting rather more successfully than our OECD partners to the twin pressures of fiscal rectitude and increasing demand for health care.

In addition to a change in the UK's position relative to our OECD partners, in some instances there has been a convergence toward the mean for all the countries in the OECD. We calculated a coefficient of variation (standard deviation divided by the mean) for all the variables to establish the extent to which this has occurred. A clear trend emerged only for a selection of the variables: the health status measures, GDP per head, public expenditure as a share of national income and public health expenditure as a share of total health expenditure. In some cases – such as infant mortality – we may all be reaching the limit of possible medical advance. However, it is interesting to note that there is no clear evidence of convergence for variables measuring overall health spending per head or for those measuring medical activity.

Finally, there is some evidence that where a relative decline in the UK's position can be established – such as for overall health expenditure – this has been halted during the early years of the 1990s. For example, growth in total volume health expenditure in the early

1990s was significantly higher than the OECD average. However, the UK has exceeded average OECD growth rates temporarily in the past; it is too early to say that this latest change represents the start of a new trend reversing the relative decline of the past 30 years.

Conclusion

There is a widespread perception that contemporary pressure on NHS resources is reaching crisis proportions, and many commentators are inclined to point the finger at the changes associated with *Working for Patients.* Whether this is legitimate or not, the analysis presented in this paper suggests that it cannot be the only explanation. The relative increase in the intensity of throughput in the British hospital system and the associated relative decline in the flow of real resources to the NHS have been emerging for the best part of a generation. Britain's economic performance has been relatively poor since 1960 and attempts to respond to this by squeezing more out of the resources actually made available have almost certainly contributed to a growing perception of pressure among health care providers. What all this means for the future of the NHS is difficult to predict. Some commentators believe that the long-term trends predicate fundamental changes to the organisation and financing of the NHS. We accept that such a possibility exists but are less inclined to accept this as inevitable. We are much more inclined to believe that the data is consistent with a view that the NHS has evolved in ways that facilitate a capacity to 'muddle through' recurrent 'crises', and that the innate British capacity for pragmatic reform will help to ensure that this continues.

GP fundholding: a review of the evidence

Nick Goodwin

In essence, *Working for Patients* has been an attempt at improving efficiency and creating value for money through a process of devolved responsibility, greater competition and enhanced consumerism to be nurtured by the internal market. By giving GP practices the option of holding budgets to cover the cost of purchasing a range of mainly elective services, the Conservative Government was extending the principle of separating the purchase and provision of services. In terms of expected tangible benefits, the introduction of fundholding had a number of specific targets: reducing inefficiencies in provider organisations; creating better quality in secondary care provision; placing downward pressure on drug costs and unnecessary referrals; enhancing practice facilities for patient care; and promoting greater choice and responsiveness to local health needs. The Government's emphasis, therefore, was on improving efficiency, quality and choice.

Research and analysis examining the potential impact of fundholding has tended to fall into two categories–a critique of the ability and appropriateness of fundholding to fulfil the objectives set by Government–greater efficiency, quality and patient choice–and fears about potential side-effects, such as greater inequity. Since fundholding was regarded as the 'wild card' of the reforms, these speculations tended to be critical of the scheme by pointing to its pitfalls rather than its potential for success. A summary of the predicted outcomes for fundholding is contained in Table 1.

Fundholding remains the most controversial element of the NHS reforms yet, despite the attention given to it, there remains little consensus about its merits. This article, taken from a systematic review of the literature evidence on fundholding, [1] assesses the degree to which consensus exists on the various advantages and disadvantages of fundholding. In order to make this assessment, a set of criteria are used which follow those used by Julian Le Grand[2] in his assessment of the 1990 reforms as a whole: efficiency, equity, quality, choice and responsiveness, and accountability. Under each heading a concise review of the latest evidence is undertaken to assess the degree of consensus among writers of the various merits and faults of the scheme. The review concludes with a balance sheet for GP fundholding which summarises the evidence, assesses how successful GP fundholding has been in fulfilling its objectives, and reveals gaps in the evidence that require filling before the overall impact of fundholding can be assessed.

Efficiency

The efficiency of fundholding has been assessed primarily in terms of cost control rather than on

Table 1 Analysts' predictions of the impact of fundholding

Efficiency

- Fundholding would reduce the effectiveness of the public provision of health care resulting from planning.
- Fundholders would be far more effective purchasers than district health authorities since they could identify with the interests of the patient.
- Fundholders would be able to exert leverage on hospitals and improve quality resulting in better relations with consultants, cost reduction, reduced waiting times, and better specialist care.
- Fundholding practices would be put at risk since there was a fear that the budget allocation to fundholders would be insufficient to cope with yearly variations and deviations in patterns of illness. Consequently, audited savings would not be channelled into enhanced patient care but pooled in order to safeguard against future overspends.
- A constrained budget would prevent GPs from referring patients in need of care.
- Practices could abuse the system by referring patients to their own private clinics.
- A cash-limited drug budget could result in patients not being prescribed the drugs they required.
- A cash-limited budget would lead to cost-shifting in two ways: first, delaying patient referrals to the point where the patient's condition requires emergency treatment (emergency cases being a cost to the district health authority) and, second, force patients to travel longer distances to receive care in hospitals offering a cheaper service.
- It was predicted that fundholding would create a high administrative burden which would create significant financial costs to both fundholders and providers.

Equity

- In order for the scheme to be successful, fundholders would be more generously funded to the detriment of funds given to the district health authority.
- Budget holding practices would indulge in 'cream-skimming' since practices would face the cost of treatment and have the incentive to discriminate against high-cost patients.
- Fundholding would create a two-tier system of access to care between the patients of fundholding and non-fundholding practices.

Quality

- The quality of care in both the primary and secondary sectors would deteriorate.
- The doctor-patient relationship would be threatened since the fundholding GP's role as patient advocate could be undermined by rationing responsibilities and the potential to make decisions based on financial rather than clinical grounds.
- An adverse impact on quality would result from the budgetary impact on referrals and prescriptions.

Choice and Responsiveness

- Fundholding would enhance the class gradient to care since only the most knowledgeable and able individuals would be able to exert leverage on the GP.
- For patients to gain an effective choice of treatment through their GP, a choice of local hospital would be required as a prerequisite.

a wider definition which would include the improved efficiency of resource allocation by fundholders. Five areas relevant to efficiency are addressed in this section:

- Prescribing costs
- Referral rates
- Shift in the location of health care provision
- Source and use of savings
- Transaction costs

Prescribing costs

The Government anticipated that fundholding would have a downward influence on the rise in drug costs since GPs, having been given an incentive to make and spend savings from their prescribing budgets, would consider more rational prescribing options. There is general consensus that, in the early years of fundholding, the rate of growth in prescribing costs was lower in fundholding than in non-fundholding practices. The Audit Commission, [3] for example, found that from a sample of fundholders the cost of prescribing rose by 10, 8 and 8 per cent in 1991, 1992 and 1993 respectively. For non-fundholders the increases were 15, 13 and 11 per cent respectively. This difference has generally been attributed to the greater use of generic drugs and reduced repeat prescribing in response to budgetary pressures among fundholders.

However, it has been argued that these observed trends for early fundholders were not due to more cost-effective prescribing. Cost-containment measures, for example, had been delayed in some practices until after fundholding status was achieved thereby boosting their fundholding prescribing budgets. This implies that subsequent prescribing savings accruing to such fundholding practices were inflated. Moreover, there are methodological problems with the research. For example, observations in small samples of first-wave fundholders may not be generalisable to more recent waves and in some studies non-fundholding controls subsequently became fundholders, casting doubt on the legitimacy of their role as control practices.

Furthermore, it has been shown that non-fundholders have been as able as fundholders in restraining the rise in prescribing costs. In Newcastle and North Tyneside, for example, non-fundholders turned 8.5 and 6.6 per cent overspends into 2.6 and 5.3 per cent underspends respectively. [4] As Roland Petchey suggests, [5] the fact that some non-fundholders have been as effective in restraining the rise in prescribing costs, whilst not being subject to budgetary restraints, throws doubt on the causal linkage implicit in the work on prescribing between financial incentives and economical prescribing.

The evidence for cost-effective prescribing by early fundholders contains many limitations. Despite these limitations, the weight of evidence shows that early fundholders reduced the rise in prescribing costs more effectively than the majority of non-fundholders. However, more recent research suggests that fundholders have lost this ability. Sarah Stewart-Brown *et al's* ongoing study of prescribing in the Oxford region, [6] for example, reveals that the ability to lower the growth of prescribing costs in fundholding practices has reached a plateau, such that no significant difference now exists between the growth in fundholding and non-fundholding practices. This common finding in more recent work is exemplified by the Audit Commission's 1996 report[7] which revealed that the difference in spending between fundholders and non-fundholders was statistically significant only for first-wave practices. One must conclude, therefore, that the initial observation that fundholders reduced the rise in prescribing costs relative to non-fundholders has been short-lived.

Referral rates

The impact of fundholding on referral rates for outpatient care has been investigated by a good number of studies. These studies hypothesised that fundholding would create the incentive to reduce referral rates compared to non-fundholding practices. This would occur because the fixed budget arrangement created an incentive for fundholding practices to make savings through providing fewer medical services. However, the evidence for a reduction in referrals is mixed. Only one study[8] shows an actual reduction in the rate of referrals whilst the work of John Howie *et al*[9] found that the drop in referral rates in fundholding practices was matched by an increase in the use of direct access services such as physiotherapy and chiropody. Work undertaken in the Oxford region,[10] however, found little difference in the rate of growth in referrals between fundholders and non-fundholders and found no evidence to show that budgetary pressures caused first-wave fundholders to reduce referral rates. Indeed, the authors suggest that the method of budget allocation may have encouraged general practitioners to inflate their referral rates in the preparatory year.

In terms of referrals for emergency care, it had been feared that fundholders would be encouraged to delay referrals of non-urgent treatments until these cases became emergencies since the bill for treatment would then be switched to the district health authority. This has not been investigated in detail but there is some evidence to suggest that fundholding has not changed the growth in referrals for emergency admissions.[11]

The qualitative evidence on referral rates is similarly inconclusive. Roslyn Corney,[12] for example, suggests that fundholders have become more aware of the financial consequences of their referral decisions and that referral rates have slowed in response to the need for 'savings'. Conversely, Howard Glennerster *et al*[13] found that the referral rates of some first-wave fundholders rose more quickly than in non-fundholding practices. A fundholding consortium, for example, was able to bargain for shorter waiting times for its patients at the local hospital but found that the growth in activity increased patient throughput and rate of referral.

Shift in the location of health care provision

It has been argued that the ability of fundholders to use savings to buy in services has meant that fundholders have been able to deliver more on-site services than non-fundholders. Many surveys have reported this to be the case and conclude that fundholders deliver more services, thus providing better access to care for local patients. This growth in practice-based services has generally taken the form of greater numbers of outreach clinics performed by hospital clinicians. However, there has been only one (as yet unpublished) study, by Paul Kind *et al*,[14] that has gone beyond opinion surveys to compare the growth in services provided by fundholding practices with that documented in non-fundholding practices. This survey revealed that there was a more rapid increase in the number of clinics delivered in fundholding practices although, significantly, this growth was regarded by the GPs as a response to the 1990 GP contract rather than as a specific outcome of fundholding. Moreover, it is clear that many non-fundholders have been able to develop more on-site services themselves without the availability of fundholding cash. This suggests that one cannot assume a causal link between fundholding and the growth of on-site services since other factors, such as patient profile, size of practice and the enterprise of those running it, may be just as important in encouraging such developments.

Some studies have also suggested that greater numbers of on-site services do not necessarily mean a more cost-effective service. For example, Stephen Gillam *et al*[15] show that whilst ophthalmic outreach care was popular with both patients and GPs and effective in filtering demand for care in the hospital, the costs per patient of the outreach clinic (£48.09) was highly unfavourable compared with that of the conventional outpatient treatment (£15.71). Moreover, a wider range of services provided in a primary care setting does not necessarily reduce prescribing or referral costs. Angela Coulter,[16] for example, found that the use of practice-based physiotherapy services by one fundholder increased the use of physiotherapy threefold but did not reduce the rate of referral to hospital consultants in orthopaedics and rheumatology.

Source and use of savings

One of the major benefits to the GP was seen as the ability to use audited savings to purchase more primary and secondary care for patients. However, there is no evidence which reveals whether the source of these 'savings' is from the fundholder's ability to be a more efficient purchaser and good financial manager or from other factors such as a possible excess of funds allocated to fundholders, underbilling by providers, reduced contract costs offered to fundholders by providers, or lower demands for care in fundholding practices due to a more healthy practice population.

There have been few studies investigating how fundholders have spent their savings. In a survey of 22 fundholding practices, the National Audit Office[17] found that savings were used to enhance practice facilities, buy more staff and develop more in-house services. Set against this, anecdotal stories suggest that 'savings' have been misused. Typical examples include the use of funds to extend practice premises to increase the capital value of the practice to the benefit of the partners and the purchase of inappropriate non-patient services.[18] The Audit Commission's figures[3] show that £111 million of audited savings were made by fundholders between 1991 and 1995. Of these, just £19 million was spent by the end of 1993/94, of which 35 per cent has been on improvements to practice premises, 25 per cent on office and equipment supplies, 15 per cent on medical equipment and, of the remaining 25 per cent, only a proportion spent on extra hospital and in-house services.

Transaction costs

The expectation was that fundholding would create significant transaction costs. It is clear that fundholders have set more complex contracts, often on a cost-per-case basis, which have required providers–and the practices themselves–to devote far greater time to collecting information and to monitoring and managing activity. Of course, the fact that many of these costs fall outside the fundholding sector does not mean they should be overlooked when examining the transaction costs generated by fundholding. For example, it has been revealed that the cost of contracting with fundholders is very disproportionate to the value of the contract. A community trust, for example, has estimated that the cost of contracting with 13 fundholders for 4 per cent of its income was four times higher than the contract with the health authority for 91 per cent of its income.[7] Fundholding has also generated considerable costs in terms of the time taken by GPs to help administer the scheme. John Cornell[19] has calculated that this cost can be up to one day per week for some GPs, potentially reducing the quality of primary care through a reduction in patient contact and the greater use of locums.

Whilst the high transaction costs appear to be recognised they have, until recently, been unquantified. There have only been a few published estimates of the additional operating costs in certain localities. Sara Pennington,[20] for example, crudely estimated the three-year operating costs of the Nottingham GP Commissioning Project at £3.9 million, compared with an estimated £7.2 million for the fundholding equivalent. The Audit Commission's report found that, up to the end of 1994/5, practices had received a total of £232 million to cover the costs in staff, equipment and computers of managing fundholding.[7] This is higher than the reported £206 million of audited underspends made by fundholders over the same period and does not take into account the additional costs imposed on providers. Given that fundholding has generated such high transaction costs, the key question about fundholding must surely be whether this extra cost can be justified in terms of greater benefits to patients.

In conclusion, most fundholding practices have produced savings on their budgets. What is less clear is how these savings were made and whether fundholders have spent their budgets and savings efficiently. Moreover, no study has evaluated adequately the transaction costs associated with fundholding, which are generally agreed to be higher than alternative forms of purchasing.

Equity

This section will address three principal issues of equity:

- Access to care
- Cream-skimming
- Budget allocation

Access to care

Access to care has probably been the most contentious aspect of fundholding. In particular, it is argued that fundholding has created a 'two-tier' system of health care in which patients are not treated fairly, i.e. according to need, but on the basis of whether or not they come from fundholding practices. Fundholders are believed to gain quicker access to hospital services for their patients at the expense of patients in non-fundholding practices.

A substantial review of anecdotal and opinion survey evidence on access to care compiled by the Association of Community Health Councils for England and Wales has highlighted a number of ways in which fundholders have been able to obtain advantageous terms of treatment for their patients.[21] In particular, fundholders have used their contracting power to obtain priority treatment for their patients and have reduced waiting times for initial consultations. Moreover, fundholding patients have had better access to local outreach clinics performed at local GP surgeries. In addition, seasonal variations exist in access to hospital care because hospitals admit disproportionately more fundholding patients at the end of the financial year to maximise cost-per-case income once the health authority's block volumes have been met. This increases the hospitals' income but means that patients are not being seen in order of clinical priority. The study concludes that there is strong evidence that the patients of fundholding GPs have enjoyed better access to hospital treatment than other patients.

Research that has compared the referral rates for patients in fundholding and non-fundholding practices provides further evidence for the existence of 'two-tierism'. A survey undertaken by Robert Kammerling and Andrew Kinnear[22] on referrals for orthopaedic care, for example, concluded that fundholding patients were seen more quickly than patients of non-fundholders, particularly if the hospital provided special clinics exclusively for fundholding patients. Research that has compared the waiting times for patients of fundholders and non-fundholders, however, does not support the existence of 'two-tierism'. For example, Andrew Peeke's study on waiting lists in the Oxford region[23] concluded there was no difference between the waiting times experienced by the patients of fundholders and non-fundholders in Oxford contrary to the widely held beliefs of the local GPs. Similarly, the Audit Commission's report found that waiting times for surgery had fallen in both fundholding and non-fundholding practices and did not differ significantly overall.[7] The evidence suggests, therefore, that inequity in access to care has occurred in referrals for treatment rather than in waiting times.

A further concern was that the most knowledgeable and able individuals would be able to exert leverage on the GP whilst the least able would not. Thus, the more able would gain better access to care. The work of Anthony Scott *et al* has shown that socio-economic status does influence GP decision- making in that patients from higher social groups were more likely to be tested and less likely to receive a prescription.[24] Whilst no study has examined whether fundholding would have the effect of enhancing the pre-existing class gradient in access to care, the greater opportunity that fundholding offered in terms of patient input at least gives rise to this possibility.

Cream-skimming

A widespread fear was that fundholders might indulge in cream-skimming. Cream-skimming is the process by which GPs would discriminate against high-cost patients by refusing them registration at the practice. Within fundholding, it had been argued that an economic rationale exists for cream-skimming since fundholding budgets have not been designed to cover the costs of really expensive patients. However, there appears to be very little evidence for it. As Howard Glennerster points out,[25] the historic cost basis of the fundholders' budget does not in itself create an incentive to drop high-cost patients since fundholders have nothing to gain by doing so. Moreover, there is little incentive to refuse access to new high-cost patients since money lost on such cases would be recuperated the following year.

Nevertheless, there was a widespread fear that any patient which becomes, or is likely to be, an unusual burden on the fundholding practice may be discriminated against. Many authors have claimed cream-skimming does occur. John Cornell,[19] for example, unequivocally states that 'a major drawback experienced by some patients is that they have either been refused registration with a particular GP or removed from a practice list on grounds of their illness being an expensive drain on the practice budget'. However, Cornell cites only the theoretical work of Bernard Crump *et al*[26] to substantiate this claim and provides no empirical evidence of his own for the existence of cream-skimming. Others have also alleged that cream-skimming exists in fundholding practices. The Patients' Association,[27] for example, have claimed that the removal of patients from GP lists is a growing trend in order to avoid excessive costs from seriously ill patients. However, despite the allegations and the theoretical incentives, the Association present no specific cases where fundholders have indulged in the process of cream-skimming. The generally held view in the literature is that fundholders have not undertaken cream-skimming.

Budget allocation

One of the predicted consequences of fundholding was that fundholders would be generously funded to get the scheme off the ground successfully. A key question addressed in the literature has been whether fundholders have gained a greater cash allocation than was their fair share relative to non-fundholders. The evidence for this is mixed. Jennifer Dixon *et al*[28] suggest that fundholders received a higher than equitable allocation in North West Thames. They showed, for example, that the per capita funding for inpatients for non-fundholding practices varied from 59 to 87 per cent of that for fundholding practices. Their work, however, was criticised for relying too heavily on the low quality routine data available and a series of 'tenuous' assumptions. Nevertheless, it is doubtful whether better data has so far been made available.

That fundholders are better resourced is disputed by Howard Glennerster[29] who describes how national and regional comparisons do not suggest that fundholders have been more generously funded. He shows that the figures for Regions suggest there has not been over-funding whilst the application of the national average costs per capita for fundholding procedures suggested that fundholding practices were getting 15 per cent less than expected. Moreover, Shaun Brogan[30] points to a study in Oxford which showed a 9 per cent under-allocation for fundholding practices compared to the regional average. In the light of these figures, it is difficult to support the contention that fundholders have been systematically over-funded. On the other hand, the methodology employed in both these studies was not fully described nor subjected to peer review.

Whilst the evidence for and against inequitable budget allocation is mixed, most commentators agree that there is a need for equity. It is pointed out that practices, whether fundholding or non-fundholding, have always been notionally allocated different budgets on a per-capita basis. The introduction of a formula to promote equity in the allocation of funds to fundholding practices is welcomed as long, as Howard Glennerster suggests, as the formula is extended to non-fundholding practices to promote the notion of 'fair shares'.

In conclusion, whilst the equity implications of fundholding have been the focus of a heated debate, there is very little hard evidence on which to make sure judgements. There is conflicting data on whether fundholders are over-resourced relative to non-fundholders; there is a weight of anecdotal evidence to suggest 'two-tierism'; and there is little evidence to suggest that cream-skimming has occurred. A more detailed examination of equity issues would seem to be required.

Quality of care

This section examines the evidence of the influence of fundholding on the quality of care provided under the following headings:

- Quality of secondary care provided
- Quality improvements in contracts with providers
- Quality of practice-based services

Quality of secondary care

Only two published empirical studies, both by John Howie *et al*, have sought to assess the impact fundholding has had on the quality of secondary care provided.[31,32] The earlier of these examined the treatment of patients suffering joint pain in six Scottish fundholding practices. It found that the length of consultation and the prescription of pain-relieving drugs remained unchanged after fundholding came into effect whilst patients reported being less able to cope with their illness. In the most recent of these studies, which investigated a dozen conditions, including asthma, angina and diabetes, the conclusion was that the quality of care had been largely maintained. However, in some clinical areas, such as patients suffering from pain and patients with social and psychological problems, the quality of care appeared to have declined.

One limitation of the work of John Howie *et al*'s before and after analysis was the lack of a control group of non-fundholders. This means caution must be taken when attributing observed changes in the quality of care to fundholding since no study has compared the experiences of fundholding and non-fundholding practices. Moreover, no work has directly investigated whether fundholding has improved the quality of clinical care provided by hospitals.

Quality improvements in contracts

The introduction of quality standards into contracts with providers has been shown to be a feature of both fundholders and district health authorities. Studies which have investigated the impact fundholding has made to contracting have tended to be surveys of the views of fundholding GPs rather than detailed analyses of contracts. Nevertheless, all of these surveys reveal that fundholders were convinced that fundholding had been the catalyst for improved quality in contracts. These improvements appear to be in the area of organisational/process arrangements rather than the actual quality of clinical care. Howard Glennerster *et al*, for example, cites examples of how fundholders have used their purchasing power to improve information flows and engender a faster response rate to their referrals and requests for information from GPs. Other studies also agree that a change has occurred in the power relationship between the fundholding GP and the providing trusts, the most important benefit of this being quicker and better communication links between the two. The main improvements for patients are reduced waiting times. But this benefit has also been experienced in non-fundholding practice largely as a result of national initiatives.

The evidence on creating better quality services through contracts consists of descriptive case-studies and anecdote. No study has sought to compare fundholding contracts with those negotiated on behalf of non-fundholders over the same period. Indeed, reports from non-fundholders involved in GP commissioning groups have made similar claims of improved standards through contracting. In the absence of a comparison between fundholding and non-fundholding practices it is unclear whether fundholding has been the catalyst to these improvements or whether it is a general effect of the purchaser-provider split.

Quality of practice-based services

The use of fundholding 'savings' to enhance practice-based facilities and the ability through contracting to develop outreach clinics have been regarded as a major benefit of the scheme. As the section on efficiency in fundholding showed, the evidence suggests that fundholders have been able to offer more on-site services and clinics than non-fundholders. Whilst opinion surveys show that these initiatives are welcomed by patients who generally prefer treatment locally within familiar surroundings, there is some disagreement as to whether the growth in on-site services necessarily leads to greater improvements to health. Michael King *et al*, [34] for example, examined a practice-based counselling service where patients referred to counsellors were often seriously distressed and where recovery was slow. The research questioned the feasibility of assessing the effectiveness of health outcomes from such services.

Owing to the lack of empirical data on quality improvements in clinical care, and the lack of any systematic comparison between fundholders, non-fundholders and other purchasers of care, it is impossible to show that the quality of care has improved through the introduction of fundholding. Except for the work of John Howie's team, the evidence is mainly in the form of case study and anecdote with most of the observed 'improvements' being in terms of organisational changes rather than in terms of health outcomes.

Choice and responsiveness

The two main questions asked in this section are:

- Has fundholding generated greater choice for consumers?
- Has patient satisfaction increased?

According to *Working for Patients*, patients of fundholders would receive a greater choice in the location of hospital for their treatment. Choice has been measured through surveys of the views of GPs and patients. Ann Mahon *et al*,[34] for example, found that fundholding GPs were more willing to take into account patients' preferences than non-fundholders; more willing to refer patients? greater distances for elective surgery; and less likely to consider only one hospital for a referral. On the other hand, patients were unwilling to travel further distances to be treated more quickly and most were indifferent on the issue of choice. This indifference is exemplified in a survey of patients by Paul Kind *et al*[35] which showed that 80 per cent of patients did not know whether their practice was, or was not, a fundholding one. Thus, whilst fundholders have reported greater willingness to offer patients more choice compared to non-fundholders, patients perceived that there was little difference in the level of patient choice.

In terms of patient satisfaction, whilst there is evidence to suggest that satisfaction remains high in fundholding practices, patient surveys show that the expectations of patients are rising; fundholding patients are significantly more critical of their GP than patients of non-fundholders, and that a reduction in patient-doctor trust has resulted. This reduction in trust has been argued to be a result of the patient feeling that decisions made regarding treatment or referral are being made on monetary rather than clinical grounds. Alternatively, the observed growth in criticism may be related to the greater articulateness of patients in the more affluent areas in which fundholding practices are located since it has been shown that the patient's willingness and ability to express dissatisfaction is related to socio-economic status.

Studies investigating patient choice are difficult to assess since they come from attitudinal surveys of patients and GP fundholders. From the patient's viewpoint, involvement in the choice of hospital has remained very low whilst satisfaction with the overall service received has remained high. Thus there is no evidence of greater responsiveness to patients' views.

Accountability

Fundholding was intended to make the NHS more responsive to its users and be more businesslike. However, as power and resources are passed to the fundholder the more the fundholder must, like any other purchaser, be made accountable for the way budgets are spent. However, the lack of an appropriate accountability mechanism, both for the GP fundholders' use of underspends and for their purchasing decisions, was of widespread concern. Concern was also expressed over the lack of accountability of GP fundholders to patients.

Due to these concerns, it has been generally regarded that accountability procedures must improve. This problem was partially addressed by the Government through the launch of an accountability framework for GP fundholders in December 1994 but, as the Audit Commission's latest report reveals,[7] no health authorities have developed explicit systems to judge how wisely fundholders are purchasing, or whether their purchasing represents good value for money.

A balance sheet

Compared to the other reforms outlined in *Working for Patients*, such as self-governing trusts, there has been far more research on the impact of fundholding in the literature. Despite this attention, the evidence is too incomplete to make a judgement about the scheme as a whole. There are, in particular, a number of problems with the evidence as presented, which makes it hard to derive clear-cut conclusions.

First, despite the high-profile nature of the fundholding initiative, there has been no centrally driven systematic effort to evaluate it. Second, the research tends to be 'localised' to specific geographical areas making generalisation hazardous since fundholding may be a better solution in some localities. For example, fundholders with a choice of local hospital can use the threat of contract shifting as an effective lever for service improvements. A fundholder faced with a monopoly provider, however, cannot use the same degree of leverage.

Third, much of the evidence on the impact of fundholding is equivocal and thus consensus exists in only a few areas. Fourth, a common problem is the inherent difficulty in comparing fundholding with other purchasing models. The main reason for this is the lack of a 'control' group with which to compare fundholders.

A fundamental point to consider when attempting to evaluate the achievements of fundholding is the self-selected status of the fundholding practice. As Roland Petchey points out, innovating practices (implying first-wave fundholding practices) were better resourced and were more likely to be located in affluent areas than in inner-cities. Fundholding practices, therefore, are not a random sample and cannot usefully be compared with non-fundholders due to their relatively privileged location and background. Thus it could be argued that fundholding has provided a further demonstration of the inverse-care law by selectively channelling additional resources and spending power into already advantaged practices.

Despite the nature of the evidence, it is possible to pick out from the review those areas of general consensus and areas where there is disagreement or a substantial lack of information. This enables a balance sheet to be constructed for fundholding which identifies the extent to which fundholding has lived up to predicted outcomes and how it measures up to the five evaluation criteria. From the balance sheet represented in Table 2, it can be shown

Table 2 A balance sheet for fundholding: analysis by evaluation criteria

Criterion	Direction of Evidence	Comments
Efficiency		
Prescribing costs	+/-	Reduced rate of growth of prescribing costs in fundholding practices initially, but appears to be short term.
Referral rates	=	No significant change in referral patterns measured.
Shift in location of care	+/-	Growth in fundholding and non-fundholding practices. Growth may be more due to GP contract. Cost effectiveness of on-site services questioned.
Source and use of savings	+/-	Evidence for both improvements to practice-based facilities for patient care and inappropriate use of resources. Reasons for savings unclear.
Transaction costs	+	Consensus of opinion is that these have risen as a result of fundholding.
Equity		
Access to care ('two-tierism')	+	Weight of anecdotal evidence suggests fundholding has created two-tierism.
Cream-skimming	?	Has not been identified but potential still exists.
Budget allocation	+/-	Evidence equivocal.
Quality		
Quality of secondary care	=	Very limited evidence. It concludes that clinical care has remained stable.
Quality improvements in contracts	+	Case study and anecdotal evidence suggests fundholders secure improvements in the process of care from providers.
Quality of practice-based services	+/-	Whilst more practice-based services have developed in fundholding practices, it has been argued that the quality of these cannot substitute for care in other settings.
Choice & Responsiveness	=	Level of patient choice varies in GP and patient surveys but suggests no change. Patient satisfaction remains high whilst expectations are rising.
Accountability	?	Concern has been expressed over weak accountability arrangements but no study has evaluated the problem.

Key: + evidence in direction predicted; - evidence in opposite direction to that predicted; +/- direction of evidence in both directions;

? no evidence; = evidence for no change;

that there is consensus on the impact of fundholding in the following areas:

- The rise in prescribing costs has been lower in fundholding practices compared to non-fundholding practices. However, this differential appears to have been short-lived.
- There appears to be no difference in the increase in referral rates between fundholding and non-fundholding practices.
- There has been more practice-based care in fundholding practices than in non-fundholding practices.
- Providers have been more responsive to the demands of fundholders than non-fundholders.
- Fundholding has created a high administrative workload and high transaction costs for both purchasers and providers.
- A two-tier system has been introduced and 'institutionalised'.
- There has been no change to patient choice.

Whilst these are consensus areas, it is important to point out that the interpretation of whether these changes are a good or bad thing is contested. For example, there have been questions as to whether greater practice-based care is better care or a more efficient use of resources than care provided in other settings. In the case of 'two-tierism', on the one hand this can be interpreted as a catalyst to the levelling-up of the quality of health care and a necessary interim product of the reforms. As Howard Glennerster argues, the two-tier effect that exists may be a transitional one, reducing as more GPs become fundholders, whilst the improvements that fundholders bring to the service can spin off on to some non-fundholding practices. This could be achieved, for example, by a hospital introducing, as a response to fundholding pressure, a new service for fast delivery and collection of test results which then becomes available to non-fundholding GPs as well as fundholders.

On the other hand, a 'two-tier' system can be seen as a major equity concern, benefiting the patients of affluent fundholders at the expense of smaller and less affluent practices with poorer populations in greater need of care. It can be argued that the NHS has always been 'multi-tiered' because the competence and energy of GPs varies. Whilst the evidence for enhanced two-tierism as a result of fundholding is anecdotal, fundholding appears to have exposed previous differences and codified them into two tiers. The main issue is whether there can be a levelling-up process and whether non-fundholders can become successfully integrated into the scheme in some form.

It is clearly very important for policy makers to have research evidence from which to make decisions. It is therefore of concern that debate and decisions on the future of the fundholding initiative may be made without the necessary information. What is alarming from this review of the evidence is the number of fundamental areas that have not been the focus for research. From Table 2, it can be seen that the major gaps in our knowledge are:

- Whether fundholding makes a difference to the quality of primary and secondary care.
- Cream-Skimming.
- Accountability.
- The true size of administration and transaction costs, particularly those falling on providers, without which the real cost-effectiveness of the scheme cannot be properly measured.

Conclusions

The nature of the evidence on GP fundholding leads to the conclusion that both a robust defence of and vitriolic attack on the scheme is possible. Thus, claims by the Government that fundholding has proved to be a success may be premature. In particular, the evidence available to assess the true impact of fundholding on transaction costs, equity and quality of care is very limited and further research into the fundholding initiative should concentrate in these areas.

A further point to consider, and one which is fundamental to the evaluation of fundholding, is the characteristics of the fundholding practices themselves. Many non-fundholding practices have in fact achieved efficiency improvements equal to, and better than, fundholding contemporaries. This greater efficiency, therefore, may be more likely to be a product of innovation in practices than the result of fundholding *per se*. By citing the research of Nick Bosanquet and Brenda Leese, which revealed the existence of a stratum of 'innovator' practices prior to the fundholding scheme, Roland Petchey supports the argument that for many practices fundholding was the logical next step in their development. This would mean that any superiority attributed to fundholding practices might be attributable to their status as 'innovators' rather than as fundholders. The Audit Commission's report[7] lends credence to this hypothesis by concluding that most fundholders are failing to secure the expected benefits for patients. Thus, whilst fundholding may have created greater potential for change, only innovative practices within fundholding have transformed patient care. As the report argues, most fundholders have had only modest ambitions and most services in fundholding practices are delivered in the same way by the same providers with few measurable extra benefits to patients. Given the high transaction costs associated with fundholding, this appears to be a damning conclusion.

As the literature shows that some non-fundholders have been able to perform as well, if not better, than fundholders, and that some fundholders have been more dynamic than other fundholders, a further potential area of investigation would be a consideration of the characteristics of 'innovator' practices. This should be undertaken because the research evidence reveals that the ability for GPs to make changes, both organisational and clinical, may be dependent on criteria other than simply becoming a fundholder. In this sense, the character of the individual fundholding practices and the interplay of the GPs within them combine with a local context, i.e. the characteristics of the patient population and provider market, to provide important catalysts or barriers to change and 'innovation'. It has been shown in other work on the NHS that the ability to make strategic change in specific localities is heavily influenced by the local context. Andrew Pettigrew *et al*,[36] for example, distinguished between 'receptive' and 'non-receptive' contexts for change in the NHS that acted as barriers to, or catalysts for, the introduction of strategic change. Thus, whilst fundholding may be an important catalyst for change, a far wider set of variables need examination to explain why some fundholders appear to perform better than others and why some non-fundholders appear to be more innovative than some fundholders.

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NHS capital charging after five years

David Heald and David A Scott

Many public services have a cost structure in which facilities and/or labour costs feature prominently. Governments have traditionally used cash accounting, under which assets are expensed – i.e. treated as a cost – in the year of acquisition and therefore do not appear in balance sheets, even when these are prepared. Such practices have been widely criticised as a potential source of inefficiency. Under capital charging, public service providers must explicitly pay for their capital through the mechanism of an annual charge, based upon the value of assets used in service provision. The rationale is that ending the treatment of capital as a 'free good' will lead to improvements in productive efficiency, thereby securing genuine cost reductions for given output levels.

It is possible to identify two distinct problems in public services like the NHS, which capital charging is intended to address. First, viewed as economic units, the delivery organisations responsible for public services have sometimes suffered from capital starvation. Budgetary limits have denied them access to the resources required, for example, to reconfigure their asset bases in line with contemporary requirements. In the medium term, this must compromise productive efficiency. Even though the aggregate amount of capital for new buildings has been tightly constrained, the incentive for individual units was always to bid for too much capital. For a variety of reasons, there have been some bad investment decisions when the full set of costs relevant to the acquisition of new assets was not properly taken into account. In the case of equipment assets, the annuality rule of government accounting on a cash basis provided incentives for wasteful end-of-year spending sprees.

Second, such economic units have been hoarders of assets because of poor incentive structures – once assets were acquired they became free goods, costless to the asset holder. The unglamorous task of asset maintenance was often neglected, partly due to the pressure of annual budgetary limits. The overall conclusion has been that managers who neither account for, nor remunerate, their asset bases tend to be neglectful of asset management.

Proposals for some form of charging for capital in the NHS designed to address these problems first surfaced in the 1970s. A proposal for capital charging can be found in the research commissioned by the Royal Commission on the National Health Service.[1] 'Notional rents' were proposed by an official Department of Health and Social Security committee chaired by Ceri Davies.[2] Although capital charging might have been implemented as a freestanding reform, this did not occur. Instead it was introduced in 1991 as an integral part of the *Working for Patients*[3] reforms.

This article:

- begins by setting out the rationale for capital charging;
- describes the implementation of capital charging within the NHS;
- describes the evidence that is available as to its impact;
- assesses how far the original objectives have been met;
- considers other developments, particularly the Private Finance Initiative;
- sets out a brief conclusion.

The rationale for capital charging

Capital charging can be seen as a means of securing greater alignment between managerial incentives and resource costs. Under cash accounting, the budgetary and resource measures of cost diverge. For example, the *budgetary cost* of health care contains two elements: current expenditure, e.g. medical and nursing salaries, and gross capital expenditure, e.g. new hospitals. However, the *resource cost* measure does not include this year's capital expenditure but instead a capital charge which has an interest component and a depreciation component. Ideally, the latter should embrace not only the wear and tear associated with use, but also the functional obsolescence associated with changing output requirements and changing technology. In general, the disposal of assets which are not fully depreciated is not treated as part of the resource cost in that year, but as an indication that there has been an underestimate of resource costs in previous years.

Capital charging should also be set within a macroeconomic context. There are many sources of fiscal stress on governments, independent of changed ideological stances on the role of the state. Many industrialised countries have experienced severe budget deficits and have confronted a growing problem of indebtedness. For those European countries which have signed the Maastricht Treaty, the convergence criteria specifying ceilings on budget deficits and on public debt/Gross Domestic Product ratios have become major constraints on fiscal policy. These macroeconomic constraints have intensified the search for means of reducing the costs of government, whether by squeezing more outputs from the same inputs or by withdrawing from certain traditional areas of service provision. A mechanism such as capital charging can readily be seen as relevant to the more efficient utilisation of the governmental capital stock. The same fiscal pressures can, however, lead to less desirable responses, including the adoption of techniques which disguise the current fiscal position by shifting costs to the future.

A powerful case can clearly be made for capital charging. Nevertheless, it is important not to lose sight of the condition for a policy improvement: the benefits of capital charging such as greater cost consciousness about assets, must be greater than the sum of the direct costs such as staff and computing, and the indirect costs such as dysfunctional behaviour. Capital charging should make decision makers choose, e.g. between buildings and nurses, whilst containing the costs of operating such a system well below the benefits.

Implementation

In our review of the implementation of NHS capital charging in Scotland, we[4] concluded that failures, notably in the areas of software and staff training, substantially increased the cost of implementation and delayed the generation of benefits. The tasks involved were more complex and time-consuming than was appreciated by policy makers. At crucial stages, capital charging attracted insufficient senior management time, in part because it seemed a technical and unglamorous component of the 1991 package of reforms which also included purchaser/provider separation and the corporatisation of providers as NHS trusts. However, the discussion here concentrates upon problems revealed during the implementation process which have continuing relevance.

Dilemmas of asset valuation

Capital charges consist of two components: interest on the average capital stock – the opportunity cost of committing capital to health care; and depreciation on the opening capital stock. The implementation of capital charging therefore requires opening and closing valuations of the asset base and a measure of the 'wearing out' of assets during the period. Capital charging is thus dependent upon asset valuation. In sectors such as health care with long-lived, highly specific assets, historical cost is not only irrelevant but probably impossible to establish reliably, as records of the original cost of acquisition typically do not exist. Because the NHS dominates health care provision, there is almost no outside market for either hospitals or hospital enterprises, so that open market value in existing use cannot be established.

In the NHS, use has therefore been made of depreciated replacement cost (DRC), a well-established basis in the property valuation literature for dealing with this kind of circumstance. In practice, all valuations of operational assets have proceeded on the basis of DRC, a process involving assessment by the District Valuer of the rebuilding cost of a like-for-like asset. Recourse to DRC encounters three serious difficulties.

First, it may seem practical to value every element of every asset and then to sum the values. However, this approach neglects the aggregation problem: some authors have stressed that the replacement cost of a system will, in the presence of economies of scale and/or economies of scope, be less than the replacement cost of the individual assets.[5] The essential point is that it may well be very much cheaper to build a new hospital than to rebuild all the individual parts. For example, it seems likely that most hospitals, which have typically grown by accretion, could have their capacity replaced with fewer buildings. Valuing all assets separately will often lead to serious overvaluation.

Second, there is an intractable dilemma with DRC: either assets are valued on the entirely implausible basis that the existing configuration of assets – despite functional obsolescence – will be replaced, or they are valued on the readily manipulable basis of what is currently declared by managers to be the relevant Modern Equivalent Asset i.e. the new asset with which the existing asset would be replaced if replacement were to be effected now.

Third, much of what is currently described as capital expenditure 'disappears', in that it does not lead to net asset creation in the sense of increases in DRC. In reality, much NHS capital expenditure is of a conversion nature, whether modifying buildings or changing their use. For example if a nurses' home became a trust headquarters, some of the original asset would be destroyed. This is a problem exposed by DRC valuation rather than caused by it.

In consequence, there has been concern about dysfunctional incentives. Potential difficulties arise when decisions have to be made on new hospitals and on make-buy decisions, e.g. the use of existing NHS accommodation with high DRC values versus contracting with the private sector. Purchasers may divert business to other providers, including those operating outside the capital charging net, even when this is not the least resource cost option. The valuation system for capital charging has produced balance sheets which greatly exaggerate the value to the owner of existing assets. The balance sheets of several NHS trusts, particularly those providing community and psychiatric health care, contain assets whose disposal value can be as low as 10-20% of the DRC valuation. The architectural listing of aesthetically pleasing but functionally obsolete hospital buildings is a major problem for NHS managers because this probably limits alternative use and hence disposal value.[6] Many of these balance sheet values are unrealistic – unrelated to potential earning power – but have to be serviced through interest and dividend payments. The fact that re-provision will necessitate write-offs may distort replacement decisions, possibly delaying them. Moreover, there is an obvious danger that such write-offs will discredit the financial regime.

The age and often poor condition of the NHS estate, coupled with fashions in hospital building design and recent changes in modes of health care delivery, mean that an NHS trust's asset base is frequently badly adapted to its present needs. Instead of a Victorian psychiatric hospital or 1960s tower block – both of which incur operating cost penalties – having low valuations, the DRC methodology attaches large valuations to them because of their construction materials and/or type.[7] Naturally, the less the hospital of the future[8] looks like hospitals constructed in the past, the greater are the problems inherent in DRC valuation. The reason for the rejection of the Modern Equivalent Asset approach is undoubtedly that it was considered too judgemental.

Furthermore, the intended level playing field within the NHS has been threatened with disruption. First, accidents of timing have had important consequences: some hospital valuations have been written down before being taken into trust balance sheets due to there being defined closure timetables. Second, capital charging will encourage the search for donations because donated assets do not incur capital charges. At present, donated assets constitute such a small proportion of the NHS capital stock that they are insignificant. The exception to this is paediatrics, where the remarkable fund-raising capacity of specialist children's hospitals can seriously affect the financial viability of paediatric services to other NHS providers, sometimes over large geographical areas. Third, there will be inconsistent treatment as between publicly financed NHS assets and privately financed assets, which are not capital charged and not subjected to periodic revaluation. The level playing field between the NHS and the private sector is also threatened by the DRC valuation rule which makes current NHS managers live with the consequences of construction mistakes, in circumstances where current private health managers would – post financial reconstruction or takeover – be able to concentrate upon finding the most profitable use of the existing facility. The problems inherent in the DRC approach are undoubtedly accentuated when the NHS ceases to be regarded as a closed system and interacts with private provision and financing, a point we return to below.

The design of purchaser budgets

Once a capital charging system has been implemented for providers, two further matters of system design must be properly addressed. The amounts allocated to purchasers need to be set at a level which allows providers in aggregate to pay capital charges. This originally took the form of directly managed units literally handing over their capital charges but was later transformed into the payment by NHS trusts of interest and dividends and, through the external financing limit system, the funding of capital expenditure. A spectrum can be defined from full reimbursement, whereby each purchaser's budget is set so that it can afford the actual capital charges of its actual providers, to full weighted capitation whereby only the characteristics of the relevant client group affect budgets, not the characteristics of individual providers. The financial pressure encountered by those purchasers currently buying from high-cost providers will be transmitted through to such providers who will be pressurised to bring their costs down into line. However, questions arise as to whether some elements of capital charges differentials are beyond managerial control, e.g. high local property costs, and, if so, whether these should be (partially) compensated.

The internal market introduced in 1991 brought together formula-funded purchasers and providers who must pay capital charges upon their assets, the existing configuration of which is inevitably heavily conditioned by past decisions. The ultimate goal of funding models is to detach purchaser allocations from the particular circumstances of their existing providers. In the interim, the impact can be softened either by (i) retaining some element of reimbursement of actual capital charges rather than moving to 100% weighted capitation, or by (ii) incorporating elements within the weighted capitation formula which proxy for differences in actual capital charges. For example, if rural areas actually have more hospital beds per head of population than urban areas, the full rigours of formula funding can be attenuated either by partial reimbursement of the higher actual capital charges or by building a population sparsity factor into the weighted capitation formula.

Capital charges money, i.e. those funds distributed to purchasers to enable them to pay capital charges, can either be kept separate or integrated into revenue budgets. Different approaches have been adopted in Scotland and England. Scotland has kept capital charges money separate over a defined transitional period in which the basis of distribution has been switched from reimbursement to weighted capitation in the following proportions: full reimbursement (1991-92); 95:5 (1992-93); 85:15 (1993-94); 60:40 (1994-95); 40:60 (1995-96); 20:80 (1996-97); and full weighted capitation (1997-98).[9] During this transition period, there has been a distinct pool of capital charges funding money which grows as new investment is made and shrinks as assets are disposed of. The actual path of transition has been less smooth than intended due to the disruptive effects of data revisions on provider capital charges, made after capital charges allocations had been notified to purchasers.

In England in contrast, there has been full 'unification' of capital charges money and other revenue funding, with effect from 1995-96. The purchaser faces no differentiation between money available to pay capital charges and money available to pay for other revenue costs. There remain, of course, differences between expenditure targets (the amount a particular purchaser would have available to spend in a particular year if the full rigours of the formula funding model were enforced) and funded expenditure (the cash-limited amount a particular purchaser does have available to spend in that year). The reasons for such differences are that central policy makers may judge that the desired convergence of all purchasers to their expenditure targets, which are themselves shifting due to population and other changes, should be accomplished over a transition period, thereby avoiding both disruptive reductions and unmanageable increases.

The discussion above has been couched in terms of the annual contracting which characterises the NHS internal market where contracts are not legally enforceable documents. The question therefore arises as to how non-marginal adjustments can be made to the capital stock, including major rationalisation schemes whereby several hospitals close and are replaced by a new facility. When many facilities serve localised markets and hospital assets have low, or even negative value in alternative use, the extent of sunk costs will alarm trusts wishing to propose major restructuring on the basis of annual contracts. There is some evidence emerging of provider hesitancy concerning new capital schemes in the face of annual purchasing contracts supplemented only by non-binding declarations of 'purchaser commitment'. If such hesitation were to prove more than a transitional hiatus, this would contrast sharply with the expectation that capital charging would promote efficiency in service delivery by leading to a smaller, more modern and better-managed estate.

Effects of capital charging

Because capital charging schemes are very recent in origin, it is not yet possible to draw firm conclusions as to whether, in practice, they deliver the expected improvements in productive efficiency. At such an early stage, attention is naturally paid to the views of the managers and accountants who have been responsible for implementation and whose decisions are supposed to have been influenced. Four surveys on the effects of capital charging have been identified, two relating to New Zealand and two relating to the NHS.

In New Zealand, capital charging was introduced for all government departments on 1 July 1991. Surveys were conducted across government departments by a Treasury questionnaire in June 1992 and through structured interviews in mid-1993 by Price Waterhouse and were reported together.[10] The conclusions of the New Zealand Treasury questionnaire were that, though not all departments had devolved the capital charge down to individual managers, most were planning to do so in the near future. Price Waterhouse's study of ten departments concluded:

> *There are sufficient examples of the way in which the charge has influenced behaviour to state unequivocally that the concept has been successful and that it is important to continue the regime and where possible improve upon it.* (p. 27)

Price Waterhouse also reported an increased awareness on the part of managers of the cost of holding on to surplus assets, thereby encouraging their disposal. Nevertheless, there were reservations which echoed those of the earlier Treasury survey, relating to both incentives and valuations. Price Waterhouse concluded that:

> *... unless steps are taken to ensure the charge had real impact on those departmental activities which are fully Crown funded, then there was a real danger of departments losing interest in the regime or finding it irrelevant.* (p. 24)

Moreover, it was found that capital charging encouraged managers to challenge the valuations placed upon their assets.

There have been two large surveys of NHS capital charging, one conducted in England in 1993 by NHS Estates and one conducted in Scotland in 1994 by our research team at the University of Aberdeen. The NHS Estates survey,[11] directed towards trusts' chief executives in England, found that such managers reported that both the acquisition of new assets and the disposal of underused or 'low-value' assets had been influenced by capital charging. Chief executives believed that capital charging would lead to a 'more cost-effective and better maintained estate'. Similarly, the Aberdeen project[12] found strong support for capital charging among NHS managers (accountants and estates/operations managers) in a Scotland-wide survey of providers. Managers reported themselves to be less likely to invest in new facilities and more likely to dispose of existing assets. Most providers intended that budgetary devolution would cover capital charges, but few had accomplished this at the date of the survey. There was strong support for the use of current cost rather than historical cost valuations, though there were complaints of 'ridiculous valuations' arising from the use of DRC. A less encouraging finding was that the effect on providers had been softened by the willingness of most purchasers to use other revenue money to meet shortfalls in capital charges funding; this had largely neutralised the move in Scotland to 40% weighted capitation in 1993-94. These UK surveys offer some support for the Treasury's claim that extending capital charging across central government will sharpen 'the incentives on departments to extract the best value from their use of capital' (p. 9).[13] Definitive conclusions must await the elapse of a considerable period of time, after which it will be possible to do before-and-after studies of the estates of a sample of providers.

The implementation of capital charging has revealed marked variations between hospitals in the level of capital charges, raising the question as to the sources of such variation. Heald and Pryce[14] sought to disaggregate variations in capital charges per average staffed bed into components: that part attributable to the function of the hospital (which should be compensated for by the health care contracting and teaching/research funding systems); that part outside managerial control (e.g. due to geography); that part which, whilst in principle within managerial control, is outside the control of existing management on a reasonable timescale; and that part which is clearly within the control of existing management. The provisional conclusions of this econometric work are that, whilst a substantial part of the variation can be explained in terms of the functional role of a hospital, much of the remainder is attributable to area per bed and to the average age of hospital facilities which are themselves consequences of hospital history and design, and only partly under the control of existing managements. An understanding of what drives variations in capital charges is highly relevant to the stance taken as to whether purchasers and providers are cushioned from, or left fully exposed to, variations in capital charges. On the basis of these findings, there is a case for partial cushioning of both purchasers and providers, until a clearer picture of the extent of local management control emerges.

Have the objectives been met?

The expectation behind capital charging is that the NHS capital stock would become smaller, though of better quality. There is a profound difference between conscious downsizing of the capital stock through, for example, community care reducing the need for beds, and a situation in which the capital stock is allowed to fall into disrepair and become obsolete. In the short term, higher output can usually be achieved by diverting resources from capital programmes and from maintenance towards pay and drugs, exploiting the gap between budgetary and resource costs. Over time, such neglect will impose serious costs which could have been avoided. Consequently, stimulating managers to think more seriously about asset management is highly desirable.

Five years after first implementation of NHS capital charging, the principal tasks relate to system maintenance, such as regular asset revaluations, and encouraging the use by managers and clinicians of capital charges data. The severe early difficulties in making the software work encouraged the view that capital charges were an external requirement, geared to upwards reporting and to financial statement preparation rather than to internal management use. The NHS has an endemic habit of incurring the set-up costs of financial systems but then experiencing exhaustion and/or disillusionment before the benefits of such systems are reaped. One practical link between accruals accounting and capital charging is that each makes the other cheaper to implement. When asset registers exist for financial accounting on an accruals basis, a heavy preliminary task for capital charging has already been undertaken. Similarly, when there is capital charging, the balance sheet values of assets are readily available for accruals accounting.

This costly phase has been completed. Survey evidence demonstrates that the principle of capital charging commands widespread support among managers in the NHS. Moreover, they recognise that capital charging is an essential component of quasi-market reforms, as otherwise there would be huge historically induced disparities between providers. Within trusts, budget devolution to clinical directorates and to clinicians should incorporate capital charges as well as other costs. The desirability of this step is conventional wisdom among trust directors of finance. Concerns about DRC asset valuation are less relevant at trust level because directors of finance have discretion about the detailed design of budgeting systems. For example, equipment is the best starting point, and buildings might initially be dealt with through a standard-rate charge on measured space. Whereas the initial inhibitor of budget delegation was software limitations, the way in which finance departments have been overwhelmed by other workload and by new initiatives continues to impede progress.

However, managerial mechanisms such as capital charging, intended to make the NHS more 'business-like' in its asset management, expose problems arising from the intensely political nature of the NHS. A problem in the NHS has always been that, however sophisticated the investment appraisal methodology, the capital facility would later arrive as a free good. This has made the appraisal process vulnerable to the hidden intrusion of political considerations, leading to uneconomic locational decisions and the splitting of investments between competing sites. However much ministers have extolled the need for greater public service efficiency, it is widely understood that they expect to derive electoral benefits from capital expenditure schemes, whether by adding to their own reputations – ministers delight in opening ceremonies – or by securing votes in marginal constituencies for their political party through their control over decisions as to where facilities are sited. Unless such motivations change, attempts to improve managerial accountability by means of financial mechanisms and more high-powered incentives can obscure rather than illuminate the effective domains of managerial and political decision making.

Capital charging may hold managers to account for excessive capital spending when this was politically rather than managerially desired or for insufficient hospital closures when these have been vetoed by ministers. The intensified central control which has accompanied the quasi-market has made it much more difficult for managers to distance themselves from responsibility for political decisions than in the pre-1991 structure. The necessity for control mechanisms to exhibit robustness to political pressure has thereby increased.

The investment choices which will be signalled by capital charging will not necessarily be the same as those chosen under discounted total cost minimisation (by suitably incentivised managers) or on the cost-benefit criterion enunciated in investment appraisal guides. A vital difference is that all relevant cash flows concerning the capital asset would be known in the latter case whereas, under capital charging, the provider is aware that a given new capital facility brings with it an unknown (because of the impact of asset revaluation) stream of capital charges. There is substantial uncertainty as to the future behaviour of property price indexes and even about the methodology used by future valuers for periodic revaluation. For example, the 1995 revaluation in Scotland was contracted out to a consortium of private surveyors whose approach differed from that of the Inland Revenue Valuation Office (which had undertaken earlier Scottish valuations and has conducted all revaluations in England and Wales).

Future developments

The major issue on the horizon is not inherent to capital charging, but originates in the conjunction of capital charging for publicly financed assets and the Private Finance Initiative (PFI) which is designed to promote the use of private finance in public services. Under the PFI umbrella, there is a range of different schemes: (a) traditional public sector responsibilities are transferred to the private sector which secures its remuneration through third-party user charges – there are no significant examples within the NHS so far; (b) private consortia finance, construct and own hospitals which are leased and operated by NHS trusts; (c) private consortia finance, construct and own hospitals in which they provide non-clinical services whilst clinical services remain the responsibility of the relevant NHS trust; and (d) the private sector tenders for contracts to provide services to NHS purchasers, thereby bypassing NHS providers. Although few PFI contracts have yet been signed, a huge amount of effort has been devoted by trust managements to the development of schemes, with the management executives having made exploration of the PFI route mandatory. During this process, there has been a decisive move away from the 'leasing hospitals' model ((b) above) to the 'buying services' model ((c) above). This appears to have been driven, not by considerations as to what NHS trusts should provide themselves, but by professional advice that the accounting standards *SSAP 21* and *FRS 5* would frustrate the paramount objective of taking such assets off-balance sheet.[15]

The PFI is portrayed by the Government as a means of securing greater efficiency in the acquisition and management of public service assets.[16] It is frequently asserted, without evidence, that the introduction of private sector disciplines will lead to savings in both capital investment requirements and in operating costs which more than offset higher financing costs. However, outside commentators have stressed the off-balance sheet character of these assets which provide a way of reducing the level of public expenditure and of the Public Sector Borrowing Requirement. A crucial difference between private and exchequer finance is that exchequer finance is front-loaded – it scores when the asset is built. In the case of PFI-financed assets, the public expenditure is scored either when lease payments are made over the life of the contract or as services are bought from the private sector. Because of the combination of asset specificity, which means that there is a high sunk cost element, and the vulnerability of the private owner to government decisions on the level and distribution of NHS expenditure, it is implausible that such a relationship could be conducted on the basis of annual contracting. Nevertheless, the super-imposition of a policy initiative favouring privately financed assets outside the capital charging net seems likely to undermine the capital charging system for publicly financed assets, by creating strong financial and behavioural incentives to substitute other financing. Moreover, it is possible that public pressure will build up for lottery funds to be used to finance NHS hospital construction, a development which would raise the profile of the treatment of donated assets.

Conclusion

Experience over five years shows that NHS capital charging is a useful but imperfect tool. Some of the imperfections stem from the institutional characteristics of the NHS: for example, near monopoly public provision means there is no real external market for hospitals and hence no externally validated alternative to DRC. There should be no illusion about the possibility of quick results: the history of NHS budgeting reform shows that much patience over the long-term is required to effect changes in managerial attitudes and behaviour. Success in refashioning the NHS estate can only be assessed over the medium term, and capital charging will be only one of the causative factors. Nevertheless, the survey evidence shows that the message that assets must be managed more systematically and effectively is being digested. Capital charging should not be swept away in an anti-commercialisation, anti-bureaucracy backlash – a reaction which current rhetoric suggests might occur after a change of government.

Cautious approval of capital charging is somewhat sapped by a concern that the agenda has indeed run on. The attitudes of the Treasury are instructive. On the one hand, experience with NHS capital charging has encouraged the Treasury to view capital charging across central government as one of the principal mechanisms for generating the efficiency gains which are projected to derive from its Resource Accounting and Budgeting initiative. In this, it can point to the role of New Zealand as leading innovator in the application of accruals accounting to government and the strong endorsement of the Organization for Economic Co-operation and Development which has taken the lead in international dissemination. This strand of the Treasury's activity is genuinely concerned about improving public sector efficiency. On the other hand, it is difficult for reforms in capital accounting and asset management to take hold when there is so much external cynicism about the Treasury's motives. When public sector capital assets – be they armed forces, housing or social security benefit offices – are auctioned against tight deadlines which are seen to be inspired by electoral objectives, the lack of trust in the Treasury's motives and sincerity is further compounded. It becomes more difficult to hold public sector managers accountable for delivering returns from the public assets under their stewardship when the Treasury will so readily deny the relevance of DRC or other current cost valuation to 'privatisable' assets. Credibility affects the efficacy of public sector control systems.

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Bridging the gap: joint commissioning of health and social care

Richard Poxton

The medium-term priorities for the NHS set out in the *Priorities and Planning Guidance for the NHS: 1996/97* include two which refer specifically to collaboration between health and local authorities. These involve the securing of integrated services to meet needs for continuing health care and to allow elderly, disabled or vulnerable people to be supported in the community; and the purchasing and monitoring of a comprehensive range of services to enable people with mental illness to receive effective care and treatment.

In 1995 the Department of Health produced *Practical Guidance on Joint Commissioning*.[1] This asserts that:

> *No authority can be sure that it is optimising the use of resources–either for the purchase of services or managerial resources for managing the process– unless it has considered the potential applications of joint commissioning.* (Introduction p 2)

The Guidance also makes it clear that there is no single blueprint for undertaking joint commissioning. Rather it should be seen as a way of helping agencies to overcome divides in order to address people's needs more effectively. In an attempt to pin down joint commissioning to something more specific than joint working or collaboration in general, the Guidance offered this definition:

> [Joint commissioning is] *the process in which two or more commissioning agencies act together to co-ordinate their commissioning, taking joint responsibility for translating strategy into action.* (p 2)

In the autumn of 1995 the Department published *Building Partnerships for Success: Community Care Development Programmes*[2] which highlighted the priority areas for further work over the next few years. In the foreword the Secretaries of State for Health and the Environment referred to the importance of 'genuine partnerships between social services authorities and the other agencies involved in community care'. The document went on to state:

> *Effective partnerships must include joint planning and joint commissioning to ensure*

> *that the implementation and development of community care is well balanced, well co-ordinated, and well suited to the particular needs of the locality. Assisting authorities to develop good collaborative arrangements, and in particular joint commissioning arrangements, is an important aim of our Development Programme.* (p 6)

Despite the importance attached to it, what precisely it is and how it can contribute to solving the problems arising at the health and social care boundary, remains unclear.

It has been used to describe the achievements of commissioning undertaken in collaborative ways, both on a systemswide basis, e.g. the full range of services for people with learning disabilities, and also looking at specific issues, e.g. a home bathing service, but it can also be seen as a more general activity which aims to pull together the health and social care cultures.

This article takes a broad view of joint commissioning, regarding it as best seen as a particular way of viewing the worlds of health and social care. More specifically it involves the sharing of information, the pooling of expertise, the joint taking of decisions on resource utilisation, the agreeing of main programme priorities and acting together in both the planning and purchasing of services.

This article begins by setting joint commissioning in the policy context which gave rise to the official guidance, defines what it might actually involve in practice, and finally identifies some key issues and questions to be addressed if it is to achieve any sort of significant success.

Policy context

Whatever else joint commissioning may be, there is general agreement that it represents a clear advance beyond joint planning. Joint commissioning takes place in the mainstream of decision making rather than in the backwaters and tributaries of joint planning. The resources which are under review are main programmes and major contracts rather than the relatively small budgets of joint finance and other special funds. One-off projects promoting particular aspects of service change are gradually giving way to more thorough reviews of how the health and social care systems respond to the needs of their shared users. The Department of Health Guidance emphasised that 'above all, joint commissioning is a process for translating plans into action, and not just for planning'.

In this sense joint commissioning has the advantage of being quite clearly at least one step beyond joint planning. Nevertheless, in many ways joint commissioning continues to be bound by the constraints operating in the 1980s and the often harsh conclusions about the relationship between health and local authorities reached then by some observers continue to apply.

For example, Gerald Wistow concluded in 1988 that:

> *The general view of both researchers and practitioners is that, at best, joint planning has achieved very limited results and, at worst, has been a total waste of time.*[3] (p 13)

And Peter Westland:

> *There is currently an extraordinary degree of interest in the process of collaboration, to such an extent that it inevitably prompts the question of whether we are in danger of concentrating attention on this issue at the expense of a concern to improve service delivery.*[4] (p 27)

Limited results and a fixation with process are charges with which joint commissioning now has to deal despite the clear water separating it from joint planning. However, key policy developments in both health and social care since the early 1980s have provided both opportunities and impetuses for shifting into a different gear for collaboration. The boundary between health and social care is now strewn with examples of issues which call for collaborative action. More precisely a significant number of major policy and practice areas now require the statutory commissioning and purchasing agencies, health and local authorities, to work together in order to have any chance of an adequate service response. The major ones are shown in Table 1.

Table 1 Policy and practice shifts requiring collaboration

- Integrated personal care packages: bringing together different services to meet individual needs
- Shorter hospital stays: ensuring a total care package is in place on discharge
- Reprovision from long-stay hospitals: care and support in domestic living situations
- Moving from home help to home care: greater co-ordination between home care and community nursing
- Greater emphasis on rehabilitation: being clear about respective roles especially Social Services

The Audit Commission had helped to draw attention in the 1980s to the importance of collaboration in ensuring the effective management of community care:

> *The differences in incentive and style have resulted in an atmosphere where there are hard negotiations and 'horse trading' between separate, self contained and often fiercely independent organisations rather than joint planning and sharing of resources between partners seeking to serve the same clients more effectively. In short bureaucracy rules.*[5] (p 60)

Although such radical options as 'community care authorities' were largely passed over by both in *Caring for People* and subsequent legislation, it had become clear by the 1990s that the search was on for a means of collaboration between various component parts of the relevant organisations in order to give greater emphasis to the effective management of the emerging community care agenda.

Joint commissioning may, therefore, perhaps most usefully be seen as the collaborative means for ensuring the effective development and implementation of the community care agenda, which necessarily involves both health and social care. Its emerging and rather fluid nature can thus be explained at least in part by the development of community care itself being far from straightforward. Resource constraints are inevitably important, the extent varying in real terms in different places and also according to the local political stance adopted.

But other major policies also impinge, not least amongst which is the development of a primary-care-led NHS; potentially this has major implications for the social care system as well, and it is this we turn to next.

What does joint commissioning involve?

Like local health and social care services themselves, joint commissioning has taken different forms according to local circumstances. Although clarity of outcome should be a key factor in determining what is involved in local examples of joint commissioning, the Department of Health Guidance also emphasised the importance of shared understandings of the wider context in four areas:

- History of joint working: identifying strengths and weaknesses
- Involvement of key stakeholders: identifying key organisations and individuals
- Geography: determining the area of activity
- Financial position: being clear about respective financial positions and spending priorities of organisations involved

In essence, joint commissioning seeks to bring together some or all of the commissioning functions of a number of different agencies, usually with health and social services at the core. It may be focused on a particular user group, on a range of services, on a geographical locality, or even on the needs of a particular individual. As such what it involves and what its main characteristics are can vary enormously.

Basic components of joint commissioning

Jointness: – being clear about the extent to which working together will influence decision making :

- 'joint' or 'collaborative' commissioning: whether decisions are to be taken together (in the same place) or separately on an aligned basis, equally being clear about decisions still to be taken within agencies
- resource implications: being clear about the extent to which purchasing decisions made as a result of commissioning should make use of budgets which are clearly identified and aligned alongside one another
- impacting upon services: co-ordination or integration–the importance of having a clear view of what is being sought in terms of services development

Commissioning: – understanding what is involved and the extent of local application:

- involves decision making from needs assessment to determining appropriate responses, on an individual, locality or service basis (or some mix of all three)
- including both strategic and operational elements
- on a rigorous and systematic basis with clear timescales and responsibilities
- based upon the statutory responsibilities of health and social care commissioners
- but also involving providers, users, carers, advocates and others who can bring an 'added value' to the process
- with users, carers and other members of local communities having an important role in decision making
- having built in mechanisms for monitoring and review

Achieving a better way of life: – sharing aims, objectives and underpinning values:

- being clear about what really makes a difference to older people's lives
- involving older people in decisions about their own lives and about more general developments
- ensuring a better understanding by older people of the health and social care systems and so promoting a greater ownership

Obtaining better services: – developing an agreed programme of service change and development:

- effectiveness: meeting needs clearly identified with user involvement
- efficiency: avoiding duplication of effort, reducing costs associated with 'non-client contact'
- accessibility: simplifying the ways in which users make use of the health and social care systems
- innovative ways of meeting needs: beyond the traditional public sector way of thinking and responding
- equity: adopting a systemswide approach to the allocation of resources

From earlier work undertaken by the present author,[6] it became clear that there were four basic components of joint commissioning which participating agencies had to address and had to reach a shared position on if they were to stand a reasonable chance of achieving their objectives. These were concerned with the degree of 'jointness' to which agencies were agreeing, the extent to which they were engaging in real commissioning, their vision of a better quality of life, in this case for older people, and the ways in which they wanted services to change in order to achieve these objectives. What they involve is set in the Box.

The King's Fund worked with five development sites and the variety of approaches adopted gives some insight into the different sets of activities which can make up joint commissioning. Of the two shire counties, one adopted a county-wide, strategy-led approach which sought to build up a collaborative forward planning system across the health and social care boundary; the other county by contrast based its work on GP practices and social care teams. Of the two London Boroughs, one had identified a specific locality and brought together local people, practitioners and their managers to identify needs and responses, whilst the other Borough experimented with examining particular needs from an even more local perspective. The fifth site explored ways of building upon close working relations at senior officer level so that both local people and practitioners could play fuller parts in determining different responses to priority needs.

To the extent that this diversity of approach reflects the real differences between user groups as well as local areas it is to be applauded. A real disadvantage is that the term joint commissioning is in some danger of becoming useless as it is appended to so many different sets of activities. This might not matter so much if this fluid approach was nevertheless producing major successes. Although some examples of 'success' are cited below, these are not considered by most observers to be of the order which had been anticipated. Identifying what makes for 'good joint commissioning' remains a hazardous enterprise.

However, some key ingredients have emerged. The main ones are:

Leadership
- *creating a vision*
- *determining ways forward*
- *ensuring cohesiveness within organisations*
- *matching goals to available skills and resources*

Effective partnerships
- *across participating agencies*
- *within those agencies at strategic and operational levels*
- *between the statutory commissioners and other partners who bring an added value (including users, carers, other local people, voluntary organisations, service providers)*

Achieving change
- *clarity of aims and objectives*
- *clear roles and responsibilities (but also the ability to be opportunistic)*
- *having a project management approach understanding local strengths and weaknesses*
- *effective commissioning skills and mechanisms involving skilled staff comfortable on both sides of the boundary*
- *determining the optimal volume and pace of change to ensure sustainability*

These key ingredients demonstrate the size of the challenge. But it is important not to regard that challenge as insuperable: what it entails is mostly well understood and thus achievable when addressed in a managed way.

It is also clear that even for relatively small-scale changes decision-making at both operational and strategic levels is likely to be required. Since the Department of Health Guidance appeared in 1995, there has been particular interest in joint commissioning involving GPs, care managers and other primary care workers. This accords with the aspirations for a primary-care-led NHS and is considered to have more chance of bringing about effective service change. But it is very unlikely that this can happen without significant involvement at strategic level. Senior managers acting in their role of strategic commissioners are able to ensure co-ordinated action at different points in the systems, thus enabling and enhancing the impact of local commissioning. An important issue here is the limited impact which small scale purchasers can have on large providers. Therefore, a key ingredient in joint commissioning is certainly a cohesion between the strategic and operational level.

But what about achievements? Across the country a long list could be produced of changes in services which are attributed to joint commissioning. Apart from reprovision from long-stay hospitals, these generally fall short of systems-wide change but are valuable as 'demonstrators' of change. The examples listed in Table 2 give an indication of what is happening.

Table 2 Some achievements of joint commissioning

- Multi-disciplinary community mental health assessment and care management team
- Mental health resource centre
- Comprehensive service for people with learning disabilities
- Specific housing improvements
- Respite care in various settings
- Generic domiciliary care service (pilot), including terminal care
- Homebathing service (generally considered the classic issue for joint commissioning!)
- 'One stop shop' for information, advice and some basic service provision for older people
- Community occupational therapy for people with a physical disability

A review of joint commissioning activities over a period of three years at one of the King's Fund sites found 39 'tangible achievements' and 17 'intangible' ones. The Department of Health Guidance listed a range of possibilities: see Table 3.

Table 3 The Department of Health's 'spectrum of opportunities'

- Strategic shift from institutional to community-based care
- Resettlement from long-stay hospitals
- Joint commissioning with housing agencies
- Joint commissioning of services to fill gaps
- Joint commissioning of quick response services
- Joint commissioning of overlapping services
- Joint population needs assessment
- Joint care management
- Joint care packages
- Joint assessment for individual users and carers

Source: Department of Health, Practical Guidance on Joint Commissioning

It is evident from Tables 2 and 3 that new processes for working together make up an important part of the achievements of joint commissioning. These are, of course, to be welcomed: service change and development will only occur in significant and permanent form if the underpinning process of assessing needs and determining responses is in good shape. Given the complexities and differences in the health and social care systems this is a mammoth task.

Underpinning all of these key ingredients is the need for trust. This applies between agencies and professions as well as within. It can depend upon the personal approach of certain individuals. It often has to be 'learnt', sometimes over a relatively long period of time. Trust is unlikely to arise simply in response to legislation or other form of instruction. Learning about each other's roles, strengths and the constraints imposed by external factors is a key pre-requisite of working together. This learning can be built on small pieces of activity initially but the experience of the King's Fund development sites was that such understanding helped create a climate of trust which enabled bigger and more sensitive issues to be addressed. At least one site ascribed the relatively painless introduction of the April 1996 Continuing Health Care Agreement to the earlier efforts put in through joint commissioning. Chris Huxham described this notion in her analysis of collaborative capability as 'the capacity and readiness of an organisation to collaborate'. She identified eight dimensions involving autonomy, structure, strategic approach and non-competitive attitude, and found that organisations scoring highly on these dimensions seemed more likely to be receptive to collaborative initiatives.[8] Having examined what is involved in joint commissioning we now turn to the key issues raised by the development of joint commissioning.

Key issues

The previous section described joint commissioning in action–the components, key ingredients and some early outcomes. Whilst the term is questioned and a precise definition remains problematic and perhaps even undesirable, it is clear that there is value in distinguishing joint commissioning from the large and growing number of examples of joint working. Both managers and practitioners are exploring various different ways of working together involving customer groups and localities. Often these initiatives lead to service changes which appear to meet needs more effectively.

But no matter how valuable these initiatives may be, it is important to begin to see joint commissioning as distinct and therefore subject to a broader but more rigorous assessment of its achievements. Such an approach does not seek to lessen the importance of joint working. Indeed joint commissioning will include various examples of joint working initiatives: the difference with joint commissioning is that these will be part of a wider view with longer-term objectives.

However, with this more ambitious outlook for joint commissioning comes the inevitable series of major hurdles which must somehow be overcome if any sort of success is to be claimed. To have a reasonable chance of success it is important to identify a series of 'drives' for joint commissioning to create sufficient momentum: see Table 4.

Table 4 Drives for joint commissioning

- Political priorities
- Efficient use of resources
- Requirements to collaborate
- Major policy changes
- More effective commissioning

There are a number of issues which straddle the health and social care boundary which are already of public concern and therefore politically sensitive. Most prominent is the need for greater cohesiveness between the eligibility criteria for health and social care services meeting long-term needs. In addition there is great concern about the care and support received by some people with severe mental health problems, getting an effective balance between providing support and treating the illness. 'Bed blocking' is often cited as an example of how one part of the health and social care system is out of step with another. Joint commissioning can make a difference to these issues by agencies bringing together their skills, information and resources. Being seen to make a difference in these key areas would clearly provide a major impetus to the notion of joint commissioning itself.

A key early impetus for joint commissioning was the prospect of some efficiency improvements or even cost reductions as a result of services being provided more efficiently. For example, if the number of practitioners regularly visiting a frail person at home could be reduced from three to one, this would cut down the travelling time and probably the 'contact' time required. This sort of shift in the skills mix of practitioners operating in the community still seems likely to come from a commissioning source rather than from providers themselves. For older people especially, there is a strong argument developing amongst some national policy makers that a fundamental review is needed of the roles of key practitioners such as district nurses, home carers etc. in order to provide a closer match with the needs which now have to be addressed.

Increasingly health and local authorities are being required by Government to collaborate on specific matters, for example hospital discharge arrangements, production of community care plans, establishment of continuing health care agreements. Of course, these issues can be addressed as separate matters concerned with specific functions. However, they are more likely to be effective if they are part of a coherent collaborative approach. Joint commissioning depends, to a degree at least, on such a collaborative culture but it also contributes to it. As noted already, at the King's Fund development sites the progress in working together as a result of joint commissioning significantly assisted the securing of meaningful continuing health care agreements. Indeed at one site the agreement was addressed as part of joint commissioning activities.

There are a number of major policy areas where joint commissioning can make an important contribution. Arguably the one important success to date has been the design and development of new ways of meeting the needs of people with learning disabilities coming out of long-stay hospitals. Addressing a clear-cut policy which was largely adequately resourced made for favourable conditions. Joint commissioning has to demonstrate a similar scale of contribution in other areas if it is to live up to the claims and expectations being made. The development of a primary-care-led NHS is one opportunity: whatever the precise definition, it seems clear that the close involvement of social care resources is crucial. At the level of individuals' needs, true user-focused care management can only really happen when the distinction between agencies' different responsibilities becomes less significant. For joint commissioning to be properly accepted as a worthwhile tool, it has to be seen to be making a contribution to these very significant health and social care issues.

The final 'drive' for joint commissioning is commissioning itself. Single agency commissioning in both health authorities and social services departments has yet to achieve its potential: too often it is held back by the demands of the contracting processes, inadequate use of needs information, 'immature' relationships with providers, either too close or too distant, and little grasp of how to achieve change in services. Joint commissioning could make a contribution by bringing commissioners together and thus enabling them to both learn from and support one another. The discipline and clarity required to make any significant inter-agency progress can also usefully be applied to intra-agency commissioning.

The hurdles which joint commissioning has to overcome obviously relate to the 'drives' identified above: see Table 5. A real weakness which is apparent in many versions of joint commissioning is the absence or diminution of role for providers of services. It is important to be able to distinguish between commissioning and purchasing. The Department of Health Guidance showed a commissioning circle where purchasing is one of a series of related activities. Involving providers in commissioning seems virtually unavoidable and certainly desirable given their knowledge of services and development opportunities. Ways have to be found of extending the collaborative culture in this direction and cutting out the wasteful parts of the competitive ethos.

Table 5 Hurdles for joint commissioning

- Developing 'mature relationships'
- Legislation and regulations
- Systems design
- Performance measurement and collaboration
- Lack of skills and knowledge
- Engaging other participants

The restrictions imposed by legislation and regulations may be more real in theory than in actual practice to date but they are nonetheless present. The Guidance made clear that the pooling of resources between agencies, effectively having one 'chequebook', was not possible. There are often ways around this barrier but it has an important psychological effect as well as creating more work on occasions. The problems of providing a combined health and social care service are very real when charges are involved. Again it is possible to create complex audit trails to get round the problem but the net effect is to deter activity in this area at a time when other policies seek to promote it.

The ways in which the two systems have developed are very diverse when comparing health authorities with social services departments; when other local authority functions such as housing are introduced the position becomes even more complicated. The main factor here is not so much the different accountability frameworks–although this can be significant–but rather where in the organisations decisions get taken. In social services departments there is an emphasis on devolution to locality or team level. Health authorities are in the process of shifting spending powers to GP fundholders but large contracts still make up a major slice of expenditure. Local authorities mostly have to budget on a year-by-year basis whereas health can look slightly further ahead. Some efforts are being made to align planning systems but the impression is that these are fairly rudimentary. It is arguable that everybody's best collaborative efforts will never produce adequate returns commensurate with the efforts put in because of these organisational obstacles. Further work is needed to understand more clearly the difference made by the lack of most of these barriers in Northern Ireland.

The collaborative culture necessary to underpin joint commissioning may be threatened by the permeating emphasis on performance measurement. For health authorities in particular there can be difficulties in justifying time and resources on activities not directly associated with effective health gain as currently measured. The very real need for trusts and other providers to retain a competitive edge may affect their ability to share information, knowledge and experience.

There is a shortage of skills and knowledge that has to be addressed. This can be seen at strategic level where senior and other managers often struggle with the requirements of commissioning and need to continue to learn about each other's roles and organisations. At operational level practitioners similarly need to understand more about each other's roles and responsibilities. The level of ignorance can be a major obstacle in joining together for joint efforts. Similarly when practitioners do make that breakthrough the scope for local progress can be significant (e.g. joint needs assessments, integrated care planning, etc.) almost regardless of other organisational influences.

The logic of joint commissioning means a variety of players other than health and social services should be involved. Certainly for older people appropriate accommodation is a fundamental of good community care, yet successful involvement of housing agencies of all kinds remains very patchy.

Conclusion

The notion and practical development of joint commissioning has undoubtedly helped to place collaboration between health authorities and social services departments much more centre stage than before. Joint working at both strategic and operational levels is now commonplace. The barriers which get in the way of effective, user-focused services are being dismantled in a variety of ways.

But this assortment of highly encouraging activity does not mean that joint commissioning is achieving the outcomes expected. This account has described the ambitious agenda and the complex issues requiring to be addressed. The indications to date are that these do offer real opportunities for securing some significant changes in the ways that needs are met but that the scale of change required and the complexities involved are making progress slow.

It may be that more support and encouragement from central government is necessary for this systemswide perspective to be maintained. A national programme of development and evaluation, using different approaches in different places, has many attractions. Pulling in some key players so far mostly absent would be an important benefit: these might include local politicians, housing associations and departments, and local authority chief executives. Joint working should continue to make progress on all sorts of different health and social care boundary issues. But it is still joint commissioning which offers the prospect of broader and sustainable change.

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How should primary care be developed?

Peter Holland

The Government's launch of a 'primary-care-led NHS' has left many working in the NHS confused both about the ways that services will be provided and commissioned in the future and about the future of primary care. This confusion has not been alleviated by ministerial pronouncements such as the Minister for Health's speech to NAHAT in January 1996 which have concentrated on the ways that decisions should be made about services, rather than on what and how services should be provided.

From the beginning, a primary-care-led NHS has been concerned with the ways that health services other than primary care should be purchased. A 'primary- care-led NHS' has provided a rhetorical gloss for finding ways to restrict the ever-rising rate of acute admissions by managing demand for hospital services within primary care. The preferred tool for this is to make primary care responsible for resource allocation through the mechanism of fundholding. As a result, until very recently, the Department of Health has had very little to say about the ways that primary care itself should be provided in the future.

This omission was a major flaw. The notion of a primary-care-led NHS, based on the expansion of GP fundholding to cover most of the population of the UK assumes a static model of primary care provision rooted in general practice with the GP at the centre. However, it is being implemented at a time when general practice is facing increasing pressures and the profession is questioning its role more than at any time since the 1960s. Belatedly the Department of Health recognised this and, having embarked on a 'listening exercise' about primary care, has now published *Primary Care: The Future'*,[1] which seeks to set out the agenda for change in primary care.

Its aims are that primary health care should:

- provide continuity of care
- be comprehensive
- be properly co-ordinated so that professionals work well together to meet a patient's needs
- be the gatekeeper to secondary care
- address the health needs of local communities as well as of individuals.

The report identifies five key 'touchstones' of primary care:

- *Quality* – This encompasses five main aspects: improving the clinical quality of primary care through training, education, research and audit; building better team working both within organisations providing primary care and between agencies; health authorities' role in supporting the development of primary care especially through capital development; developing the potential of information technology to facilitate communication; and linking practices together, for example through fundholding groups or co-operatives.

- *Fairness* – Services should be consistent and not vary widely in quality. There should be a more equitable distribution of resources to achieve this and primary care should receive an appropriate share of overall resources to reflect its growing contribution to health care.

- *Accessibility* – Primary care services should remain easily accessible, both in terms of location and time and also regardless of age, sex, ethnicity or health status.

- *Responsiveness* – Services should reflect the needs and preferences both of individuals and communities. This will require local flexibility and diversity and better information for patients.

- *Efficiency* – Primary care resources should be used efficiently and, where possible, services should be based on evidence. There is scope for many professionals, such as pharmacists, nurses, therapists and optometrists to take on wider roles, but this may need change to current contractual arrangements.

The report identified an emerging agenda with seven themes:

- *Resources* – a more equitable distribution with greater local flexibility.

- *Partnerships in care* – developing team working between professionals and agencies.

- *Developing professional knowledge* – greater emphasis on multi-disciplinary approaches.

- *Patient and carer information and involvement.*

- *Securing the workforce and premises.*

- *Better organisation* – linking practices locally and better managerial support.

- *Local flexibility* – on the ways to provide services

Few would argue with the sentiments expressed within the report. Many of its key values and 'touchstones' coincide with patient views about primary care, which, in surveys by the Consumers Association, CHCs and health authorities, indicate that they continue to value the traditional strengths of general practice: its person-centred approach, its ability to manage the vast majority of illness without referral, the continuity of care it offers, its accessibility and the co-ordinating and advocacy role it plays on behalf of individuals to ensure they get the most appropriate care from other services.

However, the report does not address some of the major tensions within primary care that have been fostered by the proposals for a 'primary-care-led NHS' and which are causing uncertainty within general practice, such as the balance between providing and commissioning in primary care, the balance between generalist and specialist services and how consistent high quality primary care services can be ensured. Consequently, the report fails to offer a vision of the role of primary care as a provider in the future. Nor does it set out a specific programme of change, defining the direction in which the Government wishes to see primary care develop. Indeed, unlike the 1990 reforms, the report argues for piloted approaches reflecting local conditions, rather than wholesale reform. Nonetheless, the Secretary of State has acknowledged that some of the proposals may require changes in legislation, which may be a prelude to the re-negotiation of the national GP contract. Any re-negotiation of the contract or significant changes to the way primary care is organised are likely to have many more implications for the shape and nature of primary care than the proposals for a 'primary-care-led NHS'.

This article will consider the changing role and organisation of primary health care as a *provider* of services and how it should be developed. While recognising the range of providers and practitioners who deliver primary care, it will concentrate on the future of general practice. It begins by considering the current role and organisation of general practice, its strengths and weaknesses and the pressures for change. It then discusses what will be needed and wanted from general practice, and more broadly primary care, how this might be achieved and the implications for the ways that primary care is provided and commissioned.

The current state of primary care

Primary care is notoriously difficult to define. There are many health service practitioners who provide primary care as well as GPs, such as dentists, opticians, pharmacists and community nurses. These services overlap with many others which fulfil similar functions, but which are provided as social care by local authority social services departments and voluntary organisations. More broadly, there are other community-based help and support which contribute to good health and are often first points of contact, including the informal care offered by friends, families and carers. All of these services and sources of help can also therefore be regarded as part of the primary care 'network'.

Primary health care has two major roles: as a provider and as an integrator of services. General-practice-based services (primarily diagnosis, treatment and care, referral and, increasingly, health promotion and prevention) account for nine out of every ten contacts patients have with the National Health Service. If other primary care services are included, such as dentists, pharmacists and opticians, this figure rises to 19 out of every 20 contacts. Consequently, primary care provides most people, most of the time, with the treatment and care they need.

Primary care also acts as an integrator of health services. The majority of other health care services are only accessed by referral from primary care. At the same time, primary care, in particular the GP, remains responsible for the long-term care of the patient and so maintains continuity of care for individuals. The integrating role has two aspects: advocacy for individual patients in ensuring that they have access to the right care at the right time; and gatekeeping to the rest of the system, in particular secondary care, by controlling access and limiting demand according to need determined by the GP, rather than the patient, which, in turn, controls costs within the rest of the system.

Current organisation

General practice remains the major provider of primary care. However, general practices vary greatly throughout the country from traditional single-handed GPs, practising with little support from other professionals or organisations, to large teams with a number of GPs supported by a wide variety of other health care practitioners either employed within the practice or networked closely with it.

The creation of the NHS determined the shape of organisation of primary care, establishing the independent practitioner status of GPs along with dentists, pharmacists and opticians, and the contractual nature of their relationship with the NHS. The model of independence and self-organisation, on which general practice is based, has successfully promoted a generalist model of medical care which underpins much of the rest of care offered by the NHS. Most of the changes that have influenced the shape of primary care, such as the development of primary care teams, have occurred organically in response to local circumstances and changes in capacity and capability, rather than as a direct result of changes in central policy. This partly reflects the lack of interest among central policy-makers in primary care of central policy-makers, except where it impacts on secondary care, but it also reflects the adaptability of general practice, through its emphasis on self-organisation. At its best, the model of primary care based on general practice offers easily accessible, high quality treatment and care which is responsive to the needs of its local community, offers continuity of care for individuals and has the ability to adapt quickly according to what is needed; but, at its worst, it provides a poor quality service that is out-dated, unresponsive and unaccountable either to the needs of patients or the NHS.

Pressures for change

The GP press, where stories of overwork, stress and overwhelming bureaucracy dominate, presents an accurate, if gloomy, picture of GP morale. At no time since the 1960s has the profession questioned its role so much,[2] while the BMA has recently reported a growing recruitment crisis facing general practice.[3] Many fewer graduates are entering vocational training and fewer recently trained GPs are entering partnership. Despite the reassurances of the Department of Health, many inner city areas are facing a dearth of locums and high levels of partnership and practice vacancies.

The waning self-confidence of general practice was symbolised by the imposition of the 1990 contract. The 'new' contract met great opposition and has never been fully accepted by general practice. It, along with fundholding and the introduction of general management into primary care, with the establishment of Family Health Services Authorities, began to re-define the relationship between general practice and the NHS. While GPs remained independent practitioners, their pay, for the first time, was linked to performance in certain activities and, as a result, they have been subjected to more rigorous external scrutiny.

However, the crisis of confidence reflects deeper pressures for change arising from changing needs and demands, as well as developing technology and skills, which are transforming the nature and role of general practice as a provider of primary care.

The demand for primary care

The major complaint of many GPs has, as in secondary care, been that of growing demand. Anecdotal evidence suggests that demand has doubled in some inner city general practices since 1990. While the published statistical evidence does not indicate such a dramatic growth in demand for primary care, it does show that it has changed. The fourth national morbidity survey conducted in 1991/92[4] showed that 78 per cent of the population consulted their GP at least once a year, compared to 71 per cent in 1980-81. Much of the increase took place in older age groups and the highest growth rates took place in the most severe categories of disease.

The survey also showed that there has been a slight increase in the number of consultations an individual makes in a year, up from 3.40 to 3.48. However, the major growth in care provided in general practice has come in the field of prevention, which has increased three times for the over 75s and 67 per cent overall, which may, at least partly, be a result of the 1990 contract. This introduced new patient checks and annual checks for the over-75s, immunisation and cervical screening targets and incentives for establishing health promotion clinics, which have subsequently been modified. While there is no similar evidence available on demand in general practice since the morbidity survey, the annual reports of general practices in South East London indicate that demand has continued to grow.

This perceived growth in demand is blamed, by GPs themselves, on 'consumerism' and, in particular, *The Patient's Charter*, which is seen as having encouraged growing patient expectations. Yet, while patient expectations have indeed changed, if only in part as a result of *The Patient's Charter*, other factors such as the rising number of elderly people have also contributed to the growing demand for primary care as have changes in policy, both nationally and locally. While the *planned* 'substitution' of services from hospital to the community, in other words the management of conditions in primary care that used to be managed in hospital, has been patchy, *unplanned* substitution has taken place, often as a result of earlier discharges, which has increased the workload within primary care.

The changing nature of primary care

The growing demands that general practice face are not occurring in isolation. Other organisations providing primary care, particularly community trusts, face similar challenges and pressures. They are also not all the result of external factors. Changing skills and technology have allowed primary care to manage more conditions in the community.

The development of primary care teams has seen a broadening of the skills available within primary care. A much wider range of generalist and specialist clinical skills is now available within many practices, including counsellors and psychologists, chiropodists, physiotherapists and, in some areas, alternative therapists. Such extended primary care teams are not confined to fundholders and many practices either employ these practitioners directly or network with other organisations to enable their patients to have access to these skills. General practice is no longer just a clinical discipline; it has become a venue for the provision of a wide range of primary care services.

The broadening and deepening of skills in primary care is most apparent in nursing. Research[5] in East Anglia between 1989-92 showed that the hours worked by practice nurses increased by 75 per cent (from 0.7 whole time equivalents per practice to 1.2). This increase is likely to have been repeated throughout the country and to have continued since 1992. Their role has developed as both clinical generalists and specialists. The East Anglia research showed that the range of procedures practice nurses carried out increased from 36 to 54 between 1989 and 1992.

Within primary care teams, nurses are increasingly taking responsibility for care of chronic illness and health promotion, and they may also provide specialist care, such as epilepsy care. Pilots in nurse prescribing indicate that the role of primary care nurses may extend further into areas traditionally provided by GPs. There is also evidence[6] that nurse practitioners can be an effective source of advice and treatment for many patients who otherwise would see a doctor, and that their care is appreciated by patients. In a few cases, nurse-led teams, with medical support, are taking the lead in providing primary care to groups of patients, for example in the care of homeless people. However, while nurse practitioners may be (and in some cases, already are) an alternative to the GP for much of the time, there is no evidence that they are a cheaper option, given their slower consultation rate, the need for supervision and current contractual arrangements which ensure that GPs are a relatively cheap way of providing 24-hour care.

As practices have grown, both in terms of the number of patients they serve and in terms of the numbers of staff they directly or indirectly employ, they have become complex organisations, needing business skills and management. The 1990 contract reinforced this trend as its requirements could not be achieved without clinical and managerial support. The single-handed practitioner working alone or with a small amount of support has been unable to provide the range of services expected by the new contract and has become increasingly isolated and rare. But many other GPs, accustomed to working as independent practitioners in partnership with their colleagues, have found it difficult to adapt to working as part of a complex organisation.

At the same time, as the range of services provided within primary care grows, the nature of relationships with other organisations both inside and outside health care is changing. This is particularly true in the field of community care. Relationships between primary care providers, especially general practice, and local authority services, especially social services and housing, have often been poor, characterised by inadequate communication, confusion between the generalist nature of primary care and the more specialist role of social services and misunderstandings about access criteria. As more chronic disease is managed in the community and at home, these relationships are becoming even more important.

What is needed from primary care?

In the face of these pressures, no consensus has emerged, either among the leaders of the profession or within the Department of Health about the way forward for primary care. However, the growing demands on primary care, the growing range of services primary care now provides and the consequent increasing complexity of primary care have highlighted the emergence of three related tensions:

- tension between the generalist and specialist roles now required in primary care
- tension between the role of the GP as a provider and advocate for individuals and his/her responsibility for the health of a community
- variability in quality of service and care between general practices.

The resolution of these tensions will determine the shape of the future provision of primary care and its future role within the NHS, as well as whether it will meet the aims of *Primary Care: The Future* and satisfy its touchstones of quality, fairness, accessibility, responsiveness and efficiency.

The generalist versus the specialist

The broadening of skills within primary care teams and development of technology has widened the scope of services that can be provided within primary care. Increasingly, much of the care given within primary care requires specialist skills. From 1 April 1996, health authorities have been allowed to contract for secondary services from general practice. Where these services can cost-effectively be provided within primary care, it will be appropriate to devolve them to primary care. However, the development of specialist services within general practice has tended to happen haphazardly, because of the interests of individual clinicians, rather than in response to need.

The increasing specialisation of much of the care offered within primary care has opened a debate about what is a 'core' as opposed to a 'non-core' primary care service within general practice. This debate is seeking to re-define 'core' general practice in terms of the traditional GP functions of treatment, diagnosis and referral. The debate, as defined by the BMA, is narrow, concentrating on the medical aspects of general practice and failing to consider the broader context of primary care. This has highlighted the lack of consensus within general practice about the future, as such a narrow definition fails to recognise that preventive care, the appropriate promotion of health and helping people to manage their own health is now an integral part of primary care. The debate also, in trying to define a specific range of services that are 'core' to general practice, ignores one of its great strengths, its ability to respond flexibly to changing needs, demands and capabilities.

However, the debate identifies a major risk: that, in promoting specialisation within primary care, as some of the implications of a 'primary-care-led NHS' have done, the generalist skills that are its foundation will be devalued. If primary care is to offer comprehensive services and continuity of care, as well as act as an integrator of services, generalist clinicians, both medical and nursing, will remain the main providers. Only their skills allow them to meet the majority of demands that present, enable them to respond flexibly to need and act as gatekeepers and co-ordinators for other services, referring on to more specialist skills when necessary.

Of course, specialist skills and services will continue to develop as an integral part of primary care, but this should be in support of, rather than at the expense of, the generalist service. However, specialist providers are less able to take an holistic view of a patient's needs and so ensure that all of their needs are met. Consequently, if the generalist role is undermined in favour of the specialist, primary care will be more fragmented and less comprehensive, accessible, cost-effective or fair than now.

The individual or the community?

Fundholding has been seen as introducing a conflict of values into general practice between the traditional advocacy role of the GP and the commissioning responsibility for a wider population and there are indications from patient surveys that there has been a reduction in the trust patients have in the GPs of fundholding practices, because of the potential for them to be making clinical decisions based on financial criteria. While this conflict is most apparent for fundholding GPs, it also now exists for all GPs as providers of primary care. The 1990 contract made GPs responsible for the health of their population in a number of key areas and this responsibility is reiterated in *Primary Care: The Future*. As teams have become broader, they have needed to identify both the range of services they should provide and the specialist support they need. To do this effectively, providers of primary care must have greater understanding of the needs of the population and communities they serve. The traditional demand-led general practitioner service with its emphasis on the doctor-patient relationship is giving way to a needs-led, population-focused service provided by a range of professionals. Increasingly, the general practitioner values of a 'high context', person-centred approach to medicine may conflict with the demands of providing a service to meet the needs of a population.

As a result, the role of the generalist is changing. In order to make best use of the skills and resources available within a primary care team, the generalist clinician, as well as being a provider of care and treatment, will act as a care manager or co-ordinator of the care provided for patients by other primary and secondary care services. To do this, they will need to combine the skills they already have to assess individual need with new skills to assess the needs of local communities. Public health and epidemiology have tended to concentrate on the assessment of need for acute conditions and have not developed techniques to assess need for primary care services. This is beginning to change as techniques are developed to assess the widely varying needs of practice populations. These include quantitative techniques, such as analysis of the characteristics of practice populations, analysis of prescribing patterns, and, at its most sophisticated, making use of data from practice computer systems; and qualitative approaches, such as patient surveys and rapid appraisals. While developing these skills will not remove the tension that exists between the person-centred approach of general practice and the population-based approaches that practitioners are learning, it will enable them to integrate the approaches more effectively.

Ensuring quality and consistency

As has already been discussed, the range of services and quality of care within general practice varies greatly throughout the country, particularly within the inner city. The current statutory framework for primary care fails to ensure consistency in the quality of service provided by general practice. While the 1990 contract introduced a degree of performance monitoring into the GP contract, the accountability of primary care providers remains weak. Self-regulation has not worked and the profession has failed to tackle poor practice. The current disciplinary framework is complex and, while it often allows the successful identification of poor practice, it often does not allow action to be taken to remedy it. Equally, little support is available to practitioners who are finding it difficult to maintain the quality of their service because of their health, workload or other reasons. And, as a wider range of practitioners provide care as members of a team, the current approach is inadequate as it does not allow them to be directly accountable for their actions. As the contract is with individual GPs, the GP is responsible and accountable for the actions of all professionals within ther team. While *Primary Care: The Future* identifies quality as a 'touchstone', it does not address the inconsistency and variability in quality that currently exists between providers of primary care.

Consequently, while *Primary Care: The Future* does not offer a clear vision for the way primary care should be provided, if its aims are to be met, primary care should:

- be founded on a service provided by generalist clinicians
- be supported by specialists
- have the skills to combine both person-centred care and population-focused services
- work within a framework that ensures consistent high quality services.

The implications

Since the creation of the NHS, general practice has proved remarkably resilient in responding to changing needs and demands and changing social and political circumstances. Any change of policy to encourage the development of primary care should seek to foster the creativity that exists in primary care and encourage the development of a strong generalist service, while also ensuring greater consistency of quality in the service that is provided than is currently the case. Consequently, policy should concentrate on the ways that primary care is commissioned and supported, rather than on the ways that primary care commissions other services and specialist services are commissioned from primary care.

Providing primary care

If primary care is to remain founded on generalist clinicians, the primary care team composed of generalist practitioners, supported by specialist skills, will continue to be the model most suited to providing primary care in the future. The primary care team based on general practice, serving between about 5,000 and 20,000 people, is likely to be the most common model for delivering primary care. General practice, comprising both generalist medical and nursing skills, is best placed to provide the generalist skills that will still lie at the heart of primary care and also has the experience to act as the integrator of other health services. Being responsible for small populations, general practice will be best placed to assess and respond to the specific needs of their communities. While primary care teams based on generalist nurse practitioners, supported by medical care, are an alternative model, there is little evidence yet that they can cost-effectively replace GPs, especially given the diagnosis and treatment skills that are needed and the current dearth of nurse practitioners. However, they may provide an alternative in areas where recruitment of GPs is difficult and in providing services to those such as homeless people who find it difficult to access primary care through general practice. Equally, the traditional model of primary care based on single-handed GPs will be unable to provide a comprehensive range of services and, increasingly, their isolation leading to poor quality care.

The composition of teams, particularly in terms of specialist support, will vary depending on the size and needs of the population they serve. Some specialist services and skills such as counselling will be most effectively provided within the team; others, such as services to meet specific needs, such as for patients with HIV/AIDS, will not be cost-effectively provided on a practice basis. Consequently, the primary care team will access them through other providers, such as community or acute trusts or, indeed, another general practice providing the service on behalf of a number of primary care teams.

As the composition of teams will vary according to local needs and the availability of resources, so will the organisational models for providing primary care. Organisational boundaries between general practices and community trusts are already blurring in some areas, such as Lyme Regis, where community and general practice services are effectively managed as one organisation. They are also blurring within general practices where, in some cases, nurses and managers are becoming partners.

The nature of organisational arrangements will matter less than the ability to build teams that are able to meet the needs of the populations they serve. It is possible, if the current statutory framework is relaxed, to envisage a range of organisational structures that will allow the creation of team-based primary care meeting population need: this could include current models where primary care teams are composed of a number of organisations based around general practice; primary care teams which employ all the core members (including community nursing and health visiting) and contract in other specialist services; and networked organisations of primary care teams which cover much larger populations than individual primary care teams and so are able to employ directly the specialist services to cover the whole population. However, at the heart of all these arrangements will be a core generalist service.

Supporting the development of primary care

Although the main model for primary care provision is familiar, the skills and capacity needed within primary care are changing, reflecting its growing complexity. The clinical skills, training and education needed by primary care practitioners and providers are beyond the scope of this article, although one of the most worrying trends for primary care is the declining numbers of medical graduates entering vocational training schemes for general practice. Clearly, if primary care is to continue to be founded on a core team of generalist practitioners, it will continue to need a well-trained clinical workforce. This may imply changes to medical education, such as redressing the balance between hospital- and community-based education, with more under-graduate training taking place within general practice, as is beginning to happen already and encouraging greater scope for long-term career development and training. At the same time, the training and education of primary care nurses is also under-developed, hindered by their lack of recognition as a separate discipline. While there are a number of courses for nurse practitioners, a comprehensive professional training and education programme is needed for primary care nursing.

However, primary care teams also need to develop their organisational capacity, including developing needs assessment skills. Many general practices and GPs have found the transition to working as a complex organisation very difficult and many primary care teams are managed weakly. This is a major obstacle to development. Primary care management is much less developed than many of the clinical disciplines and, unless it is improved significantly, primary care teams will find it difficult to provide the range of services that are needed or cope with the growing complexity of organisational relationships both within and outside teams. Health authorities will have a key role in ensuring that organisational development support is available to primary care teams to enable them to manage the transition to becoming organisations, as well as supporting the development of specific skills such as needs assessment, but other organisations, such as community trusts, may be better placed to provide primary care teams with management support and infrastructure.

Commissioning primary care

The current commissioning framework for primary care is determined by the GP contract which is set nationally and has established a highly regulated, quasi-market governing the performance and payment of much of the activity in primary care. As a national contract and in promoting the independent practitioner model, it has established a comprehensive, national primary care service based on general practice and, in many cases, has encouraged the development of a highly successful, flexible and, in most places, high quality model of primary care.

However, a national contract does not encourage health authorities to develop needs-based approaches to the commissioning of primary care and greatly restricts the range of ways in which it may be provided. Health authorities are not able to commission primary care services from general practices according to local needs or to establish different arrangements for providing primary care such as nurse-led teams, even in areas where recruitment of GPs is difficult, without the approval of the Secretary of State. This framework also discourages co-operation between practices based in a similar area, who may be in competition with one another for patients and hence income. It also limits the ability of health authorities to ensure a consistent quality of service, as it relies on self-regulation.

Consequently, any revised commissioning framework should continue to ensure a comprehensive service and maintain the existing incentives which encourage high quality practice, but also should allow health authorities to be more responsive to meeting local needs and enable more flexible organisational arrangements, as well as ensuring greater consistency in the quality of service. This should include:

- a nationally defined core generalist primary care service
- greater local flexibility over workforce planning
- greater local flexibility to meet specific needs
- the tools to ensure greater consistency in the quality of service.

While the local commissioning of primary care by health authorities may appear a tempting route, it is also very risky. Few currently have the capacity to commission primary care well, and local contracting would threaten the national and comprehensive basis of primary care, set by the national contract. *Primary Care: The Future* has recommended that local approaches for the commissioning of all primary care services should be piloted. In doing so, health authorities must be given the tools to commission primary care. If primary care is both to respond to local needs and develop innovative ways of providing services, then local approaches to commissioning must be developed.

A core generalist service A core national framework for general practice should remain, defining the generalist primary care service to which everyone is entitled, in order to ensure that patients continue to have the right of access to a common, generalist primary care service. This is currently defined in terms of what a GP provides. While the General Medical Services Council wishes to define the core aspects of the GP contract narrowly, focusing particularly on the medical aspects of primary care, this will diminish rather than enhance the generalist nature of primary care. Any core definition of the generalist service should be flexible enough to allow primary care teams to respond to local needs and should incorporate preventive care, unlike the current definition which concentrates on the diagnosis and treatment responsibilities of general practice. To allow this to happen, the core definition should be defined from the perspective of an individual's entitlement rather than a provider's contractual duty.

Planning the workforce In allowing greater local flexibility in terms of commissioning primary care, the Department of Health should allow greater freedom in terms of workforce planning. The current arrangements for the workforce planning of general practitioners are unresponsive to local need, as they are left to the bureaucracy of the Medical Practices Committee, a part of the Department of Health, while the other professions are rarely considered. Currently, every time a practice wishes to recruit or replace a partner it must seek the approval of the Committee.

The Committee allows little local flexibility in terms of the numbers of GPs within an area, and does not consider local needs, issues of recruitment or of skill mix within the area. While some controls may need to remain to ensure that areas do not become under-doctored or over-doctored, the Department of Health should delegate to health authorities the power of approval over the recruitment of new GPs in an area. They should also have powers to establish incentives for GPs to practice in areas which are relatively under-doctored, either because of the absolute numbers of doctors, or because of the needs of the area. Health authorities are also much better placed to consider the availability of medical manpower in the context of the overall skill mix within primary care in an area.

Meeting local needs Health authorities have now taken over the role and functions of family health services authorities and are responsible for commissioning primary care and supporting its development. Many FHSAs developed a range of techniques, using the levers available under the national contracts, to manage the contract with primary care providers locally and to commission primary care and built close and supportive relationships with practitioners and practices. Even within a new statutory framework, health authorities will need to learn from the skills developed by FHSAs to influence and encourage change and development in large numbers of small organisations, unlike health authorities, which are used to trying to promote change in a small number of large organisations.

However, a major area of development for health authorities will be the assessment of need for primary care, particularly if they have greater local commissioning powers and responsibilities. FHSAs have tended to be more responsive to supply side demands, especially those of GPs, rather than to the needs of patients when allocating resources, although more recently many have begun to develop methods to assess need, including the use of analyses of practice information about need and activity.

Some authorities have begun to develop approaches to commissioning additional services such as specialist nursing from primary care teams and groups of primary care teams. In some areas this facilitates co-operation between primary care teams as contracts for, for example, specialist services, are offered to networks of primary care teams. This is currently possible within the existing framework.

However, it is much more difficult for authorities to commission generalist primary care services to meet local needs, whether from general practice or other providers. The Department of Health has proposed the extension of fundholding to include general medical services as a way of allowing the development of more locally responsive commissioning of primary care. However, the current accountability framework is not strong enough either to cover their responsibilities as providers of primary care or to ensure consistency of quality. Equally, as the recent Audit Commission report has shown, there is little evidence that fundholding practices develop more or better primary care services than non-fundholding practices.

Instead, authorities should be allowed to commission primary care services from general practice and other providers, such as nurse-led teams, community trusts or groups of general practices to meet local needs, including needs which are not being met by the existing pattern of services. To achieve this, health authorities should be allowed to contract, within the national framework of entitlement for patients, with primary care teams as well as individuals. The independent practitioner status of GPs could be maintained within such a framework and health authorities could continue to contract with them if they chose. However, such a move would acknowledge that primary care is now provided by a range of professionals within a team and would enable the establishment of similar arrangements to those described earlier. While this might encourage new types of provider to offer a full range of primary care services – community trusts might choose to offer a GP service – it might also facilitate co-operation between primary care teams if contracts for, for example, specialist services are offered to networks of primary care teams. This should include the ability to establish a salaried GP service, if necessary. The independent practitioner status of the GP is linked to their resistance to a salaried service. However, increasingly some GPs, particularly within inner cities, wish to become salaried, because of the pressures they face. The complete replacement of the current arrangements with a salaried service would stifle the creativity of many within primary care. However, the introduction of a salaried service in particular cases, in response to specific needs or poor levels of care would enable health authorities to develop local solutions, particularly in areas where general practice fails to meet local needs.

Ensuring quality The major weakness of *Primary Care: The Future* is that it does not tackle the question of how to ensure a consistently high quality service. Health authorities currently do not have the tools to tackle poor performance in general practice and this is a particular problem within inner cities. The national contract currently neither protects patients from poor practice nor provides authorities with the ability to encourage practices to improve their services, if the practitioners are unwilling to do so.

As local contracting of primary care develops, authorities will be able to contract with other providers, including other general practices, to provide a broader range of services to the patients of practices which are unwilling or unable to provide such services. However, in order for this to be effective, authorities will also have to provide information to patients about what services are available where. The provision of better information about the range and quality of services available within primary care will allow some patients to make more informed choices, although this is likely to be resisted by the profession particularly as GPs are currently exempt from the 'open government' provisions in operation in the NHS.

Equally, contracts between a health authority and a primary care team, rather than an individual practitioner, would clarify the confusion between professional responsibility and the team's responsibility for the quality of the service it provides. It would, of course, be simplistic to assume that this would resolve the problems of accountability that exist within primary care. However, while agreed standards do not exist for primary care, health authorities now have access to a large amount of information about the practice of primary care teams, ranging from information about hitting vaccination targets, to information about the prescribing habits of individual GPs, to the number and type of complaints received, which enable them to monitor their performance (indeed the information is more detailed and accurate than that available for community trusts) and it may be possible to agree local minimum standards. Of course, under a local contracting system, health authorities may choose not to purchase services from providers who deliver poor quality services. Clearly such a move would be strongly resisted by the profession.

In the meantime, health authorities need powers to protect patients from poor and dangerous practice. While a recent power of suspension has been introduced, it remains a bureaucratic and time-consuming process to remove GPs from practice who are a danger to ther patients. To address these problems, the powers of suspension and removal from the medical list should be delegated to health authorities with appropriate rights of appeal to protect GPs.

Infrastructure and investment

In order to continue developing primary care, a more equitable distribution of resources between the sectors is needed, as *Primary Care: The Future* acknowledges. Investment in primary care, in the form of both capital and skills is still required in many areas to ensure that a basic level of provision is available to all. This was highlighted for London in *Making London Better*,[7] but is true of many inner city areas. A lack of capital investment can be a major obstacle to service development. London, before the introduction of the LIZ programme had a very poor capital infrastructure base. In Lambeth, Southwark and Lewisham for example almost 70 per cent of general practice premises were below the minimum standards set out within the GP contract. Much of the LIZ investment programme has been directed to the improvement of premises. Now 70 per cent of premises in Lambeth, Southwark and Lewisham are high standard. But such a large capital investment programme, however necessary, is very unusual and, with the introduction of private finance as the main route for securing capital investment, any form of capital development may become rare, as private financiers are wary of both the complexity of primary care projects and their small size which do not guarantee reasonable rates of return. Unless some form of public capital is available to primary care, or the private finance rules are relaxed further to encourage investment, service development in many areas may be blocked by the poor quality of capital infrastructure.

The lack of investment is exacerbated by current national funding mechanisms for primary care which are based on historical levels of expenditure and incremental increases, rather than any form of needs-based formulae unlike weighted captitation for hospital and community health services. To address this, the Department of Health should adopt needs-based allocations for primary care, which should remain ring-fenced to ensure their protection from the acute sector. Without this, primary care will always be vulnerable to the demands of the acute sector and; particularly in areas where it has been under-funded, remain under-developed.

A 'primary-care-led NHS' neglected the development of primary care. In concentrating on the ways to purchase other health care services, it failed to address the role of primary care as a provider in the future. *Primary Care: The Future* has tried to redress this, but, while it sets out aims and 'touchstones for primary care', it has not defined a clear vision for the role of primary care as a provider of health services.

Primary care remains the main point of access to the health care system and the major provider of services to most people, most of the time. Indeed, the range of services it provides is expanding. As this happens, and as expectations grow about the range of needs that primary care can meet, it becomes increasingly important to commission primary care according to local need and in ways that meet that need. The current statutory framework prevents this. It also allows the inconsistency in the quality of service that currently exists within general practice. This will only be addressed by allowing health authorities to tackle poor quality services directly and to develop local approaches to commissioning primary care, including generalist services. For, at the heart of primary care, is the clinical generalist. Without a strong generalist service, provided by GPs and nurses, primary care will be unable to continue to be the major provider of care and act as an integrator for the rest of the NHS. To ensure that this is not lost, the role of the generalist clinician must be valued and promoted and a core entitlement to a generalist primary care service must remain everyone's right.

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The management of emergency care: who is responsible?

Seán Boyle and Anthony Harrison

Once again the winter of 1995/96 witnessed the seeming anomaly of too few beds to cope with the number of people requiring admission as the number of emergencies increased, while at the same time, all over the UK, health service managers considered ways of reducing the number of beds available to treat people in acute need of care. The apparent shortage was typified by a series of cases where seriously ill patients were taken from hospital to hospital before being found an intensive care bed. In some cases, the patients concerned died, although whether or not as a result of their experiences was not always clear.

The British Medical Assocation and other representatives of the clinical professions argued that failure to find an intensive care bed clearly demonstrated the need for more resources. The Government responded by offering advice rather than money, claiming that with better management such incidents need not occur. According to the first view, the Government is to blame, according to the second, managers and professionals in individual trusts.

The reality is rather more complex than either of these views would suggest. Whether one or both sides could in some degree be said to be at fault must stem from a clear view about where responsibility lies for ensuring that the NHS provides an adequate system of emergency care.

Stepping back from the specific incidents, the central questions are:

- what standard of emergency care should the NHS provide?
- what steps are necessary to ensure that standard is met?

It is one of the curious aspects of recent policy towards the NHS that the first of these questions awaits an answer. While explicit and demanding targets have been set for elective care, none have been set for emergency care except for the essentially peripheral aspects embodied in *The Patient's Charter*. It has been assumed, implicitly, that hospitals will always be in a position to provide emergency care and that local purchasers and providers can be relied on to determine what standard should be made available. Only with the 1997/98 *Planning and Priorities Guidance* did the NHS Executive explicitly require purchasers and providers to have adequate resources in place to meet emergency demands. But this fell short of answering in detail the two questions set out above.

The reluctance to be explicit may reflect the Government's general unwillingness to enter into a debate on rationing. In the case of emergency care, the key rationing decisions concern the quality of the service and the central feature of that quality, the risk that whatever services are provided will not be adequate to cope with the demands placed upon them. There are some emergency situations which almost inevitably will result in death, whatever the local availability of resources. In the case of Nicholas Geldard, for example, the inquiry found that his life would not have been saved whatever resources had been available. The system failed in other ways, e.g. through the unfeeling way his parents were dealt with, which were not, directly at least, to do with the adequacy of resources.

More fundamentally, no system with limited resources can guarantee that risks of death or disability due to delays in treatment will be eliminated even when they are capable of dealing with the conditions presenting to them. Any attempt to eliminate such risks would rapidly appear profligate. Hence implicitly or explicitly, some degree of acceptable risk must be assumed.

In the absence of a standard or level of acceptable risk, the question of whether the current level of performance is satisfactory or not cannot be answered simply by comparing what actually happens with what should happen. If no conceivable system is risk-free, then the fact of failure to save a life is in itself not evidence that the system is failing although clearly a large number of such incidents would suggest that the performance level were too low. Some reports have alleged more general failures: for example a report[1] covering South West London and other parts of the South-East suggested that the hospital mortality rates for those in intensive care was 25 per cent higher than would be expected for a similar group of US patients. That is equivalent to some 240 deaths a year. If the method used to obtain these results is valid – the authors of the report are themselves cautious about it – they would clearly suggest that standards of care were too low.

This article considers how such standards should be set and then, for any given standard, or set of standards, what would be necessary to ensure it was met. The way that question is answered turns on the way that the NHS is managed, that is, how responsibilities are divided between the different management levels within it- trust, purchaser, regional office and central government. Although these questions are raised in the specific context of emergency care, the analysis presented here is relevant to any major service.

Current responsibilities

To some degree all forms of emergency care, be it in hospital or community, are linked. The availability and quality of both ambulances and primary care services will determine how many people reach hospital and the condition in which they do so.

Furthermore, recent events have brought out how far afield doctors seeking to place a patient in intensive care have looked to find a bed. Their search has extended, in some instances, outside the district or even the administrative region, in which the incident giving rise to the emergency occurred.

Nationally there has been no clear responsibility for ensuring that there are sufficient intensive care facilities which would meet the needs of the whole population. The same is true of the wider system of emergency care, which involves contributions from several forms of health care provider as well as others who are not formally part of the health care system including the general public. Thus GPs enjoy considerable scope to choose the way they respond to urgent demands for care, and they continue to enjoy that discretion even after the creation of the new health authorities which combine the responsibility for purchasing both secondary and primary care for their local population.

Thus overall responsibility is certainly not located at the individual hospital trust level: neither would it appear to be at the health care purchaser level, whether GP or health authority: each has responsibility for only a limited part of the overall system.

In the case of paediatric intensive care beds, the Secretary of State responded to the apparent crisis in a way which suggested that he accepted responsibility for ensuring provision was adequate, not merely in the ultimate constitutional sense but as the operational manager of the system. On 29 May 1996, he announced a five-point plan which provided for the remarkably precise number of 37 extra beds.

A little earlier however, a series of other announcements were made such as the list of 'good practice' ideas for A & E departments which left individual trusts to respond. The first appeared to represent a 'command and control' response, the second was consistent with a quite different management style – one in which responsibility for achieving a given standard was clearly local.

The second response was more in line with recent changes to the structure of the NHS. The structure resulting from the 1990 reforms was based on the belief that responsibilities could be handed down to small business units – trusts and GPs – and, with the growth in fundholding, increasingly small purchasing units. Each is responsible for planning its own 'business'. Every hospital trust, every community trust, every GP fundholder and every district health authority must produce an annual business or purchasing plan. In contrast, there is no national plan for intensive case underlying the Secretary of State's announcement. It was based on a report[2] from the NHS Chief Executive, but this fell short of being a planning document. Indeed, the report makes it clear that the information is not available to prepare one.

Thus it would seem that emergency care is being managed in two apparently incompatible ways. On the one hand a degree of independence has devolved downwards within the NHS; on the other, the Government through the Secretary of State for Health retains overall responsibility should anything go wrong and intervenes directly, in a way which may override local priorities. That might be described as a 'long stop' interpretation of his role.

If it is accepted that the Secretary of State has ultimate responsibility for the delivery of health care then the question remains how this responsibility is most effectively operationalised. Should his office be expected to have an intimate knowledge of local health care environments – in some cases the media treat the office-holder precisely in this way? Or should the Secretary of State be able to set targets to achieve the ends and objectives of central government, and be judged on these? If it is the former, then the issue is how the Secretary of State can obtain the knowledge and, in the present system, the powers, to do what is required. If it is the latter, then it is very important how these targets are set and monitored.

In what follows, we examine the implications of the second view of how the emergency system should be managed, in which all responsibility for meeting national standards, except that of 'long stop' is delegated downwards. As we shall see, however, though apparently sharply distinct, the two management models possess many features in common.

Setting targets

National targets are currently set for a wide range of activities for most providers and purchasers through *The Patient's Charter*, the GP contract and the purchaser efficiency index. However, setting targets for performance in relation to emergency care presents particular difficulties.

First, emergencies do not arrive in the system to a timetable. A hospital might find it easier to meet targets set in terms of speed of admission by shutting up its emergency inlet when demand was reaching capacity, but why should other hospitals not follow suit? The outcome is that rules would have to be in place, as they are, to prevent such a fall-over in the system of emergency care. The very need for such rules recognises that a *laissez-faire* approach will not work and hence that the possible response to simple standard setting has to be anticipated and allowed for. The 'new' NHS, and its independent trusts in particular, are likely to have encouraged behaviour in line with trusts' own objectives rather than those of the system as a whole. Thus if the Government retains overall responsibility and hence is to interfere from time to time, then it has to understand the system which it is managing – albeit at arm's length. When disaster strikes it becomes a very short arm.

Second, the form of the target would be contentious. In the case of ambulance response times national standards have been in force since the 1970s and have recently been revised. They are set in terms of response times to be attained in 95 per cent of the cases attended. What happens on the other 5 per cent of occasions is left unspoken: the level of risk remains implicit. If standards were set in terms of performance, e.g. in the terms in which individual A&E departments judge themselves, the lives lost that might have been saved, then the risks would become apparent and subject to public attention and debate.

An alternative is to set standards in terms of inputs such as staffing and equipment levels and operational procedures. Central government, and the professions, have put out advice in these terms, but it is a large step from doing that to specifying precisely what resources should be in place in each and every hospital. Standards so defined would seem to fit the command and control rather than the delegated or 'long stop' approach. However such standards still fail to make explicit the relationship with the primary policy objective of saving lives.

Third, there is the question of consistency of targets. This has two aspects, within the emergency care system and between it and other forms of care. As the performance of an emergency care system depends on the performance of a number of distinct agencies, it is necessary that the targets set for any one do not result in behaviour which reduces the performance overall. For example, a target set for times from incident to hospital would create incentives to reduce paramedical input. Equally, a target set for paramedical input might increase those times. In both instances improving one element of the service may be to the possible detriment of emergency care as a whole.

The need for consistency between targets for different types of care arises because they use common resources, be it doctors or the physical facilities of the hospital. While the NHS is not centrally planned, and central targets bear only on part of what hospitals do, they are nevertheless of sufficient range and significance for them to interact with each other. The central complaint of trusts during 1996 has been that taken together with other policy requirements such as the reduction of junior doctors' hours, the targets set them are not attainable. Although many factors are involved, perhaps the most important is the pressure to improve throughput for elective work and increase day surgery rates, which together with other performance standards, has reduced the amount of 'slack' available to hospitals to deal with demand variations.

Up to now the Government has been able to ignore the need to set consistent targets. It has succeeded, through waiting time and efficiency targets, in inducing extra hospital activity, at least as currently measured, and other aspects of improved performance in line with *Patient's Charter* requirements. But the pursuit of national targets without regard for the local situation and the capacity of individual providers to respond becomes riskier, the longer they are in force, since the likelihood that they will not match the local situation increases.

The events of early 1996 tend to suggest that this point has been reached, though whether it has or not is not entirely clear as we have argued elsewhere.[2] Thus if targets, however determined, are to be set, those responsible for setting and meeting them need to understand the demand that is likely to arise and the means available to meet it. The next two sections consider where that understanding should lie, with providers or purchasers or elsewhere.

Forecasting demand

In principle, it is possible to imagine a 'com-mand and control' health care system in which each 'business unit' was told how much it would have to produce in the coming year. On the elective side of the hospital system, current arrangements do not fall far short of that. Although in formal terms hospitals contract for the care they provide, they are in fact faced with a predictable volume of work with largely stable characteristics, and which they have little control over.

In contrast, in the case of emergency care, as things now stand, individual hospitals, or purchasers on their behalf, need to be able to predict with a reasonable degree of accuracy the demand for emergency admissions they are likely to face. Doing so can be difficult both in the short and long term.

Work by the present authors and others[3] suggests that while over a year individual hospitals may face quite small increases in the number of people presenting as emergencies, they can still feel very stretched. This stems from the fact that at any one time hospitals find it difficult to predict when they will have to cope with a sudden surge in demand, perhaps of 10 to 20 per cent from one month to the next. Add to this insufficient slack in resources available – both beds and staff – to deal with the problem. Confusion and crisis can ensue from what overall may not be a large change taking the year as a whole.

Unpredicted surges may be relatively short-lived or recur over a two- or three-month period. However, the effect of such surges may reverberate through the system over a period of several months. Christmas is often seen as a bad time but, in the words of one NHS manager, it always seems to come at the same time each year. Why then is it so difficult to anticipate? In the absence of pure managerial ineptitude as an explanation, this suggests insufficient capacity to deal with extreme situations even when it is known that these will always happen at least once a year. This would appear to represent a failure of supply rather than forecasting – we turn to this in the following section. However, although the general pattern of emergency admissions is known, the particular days or week when they peak varies and is not readily predictable.

So far we have concentrated on the short-term management of the hospital system but in the longer term hospitals may face extra demands on their emergency services. Indeed, it would seem from Stephen Kendrick's work[4] that as far as emergency admissions are concerned, there is a long-term upward trend – the picture is less clear for A&E attendances. Whose concern should this be? The answer depends in large measure on the reasons for such an increase.

Factors such as the ageing population, changes in morbidity, changes in atmospheric conditions such as pollution or sunlight, changes in alternative ways of meeting needs, e.g. GPs being more reticent to treat out-of-hours or more generally even to take risks where there is uncertainty around a particular patient's diagnosis, changes in the patient's perception of their own needs or how these would best be satisfied, will all lead to increased pressure on what is becoming a shrinking hospital resource. Where does the responsibility for understanding these factors lie?

The individual hospital certainly requires some understanding of likely future demand conditions. In other industries we would expect firms to put considerable effort into deriving demand forecasts for their products, based on an understanding of their overall market position. To what extent can individual NHS hospitals adopt this stance? Our previous discussion would suggest that the answer is – only to a fairly limited degree.

The extensive work that has been done on both emergency medical admissions and on A&E attendances suggests that the factors at work are complex and hard to understand. It therefore does not make sense to encourage each purchaser and each provider to attempt its own 'market analysis'.

If so, then the responsibility lies at some 'higher' level. Of course, there will be local variations and it can be reasonably argued that these are best understood by people at the local level. But the centre, even in a devolved system, should take responsibility for producing an appropriate analytic framework plus supporting research into individual topics. For example, it is unreasonable and inefficient to expect each trust to research into the implications for its services of changes in morbidity patterns or GP behaviour.

Furthermore, to the extent that the emergency care system does function as a national or regional entity, then it makes no sense at all to expect the individual hospital to understand it.

However, the mere fact that demand for the services of any one hospital may come from all over the country does not in itself argue that the delegated model will not work. For one thing, such 'out of locality' demands may be small; for another, if they are large and hard to predict, a regional or national forecast combined with local knowledge may be entirely adequate for local planning purposes. But the larger-scale forecast would have to be the responsibility of a regional or national level body.

Organising supply

A hospital must not only plan its provision of services based on best estimates of the demands which it will face, it must ensure optimal use of its facilities. Internal hospital procedures include the admissions process, the management of the patient's care while in hospital, and discharge procedures, all of which in a day-to-day sense are clearly the responsibility of the individual hospital or trust. But the context in which these basic activities of the hospital are carried out may in part affect the efficiency it can achieve within them.

Effective management of a patient's care will minimise bed occupancy, hence increasing the effective utilisation of the bed stock, and minimising the potential build-up of pressure. This is not so much a factor in determining the level of admissions as the ability of the provider to cope with variations in the level of admissions.

Equally important is the ability to switch both beds and staff between elective and emergency work, or between medical and surgical specialties. Managing the uncertainties in emergency work may entail shifting elective work in ways which suit neither the hospital clinician nor the patient but which are necessary for the efficient running of the hospital.

All these tasks clearly fall to local management. Nevertheless, our own experience suggests that many hospitals find it hard to deal with these tasks, partly because of the large number of other factors which have to be taken into account, many of which, e.g. changes in medical staffing or training requirements, are the result of national policies. However, responsibility for ensuring proper execution of these tasks can hardly be placed elsewhere. The role of the centre here is to advise and provide support, not to direct and that would be true even under a 'command and control' system.

While it clearly falls to local management to get its own operational procedures right, nevertheless how well they do so is not solely a matter of their own competence. In the early part of 1996, the NHS Executive issued a series of guidance notes[5,6,7] covering intensive and high dependency care as well as good practice in A&E departments, actions which were in line with the supporting role. What is missing, however, is any centrally driven attempt to assist in the management of hospital activity as a whole through developing an understanding of how its various activities inter-relate and impact on each other. Instead this is being left to others including private sector consultants.

Furthermore, each hospital or community trust or GP practice is part of a wider system. The ability to discharge a patient once there is no longer a need to provide medical care is vital to the ability of the hospital to manage within a relatively tight bed stock. It is clearly up to the individual hospital to ensure that its information and management procedures are effective in determining when patients are likely to be ready for discharge and making arrangements accordingly. But however efficient they are at these tasks, their ability to discharge is in part dependent on other agencies, particularly local authorities but also GPs and community health services, over which they do not have direct control.

Moreover as noted already, the number and type of emergencies faced by the individual hospital depends on the effectiveness of other providers outside of the hospital – from nursing and residential care at one extreme to the ability of the individual to cope within his or her own home environment at the other. Changes in the conditions affecting the supply of factors such as provision by other hospitals, GP care, nursing care in the community, the degree of security felt by the individual within the community – this affects young as well as old – will all impact on both the level of demand faced by an individual hospital unit and its ability to cope with this demand.

Thus it is not a large step from matters that appear to be clearly operational, to those which involve the wider health care system as a whole. Once again the issue is one of responsibility for understanding how the system of health care delivery as a whole interacts. We conclude by asking who should ensure that a health care system with all of its complexities is able to cope with variations in demand.

Implication of the analysis

The hospital must understand its own 'technology' or operational capacity and try to maximise its ability to cope with predictable variations in demand. These are tasks in which purchasers would expect little or no involvement, in much the same way as private sector firms would normally not expect to become involved in the management of their suppliers.

However, genuinely unexpected variations in demand which might arise from a major flu epidemic are another matter. The purchaser, it might be argued, has the overall responsibility for ensuring a viable response from the provider with which it contracts and should allow for that when negotiating.

It has been common for hospitals to operate on the basis of what are effectively guarantees to deliver unlimited emergency care. When there are unforeseen increases in the number of emergency cases these can only be dealt with at the expense of elective work and the forgone activity and revenue which this implies. Even when increases are foreseen, hospitals may have difficulty coping within the limits imposed by other targets. Achieving consistency and making sure that targets are consistent, must be a concern of both purchasers and providers if they are to negotiate feasible contracts.

When it comes to the larger picture, the issues become more difficult. To understand the overall system of care provision, even within a relatively confined geographic area, requires analysis of a complex set of relationships between providers, purchasers and individuals. In principle this is a task which may be carried out by purchasers. But they too may be small relative to the geographic area over which planning should take place. Moreover many of the arguments set out above in relation to trusts apply to purchasers – both are dealing with issues which are common throughout the country.

There is therefore a case for a broader-based effort to monitor and perhaps also direct the provision of emergency care across whole geographic areas. An example of one such attempt is the efforts of the Anglia and Oxford regional office of the NHS Executive to identify *Opportunities for Emergency care*,[8] drawing on both research evidence and local knowledge.

However, it did not take the further step – as a Regional Health Authority might have done – and produce a plan for the location of emergency facilities.That in the current NHS climate would not have been acceptable. However both *Opportunities for Emergency Care* and the Audit Commission in *By Accident or Design*[9] put forward arguments which suggest the need for changes in the distribution of emergency facilities as between trusts.

The Audit Commission concluded that:

> *Planning needs to be integrated at regional level to achieve an optimal distribution of emergency care facilities for a population wider than that of a single commissioning agency's patch.* (p 73)

If the system does need restructuring, how is to be brought about? At the moment the question remains unanswered. Yet, if the Audit Commission's analysis is right, it cannot be the individual provider or purchaser but must be some higher level body. It may be possible, as in some parts of the country, to achieve change through collaboration between purchasers. But if that fails, then clearly some other agency be it regional or central must take over.

Conclusions

The key question this article has addressed is where and how the responsibility is located for ensuring that the health care system is able to meet basic needs for emergency health services. We noted at the beginning that the present Government is implicitly answering this question in different ways and we would not wish to argue that there is only one uniquely correct way of achieving whatever it deemed an appropriate standard of emergency care. But whatever the precise arrangements, our argument suggests that the following four points need to be taken into account.

First, no individual provider should be expected to cope with all possible contingencies in what is a complex interactive system of health care delivery. This applies whether the organisational unit under consideration is a general hospital, community health services provider, A&E department, ITU or HDU, or general practice. The existence of sufficient slack – which perhaps characterised the position in parts of the system in the fairly recent past but not at present – may allow the NHS as a whole to cope with fluctuation in demand without serious breakdowns in service. However, current pressures are making obvious the inability of individual units to manage in isolation.

Second, the implication of this first point is that some overview of how the system as a whole operates is necessary if the health care system is to perform adequately.

Third, this alone is not sufficient. It is necessary to exploit this understanding in a way which allows individual organisational units within the system to respond correctly to stimuli designed to reflect best evidence about the required directions in which policy targets should move. This requires both fundamental targets such as saving lives and operational targets such as response times. It may require, as Matthew Dunnigan has suggested,[10] the development of 'crisis' or stress measures, which may be used to indicate where failure to meet targets is likely to arise.

Finally, while there are options available for determining where this system-wide knowledge is best located, it seems clear that it is required at a larger level, whether this is considered geographically, in pure population terms, or financially, than the individual trust or district.

One option is to introduce a regulatory framework at a higher level – this has to be at the level of central government under current political imperatives – to set targets and monitor these in order to ensure that primary objectives are met. In one sense this is currently done: central government responds to crisis when crisis becomes evident.

We would argue that current national policy is inadequate because it fails to state *clear* primary targets; it fails to understand the interactions between targets and policies, to understand how lower level targets impact upon the primary objectives; it fails to monitor policies in a way which would allow swift effective reactions in order to avoid crisis management and to ensure steady systematic improvements.

None of this should be surprising given the current knowledge vacuum within which policy-making takes place. To be able to set and manage national health policy objectives effectively requires an overview of the system of health care delivery which is sadly lacking at any level in the current NHS. This overview is required, if the arguments in this article are correct, whatever management model is in operation.

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Can expenditure on drugs be contained efficiently?

Karen Bloor, Alan Maynard and Nick Freemantle

Pharmaceutical expenditure in the UK National Health Service represents over 10 per cent of the total NHS budget and has increased steadily over recent decades in cash terms, per head of the population and as share of total NHS spending: see Table 1.[1,2] Similar increases have occurred across health care systems throughout the developed world: as a result, governments throughout the world have adopted various policies to control pharmaceutical expenditure, with varying degrees of success. Health care systems have been subjected, in Rudolf Klein's words, to a 'global epidemic'[3] of health care reforms, stimulated by increasing health care expenditure, ideological change and governments' desires to control costs.

Table 1 Total NHS expenditure on pharmaceuticals at manufacturers' prices, UK

	NHS medicines £m cash	*Per head £1993 prices**	*% total NHS spend*
1970	176	38.31	8.6
1975	353	37.33	6.6
1980	1000	48.09	8.4
1985	1706	52.94	9.2
1990	2796	55.50	9.7
1991	3106	58.82	9.6
1992	3481	63.29	9.6
1993	3821	65.69	10.1
1994	4108	68.87	10.1

**As adjusted by the GDP deflator at factor cost*
Source: *OHE Compendium of Health Statistics, 1995*[2]

Increasing expenditure on pharmaceuticals tends to be a particular target for cost containment policy. Pharmaceutical expenditure is highly visible, and in the UK and elsewhere, it is often more clearly identifiable than other areas of expenditure. The prices of new drugs continue to increase at a much faster rate than general price inflation, and faster than many other areas of health care costs. The NHS drug bill in England increased by over 40 per cent between 1992 and 1995, as a result both of increases in the volume of prescriptions and of their average price.[4] Finally, the pharmaceutical industry is in the private sector and despite, or perhaps as a result of, considerable government regulation, it generates high profits and high rates of return on capital employed.

A wide range of Government policy initiatives, including provision of Prescribing Analysis and CosT (PACT) data, the selected list, and the indicative prescribing scheme have been designed to contain the cost of pharmaceuticals. These initiatives appear to have failed: can expenditure on drugs be contained and if so, in a cost-effective manner?

This article begins by considering why the drugs bill has been rising. It then considers UK attempts to regulate pharmaceutical markets, contain expenditure and link costs with effectiveness. These are then compared with attempts from other health care systems. A concluding section describes some policy options and emphasises the need to accept that the primary goal of government policy may be trade – to enhance employment and protect the favourable balance of trade in pharmaceuticals. The cost of pursuing this goal needs to be made explicit and accountability enhanced. The second goal of policy, the efficient use of drugs, must then be addressed. The article concludes by suggesting how this might be done.

Why is the drugs bill increasing?

The two main reasons for increases in the NHS drugs bill are demographic change and technological progress. Demographic changes have contributed significantly to the steady rise in the number of prescriptions dispensed during the past decade. The number of elderly people has been rising and they are by far the heaviest drug users. Elderly people, i.e men over 65 and women over 60, were dispensed 179.2 million prescriptions in 1994, 44 per cent of total prescriptions.[2] In 1978, elderly people received an average of 12.2 prescription items each. By 1994, this had increased to 20.1 per year. This compares with an overall average of 8.5 per year, and only 2.2 per year in the group for whom prescriptions are chargeable.[2]

The average cost of newer, branded prescriptions in 1993 was £8.85, over four times as much as the average cost of established, generic drugs (£2.06).[2] Genetically engineered pharmaceuticals such as erythropoietin (used to treat anaemia in dialysis patients), granulocyte-colony stimulating factor (G-CSF, a treatment to minimise cancer patients' susceptibility to infection while undergoing chemotherapy) and tissue plasminogen activator (r-tPA, a thrombolytic clot dissolving agent for acute myocardial infarction) illustrate the cost of technology. Studies have suggested that on average the R&D cost per approved new chemical entity may be over US$200 million.[5] G-CSF costs up to £630 for a course of five treatments, and r-tPA up to £816 for a single dose.

Even more significant in terms of overall health care expenditure are 'small ticket' technologies where the cost of a newly introduced drug, while significantly greater than the established technology, appears excessive only when it is prescribed widely. Recent examples of drugs which have contributed considerably to increases in drug expenditure include the proton pump inhibitor omeprazole, commonly prescribed for peptic ulcer, and the new generation of selective serotonin reuptake inhibitors, increasingly commonly prescribed for depression.

Regulating the market for pharmaceuticals in the UK

Policies in the UK and other health care systems attempt to regulate and control both the supply side and the demand side of the market for pharmaceuticals. On the supply side, policies aimed at manufacturers, wholesalers and pharmacists can control prices, profits and level of reimbursement. On the demand side, policies can aim to change the behaviour of doctors, for example the use of prescribing guidelines and indicative budgets, or of patients, for example through prescription charges. We take these in turn.

Supply side controls

Licensing procedures In the UK, all drugs must receive marketing approval from the Committee on the Safety of Medicines. This approval is based on evidence of efficacy, safety and quality, and requires evidence from randomised controlled trials. There is no formal requirement to submit economic evaluations for licensing or reimbursement, as there is in Australia, but the UK Government appears to be encouraging the use of economic evaluation of new pharmaceutical products, at least rhetorically.

The Department of Health has recently released 'guidelines for the economic evaluation of pharmaceuticals'[6] – see Box overleaf – which have been endorsed by the Association of the British Pharmaceutical Industry. However, it is not clear who, if anyone, will monitor and enforce these guidelines, which are merely a voluntary code of practice. Manufacturers are not required to submit economic evaluations either for licensing or reimbursement purposes, and the capacity of NHS purchasers to monitor and police the guidelines is very uncertain. A critical review of all UK economic evaluations of pharmaceuticals has been undertaken at the University of York Centre for Health Economics and a database of studies, with critical abstracts, is maintained at the NHS Centre for Reviews and Dissemination, also at York. This may inform monitoring of economic studies and help ensure their quality, but only in conjunction with a formal requirement for economic evidence in the licensing process, a point we return to below.

In 1985 a 'limited (negative) list' was introduced, restricting the range of drugs which can be prescribed on the NHS. Drugs including some in the categories of cough and cold remedies, antacids, laxatives, benzodiazepines and mild analgesics were affected. With the exception of benzodiazepines, these are medicines for which over the counter alternatives are widely available. The introduction of the list was opposed vigorously by both the British Medical Association and the Association of the British Pharmaceutical Industry, neither of whom was consulted.

The Government claimed £75 million savings from the operation of the limited list in 1985-86 and continuing 'significant savings'. However, the saving was estimated by simply adding up the previous year's cost of the products on the limited list, which may not accurately estimate real savings. For example, Reilly *et al*[7] observed an increase in orders for H_2 antagonists following restrictions on prescriptions of antacids, suggesting that 'switching up', (substitution) may occur, which could significantly reduce potential savings from a limited list. The negative list has since been extended to include other therapeutic categories including appetite suppressants and topical anti-rheumatics, where particular drugs may not be prescribed on the NHS when effective alternatives are available at lower cost.

Profit regulation Most health care systems use some form of national government control over the price of pharmaceuticals. Prices are either controlled directly, with a price set by government for all registered drugs (Spain, China), or indirectly through agreed reimbursement prices. The UK is unique in allowing freedom of pricing for individual products but controlling prices indirectly through a profit target, which is set by the Pharmaceutical Price Regulation Scheme (PPRS). In the UK, a 2.5 per cent cut for all companies with sales to the NHS over £1 million was negotiated in 1993, and prices of existing products were frozen until the end of September 1996.

PPRS is a voluntary agreement between the Department of Health and the Association of the British Pharmaceutical Industry. Companies are given target profit rates to be achieved from sales of drugs to the NHS. This rate is between 17 and 21 per cent rate of return on capital employed with limits on some costs such as marketing and promotion. Foreign-owned companies with relatively small UK capital bases are assessed in terms of a target return on sales, when annual sales exceed the capital employed by a factor of 3.75 or more. Firms set their own prices and can negotiate prices upwards to achieve this target rate, if they forecast profits more than 25 per cent lower than their target return. However, companies earning excessive profits may be required to cut prices to the NHS, such as the recent negotiated price cut for fluoxetine.

Companies supplying NHS medicines with total home sales over £1 million fall within the scope of the scheme. Those with sales over £20 million have to make financial returns to the Department of Health each year, which assesses firms' profitability in relation to the targets. These are set to ensure that costs, profits and prices are 'reasonable'. The debate around what

Department of Health/Association of the British Pharmaceutical Industry Guidelines for the Economic Evaluation of Pharmaceuticals[7]

1) The question being addressed by the study, including the demographic characteristics of the target population group, should be identified and be set out at the start of the report.

2) The conceptual and practical reasons for choosing the comparator should be set out and justified in the report of the study.

3) The treatment paths of the options being compared should be identified, fully described, placed in the context of overall treatment, and reported. Decision analytic techniques can be helpful in this regard.

4) The perspective of the study should ideally be societal, identifying the impact on all parts of society, including patients, the NHS, other providers of care, and the wider economy. However, costs and outcomes should be reported in a disaggregated way so that the recipients of costs and outcomes can be identified. Attention should be drawn to any significant distributional implications. Indirect costs should normally be included in a societal perspective although care should be taken to avoid any double-counting and results should be reported including and excluding these costs.

5) The study should use a recognised technique. These include: Cost Minimisation Analysis (CMA), Cost Effectiveness Analysis (CEA), Cost Utility Analysis (CUA) or Cost Benefit Analysis (CBA). Any one of these could be appropriate according to the purpose of the study. The report of the study should include justification of the technique chosen.

6) In choosing the method of data capture and analysis, the use of one of or a combination of RCTs, meta-analysis, observational data and modelling should be considered. The reasons for choice of method and, where relevant, for choice of trials should be reported.

7) Assessment of the question should include determining and reporting what additional benefit is being provided at what extra cost using incremental analysis of costs and outcomes.

8) Outcome measures should be identified and the basis for their selection reported. Where CUA is used, proven generic measures of Quality of Life are preferred.

9) All relevant costs should be identified, collected and reported. Physical units of resource used should be collected and reported separately from information about the costs of the resources. Costs should reflect full opportunity cost, including the cost of capital and administrative and support costs where relevant. Average cost data is often acceptable as a proxy for long-run marginal cost.

10) Discounting should be undertaken on two different bases:

- all costs and outcomes discounted at the prevailing rate recommended by the Treasury, currently 6 per cent per annum
- all costs and monetary outcomes discounted at the Treasury rate but non-monetary outcomes not discounted.

11) Sensitivity analysis should be conducted and reported. The sensitivity of results to all uncertainty in the study should be explored. This should involve the use of

confidence intervals and/or ranges for key parameters, as appropriate. The ranges and choice of parameters to vary should be justified.

12) Comparisons with results from other studies should be handled with care. Particular attention should be paid to differences in methodology (such as the treatment of indirect costs) or differences in circumstances (such as different population groups).

Source: *Department of Health PR94/251*

is 'reasonable', problems of defining the capital base upon which to calculate rate of return figures, and the potential for perverse incentives, for example by possible conflict with other Department of Health cost containment measures makes PPRS controversial.

The present scheme, implemented in 1993, will operate until 1 October 1998, unless varied by mutual consent. However 'in the event of major changes taking place within the NHS pharmaceutical services, either party may request an interim review after not less than three years. Following such a review, the terms of the agreement may be modified by mutual consent or either party may give six months' notice of termination of the agreement'.

The advantage of profit regulation is that it avoids the need to identify separately the R&D and other overhead costs for each individual product and recognises the characteristics of the innovation process in terms of many products being developed but very few contributing to overall profit at any one time. However, PPRS may also result in perverse incentives, for example by reducing inducements to control R&D costs within companies if profits can be maintained by increasing prices to the NHS. There may also be a conflict with other Department of Health cost containment measures such as encouragement of the use of generics, provision of activity data through PACT and other demand side measures. PPRS may negate or compromise policies to contain pharmaceutical costs by allowing companies to increase prices when profits are threatened by demand side measures.

Profit regulation measures such as PPRS make no attempt to link prescribing with cost-effectiveness: products that are cost-effective and those that are not are treated equally under the scheme. It may be possible to link profit returns to some form of cost-effectiveness 'score' for new products, but in practice this has not been attempted. Profit controls are crude measures of expenditure control, can conflict with other measures if the Government prioritises trade interests at the expense of the NHS, and they fail to enhance the cost-effective use of drugs.

Policies to influence pharmaceutical wholesalers and retailers The UK and most other governments have a fixed profit margin for pharmaceutical wholesalers and retailers which may facilitate the control of costs. The wide variation in prices of branded drugs has led to parallel importing by the wholesale pharmacy sector. In the European Union, the absence of trade barriers has meant that firms cannot prevent the movement of products from one market to another except by special agreements such as recent restrictions on exports from Spain.

The use of generic pharmaceuticals is strongly encouraged by schemes such as PACT and indicative prescribing, but is not mandatory. Generic substitution by pharmacists is permitted by some countries, and has been promoted in the UK, for example by the Royal Pharmaceutical Society,[8] but is opposed by the pharmaceutical industry. Despite this opposition, the use of generics has grown considerably, from approximately 16 per cent of prescriptions written in 1977 to 52 per cent in 1994,[9]and this proportion continues to rise. Increases in the proportion of generically written prescriptions are however likely to diminish as the maximum proportion is approached. Generic substitution may reduce expenditure on pharmaceuticals, but it can only tackle part of the cost containment problem, as new drugs are patent protected and their use will not be affected.

Demand side controls

Demand side measures can be split into those aimed at the doctors and those aimed at patients. The primary method used to influence patients' behaviour is the prescription charge, which is used in conjunction with exemption policies to maintain equity. Policy initiatives used to influence doctors' behaviour are varied and include financial and non-financial incentives.

Prescription charges The prescription charge covers around 40 per cent of the average prescription cost, but only around 12 per cent of prescriptions are chargeable.[2] Exempt prescriptions include those for patients with certain chronic diseases, e.g. diabetes, certain therapeutic categories of drugs (e.g. oral contraceptives), elderly people and those on a very low income.

Policy makers apparently use prescription charges for ideological reasons, in the belief that charges reduce 'misuse' of health care services. This argument is problematic. Given the technical complexity of diagnosis and therapy, if health services are misused this may be the result of inappropriate decisions by providers rather than patients. In addition, charges may reduce the utilisation of cost-effective and less cost-effective services, and do nothing to increase efficiency.

The influence of prescription charges on patient demand for pharmaceuticals and utilisation of health services for the minority that pay them in the UK is significant. Lavers[10] analysed data from the UK from 1971 to 1982 and concluded that demand for prescriptions had been responsive to price, with a price elasticity of between -0.15 and -0.20. This means that a 10 per cent increase in the prescription charge could lead to a 1.5 - 2 per cent decrease in the demand for prescriptions. Mandy Ryan and Stephen Birch[11] analysed data in England for the period 1979-85 for the non-elderly patients who were subject to prescription charges. They found that the policy of increasing NHS prescription charges has been associated with a significant reduction in the rate of utilisation of prescribed drugs among non-exempt patients. Bernie O'Brien[12] estimated a time-series regression model from 1969 to 1986 which suggested an overall charge-volume elasticity of -0.33, rising to -0.64 in the period 1978-86. Over-the-counter products also demonstrated a positive cross-price elasticity of 0.22 with chargeable items, which suggests that over-the-counter products are used as substitutes for prescription medicines, but they were shown to be less clearly substitutes for prescriptions exempt from charge.

The appropriateness of UK policy of increasing charges has been described by some authors as being contrary to the aim of the NHS and representing a regressive tax on the sick[13]– the equity issue is only partially addressed by exemptions. Furthermore, even though demand is inelastic, charges may result in other costs such as the health consequences of reduced utilisation, at least for some user groups. Canadian economists Barer, Evans & Stoddart[14,15] have argued that user charges are 'misguided and cynical attempts to tax the ill and/or drive up the total cost of health care while shifting some of the burden out of government budgets'. Prescription charges do not contain costs, due to the scale of exemptions, they do not promote equity and they do not encourage the efficient use of pharmaceuticals. They should be recognised for what they are: disguised taxes levied on a sub-set of the ill.

Over-the-counter switch Over-the-counter (OTC) drugs are available to the public without prescription. Britain has two categories for OTC drugs: drugs on the general sales list may be sold by any retailer, whereas drugs in the pharmacy category can be sold only by registered pharmacies, in order to advise on and monitor use. However, a recent study by the Consumer Association has strongly criticised the advice offered by community pharmacists and their assistants, and questioned the safety of increasing over-the-counter switches.[16] Recent trends towards deregulating drugs previously available on prescription only has meant that increasingly powerful drugs are available without prescription.[17] In 1992, Britain's Medicines Control Agency streamlined the process for deregulating prescription-only drugs, and since January 1992, Britain has deregulated 27 drugs from prescription-only to pharmacy status.[18] In 1994, sales of OTC drugs in pharmacy and grocery retailers reached £1.2 billion, around a third of the NHS drugs bill of £3.6 billion.[17] In nominal terms this market has increased since 1980, but adjusting for inflation the increase is much less apparent, and the market size shows little or no increase between 1988 and 1992. Since 1992 there has been significant growth in the market, largely due to the increased OTC switch.[19]

Governments throughout the world use self-medication policy as a way of shifting some of the cost of health care on to consumers, while potentially promoting direct access to medication, maintaining industry profits and extending the role of community pharmacists. However, the current system of exemptions from prescription charges means that there are continuing incentives to obtain products on NHS prescription even when they are available over the counter. Simply increasing self-medication is unlikely to have any effect on the drugs bill unless the level of GP consultations can be lowered as a result of individuals treating their own conditions.

Feedback to general practitioners: the PACT scheme In the UK, a number of initiatives have been introduced which aim to improve the efficiency of GP prescribing behaviour. These include provision of PACT data, indicative prescribing budgets and GP fundholding. However, the impact of these policies on prescribing expenditure appears to have been limited.

Prescribing Analysis and CosT (PACT) data was introduced in England and Wales in 1987, and revised in 1994. Similar schemes exist in Scotland and Northern Ireland. PACT attempts to disseminate information about prescribing behaviour to GPs and to increase their awareness of costs. Prescriptions are collated by a national authority, the Prescription Pricing Authority, and information fed back to GPs on a quarterly basis. A standard format contains practice-specific prescribing information, and national trends in prescribing. The Prescribing Catalogue, provided on request or when practice costs are significantly greater than the local average, contains more prescribing detail. Comparisons between practices and the local average are weighted by 'prescribing units', refined in 1993, which take account of patients' age, sex and frequency of consultation.

PACT has not been thoroughly evaluated, and its effects are difficult to predict *a priori*. For example, discussion of the mean as the appropriate level of treatment has encouraged industry marketing efforts to target low users and raise their treatment levels. The Department of Health and the NHS have sought to do the opposite. There is no way of knowing which policy dominates and whether either is cost-effective.

Indicative prescribing budgets The indicative prescribing scheme was introduced in *Working for Patients* and implemented in 1991. An annual block allocation is divided between Family Health Services Authorities (FHSAs) on the basis of assumptions of prescribing costs in each area. FHSAs then set indicative prescribing amounts for each GP practice, based on a number of factors including existing prescribing costs, numbers and age of patients, local social and epidemiological factors, morbidity and special circumstances. The FHSA compares the practice's prescribing with the average of broadly similar practices. If a practice overspends, FHSAs offer advice and may initiate peer review of prescribing behaviour. GPs who persistently over-prescribe can have remuneration withheld. The use of generics is encouraged, and also practices are encouraged to design a 'practice formulary', providing firm and logical guidelines for prescribing. As with most of the reforms implemented in 1991, the lack of formal evaluation leaves the impact of this scheme uncertain.

GP fundholding The GP fundholding scheme, also introduced by the 1989 White Paper, has a prescribing budget similar to the indicative amount of non-fundholders. However, for fundholders this is a real budget, and savings can be spent in other areas. Preliminary evidence suggested that fundholding provided an incentive to constrain the costs of prescribing and increase the proportion of generic drugs dispensed.[20,21] However, a study three years after the reforms suggested a more complicated picture.[22] By 1993/94, the group of eight first wave fundholding practices were no longer spending less on drugs, in fact non-dispensing fundholders were spending more than a group of non-fundholding practice controls. Fundholders may have increased or maintained their prescribing costs in the year prior to fundholding to produce subsequent 'savings'. One high prescribing practice has recently admitted delaying the introduction of cost-saving measures until becoming a fundholder.[23] As Nick Goodwin argues elsewhere in this volume, it is difficult to assess the fundholding initiative and how financial incentives influence prescribing as the majority of studies of fundholding have been descriptive and none are adequately controlled.[24]

Overview

The Government has made several attempts to link prescribing decisions with cost, including the limited list, PACT data, GP fundholding and indicative prescribing budgets. In spite of these initiatives to contain the cost of pharmaceuticals, the drugs bill has grown rapidly. The overall drugs bill is a product both of the price of pharmaceuticals and the volume prescribed. Both must be controlled, with links to the relative effectiveness of products, in order to contain costs and enhance the cost-effective use of medicines. The pharmaceutical price regulation scheme, based upon controlling profits rather than drug prices or reimbursement contains no incentives for improving cost-effectiveness of the use of pharmaceuticals and may even contradict other policy initiatives.

The relative and absolute cost of pharmaceuticals in the NHS is higher than many European Union countries – see Table 2 –, although lower than in other developed countries notably the USA. The cost of pharmaceuticals continues to rise. Can the UK learn from the experience of other countries in implementing policy initiatives to contain the costs of pharmaceuticals?

Regulating the pharmaceuticals market: international experiences

We recently carried out a review, commissioned by the Department of Health, of other countries' policies to control pharmaceutical expenditure and improve the efficiency of pharmaceutical

Table 2 Prices of medicines, in relation to EU average and when allowance is made for price levels in general (purchasing power parity)

Country	*Price index*		*PPP comparison*
Year	*1991*	*1993*	*1991*
Belgium	101	116	99
Denmark	143	133	112
France	64	63	61
Germany	111	106	96
Greece	86	85	128
Ireland	130	133	134
Italy	96	96	99
Luxembourg	95	97	98
Netherlands	134	148	136
Portugal	58	67	102
Spain	84	93	98
UK	125	123	136

Source: ABDA, in World Health Organization: *Drug pricing systems in Europe - an overview.* WHO Regional Office for Europe, Copenhagen, June 1994 use, and examined evaluative studies with rigorous designs, where they are available, to assess the impact of these policies on prescribing. This revealed a number of initiatives from other health care systems, described in more detail and fully referenced elsewhere,[25,26,27] which could inform UK regulatory policy?

Supply side controls

Licensing and reimbursement Registration procedures for pharmaceutical products are broadly similar in most countries, and are often based on US Food and Drug Administration regulations. Procedures generally require evidence of efficacy and safety of new products, but as Hutton *et al*[12] point out, registration may be 'ultimately the most powerful economic control as it can exclude products from the market'. No countries currently decline to register pharmaceutical products on economic grounds, but an increasing number use economic data to inform decisions about the reimbursement of drugs. In many countries, governments restrict the registered drugs which will be reimbursed by the public health care system, either by positive lists (New Zealand, Italy, France) or by negative lists (Germany, Ireland, The Netherlands, Spain). These decisions are made on the basis of information on safety and efficacy, professional opinion and, sometimes, on information about cost-effectiveness. Increasingly, the provision of economic data and evidence of the cost-effectiveness of new pharmaceutical products is being encouraged by governments. The two countries that have been at the forefront of this trend are Australia and Canada: their initiatives are described in the Boxes overleaf.

Other countries including France have made some attempts to encourage provision of economic data, and guidelines for economic evaluation have been released by researchers in Germany. Principles for the review of pharmacoeconomic promotions have been released by the US Food and Drugs Administration, and the US pharmaceutical industry association, PhRMA, has developed voluntary guidelines for measuring the cost-effectiveness of drugs. The US Health Care Financing Administration has also, for the first time, included cost-effectiveness as one of its criteria for deciding whether or not to reimburse a drug for Medicare patients.

The reluctance of the British authorities to move from a voluntary system to a mandatory 'fourth hurdle' in the registration and reimbursement process ensures that suppliers can continue to neglect cost-effectiveness and, in so doing, deprive NHS purchasers of evidence relevant to difficult rationing choices such as those arising from the use of *beta interferon* for patients with multiple sclerosis.

Price controls In reference price systems, a reimbursement price is set for a therapeutic group and patients pay any difference between the price of the product prescribed and the reference price. The reference price may be the average price of drugs in a category (Netherlands, Germany), the lowest priced drug (New Zealand) or the lowest priced generic plus some amount (10% in Sweden). 'Breakthrough' drugs are not covered by reference price systems. Introduction of a reference price scheme may result in price cuts by pharmaceutical manufacturers with products priced above the reference price. This occurred in Sweden after the introduction of the scheme in 1993, as companies anticipated that consumers would not pay the higher price.

Until 1994 Italy's pricing system used a formula based upon raw material costs weighted by the spread of disease, innovation, manufacturing technology and the economic impact of the product. However, widely varying prices were assigned to similar products. In Spain, maximum prices are set for each product, comprising total cost and company profit, with a range of 12 to 18 per cent allowable profit margin. Italy and Spain both have average prices at or below the European average, suggesting that strict 'cost plus' pricing may have advantages. However, price variation has caused Italy to move to an external comparison system, and both countries are considering reference pricing schemes.

Canadian and Ontario guidelines

- In October 1991, the province of Ontario in Canada provided draft guidelines for preparation of economic analysis to be included in submission to its Drug Programs Branch, for listing in the Ontario Drug Benefit Formulary/Comparative Drug Index. These guidelines are being discussed as part of a continuing debate on the topic in Canada, and have been revised.
- The Ontario guidelines state that the Drug Quality and Therapeutics Committee (DQTC), which advises the Minister of Health about public funding of pharmaceutical products in Ontario, has always considered cost in addition to effectiveness. The request for information on cost-effectiveness is not therefore reflecting new criteria, but offering guidelines to manufacturers on how to address economic issues to satisfy the information needs of the DQTC.
- During 1992 the Canadian Coordinating Office for Health Technology Assessment (CCOHTA) determined that it would be useful to develop a set of Canadian guidelines, that each Province in Canada could adopt as they saw fit. The Canadian guidelines are similar in content to those developed in Ontario. The Canadian guidelines have been developed through a process of broad input and wide consultation.
- Health is a provincial responsibility in Canada. The plan is for the guidelines to be maintained by the Canadian Coordinating Office for Health Technology Assessment, a national agency funded by, and acting on behalf of, the provinces and territories. Further, a periodic process to evaluate the guidelines is to be developed, and amendments made as appropriate. The guidelines have been accepted by CCOHTA as guidance for studies that they undertake or fund, and have been submitted to the provinces for consideration. It is anticipated that most provinces will endorse the guidelines as representing the type of studies they wish to see when new drugs are submitted for funding approval for their provincial drug plans.
- The CCOHTA guidelines state that pharmaco-economic studies should be used to inform rather than to replace decision making. The guidelines aim to leave scope for innovation and creativity within each study, to enable deviations from the recommended set of methods when justified, and to allow additional analyses to those required in the guidelines.

Direct price control can lead to cost shifting from countries where prices are controlled strictly to those which allow freer pricing. This has created cross-subsidisation between countries, and incentives for parallel importing of drugs. In the European Union, the absence of trade barriers has meant companies cannot prevent the movement of products from one market to another except by special agreements such as recent restrictions on exports from Spain. This encourages external comparison schemes, and Ireland has recently introduced a five country formula to establish a 'Northern European Price' in an attempt to avoid historically high relative prices due to links with the UK. Italy links its prices to the average in the UK, France, Germany and Spain.

France has a system of volume-related price cuts. If expensive drugs pose a financial threat to the reimbursement budget, prices may be reduced. Recent imposed price cuts ranged from 3-20 per cent, and included omeprazole and ciprofloxacin. Although France has consistently the lowest priced pharmaceuticals in Europe (Table 2) high consumption of drugs makes overall expenditure on pharmaceuticals 16.7 per cent of total health care expenditure. Despite having the joint highest priced pharmaceuticals in Europe (using a purchasing power parity comparison as in Table 2), the UK spends

Australian reimbursement of pharmaceuticals

- Australia has two tiers of drug regulation: marketing approval and reimbursement.
- From 1 January 1993, pharmaceutical companies have been required to include an economic evaluation of their drug products in their applications for reimbursement through a positive national formulary (the Pharmaceutical Benefit Scheme).
- Guidelines for the preparation of applications to meet these requirements were released in 1990 and revised in 1992 and 1995.
- A company requesting subsidisation for a new drug, or changes to current prescribing restrictions on existing drugs, is required to state the clinical claims of the drug, substantiate these claims with good quality data, and perform an economic evaluation that is consistent with this evidence.
- The Australian guidelines are described as 'outcomes-based': they focus on comparative outcomes of therapy and then the economic evaluation. This evidence is used to assess any benefits from reimbursement under the PBS, and then to negotiate the price at which products may be reimbursed.
- The guidelines are intended to be pragmatic, for example by recommending the use of cost-effectiveness analysis (CEA) rather than cost benefit analysis (CBA) in recognition of the difficulty in estimating values of broad costs and benefits required for CBA.
- The 1995 guidelines have set considerably more demanding standards in the reporting of randomised clinical trials, and the choice of comparator, emphasising that 'head to head' trials which compare the proposed drug directly with the main comparator are preferred. This is a response to a lack of scientific rigour in the pharmaceutical industry submissions since 1993.
- They represent the first legislative requirement for economic evaluations in the world. This has elevated economic evidence to a status near to the results of tests for efficacy and safety, which are required prior to government approval of new pharmaceutical products. The lead taken by Australia has since been followed by action in some other countries, which are producing guidelines prior to the implementation of similar schemes.

approximately 10 per cent of health care expenditure on drugs. This illustrates the need to consider supply side regulation such as price control alongside demand side policies which affect utilisation.

Regulating pharmaceutical wholesalers and retailers Most governments have a fixed profit margin for pharmaceutical wholesalers and retailers, and this may facilitate the control of costs. The wide variation in prices of branded drugs has led to parallel importing by the wholesale pharmacy sector. This is encouraged actively by some countries, particularly the Netherlands and Germany, and this is likely to have an impact on pharmaceutical prices.

Generic substitution Use of generic pharmaceuticals is encouraged in most countries, but substitution by pharmacists is permitted in only a few countries (Germany, Denmark, USA, and the Netherlands). Generic substitution may reduce expenditure on pharmaceuticals, but it can only tackle part of the cost containment problem, as new drugs are patent protected and their increased use will not be affected.

US 'best price' legislation Pharmaceutical prices in the USA are considerably higher than in other industrialised countries, and rising costs have resulted in proposals for Federal regulations. Large purchasing groups and health maintenance organisations are using purchasing power to reduce drug prices, and the US government is turning to managed care schemes. Considerable debate is underway in the USA, fuelled by media attention on vulnerable groups who cannot afford essential therapies. There are also stories of *'price gouging'* or price discrimination, e.g. claims that one company charges $1.75 for 36 tablets of a drug when it is used to treat sheep and $230 when it is used to treat humans.

US Congress passed legislation in 1990 enabling state Medicaid programmes to benefit from price differentials within the pharmaceutical industry. Participating manufacturers must rebate prices to the state Medicaid programmes by the difference of the price charged to Medicaid patients and the lower of average manufacturer's price minus 12.5 per cent (10 per cent for generics) or the 'best price' for that product dispensed to any insurer or purchaser in that state. In return for the rebates, the participating manufacturers gain unrestricted access to Medicaid formularies. The impact of 1990 legislation has not been substantial, largely because of an increase in the 'best prices' of pharmaceuticals relative to average market prices reducing potential discounts.

Demand side controls

Influencing patients A number of interventions are used to depress the demand for pharmaceuticals, by limiting reimbursement of products and providing an incentive for patients to reduce their consumption of drugs. Co-payments involve the payment by patients of a proportion of the cost of a prescribed product. Patient caps limit the number of reimbursable prescriptions per patient. The withdrawal of reimbursement of a drug may also be used in attempts to reduce prescribing.

The flat rate prescription charge applied in the UK is less sophisticated than that applied in some other health systems. In countries with a reference price scheme, co-payments commonly include a fixed charge plus any difference between the actual price and the reference price. In Germany, there is a fixed charge of DM3, 5 or 7 (£1.50 - £3.50) based on the package size of a prescription item, plus any difference between the reference price and the retail price for pharmaceuticals that are priced higher than the reference price for their group. In New Zealand and Sweden there is a fixed maximum prescription charge plus a premium for drugs costing more than the reference price.

Co-payments also reflect the severity of condition in a number of countries, such as France, Italy and Spain. This is usually combined with a maximum annual rate and exemptions. For example, in France co-payments are based on the drug reimbursement rate (assessed by the *Transparency Commission*). Drugs for serious and chronic conditions and exceptionally expensive drugs are fully reimbursed. Other drugs are reimbursed at 65 per cent, or 35 per cent for the treatment of minor pain.

Co-payments have been shown to reduce utilisation of pharmaceuticals in a single large controlled 'before and after' study in the USA. However, at moderate user charges, the utilisation of pharmaceuticals defined as 'essential' (including antihypertensives, cardiac agents, diabetic agents and thyroid agents) were also reduced substantially. In a series of quasi experimental studies by Soumerai and colleagues, limits on the number of reimbursable drugs per patient known as caps, have been shown to reduce the number of prescriptions filled when compared with a prior co-payment system. However, these studies revealed an increase in related health care costs such as acute psychiatric services, institutionalisation in nursing homes for elderly people or a substantial reduction in the use of essential drugs such as insulin, thiazides or frusemide. In the latter study, restoring a co-payment system returned prescriptions to near the level found prior to the reimbursement caps scheme. The impact of the scheme upon certain particularly vulnerable patient groups appeared substantial. For example, limiting reimbursement to three drug prescriptions per month in the treatment of patients with major psychiatric illness in New Hampshire has been estimated to cost 17 times more than it saved, due to increased use of mental health services and hospitalisation.

The removal of a product from reimbursement may also lead to unexpected and unwanted outcomes: withdrawal of 12 categories of drugs with questionable efficacy in a random Medicaid sample resulted in an increase in prescriptions overall due to substitutions, many of which were not desirable.

Budgetary restrictions for doctors In Germany budgetary restrictions placing a ceiling on pharmaceutical expenditures were introduced in January 1993. The first DM280 million (£130m) spent above this ceiling is paid for out of physicians' remuneration budgets. It was not anticipated that this small (1 per cent) proportion of total physician income earned in the treatment of statutory health insurance patients would have a dramatic effect on physicians' prescribing. However, there was an immediate and pronounced drop in the number of prescriptions, which fell from 795 million in 1992 to 712 million in 1993. This was accompanied by a change in the product mix, in particular a move to generic substitutes and to older established medicines. Expenditure for drugs fell in 1993 by 25 per cent in comparison to 1992. Since this time prescriptions have tended back to previous levels, but it is claimed frequently that the scheme has realised savings of around 10 per cent of the drugs budget. Drug prescription monitoring by the Scientific Institute of the Federal Association of Local Funds suggested that savings on 'dubious' products amounted to DM1.8 billion (£900m), and the shift to generics savings of DM350 million (£170m). It has been suggested that physicians have shifted costs by referring more to the hospital sector, but this study is small and may not be generalisable. A formal analysis of trend is not available for these changes, and it is not possible to identify the extent to which may be attributable to other policy initiatives or chance. However, budgetary initiatives have indicated that drug costs may be guided by financial incentives or penalties for doctors working within a global drug budget, and this approach may warrant further attention and rigorous evaluation.

Information and feedback to physicians A number of countries have information feedback systems for physicians in place, similar to the PACT scheme. However, most of these strategies are not enforced, and information may be ignored. This is perceived to be the case in France, where data on prescription drug costs in relation to consultations are tracked and fed back to physicians to enable them to monitor their own prescribing patterns. In Germany, sickness funds compare doctors' prescribing with the average levels of prescriptions written by other colleagues. In New Zealand, the *Preferred Medicines Concept* provides information on GPs prescribing patterns in relation to the national average. All these schemes are advisory, and provide information on the volume of prescribing and on cost, but, crucially, not information on the cost-effectiveness of prescribing and so may penalise the use of those expensive pharmaceuticals that have the potential for benefits worth the extra costs involved.

Prescribing guidelines In France, a national contract has introduced National Medical Guidelines for doctors with respect to diagnosis and treatments, including antibiotic prescriptions, NSAID prescriptions, medication for elderly patients, surveillance of oral contraceptives and other health areas. As an incentive for following these guidelines, doctors were awarded a 5 per cent increase in their fees, and those who fail dramatically to comply with the guidelines face fines. Surveys suggest that 75 per cent of French doctors are prescribing in line with the new treatment guidelines.

The use of guidelines to inform professional behaviour, including the cost-effectiveness of prescribing, takes place in other countries, for example the Agency for Health Care Policy and Research Guidelines released by the US Department of Health and Human Resources (e.g. on pressure ulcers, and on benign prostatic hyperplasia) which are similar to the *Effective*

Health Care Bulletins commissioned by the UK Department of Health, e.g. on the treatment of depression. However, these are advisory without clear incentives to reward compliance. Published guidelines tend to have only a small behavioural impact without more intensive programmes of dissemination, may often be developed crudely, based on professional opinion rather than systematic evidence and tend to be related to effectiveness and not efficiency.

Overview

Supply side measures such as price regulation devices tend to be relatively crude measures of cost control. Few countries have managed to encourage cost-effective prescribing by using price regulation of pharmaceuticals. Price negotiations in France, and the use of reference pricing systems may begin to do this, by allowing a premium price only if there is evidence of significant therapeutic benefit. However, without the use of carefully monitored economic evaluation such as in Australia, price regulation remains crude and may result in compromised patient outcomes or increased overall costs to the health care system if expensive but cost-effective pharmaceuticals are restricted.

The overall drugs bill is a product both of the price of pharmaceuticals and the volume prescribed. Both must be contained, with links to the relative effectiveness of products, in order to control costs and enhance the cost-effective use of medicines. Whereas the primary goal of policy may be to improve the efficiency of prescribing, taking into account a broad range of costs and benefits, policies are often initiated in response to the 'system panic' induced by increasing drug budgets, and therefore the architects of most policies adopt a short-term focus of cost containment rather than efficiency. In brief, there have many attempts to introduce cost control in pharmaceuticals, but much little progress in increasing the efficiency of drug use, despite advocacy by some individuals over many years.

Conclusion

National and international experience of a variety of policies affecting the supply of and demand for pharmaceutical products shows that short-term, once and for all effects can contain pharmaceutical expenditure. Examples include price cuts and freezes, and the German cost controls linked to physician payment. However, none of these policies address the central issues of pharmaceutical policy. There are two apparently contradictory policy objectives: supporting industry and using drugs efficiently in the national health service. Both must be accommodated in some way. Is the maintenance of the industry the primary objective of government and, if so, how can that objective be achieved with the greatest degree of efficiency in drug use?

At present the European Union regulatory bodies wish to sponsor the pharmaceutical industry for balance of trade and employment reasons. Member states of the EU also wish to sponsor the industry, for the same reasons. However, each state wishes to use its regulatory powers to further its own national interests. The 'noise' created by the EU regulatory debate disguises the true nature of the EU and member states' goals, making it difficult to engineer policies which may produce greater efficiency in the use of pharmaceuticals, both nationally and across the EU.

This international debate enables the UK government to 'fudge' the debate around the Pharmaceutical Price Regulation Scheme and the creation of a 'fourth hurdle', i.e. obligatory use of economic data to inform reimbursement decisions. It is important to consider the objectives of the UK government as a whole rather than separating the demand and supply sides of the market for pharmaceuticals, especially in the context of a commercially successful domestic pharmaceuticals industry which contributes much to the UK balance of trade. There are potential conflicts between industrial policy and health policy regarding the pharmaceutical industry. Such conflicts should be made explicit and accountable.

The Government has agreed to produce an annual report on PPRS, and the 1996 report has recently been published. PPRS uses complex processes. Dr Brian Mawhinney, when Minister of Health, stated in evidence to the House of Commons Health Committee that:

> *...the PPRS is inordinately complicated and I made it clear to the Committee that I would never take it as my question on Mastermind.* (HC 80-I, 1994, p.xix)

The annual report should reveal these complex processes and the achievements of the scheme in engendering efficient research and development within the industry. The real price paid to subsidise the industry should be made explicit and the subject of policy debate. Is PPRS the best way to foster R&D? Would the funds produce more – and more useful – new chemical entities if they were given to Universities via the Medical Research Council? Can the opportunity cost of fostering R&D be reduced? Can the use of efficiency as a pricing criterion reward companies or other institutions for innovation in useful products which provide cost-effective NHS therapy?

The rigorous evaluation of PPRS should be complemented by a regulatory mechanism which makes the Department of Health-ABPI guidelines for economic evaluation[6] obligatory. The economic evaluation data so produced should then inform the deliberations of a committee which would determine which drugs were to be reimbursed by the NHS, and at what price. This would facilitate national prioritisation of drug therapies. Such reimbursement committees exist in other countries, notably in Australia, where the Pharmaceutical Benefits Scheme recognises that a balance has to be found between providing equitable access to safe, high quality pharmaceuticals to all Australians, and limiting budgetary costs to Government. Companies submitting new drugs to the scheme are therefore required to justify their price with evidence of cost-effectiveness, which is carefully scrutinised.

If the price of drugs supplied to the NHS were similarly required to be justified with cost-effectiveness information, the need for direct price or profit regulation of the industry would be reduced. However, an NHS formulary listing cost-effective drugs at reasonable prices still does not guarantee efficient use of pharmaceuticals, as it regulates price but not volume. It would have to be supplemented with guidelines for new pharmaceuticals disseminated to all GPs, which outline appropriate and cost-effective use. Monitoring might be facilitated by adding a request for doctors to add the diagnostic condition to prescription forms, which would then be returned to the Prescription Pricing Authority.

None of these policies would contain costs instantly but both may affect expenditure in the medium term. In time as the policies affect resource allocation there may be greater confidence that the industrial and health goals of pharmaceutical policy were being achieved more efficiently. Without explicit definition and ranking of policy goals, and evaluation of performance in terms of trade and health objectives, drug expenditure will continue to inflate with little accountability, much rhetoric and inadequate benefit for patients.

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Long-term care: another policy crisis?

Nick Morris and Tim Wilsdon

Most of us need care, or at least help, as we reach the end of our lives. This can vary from assistance with disability while we still live in our own homes, to extensive residential nursing and medical care. For the one-in-four who will need substantial care, the costs can be large, from £10–15,000 per year, up to £100,000 for the most extreme cases. Most, however, rely on the time of relatives and friends; over 70 per cent of the total caring hours are provided by informal carers.

At present, some 6.5 million people in the UK are aged over 70, making up 11 per cent of the population. By 2030, this will have grown to 10.3 million, or 17 per cent. As the box on p. 190 highlights, this 'bulge' in the population – the post-war 'baby boomers' – is accompanied by a 'trough' of those aged 45-70. It is these two demographic changes which, taken together, cause the current policy concern, and which may – if suitable policy actions are not taken soon – lead to a crisis in the next millennium. Even if tomorrow's carers are willing to provide as much care as their parents did, the combination is likely to lead to a tripling of the need for care involving health and social services professionals: see box overleaf.

Most people look to the Government to provide the help they will need. Despite the growth in personal pensions, and greater awareness of the need to save for old age, the generation which will be old at the beginning of the next century have been led to believe that the welfare state will provide health, and if necessary residential, care when they need it. If the state does so, it is likely to require an extra £4.3 billion in public expenditure (in 1996 prices) in 2031, equivalent to an additional 2.15p on income tax or 13.5 per cent of the current Department of Health budget.

The effective provision of care for the elderly involves a multitude of public and private sector institutions and individuals. Care is provided by family and friends; health and social service professionals assess and meet care needs; public and private sector providers build and run nursing homes, day care facilities and rehabilitation units; voluntary and charitable organisations play a key role; and most other services become involved in some way.

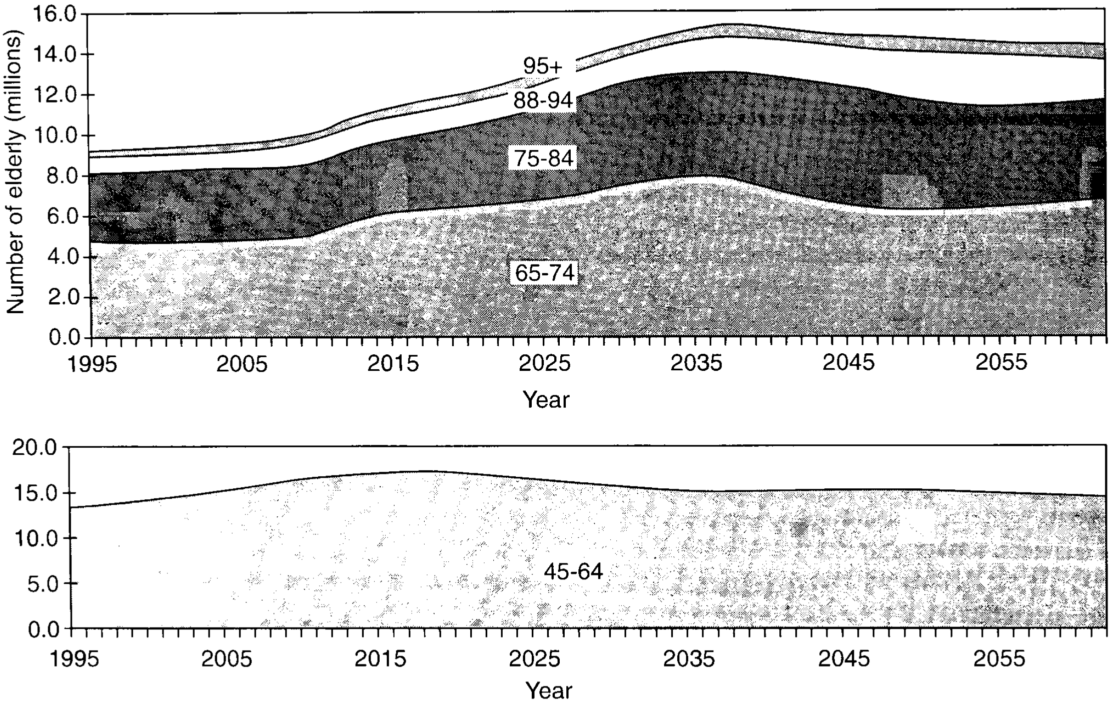
Equally, the financial contribution necessary to pay for this care comes from public and private sources. Spouses, families and communities make sacrifices; pensions, insurance policies, housing equity and savings provide finance; taxpayers pay both for social security payments and for the health service. People are already forced to pay for their own care unless:

- their income is lower than the maximum allowance received under income support

- their assets, including home, savings and investments, are worth less than £16,000. If

A changing population

Demographic patterns are created by events in history, which then have knock-on effects over the decades. In Europe, the two world wars had fundamental effects both on the numbers of men available to create families, and on the behaviour of couples. This is re-inforced in swelling the numbers of elderly people by dramatic improvements in life expectancy. Figure 1 shows how the two effects carry through to swell the numbers of those aged 70-90 in 2035 (who were born between 1945 and 1965). The numbers aged 45-65 – the principal group available to provide care – decline over the same period; the rise in female participation in the workforce since the 1960s has meant both delay and reduction in fertility rates.



they have assets between £10,000 and £16000, they will be asked to contribute towards their care costs.

If the dependant satisfies these criteria and is assessed as in need of care, the local authority pays for care up to the standard it determines to be necessary. This can be topped up by relatives, although not currently from the dependant's own capital.

As the need for care rises, all of these sources will face increasing strain. Working out the best way of providing care will require:

- Cost-effective provision of more residential care facilities;
- Better support for those who choose to stay in their homes;
- Encouragement and help for voluntary carers;
- A rethinking of people's life-cycle savings patterns to cover a longer, and more expensive, old age;

The scale of the problem

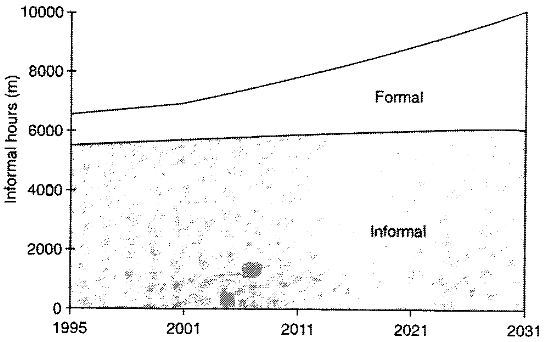
To frame sensible policy responses, we need to know in some detail who may need help, where and when. The Consultation Paper provides some indication of what the Government believes; however, this is optimistic compared with most external commentators. A 'central' estimate, based on academic and private sector work (and taking as its starting point the demographic changes described above) so far might be:

- the number of people needing care will rise from 6.6 to 8.8 million by 2030
- the number of hours informal carers will be able to provide will remain more or less constant
- so the residual number of hours of care – assuming current needs – will rise by 250 per cent
- depending on how this help is provided, and its quality, the cost will rise from a 1996 level of £29.7 billion to £53.7 billion.

Substantial modelling of these issues has been undertaken in the USA – which like most countries faces a similar problem – notably by the Brookings Institution. In the UK, existing work and the data available to carry it out are much more limited. The two most extensive studies so far are by the Institute of Actuaries (which concentrated on identifying the need for care) and by London Economics (which focuses particularly on how the care might be provided).

London Economics results are shown in the diagram. These were derived by detailed modelling of over 1500 population cohorts. The top line – the total need for care – assumes:

- population projections as forecast by OPCS
- medical needs in the last years of life similar to present
- the elderly – and their doctors – make the same choices about whether to live at home or enter residential care as at present.



Division of formal and informal provision

The second and third of these assumptions are contentious; medical opinion is divided over whether greater longevity and treatment possibilities increase or decrease the care needed at the end of life. This top line is similar to that estimated by the Institute of Actuaries, and by the Government in its Consultation Paper.

The lower line is the most difficult to estimate, and the one which the London Economics model focuses on. It is crucial because at present over 70 per cent of all caring is done by relatives and friends 'informally'. Should their willingness or ability to care change, this can have dramatic effects on the need for formal care. The assumptions used here include:

- OPCS population forecasts for the potential carers
- projections of female participation in work, unemployment and family size (key determinants of available time)
- changes in family structure such as divorce and children leaving home earlier
- caring behaviour of the next generation similar to that of the present.

The last assumption is the most contentious, and worrying. Sensitivity tests using the model show that quite small changes to this assumption can cause large changes to the implied cost of long-term care. Some *(cont.)*

commentators have argued that the next generation of carers have been brought up in the era of the 'Welfare State' and are thus expecting the Government to provide; they will have much less willingness to care than their parents did.

London Economics model then translates the requirement for formal care – and the provision of informal care – into a cost. Here some assumptions are made about efficiency improvements – 1% per annum – and other factors (one of the reasons for the Government's lower figures are that they expect an ambitious 2% per annum for 40 years). The table summarises our estimates.

The costs of long term care (£ million)

	1995	2001	2011	2021	2031
Formal costs	12,000	13,200	17,600	24,800	33,500
Cost to taxpayer	8,800	9,000	9,700	11,200	13,100
Notional monetary cost of informal sector	33,800	34,300	34,600	33,300	31,700
Opportunity cost	29,700	31,700	37,000	44,400	53,700

Source: *Paying for Long-term Care IPPR, London 1996*

The table shows four measures of the cost of long-term care. Formal costs represent all market-provided long-term care services. A falling proportion of this is predicted to be financed by the taxpayer (this is modelled using the unlikely scenario that current eligibility criteria for means-tested support are maintained). The notional cost represents the replacement cost if current informally provided care were to be replaced by formal provision. Finally, the opportunity cost represents the resource cost of current provision in terms of the value of those resources in their alternative use.

The overall story from this analysis is that if current mechanisms are retained we would see a much larger long-term care sector financed to a much greater degree by private individuals and provided in the formal sector.

- Suitable financial products to assist people in insurance and saving;
- Greater public expenditure and therefore taxation.

Health and social services purchasers and providers have been tackling some of these challenges, for example in some areas community health trusts, acute providers and social services departments have developed better methods of working together. The financial services industry has also been seeking to develop new products to help people finance their own insurance and provision; however, by the end of 1995 only 22,000 policies had been sold. A variety of charitable organisations are doing impressive work in funding and running residential and other facilities. So far, however, these initiatives fall far short of what will be needed as the number of those requiring care rises.

All involved have been waiting for the Government to take a lead. In particular, those seeking to provide private-sector facilities find it is difficult to persuade people to pay for insurance policies and health care plans when they believe the Government may provide the service for nothing.

The Government's response

The Government is acutely aware of this issue, which is moving towards the top of its list of priorities. The 1995 Budget made some preliminary changes:

- all benefits paid out by long-term insurance policies are to be exempt from tax (previously only those paid directly to nursing homes were tax free);

- the assets threshold below which individuals do not make any contribution to the funding of their long-term care was raised from £3,000 to £10,000, and the ceiling from £8,000 to £16,000.

The long-awaited consultation paper *A new partnership for care in old age* was published on 7 May 1996. Shortly before that, on 30 March 1996, John Major used long term care – and the Government's determination to do something about it – as the theme of a major policy speech. Addressing the Conservative Central Council in Harrogate, he said:

> *More people are living longer. We need to help families to support relatives who can no longer be cared for at home. Our party feels strongly about this.*
>
> *We'll . . . deal with this challenge – to help protect the family home and lifetime savings. Responsibility will be rewarded. Prudence will be recognised. And the elderly will have the chance to protect the savings they've worked for all their lives.*

This determination is mirrored in the consultation paper:

> *The Government wants to create an environment where people who plan for the full range of their potential care needs in old age as a matter of course. It aims. . .to promote greater understanding. . .to encourage people to make provision. . .to stimulate the financial services industry.*

Unfortunately, the Consultation Paper made few concrete proposals, but merely listed the various options available to reduce the strain on public finances. While not ruling out other financing mechanisms such as equity release, it focused on three alternatives for private sector provision:

- Indemnity insurance – like current long-term care insurance policies.

- Immediate needs annuities – these involve the purchase of a fixed length annuity for those already in care or entering care.

- Flexible and better pensions- these allow a lower pension to be paid in early retirement, and a larger pension in late retirement when the need for care is more likely to arise.

Possible policies for funding long-term care can be broadly differentiated by four characteristics.

- *Compulsion.* The extent to which financing is compulsory can vary dramatically, for example social insurance schemes are universal (as in Singapore); this is in contrast to voluntary insurance systems (such as the US system).

- *Division of cost between old and young.* Pay-As-You-Go schemes (such as Germany's recent provision for elderly care) are financed by the generation in need of care; funded policies are financed by the current working generation (such as Singapore's Central Provident Fund).

- *Saving versus insurance.* Resources can be either shared or ring-fenced to particular individuals. Once care is needed, dependants draw either from a pool or their own reserves: at present, the UK system is broadly based on saving rather than insurance.

- *Public versus private.* The division of public versus private provision is not straightforward; the line can be drawn in a number of ways. The UK distinguishes between income and assets; France between care and hotel costs.

The Government has ruled out the possibility of compulsion but has not adopted a clear position on the other three features. It has taken as its basis for future policy the establishment of what it terms a **partnership** between the state, individuals and their families and the relevant financial institutions. The stated aim is to keep the costs to all parties within reasonable limits, while allowing the maximum of freedom over the way that care is provided.

Towards a solution

The Consultation Paper puts strong emphasis on encouraging both personal provision for old age and the development of suitable financial services products. Since it was published, the industry has been sceptical as to how far either can be expected to contribute. The fundamental problem is how to persuade individuals that they need to do something when:

- they have come to expect the State to provide care, and indeed know that it will if they have insufficient assets;
- they are struggling to meet existing pension and other expenditures.

To achieve a change in behaviour, it will be necessary both for the Government to define clearly what it will and will not provide in the future, and for some greater incentive – possibly through the tax system – to channel money into this sort of provision.

The criteria by which any potential solution might be judged are set out in Table 1. The criteria can be divided into *principles* and *pragmatics*. 'Principles' represent an assessment based on ideal criteria. 'Pragmatics' assesses different options by relating them more closely to the current system and to contemporary political and economic priorities.

Insurance partnership

Long-term care insurance has yet to succeed anywhere in the world in financing a significant proportion of the costs of long-term care. Even in the United States it represents only a small proportion of the market. This goes some way to explain why the Government has suggested the use of partnerships.

A partnership is when:

> *those who for a time finance their care costs in whole or in part would at the end of that time be able to receive in return the benefit of extra protection from means-testing.*

In this way, the Government intends to increase the assets the dependant is allowed to have while still receiving help from the state. Underlying this model, the security net based on the means-testing principles of the current system would remain.

The basic principle is that every pound spent on indemnity insurance to meet long-term care costs counts as extra protection against the means test, once this insurance is exhausted. The Government has set out a number of alternative ways by which assets can be protected:

- an extra £1 or £1.50 of capital disregard for every £1 of insurance benefit paid out; or
- an extra £15,000 of capital once the individual had funded his own residential care, with the help of insurance, for four years.

Partnership schemes are intended to share the financial burden between the private and public purse. Any partnerships solution that shares the financial burden of care between public and private sector by limiting the coverage of private insurance is subject to a number of problems.

One of the first issues faced by partnership solutions is the need to establish common requirements and rules. A simple criterion is needed for indemnity products that qualify under the terms of the partnership. They will need common triggers for rights to care provision, based on 'activities of daily living' or cognitive impairment.

Without such criteria or if the criteria are set

Table 1 Principles and pragmatics

Principles	*Pragmatics*
Fairness:	Distributional impact:
• inter-generational equity	• who gains, who loses?
• equal treatment for equal need	Cost implications
Efficiency and quality of care:	• effect on public expenditure
• how cost-effective is a scheme	• increased costs for individuals
• what is the quality of care	Broader political and economic factors
Impact on economic and social behaviour:	• home ownership
• to save	• inheritance
• to work	• impact on other savings and investment
• to care	• inter-relation with health and social security policy
Individual liberty	
• compulsion and choice	
• dignity and security	
• accountability	

too low, it will be tempting for insurers to provide the least cost care which satisfies their commitment, ie at the stage before people require intensive support, leaving the state to pick up the bill for that. Equally, they will have no incentive to provide care which improves the health of the insured in anything but the short term.

Furthermore it is not only the incentives of insurance companies which must be considered if the policy is to work well, but also those facing the policyholder. A scheme of the kind proposed introduces an incentive for the insured to enjoy expensive care while using their policy in the knowledge that the state will step in once their funds are exhausted.

A possible solution to this problem is to make the state support purchase only basic quality and very basic provision. This will encourage the dependant to only use their (high quality) insured care once they are really in need of care, and use it sparingly.

Will partnership work?

Partnerships would clearly reduce the price of insurance policies by capping the commitment of the private insurer. They would reduce the possible payout by limiting the coverage and lowering the risk since the insurer would only be responsible for the initial period of care and for a set maximum period. The combination of insurance for a limited period combined with a state commitment to further support would offer a lower cost way of financing comprehensive insurance than is now currently on offer. That should lead to an increase in the number of policies purchased.

It is possible to argue that this system is not much different from today. Most people who will buy insurance under this partnership will have houses and be likely to have financed three or four years' insurance prior to satisfying the means-testing criterion. In this respect we are swapping insurance for saving, freeing resources for additional consumption. Although this is beneficial, it also indicates the limited ambition of the policy.

The policy would be successful in removing, to some extent, the disincentive to save towards care costs, and, to some extent, increase the equity of provision. Those who have saved all their lives can pay to protect their assets from means-testing.

However, the comprehensiveness of insurance will attract care to the formal sector and away

Lessons from overseas

Several overseas countries, notably the United States, France, Germany and Singapore have experimented with systems whereby the state encourages both saving for the purpose of long-term care and for development of long-term care facilities.

The United States

The United States is often cited as the best example of insurance-based health provision. It is the most mature long-term care (LTC) insurance market; LTC insurance has been available there for the last 10-12 years. However, the number of sales has been relatively small (about 5 million policies have been sold representing approximately 3% of the potential market).

The US pioneered the development of partnership schemes which blend private and public insurance. Using grants funded by the Robert Wood Johnson Foundation, eight initiatives have been undertaken. Four partnership schemes currently exist – Connecticut, New York, Indiana and California. These share a number of characteristics:

- private insurance covers nursing home care and home care costs in the initial period
- public expenditure covers long-term expenditure through Medicaid without beneficiaries having to run down assets
- there is common eligibility built on ADL[3] – usually two.

They differ in:

- the amount of insurance an individual is required to purchase (varies from 1-3 years)
- the level of public coverage, that is the rate at which asset protection rises after purchase of qualified insurance.

One aim of the schemes is to reduce public expenditure – the Connecticut scheme expects to produce savings of 7% on Medicaid expenditure by 2020. However, the take-up of these schemes has not been as large as expected. In its fourth year, 2,327 partnership products have been sold in Connecticut against the target of 50,000 for the first five years of the scheme. After three years, only 9,800 policies have been sold in New York.

The model set up in Connecticut is similar to the system proposed for the UK *(cont.)*

from the informal sector. To the extent that family care is the most efficient method of care, a form of no-claims or post-death partial refund may be beneficial.

The scheme is intended to allow people to be cared for in their own homes if this is their choice. For this reason the Government proposes to allow any benefits paid for formal domiciliary care provision to count to the dependant's entitlement to extra protection from means-tested residential care, although not against means-tested domiciliary care. It suggests the partnership will be provided irrespective of where care is available. If so, there will be a need for much tighter national standards on provision of domiciliary care.

One way of assessing if a system is likely to work is to look at the application of different policies in other countries. In the Box we look at a range of countries that have adopted very different solutions to the problems of financing long-term care.

The Government's proposal appears to have learned a number of valuable lessons from the USA. In New York for example, the system has been very poorly taken up. Aimed mostly at the well-off, it is limited, as it only applies to state-qualified homes (usually of a lower quality) and it does not allow financial top-ups. The UK system would get round these two problems. Dependants are to be free to choose their care already within bounds of affordability and receive top-ups from relatives – this should be expanded to the use of the dependant's capital, while the more well-known New York model gives infinite asset protection if 3 years of insurance cover is purchased.

France

The French system also divides the cost of care; it is effectively a partial social insurance scheme with a means-tested safety net. It makes a distinction between "care" costs and "hotel" costs. Hotel costs are means-tested, with residents liable to pay all of their income, except for pocket money, towards this element of cost. Care costs are not means-tested, and are financed by the state. A small contribution may be expected from children. Owner occupation counts as an asset.

Private long-term care insurance was introduced in France in the mid-1980s. Sales were poor, however, probably due to expense and low public awareness. There have been recent attempts to develop the market again.

Germany

Until recently, the German system was based on quite severe means-testing. Germany has introduced a new social insurance benefit. Eligibility now depends solely on disability, with no regard to financial status. Beginning in 1995 for community-based long-term care, this was extended in 1996 to cover institutional care. It is provided through Germany's mandatory private health insurance system. For home care, people are given a choice of in-kind benefits or a lower but substantial level of cash benefits. The cost of the system is shared between employers and workers. The increased expense for employers was compensated by reducing workers' paid holiday allowance by one day. This system is characterised by:

- compulsion – unless private arrangements are made
- provision of payment for home care
- government rules for eligibility.

Singapore

Asia is also facing an ageing problem. The problem is arriving faster than in western countries, because it is occurring at an earlier stage in the economic development of the country. The financing of long-term care is only one element of Singapore's fully funded social insurance system – called the 'Central Provident'.

which currently falls outside the disregard. Protection in the USA falls only on assets and not on income. This appears to have reduced the incentive for the more well-off to join the system. The UK is also considering only protecting the level of assets.

Of the several criteria set out above it is natural to focus on the distributional effects of this financing mechanism since the Consultation Document proposes little or no change in the mechanism of provision itself.

The distributional criterion is fundamental to the cost-effectiveness of the policy in terms not only of its impact on future public expenditure but also its perceived fairness and likely popularity. The critical issues therefore are the revenue neutrality of the scheme to Government and the actuarial fairness to the private individual.

If the amount the Government saves through reduced public spending outweighs the extra cost from increasing the asset disregard after 4 years, then on average it is unlikely that individuals will find the Goverment's offer attractive. Assessing this revenue neutrality is complex; it is determined by both the distribution of assets and income across the population and by the distribution of care need. These factors determine whether the Government will face increased expenditure as it pays for many years of high intensity care or alternatively, whether it finds itself responsible for only a few. Without careful analysis of these distributions, assessing the likely success of any partnership is very difficult and the practical implementation of such a policy even more difficult still to assess.

What health and social services can do

Whatever happens on the finance side, the largest burden of ensuring that adequate formal care is provided will fall on the public sector. Local authorities, community health trusts, social services departments and GPs will all need to work well together to ensure – as always – that limited budgets can be stretched to cover as many people as possible. The systems that are developed need to do the dual job of helping individuals and their relatives and friends to cope where care can be in the home, and where residential or hospital care is needed that this is the most appropriate for the individual concerned.

Current experience suggests that:

- many people are admitted to nursing homes because nothing else exists and no-one has advised on alternatives;
- families can get to breaking point, often over issues that could be resolved with limited help;
- sometimes admitting people to nursing homes or hospital is seen as the 'easy way out' by doctors and relations;
- there is often confusion between agencies over assessments and who is responsible for what.

Taken together, these can lead to expensive care being provided which is not in the patient's best interests. Acute care providers are reporting increasing strain on beds as some are occupied by those who could be cared for in other ways. Better co-ordination and delivery mechanisms need to be derived which both identify the best course of action and minimise the cost of providing it.

There are some examples of places where progress is being made on these issues. In South Bedfordshire, for example, a multi-disciplinary team is being established consisting of therapists, care assistants and home carers (on piece rates), based around a facility which acts as team base, rehabilitation centre, short-stay respite/treatment centre and multi-agency social centre. Although it is too early to test how effective such a solution might be, the claim is that the unit can provide cost-effective assessment and rehabilitation for 100-150 elderly people. Duplicated around the country, such initiatives might be able to make a significant impact on the cost of care provision.

The analysis above highlights the importance of informal carers in keeping the need for formal care within reasonable bounds. Small changes in the behaviour of relatives and friends of those needing care can have dramatic effects on the likely cost of formal care. Investing in making it possible for carers to cope, by limited provision of equipment and facilities, through respites and through timely advice, could have a major impact in reducing future costs. Generally, very little is known about the sociology and psychology of caring, and more research in the area of why families make the choices they do could pay dividends.

Financial services products

Of the three possible financing mechanisms put forward in the consultation paper, we have focused only on partnership in long-term care insurance. Partnerships in immediate needs annuities are unlikely to prove attractive but the third option, a *variable pension,* is more promising.

Instead of paying into a pension throughout his or her working life in order to receive an annual income upon retirement, a plan member would be able to secure a higher income stream in extreme old age. This could point the way towards the development of a *combined product.* Such a product might deliver a lower annual income than a conventional pension but might also include long-term care insurance.

The attraction of this solution is its simplicity. Many people take out private pensions; this might increase the coverage of long-term care insurance and would encourage provision to be taken out earlier in life.

Alternatively, equity release products have not been ruled out by the Consultation Paper. The systems currently proposed do not help the many asset-rich but income-poor pensioners but equity release – or home income plans as they became known have attracted very bad publicity. A potential solution to this is partial equity release insurance (or PERI) proposals, as outlined in *Paying for Long-Term Care.* This allows a fraction of the home to be released to finance the cost of care provision.

Even without Government support, interest in financial services solutions by both suppliers and consumers is clearly growing but does not seem likely by itself to solve the issue of how the increasing costs of care is financed. A radical change in people's savings and insurance behaviour that will be needed for private pensions to make a major contribution will require Government encouragement, akin to that which triggered the personal pensions revolution.

Conclusion

The problems of financing care of elderly people are not going to be easily solved. The demographics suggest every method will prove expensive and examples of systems adopted abroad suggest there is neither a perfect nor low cost method.

Inevitably society will, and should, insist on a safety net for the elderly and sick and much of the cost is likely to be financed through this route. It is important, however, that any system spreads the cost fairly across those able to pay and does not distort methods of provision. Above all the support of family and friends, who are the primary providers of long-term care in this country, must be supported and encouraged.

Where private individuals can be encouraged to make provision through the purchase of financial instruments, this also should be encouraged and not penalised. The tools to incentivise private provision exist but need to be clear and significant. The Government has gone some way to clarify the boundary between private and public provision but the long-term care market, as with private pensions before it, will need more encouragement with considerable tax breaks and commitments regarding future policy than anything proposed in *A new partnership for care in old age.*

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