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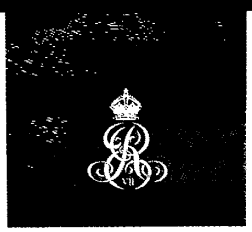
Jo Ivey Boufford



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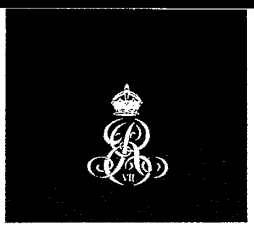

Introduction

This paper is based on a speech delivered at the 1993 Annual Meeting of the National Association of Health Authorities and Trusts. There is enormous interest in this important policy issue for the future NHS. This is offered as another in a series of papers published by the King's Fund College to enrich the debate and, we hope, assist those who need to make the changes happen 'on the ground'.

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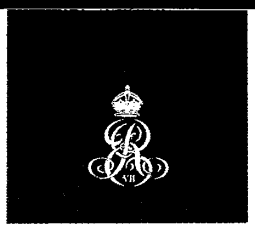


Shifting the balance from acute to community health care

This topic is rather like apple pie and motherhood – everyone is in favour of it in principle, the difficulty comes in defining it and working to make it happen. Even if you do, the results sometimes appear invisible since they are all 'out there', away from the hospitals, offices, and big institutions in which many of us spend most of our time.

The issue has been rehearsed over and over, so one risk is making any substantive contribution to the debate. A second risk is that the whole area is a minefield, one into which I have ventured a number of times in the last three years since coming to the UK. When I first came here and tried to relate my understanding of words like community care, primary care, general practice, community health care, out-patients, etc., I would find my British colleagues either looking at me as a visitor from another planet or moving quickly into armed camps wearing the mental uniforms of these different groups. It is obvious that each of the words has a history, precise definition, and political valence in this country that can sometimes create real obstacles to thinking about integration of services for patients, even within the community-based sector.

As an American who has been observing and involved in the National Health Service (NHS) changes since 1989, I hope I can be forgiven for making obviously 'ridiculous suggestions', but by the same token, the UK reader can suspend their usual point of view to see if a different perspective can offer some new ways of thinking about and, perhaps, acting on one of the most critical policy initiatives for the future of the NHS.

So, on to the first problem – what are we talking about? Let us start with the title for this paper: *Shifting the Balance from Acute to Community Health Care.* When I think of 'acute care', I think immediately of 'providing medical care to people who have just recently become sick'. This can obviously be done in a hospital or in a doctor's surgery or in the home, but as I understand the term here it usually means 'hospital care', or is shorthand for the hospital sector. So for the purposes of this talk, let us translate 'acute' to mean 'hospital-based'.

Community health care means 'the full array of health care services provided in the community (e.g., not in the hospital)', even including social care and care for what are here designated as priority groups – learning disabled, mentally ill, and the elderly. In the UK, I have come to learn, it refers to a specific segment of NHS services provided by a specific set of people in specific organisational structures called the Community Health Services.

While a useful organisational distinction, it feels like an artificial one from a patient care point of view. It becomes clearer when you understand that GPs, the other major group working from a community base, are individual contractors and *not a part of the NHS*. Now this latter fact is not something most people from outside the UK know. They think that the NHS provides the full continuum of care – with the GPs, in a sense, being the most well-known and, from an international perspective, valued segment of the service.

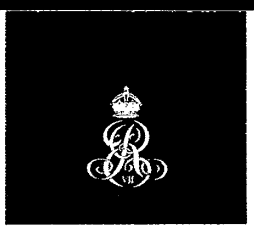
Next, I assumed that the GP was a major provider of primary care, but then I have had people argue with me that GPs do not provide primary care, they provide general practice care and, anyway, nobody can really define primary care, so the whole thing is best dropped. By now I feel a little like Alice Through the Looking Glass. However, for the purposes of this discussion, let us consider that 'community health care' means 'the array of community-based health services provided by GPs (and the other health professionals funded through Family Health Service Authorities (FHSAs), the practice team, and community health care professionals'.

Finally, I do want to offer a definition of primary care which, from the patient's point of view, must be our overarching goal. I want to argue that if all of us involved in providing health services could keep in mind a shared definition of a 'primary care' oriented system, we could help make the links patients need. At the same time, we could have a shared policy framework for shifting health services towards a community base, linking hospitals, social services *and* care for priority groups.

Primary care

Primary care can be seen as a process of service provision, rather than something done only in a particular place or by certain health professionals. To guarantee it, all segments of the health care system have major contributions to make. It is inclusionary, not exclusionary. While many discount the 'health for all' rhetoric as overly idealistic, I think the idea for primary care behind the Alma Ata Declaration of the World Health Organisation (WHO) – seeking to establish a unified biopsychosocial model as a health care framework – is important.

An expert consensus panel convened by the US Institute of Medicine (IOM) issued its definition of primary care in 1978.[1] The project was an effort to promote primary care service and education in a country in which more than 60 per cent of doctors at the time were specialists. The IOM sought to develop a process definition that could be tested against the practice of any particular doctor or other health professional to see if they were in fact providing primary care. It was also used to diagnose the completeness of the delivery system in certain areas of the country. While the applications would be different here, it can help us identify the characteristics of a robust primary health care system that is inclusive of all services needed by an individual patient.



So, primary care is:

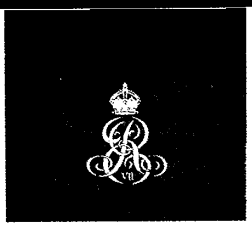
- *first-contact care* at the patient's point of entry into the health care system;
- *comprehensive care* to the patient (including preventive, curative and rehabilitative care);
- *continuous care*, in which the patient has an on-going, personalised relationship with a primary care provider or team for his/her health care;
- *co-ordinated care*, in which the primary care provider serves as the co-ordinator of all patient care, including referral for hospitalisation and specialist consultation, including mental health specialists, and related community-based health and social services. The primary care provider acts as the patient's advocate to assure that care received is appropriate to the patient's needs and that the patient is an informed participant in decision-making about the overall care plan.

There are some additional features of adequate primary care:

- *assuring access* for the patient to needed health services (bars to access can include operating hours, geography, finances, culture, and language);
- *assuring accountability* of professional and administrative staff for the quality of services rendered, the ways in which they are provided, and the outcome of care. This involves accountability to internal and, potentially, external review criteria as well as to the patient.

In revisiting this definition today, I would add the concept of 'community-oriented' care, with primary care providers assuming some role, if not responsibility, for improving the health of the community served.[2]

Any decision to dismantle the GP referral system or the excellent traditional community health care network in the UK would be a disaster. They are truly international models. However, with such an infrastructure in place, linking them under an umbrella concept of primary care can be very important, especially if we acknowledge that, for most people, there are two doors into the health care delivery system – the hospital emergency room and the GP's surgery. The GP may in most cases take the lead in assuring the patient enters a primary care service system, but, just as well, district nurses, health visitors, community-based therapists, the hospital consultant for the patient admitted from the emergency room, and the social services professional are potentially linked into such a system and, in fact, depending on the patient or client's problem, may assume the lead in assuring the needed array of services is available.



'Shifting the balance'

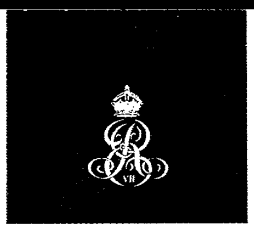
A policy initiative which calls for a shift in the balance of services from the hospital to the community reflects a failure to understand the reality of the current health care delivery system. The vast majority of health services are already provided in the community, including doctor services.

My favourite example is shown in an often-quoted study conducted in the 1960s by Kerr White.[3] In a classic paper using data from the *Survey of Sickness in England and Wales* and the *US National Health Survey*, he analysed the sickness behaviour of 1,000 adults over 16 years of age during one month. He found that of this thousand, 750 experienced some health complaint, 250 of which sought medical attention, 9 of these were admitted to a community hospital, 5 referred to another physician and one was admitted to a teaching hospital. Applying these findings to our evaluation of the relative role of components of the health service, we realise that the hospital, clearly the focal point of the traditional delivery and medical education system, is actually needed *by less than 4 per cent of individuals who enter the formal health care system.* Most are treated in an ambulatory care or primary care setting. A similar review in 1983 showed even less initial use of the physician and, once the patient had entered the service system, less use of hospital – a trend likely to continue.

Relative activity figures for community-based NHS services (using my definition) are equally dramatic when compared to hospital-based activity. According to the Office for Population Censuses and Surveys (OPCS),[4] there were about 216 million consultations with GPs in 1991–2, and over 17 million additional contacts with the array of community health and paramedical health service professionals. This compares to about 7.7 million in-patient episodes, 1.6 million day cases and 20 million new attendances in out-patient and accident and emergency. These figures are quite consistent with the relative percentages of care in and outside hospital in White's study.

At this point, I could declare victory at having succeeded in shifting the balance. But a few problems remain. While the balance has shifted in terms of activity, it has not in several other important respects.

First, health personnel. Again from the OPCS,[5] in 1991–2, there were about 26,000 unrestricted principals in general practice and about 88,000 other clinical staff in family health services. Department data indicated that, in 1990, of 396,000 nursing and midwifery staff, only about 42,000 were in primary health care. Other comparative data become difficult, but the Department of Health Reports for 1990 showed about 40,000 hospital medical staff, including about 14,000 consultants.[6]



Second, money. In 1990, according to the Audit Commission, 57 per cent of NHS revenue expenditure went to hospitals. Unpublished 1993 estimates indicate about the same percentage against a revenue budget of £27.5 billion. This is about at the EC average.

It would be naive and simplistic to expect that the percentage of staff and financial resources could be truly aligned with activity levels between the hospital-based and community-based sectors, but further rationalisation is clearly possible.

However, a policy initiative must be more, it must be about an affirmative statement of a broader goal, the goal of achieving a true primary care system, not just a statement about moving services from one site to another. To move closer to this goal a few other 'shifts' are needed, including:

- a shift in paradigm to see the NHS as an instrument for improving the health of the population and to recognise the importance of primary care in such an effort;
- a shift in the mutual understanding of the professionals who work in the hospital and community-based health care sectors;
- a shift in understanding and confidence about what types of medical care can be delivered in which settings by which kinds of health professionals.

Let us explore each of these briefly.

Improving population health status

In *The Health of the Nation*, the initial vision held by those who created the NHS has been revitalised, i.e. that it should be an instrument for improving the population's health – a responsibility beyond caring for and curing the individual patient. In public health terms this might be seen as a shift from a *numerator*-oriented health care delivery system – responding to the needs and demands of those who present for care – to a *denominator* focus that goes beyond the needs and demands of active users of the delivery system and looks at those of the population (or community) of which the individual service user is only a part. In other words, the community becomes the patient.

There is considerable debate about the appropriateness of such a goal. Some see it as a cynical attempt to deflect attention from the problems of a service that is underfunded for its current responsibilities; others view it as unrealistic because health care exerts only a small influence on overall

health. But, what are the critical influences on a community's health status? Figure 1 lists the parameters proposed for measuring the health of a city – a complex, geographically defined community, developed as part of the WHO's Healthy Cities project.[7]

FIGURE 1

PARAMETERS TO MEASURE THE HEALTH OF A CITY

1. **Demography**
2. **Quality of the physical environment**
3. **State of the local economy**
4. **Quality of the social environment**
5. **Personal safety**
6. **Aesthetics of the environment**
7. **Appropriate education**
8. **Extent of community participation, structures of government**
9. **New health promotion indicators**
10. **Quality of health services**
11. **Traditional health indicators (mortality and morbidity)**
12. **Equity**

(SOURCE: ADAPTED FROM ASHTON J. HEALTHY CITIES: CONCEPTS AND VISIONS. UNIVERSITY OF LIVERPOOL, DEPARTMENT OF COMMUNITY HEALTH, 1988)

There is considerable research indicating that factors such as housing, jobs and education probably have more significant long-term effects on health status than more traditionally emphasised parameters such as healthy behaviours and health services (items 9 and 10 on the list); but all are important.

In the NHS, the District Health Authority (DHA), as commissioner of care for its resident population, has responsibility for securing overall improvements in the health status of a geographically defined population. It seeks to do this primarily by exerting leverage over or working in partnership with institutional and individual providers and purchasers (general practitioner fundholder and local authorities), each relating to smaller communities within the patch.

These organisations will logically be the operational focus of change efforts. But the key question is: *what do we want them to do to promote better community health?*

FIGURE 2

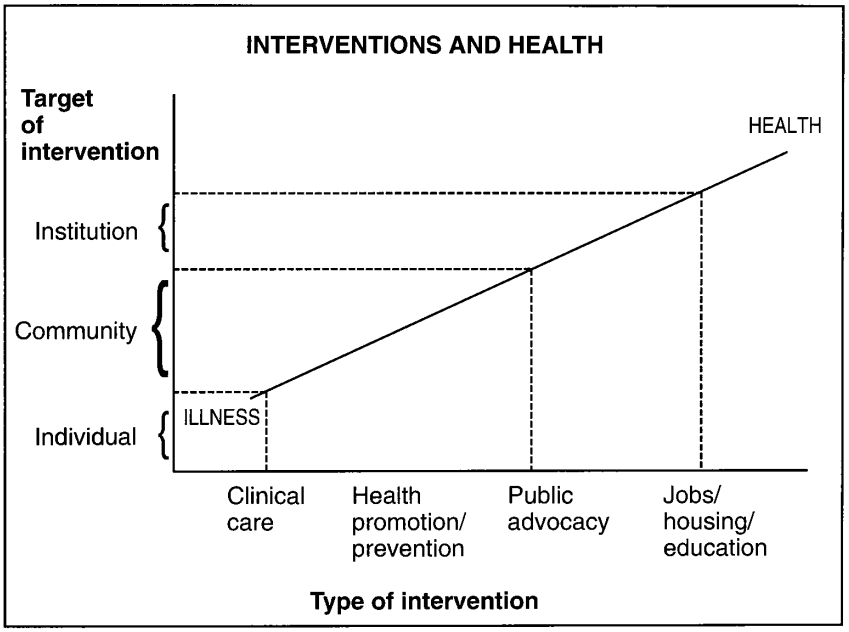


Figure 2 presents a possible answer to this question and can provide a conceptual framework for managers. The horizontal axis identifies the type of intervention needed to promote the community's health; the potential targets of the intervention – the individual, the community, or the institution – are shown on the vertical axis; and the impact of these interventions is represented on the third dimension of this diagram, the continuum from illness to health. Institutional and individual purchasers and providers are in a position to act at each of these levels, if they are aware of their potential and are provided with the proper incentives to do so. If we only provide traditional clinical medical care in the hospital setting (the lower left-hand corner), even though ensuring the effectiveness of each intervention, we limit our ability significantly to influence the health of the larger community, though we may save enormous resources.

If we can unlock the potential of community-based health care services as part of a comprehensive primary care system, we can provide health promotion and disease prevention services as well as treatment and rehabilitation, and begin to reach out to the community and take greater advantage of the power of the health care system as an instrument for

improving community health. A 'denominator' focus for primary care services linking DHA, FHSA and GP practices in a concerted effort to tackle identified health problems can assure the best use of limited health care resources.

Finally, the longer-term challenge for the future is the need for the right incentives for purchasers and providers to use their overall institutional resources for improved community health as advocates and political and economic forces in the community.

Better mutual understanding

The second shift needed is one towards better mutual understanding among individuals in the different sectors of the health care system. The reforms have in many ways promoted better communication than ever before between GPs, especially fundholders, and hospital consultants and managers. Similarly, FHSAs, GPs, community health care units and local authority social service professionals are starting to work together in many locations. But there are still some pretty strong stereotypes and tensions that need to be addressed before we can deliver an effective primary-care oriented service.

There are quite real differences in the nature of the work done in hospital and community-based services that can lead to the creation (and defence) of quite different organisational and clinical cultures. There are two critical factors which, arguably, drive these differences – the dramatically different power relationships between patients and providers and the differences in the kinds of problems seen in each setting. A few examples are illustrated in Figure 3.

FIGURE 3

MAJOR DIFFERENCES BETWEEN ACUTE HOSPITAL AND PRIMARY CARE

Acute experience	**Primary care experience**
Site and pace of work	
Hospital-based ward; medicine is major use of time; patients seen intensively for short periods of time.	Out-patient setting is a major focus; patients seen intermittently over long periods of time.
Goals	
Disease-centred problem-solving; disease classification and death prevention.	Disease prevention; problem management; reduction of discomfort, dissatisfaction, worry; health promotion.

Acute experience	Primary care experience
Role models	
Faculty 'stars' in clinical research and high-prestige areas of surgery; subspecialty medicine.	Primary care physician in pediatrics; general internal medicine; family medicine; family practice (not always on the faculty, therefore low prestige in medical school).
Knowledge and skills	
Knowledge, skills, technology in medical 'science' are the central focus of training.	Knowledge and skills in general medicine, psychosocial and problem management are central.
Diagnosis and treatment	
In-patient diagnosis is deterministic and treatment is controlled and closely observed.	Ambulatory diagnosis relies on probability derived from clinical experience and epidemiology. Treatment is frequently a 'clinical trial', with many unknown variables.
Doctor-patient relationship	
• Hospital relationship is time-limited and the ward ritual assures a 'safe' distance between doctor and patient.	• Relationship between doctor and patient is one-to-one, continuous, close and extended in time.
• Doctor is in total control of the environment (medicine taking, information giving, degree of patient contact with family) while in hospital.	• Doctor has little control over patient's environment, must deal with patient in complex social network.
• Assumption is made that any doctor can be replaced by any other at any time provided he/she has similar skills and experience (ward rotations).	• Nature of care creates one-to-one relationships and the individual 'healing abilities' of the doctor are critical.
• Physicians are specialists, rarely in position to be criticised since they are solving 'problem cases' referred by other MDs.	• Physicians are first-in-line contacts by the nature of the referral system; are also in a position to be criticised by specialists.

Acute experience	Primary care experience
Doctor-patient relationship	
• Patient is acutely ill, totally dependent on MD.	• Ambulatory patients are 'functioning' at some level, are more self-reliant, are subject to outside influences.
• Gratification is immediate: patient survives the acute episode; acute infection cured; surgical problem treated	• Gratification often delayed: chronic disease with long-term management, psychosocial problems with ambiguous outcomes.
• Major need is scientific technology, so the doctor is the key figure, solo performer autonomous in managing 'medical problems'.	• Because of the complex nature of problems, the doctor works on a team and makes decisions collaboratively.

Sustained dialogue and understanding among doctors, nurses and paramedical staff in the two parts of the system will be critical to appreciation of how they are different and how these differences must be preserved and respected if a comprehensive health care system is to be created.

Another important aspect of the difference in cultures between the acute and primary care services is the difference in the presenting problems of the patients in each setting. Patient behaviour and expectations differ; so do the requirements for responses from doctors, nurses and other health care professionals. Over time, this has created very different enactments of roles by health care professionals who carry the same titles.

Data from a recent publication of the Redbridge and Waltham Forest FHSA are very illuminating in this regard and not atypical of other such comparisons (see Figure 4).[6] The mortality statistics can serve as a proxy for the kinds of problems commonly seen in hospital in all their complexity. The reports of patients about their own health problems are quite close to those of their GPs. However, when people are asked about what they see as the major health problems in the community, their answers often have very little medical content but may mention broken glass in the parks or a particular pedestrian crossing that is unsafe. There is a clear need to pull together all the 'views of the elephant' that are available throughout the health care system if we are to make it truly effective.

FIGURE 4 HEALTH NEEDS IN RANK ORDER BY SOURCE

Routinely published vital statistics (mortality)	Survey of general public	DHA/GP interviews	GP delphic survey
IHD	URTI	Elderly people	Depression/neurosis
Cerebrovascular disease	Back pain/arthritis	Social problems	URTI/respiratory symptoms
Lung cancer in men	Hypertension	Ethnic minorities	Maternity and gynaecology
Motor vehicle accidents in men	Skin problems	Infant mortality	Musculoskeletal/ arthritis
Cervical cancer in women	Musculoskeletal problems	Psychiatric problems	Hypertension/IHD
Breast cancer in women	Depression	Low vaccinations and immunisations	Dermatology
Perinatal mortality rate	Maternity		
Children 0–14 years	Gynaecology		
Suicide in women			
Abortions			

(SOURCE: REDBRIDGE AND WALTHAM FOREST FAMILY HEALTH SERVICES AUTHORITY. FAST-TRACKING THE CHALLENGE OF THE 21ST CENTURY. 1993)

Is it safe to move services?

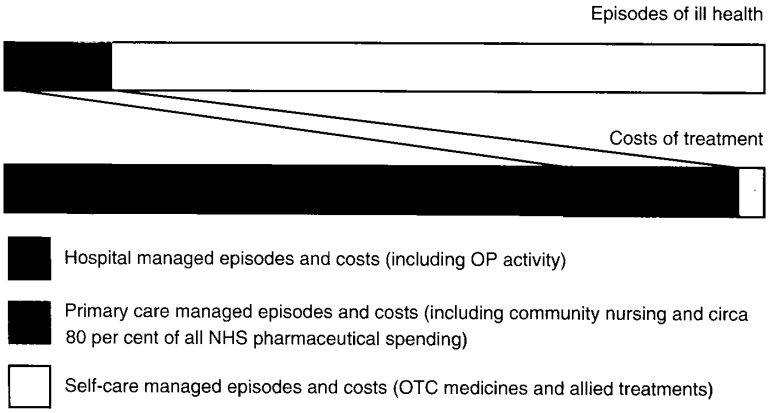
The final shift needed is that in our current understanding and confidence about whether moving care from the hospital to the community base is wise – is it medically appropriate and is it more cost-effective, two criteria commonly cited both by those who would be convinced and by advocates. There is no doubt that the medical appropriateness criterion is a legitimate one, but it should be applied just as stringently to services in the hospital setting.

The cost effectiveness criterion is a more controversial one. At an aggregate level, we can see evidence of considerable cost-effectiveness of community-based services, which may reflect more the current relative investment in the hospital and community sectors than the ideal (see Figure 5).[9]

Moving certain health services into an adequately resourced community base may not be cheaper, especially at the outset when the service must be 'established', equipment bought and staff trained. But there is another criterion that must be weighed here as well, convenience and preference of the patient. This will obviously be heavily influenced by the opinions of doctors and nurses, but in most open-ended surveys, patients would prefer not to go to hospital unless absolutely necessary. Safety is a non-negotiable criterion, but cost-effectiveness and patient preference should be weighed against each other carefully.

FIGURE 5

HOSPITAL, PRIMARY AND SELF-CARE TREATMENT COSTS – A COMPARISON



(SOURCE: TAYLOR D. DEVELOPING PRIMARY CARE OPPORTUNITIES IN THE 1990s. LONDON: KING'S FUND INSTITUTE, 1991)

So what do we know about the safety and relative cost of services provided inside and outside the hospital? There is a wide-ranging literature, but a few examples are important to our discussion.

First, we know that *there is wide variability in decisions by doctors to admit patients with certain problems to the hospital.* These are well documented in many countries. Built on the work of Jack Wennberg in the USA,[10] and extended by Klim McPherson of the London School of Hygiene and Tropical Medicine and others in the UK, this is called 'clinical practice variability' and reflects two facts: (a) variability is higher when the most effective treatment of the condition is less clear; and (b) doctors in the same small geographic area tend to practise in the same way (peer influence).

Wennberg and colleagues have developed their work with the idea that for conditions in which the actual outcome between different treatment methods is not conclusive, patients should be more involved in making the decision about which treatment they prefer. Nine such conditions have been used so far to develop video techniques for individual patient participation in decision-making. Some are being piloted here at the Central Middlesex in a project supported by the King's Fund.

A UK example of practice variance is found in the recent Audit Commission Report on Children in Hospital,[11] showing four-fold variance in hospitalisation rates for children with asthma across UK districts. The reasons explaining this variance are obviously complex, but the degree of variability is important.

Data in the same report reviewed the management of glue ear and, again, showed massive variance in the rate of surgical intervention to insert grommets, in spite of over 19 randomised controlled trials that demonstrated that most cases of glue ear resolve without surgical intervention. Out-of-hospital management is most effective when ENT surgeons and GPs agree a protocol for care against which they monitor their performance. Reductions in use of hospital here have enormous implications, since 47 per cent of the work of ENT surgeons is with children.

Other examples of reduced hospitalisation have been demonstrated in a number of projects in the UK, most involving collaboration between GPs and hospital consultants in various specialties to examine their current referral patterns, agree criteria for appropriateness, identify areas in which GPs can and are willing to increase their expertise to handle problems in their practices and agree on protocols when referral is important.

There are also a large number of studies identifying unnecessary hospital days, once the patient is admitted. A British application of a US-developed 'Appropriateness Evaluation Protocol' involving doctor and nurse reviews of medical records (modified in the UK to involve interviews of nursing personnel) revealed 62 per cent of bed days in acute medicine in a provincial teaching hospital were judged inappropriate on purely medical grounds. The usual reasons are days spent for diagnostic tests that could have been done as an out-patient or, more commonly, days when the patient could have been cared for at a lower level of care, in home, or an intermediate setting. The obvious problem is the lack of such settings in many areas.[12]

A BMJ study in 1988[13] showed how hospital-based care attendants meeting elderly patients the day before discharge and working with them for up to 12 hours/week for two weeks providing practical, self-care, and social networking services, reduced re-admission rates from 15 to 5 per cent. They estimated that if the policy were extended to all patients over 75 admitted to the hospital they studied, they might save the equivalent of 23 beds at £287,000/year. After netting out staff costs of £66,000, a residual £220,000 could be redeployed, if the beds were closed.

A third area of important work on hospital use involves the provision of tertiary care services in multiple sites with small volumes of cases. As shown in the Audit Commission study on children's hospital services, this is both expensive and dangerous. Two examples were explored in depth:

- cancer services, where three-year survival rates in children's oncology centres were 32 per cent, while children receiving care for the same cancer in a non-teaching hospital showed a 6 per cent survival rate;

- survival studies of newborns under 28 weeks showed a 52 per cent survival rate in neonatal centres with more than 5,000 cot days/year versus 22 per cent survival in smaller hospitals with 1,000 cot days/year. The cost per case, including transport from the birth hospital to the centre, was 20 per cent less in the high-volume location.

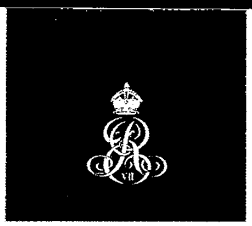
These examples are all about reducing unnecessary hospitalisation and are presented for three reasons: (a) to show that there is lots that goes on in hospitals that need not, even as judged by health professionals themselves; (b) to indicate that there is potential for cost savings and reinvestment if changes that are relatively non-controversial on medical grounds are made; and (c) to indicate that in many cases front-end investments may be needed in community-based health care services to achieve the change.

Some hospital-based specialists argue that there will be no savings because there are always appropriate cases waiting to take the place of patients who leave more promptly or who are never admitted, so the necessary community health care services will require new investment.[14] If there were unlimited funds, this would probably be true, but the issue in a globally budgeted system must be one of relative priorities.

The most visible and less controversial example of services being moved from the in-patient side to out-patients, and potentially into the community, is day surgery. The Audit Commission study[15] showed that day case treatment typically cost 20–30 per cent less even when aftercare costs were included. A study of comparative re-admission rates and complication rates for comparable patients undergoing 12 procedures in an in-patient or day-surgery treatment setting in Oxfordshire, showed few differences between the two, and higher re-admission rates for those operated as in-patients.

There is still a relatively low rate of day surgery in the UK compared with other countries. Few regions exceed an average of 20 per cent of surgical procedures on a day case basis and many of these are still relatively minor problems. This is compared with nearly 65 per cent of all elective surgery on a day case basis in the USA and projections in Sweden that 80 per cent of all elective surgery will be done on a day case basis without general anaesthetic by the end of the century.[16]

Again, potential new costs here are ensuring adequate theatre and recovery facilities in hospital and developing these facilities in a cost-effective way in the community. Retraining of staff is also a key factor. While it can be expected that some of these procedures may shift into the GP surgery, it would be expected that most of this day surgery will be done by consultant surgeons. Some have raised the very real issue about whether or not the numbers of consultants are adequate to cover both a more complex in-patient service and day surgery or out-patient medical specialty consultations in non-



hospital settings. This will need to be determined in each patch. It also raises the issue of the role of junior doctors in doing much of the current in-patient work. They are unlikely to be welcome or appropriate in community-based settings in other than the role of learners.

There is much to be done in rationalising current patterns of hospital care and planning to move even those services now deemed medically appropriate into a community-based delivery setting. I do not think we are in a position of needing to 'wait for the research' to accelerate the process in most places. In fact, very few people seem to be waiting. There are scores of published examples of innovation and experimentation on the ground in moving services from a hospital base into the community. And, given the time it takes to actually write up and publish one's own experience, it is probably safe to assume that for every one published, there are many more unrecorded examples around the country. These innovations involve *moving money into community-based health services.*[17] For example:

- Wessex Region investing £12.5 million to transfer ownership of health centres to GPs for the development of multiservice premises;

- many patches seeing the results of several years' experience transferring mental health services out of the asylums into the community – a recent report from Exeter documenting a 20 per cent reduction in overhead costs with actual institutional closure is complete.

- South-East London Health Authority deciding to ring-fence its investment in community health care, even in the face of significant shortfalls in overall allocations for purchasing for 1993.

There are also large numbers of innovative service models being developed and tested. The best known of these perhaps is the Lambeth Community Care Centre developed over a period of ten years through the collaborative efforts of local GPs, the community health councils (CHCs) and the local authority, now part of a community trust. An intermediate care centre in a complex urban community, it seeks to extend the capacity of local GPs to care for patients in the community by providing therapy services, day hospital and a small number of beds used for minor acute medical support, rehabilitation, respite and some hospice care. Such a facility, along with other larger health centres could also serve as a logical site for day surgery and rotating consultant out-patient sessions fitted to the needs of local GPs.[18]

Ideas are also developing for primary care resource centres and other models that would make available extended diagnostic service for GPs, community-based out-patients sessions provided by consultants from a nearby teaching hospital and an operating base for community health care unit therapists and nurses to co-ordinate increasingly intensive home-care

services.[19] In one patch, local authority care managers are based in GP practices to co-ordinate local social services with GPs.[20]

There are also a large number of *structural and managerial models in use or being developed,* many to get around current statutory structural limitations on organisational form or financial flows. For example:

- Derbyshire FHSA has been delegated responsibility for managing fundholding by the Region linked to its corporate contract. A focus of their work is on population responsibility. GP practices, not just individual GPs, are being contracted and are, in turn, contracting with community and hospital trusts. GPs are pooling their money and clearing waiting lists, sometimes using the private sector as well as funding an aftercare programme provided by the CHC.[21]

- In the North-East Thames Region, a primary health care strategy includes establishing a Primary Care Development Agency for City and East London which will combine the FHSA and all primary and community care services currently led by the Bart's and Royal London trust.[22]

- Wessex has established its Health Commissions to develop more coherent purchasing of 'seamless care' in the face of legal blocks to the merger of DHAs and FHSAs. Other purchasers are designating lead providers for a service that requires co-ordination of in-patient and community-based services and expecting the lead provider to deliver the co-ordination of care as a condition of the contract.[23]

Finally, new approaches are being explored to *raise private capital for development of primary care.* The London Implementation Group has sponsored a feasibility study to see how NHS ownership of commercially valuable land can lead to a partnership with private developers to site a health care facility in a newly developed shopping centre, or health mall.[24]

These examples are just the tip of the iceberg. They seem to validate a very interesting theory of change which argues against the conventional thinking that sees making change as a disruption in a stable order requiring persistent efforts. Rather, the argument is that change is everywhere and will generally occur swiftly and naturally, unless it is actively stopped from happening deliberately or by default. In other words, change is achieved by releasing it: we identify the precise constraints keeping the desired change from occurring naturally, and selectively remove these constraints. Fundamental to this view is that examples of the desired behaviour or change are 'buried' within the present situation and, if we find them, they can illuminate the kind of constraints that need to be lifted to help them flourish. Surely, there are myriad examples of the desired change towards more integrated systems

providing primary care, and the challenge is making it easier by removing the obstacles.

Because primary care is so complex and must, by its nature, be individualised to the patient's needs, it cannot be effectively directed from the top down. It must start at the grass roots with individuals in organisations linking together with an eye on the needs of the patient and community. There are, however, a few actions that could be taken at higher levels in the system to accelerate primary care development. Let me highlight four:

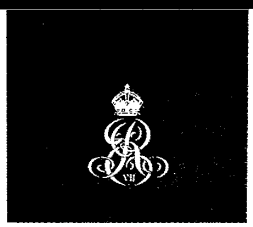
- creating the vision
- adjusting the market framework to support primary care
- attending to health profession's staffing and education
- promoting primary care R&D.

The vision

The most positive statement of vision so far articulated is 'the NHS as a primary-care led service'. For reasons identified earlier, this has not been terribly helpful, because few professionals agree on what primary care is and, for the public, it is not tangible, i.e. it does not clearly relate to the 'two doors' into the health care system that most recognise. I have suggested a potential definition that tries to integrate all segments of the system in an overall primary care approach. It will become increasingly important not only to provide clearer definitions of what is meant by primary care, but also to create tangible images for the public from current examples of good practice.

The media can play a critical role in educating the public and offering positive alternatives to what is now seen mostly as loss of service, closure of beds, closure of a hospital – always an easier focus for the headlines. But the alternatives must be real: the enhanced GP surgery linked to a new community-based primary care resource centre where patients can see a consultant, perhaps from their familiar hospital without one or more long trips. In some patches, it may be an expanded health centre or polyclinic featuring day surgery; in others a health mall or a GP surgery attached to a pool and gym for community recreation.

The vision will need to be much more precise for the health professionals and managers involved. Right now many hospital consultants are fantasising that GPs will be putting them out of jobs or putting the public at risk by taking on responsibilities for surgery and specialty medicine. At the same time, GPs are fearful that the core reason for their professional choice – the fact that they



can be generalists – is at risk in the face of increasing demands for specialty care in the community base. Clearly, where dialogue and partnership between GPs and consultants have been possible, these issues can be resolved. It is important to remember that as long as the GPs are unclear about or downright hostile to the changes, this feeling will be transmitted to their patients and diminish patients' willingness to accept new ways of practice. A recent British Medical Association attitude survey of GPs on the effect of reforms in London showed, along with a normal concern about service losses, a particularly troubling lack of specific information about the reasons for change and the alternatives being proposed.

Hospital consultants and other health professionals face another kind of need for a positive vision, as their major experience is loss of the world as they know it – if service closure is clearly threatened – or alternatively, demands that they do new things in new settings of which they have no experience. Both provide strong reasons for resisting change. If hospital-based health professionals and managers can begin to see positive images of new forms of health care in a community base, they can begin to see a role for themselves. Some may even help to reinvent a role for their hospital to meet some of these new needs, but they can only do so if they are aware of the options.

Doctors, nurses and other professionals who can only work from a hospital base must begin to plan for the future they will face in an increasingly technically complex environment, taking the emphasis off what will be lost to what must be built to meet these new challenges.

The market

A critical factor in the reforms has been the introduction of an internal market. There are different mechanisms used to manage the market in every country in which it exists. In the UK, a major limit on the market is the existence of a *global budget*. This means that one institution's increased resources can almost always come only at the expense of another. There are some minor rules for dispute arbitration, price–cost relationships, etc., and, in some patches, purchasers have been able and allowed to shift service patterns. I use the word 'allowed' advisedly, because there are also many examples of purchasers who have felt that the political and institutional consequences of such shifts would be too severe. This has denied much freedom for the market to function.

Many say the market has failed, often for very different reasons: some because what they see as logical changes in service patterns have not occurred, and others because they have occurred and their institution has been hurt. Both of these interpretations are possible because there is not yet

a clear view of what this market is supposed to do. Markets have no inherent intelligence. They must be guided by decisions on the flow of money or by a regulatory framework to achieve the desired goals. Markets are, in a very real sense, a management tool, not a magic wand.

There needs to be a clear framework for market management that supports the development of a primary-care led service and we need to be clear who is responsible for managing it. The current functions review is presumably designed to achieve this. History aside, my own view is that Regions are very important as more locally sensitive agents of the NHS ME to manage a market using a clearly articulated policy framework agreed with Ministers that applies equally throughout the NHS.

The key is an agreement on the core policy elements and assurance that management actions are consistent with them, leaving the ways in which they are to be achieved to local people. Currently, the publicly stated elements in such a framework would be seen to be:

- improvement in population health status
- equity in access to care and allocation of resources
- value for money
- quality.

To achieve the goal of a primary-care led service, we might add the following:

- location of services as close to the patient as is medically safe and financially feasible;
- maximisation of effective linkages between services to facilitate most effective use by patients.

We should be able to expect leadership from the centre and the Regions through corporate contracts to guide the investment strategies of purchasers in the direction of these policy goals.

Centre and Regions must be prepared to allow local people to manage the political tensions that will be created in some situations of service closure or relocation, by supporting managers and health professionals working with their local communities to deliver the agreed agenda. Performance indicators must also be linked to the desired goals. Hospital-driven performance indicators alone will not work to support the development of a primary care agenda.

Progress should be also made to:

- eliminate barriers to the merger of FHSAs and DHAs. This is different from saying that all of them must merge; it provides the option for choice, depending on local circumstances;

- eliminate barriers to the merger of acute and community trusts – not to dictate that all must merge, but to allow those who feel it is in the best interest of achieving the desired model of care to do so;

- eliminate barriers or provide incentives for acute or community trusts to develop primary care satellite centres in the community that may wish to employ GPs and other primary care professionals as well as offer consultant out-patient sessions;

- address current barriers to more flexible GP contracts that fit local circumstances. Agree a national framework that preserves the strengths of general practice and incentives which make it attractive, but allows local flexibility for GPs to work with FHSAs, DHAs and Regions to strengthen general practice in their areas. If that means influencing the choice of contractors, location of practices, more flexible use of the non-cash limited budget, increased discretion for employing GPs and more flexible capital rules – most of which are now denied to them – then one must create the possibility that this can happen with mutual agreement of local GPs and NHS managers. This is the idea behind the London Initiative Zone (LIZ) zones designated for primary care development in London, and surely could be useful elsewhere in the country;

- address the policy vacuum in relation to GP fundholders. We see exciting and positive innovation, and the approach is bound to continue as an important engine for change, but we also see increasing concern that the differential access of their patients conflicts with an NHS principle of equity. In addition, the fact that they have no obligation to deliver on the population health agenda would seem to be inconsistent with a market framework that promotes purchasing for improved population health. The action needed here, unlike those above, may be to place some obligations on fundholders or link them formally to other purchasers in order to realign their work with NHS policy.

Health personnel and education

Any new vision for the health care system can only be reached if the people in it, especially those health professionals who will have to change their roles or change the ways in which they relate to others in the system both understand what is expected of them and are assisted, through training and incentives, to prepare for the new roles. In thinking through these workforce issues, it is important to have clear ideas of what the new ways of working will be. Plans cannot be based only on projections of the number and types of people we now use to do the things we now do. Or, at its most simplistic, if X beds close, we need Y fewer consultants and nurses. If GPs are asked to do more, we cannot just project additional numbers of them and practice staff, based on their current practice pattern.

Some have raised serious questions as to whether there can be a major shift towards community-based out-patient clinics, given the present number of specialists. This is perhaps a special issue for safeguarding in-patient coverage in busy DGHs, but raises challenges for the redeployment of any real excess specialists in major teaching centres.

A critical issue for teaching hospitals is the degree of active involvement of consultants in clinical care.[25] With reduced junior doctors' hours, more complex cases and increasing pressures for efficient movement of patients through hospitals, many feel that current consultants are inadequately involved in the day-to-day care of patients to provide proper supervision and efficiency. Thus, if current numbers of consultants per bed are taken as the basis for reductions, there could be serious problems. By the same token, consultants may need to be prepared to assume more intensive roles. There may also be issues for hospital nurses; as patients become sicker and students are increasingly expected to be learners rather than doers, demands will increase on professional nurses. Such issues must be addressed if there is to be a successful policy for shifting the balance of services further into the community *and* preparing for the hospital of the future.

Issues of similar urgency arise in the community base. Aside from the fact that many GPs already feel overburdened with new contractual responsibilities and paperwork, their roles could be changing even more dramatically, not from assuming specialty responsibilities, but coping with the future shape of general practice. Increasingly, general practice will be about chronic illness management, psychosocial and counselling issues, and preventive services that can only be provided through more extensive patient education. The current 5 to 7 minutes long consultation will not be workable.

Clearly, better use of other health professionals, especially clarification of the role and training of practice nurses/nurse practitioners can help, but extensive data on patient behaviour change indicate the power of the doctor's intervention in many of these areas. An example is coronary heart disease (CHD), the cause of 26 per cent of premature deaths in the UK and 2.5 per cent of all NHS spend. The four risk factors for CHD – smoking, increased cholesterol, high blood pressure and lack of physical activity – are all subject to health education interventions by primary care personnel, which must raise real questions about the best use of their time.[26] Similar issues could be raised about mental health complaints, sex education for teenagers, and increased involvement of patients in decision-making about their care using models like the Wennberg tapes.

The traditional work and roles of health visitors and district nurses also need questioning. If patterns of care shift in the future, these professional groups will need, for example, to emphasise home care, and patient and carer training to a much greater extent and with a much wider range of people and conditions than previously.

The shifting of health profession's education is a critical factor in preparing the workforce for a new primary care emphasis. At its most obvious, GPs have complained for some time that GP vocational training is still too hospital-based. If more specialty care is to be provided in out-patients and out of hospital, flexible training models for specialists will be necessary to make this possible. There are serious financial barriers to moving medical training into the community and these must be removed. Resources for faculty development will also be critical.

Research and development

As discussed earlier, there is much that can be done to shift services without waiting for the results of new research. We must focus adequate future resources on evaluating those shifts of service that are made for their effects on patient safety, quality and cost-effectiveness. Conducting such research in community-based environments will be very challenging to traditional researchers. The field of health services research is still relatively new in the UK and must be encouraged. We must also develop ways to provide for better dissemination of what we do know and methods of influencing practitioners to adopt changing patterns of clinical care. Investments will be needed in the developmental side of the R&D agenda. Recent initiatives from the ME Research Directorate are encouraging in this regard.

All this is an enormous task, but I want to emphasise again that much of it is happening on the ground already. Our challenge as managers and policy makers is to be clear that we are committed over the long term to reconfiguring a health care system to have its maximum impact on improving

population health. As we develop local partnerships between DHAs, FHSAs, all types of GPs and local authorities in order to assess and purchase against population need, we should also develop a shared vision of an integrated service system, one which links hospital and community-based providers into a primary care approach, shifting services as close to the patient as possible.

We must systematically identify those barriers that stand in the way of the needed changes – be they policy, financial, educational or attitudinal; and they must be removed to the degree possible. We must also assure that the necessary incentives are in place to retain and strengthen the very positive aspects of the current system in the face of change, especially general practice and community nursing. We must provide a positive, explicit vision of what this change will look like on the ground that is clear to patients and the community, and involves them in its development. Most important, we must assure that the little decisions we make every day lead us to the desired goal.

In a recent speech, Rosabeth Moss Kantor identified two requirements for real change: the bold stroke and the long march. Change towards a primary-care driven system is definitely a long march, but its achievement will put the patient and, hopefully, the community first – clearly a bold stroke for any health care delivery system.

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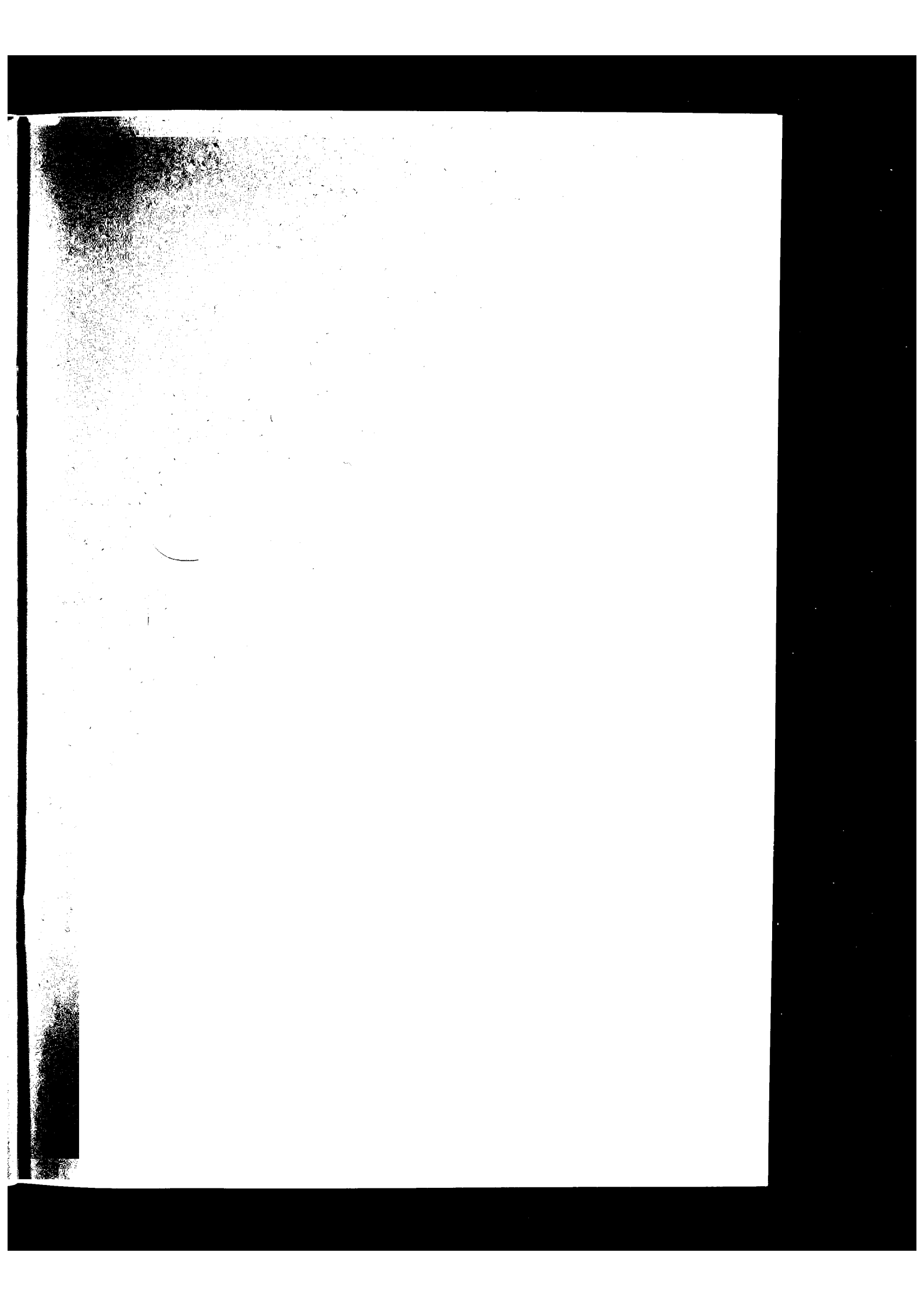

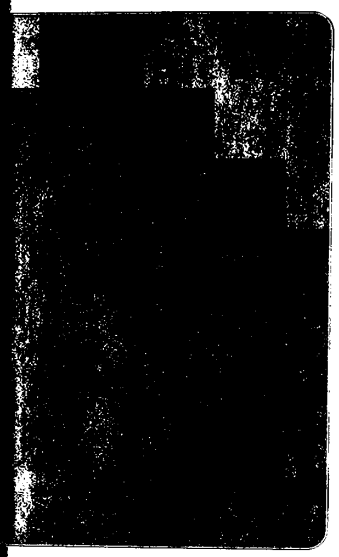

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