ISLE OF WIGHT HEALTH AUTHORITY

ASPECTS OF CURRENT DEVELOPMENTS IN HEALTH CARE IN FINLAND

A C Blee and Dr G Gent

SUMMARY

This paper describes impressions of some aspects of developments in health care in Finland formed during a visit to health departments and institutions in that country from 18 - 25th March 1990.

PREVIOUS DEVELOPMENTS

Finland has a long tradition of local administration: Local Authorities - "Communes" - were established in the 1860s and in 1979 each commune was required by statute to establish a Health Care Board for the supervision of Health and the provision of care. Government support to the Health Boards was provided from the 1880s.

Hospitals were maintained by the Government from the late 18th Century. Then, in the late 19th and early 20th Centuries the communes, or federations of communes, established more locally based hospitals. Later hospital development was led by the way in which TB hospitals developed: originally the voluntary sector provided care for TB patients. Then federations of communes formed TB districts and by the 1920s the Government was providing support for these hospitals. This model was extended to Mental Illness and eventually to the general hospitals. After the second world war it was firmly established that the local authorities were responsible for organising health care and that financial responsibility was shared by the local authorities and the Government. The development of the hospital service continued and between 1945 and 1975 approximately 19,000 general hospital beds and 11,000 psychiatric beds were provided.

Health Insurance was established in the 1960s to try to remedy the inadequacy of the primary care services, the failure of people to seek treatment because of high cost and the lack of sickness benefit.

By the 1970s other problems were coming to light:

- There was a need to expand health services and insufficient resources to do so:

- The system worked in favour of wealthy towns and cities and to the detriment of the less wealthy:

- More and more was being spent on hospital care:

- In particular, primary health care services were inadequate and inconsistent.

The general consensus was that these defects could be put right only through the development of national priorities and policies which would lead to a preferred redistribution of resources between primary and secondary care. This led to the Primary Health Care Act of 1972.

The main aim of this act was to deal with the problems mentioned above by shifting the emphasis to preventative and ambulatory care and to create the administrative and financial machinery for this to happen. The detailed implementation of the new primary care initiative was controlled through five year plans approved by government and through the subsidies from government and the local communes.

The Act worked: the number of Health Centre staff tripled in ten years, (Health Centres in Finland include "community hospital" beds).

Investment in primary care services and health centres has been made in those areas that needed it most.

Expenditure on primary care has risen from 10% to 30% of public health care expenditure.

This expansion of primary care services has not led to a great increase in total health care costs: just under 7% of the GNP goes on health care.

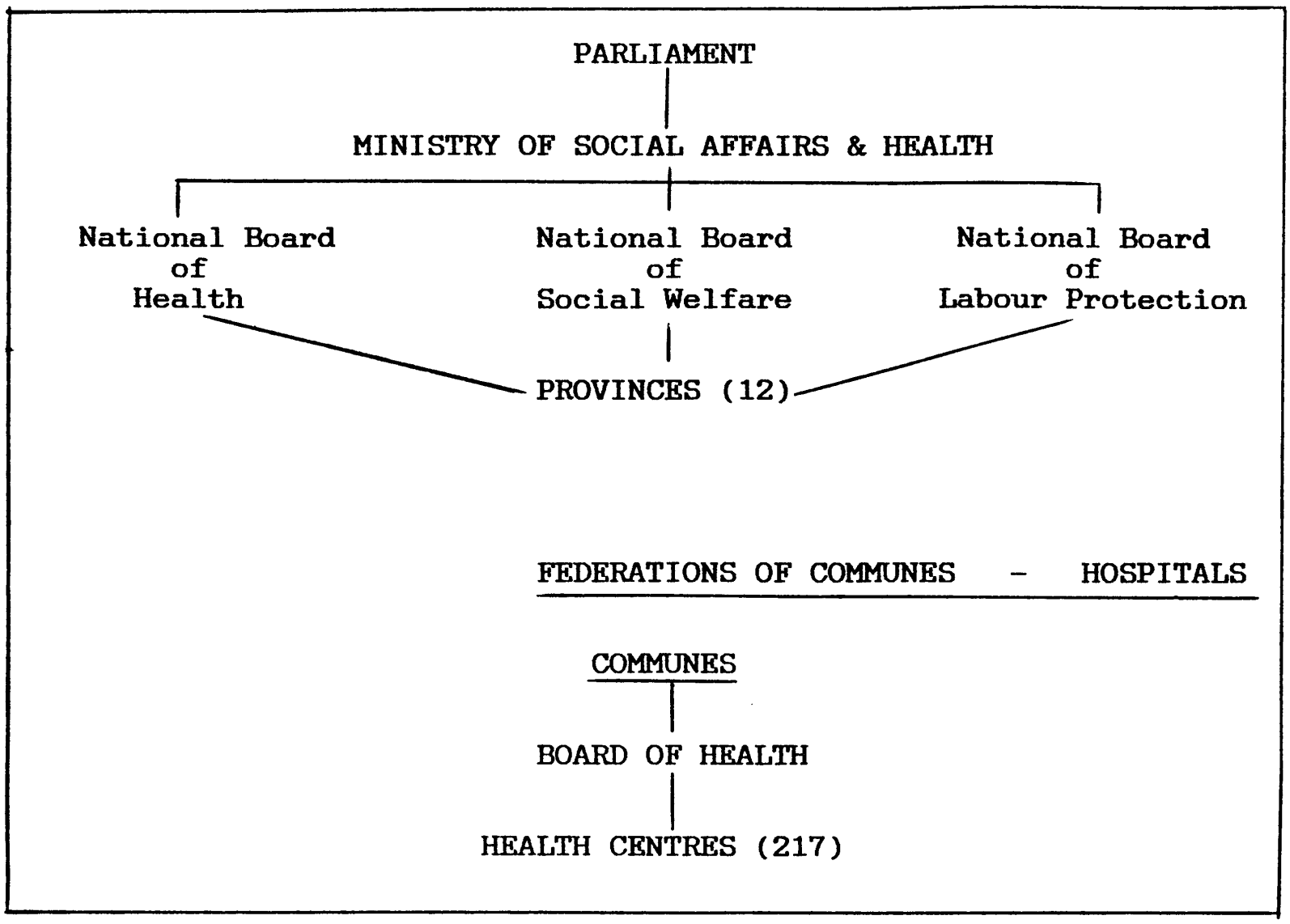
Local needs have been more clearly identified and strategic plans to meet them developed.

Although the 1972 Act was by any standards successful in overcoming the perceived problems at that time, those problems - not surprisingly - have been replaced with other problems which will be discussed later. Before doing so, however, it will be helpful to describe briefly the present organisation of health services.

THE ORGANISATION AND FUNDING OF HEALTH SERVICES

The structural organisation of the Finnish health system is shown in fig.1. The Ministry of Social Affairs and Health is accountable to Parliament. Accountable to the Ministry are - at present - the three boards of Health, Social Welfare and Labour Protection. Administrative responsibility is then devolved to twelve Provinces (Regions). Local care is the responsibility of the communes (Local Authorities) which combine to run hospitals. Each commune has a Board of Health which runs Health Centres. (Smaller communes combine).

FIGURE 1


PARLIAMENT
MINISTRY OF SOCIAL AFFAIRS & HEALTH
National Board of Health
National Board of Social Welfare
National Board of Labour Protection
PROVINCES (12)
FEDERATIONS OF COMMUNES - HOSPITALS
COMMUNES
BOARD OF HEALTH
HEALTH CENTRES (217)

THE NATIONAL BOARD OF HEALTH

The National Board of Health is about 300 years old and was originally, when Finland was under Russian rule, accountable to the Ministry in St Petersburg.

It is currently responsible for developing national policies and strategies and for approving the five year plans of the Provinces and communes concentrating on staff establishments and capital planning.

In 1991 it is to be merged with the National Board of Social Welfare and will assume an advisory role. There will therefore be a much stronger line of accountability from the Ministry to the Provinces. This move is regarded by many, particularly those working at the National Board, as leading to its eventual abolition with all control passing to the Ministry.

There is great political pressure to decentralise - "The Liberation of the communes" - and this, together with increased control by the Ministry, is giving rise to worries about uneveness of care developing again the possible destruction of central policies, eg, on mental health. As one official put it, "there could be too much emphasis on local independence rather than on local needs".

THE COMMUNES

There are 464 communes ranging in size from Helsinki with 800,000 (?) population, to an island with only 200 people. The smaller communes form themselves into Federations. A Communal Council is elected every four years. The Council establishes a Board for the various services - Health, Social Welfare, Education, etc.

Federations of communes are responsible for the provision of hospital care. There are 5 University hospitals and 21 central (Provincial) hospitals.

BOARDS OF HEALTH

There are 223 Boards of Health: about 80 are responsible to one commune, the remainder serving a Federation of communes.

FINANCING THE SYSTEM

On average, about 49% of Health Care is paid for by the State, allocated by the Ministry, 40% by the commune and 11% by the patients themselves and from private insurance schemes.

The State's share of hospital costs is at present paid direct to the hospitals. The local Boards of Health are not responsible for hospital care.

The Ministry allocates money according to the wealth of the commune, taking into account such factors as the average salary, the amount of industry, agriculture, etc., on a scale of 1 to 10, eg, 6 would mean that the state subsidy was 60%. The richest communes receive a subsidy of about 29%, the poorest about 67%.

The commune then raises a local tax - somewhere between 14 and 19% on individuals and on businesses within its area.

From 1991 the state money for hospital care will be given direct to the communes. This already happens for Education and Social Services. It will mean that the communes will be free to use whichever hospitals they wish, rather than being restricted to the ones in their own province or to their nearest University Hospital.

There is a well developed private sector with a considerable Government subsidy through the social insurance scheme that acts as an incentive for many people to use the private sector.

CURRENT PROBLEMS

Having achieved remarkable success with its Public Health Act both in remedying the problems that previously existed and in improving the health status of its population, particularly in maternity and child health services, Finland is now experiencing problems with its health services, some of which it shares with other developed countries and others which are peculiar to the Finnish system and country.

Some of the more significant problems arise, strangely enough, from the country's wealth. For, although the proportion of the GNP spent on health care is not that high compared with other countries, Finland is certainly one of the richest countries in the Western world. This has meant that many difficulties have been solved simply by putting more money into the system. For example, although primary care has grown as indicated above, this has not been at the expense of the hospital sector. Generally there has been a continuing expectation of growth. This has led to a very high standard of buildings and equipment, and, until recently, high staffing ratios. There appears, as a result, to have been very little emphasis on the management of the service or achieving value for money. With the state subsidy going direct to the hospitals, there has been no incentive for anyone, certainly not locally, to worry very much about hospital costs. Even the bill that has to be paid by the commune for its

population's hospital care is based simply on the number of bed days multiplied by the average cost per day in the particular hospital.

People throughout the service, and throughout the country, are becoming aware that they cannot go on like this. WHO has been invited, as part of the Health for All strategy to help analyse current problems and suggest solutions.

Examples of apparent current problems are:-

- Very little management of the service either nationally or locally with any initiatives (and there are some very good ones) depending on the natural ability of individuals. No management training.

- Shortage of staff - particularly professional staff. Many Health Centres are working with numbers of medical and nursing staff well below establishment.

- Growing waiting lists for surgery.

- High suicide rate.

- Growing numbers of elderly. Almost all the beds in Health Centres were occupied by the elderly. Very few Geriatricians.

- Alcholism - a far-reaching problems that is proving very difficult.

- Growing public awareness of health matters and pressure to provide more.

- The need to do something about the "Cinderella" services. Much of the care for the Mentally Ill and Mentally Handicapped is still institutional.

MATERNAL AND CHILD HEALTH

The population of Finland is approximately five million. The population is expected to decrease from the year 2000.

One of the greatest, and most well known, of the achievements of the Finnish health system, is the development of maternal and child health care services. Legislation in 1944 led to a comprehensive network of maternity and child health centres and a full programme of inoculation and prevention measures. In 1944 perinatal mortality was 34.9 per thousand and infant mortality 68.6. Today those figures are 6.8 and 6.1

Much of the improvement is due, as elsewhere, to the general rise in the standard of living and social development rather than pure health measures and, as one provincial official put it, "We have had no big catastrophes". Whatever the reasons, it is a very impressive result. (Full figures are given in Appendix 1.

HEALTH PROMOTION

Finland is also well known for its apparent achievements in health promotion and particularly for the North Karelia project and the apparent reduction in Coronary Heart Disease. The word "apparent" is used because much scepticism was expressed in Finland about the results claimed for this project - the general opinion being that the population of this particular area improved its standard of living and altered its dietary habits along with the rest of the population.

However, there is no doubt that the Finns put great emphasis on health promotion. Each Health Centre is required by statute to undertake health promotion and the norm is one full-time health promotion officer for 20,000 population. Health promotion is integrated into every contact, including mental health.

The occupational health system is used to a great extent for health promotion. Each company or business is required to provide occupational health services to its employees and they either organise their own service or buy it from the local Health Centre.

This provides an excellent opportunity for health promotion with the individual and also for building up local health profiles. About 2 million of the total population are covered in this way.

HEALTH CENTRES

Health Centres are the keystone of the Finnish health system and provide a focus for health care in each locality. The following descriptions of Health Centres visited may give some indication of the services provided and of current developments.

The Health Centre at Nurmijarvi serves a population of 27,000 to the north west of Helsinki. It has 45 beds and there are a further 126 beds for the elderly next door which are provided by Social Services. It also serves two other villages - one with 5,000 inhabitants and one with 10,000 - each with its own clinic and medical staff (3 in the smaller village, 5 in the other). It is the biggest Health Centre serving one commune.

Mother and Child Clinics are run in 5 areas run by public health nurses and midwives. There are 400 deliveries a year - all in hospital with a length of stay of 3-7 days.

The Health Centre has an establishment of 7 doctors but there are only 4 in post. There are also several vacancies for nursing staff. The total establishment is 185. A Consultant Radiologist visits from the hospital once a week. The centre has just started to carry out gastroscopies (again with a visiting consultant) and ultrasound will be started in the near future.

About 36 of the centre's 45 beds are occupied by the elderly and day care is provided. Only 8% of the total population of 27,000 is over 65.

Although the adjacent Social Services home is administered separately, there is close cooperation. Nurses carry out home visits and doctors also will visit all elderly people in their homes at least once a year. In some communes there is a combined Health and Social Services Board; this is a matter for local decision but most have kept them separate.

The Health Centre at Karhula on the coast to the east of Helsinki serves a population of 57,000. It serves three communes which formed a federation in 1977. It has a hospital adjoining it.

This is a rare example of an amalgamated Health and Social Services Board. The Board has a Social and Health Care Director.

Of the Board's 1988 budget, 50% was spent on hospital care, 20% on its own hospital and 13% on open care. There has been an increasing move to stop people going to hospital unless they really have to and the Director has saved about 20,000 patient days in the last 2 years. As yet there is no financial reward for doing this but from 1991 this will create extra funds for use locally.

Care of the elderly is well advanced and clearly benefits from Health and Social services being merged. A computerised information system maintains a register of individuals with incapacity and disability and is used to secure the most suitable placement and treatment for the individual.

There is nearby a group home for the elderly which is unstaffed at night but which has TV surveillance so that help can be sent in if needed.

At night an assistant nurse and a Home Help patrol the locality in a car with radio contact so that any emergencies at home can be coped with quickly.

There are two kinds of Home Helps; those with a two-year training primarily in the care of children but who are now used mostly

for the care of the elderly because of the workload; and those with six months' training who provide more basic care. The service includes weekends and a separate night team.

The day hospital is open from Monday to Friday from 8am - 4pm. It runs two groups twice a week (6 - 10 patients in a group) and one group once a week. The maximum period of attendance is three months and the patient has to have a physician's referral. The patient pays just under 7FM per day which includes transport costs.

Criteria for admission to the day hospital are:-

- Must be mobile - at least with a wheelchair.
- Able to adapt to the group.
- Able to care for self at home.
- No acute serious illness.
- Physically able to carry out daily activities
- Not unduly senile.

The day hospital aims to:-

- Assess, observe and treat the patient.
- Care for the patient's needs - food and hygiene.
- Provide a personal rehabilitation programme with occupational therapy, phsiotherapy, speech therapy and psychology.
- Provide the services of a social worker, aids, patients' benefits, domestic help.
- Provide social activity - games, handicrafts, theatre visits, picnics, etc.
- Provide transport.
- Provide respite care, if necessary.

The daily programme is:-

- 8am - 9am - Arrival and breakfast.
- 9am - 12 noon - Medical examinations, baths and treatments
- 1.30pm - Social Activities.
- 2.30pm - 3pm - Transport Home.

The Health Centre at Varkhaus serves a population of 25,000 in an industrial town about 300 miles to the north of Helsinki. 13% of the population are over 65.

The Health Centre - the responsibility of the local Health Board - is on the same site as a hospital which is the responsibility of a different Health Board, so the greatest cooperation in the provision of services. The hospital was built in about 1960 and the Health Centre was added in 1984.

The Health Centre provides primary care services plus 110 chronic beds, a 15 place day hospital and a first-aid station.

The hospital has 142 beds:-

Internal Medicine (CCU-4)	43
Surgery	43
Obstetrics and Gynaecology	32
Ophthalmic	6
ENT	4

The average length of stay is 6 days compared with 128 days in the Health Centre.

As in Karhula, the Health Centre runs the pernal doctor scheme (see below).

The shortage of doctors was acute here - only 10 in post against an establishment of 24. This means that patients could wait up to 6 weeks for a "general practitioner" appointment. The effect of this was that more people were using the private sector.

The Centre had an active health promotion programme and took one general topic, eg, Outdoor Activities or Health and Human Relations, on which to base its programme for the whole year. The cholesterol level in the population is 10% less than it was 5 years ago, but it was admitted that this could be due to a general change in eating habits rather than as a result of a specific programme.

The Health Centre had a comprehensive information system - Finnstar - which is based on Costar (Computer Stored Ambulatory Record). This stored the patient's complete medical record and had a useful security device that made it possible to identify everyone who looks at a particular record.

THE PERSONAL DOCTOR PROGRAMME

For some years now Finland has been carrying out studies with a view to introducing a personal doctor programme throughout the country. The previous - and in most places current - system meant that the patient might be seen by any of the doctors working in the Health Centre and consequently there was little continuity of care. At present about 20% of patients have seen the same doctor on a previous occasion.

The personal doctor programme works similarly to the British system in that the population is divided up into segments of 2,000 and patients are assigned to a particular doctor. The patient is at liberty to request to go on another doctor's list.

Generally the programme is welcomed by the patients because they receive continuity of care and by the doctors as it saves them time and allows them to be more flexible in their methods of working.

CONCLUSIONS

The Finnish health system offers some interesting comparisons and parallels with our own system, particularly as we go into a period of major change. Much of the Finns' experience is reassuring in that it confirms that we are on the right lines. Much of it too serves to show that there is no panacea and that managing health services is complex.

The first encouraging aspect is that money does not solve all the problems. The Finns have very high standards of buildings and equipment which we in this country would envy. However this does not guarantee that health care will be any better and it does seem to have led them into a situation where they are not making the best use of resources.

This in turn has led them to ignore management and management training; as things get more difficult they are realising the need to put this right.

They too are struggling with the problem of how to run a National Service while, at the same time, allowing maximum local discretion. The planned change in the funding of the service so that local authorities have the ability to buy the most cost-effective service for their population is very similar to our plans for the specification and contracts for services. Hospitals there feel very threatened because of the sudden need to become or remain competitive.

Their personal doctor system is, or will be, very similar to our own. The big difference is that they have the problems of the salaried service with their doctors very conscious of their 37hr week.

APPENDIX 1

1.12.1989

Births, maternal mortality, perinatal mortality and infant mortality in Finland 1936-1985

Year	Number of births	Number of mothers died in delivery or pregnancy complications	Maternal mortality per 100 000	Perinatal mortality per 1 000	Infant mortality per 1 000
1936	69 602	374	537	43.1	65,9
1937	72 919	364	499	42.8	68,6
1938	77 342	330	427	43.0	67,8
1939	78 592	314	400	39.8	69,7
1940	66 105	314	475	39.8	88,3
1941	90 050	308	342	36.9	59,2
1942	62 111	263	423	36.1	67,3
1943	76 479	314	411	34.9	49,5
1944	78 817	352	441	34.9	68,6
1945	96 271	385	400	37.2	63,2
1946	106 488	283	266	35.1	56.2
1947	108 684	232	213	34.6	58,5
1948	108 163	186	172	34.2	51,9
1949	103 859	161	155	34.0	48,3
1950	98 432	143	145	34.5	43,5
1951	93 402	113	121	33.3	35,4
1952	94 568	118	125	34.0	31,8
1953	90 990	121	133	33.2	34,2
1954	90 033	96	107	32.7	30,6
1955	89 876	94	105	33.0	29,7
1956	89 087	66	74	31.9	25,7
1957	87 134	77	88	30.4	27,9
1958	81 246	81	100	29.9	24,6
1959	83 351	56	67	29.4	23,6
1960	82 197	59	72	27.5	21,0
1961	81 918	45	55	27.5	20,8
1962	81 345	42	52	27.0	20,5
1963	82 112	41	50	24.6	18,2
1964	80 288	34	42	24.5	17,0
1965	77 808	20	26	23.6	16,7
1966	76 493	24	31	21.5	15,0
1967	77 049	16	21	20.9	14,8
1968	73 479	21	29	19.7	14,4
1969	67 261	10	15	18.8	14,3
1970	64 295	8	12	17.0	13,2
1971	60 817	5	8	16.5	12,7
1972	58 639	7	12	16.9	12.0
1973	56 540	6	11	14.8	12.0
1974	62 227	3	5	14.6	10.6
1975	65 343	7	11	12.4	11.0
1976	66 484	6	9	11.4	10.0
1977	65 278	5	8	11.2	9.2
1978	63 578	2	3	9.4	8.8
1979	63 015	4	6	9.3	7.8
1980	62 624	1	2	8.4	7.7
1981	63 038	3	5	7.9	7.6
1982	65 635	3	3	7.4	6.1
1983	66 425	2	3	7.4	6.1
1984	64 629	1	2	7.6	6.6
1985	62 311	4	6	7.3	6.3
1986	60 157	4	7	6.4	5.9
1987	59 812	3	5	6.8	6.1

MV/M/mmp

Snakes and ladders

Introducing case management may be a solution to the fragmentation of service provision, but has the Government thrown an ill-conceived notion into the cap of SSDs?

By Edward Peck, lecturer in management, health services management section, University of Newcastle

And Ingrid Barker, policy advisor (mental health), Northern Regional Health Authority

On reading *Caring for People*, one could be forgiven for thinking that the implementation of case management is one of the central planks of the Government's strategy to develop community care services.

Interest in aspects of case management has been evident in a train of government reports since the Short Report recommended a system of individual care plans *(HMSO 1985 para 45)*. The Audit Commission reflected on the need for an individual responsible for a single budget *(HMSO 1986 p75)*, while Griffiths recommended a more thorough going case management system *(HMSO 1988 para 3.8)*.

So it is not surprising that in *Caring for People* we find the proposal that case managers be appointed 'to take responsibility for ensuring that individuals' needs are regularly reviewed, resources are managed effectively and that each service used has a single point of contact' *(HMSO 1989 para 3.3.2)*.

The core functions of the case manager as understood by American writers and largely reflected in government thinking are: assessment of client need; development of a comprehensive service plan; arranging for services to be delivered; monitoring and assessing the services delivered; and evaluation and follow up of the client.

So what has made case management so attractive to policy makers?

It provides a means of co-ordinating fragmented services and ensures that comprehensive services will be provided for an individual and will be adapted to meet their needs over time. It can also be seen as a means to increase accessibility, accountability and cost effectiveness of services *(Intagliata, 1982)*.

At a time when much political embarrassment is caused by publicity claiming that 'cardboard cities' are populated by people who have fallen through the mental health services net, a system which makes an individual worker responsible for ensuring services are provided to a particular client must be of considerable political interest.

Yet, since its publication, the White Paper's emphasis on case management is being underplayed on two main fronts. First, advice from the Social Services Inspectorate seems to suggest that case management should not be seen as a priority by social services departments and that its implementation will not be mandatory. Second, the Department of Health's delay in issuing its case management circular together with informal mutterings in the corridors of power suggest that case management has slithered down the political agenda.

Here we are seeking to identify the issues which may have led to this sudden decline in the fortunes of case management and to reassess its value as a tool for implementing community care.

Firstly, case management is not a panacea. The White Paper frames the policy of community care in such a way that it avoids giving offence to the lobbyists concerned that hospitals are being closed without adequate alternatives being in place. '...The number of hospital beds should be reduced only as a consequence of the development of new services.' *(HMSO 1989 Ch7.)* Yet it remains the case that the Government is committed to hospital closures. One of the worries about case management might be that it slows down this closure process. Without a very wide range of services available outside institutions we may find ourselves with patients ready to leave hospital who cannot do so because their individual service plan is not yet realisable.

Intagliata puts the point succinctly: 'Since case management is primarily a service linking and co-ordination function its impact ultimately depends on the availability of the needed services.' *(Intagliata, 1982, p664.)*

Secondly, case management is ideologically fraught. Every public service design reflects the interests and assumptions of those involved in its formulation and implementation. Case management is no exception. We see the ideological battle played out in the variety of models of case management evident both in Britain and America.

For instance, one model is of a clinician as case manager. The case manager continues to hold a clinical case load and this role as service provider will influence the referral procedure, assessment methods, the kinds of services bought and the basis for evaluation. The case management role is not independent of clinical judgement and arguably shows a tendency to guide the client into the clinician's view of what is best. In a sense, then, this model is quite controlling.

On the other hand, take a model where the case manager is not part of a clinical team but operates primarily as a purchaser. At its best this offers a wider perspective on the core functions of assessment, package development and evaluation. The freedom from practitioner interests should make this model more enabling to the client.

So there is an ideological conflict between models which are clinical/controlling in nature and those which are administrative/enabling. This conflict is to some extent mirrored by the

split made in the White Paper between health and social care needs. At the moment, the DoH seems to be leaning toward a 'clinicians as case managers' model which defers to medical concerns in particular, but which is a disappointment to those in the field who see merit in a more deprofessionalising outlook.

Current thinking in the DoH on case management for people with mental health problems seems to suggest a consultant led model which will protect the last vestiges of the myth of medico-legal responsibility.

Thirdly, case management presents staffing difficulties. Most literature on case management suggests that the two professions most likely to take on the role of case manager are social workers and community psychiatric nurses. In both these professions there are already recruiting difficulties because of shortages of trained personnel.

Where a budget holding model of case management is being considered, there may also be some resistance from social workers, who have already shown their unwillingness to take financial responsibility under the Social Fund. Without adequate resources for training, the case management initiative could be reduced to existing staff being relabelled as 'case managers' without having an understanding of the role or the new skills (for example contract negotiation) needed to undertake it effectively.

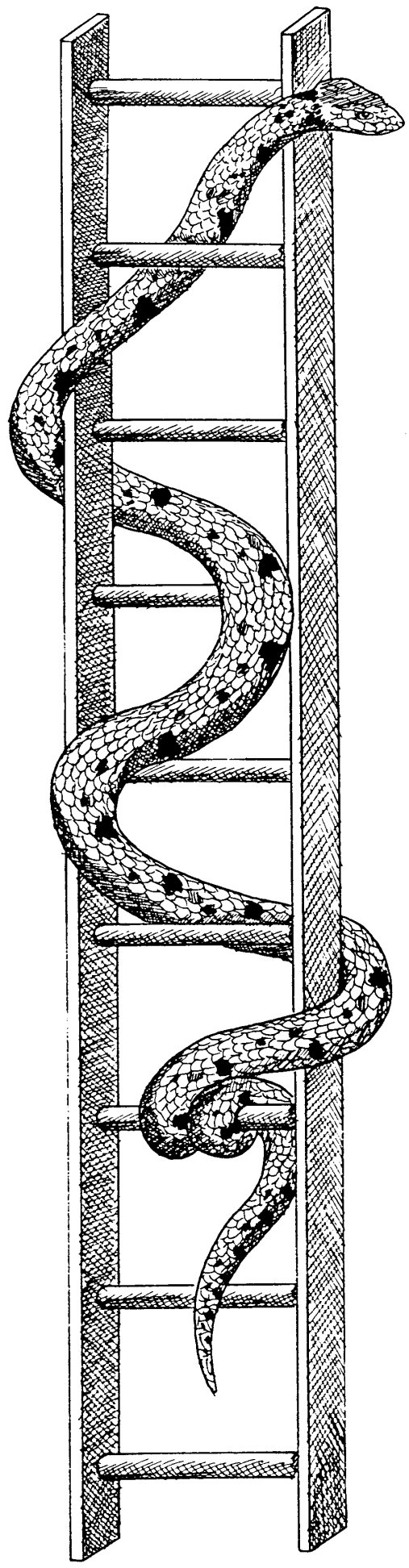
There is little evidence to suggest that the Government had given consideration to those important staffing issues when case management was proposed in the White Paper. Health Minister Virginia Bottomley recently failed to commit the Government to funding the training implications of the White Paper for local authorities, which indicates some reticence to provide the resources necessary for case management.

Finally, case management further complicates contracting. The connection between case management and contracting is central to the White Paper. The first connection is between assessment of individual need and assessment of wider patterns of need. The aggregation of these individual assessments should provide the basis for purchasers to formulate contracts for services.

It is therefore crucial that these individual assessments assess actual need rather than merely the client's suitability for current services.

The second connection is more problematic. It is the link between the case manager as co-ordinator of individual services and the purchaser of blocks of services, made more complicated where the case manager is actually a budget holder. The difficulty is in reconciling the proposal that case managers should buy customised services for individuals outside of the macro contracts negotiated by purchasing agencies.

Thirdly, there is a connection between the case manager as the person monitoring individual service packages and the purchaser as the agency responsible for ensuring contract compliance.



Given the nature of the other White Paper, *Working For Patients*, it is clear that the Government's primary interest is in establishing a contracting system on a macro level. Should case management appear to complicate the major purchasing roles of assessing, buying and monitoring services then it may be seen as politically expendable.

So is case management just an optional extra in the community care developments of the 90s? In the Government's view this is possibly the case; but then there does not seem to have been any detailed thinking behind the White Paper enthusiasm for the approach. Case management may have been adopted as an off-the-shelf solution to problems of fragmentation and accountability, but it is a more complicated initiative than was realised.

However, in our view the benefits of case management as a means for delivering customised, rather than block, services make the complications worth struggling with. There are a number of practical issues which need to be dealt with before progress can be made.

- Organisational: The American literature is unequivocal in suggesting that successful case management systems depend upon being implemented as an integral part of a comprehensive service design. This involves defining roles and relationships between agencies at a senior level as well as in relation to the case manager herself. Systems that are 'tacked on' to existing hierarchies rarely succeed in achieving the full potential of case management.
- Staff & Status: If case managers are to negotiate effectively then they need to have authority both in terms of their skills and their standing in the service system.
- Training: There is no professional group which currently has all the skills and experience necessary to perform the case management role. Resources for training are therefore essential.
- Evaluation: Since the outcome of the case management effort needs to be measured in terms of its impact on service users, evaluation should be considered at the development stage and its means built on to the system.

Public concern as orchestrated by relatives' pressure groups has focused on the plight of individuals who have lost control with services.

The conclusion of these groups is that the closure of hospitals should be halted. This is not one currently shared by the DoH.Nevertheless, if service providers are unable to guarantee through a system such as case management that such neglect is a thing of the past, then a future government might see fit to reverse the community care policy.

References

Second Report from the Social Services Committee (Session 1984-85), HMSO 1985.
Audit Commission Report, *Making a Reality of Community Care*, HMSO 1986.
Community Care: Agenda for Action, HMSO 1988.
Caring for People, HMSO 1989.
Intagliata J. *Improving the Quality of Life of Community Care for the Chronically Mentally Disabled: The Role of Case Management*, Schizophrenia Bulletin, Vol 8, No 4, 1982.