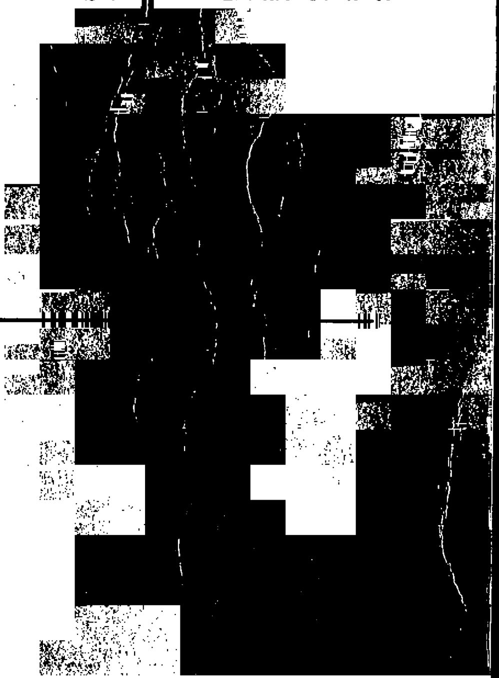
HEALTH CARE UK



1994/95

HEALTH CARE UK
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an annual review of health care policy

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Health Policy Review 1994/95

Part 1 Main Events

A critical account of the main policy developments during 1994/95.

1.1 Creating the New NHS

The transformation of the NHS providers into trusts was virtually completed while GP fundholding continued to grow. But that very success raised questions about the accountability of GPs and also the administrative costs of fundholding. Within London, the Government announced a series of changes to the way that hospital services are provided, but some plans for change were put on hold.

1.2 Community Care

Further evidence emerged as to the impact of the reform of community care. Some of it supported the Government's view that the changes introduced in 1993 have been successful. Other evidence suggested they were not. This was particularly true of mental health, where a number of specific incidents showed that the community support network was not functioning properly.

1.3 Public Health Strategy

A number of monitoring reports appeared during the year which gave different degrees of comfort for the Government's attempts to promote *The Health of the Nation*.

1.4 Serving the Consumer

Extensions to the Patient's Charter were announced but monitoring of some of the existing standards showed that there were numerous shortfalls. The Government accepted the need to change the way that complaints were handled and it took positive measures to promote choice in maternity care but not so far in other services.

Part 2 Commentary

2.1 Efficiency and Finance

The Government's basic approach of trying to extract more care per pound spent remained unchanged. Issues continue to emerge at the 'margin' of the NHS, particularly long term care.

2.2 Accountability

Financial scandals continued to emerge but this time within primary care. Although the Government took steps to promote financial accountability in all parts of the NHS, the main focus of debate on accountability has shifted towards the professional end of the spectrum and the need to ensure that clinical practice rests on a secure knowledge base.

2.3 Equity

The Government accepted the need to change the formula for allocating financial resources to different parts of the country though it did not go as far as it might. It also took a tentative step towards considering the implications of differences in health status between different social groups.

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After some four years of the new NHS it is time to take stock. But not only are satisfactory measures of success hard to come by but the terms in which success should be measured are not clear.

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A list of the main events in 1994/95.

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by Angela Coulter
The Government's commitment to an explicit research and development strategy can be welcomed but whether it can be implemented successfully is another matter.

Economic Regulation and the NHS Market
by Carol Propper
The NHS is already tightly regulated. But new forms of regulation are required if the benefits of an internal market are to be realised.

Health Care for All? How to Take Equity Seriously
by Michaela Benzeval
Equity is a long standing objective for the NHS but some evidence suggests that some groups do not enjoy the access their needs would suggest they deserve. A range of measures may be used to reduce barriers to access but their use must be based on careful analysis of the reasons why utilisation rates vary.

Long Term Care: Who is Responsible?
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The Government responded to the Health Service Commissioner's report on the Leeds case with new guidance on the role of the NHS in continuing care. But there are grounds for arguing that it is not sufficient to clarify precisely where responsibilities lie.

Service Development: Conflict and Consistency
by Anthony Harrison
In recent years the Government has taken a wide range of policy initiatives running right across the health and social care sector but there are signs that in some areas they are inconsistent with each other. There are a number of ways of reducing conflicts of this kind, but if they are to be successful they require an understanding of the scale and nature of interdependence between different parts of the health and social care sector.

Attitudes to Health Services 1983–1993
by Nick Bosanquet and Anna Zarzecka
The British Attitudes Survey has monitored people's views of the NHS since 1983. These vary between parts of the country and between social groups. Furthermore, changes over the ten years show regional and other differences.

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PART 1: MAIN EVENTS

This years Review follows the pattern of previous year's by examining the events of the year in four key policy areas:

- creating the new NHS
- promoting community care;
- promoting public health
- promoting the interests of users

The second part of the part also adopts the framework of previous years, looking at developments within the broad areas of finance and efficiency, accountability and equity.

1.1 Creating the New NHS

The implementation of the 1990 Act began in 1991 with the creation of the first round of trusts and a few GP fundholders. Each year since then further trusts have been created so that, by the end of 1994, the new structure for provision of hospital and community health services was almost complete, with just over 400 trusts responsible for the provision of hospital and community health services. In March 1995, a near final tranche of 21 trusts was announced bringing the total to 433 at 1 April 1995. As a result, virtually all NHS provision of hospital and community health services is now the responsibility of trusts.

The number of GP fundholders also continued to grow: see Table 1. As from April 1995, a further 1,300 general practitioners in 500 practices became fundholders, bringing the number of fundholding practices to over 2,500, involving around 10,000 GPs and covering over 40 per cent of the population. In addition, their potential role was enlarged. In September 1994, speaking at the Conservative Party Conference, the Secretary of State announced that fundholding was to be extended in several ways, designed to achieve:

> *a primary care led health service in which decisions about healthcare are taken as close to patients as possible. Teams of health professionals based in GPs' surgeries or new health centres are the focal point of the modern NHS. This is a practical way in which we are putting quality and patient choice first. GPs and their teams are closest to patients: they are best placed to shape services according to patient needs.*

The new arrangements set out in *Developing NHS Purchasing and GP Fundholding* EL(94)79 envisage three levels of fundholding:

- expansion of the existing scheme for practices with 5,000 patients or more to include specialist nursing services such as diabetic and stoma care and virtually all elective surgery and outpatients;
- experiments with total fundholding with 25 groups of practices each serving at least 30,000 patients; and
- community arrangements for practices with 3,000 patients or more to purchase staff, drugs and diagnostic tests, and community health services with the exception of mental illness and learning disability.

Subsequently, the number of pilot sites for total fundholding was raised to over 50, with most starting in April 1995 on a two-year pilot programme which, unlike the earlier stages of fundholding, will be assessed by centrally commissioned research.

GPs do not yet purchase the majority of health care services. Apart from the experiments already underway with total fundholding, fundholding GPs only control a fraction of the total budget for hospital and community health services. The more expensive services and a range of other treatments are still funded by district health purchasers. As Table 2 shows, the average budget per patient has been rising as the scheme has been extended and is now £150 over England as a whole.

This further extension of fundholding clearly undermines the role of district health authorities. The circular announcing the changes emphasised that the new joint authorities created by the merger of districts and family health services authorities would continue to have an important role in three areas:

> *Strategy: the new joint authorities are charged with developing strategies to meet national and local priorities. They remain responsible for public health functions and for establishing a local population perspective of health and health care needs. They are also expected to involve the public in developing local strategies and to increase public understanding of health and health care issues.*
>
> *Monitoring: they are to advise on budget allocations to GP fundholders and ensure that the way GPs fulfil their providing and purchasing role is in the interests of local*

Table 1: Number of Funds

	1991/92	1992/93	1993/94	1994/95
Northern	27	38	69	84
Yorkshire	34	59	108	133
Trent	28	58	138	212
East Anglian	9	13	48	78
North West Thames	22	43	88	105
North East Thames	13	23	48	71
South East Thames	15	28	77	143
South West Thames	21	39	66	116
Wessex	17	34	54	85
Oxford	25	46	74	107
South Western	20	38	69	100
West Midlands	26	58	131	219
Mersey	21	46	84	101
North Western	16	29	66	110
England	294	552	1120	1673

Source: House of Commons written answers, 21 July 94

Table 2: Estimated Average Budget Allocations per patient made by Regional Health Authorities to General Practitioner Fundholders 1991/92 to 1993/94

Region	1991/92	1992/93	1993/94
		£s	
Northern	130	140	170
Yorkshire	120	140	160
Trent	110	120	140
East Anglian	120	130	160
North West Thames	110	120	160
North East Thames	110	100	130
South East Thames	100	110	150
South West Thames	100	110	140
Wessex	110	130	150
Oxford	100	110	130
South Western	100	120	150
West Midlands	120	130	150
Mersey	110	130	160
North Western	110	120	150
England	110	120	150

Source: House of Commons written answers, 20 July 94

people and also that national policy and local strategy are implemented effectively.

Support: they are to provide support to GPs through advice, investment training and provide information to support GP purchasing.

These roles look less substantial than what were laid out when the 'new' NHS was created; the reason for this is the growth of what was originally an experimental form of purchasing – GP fundholding – and the perception that it has been more effective in terms of the original objective of the purchasing function of relating services to need. The National Audit office report, *Contracting for Acute Health Care,* could find little evidence of impact from district level purchasers, in large measure because of the poor information available to them; among other recommendations, it proposed greater GP involvement in contracting.

The rhetoric of fundholding – decisions to be made closer to needs – giving family doctors freedom to

Effects of Fundholding: National Audit Office Survey

What improvements in service, if any, have been obtained through practice contracts?

	Achieved	Not Achieved %	No Change Needed	No Reply
Information:				
Faster response to GP enquiries	54	19	24	3
Faster receipt of discharge letters	54	38	4	4
Agreed protocols for referrals	40	36	19	5
More informative discharge letters	45	41	11	3
Diagnostic Services:				
Reduced waiting time for X-rays	43	12	41	4
Faster reporting of X-ray results	39	24	36	1
Faster reporting of pathology results	48	8	43	1
Other:				
Fewer follow-up outpatient attendances	49	40	7	4

What new services, if any, has the practice set up or planned to provide in the practice premises?

	Provided %	Planned
Consultant outpatient clinics	54	25
Counselling	59	15
Physiotherapy	62	10
Minor surgery (Non-general medical services)	37	19
Chiropody	33	16
A wider range of diagnostic tests	20	15

What improvements in service, if any, have been obtained through practice contracts?

	Achieved	Not Achieved %	No Change Needed Or No Reply To Question
Reduced waiting times:			
For non-urgent first outpatient appointments	70	23	7
For non-urgent hospital admissions	66	26	8

Sources: National Audit Office; *General Practitioner Fundholding in England*

innovate is, to some degree, matched by achievement. The freedoms and scope for independent action created by fundholding have led to improvements in existing services and the development of new ones. Last year, the Review cited some results of the work done by Howard Glennerster and his colleagues at the London School of Economics. In December 1994, the National Audit Office published the results of its investigation *General Practitioner Fundholding in England* which looked at the impact of fundholding on patients, budget setting and accountability. The findings with respect to the first of these are set out in **Effects of Fundholding**.

Over and above such direct patient benefits, fundholders were reported as making savings of £64 million during 1993/94, or 3.5 per cent of their budgets. In announcing these savings, the Minister for Health, Gerald Malone, was at pains to emphasise that such savings would benefit patients, while ignoring the benefits that GPs themselves may be able to realise through the enhanced value of their practices:

> *Fundholders are not only improving services, they also made savings of £64m in 1993/4. This is about 3.5 per cent of budgets set and is similar to the levels of efficiency savings made by fundholders in the first two years of the scheme.*
>
> *These savings do not disappear into GPs' pockets or a black hole in Whitehall. They are used to benefit patients in many different ways, such as buying new equipment, more hospital care or improving premises. It must be right to encourage GPs to prescribe more effectively, as fundholders are already doing. There are of course clear rules on what fundholders can and cannot use their savings for. The bottom line is that it must always be patients who see the benefits and up and down the country this is the case.*

The more widespread GP fundholding becomes and the greater its coverage of service, the greater the number of factors that have to be brought into account when evaluating its benefits. One such area is accountability. GPs are independent contractors: their contracts are broadly drawn, giving them massive scope for exercising discretion in the way they use the resources at their disposal, a discretion which they are currently able to use without being called to account. Recognising this, the Secretary of State announced in October that steps would be taken to plug this gap; the proposals are described in Part 2.

Another area of concern, not least for GPs themselves, is the amount of administration they have to carry out, whether fundholders or not. Recognising this, the Secretary of State announced in December an efficiency scrutiny into bureaucracy in general practice, with the following terms of reference:

- *to identify achievable reductions in the administrative burden associated with the work of contemporary general practice; and to recommend action which will eliminate unnecessary bureaucracy;*
- *to suggest ways in which general practice and health authorities can be helped to deal with necessary administration more efficiently – including, where it is appropriate, the need to build a consensus for change and to develop the skills required for its effective implementation.*

However, while at the moment the tide seems to be running ever more strongly in favour of fundholding, it may perhaps turn as the implications of extending it become clearer. Some health authorities, or commissions as they are now more commonly described, are already offering some of the benefits of fundholding to GPs without the administrative hassles. A NAHAT report, *Shared Purchasing*, suggested that:

> *Where there has been little or no collaboration between GPs and the health commissions, services risk becoming fragmented. Where there has been a maturing of purchaser relationships, there is a recognition that the roles are complementary and that this calls for co-ordination of activities. As collaboration between the commissions and non-fundholding GPs develops and produces tangible results, so the incentive for those practices to become fundholders reduces. However, commissions need to ensure that the beneficial effects of fundholding can likewise be achieved under these arrangements.*

Several collaborative models are described in the study and some are in use in different parts of the country. Thus, the results may be that, even without a change of Government, the transition to fundholding may, like direct grant status for schools, peter out. In Chris Ham's words (British Medical Journal, 22 October 1994):

> *Although great strides have been made in improving primary care services, standards remain variable. This should not deter well organised practices from assuming greater responsibility for the care of patients, but it casts doubt on the ability of general practice as a whole to perform the functions envisaged by ministers. Unless a major effort is made to tackle this issue the vision of an NHS in which purchasing is truly led by primary care will remain unfulfilled.*
>
> *All of this suggests that reports of the death of health authorities may be premature. The reality is that purchasing will continue to develop in various ways, and no single model is likely to prevail.*

One of the reasons why the Government has sought to expand fundholding is undoubtedly that it has had some discernible impact. When the idea of free-standing purchasers was first introduced, the theory was that they would make their own assessment of local needs and purchase accordingly. In general, that model has not worked. The link between needs analysis based on population characteristics the known incidence of different conditions and what an acute hospital and community health service actually does is far from clear. Furthermore, as the Health Committee discovered in its investigation into priority setting, purchasers are not able to choose between the merits of different spending options:

> *In our analysis of . . . 100 purchasing plans [Professor Klein and his colleagues told us] we did not come across a single example of a commissioning authority deciding among competing spending options by comparing the 'health gains' they offered or by using cost utility analysis ... This omission indicates not perversity or inadequacy on the part of commissioning authorities but the difficulties involved in cost utility analysis to determine priorities.*

What providers respond to is work 'coming through the door' and the pressure imposed by the Executive from 'above' to do more day surgery, to reduce waiting times for elective operations and to increase activity in line with the centrally imposed efficiency targets. Thus, it is hard to demonstrate that purchasers have been able to influence the 'mix' of care provided, except through their attempts to meet national targets. As a result, the suspicion arises – proof is not available – that clinical priorities have been unjustifiably distorted.

A striking example of the weakness of the link between needs analysis and hospital activity began to emerge during 1994. For some time before that, acute providers were noticing an increase in emergency medical admissions. Needs analysis shed no light on why this was occurring but for both purchasers and providers of hospital services it was a most important development, threatening to drive providers into deficit and undermine the achievement of targets for elective surgery.

During 1994, a number of studies were made aimed at explaining why emergency admissions were rising, and the NHS Executive carried out an investigation of its own. That, based on a small sample of provider units, suggested that there was no cause for concern. Other studies, summarised in a NAHAT briefing paper, *Emergency Medical Admissions*, gave a different impression. But neither could demonstrate conclusively why, at least in some areas, emergency medical admissions were rising rapidly. In that sense, purchasing as an intelligence function has proved ineffective.

Management Structure

As foreshadowed last year, change in the administrative arrangements for managing the NHS was taken a stage further. Following on from *Managing the New NHS*, three reports were issued in July 1994 which took the process of restructuring the management further.

The first of these, *Functions and Responsibilities in the New NHS*, essentially confirmed the conclusions of the earlier review that the existing regional health authorities should be abolished and be replaced by a single structure for central management comprising an NHS Executive HQ and eight regional offices, and that district health and family health services authorities should be merged. The second, *The Review of the Wider Department of Health* (known as the Banks review), proposed a series of changes within the Department of Health and the NHS Executive, and the third, *Public Health in England*, focused on the arrangements for that function. We concentrate on the first of these here as it has most bearing on the future development of the NHS.

The Functions review confirmed the Government's commitment to the new arrangements, the heart of which is the purchaser/provider split. It also confirmed a commitment to competition stating that the NHS has to have:

- a market structure that is competitive;
- good information on prices and quality;
- providers motivated to be efficient and purchasers motived to act on behalf of users;
- price structures which limit the opportunities for providers and purchasers to choose patients on the basis of costs of services rather than need.

It went on to say that regulation should:

- promote competition wherever possible and regulate only where competition is not feasible;
- be clear and consistent;
- take into account the different amounts of information available to the regulator and to market participants.

What all this is to mean in practice, however, remains far from clear. The review was not accompanied by any analysis of the factors which might determine the extent to which NHS providers could be in competition and what specific measures might be needed to create competitive conditions. The new arrangements clearly envisaged that trusts' access to capital will continue to be controlled by the Executive, to which they must continue to present their business plans and business cases for specific new investments, despite the fact that they are being actively encouraged under the private finance initiative to borrow from and work with the private sector.

Furthermore, the Review did not envisage the introduction of a compulsory tendering process for clinical services comparable to that introduced in the early 1980s for ancillary services. The amount of competitive behaviour in this area so far has been limited: only a small proportion of providers have experience of competitive contracts for clinical services; the vast majority of clinical services remain unaffected.

Thus the central question, identified in last year's commentary, of what the rules governing the new arrangements should be, remained unanswered at the end of the year. While the Government remained committed to a competitive regime, it did not take the steps it might have done to realise its potential, for example, by freeing up the financial rules governing trusts to allow them the greater flexibility that a genuinely competitive market requires. Service innovation, particularly if it involves capital investment of a speculative nature is hard to achieve. New facilities or re-organisation of existing ones still require purchaser support – not only within the business cases presented to the NHS Executive but also in the consultation documents put before the public – which remain the responsibility of purchasers when major changes in services are being planned.

However, in December 1994, the Executive issued *The Operation of the NHS Internal Market: Local Freedoms, National Responsibilities* (HSG(94)55) which aimed to provide 'a simple set of ground rules that everyone in the NHS can work by'. Unfortunately, that aim was not achieved, useful though the Guidance paper may be in identifying many of the issues which have to be faced if the internal market is, to some degree at least, to allow genuine market behaviour.

The central dilemma, which the Guidance recognises, is that the production of health care is a co-operative activity and co-operation does not always sit easily with competition:

> *The internal market itself does not, and was not expected to, achieve all the goals of the National Health Service. It does, however, go a long way towards supporting them. A strategic perspective will always be important, especially where we are faced with continuing change as a result of medical and technological advance. We need constructive co-operation between different parts of the NHS as well as the beneficial impact of competition. Improving health care is not a question of choosing one or the other. We have to find the appropriate balance between the two.*

The Guidance put the case for maintaining competitive pressures:

> *Competition provides the stimulus for hospitals and community health services to be efficient and to respond to the needs of patients and the public. Health authorities and GP fundholders, who purchase health services on behalf of patients in the new system, usually need to have a choice of providers to get the best possible service. For many services, it is therefore efficient to have competition between several providers. For other services (for example where there are economies of scale) it may be more efficient to have just one provider, whose behaviour is stimulated by the knowledge that another provider could replace it. In this case the system is contestable if not directly competitive.*
>
> *To promote the benefits of competition, new providers must be able to introduce alternative services. By the same token, existing providers who do not respond to the needs of patients should risk losing patient and purchaser support and ultimately face change, including restructuring or closure. The new system is a powerful mechanism for identifying where such change is necessary so that patient care can be provided in the most modern and effective way. Competition also motivates purchasers. Thus GP fundholders lose income if their patients choose to move to another practice. Public comparison, in the form of "league" tables for example, will challenge poor performing purchasers to improve.*

In a commentary on the Guidance (British Medical Journal, 17 December 1994), Julian Le Grand pointed out that while they represent 'an impressive beginning', they do not address many of the central issues which must be tackled if market processes are to work: provision for 'provider exit and entry', greater financial freedom and so on. At the Health Financial Management Conference in November, the NHS finance director indicated that some move in that direction might be considered. But such evidence of new thinking does not appear to go as far as suggested in Sean Boyle and Adam Darkins' article in last year's edition of *Health Care UK*.

In that article, the authors suggested that provider and purchasing structure should be reconsidered. In an extension of this analysis, Sean Boyle and Anthony Harrison (Health Service Journal, 30 March 1995) suggested that the central role of trusts might have to be transformed into 'intermediate' providers offering infrastructure to providers based on particular services. But, at present, official policy has not got round to considering such possibilities.

The clear intention behind the creation of trusts was to give them more scope to set their own arrangements for pay. Until 1994 the Government had not put any significant pressure on trusts to do so. In February 1994, the Government, having declared in the previous Autumn Statement that no pay rises should be given without productivity growth, accepted the Pay Review Bodies' recommendations for clinical staff of across the board rises of 3 per cent. That effectively pre-empted local action, even though the Pay Review Bodies recommended movements away from national pay bargaining.

In June, Alan Langlands wrote to all trust chief executives requiring them to inform the Executive of their plans to introduce local pay arrangements. The letter also indicated that the Executive favoured moving in the direction of performance related pay:

> *The Secretary of State has said she affords 'the highest priority to the early introduction of arrangements which will link a significant proportion of pay increases from 1995 to the performance of staff achieving improvements in local services'.*

Neither proposal was received with great enthusiasm either by the majority of trusts or by the main groups of professionals. A survey by Industrial Relations Services toward the end of 1994 suggested that a substantial number of trusts – some 200 – had not responded to the letter.

Their reluctance is readily understood. In the first place, as the Government itself recognised, most trusts did not have the capacity to introduce new pay systems. But even for those with well developed personnel functions, the issues were daunting. One of the key areas for change in the NHS lies in the boundaries between professionals which existing pay arrangements tend to confirm. That argues for a single pay scale or at least a significant reduction in their number but the process of achieving either is likely to be difficult and prolonged.

Secondly, how to link performance to pay is by no means clear. Initially, the emphasis was on individual performance. However, in June, the Secretary of State suggested that:

> *local pay arrangements should be linked to the success of the organisation. That success is, of course, determined by the organisation meeting its objectives to improve the quality and quantity of patient care. Properly handled, local pay will encourage and promote good clinical practice, not distort it. I am determined that local pay will be introduced constructively and in a way that benefits patients and supports the team.*

However, that determination was not based on a clear view on the part of the Executive as to how local pay should be introduced either at the individual or organisational level. How to do it was left firmly in the hands of trusts.

In the area of capital finance, their powers remained essentially unchanged and here, too, a policy designed to create new opportunities appeared more like an imposition. In this case, it was the private finance initiative, under which, during 1994, the Government imposed the requirement that trusts should consider using private sources of capital for all schemes over £100,000.

Both these centrally-driven policy changes required more management effort at local level. Last year, we suggested that the main value of the changes planned to regional level organisation might lie in the fact that it allowed the Government to claim it was cutting back on managers' jobs. It was, therefore, no surprise that as each part of the regional re-organisation, and the

Department itself, was announced, the figures for jobs saved – or lost – featured prominently.

Nevertheless both the Government and the NHS in general continued to be attacked by the Opposition and the press on the grounds that management costs were too high. In response to a Commons question, the Department of Health revealed that administration costs had gone up rapidly since the reforms were introduced: these peaked in 1991 at more than £1 billion, according to a parliamentary answer given on 23 February 1995, fell to less than £900 million, and rose to over £1.1 billion in 1994 .

Commenting on the figures relating to increases in the number of managers, the Department said that is was intending to reclassify many staff designated as managers, returning them to professional or clinical groups – which might cut the costs shown above by up to 45 per cent. The Secretary of State added:

> *The figures look inflated because we started from a low base – a base that was too low. For too long people had taken refuge in the simple argument that the health service was under-funded when in fact it was under-managed. The enormous sums of money spent was poorly-targeted and inefficiently used. It was a long-standing problem to find high-performing hospitals running out of money because of poor managerial control.*

But these figures are in any case largely beside the point. It is apparent that the 'new' NHS and the environment it has created is enormously demanding of management time, including that of senior clinicians as well as that of those actually classified as management. Many of these demands have nothing directly to do with the 1990 Act – they arise from more recent initiatives – and many are the result of clinicians and managers combining to improve their service in a radical and carefully considered way.

But some do arise directly from the nature of the new arrangements such as the contracting process. Here, it would seem the Government would prefer to be ignorant, or so the following parliamentary written question and answer (15 July 1994) suggests:

> *Ms Primarolo: To ask the Secretary of State for Health what estimates her Department has made of the annual cost of negotiating and managing NHS contracts.*
>
> *Dr Mawhinney: None.*

So there is no official calculation of what it costs to service the new arrangements, perhaps not surprisingly in view of the complexity of doing so. The Audit Commission and the NHS Trust Federation took steps during the year to produce an agreed basis for counting management jobs. But that is likely to be of only limited help if, as seems likely, the impact of the new arrangements is a matter of the way working time is used rather than a matter of the creation of entirely new jobs.

If we look at actions rather than words, it would be easier to regard the new NHS not as a competitive structure, but rather one in which providers are increasingly having to respond to central targets set for the reduction of waiting lists and other requirements of the Patient's Charter, for the introduction of higher rates of day case surgery and for the reduction in costs or cash releasing efficiency savings. Targets are set nationally in the best traditions of Soviet-style planning and then faithfully passed on by purchasers to their main providers, often unamended in the light of local circumstances or to the scope of savings in particular forms of care. Thus, many community trusts are being asked (Health Service Journal, 27 October 1994) for the same level of savings as acute trusts despite the fact that they do not have the same scope for changing the way they deliver care. Indeed, they are being pressed in the field of mental health to incur additional costs through supervision registers, and are having to cope with the consequences, in terms of additional after- care, of higher levels of elective surgery, shorter lengths of stay for inpatients and a rising proportion of work done on a day basis, *ie* the very changes which enable hospitals to reach their efficiency targets.

On top of that, changes are occurring within local authority social services, which impact on providers of both hospital and community health services in ways which are not explicitly acknowledged in the efficiency targets set for them. Similarly, the Government have continued to press for a reduction in junior doctors' hours. In itself, this is an objective which would command general support, but together with other changes required to doctors' training to meet European Union standards, it reduces the ability of hospitals to provide continuous medical cover, particularly in accident and emergency departments.

The question arises, therefore, as to whether in this day to day operational sense the policies which are being pursued for different parts of the NHS are consistent with each other. Anthony Harrison addresses this issue on page 72.

London

In August 1994, Robert Maxwell, in the first King's Fund overview of the situation in London since the Tomlinson Report, reaffirmed the need to state the direction in which policy as a whole is moving and to be clear about the fixed points within that overall strategy, while maintaining transitional funding to make the process of adjustment easier.

However, his most striking conclusions were that there should be no further overall bed reduction and that there should be great care about the closure of A&E departments. The main argument for drawing a temporary halt to the process is that some London hospitals are finding it hard to cope with emergency patients. Numbers of emergency admissions have been rising and patients in a number of hospitals have been forced to spend hours on trolleys waiting for a bed after the decision to admit has been taken. At King's College Hospital, where these difficulties attracted a good deal of media attention, the purchaser, South East London Health Agency (SELHA), accepted the case for increasing the number of acute beds.

A report prepared by the London Health Economics Consortium for inner London purchasers recorded that many providers were working under extreme pressure. Nevertheless, it did not recommend any increase in bed numbers, nor even a halt to their reduction:

> *The overall conclusion was that London's acute hospitals are operating under very considerable pressure. If dysfunction and disruption are to be avoided, hospitals require better bed management systems and some have to operate at lower levels of occupancy. What is needed is not more acute beds in total but a better disposition of specialist and general acute beds – and medical surgical teams – to meet the needs of patients. Improved services for the care of the elderly are required if there are to be further reductions in acute beds.*

As for the A&E departments, concern here arises because of the scale and number of changes proposed to them. Although closure of A&E facilities at Bart's attracted most national attention, closure of a number of other facilities was proposed in a series of consultation documents issued by purchasers throughout London for the re-organisation of acute care. Among them was the proposal which had emerged from the Tomlinson enquiry to close Guy's to emergency work. After extensive local consultation, the purchaser decided to postpone closure, a decision which the Secretary of State supported in a wider ranging statement in early April 1995. The main features are set out in Table 3.

In justifying the proposals, the Secretary of State said she had been guided by four principal goals:

- to strengthen specialist services by concentrating them in fewer, high quality centres of excellence;
- to preserve and enhance London's international reputation for treatment, teaching and research;
- to provide more modern acute hospitals closer to the major centres of population; and
- to improve family doctor and other community health services so that Londoners enjoy the access, level of provision and standards of excellence common elsewhere.

Again, these are objectives which would command general support. But the same question arises here as for the reforms as a whole of whether the various strands of policy are mutually consistent and whether, in particular, plans for change to hospital services are consistent with changes being made within primary care.

The Tomlinson review argued that:

> *The long term trend is an increase in ambulatory and community-based care, and a corresponding fall in the relative importance of hospital inpatient facilities to the provision of health care. Increasingly, chronic conditions such as diabetes, stroke, asthma and HIV/AIDS can be effectively supported in the community, rather than in hospital, and this provides a better service to the patient. In inner London the overwhelming emphasis historically has been on hospital facilities; the potential scale of substitution between secondary and primary care is considerable. This trend requires a shift in the balance of expenditure between the acute, and the primary and community sectors.*

Work carried out at York University aimed at finding an improved formula for the distribution of NHS resources between different parts of the country suggested that use of hospitals is higher where facilities such as nursing homes are in relatively short supply. London has such a 'deficit', probably due to higher property values which have made such facilities uneconomic to provide within the capital itself.

Table 3: London Hospital Re-organisation

- *The Royal Hospitals Trust has been given the go-ahead to concentrate acute and specialist services over time at the Royal London Hospital in Whitechapel with services transferring from St. Bartholomew's and the London Chest Hospital.*
- *St. Thomas' Hospital will be developed as a major specialist and acute hospital in South London while Guy's will continue to provide a wide range of specialist and local hospital services many of them at the leading edge of clinical practice.*
- *A new district general hospital will be established for Greenwich.*
- *Hospital services at the Homerton, Lewisham and King's will be modernised.*
- *A major new neurosciences and neurosurgery centre will be created at King's.*
- *The Barnet General Hospital will be upgraded to serve as the major district general hospital for the area, with a completely modernised accident and emergency department.*

In line with this, Robert Maxwell argued in the statement referred to above for continuation of the policy of strengthening primary care, but on a broader basis than envisaged hitherto, so as to include nursing and residential homes and community health services. He went on to suggest new forms of health care delivery – at least new in the capital – such as 24 hour primary care centres and community hospitals which help bridge the gaps between existing providers.

The Government's own commitment to the strengthening of primary care in London remains high. In October, a Primary Care Support Force was announced with the task of:

- the promotion and dissemination of good practice and new ways of working; the identification of potential barriers to progress;
- support and practical advice in resolving implementation and developmental issues;
- working, by invitation, with individual health authorities and other organisations which may be experiencing difficulties in implementing development plans;
- briefing all those who need information and ideas to help take forward the development of primary and community services.

These measures come over and above a series of projects, over 1,000 in all, paid for from some £125 million of earmarked funds, designed to strengthen general practice, and a further £85 million announced in February.

The projects may well be desirable in themselves, but following Tomlinson's argument the expectation has been that investment in primary care facilities would reduce hospital use. However primary and secondary care are not only substitutes but also complements for each other, so it cannot be simply assumed that better primary care means less work for hospitals. In many of the areas where primary care is weak, it would be a reasonable expectation that better care would lead to better identification of conditions which would benefit from hospital treatment. Appearing before the Health Committee in May 1995, the Secretary of State was forced to admit that no evidence existed that better primary care would reduce demand for hospital services.

In the short run, however, consistency may be more a question of the speed with which changes can take place. Neither Tomlinson nor anyone else has attempted to define a *process* of change which would ensure that the roles of all providers of care developed in a mutually consistent manner. There is no longer any organisation with responsibility for London as a whole which might take on that task. In February, the Minister for Health announced that the London Implementation Group was to be wound up, and its responsibilities transferred to the two regional arms of the Executive, North and South Thames. Change within London will not, however, stop with the Secretary of State's April announcement and hence the question of whether the process will be managed effectively will continue to give rise to concern.

1.2 Community Care

Last year, our overall conclusion on the first year of the Community Care reforms was that disaster had been avoided:

> *there had been no major failure of liaison between health and social service authorities.*

This year, however, that conclusion is harder to justify. From the autumn of 1994 onwards, it became clear that a number of local authorities were finding it hard to cope within their social service budgets, with the result that beds were being blocked in acute hospitals by patients waiting to be transferred to nursing homes. Two factors appeared to be at work, a change in the formula for allocating cash to local authorities and a general increase in demand for social services, in part as a result of the success of the new arrangements in identifying need.

In the first year of the new arrangements, the cash transferred from social security was allocated partly on the basis of population, partly on the basis of the scale of current take-up, which was higher in retirement areas and low in the larger cities. The half and half rule was designed to ease the transition towards a population-based system. In the second year, however, the Government completed the switch, thereby reducing grant to those authorities which benefited from the transitional relief. In many such areas, social services budgets for new commitments began to run out in the middle of the financial year.

The Government placed the blame for this firmly on authorities themselves, as the following exchange before the House of Commons Health Committee revealed:

> *Any evidence of any authorities underfunded?*
>
> *(Mr Bowis) No, there is no evidence. Any authority I am sure will always claim to be short of a penny or two in some areas. That has not been the problem. The issues have been to get the policy in place, to get the assessment situation in place and then to enable people to be assessed and placed. I am not conscious of where there have been problems. I would not for a minute suggest that, although all the evidence that has come to us from independent sources as well as our own monitoring is that it has been very encouraging and I pay tribute to those who have made this possible. Of course there has been the odd rough patch, of course there have been the odd parts of the country where some aspects of community care have not been implemented as well or as quickly as others. I do not believe that has been as a result of resourcing.*

A reassurance of this kind is guaranteed to induce a feeling of unease, resting as it does on general arguments rather than comprehensive monitoring of the effects of the changes on those requiring care. Most of the monitoring reports appearing during the years, however, offer support to the Government's position with varying degrees of qualification.

According to the *Community Care Monitoring Report 1994*, in which local authorities report on their own progress, there is:

> *. . . a steadily improving picture which reflects a great deal of credit on all the agencies concerned. However, it is evident that there is considerable progress to be made in a number of areas in order to deliver the full benefits of the new community care arrangements for users and carers.*

Reports by the Local Government Management Board – *From Social Security to Community Care 1 and 2* – confirmed that, in general, the new arrangements had been working, in operational and administrative terms. In particular, a larger than expected number of people had been helped to stay in their own homes instead of moving to residential care, but the health/social care divide continued to give difficulty:

> *The boundaries between the responsibilities of health and local Government services are blurred around community health services. There has been a lack of clarity and a tension which needs to be resolved between health and social care, with some concern over definitions of what cases should be considered residential care or continuing care. Authorities had been waiting for the draft guidance on continuing care, but on their publication found them to be 'less that useful'. Over the whole year the situation appears to have worsened, with no resolution over the divisions of responsibilities.*
>
> *Concern was expressed by a number of authorities about the turnover in nursing homes after discharge*

> *from hospital. It seems that there may be some people inappropriately placed in these homes, when they needed continuing medical care, with one authority stating that such activity is 'arguably abusive'.*

The Nuffield Institute/King's Fund's joint monitoring project – see **Community Care Assessment** – also concluded that there were both good and bad things to report.

In its more measured way, the Audit Commission's *Community Care Bulletin No 2* reported substantial progress on the part of authorities in adapting to the new demands placed upon them, but also cited a number of user concerns, most of which as the Bulletin acknowledges, are well known to social services departments. It concludes:

> *A needs-based approach requires a number of complex new arrangements, including needs assessment and budgeting, some flexible commissioning and a more diverse and innovative range of services. As it is still early days, it is difficult to predict what the ultimate shape and balance should be between central and local commissioning, between spot and block contracts and between local and non-local authority services. The balance will depend on local circumstances. While authorities are beginning to address these issues we would encourage them to experiment and develop different approaches. A particular challenge looms for new unitary authorities replacing some of the former counties to ensure that the goals of more sensitive, flexible and responsive provision for people in need is delivered.*

The general, rather abstract nature of this conclusion serves to emphasise the challenges which the new arrangements pose to local authorities and to those responsible for monitoring them. But its language is far removed from the concerns of users. Last year, the Review drew on a report by RADAR which cited the difficulties faced by a selection of users who had contacted the organisation for help – some of Mr Bowis' 'rough odd patches'. The final report of that project, *Disabled People Have Rights*, confirmed the earlier picture. A survey of GPs by the British Medical Association also found some more 'rough patches'. Only 500 GPs replied out of 1,500 contacted so again the results do not add up to a statistically valid sample.

The Government can of course shrug off criticisms of this kind on the not unreasonable ground that it is early days yet. Furthermore, with the announcement of the introduction of community care charters, it directly addressed some of the weaknesses that reports such as RADAR's reveal.

However, evidence emerged of changes affecting the interests of users of a long rather than a short term nature. Many NHS providers appear to have reacted to budgetary pressures by reducing services in areas such as services for the mentally ill and domiciliary nursing where the health and social care roles frequently overlap. While NHS agencies were, apparently, attempting to shift costs on to local authorities, local authorities increased their efforts to pass costs on to users. A report by the Local Government Anti-Poverty Unit found that nine out of ten authorities were charging for domiciliary services and the level of charges was rising sharply.

At present – see Table 4 – fees and charges form a very low percentage of total income. But the clear indication of the Unit's survey is that the proportion is set to rise.

As noted last year, the Government issued a circular in January 1994, further encouraging local authorities to use the discretion allowed to them under Section 17 of the Health and Social Services and Social Security Adjudication Act 1983 to impose charges for non-residential services. There is some evidence that, reflecting the financial pressure to which they are subject, local authorities are increasingly seeking to take capital into account. It was revealed in December that Hereford and Worcester were considering putting a charge on housing assets to finance domiciliary care. According to the Association of Metropolitan Authorities and Local Government Information Unit, in its critique *Commentary on Social Services Inspectorate Advice Note on*

Table 4: Fees and Charges for Social Services

	1991/92	1992/93
	% gross expenditure	
Residential care for:		
Children	2.5	3.8
Elderly and younger physically disabled people	30.5	28.7
People with learning disabilities and people who are mentally ill	18.9	18.2
Services for all client groups:		
Home care/home helps	6.5	6.9
Day centres and lunch clubs	8.2	8.9
Field social work	0.3	0.2
Meals on wheels	38.2	38.4
Other day and domiciliary care	3.4	3.2

Source: House of Commons Health Committee, Memorandum from the Department of Health on Public Expenditure on Health & Social Services HC617

Community Care Assessment

Hospital discharges

A survey by the Research Unit of the Royal College of Physicians is reporting a fall in inappropriate use of hospital beds and a reduction in the time patients have to wait to leave hospital.

Services

Improvements are emerging through innovative solutions: some care managers have developed for individual care packages; increased diversification into day care services by the independent sector; and increased flexibility in day and domiciliary services now operating at weekends and evenings. Investment in advocacy services is evident (although it is not clear how secure these services will be in the longer term).

There is some evidence of carers being listened to and offered separate assessment of need, although a less positive picture is painted by research conducted by the Carers National Association.

Co-operation between health and social services

The structures and processes required for joint commissioning are being put in place in some localities. Hope remains high that joint commissioning will eventually result in good services in the grey area between health and social care. There is a growing amount of joint training taking place.

The interface with general practice and primary care

GPs are still not sufficiently on board. There is little evidence yet of any substantial shifts from acute to primary health care. This is disappointing, as strong and expanding community health services would strengthen community care provision.

Joint commissioning

Changing health and local authority boundaries will not help in the task of building strong joint commissioning arrangements. In addition, the related staff changes are damaging the continuity of collaborative relationships. The move towards 'total fundholding' is a further concern.

GP fundholding is complicating the process. There are some good examples of joint commissioning around general practices (fundholding and non-fundholding), but fundholders are more often than not purchasing independently of health and social care joint commissioning intentions.

Finance

The true costs of community care are not being calculated; contributions of family care, the NHS as well as local authorities should be recognised. It is anticipated that there will be less money for community care next year. This is leading to anxiety and some early signs of cuts taking place (*eg* through freezing posts).

The position for care home owners

Care home owners continue to express their concerns about:

- users' choice of home being restricted;
- complex contracts with local authorities;
- the slowness of some local authorities to take up new services being offered by the independent sector;
- perceived conflicts of interest among local authorities as regulators and purchasers;
- large conglomerates being able to cope with changing conditions, while small home owners face bankruptcy.

Shifts from health to social care

With regard to front-line staff, there is some confusion about who is responsible for what and the extent to which duplication of effort exists. NHS withdrawals from continuing care remain a worry. Neither staff nor users and carers are clear about what the NHS should fund and there is widespread disquiet about the current position.

The consequences of targeting

Eligibility criteria are being tightened, focusing on individuals regarded as in greatest need.

Staff stresses and strains

Staff are frequently having to operate very bureaucratic assessment systems, dominated by form filling, check-lists, etc. Some are undertaking financial assessment before embarking on any discussion about need. Reviews of users' changing needs are often neglected.

Many staff are feeling de-skilled, having far fewer opportunities for therapeutic work and being reduced to administering a system akin to social security.

Demands on social workers and nursing home staff appear to be increasing.

Source: King's Fund and Nuffield Institute for Health. Making a Difference, Executive Summary

Discretionary Charges for Adult Social Services:

> *a growing number of authorities appear to be taking capital into account.*

As this analysis stresses, the imposition of charges is a complex matter, more complex than the official advice acknowledges. This is particularly true in those areas where health and social care are closely related:

> *11.1 The advice note recognises that this is clearly a difficult area given that health care must be provided free and social services have a discretion to charge. We wonder how health authorities, and health trusts in particular, will feel about the advice in paragraph 11 of the SSI note which suggests that authorities can charge the full costs for social care services which have already been subsidised or met in full by the health authority or trust. Considerable difficulties seem likely to result from trying to implement the advice at the end of paragraph 11 regarding charging when the health authority purchases the health care and a local authority buys the social care from the same provider. For example, social services departments and district health authorities are already locked in debates about when a bath is or is not a social bath. Imagine trying to explain to two users who both get the same number of baths each week that one of them pays less because two of her baths are for health reasons.*

The health bath versus social bath is the tip of a larger issue: who should bear the financial responsibility for long term care? As noted last year, the Health Service Commissioner had, in a special report, highlighted the issue so effectively that the Government could not fail to respond with a consultation document and a subsequent revision of the existing guidelines. The Government argued that in all essentials the situation remained as it had been since 1948; however, Gerald Wistow argues below that the new Guidance represents a fundamental shift in responsibilities between the NHS and social services and hence between individuals and the State.

The interface between the NHS and social services is not, however, the only one where community care may fail and users suffer. Our 1993 Review drew on work from the Rowntree Foundation which highlighted both the importance of housing to community care and the failure of housing and social services departments and authorities to work together. In November 1994, the Department of the Environment and the Department of Health published the results of a Housing and Homeless study which looked at the housing aspects of community care. The main findings were as follows:

> *1.1 An interdepartmental study of the implementation of community care with regard to housing and homelessness found that, while significant new approaches to achieve common policy aims were being explored, progress was impeded by a lack of shared vision, coordinated planning/commissioning or integrated systems among social services, housing, health and other agencies at a local and national level.*
>
> *1.2 Although housing agencies were beginning to be engaged in community care implementation, housing solutions for people with 'special' needs and homelessness [sic] people were being developed in isolation, and links between community care and housing assessment procedures were rare. A number of health-funded schemes provided essential health care services to homeless people, but a stronger [social services] role was needed to coordinate a cross-agency strategy on provision for homeless people with community care needs, including clearer links with the criminal justice system/probation services and mental health provider agencies and users groups.*
>
> *1.3 Some authorities had embarked on new strategies of capital and revenue funding for community care schemes which included a housing/health element despite high levels of uncertainty about current and future funding. There was little evidence of user and carer involvement in strategic planning; progress towards meeting the needs of black and minority ethnic people remained ad hoc and uncoordinated.*

As this summary indicates, the earlier findings remain valid. The report goes on to identify a large number of specific obstacles on the margins between the various agencies involved:

> *7.2 Among the concerns expressed by social services, health and housing authorities and other agencies were the following:*
>
> - *lack of clarity or consistency of policies of main funders, lack of coordination of existing legislation affecting community care, and lack of synchronisation of housing, health and social services planning cycles and systems;*
> - *lack of flexibility of Special Needs Management Allowance (the Project fieldwork was carried out prior to the Department of the Environment announcement of planned reforms to SNMA subsequently set out in a Housing Corporation Consultation paper);*
> - *lack of consideration of cost benefits to different interventions/services, eg adaptations such as stair lift vs care assistant; new special projects vs support in ordinary housing; new developments vs improvement/adaptation of existing stock;*
> - *different purchasing model preferred by social services (spot purchasing) and health (block contracting);*
> - *the costs of joint working and joint planning, in terms of skilled worker time, which placed particular constraints on small organisations;*
> - *housing cost yardsticks of Department of the Environment and the Housing Corporation for projects which made it difficult for housing providers to meet space standards which could provide a real alternative to residential and/or nursing home care for disabled or frail elderly people.*

As is typical of studies of this kind, examples of innovative, cross-agency projects were identified. The challenge is to generalise from isolated examples of good practice. Nowhere is this more true than mental health.

In this area, the Government has been forced to respond to a widely perceived failure of the community care policy. The 1990 Act pushed further the process of 'normalising' care for people suffering from mental illness which was set in train more than two decades ago. Although the bulk of resources remained with the NHS, local authorities were given the lead; in principle no-one should be discharged from NHS inpatient care without a care plan being prepared in conjunction with local authorities.

The key, but not unique event, provoking public disquiet was the murder by Christopher Clunis of Jonathon Zito. The report by Mrs Justice Ritchie found that while a large number of public agencies had been aware of Clunis' condition, the system as a whole had failed. None had taken the decisive action required to protect the public from the risks that Clunis posed. In other instances, it appeared that resources within the NHS were insufficient to deal with the scale of the burden being placed upon it, particularly in urban areas.

A number of reports, from the Royal College of Psychiatrists, the Audit Commission, the Mental Health Commission and the Mental Health Foundation, found the level of inpatient bed provision was inadequate and services badly co-ordinated. The situation in London was identified as being particularly acute. In a report issued in September 1994, the Royal College of Psychiatrists identified a shortage of beds within much of inner London, which meant that some patients with severe and chronic mental disabilities are being discharged without adequate supervision.

The Audit Commission's report, *Finding a Place*, made a number of trenchant criticisms of current policy – see Table 5 – so trenchant that the Department of Health reacted strongly to it. The junior Minister, John Bowis said:

> *I have seen many good and useful reports from the Audit Commission. I have to say that I am not sure this is one of those because of the way it has been presented.*

The Minister, however, did not disagree with the Commission's diagnosis, but suggested that a great deal had been done to deal with the issues raised since the 10 Point Plan was announced in August 1993:

- *the introduction of supervision registers, which has now been successfully completed by more than 80 per cent of NHS units;*
- *the issuing of guidance on procedures for discharging patients from psychiatric hospitals;*
- *the provision of new advice and guidance for managers and professionals on targeting services, which was contained in the second edition of our Mental Illness Key Area Handbook; the introduction of facilities to build up managers' confidence and expertise, such as the London Centre for Innovation and Leadership in Mental Health, which I launched last week;*
- *the draft inter-agency guide, launched by the Secretary of State on World Mental Health Day, which emphasised the need for better inter-agency co-operation;*
- *the funding of local projects illustrating good practice, which has been carried forward by the Mental Health Task Force, and has recently been complemented by the launch of the Sainsbury Mental Health Initiative.*

The Audit Commission's findings were, however, in line with the findings of other bodies. The Mental Health Foundation also concluded that policy was fragmented and that more funds were required in the NHS and those areas complementary to the NHS – housing and social services. Again, the Parliamentary Secretary John Bowis felt that the criticisms were unfair:

> *The Mental Health Foundation do not seem to recognise that we have been issuing reports, guidance and advice on all aspects of mental illness, including provision for mentally disordered offenders.*
>
> *We have a programme to ensure more appropriate placement of mentally disordered offenders in hospital rather than in prison. This has led to the transfer of more than 1,300 people from prison to hospital in the last two years.*
>
> *We have embarked on a £45 million programme to bring the number of medium secure places up to nearly 1,200 by 1996 and only last month we issued – in draft form – a guide to arrangements for inter-agency working for the care and protection of severely mentally ill peo-*

Table 5: Audit Commission Critique

The Commission's central points were these:

- People with mental illness prefer community services to hospital. They and their carers want relatively simple help such as cooking, cleaning, advice and daytime activities.
- Some areas need four times as much funding for mental health services as others.
- Community psychiatric nurses are often failing to focus on the most ill patients.
- Some hospitals admit patients who should be cared for in the community. Hospital care costs more than £600 per week.
- Implementation of the care programme approach, by which the mentally ill should receive community services from various agencies under a single plan, has been patchy;
- Apart from 'a few exceptional individuals', managers of mental health services have not been of sufficient calibre to make the necessary changes.

Source: Audit Commission

> *ple. This documents appears to be precisely what the Mental Health Foundation think is lacking.*

The Mental Health Commission report for 1991/93 (sic) identified high levels of bed occupancy sometimes reaching in excess of 100 per cent. That may seem a logical impossibility but it means that patients are temporarily discharged on leave and their bed used by someone else. It also found that the care programme approach which the 1990 Act introduced for patients being discharged from inpatient care was 'barely evident'. It recommended a fundamental review of the policy framework:

> *It is at the very least arguable that the radical transformation of mental health services, from being primarily hospital-based to community-focused, should be reflected in the legislative framework. In short, the legislation should give priority to provisions for care and treatment in the community – the proposed "supervised discharge order" is an example of a new form of compulsory care in the community. Compulsory admission powers, while extremely important in terms of loss of liberty, should reflect society's resort to hospitalisation sparingly and secondarily. At the same time a review might provide an opportunity to frame legislation which, whilst recognising the importance of patient rights and professional discretion does not merely find a new location on that particular pendulum, but also takes into account the new, radically different, approaches to mental health law that have developed in recent years.*

The small number of tragic events during the year combined with an apparent growth in the numbers of people requiring inpatient care appears to suggest that the balance of care is wrong or that community services are not well enough developed to offer effective alternatives. In particular, as the Clunis case demonstrated, the various actors do not mesh properly together. The Government, as we shall see, rejected the call for a fundamental change in the statutory framework. But it was forced to acknowledge that existing arrangements were not working properly.

In October, the Parliamentary Secretary John Bowis, commenting on another incident, said:

> *. . . . a person who was discharged from hospital into the community and then committed a serious crime. Sadly, it seems that a combination of poor compliance by the patient with plans for after-care, combined with inadequate planning by the multi-disciplinary team responsible for him, led to things going disastrously wrong.*
>
> *This tragic death occurred more than two years ago – well before our latest initiatives to tighten up community care, but certainly after introduction of the Care Programme Approach (CPA) in April 1991.*
>
> *Under the CPA, no patient should ever be discharged from a psychiatric hospital without a full assessment of their needs for health and social care, and an agreed programme of action – involving the patient, relatives or friends, and necessary health professionals – for their care in the community.*
>
> *I am glad to see that the North West London Mental Health Trust is taking steps to ensure that the caseloads of community psychiatric nurses are monitored, and that no-one will in future be removed from a nurse's list of clients without agreement at senior level.*

What is striking about this statement, from a Minister who as we have seen is strong in defence of the Government, is its frank admission that the Care Programme Approach system has not been properly implemented, even though it has been nominally in force since 1991. However, the only systematic assessment of its effectiveness (Lancet, 345, pp. 399-400) suggested that care management offers no important improvements over standard care, with the possible exception of reduction of deviant behaviour. On that basis, it would seem that present policy is built on insecure foundations, but that implication has not yet been widely drawn.

The Clunis case and others like it do not undermine the general policy of transferring care from the old large long stay NHS hospitals that characterised provision until very recently in favour of smaller inpatient institutions and care, whether NHS or local authority, offered in the home, health centres or other small institutions. Most people who are mentally ill are not dangerous either to themselves or others and can be allowed considerable freedom without imposing undesirable risks. It is common practice, for example, for people who are detained compulsorily to be allowed freedom during daytime hours and lead a more or less normal life while subject to compulsory medication to control their condition.

However, given the number of well-publicised cases where people released from hospital committed crimes of violence, it is not surprising that the Government pushed ahead with its intentions announced earlier to introduce more formal monitoring of those deemed likely to pose risks.

Providers were asked, in line with the 10 Point Plan, to introduce supervision registers in October 1994 which were designed to ensure closer monitoring of those thought to be a risk to themselves or others. The Government also announced its intention to increase the period for recalling patients on extended leave from six months to one year.

This measure poses considerable problems of both principle and practice, as the following extract from a statement (British Medical Journal, 3 September 1994) by the Royal College of Psychiatrists indicates:

> *The issue is much more than a little local difficulty between psychiatrists and the Department of Health; its resolution will be important for all mental health professionals and for purchasers of psychiatric services. The college is concerned that the criteria for including patients on supervision registers are too broad and about the substantial costs of setting up and servicing the registers. It is also worried about the unclear arrangements for withdrawing patients from a register once they have been placed on it and the implications for patients' civil liberties – and about the legal position facing clinicians and trusts in the event of a serious assault or suicide of a patient.*

However, in the face of public concern, the Government went further and introduced a Bill to bring in new powers of supervised discharge for patients leaving hospital after detention. According to the Parliamentary Secretary for Health:

> *Supervised discharge in particular will help to allay the concerns that a number of severely mentally ill people are falling through the net of care. It provides legal backing to the good practice enshrined in the Care Programme Approach. It will be negotiated with the patient and informal carers and will be applied so as to ensure an appropriate form of care, compatible with the patient's health and safety, and the safety of other people.*
>
> *Under supervised discharge a patient must abide by the terms of his after-care plan, drawn up by a multidisciplinary team according to the Care Programme Approach. Not only will this plan specify any necessary after-care but it may include conditions such as residence and attendance for medical treatment or education and training. There will be a 'supervisor' (normally the key worker) who will be responsible for ensuring that the plan is followed.*

Reactions to these proposals have been mixed, some seeing them as not going far enough, others as going too far. As the Registrar of the Royal College of Psychiatrists wrote in a letter to The Times (23 March 1995):

> *Those who would be subject to the Bill are a relatively broadly defined group who would be subject to various restrictions and to the power of a 'supervisor' to convey them to a place where they would be offered (but would not be compelled to accept) treatment.*
>
> *To many psychiatrists and others, this is the worst of both worlds. The mentally ill will be subject to the power of 'arrest' to no apparent purpose. Psychiatrists remain deeply sceptical and believe that the Bill will not provide the extra public safety which the Government is hoping for.*
>
> *It must now be clear that the problems which the Bill seeks unsuccessfully to address are much broader than at first appears.*
>
> *First, the resources in both the community and the hospital sector for adequate mental health care are lacking. Secondly, the Mental Health Act 1983 is based on an outdated notion that medical care can take place only in mental hospitals. The vast majority of mental health care already takes place outside hospitals and we need a Mental Health Act which starts from that assumption and facilitates treatment and care wherever it is delivered.*

By the end of March 1995, the final shape of the proposals had not been determined.

An earlier Review concluded that the implementation of community care was more demanding than the other parts of the 1990 Act. In the case of mental health, the evidence and argument presented here tends to confirm that conclusion. Across community care as a whole, as with reform of the NHS, change appears to create the need for further change, but at the same time, the long standing issue remains of how to weld together services run by different organisations and financed in different ways.

1.3 Public Health Strategy

Public health strategy is by its nature a long term matter and results emerge only slowly, if they emerge at all. *The Health of the Nation* initiative, which Mark McCarthy assesses below, has largely had to rely for measures of its success on existing sources of data. In the case of dental health, monitoring arrangements have been in force for many years. In December, the Department of Health was therefore able to announce that five times as many children aged 15 are now free from tooth decay than in 1983. The findings, published in Children's Dental Health Survey (claimed by the Department of Health to be the only study of its kind in the world) are striking:

- *By the age of 15, 40 per cent of children were free from tooth decay, compared with only 8 per cent in 1983.*
- *Just 16 per cent of children aged 10 had one or more permanent tooth filled in 1993, compared with 45 per cent in 1983.*
- *The same statistics for 15-year-olds showed a drop from 85 per cent in 1983 to 48 per cent ten years later.*
- *One in 20 15-year-olds had teeth extracted because of decay, compared with over a fifth (21 per cent) in 1983.*

In contrast, the *National Diet and Nutrition Survey: Children aged 1.5-4.5* produced mixed results. In general, children are well nourished and are taller and, in some groups, heavier than in the last comparable survey in the late 1960s. However, not all children were found to be faring equally well:

- *Children from households of lower economic status tended to have lower intakes of total sugars but higher intakes of starch than other children.*
- *Intakes of some vitamins and many minerals were lower in children from households of lower socio-economic status.*
- *Children from lone-parent families had higher intakes of fat than other children and those from lone-parent families with more than one child had lower intakes of vitamin C and some minerals than other children.*

In other areas, the news was also mixed. The 1993 *Health Survey for England* found that, although over three-quarters of men (77 per cent) and women (76 per cent) thought that their general health was very good or good:

- *44 per cent of men and 32 per cent of women were overweight, and an additional 13 per cent of men and 16 per cent of women were obese.*
- *Among people who drank alcohol, 20 per cent of*

ADVERTISING CONTROLS

The Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship reported a series of new agreements which extended those already in force:

Outdoor advertising

- the removal of all permanent shopfront advertising for all tobacco products by the end of 1996;
- a reduction in the expenditure allowed on cigarette poster advertising by 40 per cent;
- the removal of all small poster advertising for cigarettes and hand-rolling tobacco, including bus stop advertising (48 sheet posters and above will still be allowed);
- the removal of all mobile advertising for cigarettes and hand-rolling tobacco;
- the removal of all poster advertising for all tobacco products from within a 200 metre radius of school entrances.

Health Warnings

- an increase in the size of health warnings on cigarette and hand-rolling tobacco advertisements of 20 per cent of the total area, and an increase in the size of the lettering of the warning by approximately 80 per cent in posters and 50 per cent in press advertisements. The presentation of the health warning will be rotated between black lettering on a white background and white lettering on a black background;
- the introduction of health warnings on cigar and pipe tobacco advertisements covering 10 per cent of the total area;
- a requirement for all point of sale advertising material for all tobacco productions to carry health warnings (not just larger items of cigarette and hand-rolling tobacco advertising) and the introduction of health warnings on certain items of promotional material for cigarettes and hand-rolling tobacco;

Other main provisions

- the controls on the content of cigarette advertisements, operated by the Advertising Standards Authority, will prevent the use of humour in cigarette advertisements which would be likely to have a particular appeal to the young;
- the introduction of a new Code of Practice to help ensure that free samples of cigarettes are not available to under 18s;
- a ban on advertising for tobacco products on computer games or on other computer software;
- a provision for increased expenditure by [the Committee] on monitoring compliance with the new agreement.

men and 14 per cent of women said that they felt that they ought to cut down their drinking.

- *Men were twice as likely as women to have ever had a heart attack (4% and 2% respectively) but a quarter of both men and women said that they had had a cardiovascular disorder diagnosed by a doctor at some time in their lives.*
- *Among men participation in physical activity decreased steadily with age but among women there was little difference in activity between the ages of 16 and 54. Relatively low levels of activity among young women (16-24) reflected the fact that they were less likely to have taken part in sports activities than men of the same age and less likely to have done housework, gardening or DIY than women in older age-groups.*

The 1993 OPCS *Survey of Smoking Among Secondary Schoolchildren* contained the disappointing news that there had been little change since the 1992 results. Consequently, there is little chance that *The Health of the Nation* target of less than 6 per cent by the end of 1994 has been met. In response to the findings, the Minister announced:

- *The Department of Health will be launching a new £12 million national health education campaign on smoking later this year, with a particular focus on the influence parents can have on their children's smoking.*
- *The Chancellor of the Exchequer gave a commitment in the November budget last year to increase tobacco duties on average by at least 3% in real terms in future budgets. Price is an important influence in reducing smoking among young people.*
- *We have recently agreed a significant strengthening of the controls on tobacco advertising with the industry [See: **Advertising Controls**] The new measures including the reduced level of poster activity, removal of all permanent shopfront advertising, tight controls on the use of humour in advertisements and bigger health warnings – can be expected to have a major impact on young people's exposure to advertising.*

The seventh report of the Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship reveals that it had received eight letters of complaint and two queries on tobacco advertising and four on sports sponsorships. However, the Committee also relies on consultants to check implementation. The most recent checks by Coopers & Lybrand found that external permanent advertising signs for cigarettes and hand-rolling tobacco at retail premises had declined at least 20 per cent from the 1991 audit base and that the number of signs visible from schools had fallen by 83 per cent from the audit base.

While *The Health of the Nation* initiative has won support as a strategy, it is only as good as the evidence underpinning it on the links between individual behaviour and health. In the case of smoking, the evidence is largely secure. In the case of alcohol, a number of papers have appeared which suggest that, at least in certain forms, levels of consumption above those currently regarded as maxima may promote health.

In November, the Committee on Medical Aspects of Food Policy reported on nutritional aspects of cardiovascular disease. It confirmed *The Health of the Nation* targets for fat consumption and reductions in obesity. However, in the case of alcohol it acknowledged:

> *new evidence ... about the long-term effects of drinking alcohol. Press reports have suggested that alcohol seems to reduce the risks of some forms of coronary heart disease and that studies have shown that the healthiest people in some groups have been those drinking above the sensible levels. The findings of such studies are usually more tentative than the reports would suggest. Often they depend on how findings are interpreted and in turn on the size and type of the sample investigated, how closely drinking behaviour is monitored and how well other possible causes of the results are controlled for.*

While eating, smoking and drinking habits are a matter of personal choice, albeit influenced by other factors, they are only one source of differences in health status. The original strategic statement largely ignored other causes of poor health, particularly those that could be associated with low incomes and poor environment. However, at a conference organised by the British Medical Association, Action on Social Inequalities and Health, it was announced that the deputy chief medical officer, Dr Jeremy Metters, would be chairing a new interdepartmental Government working group which is to examine the links between social inequalities and health as part of a continuing review of *The Health of the Nation* targets.

Another essential underpinning of a public health strategy is an effective system of implementing preventive programmes. Earlier Reviews have shown that cannot be taken for granted. *First Five Years of the NHS Cervical Screening Programme* (National Co-ordinating Network, Anglia and Oxford Regional Health Authority) reported that the number of women being treated had doubled in the last five years. Coverage among those most at risk – women between 60 and 64 – had trebled. But there were three incidents during 1994 of the test programme itself being incorrectly implemented, affecting in all over 4,000 women. Furthermore, different parts of the country appear to be using different criteria to identify abnormal smears. Nevertheless, the programme appears to be saving about 1,000 lives a year – if all the fall in the number of deaths from cervical cancer can be attributed to it – at a cost of around £100 million.

1.4 Serving The Consumer

The Patients' Charter, like its counterparts in other services, is largely procedural; in its original form, it created no new rights to service but it laid down national performance standards and encouraged local ones for aspects of the delivery of care which are important to people, particularly time spent waiting for treatment and time spent waiting in the GP surgery or A&E department.

These rights have been extended since the Charter was first introduced: in April 1994, the Secretary of State announced plans to extend the range of areas covered by the Charter to include a national target for the length of time patients have to wait for their first outpatient appointment and to set a target of patients waiting for Coronary Artery Bypass Graft of admittance from the waiting list within 12 months. A number of other proposals designed to make the NHS more attractive to patients were announced at the same time – more choice of food, timed appointments for community nurse visits and some control over the time itself, and better complaints procedures. In January 1995, the revised and expanded Charter was officially launched and its precise contents announced in March in HSG(95)13, as follows:

with immediate effect:

- *the right of a patient to know before going into hospital if s/he is to be placed on a mixed sex ward;*
- *national standards addressing security and cleanliness in hospitals as well as single sex washing and toilet facilities for patients in hospital;*
- *a standard setting out that children should normally be admitted to children's wards under the care of a paediatric consultant rather than adult wards.*

from 1 April 1995:

- *18 month guarantee for waiting time for all inpatient treatment;*
- *26 week standard for first outpatient appointments – this includes a target of 90% of all Trust outpatients to be seen within 13 weeks;*
- *12 month standard for Coronary Artery Bypass Grafts and some associated procedures;*
- *3-4 hour standard for emergency admission to hospital through A&E departments. To be strengthened to 2 hours from April 1996;*
- *a standard of 2 hour time-band for home visits by community nurses and other standards addressing how quickly visits should be made;*
- *a standard addressing hospital catering services;*

The document also sets out the rights and standards the public can expect from dentists, optometrists and pharmacists, including a new standard for FHSAS; FHSAS should help the public find an NHS dentist and should respond to their requests within five working days. In *A Framework for Local Community Care Charters in*

Table 6: Summary of Performance against Three Key Patient's Charter Standards 1994

	A&E Assessment Patients Assessed Immediately Qtr 4 %	Waiting in Outpatient Clinics Patients Seen Within 30 Minutes Qtr 4 %	Cancellation of Operations: Patients not Admitted Within Month of 2nd Cancellation Qtr 4 no.s
Northern	88	87	0
Yorkshire	90	79	10
Trent	91	79	4
East Anglian	91	82	3
NW Thames	87	78	38
NE Thames	87	81	54
SE Thames	88	83	10
SW Thames	86	82	6
Wessex	83	85	0
Oxford	81	77	3
South Western	80	75	2
West Midlands	92	89	7
Mersey	91	83	2
North Western	82	80	3
SHAs	97	78	1
England	87	82	10

Source: as Table 4

Table 7: Summary of Performance against Three Key FHSA National Charter Standards and Information on GP Practice Charter Development 1994

	Medical Records Transfer % Within Standard		Allocation to a GP (% Within Standard)	Development of Charters	
	Urgent	Routine		% with Charters	% of Practices Developing Charters
Northern	55	72	99	9	25
Yorkshire	70	72	100	25	14
Trent	55	86	100	22	16
East Anglian	30	71	98	6	14
NW Thames	47	49	82	12	22
NE Thames	57	52	97	4	10
SE Thames	30	60	99	46	18
SW Thames	62	45	100	15	27
Wessex	84	54	100	16	18
Oxford	100	77	100	16	25
South Western	48	71	100	10	17
West Midlands	91	80	100	26	20
Mersey	85	80	100	35	13
North Western	64	68	100	19	15
England	56	66	98	20	18

Source: as Table 4

England, a series of proposals was made for social services.

So far, reporting on the achievement of existing standards has been limited. In July 1994, the Department of Health published league tables on hospital performance in relation to Charter standards, but they reported on only three of the standards – waiting times in outpatient clinics and accident and emergency departments and cancelled operations: see Table 6. The detailed figures are too bulky to cite here but, even with aggregate figures, substantial variations in performance are apparent, particularly in respect of cancellation of operations where the best regions show that everyone was re-admitted within a month of the second cancellation as opposed to 54 per cent in the worst. Within primary care – see Table 7 – performance also varies widely. In the case of transfer of urgent medical records, the proportions meeting the standard range from 30 to 100 per cent. Other standards showed less variation.

The idea underlying publication is to allow choices to be made in relation to performance but the Government has proved reluctant to require providers to reveal information bearing on clinical quality. It has, in particular, hesitated to require publication of hospital death rates, though the Scots have gone ahead and done so in *Clinical Outcome Indicators* (MEL(1994)82).

In evidence to the Health Committee, the Department expressed the obstacles to publishing such information as follows:

> *Developing information to allow valid comparisons between hospitals on the basis of the results of clinical care (clinical outcomes) is technically very complex for the following reasons:*
>
> - *the patient populations may not be comparable between hospitals in terms of age, sex, severity of disease and ill health, risk of developing complications, presence of other clinical conditions, and other factors;*
> - *data on outcomes may be incomplete. For example, death may occur at home after discharge from hospital. It is not possible at present to link hospital and community data because routine patient-based data are not collected in the community in the same way as for hospital admissions;*
> - *attributing a clinical end-point eg death, to what happened in hospital may not be valid as death may be a consequence of the cumulative effect of a variety of services ie primary care, hospital outpatient care, community care, the patient's own actions, and non-*NHS *influences;*
> - *the completeness and quality of information may vary between hospitals.*
>
> *Although death following admission for hospital care may theoretically act as a measure of the quality of care, it is not possible, at present, to allow for all of these variables in interpreting currently available data on deaths. Death also presents an incomplete picture, as there are many other possible clinical end-points eg changes in clinical signs and symptoms, function, handicap, well being, which could be considered as part of clinical outcomes and which might be more appropriate and relevant as measures of quality of clinical care.*

These points are all valid, but the danger is, if they are regarded as overwhelming objectives, no progress will be made at all. As *Clinical Outcome Indicators* put it:

> *The indicators are being published now with the specific aim of stimulating local discussion about the possible reasons for any apparent variation so that this may be investigated and appropriate action taken; for example by setting in train a clinical audit to identify the likely cause of the disparity.*

Nevertheless – see **Outcome Measures** – it added an explicit 'health warning' on their use.

Better and publicly available outcome measures should in principle lead to poor providers losing business. But things will still go wrong even in the best hospitals. If they do, patients require proper avenues for complaint and, if necessary, redress. As reported last year, the Government had acknowledged that the existing avenues of complaint were inadequate.

In 1993, the Government had set up a Committee chaired by Professor Alan Wilson to assess the systems in place for handling complaints and to make recommendations for their improvement. That Committee reported in 1994 and made a large number of proposals for improvement in existing arrangements. The weakness of these emerged very clearly from the Report of the Health Commissioner published in July 1994:

> *In many of the cases which I investigated I was obliged to criticise what can only be regarded as an abrogation of responsibility and neglect of management. Far too*

Outcome Measures

Clinical Outcome Indicators, acknowledging the limitations of the information it presents, warns that:

No direct inferences can be drawn about the quality of clinical care in different hospitals or health board areas on the basis of the information provided. This is because these clinical outcome indicators do not provide directly comparable information either about the efficacy of treatment for a particular condition in different hospitals or about the effectiveness of services provided for the inhabitants of different health board areas. Variations in clinical outcome may be due to the relative quality and completeness of the data supplied by hospitals and health boards to ISD for the Scottish Morbidity Record (SMR), local case mix, geographic variations in disease, socio-economic and other factors.

Furthermore, each table is accompanied by a statistical health warning:

WARNING: This information should be interpreted strictly in accordance with the general and specific guidance given in the report.

> *often I have to deplore the treatment of patients which shows disregard for the needs and care of fellow humans. Far too often nothing has been done to manage patient care properly until I have completed an investigation. In cases such as that those responsible should feel a sense of shame.*

The Commissioner, Mr Reid, also reported to the Administration Committee of the House of Commons that complaints addressed to him were rising. In part, this may reflect a greater willingness to complain:

> *(Mr Reid) I think the continuing rise in the number of complaints is due to publicity. The fact that there are national and local charters issued by the health departments, issued by health authorities, issued by hospitals, has made it possible for the questioning by querulous people that I mentioned in my report to get on with it. That I think is the first point. The second point is that there has been, as I say, bad local handling and when people find they are treated discourteously locally, when they find that one of their questions is answered but four others are not, when they find that it takes a very long time to get a reply, and when they find that the reply is couched in terms that a doctor would understand but a lay person would not, it is hardly surprising that they want to complain to someone independent to look at and investigate their complaint.*

But in part it may also reflect the structural changes brought about by the 1990 Act:

> *(Mr Reid) . . . the complaints caused by failures in communication have been aggravated by splitting health care into a number of entities. Before those reforms you had one health authority responsible for a whole area, now you have it – I was going to use the work balkanised – split into a number of health authorities. I make no value judgement whatsoever about that decision. What I do say is that, having smaller entities, ought to mean that those who provide the service locally will be closer to the users of that service, and that ought to be a good thing, it ought to mean they can have any complaints dealt with locally, quickly and effectively. What I have criticised, however, is the fact that because there are more bodies involved, communications, if they are poor, will become worse, because they have to be communicated not between one body but between a number of bodies.*

In March, the Government responded to the Wilson Report in *Acting on Complaints.* In general, the Committee's report was accepted and a new unified system is to be established see: **New Complaints Procedures**. Furthermore, the Government accepted that the role of the Health Service Commission should be extended to the clinical area.

While better complaints procedures are important to patients, they do not promote what the Government promised that the reforms would do, *ie* choice in relation to place of treatment. Research reported in last year's Review indicated that improvements in this area had been slight. However, following a report by the House of Commons Select Committee on Health published in 1993, the Government announced during 1994 that steps were to be taken to improve choice in maternity care. The Committee had concluded that the NHS was not offering women a choice between hospital and home deliveries and that there were significant numbers of women who might choose the latter if it was regularly on offer. In April 1994, the Government announced a Maternity Services Charter which offered the right to choose place of birth and who could be present at the birth, as well as other rights such as a named midwife. A series of pilot projects in 1994 followed by a second in 1995 were given central funding to ensure *Changing Childbirth* becomes firmly established in the NHS.

These rights represent a genuine improvement in service for some women. But maternity is only one of many areas where options are available to patients. The classic defence of restriction of choice in health care is that the patient is not well enough informed to make a sensible choice. But steps can be taken to remedy that situation in relation both to forms of treatment and place of treatment. So far the Government has not supported this as a specific objective, content to confine its support to generalities, as the following written answers indicate.

New Complaints Procedures

Under the new arrangements, complaints to hospitals, the providers of community health services and family health services will be dealt with in similar fashion at two levels:

- **Stage One** provides a quick and informal way to complain direct to the provider of the service. The Trust or practice will respond to the complain and endeavour, possibly by using conciliation, to provide an answer which satisfies the patient. We anticipate most complaints will be handled this way.
- **Stage Two** – if complaints cannot be resolved at this level, complainants can ask for a further review. This may include establishing an independent panel under an independent lay Chairman and with a majority of members independent from the provider of the service. Independent clinical advisors will provide advice in appropriate cases. The decision to convene a panel will be taken by a non-executive member of the Trust or of the health authority in cases involving primary care services. In both cases this will be in association with the independent Chairman.

The Health Service Commissioner will continue to be at the apex of the complaints procedure. Patients can refer complaints to the Ombudsman if they are not satisfied with the response from the NHS or if they are unhappy about a decision not to convene a Stage Two panel. Community health councils will retain their role in providing information and support to complainants.

Consultants (Choice)

Mr Bayley: To ask the Secretary of State for Health; (1) what proportion of NHS *patients referred to hospital between January and March were given a choice of consultant: (2) what proportion of* NHS *patients (a) requested and (b) were granted a second medical opinion following a diagnosis by a consultant between January and March.*

Mr Sackville: The information is not available. The patients charter included the right for a patient, when his or her general practitioner thinks it necessary, to be referred to a consultant who is acceptable to the patient; and to be referred for a second opinion if the patient and the GP *agree that this is desirable.*

Source: Written answers, 15 July 94.

Patients' Choice

Ms Primarolo: To ask the Secretary of State for Health what degree of patients' choice as to place of treatment was available (a) before and (b) after April 1991.

Dr Mawhinney: A key aim of the national health service reforms is to improve patient choice. Since 1991, district health authorities and general practitioner fundholders have been able to purchase services, on behalf of their patients, and in consultation with them, in whatever place of treatment offers the best quality and value for money.

Source: Written answers, 20 July 1994.

The 'structural' answer begs a number of questions, not least the ability of professionals fully to interpret both the needs and the wishes of their patients. Better information helps. Launching a series of Patient Perception booklets, the Secretary of State said:

> *We are creating a listening health service, and this is illustrated by these booklets which provide a chance for patients and their families to give an appraisal of a specific healthcare service. They have been asked what they genuinely think of the service they are offered, and their comments are invaluable reading. I welcome the frank nature of some of the comments: the* NHS *must listen and learn from what its users tell it.*
>
> *The ultimate test of the* NHS *must be the patients' own perception of the care they receive. The challenge for the* NHS *is to translate the real concerns of patients into quality improvements locally. The needs of patients must be paramount in every decision made in the* NHS *and these booklets will be first-rate aids to making this happen.*
>
> *Built around comments by patients, the stroke booklet highlights areas where the service can be most sensitive to patient needs, such as rapid assessment and structured rehabilitation, involving both hospital and primary healthcare.*

Experience within social services, however, suggests that such measures may not be enough. A previous Review cited evidence from the Independent Living Foundation of the advantages perceived by those the Foundation assisted in being able to use cash to buy the care they wanted, as opposed to having to accept whatever they were offered. As things stand, local authorities do not have power to make cash payments though some manage to do so by backdoor means and the Government has until recently shown no signs of wanting to change the law. However, the Secretary of State told the annual social services conference in November 1994 that she intended to introduced cash payments:

> *Direct payments fit in well with our general philosophy of choice. They are a logical extension of the principles at the heart of community care and the Citizen's Charter – of involving users and carers directly in their care. They are principles to which the Government is firmly committed.*

Subsequently, in *Ending Discrimination against Disabled People,* which covered all relevant areas of public policy, the Government acknowledged that there were difficulties in moving in this direction but indicated it was still intending to do so:

> *The overall objective of the policies mentioned in this document is to give disabled people more power over their own lives. It is important, therefore, that policies on community care support this objective wherever possible. The Department of Health has recently announced its intention to introduce a new power to enable social services authorities to make cash payments to disabled people in lieu of providing community care services. This will give disabled people greater independence and choice and involve them and their carers more fully in their own care . . .*
>
> *Whilst there are still many complex issues to be resolved surrounding the operation of the new scheme, the Government will be looking to introduce the necessary legislation as soon as Parliamentary time allows.*

Vouchers could, of course, be used within the NHS. Within the existing system of finance, their role would inevitably be limited. But for those who rely permanently on health and social services, their introduction could go some way towards reducing the persistent boundary issues as well as giving patients some genuine degree of control over the care they receive. Thus, the Government can claim that progress has been made in better representing user interest, but a far more comprehensive approach is required to do the job properly.

PART 2: COMMENTARY

We begin this Part of the Review by updating last year's account of issues relating to finance and efficiency. We then turn as before to accountability and equity; in both areas, major issues continue to arise but their nature has changed from those discussed in earlier Reviews.

2.1 Efficiency and Finance

In the 1994 Autumn Statement, the Government announced that spending on the NHS would be increased by £1.3 billion, an amount which it judged would result in an increase in the real resources available to the NHS of one per cent which, combined with a three per cent efficiency target, was forecast to allow an increase in the volume of activity of four per cent. Whether that figure is achievable, and if so on what terms, turn first on the level of pay settlements and second on the scope for raising efficiency.

As reported last year, the Government stated in November 1993 that there should be no increase in public sector pay unless that could be linked to performance. In the event, it accepted the recommendations of the Pay Review Bodies for increases of 3 per cent, which were not linked to performance in any way. The Government returned to the issue in 1994, again seeking to enforce a link between pay increases and performance. However, during the course of the year, the emphasis on the nature of the link changed from an emphasis on the individual to the organisation. The letter to Trust Chief Executives sent out in June asked them to propose action plans for local pay determination by October 1994 and to have local pay bargaining machinery in place by February 1995 so that pay could be 'based on local needs and achievements'.

Later the same month, the Secretary of State said:

> *As we have been reminded over the last week, linking pay to performance, however it is done, can be a sensitive issue – and not just in the* NHS. *In my book, local pay arrangements should be linked to the success of the organisation. That success is, of course, determined by the organisation meeting its objectives to improve the quality and quantity of patient care.*

But the following month, the NHS Director of Human Resources, Ken Jarrold, interpreted the link between performance and pay rather differently.

> *The Review Body . . . said that trusts are ideally placed to identify achievement targets – either for individuals or for teams – which take account of quantity of output but also of wider and more qualitative health care objectives. I strongly endorse the views of the Review Body.*

Whether performance is to be linked to organisations, teams or individuals, the issues are essentially the same. Despite Jarrold's subsequent reference to 'robust measures', there is no sign of any emerging and, given the well known difficulties of measuring health care outcomes and the quality of care, very little chance of any emerging that would provide the basis for an across the board measure of performance.

Thus the Executive has been offloading to trusts a set of issues which it does not know how to handle. The result, as the Pay Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine pointed out in its 1995 report, has been confusion:

> *The changes of approach over the years on 'local pay' have ensured a period of continuing uncertainty in the NHS about what is meant by that term. Last year the Departments were emphasising the value of performance-related pay, and seeking to encourage local schemes based on increased individual productivity or improved efficiency. In their 1994 evidence the Departments have not encouraged linking pay and individual performance but proposed that local payments should be linked to the performance of each employing unit in relation to its objectives. They have emphasised that it would be up to each Trust to specify the form of its own local pay arrangements, but suggested that performance might be assessed against a number of factors including for example, the achievement of quality standards and target case volumes, as well as Trusts' financial targets.*

Against this background, it is scarcely surprising that trusts did not take the June letter seriously.

The reaction to the notion of local pay was strong: the Royal College of Nursing, the British Medical Association and the unions representing other workers all came out against it. The British Medical Association expressed its resistance to local pay as follows:

> *We believe that doctors should continue to be paid*

> *according to national pay scales, determined on the advice of an independent body.*
>
> *This does not prevent employers rewarding those who perform at the highest levels – through the distinction award scheme for example, nor those with the heaviest workload.*
>
> *The medical profession is profoundly opposed to individual managerially driven performance related pay of this kind as it would be divisive and inappropriate to medical work.*
>
> *It is our belief that most trusts do not have mechanisms in place to measure performance and we believe local pay for doctors is likely to lead to a waste of time and resources on annual pay negotiations duplicated in every trust in the country with a real danger of industrial disputes when negotiations break down.*
>
> *It will also cause variations in doctors' pay by specialty and by geographical location – given that some trusts will not be able to afford pay increases – while others may reward only those specialties which bring most 'business' to the hospital.*
>
> *This will cause recruitment difficulties in some specialties and some trusts, and particular problems for junior doctors who move around the country at frequent intervals in the course of their training.*
>
> *Finally, it will mean undermining the role of the Doctor and Dentists' Review Body which looks at doctors' pay on a national basis which takes into account the pay of other professions outside the NHS and the state of the national economy.*
>
> *We remain determined to persuade the Government that insistence on local pay will be an expensive distraction to NHS trusts, a divisive force in the NHS, and a threat to the integrity of patient care.*

In December, the Central Consultants and Specialists Committee of the BMA threatened action on two fronts if local pay arrangements were introduced:

> *Firstly, consultants would insist on treating all patients on the basis of clinical need regardless of whether they were being treated under contract with the trust. This procedure would bypass any two tier systems that give priority for non-urgent treatment to patients of general practice fundholders or to patients being treated under the waiting list initiative ... Decisions about clinical need would be taken by doctors and not by managers.*
>
> *Secondly, consultants would consider giving up their goodwill work for the NHS. At present consultants work 10 notional half days a week, which represent their contractual commitment. But on average each consultant works an additional 14 hours each week, much on unpaid management work...*

However, the BMA is not opposed to all links between pay and performance, as a further extract from the December statement indicates:

> *We have a possible solution for consultants in the form of the recently published working party report on distinction awards. This report offers a way forward on doctors' pay since it offers something of the best of both worlds – greater local discretion within an overall national framework.*

The difference is of course that, under local pay, most will be assessed by quite different criteria, namely that of NHS managers, not (in the main) fellow clinicians.

In the event, the Pay Review Bodies chose different options. That for doctors recommended a 2.5 per cent across the board increase where what it termed transitional pay arrangements were not in force; that for nurses, a 1 per cent across the board rise, with any further increase to be left to local negotiation at trust level. While this left the doctors content and dispelled fear of industrial action, the nurses were far from happy. By the end of March 1995, the nurses, along with ambulance staff, were still seeking a satisfactory national settlement while Ministers tried to reassure them that there was sufficient money 'in the system' for satisfactory local pay awards to be met. In a letter to the Royal College of Midwives, who had successfully balloted their members on the removal of a 'no industrial action' clause, the Minister of Health, Gerry Malone, wrote:

> *The Review Body expects the majority of midwives to receive pay increases of between 1.5 and three per cent. Ministers have frequently said they endorse this conclusion. We have also made clear that, provided the extra £1.3 billion for the NHS in 1995/96 is used efficiently, the money is available both to fund the pay awards and ensure that the quality and quantity of patient care continues to improve. Midwives have a very important and valuable role in this.*
>
> *You will also be aware that 70 per cent of the Trusts that have already indicated their intentions have offered around three per cent. We expect this trend to continue.*
>
> *Industrial action has no place in the National Health Service. I am disappointed that the Royal College has been considering changing its rules. I am sure you will share my hope that no action is taken which damages patient care in any way.*

By the middle of 1995, the nursing and ancillary staff unions had still not accepted local pay, no industrial action had been taken but an end to the dispute was not in sight. Though the Government had made some concessions, it was still committed to local pay bargaining. But while the Government has emphasised the need to link pay to performance in fact, as the following extract from the Nurses' Review Body's 1995 report makes clear, local pay is not so much about performance as the ability to restructure jobs and to respond to local market conditions:

> *The Departments made clear to us that the future benefit they expected from introducing local pay arrangements was greater flexibility and efficiency in delivering health services. They pointed out that jobs could be tailored to meet the needs of the local organisation and pay could reflect local employment market rates.*
>
> *Locally determined pay also offered the flexibility to concentrate organisational and team efforts where they could have most effect in improving the quality and*

> *quantity of patient care. In effect Trusts would be able to use any resources available to them for this purpose to assist in bringing about change, for example by 'buying out' inefficient working practices. The Trust Federation and NAHAT confirmed that this would indeed be their members' intention, and gave us a number of examples including harmonising terms and conditions (eg basic hours across different groups), reducing absenteeism, and changing nursing practices to incorporate tasks currently done by junior doctors.*

That there are issues in the deployment of staff to be tackled is undoubted. Boundaries can and should be broken down between what are now separate professional groups. In early 1995, it was discovered that a nurse had assisted in a surgical procedure. While the media reaction was hostile, an editorial in the Lancet [18 March 1995], reacted quite differently:

> *Perhaps much of the anxiety expressed by the surgical establishment was engendered by the inevitable inference that a great deal of surgery in many countries is not carried out by consultant-level surgeons. Workload, manpower, and cost considerations dictate that this must be so, and it does not seem to be detrimental to the general public weal. While this situation is not hidden from the lay public neither are they gratuitously reminded of it. For certain definable operations, suitably trained and supervised personnel taken from the ranks of operating room staff should be in no different a position than are junior medically qualified trainees. These latter individuals have only a veneer-thin familiarity with the world of operative surgery and can seldom begin to approach the skills and knowledge of senior operating room nurses. They often perform operations such as appendectomies, and sometimes under far less experienced supervision than was available to Mrs Tomlinson (the nurse concerned).*

Individual trusts can make progress in such areas; some have already 'broken boundaries' and re-allocated work between doctors, nurses and technical staff. The reduction in junior doctors' hours is actively compelling such changes.

A major obstacle to greater flexibility, however, lies in the rules governing the deployment of medical staff. Some of these, such as duty rosters and the organisation of medical 'firms', as the Audit Commission's report *The Doctor's Tale* made clear, do lie within the power of trusts to tackle as its recommendations on skill mix and deployment indicate: see Table 8.

Table 8: Audit Commission: Recommendations on Doctors' Roles

1. Trusts should clarify the roles of doctors and other professions by:
   - ensuring that all doctors have job descriptions setting out the service and training content of their work;
   - developing clear written guidelines about the allocation of tasks between doctors and other professions and between the different grades of doctors;
   - ensuring that tasks are efficiently matched to the competence of the doctors involved.
2. Policies should be developed by trusts in co-operation with postgraduate deans on the nature and extent of supervision of junior doctors. Juniors must know when to seek help and seniors must be aware of their responsibilities.
3. Junior doctors should at all times have access to a consultant who has the power to make decisions about the care of individual patients in the absence of a patient's named consultant.
4. Trusts should manage demand more effectively and encourage consultants to share the workload more evenly. Where possible, patients awaiting emergency operations should be grouped into scheduled sessions.
5. Doctors should be deployed more efficiently to meet both service and training needs:
   - junior doctors' basic working hours should be allocated more flexibly across the day;
   - shift and partial-shift systems should be encouraged because they offer advantages to both patients and doctors;
   - protected time for handover between shifts and rotas is needed to ensure continuity of patient care;
   - the number of tiers of staff providing emergency cover should be reduced if the demand is not sufficient for the current number; and
   - where appropriate, specialties should also be combined to provide emergency cover.
6. Trusts must develop policies and posts in cooperation with postgraduate deans and the royal colleges to take account of the special needs of doctors with family commitments.

Source: Audit Commission, *The Doctor's Tale*

Other obstacles are more difficult to remove. Perhaps the most important of these is the rules governing medical staff in training posts which are set by the Royal Colleges. These largely determine how staff in training grades are used, leaving little scope for local variations. Yet they are not subject to outside assessment and it would be hard, if not impossible, for an individual trust to try to modify them as in doing so they might find recruitment impossible. Some relief may be found through the use of foreign doctors, particularly from other member states of the European Union, an option which some hospitals have already made use of. But if fundamental ways of restructuring medical work particularly in hospitals are to be explored, all the relevant elements determining the deployment of doctors must be considered together; individual trusts cannot do this, so local pay will not help.

The second leg of the case for local pay is the argument that pay should be related to local market conditions. In other words, if recruitment is easy and staff retention levels high, then pay should be increased by a lower amount than in areas where the reverse is true. This argument can be found in the official evidence to the Pay Review Bodies in the late 1980s, well before the trust regime was introduced. But neither then nor subsequently has a figure been put forward for the scale of the potential saving.

What does seem clear, however, is that however large the potential saving might be, little will be achieved this year. If, as seems likely at the time of writing, the Government does not yield to pressure from the nursing unions, most trusts will make settlements at or around 3 per cent. If that proves to be the case, then the main burden of raising efficiency will have to fall elsewhere, principally from pressure applied through purchasers to raise activity levels within existing budgets.

Although labour costs are by far the most important single item in NHS costs, Treasury hawks have had their eye on the drugs budget for years but it has resisted explicit containment: instead a number of strategies have been pursued designed to reduce it, short of actually imposing a fixed cash limit.

The most important are: the pharmaceutical price regulation scheme, restrictions on prescribing – the limited list – and influences on prescribing behaviour. We take each of these in turn, drawing on an investigation by the House of Commons Health Committee *Priority Setting in the NHS: the NHS' Drugs Budget.*

Price Regulation: in *Health Care UK 1990* Anthony Harrison suggested that the pharmaceutical price regulation (PPRS) scheme might be less onerous on the industry than it sometimes tried to make out. The Committee took a similar view and concluded:

> *The lack of transparency in the workings of the Scheme means that it is simply not possible for Parliament or the general public to know whether or not taxpayers' money is being directed towards medically useful research.*

Accordingly it made a number of suggestions designed to open up the scheme to public scrutiny, including an assessment by the National Audit Office and also proper and regular reporting.

> *We therefore recommend that the Department of Health introduce greater transparency into the Scheme: in particular, by means of publishing an annual report on the PPRS which shall include the aggregate profit earned by each company as assessed under the Scheme, the total amount of profit which is assessed as being within profit targets, the total profit which is assessed as being above target profits but within the Margin of Tolerance, and total profit which is above the upper limit of the Margin of Tolerance, and the allowances for research and promotion founded upon these returns. It should also include the aggregate profit declared under the Scheme, the total value of all repayments made to the Department of Health as a result of excess profits and the total value of any price reductions. This report should be laid by the Secretary of State before Parliament.*

The Government rejected most of the Committee's criticisms:

> *The Government has carefully examined whether there is unnecessary secrecy in the way the PPRS operates and there are proposals below for making further information available. In general, however, the Government does not accept that the scheme is operated in an over-secretive way, that it is tilted in favour of the industry, or that it is impossible for outsiders to establish the facts on which this view is based.*

Limited List: previous Reviews have reported on the steady growth of items added to the List picking out some which it was hard to see were justified as prescription items. The Committee, however, found strong opposition to the List both from the industry and user groups. They nevertheless stuck to the principle which underlies the scheme that limitation on the grounds that some drugs are ineffective or more expensive than other equally effective drugs is justified. But they made a number of recommendations designed to improve it:

> *We believe that a logical and desirable extension of the Selected List policy would be the development of a National Health Service Prescribing List, in other words a 'white list' covering all therapeutic categories. This would contain a wide spectrum of products which the NHS was prepared to buy. The list would automatically include all drugs at the time of their launch and for five years thereafter. In other words, all new products would be prescribable on the NHS. After five years, a time sufficient to allow formal assessment of the therapeutic value of the product, each drug would be reviewed according to the criteria applied to drugs in the current NHS Selected List. Those drugs which were found to be less effective, or more expensive with no therapeutic advantage, than competitor drugs would then be excluded from being prescribed on the NHS (although doctors would of course remain free to prescribe them privately). In this way a 'national formulary' would be gradually built up in a predictable, rational way.*

Under this arrangement, new drugs would in effect be given a chance to prove themselves and those found to be less effective or more expensive with no therapeutic advantage in the five year period would not be paid for by the NHS.

The Government welcomed the Select Committee's findings on the list:

> *In particular, we welcome the Committee's careful examination of the Selected List, which has been the target of much ill informed criticism, and their support for the principle which underlies the scheme, namely that drugs, which are ineffective, or which are more expensive than other equally effective drugs, should not be prescribed.*
>
> *The Committee recommended that there should be a National Prescribing List. In the period leading up to the review of the Pharmaceutical Regulation Scheme due before 1998, we will be considering a range of options. These will include replacing the Selected List*

Scheme with a positive list on the lines recommended by the Committee. However before adopting such a course we would need to be absolutely confident that patients would continue to receive all the medicines they need.

The Government welcomes the Committee's endorsement of the policies we are taking on prescribing and the recognition that good prescribing does not mean scrimping on patient care. We are building on those policies in particular with the development of GP Fundholding.

Prescribing Habits: the Committee made a number of suggestions designed to bear on under- as well as over-prescribing. Overall, however, they clearly felt net savings would result. A similar conclusion was reached by the Audit Commission. In *A Prescription for Improvement*, it argued that both the quality and the cost of prescribing could be reduced. It found evidence of both under- and over- prescribing, but on balance concluded that savings could be made. Their forecasts are set out in Table 9. Total savings are estimated to be very high – some £500 million – though in the Commission's view some of these should probably be offset by higher prescribing for some conditions such as asthma and other chronic conditions where there was evidence of under-prescribing. The problem is: how can savings of this order be achieved?

One instrument is feedback, using information from the Prescription Pricing Authority. In 1994, a new improved form of report was introduced. But there is little evidence of the effectiveness of the reports, *eg* a study by Leeds Prescribing Research Unit suggested that practices with high costs did not respond to being informed. However, fundholders do appear to respond, if not quite in the way expected, as Table 10 shows. Fundholders appear to prescribe fewer but more expensive drugs.

The Government took action to reduce the pressures that drug companies can impose on GPs. New regulations implementing the EC Directive on the Advertising of Medicines were announced in July which are

Table 9: Potential Long Term Savings from Better Prescribing

Over-Prescribed Drugs	Up to £300m
Less Prescribing of Drugs of Limited Therapeutic Value	About £50m
Substitution of Alternative Drugs	Up to £110m
More Generic Prescribing	Over £85m
More Selective Use of Expensive Formulations	About £40m
Less Double Counting of Savings on Over-Prescribed Preparations	[£75m]
Total Potential Savings	About £500m

Note: Figures are based on 1992/93 prescribing patterns and September 1993 drug prices and are rounded to the nearest £5 million

Source: Audit Commission, *A Prescription for Improvement*

Table 10: Prescribing Data for GP Fundholders and other GPs

	Expenditure		Prescription Items		
	Cost	Cost per Head	Items	Item per Head	Cost per Item
	£m	£	Nos.	Nos.	£
1991/92					
Fundholding	172	51	26	7.7	6.60
Non-Fundholders	2415	54	381	8.5	6.34
Total	2587	54	407	8.4	6.36
1992/93					
Fundholding	356	56	51	8.1	6.93
Non-Fundholders	2545	61	372	8.9	6.84
Total	2902	60	423	8.8	6.85
1993/94					
Fundholding	741	61	102	8.4	7.29
Non-Fundholders	2451	67	339	9.3	7.22
Total	3192	66	441	9.1	7.24

Source: as Table 4

designed to tighten controls on hospitality and other inducements offered by drug companies to influence GP prescribing. The regulations prohibit drug companies from offering expensive gifts, pecuniary advantages or benefits in kind as inducements to prescribe and also set limits to the levels of hospitality which may be offered.

The Government also urged health authorities to take a more active role in ensuring good prescribing through:

- developing shared agreements between GPs and consultants for the use of new expensive drugs and rigorously auditing clinical outcomes;
- developing contracts between fundholders and local consultants specifying that referral letters should recommend a drug type not a specific drug or brand;
- encouraging hospitals to think carefully before accepting preferential discounts to use a certain drug which can lead to short term savings for hospitals but large costs passed on to primary care.

The Committee report and the Government response describe a wide range of measures designed to reduce the rate of increase in the cost of drugs, too many to consider here. However, according to Nick Freemantle and others (British Medical Journal 310 pp 955-56), they do not go far enough. Drawing on experience in Australia and Canada. they suggest that the guidelines issued in 1994 for the economic evaluation of medicines should be made effective. In the Australian case:

> *The use of economic analysis is having an impact on decisions on listing and drug prices in Australia. Manufacturers of new drugs that have no demonstrable advantages over existing products are offered the same price as that for similar products. Those that are superior, on the basis of data from clinical trials, have their incremental cost effectiveness assessed to determine whether they represent 'value for money' at the price being sought by the sponsor. While the deliberations of the advisory committee are confidential, some recommendations have received press coverage for example, the failure to agree prices for sumatriptan and salmeterol and the rejections of applications to list finasteride for prostatic hyperplasia and DNAse for cystic fibrosis. There have also been instances in which good data and competent economic analyses have been used to justify higher prices than would have been achieved if a more arbitrary approach had been used. As these successes have not received press coverage their details remain confidential.*

On this basis, the authors imply, the industry should find their proposals acceptable and the conflict between regulation and profitability reduced. Their main point, however, is that licensing should involve cost effectiveness not just effectiveness:

> *The pursuit of effectiveness alone, regardless of cost, can deprive other patients of care from which they would benefit more. Such care may be clinically effective but is inefficient and unethical. If scientifically rigorous guidelines for the conduct of economic analyses are not linked to some kind of regulatory mechanism or positive incentives there is little chance of their influencing clinical practice and therefore benefiting patients. This is recognised both in the Australian attempt to link reimbursement with evidence of cost effectiveness and in the consultative process for the Canadian guidelines, which includes users as well as producers of analyses.*

Offloading Finance

Last year's Review described the private finance initiative, seeing it as part of the Government's broader strategy towards the public sector. In general, despite the relaxations to the rules governing the use of private capital for public projects recorded last year, trusts proved slow to make use of it and, as Table 11 shows, most schemes are concerned with accommodation or hospital service. A rare exception is a major scheme at St James' University Hospital, Leeds. This, costing £25 million, comprises clinical facilities along with non-clinical elements.

A briefing issued by the Executive in March 1995 reported that 40 schemes, each with a capital value of £1 million or more, had been approved. At the same time, new guidelines were introduced (HSG(95)15), which stated that:

> *NHS Trusts and Health Authorities should rigorously explore private finance options.*

The Capital Investment Manual published in 1994 'makes clear that *every* business case must show that serious consideration has been given to private finance options'. The Guidance fails to make clear, however, what the benefits to trusts of this requirement is. It would seem that in some areas there are none. In the case of the cardiac unit at the Morriston Hospital in Swansea, which was put out to tender, the internal bid was substantially lower than the private largely, it would seem, because private bidders had to include a large risk premium to allow for the fact that purchasers were not in a position to offer long term contracts.

The proportion of NHS costs met from prescription charges is low, but the Government, with successive increases in the charge per prescription, has succeeded in raising the revenue raised from them. In March 1995, prescription charges were increased further from £4.75 to £5.25 along with dental charges and voucher values for spectacles. A fundamental principle of taxation is that its level should not be pushed beyond that where net revenue drops. In respect of prescription charges, there are some signs that the Government may have reached that point. The charge does not vary with the nature of the drug prescribed, so for inexpensive drugs it is often cheaper to buy privately. It appears that many GPs and pharmacists write private prescriptions where the cost of the medicines are less than the charge. The precise situation appears confused. According to the Consumer's Association, there are over 700 over-the-counter medicines and 350 prescription-only charges. However, private prescriptions only produce a saving for patients if GPs do not charge for them and dispensing fees are low. Furthermore, according to the BMA, GPs' contracts do not allow them the discretion to suggest

Table 11: NHS Projects using Private Capital over £1M approved since February 1993

	Capital Cost (£m)
Lease of Office Accommodation	3.0
Clinical Waste Incineration	6.0
Staff Residences	1.4
Endoscopy Unit	1.0
Residential Accommodation	1.4
Clinical Waste Incineration	2.6
Lease of Office Accommodation	2.0
Lease of New Headquarters	2.0
Clinical Waste Incineration	3.0
Residential Accommodation	2.3
Clinical Waste Incineration	2.0
Staff Residences	2.5
Residential Accommodation	3.0
Residential Accommodation	2.1
Clinical Waste Incineration	2.7
Staff Accommodation	3.3
Combined Heat And Power Plant	3.0
Lease of Office Accommodation	4.2
Lease of Office Accommodation	1.7

Source: House of Commons written answers 3 May 1994

over-the-counter medicines; it has asked for a minor change in the contract to allow this.

It is hard to discern from all this just what the Government intends. It customarily refers to prescription charges as 'contributions towards the NHS' without explaining why this particular service should be picked out. When charges were introduced, one rationale offered in their defence was that people needed to be deterred from over-use, but of course that would require an across-the-board charge. A more plausible interpretation, one which reflects the current position better, is that drugs are moving in the same direction as dental charges, *ie* towards total privatisation for certain users.

Off-Loading Services

Last year we identified three areas which appeared to be at the margin of the NHS, long term care, dental services and drugs where the Government appeared to be intent on narrowing the scope of free provision. Before looking at long term care and dental services again, we look briefly at eye services (see *Health Care UK 1990)* and foot care.

Eye services: on 1 April 1989, unconditional free sight testing was withdrawn. Free tests remained for students under 19, those on income support, diabetics and glaucoma patients, those requiring complex lenses and those registered as partially sighted or blind.

At the time, it was suggested that one effect would be to reduce the number of sight tests, particularly among elderly people, and as a result, the incidence of ocular disease, for which the sight test was the only screening mechanism, would increase. The introduction of charges led to a large increase in tests just before the charges came into effect and a decline thereafter. Since then, the number of NHS tests has risen as Table 12 shows.

The sight test is the only existing means of screening adults for eye diseases. According to a report by Laidlaw and others (British Medical Journal 309 pp 634-636) on referrals to the Bristol Eye Hospital, introduction of the test fee has led to a fall in the numbers of people identified as having glaucoma. The shortfall

Table 12: Number of NHS Sight Tests

	Millions
1989/90	6.0
1990/91	4.8
1991/92	5.8
1992/93	6.4
1993/94	6.9

Note From 1 April 1989, NHS sight tests were restricted to certain eligible groups in the population. The figures for 1989/90 included 1.82 million sight tests paid for in 1989/90 but conducted in 1988/89 under the previous scheme. The remaining 4.22 million were conducted and paid for in 1989/90, which does not constitute a full twelve months of the new scheme. The figures for 1990/91, which do represent twelve months after the new scheme, are not therefore directly comparable with those for 1989/90. The 1993/94 figure is provisional.

Source: House of Commons written answers 6 July 1994

UNEXPECTED COSTS AFTER TRANSFER TO A PRIVATE HOME

Matters considered
Transfer to private residential home without prior notification or discussion about responsibility for payment of fees.

Summary of case
An elderly woman who lived alone fell and was taken to the accident and emergency department of the West Cornwall Hospital where her leg was put in plaster. She was unable to walk and could not be discharged home but was transferred the same day to a private residential home. On receiving a bill for £928 for her stay in the home she asked the Royal Cornwall Hospital NHS Trust to pay but they declined. She complained that her transfer without agreement beforehand about responsibility for paying fees was contrary to Department of Health guidance, and sought redress.

Findings
A casualty doctor decided that the woman did not need to be kept in hospital, although several days later a fracture was diagnosed. When nurses found that the woman could not walk even when assisted, the casualty doctor telephoned a general practitioner and arrangements were made to admit the woman to a private residential home. I found no evidence that attempts had been made to find her a hospital bed, though it would have been possible to do so. The staff had not told the woman about fees for the home, nor had they followed the Department of Health guidance issued in 1989 or the local guidance about discharge procedures. The casualty doctor thought that any discussion about fees should have been the responsibility of the general practitioner. I upheld the complaint.

Remedy
The Trust apologised and paid the bill. They agreed to ensure that staff knew what was required of them under national and local guidance about discharge arrangements, and to discuss with social services the arrangements for ensuring that timely advice was available before any transfer to a private home.

Source: Health Service Commissioner

was estimated to be one case per 10,000 population. From this admittedly limited evidence, it would seem that the Government's financial off-loading policy has resulted in lowering the quality of care.

Footcare: in September 1994, a joint Department of Health/NHS Task Force reported on chiropody services. *Feet First* identified those types of need for foot care:

The foot problems of people with 'at risk' feet, for example when diabetes or peripheral vascular disease has caused impaired circulation. The report states that where there is impaired circulation, infection is slow to heal and can eventually necessitate amputation.

Disabling foot conditions: Conditions which cause severe functional incapacity with immobility.

Basic foot care and nail-cutting for people who do not have 'at risk' feet or disabling foot conditions but who cannot reach their own feet and who cannot see well enough to cut their nails, or cannot use scissors or clippers because of problems with their hands.

Feet First states that in the past specialist chiropody services have dealt with all these different types of foot problems but implies that, in future, this may not be possible. The implication to be drawn from this is that the NHS should no longer be relied upon to provide footcare in the third category.

Long Term Care: last year, the Review contained an extract from a special report by the Health Service Commissioner on the case of a patient in Leeds who had been discharged from hospital in to private care. The Commissioner concluded that he should have remained the responsibility of the NHS. As **Unexpected Costs after Transfer to a Private Home** indicates, the case was not unique. No one appears to be clear where the responsibility for long term care lies. The Government issued a consultation document (HSG (94)) in August designed to clarify the situation. In practice, however, a precise form of words proved elusive.

New Guidance was eventually issued in February 1995 in HSG(95)8 but while this went further than the earlier consultation paper, it still did clarify precisely the range of patients that would qualify for NHS support, as Gerald Wistow explains below.

Alan Langlands was right to claim in a letter to the same issue of The Independent (28 February 1995):

> *The guidance does not change two fundamental principles that have been in place since the foundation of the welfare state in 1948.*
>
> *First, that NHS care is provided, free at the point of delivery, to patients on the basis of clinical need, whatever their age. Crucially, it is doctors with nurses and other health and social services staff who decide whether a patient needs continuing care from the NHS.*
>
> *Second, since 1948, there has been a widely recognised boundary between the responsibilities of the NHS and social services. The guidance does not shift that boundary. It does make it considerably clearer where the responsibilities of the NHS lie, by offering a comprehensive national framework of the full range of NHS responsibilities.*

But the point this skates over is that because average lifespan has increased, the 1948 policy framework is not as appropriate as it then was. Life expectancy has risen while working life has shortened. Furthermore, the existence of Alzheimer's disease was not then recognised. The prospect of the spouses of Alzheimer's sufferers is a dismal one, in both emotional and financial terms. It is hard to see why a national health service should leave such an issue for local determination. Furthermore, the Guidance evades the central issue, that the financial consequences of the decision going one way or another are so vast.

Most people will not need extensive periods in residential care but will require both health and social care in their old age. For them, the key issue is whether the differences in financial regime between the NHS and social services and the uncertainty over the boundary wherever it is gets in the way of effective collaboration between the two.

The Association of Directors of Social Services pointed out in their discussion document, *Continuing Care: continuing concern*, that the real object of concern, ought to be the quality of life of elderly people. That involves effective joint working, which despite the rhetoric often does not take place. It also involves a more explicit concern with outcomes, including functional gain as well as longer lives.

The requirement to adopt a multi-disciplinary assessment for community care involving both NHS and social services staff is clear in the 1990 Act and in the guidance but, as the Social Services Inspectorate study, *Community Care Packages for Older People* demonstrates it has rarely been carried through in practice. Yet collaboration and joint working in assessment is considerably easier, given the will, than collaboration in service development and service provision.

Dental services: in July 1994, the Government finally published its Oral Health Strategy, together with a white paper, *Improving NHS Dentistry*. In its white paper, the Government argued for a new approach while retaining the central elements of the old. It proposed no change as far as charges are concerned for the exempt groups, but did suggest that charges for routine examinations should be reduced leaving those paying for treatment now to pay more. It also proposed changes in the structure of the contract. The main suggested innovation was the introduction of session payments, designed to remove the incentive to overtreatment that a fee for service system was thought to create.

It also proposed improved mechanisms for targeting services where needs are greatest, *ie* where dental health is poorest. As we pointed out last year, dental services provide in some respects a test of whether the Government is committed to a needs-based approach. Unlike most other parts of the NHS, there is good information about the state of dental health and that information has persistently revealed wide disparities between different parts of the country. Hence, it is feasible to allocate resources to those areas where needs are greatest.

Reaction from the profession proved hostile. The British Dental Association rejected the white paper in summary terms:

> *If the Government's proposals come into effect, dentists predict serious consequences both for patients and NHS dentistry. Patients will have more difficulty obtaining NHS treatment. They may not be seen by the dentist of their choice and may not be able to receive the treatment they want. There will be waiting lists and patients will have to pay more for their treatment.*
>
> *For NHS dentistry, Government proposals will increase bureaucracy to the detriment of patient care. Dentists believe that the service is already underfunded, yet there is no guarantee that existing funding will be maintained, let alone increased. Whilst the present underfunding persists there is no prospect of improving NHS dentistry.*

It went on to say that 'the sessional model is not acceptable to a large majority of the profession. It will have adverse effects on the care of patients, the provision of services and the viability of practices'. It also reported that:

> *There is no great enthusiasm among dentists for the purchaser/provider system. About one third of Local Dental Committees, however, may be prepared to take part in pilot studies.*

As usual with statements of this kind, concern with the profession's and the patient's interests are intertwined. The profession clearly see the idea of introducing the purchaser/provider split as the thin end of a wedge, at the broad end of which is loss of independence. As for patients, the General Dental Standards Committee argues that:

> *Patients will have difficulty in obtaining NHS treatment and may not be able to afford private treatment. The proposals present no real improvement for children's dentistry or patients in general.*
>
> *Patients may not be seen by the dentist of their choice and may not be able to receive the treatment they want. They will have to wait longer and pay more for their treatment.*

In April 1995, the Government announced its plans. These are in two phases. In the first phase, four changes are to be introduced:

- improvement of the capitation system already in place for the care of children by relating payments to dentists to disease levels in children most at need;
- introduction of more rigorous prior approval procedures to ensure that only those treatments which are clinically essential are carried out;
- reform of the system of continuing care payments;
- development of the role of the community dental service to meet the needs of patients in areas where it is difficult to get NHS treatment.

In the second, longer term phase, the Government intends to introduce a system of local contracts between health authorities and dental practices, similar to that in the rest of the NHS. As envisaged in the white paper, it will be 'carefully piloted and thoroughly evaluated'. Pilots will, however, require legislation so they are 'unlikely to commence for some years'.

With this announcement, the Government backed off some of the most unpopular parts of the green paper proposals, specifically the sessional payments and higher charges for non-exempt patients. But the fact that these proposals were not announced in a white paper and remain in part subject to consultation with the profession suggests that policy is some way from being settled.

2.2 Accountability

The continuing need for improvement in financial accountability was underlined by an Audit Commission report, *Protecting the Public Purse 2. Ensuring profits in the NHS* in the following extract from the summary. Some examples are given in **Fraud in Primary Care**.

Unlike the Wessex and West Midlands disasters reported last year, these frauds are relatively small. However, they appear to be more numerous.

> *Primary health services currently account for a quarter of NHS expenditure and the proportion is growing. They face the most pressing problems in preventing and detecting fraud and corruption. Family health services authorities (FHSAs) have the responsibility for monitoring claims for payment from local GPs, opticians and pharmacists. However, the current methods of payment to these independent professionals carry inherent risks of fraud in that they involve large numbers of claims for payment that depend on trust, and provide little opportunity for prepayment checks. Many FHSAs do not have adequate systems to undertake proper monitoring, and have no direct financial incentive to prevent or detect fraud, as the money saved would not accrue to the FHSA. Further investigation into the full extent of the problem is required, but there is little doubt that the application of new technology would improve monitoring in some FHSAs.*

In March, the Government expressed faith in old technology when the Minister for Health announced a 'new-look' prescription form which put the onus on the patient to show why they are not paying a charge. Prescription fraud is estimated to cost the NHS £30 million a year or, as the press release put it:

> *7,000 hip replacements, 20,000 cataract operations, or 3,000 heart valve operations.*

Last year's Review reported on the major financial and clinical scandals that emerged during the year, prompting the Government to promise a new code of practice, which duly appeared in April 1994. It was sensible enough, but broke no new ground – essentially it represented a restatement of traditional public sector values. It also restated some basic requirements:

> *The Government's commitment to strengthening accountability is demonstrated in the new Codes of Conduct and Accountability in the NHS, issued in April last year, reaffirmed the public service values of openness, probity and accountability. They draw on existing good practice and impose new requirements for each NHS board. These include:*
>
> - *the need to establish separate committees for audit and board members' remuneration and terms of service;*
> - *the need for health authorities to publish annual reports;*
> - *the need for all NHS boards to maintain a publicly available register of members' private interests;*
> - *the need to publish directorships and other interests in the annual reports.*

In September, a draft *Code of Practice on Openness in the NHS* was launched for consultation which was designed to help the public to be 'confident that those appointed and employed to run the NHS take seriously their duty

Fraud in Primary Care: Some Examples

Case 1
Complaints against a GP by a patient led to investigation by an FHSA and the police. Evidence was found of fraudulent inflation of the GP's practice list as well as evidence of false claims and collusion with a pharmacist to dispense bogus prescriptions. Investigations identified that the list included 45 people said to be living at the same address, a three bedroomed house. Enquiries revealed that only six people lived there. The GP was brought to trial but, after several weeks, the judge ruled that the complexity of the prosecution prejudiced a fair trial.

Case 2
Another FHSA's internal controls recently identified that a GP was claiming for 23 patients living at the same address, a one-bedroomed flat owned by the GP. The case is currently with the police.

Case 3
Internal auditors identified that a fundholding GP fraudulently charged payments to the management allowance, although they should have been charged to the practice account. He attempted to conceal the fraud of £8,000 by false accounting. The fraud was reported to the FHSA's medical service committee and recovery was made by withholding part of the management allowance for the following year.

Case 4
A GP submitted claims for practice staff for amounts in excess of actual costs. The fraud which totalled over £27,000 over a two-year period was identified by FHSA staff. The GP has agreed to repay the amounts fraudulently claimed (together with the FHSA's costs). The case was referred to the General Medical Council.

Case 5
The new GP contract introduced in 1990 raised a GP's fee for a night visit from £20 to £46. One GP's patterns of claims changed markedly following the change. Before 1990, he claimed 196 visits per year, but in 1991 and 1992 claimed for 500 visits a year, compared with a FHSA average of 60 visits per GP each year. The FHSA raised their concerns with the GP but made no progress in 15 months, despite the support of the local medical committee. The matter was referred to the General Medical Council, who are still awaiting the outcome of court action.

Source: Audit Commission, *Protecting the Public Purse 2* to look after taxpayers' money and ensure it is used to best effect for patients'.

The Code is intended to ensure that people:

- *are able to get information about how well the NHS is doing, the cost of services and the standards of service you can expect;*
- *are given an explanation about any proposed changes to services, and given the chance to have a say in the decisions made about those changes;*
- *know the reasons for decisions and actions affecting your treatment.*

Announcing the draft Code, the Secretary of State said:

> *The health service has been built on the foundations of three key elements: public understanding; public involvement and public confidence. The NHS reforms and, in particular, the clear separation at local level of purchasing and providing functions have already done much to make the NHS more transparent.*
>
> *I expect the reforms to lead to a sharper focus on health gain and clinical outcomes as a fair and rational basis for taking decisions about health care. This process must command both the confidence and understanding of the public. They must be involved in decision-making so that they can feel the Service is responding to their needs.*
>
> *Sharing information with the public is vital to fostering confidence and trust. Our proposed Code of Openness states that information should be made available unless there are good reasons – for example patient confidentiality – for not doing so. And I will have no time for 'Yes Minister' definitions of 'a good reason'.*

The Code was published in its final form in April 1995. It describes the information that trusts and health authorities should make available in the following terms:

- information about what services are provided, the targets and standards set and results achieved, and the costs and effectiveness of the service;
- details about important proposals on health policies or proposed changes in the way services are delivered, including the reasons for those proposals;
- details about important decisions on health policies and decisions on changes to the delivery of services;
- information about the way in which health services are managed and provided and who is responsible;
- information about how the NHS communicates with the public, such as the details of public meetings, consultation procedures, suggestion and complaints systems;
- information about how to contact community health councils and the Health Service Commissioner (Ombudsman);
- information about how people can have access to their own personal health records.

The Code forms part of the wider Government commitment to open government, made in the 1993 white paper. The Government also responded to a specific NHS concern with the way in which appointments of chairs and non-executive members of trusts and health authorities have been made. In February 1995, the Government published guidelines for appointments of chairs and non-executive members of trusts and health authorities. Announcing them, the Secretary of State said:

> *The public should know who is on their local trusts and health authorities and have confidence in them. Above all they must be able to expect non-executives and chairmen to work effectively on their behalf to ensure that local health care needs are properly met.*
>
> *All non-executives and chairmen must sign up to the Codes of Conduct and Accountability, which set out the standards expected of public servants. It is important that those appointed are committed to the public service values of the NHS and reflect them in their work.*

The Code was primarily addressed to health authorities and trusts – a separate draft Code for members of community health councils was circulated in April 1995 – but as noted in Part 1, the spread of GP fundholding has brought with it accountability issues of its own, as the Secretary of State recognised when announcing her proposals for the extension of fundholding:

> *The public must be confident that innovation is backed by proper accountability; family doctors must be responsible (sic) for the use of taxpayers money. We will set out the ground rules of accountability which secure this objective without imposing unnecessary bureaucracy on GPs. We will be looking at how we can simplify as well as clarify accountability.'*

The Government's proposals, *An Accountability Framework for GP Fundholding*, were circulated in December (EL(94)92). This proposed four basic requirements for management accountability:

- *advance announcement of major purchasing shifts*
- *an annual practice plan*
- *a performance report*
- *performance review*

as well as additional requirements in respect of accountability to patients and the wider public, financial accountability and clinical and professional accountability: see **Accountability in General Practice: Key Features.**

As the National Consumer Council pointed out in its response to the consultation draft, while the proposals go far beyond the existing arrangements, they do not deal adequately with the situation as it will be under total fundholding. That, of course, is some way off, but the Council's response identified a number of other weaknesses which apply now:

- *The framework does not address the central issue of*

Accountability in General Practice: Key Features

Management Accountability

- preparation of an annual practice plan
- signalling major shifts in purchasing intentions
- preparation of an annual performance report
- review performance with the health authority within the national framework

Accountability to Patients and the Wider Public

- publishing information (*eg* annual practice plan and performance report)
- involving patients in service planning
- ensuring an effective complaints system

Financial Accountability

- preparation of annual accounts for independent staff
- providing monthly information for monitoring by the health authority
- securing health authority agreements to use of savings
- stating planned contribution to the local efficiency targets set by the NHS Executive

Clinical and Professional Accountability

- participating in clinical audit of general medical service activities
- ensuring appropriate clinical audit of purchased hospital and community health care

> *the relationship between doctors and patients. If true accountability is to be achieved, the nature of the doctor/patient relationship needs to be more fully explored.*
>
> - *The document does not describe clearly enough the dual role of GP fundholders – as independent contractors of General Medical Services, and as purchasers of certain services through the fundholding scheme. These relationships will become more complex and more difficult for patients and others to understand if the fundholding scheme expands to include 'community' fundholding, as well as variations on the theme of 'total' fundholding.*
> - *The 'framework' appears neither to set out a framework nor to set out the different lines of accountability which affect GP fundholding. The 'framework' appears to be a discussion of current policy and practice, in effect fudging the many difficult issues of accountability which arise because of fundholders' dual role (as fundholders and as contractors for general medical services), and because of the blurred roles of regions and local health authorities in monitoring and regulating the fundholding aspects of GPs work. Greater clarity is needed, for instance, about how GP fundholders can be held to account by regions (or the regional Executive outposts from 1996), FHSAs (or the new health authorities from 1996), and by patients.*

However unsatisfactory, the proposals for GP accountability recognise the need for bringing medical practice under scrutiny. The Audit Commission report *The Doctor's Tale: the work of hospital doctors in England and Wales,* was so entitled to reflect the quaintness, or antiquity, of the working methods it discovered. As the report evenhandedly put it:

> *[The report] contains a number of examples of good practice where positive action has already been taken to improve care processes and training. Equally, as the reader will see, it contains evidence of outmoded practices which must change as a matter of urgency.*

Some of these outmoded practices fall within the managerial sphere, *eg* the timing of ward rounds and discharge procedures; some, such as the organisation of the medical firm, combine both managerial and clinical considerations; others fall clearly within the medical or clinical ambit. Accountability in this third area is clearly a matter for the professionals.

This is partly a question of disciplining doctors who perform badly. In 1992, the General Medical Council, which is responsible for the registration of doctors, published a consultation document setting out new proposals for tackling this issue. It argued that new powers are required to deal with doctors demonstrating consistently poor performance. In March 1995, the Government published the Medical (Professional Performance) Bill to provide the necessary powers.

Persistent poor performance is rare. The more significant question is whether performance as a whole rests on a secure foundation. The proportion of health care interventions which have been shown to be beneficial by randomised trial is probably less than one quarter. But, as Sir Norman Browse argued to the Health Committee, that figure should not be taken to imply that over three-quarters is harmful or ineffective:

> *I think one must come to the defence of the medical profession, and I do hope you have not been brainwashed into believing that none of us knows what we are doing, because that is the message from some, particularly the medical economists and so on. They pick out particular conditions where studies have shown that they are not effective. I bet that every one of you has been to a doctor, and probably two-thirds of you have had an operation and you have all been satisfied with the advice you got and the operation you had done. 95 per cent of what we do seems to work and be effective. There has never been a clinical trial on removing or not removing an acutely-inflamed appendix. You know of the complications which occur if you do not remove it; you know that it is the right thing to do. Just because there have not been double-blind, randomly-allocated clinical tri-*

> *als of everything, that does not mean to say that the knowledge which has been accumulated since the Dark Ages finished in about 1415 does not mean something. You must not go away with this notion that we are all being ineffective, we do not know what we are doing or, for that matter, that we do not look at what we are doing and change if we find something is ineffective. We do, and really all doctors have always done that. They have done it in perhaps a small local way or perhaps, if something is not in a big enough group, not in a national way which will always give you the right answer. That is something which we need to enlarge and develop with some of the interventions now which are really additions to an overall plan which is established. So yes, we are very concerned about effectiveness, we do not want to do anything which is ineffective, but for most of the time we do know what we are doing.*

But as he and his colleagues accepted, that does not mean that practice can go unchallenged. As Sir Leslie Turnberg put it:

> *There are thousands of years of medical practice which, in a sense, have to be gone through. There is a large accumulation of information, of procedures and so on which has to be looked at. So there is a huge backlog, but I think we have embarked on this.*

As far as recent Government policy is concerned, that process began with the NHS and Community Care Act. The Act required, for the first time, that medical audit should be introduced on a systematic basis. A report by CASPE Research, (*The Development of Audit: findings of a national survey of healthcare provider units in England*) found as follows:

> *This survey suggests that medical audit has been established as part of clinical practice and healthcare provision .... in England, although there is considerable variation in the progress made by provider units and some important areas of concern exist. Nevertheless, a good foundation for the future development of clinical audit and quality improvement has been created. The survey highlights some important areas for further research and development such as the links between audit and providers' wider quality strategies, approaches to planning and managing audit programmes, the role and function of audit staff and audit departments, the barriers to the development of clinical audit, and the information needs of audit and quality measurement.*

A report by the National Audit Office confirmed this picture of mixed progress. In *Auditing Clinical Care in Scotland*, the National Audit Office concludes that 'the National Health Service in Scotland has made significant progress towards the goal of having all health professionals involved in audit and the process of delivering multi-professional clinical audit has begun'. However, as this report and that subsequently issued by the Committee of Public Accounts also make clear, there remains a long way to go. The Committee therefore pushed the Department to do more:

> *If the Department are serious . . . we consider that they should set targets and timescales for involvement by all health care professionals in the process. However, as the cross-examination of departmental witnesses by the Committee made clear, there are obstacles to this approach.*

This recommendation stemmed from the Committee's dissatisfaction with the reported rate at which doctors are being brought into the audit net:

> *(Mr Scaife) In answer to the Chairman I said that a little over 50 per cent of general practitioners are engaged in clinical audit. I also explained that of the different specialties some 60 per cent are engaged and we have a target that within the next three years we will manage to increase that to 90 per cent involvement. Obviously in a process such as this – and we have an awful lots of doctors and nurses working in the National Health Service, some 11,000 doctors in the National Health Service in Scotland, we have to spread the thing in and that is what are doing.*
>
> *I appreciate that: I did hear the answer to the Chairman and I must confess I was appalled at how low the percentage was. If one carries down the principle of clinical audit to paragraph (e), it says 'where necessary, management must be able to initiate an independent audit'. How many managements have initiated those independent audits since 1989?*
>
> *(Mr Scaife) We do not have a figure for the initiation of specific audits.*
>
> *You are telling us that you do not have a figure for where management, bearing in mind that this was set up in 1989, where 50 per cent of the doctors have not bothered to take part in this systematic medical audit and you are telling us that you do not have a figure for where management has actually bothered to check up and see whether they were taking part and instigated their own reviews. Is that what you are telling this Committee?*
>
> *(Mr Scaife) I am telling the Committee that I do not have a figure for where management has specifically instigated an audit but I ought to emphasise to the Committee that it is not a question of doctors not bothering, it is a question of a deliberate policy of spreading audit systematically through the system, picking up major specialties, picking up areas where we believe there is potential for improvement and we have a whole host of initiatives where every single clinician working in a particular specialty is engaged in clinical audit in Scotland. It really is not a question of doctors not bothering, it is a question of having to introduce audit in a cost effective way, thousands of doctors, 70,000 nurses in a complex National Health Services.*
>
> *That has been going for a number of decades.*
>
> *(Mr Scaife) Yes.*

The introduction of audit across all professionals in the NHS is indeed an immense task. But it is not in itself sufficient to satisfy the requirements of professional accountability.

In October 1994, the Chief Medical Officer, Kenneth Calman (British Medical Journal, 29 October) proposed that, as well as audit, the profession's core values comprised standards, outcomes and effectiveness. To mean anything, these values must be translated into procedures and programmes of work which can realise them. In the previous month, the NHS Executive issued *Improving the Effectiveness of the NHS* (EL(94)74) which begins:

> *Improving health is the core purpose of the NHS. This means that improving the effectiveness of clinical services must be a constant aim.*

It goes on to set out a wide range of measures which the Government has already taken to improve effectiveness.

This Letter represents a significant step in the development of health policy. But it is only part of the story; the underlying knowledge base has to be created first and then measures taken to ensure it is subsequently exploited. As Nick Mays showed in *Health Care UK 1993/94*, the obstacles to making use of research findings are immense. In other words, while the Government, as Angela Coulter argues below, can claim the credit for the series of central initiatives designed to improve the knowledge base from which NHS professionals work, that does not itself guarantee that such knowledge will be exploited.

2.3 Equity

The central point of last year's discussion of equity issues was that the reforms were at one and the same time promoting diversity but also creating mechanisms which tended to reduce it and also to throw up in relief some of the inequities in terms of service provision which the 'old' NHS had contained.

A key mechanism for promoting equity between different parts of the country is that governing the distribution of revenue resources. Since the first explicit formula designed to even up resources relative to needs was introduced in the mid-1970s (see *Health Care UK 1990*) the method of calculation has been altered several times as new information and methodology has been introduced in order to get better measures of relative need for care.

In October 1994, the latest attempt to ensure equality of resources across the country was announced – a revision of the formula used to allocate revenue resources to each part of the country, based on new research carried out at York University.

The key technical achievement of the research team was to show that the higher levels of use of hospital services in some areas could be attributed to higher needs rather than higher levels of provision. These areas contained larger than average numbers of people in the social groups 4 and 5. Since there is a vast volume of evidence suggesting that those lower socio-economic groups have poorer health, the result is not surprising. But it proved hard to demonstrate it and even now doubts can be raised about the findings because of the inherent difficulty of distinguishing 'needs' effects from 'supply' effects. Indeed other work carried out at York using routinely collected data about hospital use failed to identify the impact of factors other than the age and sex structure of the population.

The York work came to three other important conclusions: first, that previous analysis had overstated the cost of caring for elderly people in hospitals: although they have relatively long stays, the cost of these extra days is below the average cost of a day in hospital; second, the formula for general acute services should be different from that for psychiatric care and finally, the level of hospital use is affected by the availability of other health facilities, particularly nursing homes.

The Government largely accepted these findings and announced in FDL(94)68 that allocations would be changed over a period of time in response to the new results. In itself, recognition of the deprivation effect would have produced large switches of funds away from many parts of the south east. Working the other way, however, was a modification to the existing allowances for higher costs in some parts of the south east which extended the area covered. As a result, some areas in the south east and neighbouring regions stand to gain, while others will lose.

However, the new formula falls short in that it still does not include family health services, nor does it deal satisfactorily with community health services for which no measures of need were derived. Resources are, therefore, to be allocated on a *per capita* basis.

Furthermore, while a better distribution policy is a pre-requisite of equitable provision, it is not a sufficient condition, since health authorities can deploy the resources at their disposal in different ways. Despite the longstanding commitment to equity, at regional level, what it should mean locally has never been defined in central guidelines. The RAWP formula and its successors were not systematically applied at district level, still less within districts.

For a national health service which has equal access for equal need as one of its founding principles, the most worrying indictment is how little is known about whether it achieves this or not. One way of finding out is through systematic monitoring of how resources are being used and who benefits from them. As things stand, the resource allocation formula, like that for local authorities, creates potential equity, but does not and cannot guarantee it.

Before monitoring can be properly carried out, the criteria to be used must be clear. In practice, however, what is meant by equity is tricky to define in terms which give clear guidelines for action at local level. In June 1994, Alan Langlands argued that:

> *the key result the NHS needs to achieve is:*
>
> *equity – improving the health of the population as a whole and reducing variations in health status by targeting resources where needs are greatest.*

This definition of purpose – set out under the headline 'A clear future for the NHS' is muddled. Bringing about the greatest improvement may increase inequalities; to decrease 'greatest need' – if that means poor health status – is not synonymous with producing greatest benefit, if that means increase in health status. To target those people or areas where 'needs are greatest' may mean because resources are limited, restricting access to services which yield significant improvements in health status. Furthermore, if, as some evidence suggests, preventive programmes designed to improve health across the board are taken up more eagerly by groups whose average health status is already relatively good, differences between groups will be increased.

If equity means 'equal access for equal clinical need', what evidence exists on the availability of services in different parts of the country suggests not that inequity is commonplace, but that there is no mechanism currently in operation which will remove it. The Patient's Charter can be seen as a device for ensuring equity of access within strictly defined limits. Outside those limits, it has no effect whatsoever. As noted above, the proposals for long term care have been criticised precisely because they do not guarantee the same degree of access in different parts of the country. The question that leads on to is: can a set of services be defined which should be equally available in all areas and if so, how should that equality be guaranteed?

This issue was explicitly addressed by the Health Committee in *Priority Setting in the NHS Purchasing*. The report points out:

> *A balance always needs to be struck between the individual's expectations that he or she should have access to a certain package of services, irrespective of where they live (the individual's perspective) and the desire to allow purchasers the freedom to deploy resources in a way that will best address inequalities in local health (the population-based perspective). In doing so, purchasers are having to grapple with and balance a number of inter-related principles; accessibility, comprehensiveness, equity etc.*

How should the balance be struck? In her oral evidence to the Committee, the Secretary of State indicated support for diversity:

> *The excitement of the change has been that yes there are national priorities but it is a National Health Service with a local dynamic. Now we want health authorities to create diversity which will meet the local health need. So I am content that there should be diversity so long as I am satisfied that the health authority has behaved responsibly in allocating the resources to meet the health needs of that population. Were I to feel it was arbitrary I would intervene or ask the Chief Executive to intervene, but if I am satisfied that was a responsible well founded decision which will maximise the health gain of the local community then I would not intervene.*

The Committee evidently felt this general endorsement to be insufficiently precise:

> *We are concerned that at present these decisions are taken by purchasers in the absence of any firm lead from the Department. For example, how much discretion should reside with individual purchasers? What rights do individuals have to challenge these decisions? What values and criteria should purchasers use to assess the limits of local provision? In making these observations, we fully recognise that it would be futile to define in detail a minimum inventory of specific services that must be provided. There will always be differences in the services available across the country, reflecting in part differing local needs, inherited patterns of care and the need for local flexibility. We recommend that the Department set out clearly the framework within which purchasers will be expected to define the local packages of services, and set out the criteria by which these decisions may be scrutinised, debated and if necessary challenged by individuals. Our call for a clear well-understood set of national principles may well assist this.*

It is scarcely surprising that it should prove so hard to determine how the balance should be struck. In the past, the issue has been latent: professionals were aware of differences in provision – both quality and quantity – between areas, but in general the public was not. That is changing.

In the case of breast cancer services, a King's Fund initiative in conjunction with the Macmillan Fund led to the publication of the first national directory of services for the disease. That revealed in full what was already known in general terms how poor provision is in many areas. Similarly, the Clinical Standards Advisory Committee revealed in its report, *Access to and Availability of Coronary Artery Bypass Grafting and Coronary Angioplasty*, the wide variation in rates of CABGs, much wider than can be ascribed to differences in need. Few patients will read its report, but it is a fair guess that this report, and others like it, will also contribute to the pressure for less variation in the level of service between different areas.

It might be argued, however, that concern with territorial equity is misplaced in the face of the massive differences in health status as between different sections of the population. There is no explicit policy commitment to reducing health inequalities at least in England, though in Wales some of the targets set for health gain do focus on reducing disparities, *eg* in infant mortality.

However as mentioned in Part 1, in May 1994, the Chief Medical Officer's Health of the Nation Working Group established a sub-group to look at 'variations in health' which was required, to produce a report by Spring 1995 as to how the Department of Health and the National Health Service can make best use of existing information in tackling ethnic, geographical, socio-economic and gender variations in health status, with particular reference to the strength of observed relationships and evidence about the effectiveness of interventions. There are many things that the NHS can do, as Michaela Benzeval argues below.

The implied agenda is a massive one as this extract from *Tackling Inequalities in Health: an agenda for action* (King's Fund, 1995) indicates:

> *A crucial step in tackling inequalities in health is the need to create opportunities for prosperous and fulfilling employment for all citizens. The causal link that runs from deprivation to poor schooling, unemployment, low earnings and poor health must be broken. We highlight four key policy initiatives that are required to help both the next generation of workers and those who currently find it difficult to find opportunities in the world of work.*
>
> - *Preschool education should be expanded, particularly for children living in disadvantaged circumstances, to*

give them a better start in life and to create greater equality of educational opportunity.

- *Particular efforts are needed to increase resources for education in disadvantaged areas and to support those working there.*
- *Long term unemployment should be tackled by improving education and training programmes, overhauling the tax and benefit system, and stimulating new patterns of working and entrepreneurship.*
- *The quality and quantity of childcare services in Britain need to be improved. The lack of provision of childcare facilities is thought to be a major cause of poverty, since it prevents women, particularly lone mothers, from taking up paid employment.*

The health of the nation is, in other words, a reflection of society as a whole. To change that requires:

> *a greater commitment by policy makers to promote action which will improve the health prospects of those whose lives are blighted and shortened by avoidable and unacceptable disadvantage.*

PART 3: OVERVIEW

Now that 'the reforms' have been in place for four years, the question of whether or nor they have been successful becomes more pressing. Last year's Review cited the published figures for the cost of introducing them: a further £400 million or so have now been added to these figures, arising from the costs of extending the trust regime. These, as we pointed out then, take no account of the wider effects in terms of the clinical and management time absorbed in learning about and adapting to new procedures and ground rules.

But while the question of success becomes more pressing, what should count as an answer becomes the more difficult to establish. Last year, we gently derided the Government's attachment to the rate of increase in general and acute cases as a measure of the success of the reforms. Heedless, the Parliamentary Secretary for Health announced on 25 October 1994 that the further 4.76 per cent growth reported in the latest NHS *Hospital Activity Bulletin* was evidence of success:

> *This is a true measure of the success of the reforms and underlines the importance of the changes we have put in place for the benefit of patients.*

If it could be shown that the NHS was now producing more care, relative to the resources available to it, and that the increase during the period of the reforms was greater than in the equivalent period prior to them, then that might be taken as good though not conclusive evidence that the new NHS performs better than the old. But neither the *Bulletin* nor any other data demonstrates this, for what are now well-rehearsed reasons. Even if activity were accepted as a satisfactory measure of improvement, the way it is measured – finished consultant episodes – is open to 'inflation'. Although that risk is well known, the Executive has not yet published a systematic assessment of its extent. The Radical Statistics Group, which has recently set out a systematic critique of the activity figures (British Medical Journal, 22 April 1995), suggests that such work is underway.

Another measure the Government has put forward as evidence of success is reduction in waiting times for elective procedures. The numbers waiting for treatment within hospitals have been rising, but provisional figures for the first quarter of 1995 suggest the total fell by nearly 3 per cent: see Table 13. However, it still remains over 1 million. The Government argues, correctly, that what is important is not numbers waiting

Table 13: Numbers Waiting for Elective Procedures, March 1995 and Change since December 1994

Region	Nos. waiting 0-11 months	Change %	Nos. waiting 12-17 months	Change %	Nos. waiting 18+ months	Total Nos. Waiting	Change %
Northern & Yorks	140,124	0.3	1,765	-77.3	0	141,889	-5.2
Trent	89,522	-2.2	1,004	-76.3	3	90,529	-5.5
Anglia & Oxford	103,980	3.1	2,882	-33.3	0	106,882	1.6
N Thames	161,166	1.5	14,781	-4.5	274	176,221	0.7
S Thames	145,121	0.9	10,825	-13.4	0	155,946	-0.3
South & West	119,249	-1.7	31	-97.9	0	119,280	-2.9
W Midlands	90,549	-6.7	65	-98.2	0	90,614	-10.4
North West	157,067	-2.9	0	-100.0	0	157,067	-4.1
All regions	1,006,778	-0.9	31,353	-38.9	277	1,038,408	-2.9
Special Health Authorities	1,748	2.6	5	-70.6	0	1,753	1.7
Total	1,008,526	-0.9	31,358	-38.9	277	1,040,161	-2.9

but time spent waiting. On this basis, performance has been improving, not only for those who otherwise have had to wait for over 18 months, but for the shorter waits as well, in most parts of the country.

Even if reduction in waiting times was in itself regarded as evidence of success, the available data are not reliable measures even of that because they do not take into account the time which elapses before patients see a consultant for their first appointment and hence the starting date of the defined wait. The Government has acknowledged this point and statistics are now being collected in a way which allow for it. But until these are available, this source of benefit must be regarded as non-proven.

While the available measures can be criticised, no alternative ones are available, nor are they likely to be. The range and complexity of what the NHS does preclude a simple overall index of improvement and render the task of finding measures relevant to all categories of care and all categories of patient equally daunting. For this reason, it might be argued, it is better to adopt what can be termed a structural approach, which involves evaluating the incentives and constraints facing trusts, GPs and purchasing commissions and judging whether these are likely to be more effective than the pre-reforms structure of the NHS, in reducing costs and improving the quality of care. This approach can be adopted at a very general level – the NHS as a whole – to particular services or to particular mechanisms or policy instruments.

At the overall level, Julian Le Grand, drawing on the evidence emerging from early research on the impact of the reforms published in *Evaluating the NHS Reforms* (King's Fund Institute 1994) concluded:

> . ., *what some of the results of the direct and indirect research suggest is that, at least in some areas, there is potential for real gains arising from the reforms. Many hospitals are in competitive situations. Trust managers are looking for efficiency improvements. Fundholders do appear to be obtaining quality improvements for their patients, although the extent to which this is the result of the fundholding scheme per se is not clear. Medical audit is leading to changes in behaviour by clinicians. There are equity worries, but as yet no evidence that some of the principal areas of concern, such as cream-skimming, are more than theoretical issues.*

At the level of the individual service, a quite different conclusion might be drawn. Matt Muijen and Trevor Hadley have argued, in relation to mental health (Health Service Journal, 9 March 1995), that the new structure is worse than the old one, despite the fact that many of the individual features are themselves acceptable. The framework, taking all the elements bearing on this particular service, is unlikely in their view to produce good quality care.

> *Across agencies the incentives are almost invariably in conflict. . . Where incentives towards service development appear to be in the same direction, they mask contradictions as in the case of social workers and CPNs. The consequence for mental health care is that it is fragmenting as a result of market forces, rather than being steered towards common objectives and integration by clear policy guidance.*

The third variant of the structural approach is to consider the merits of particular mechanisms. This was adopted in a recent survey of public health directors by David Marks (*NHS Reforms: The First Three Years*). They were asked whether they thought that the effectiveness of services in their district had been altered for the better or the worse by the introduction of any of the measures listed in Table 14. The survey found considerable support for some of the structural features of the reforms, as the Table brings out. The number of respondents citing each element of the reforms is shown in brackets. The purchaser/provider split gains the most support, along with clinical directorships.

The purchaser/provider split has become accepted across the public sector. However, the evidence that it is effective within the NHS is slim.

Taking trusts first: the latest NHS Annual Report had this to say about progress up to April 1994:

> *The fourth wave of trusts established by March 1994 brought the total number to 419. One effect has been to strengthen the local identity of hospital and health*

Table 14: NHS Reforms: Views of Public Health Directors

	Improvement	Deterioration	No change
		%	
1% efficiency savings per annum (98)	15	30	55
Individual patient billing (62)	8	37	55
GP fundholding (107)	45	25	30
Merger of DHAs (82)	29	10	61
NHS Trust hospital/units (105)	24	19	57
Competition between hospitals (116)	34	17	49
Purchaser/provider split (115)	57	9	34
Clinical directorships (105)	57	1	42

> *centres. Local people can judge them by the quality and choice of the services they deliver.*
>
> *Trust status has also allowed greater flexibility to create more interesting jobs and make more efficient use of support staff, redefining roles and breaking down demarcation lines. This offers the chance of greater job satisfaction and higher quality of service which in turn gives better value for money. For example, Bradford Community Health Trust has used the flexibility of trust status to create 150 new community care jobs in 60 community staffed units for people with learning disabilities.*
>
> *Better information systems among providers, and a clearer understanding of the workload and service costs, are also helping hospitals to improve their efficiency.*

The slimness of the evidence cited invites the question: is that all that can be said about trust status? As far as government sponsored research is concerned, the answer seems to be yes. The August 1994 edition of *Health Services Management Research*, however, contains the reflections of a series of authors on that question. In the conclusion, Edward Peck suggests that the impact of trusts is to be seen in the impetus they gave to 'managerialism' but suggest that 'Boards appear to represent a major investment of management time as well as financial resources for, to date, a very limited return. . .'

He goes on to argue that:

> *In the long term, therefore, it is questionable whether trusts in their current form will continue to be the preferred model of providers in the purchaser/provider split, either with the NHSME or local purchasers. It is conceivable that they will slowly give way to a range of not for profit and private providers with alternative arrangements for governance.*

If that is correct, then the benefits of these aspects of the reforms are yet to accrue: trusts are just a stage towards a more fundamental reform of the supply of health care services.

The National Audit Office report, *Contracting for Acute Health Care*, reached essentially the same conclusion with regard to district purchasing though the basis of their conclusion was different. In their view district purchasing had been hindered by lack of information. The clear implication is that unless that is remedied then it has no chance of success. GP fundholding on the other hand has gained considerable support as a mechanism for producing benefits, both from research studies such as those of Glennerster cited in last year's Review and also the National Audit Office (see p 3).

Strictly these findings are not in themselves sufficient since there is no agreed way of relating the benefits reported to the costs of producing them. But even if they are accepted as evidence of success, the question then arises as to whether it was necessary to devise a measure such as fundholding to produce them. Given the approach adopted in the Patient's Charter, the Government could well have stipulated, for example, that a given proportion of outpatient consultations took place 'closer to home'.

Other benefits however could not have been achieved in this way. Furthermore, it could be argued that the Government would not, in fact, have considered using the *Charter* or some other central initiative: it took fundholding to show that benefits could be achieved in the ways the National Audit Office and other researchers identify. However, this could not be argued in relation to another assessment of the reforms.

Thus, in Chris Ham's view (Guardian, 4 January 95), the success of the reforms is measured by a shift in the balance of power in favour of general practitioners:

> *The most important effect of the reforms has been to shift the balance of power within the NHS. The old system of planning by decibels in which those running hospital services exerted most influence has been replaced by an arrangement in which health authorities and GPs are in a much better position to shape the direction of service development. As a consequence, the providers of hospital and community health services are held more accountable for their performance than in the past and GPs and health authorities are able to use their resources to purchase care more appropriate to the needs of patients and the public.*

He then goes on to cite what he considers evidence of success:

> *Perhaps most significantly, there has been a strengthening of primary care services. This is evident in the employment of more nurses, physiotherapists and counsellors by GPs, an increase in the number of specialist clinics carried out in GPs' surgeries, and a greater emphasis on health promotion in general practice.*

But most of these reflect changes already underway when the 1990 Act came into effect and the last of these, the emphasis on health promotion, is specifically due to the new GP contract. There is no doubt that such changes could have been achieved under the old regime, with the exception of the specialist clinics which it probably required the threat implicit in fundholding to bring about. Furthermore, in areas where primary care is weak such as parts of London, the Government is using mechanisms of intervention which do not form part of the reforms.

The same approach – that of identifying a good effect and attributing it to the reforms – is taken by Nick Freemantle in the concluding chapter of *Working for Patients: early research findings* (Nuffield Institute for Health 1994):

> *... it seems clear that a more explicit perception of the need to make conscious choices in health care is emerging. Some of the origins of this lie outside the NHS reorganisation, and include financial pressures and the role of the news media. But others lie inside the NHS: the need to make contracts, to deal with ECR [extra contractual referrals] requests and to redefine the role of public health medicine. A surprising amount of*

> *progress has been made in placing the effectiveness of health care interventions on the political and managerial agendas. It is difficult, however, to see how this relates to GP fundholding, where it seems likely that decision making will continue on much more implicit criteria.*

As Freemantle acknowledges, however, recognition of the need to make conscious choices has been the result of other forces, principally financial stringency combined with media attention on some particular instances of rationing such as Child B in Cambridge. But it is less easy to argue that those forces would have produced the emphasis on effectiveness. This highly desirable outcome might well be attributed, at least in part, to the identification of purchasing as an explicit task. But again the question is whether the same results could have been achieved without the reforms.

As it happens, in an article published in 1989 (British Medical Journal, 12 August 1989), Lois Quam raised exactly this question and concluded that progress could be made on clinical effectiveness without the reforms and indeed the reforms would hinder it. She argued that managers lacked the information to purchase properly because they lacked measures of effectiveness. Hence the only sort of competition which could result was one based on price. Instead she proposed a three part reform as follows:

> *Firstly, a substantial increase in funding for research and epidemiology to support a research agenda which informs key clinical and general management decisions is necessary. In particular, clinical management decisions for illnesses about which there is uncertainty over the efficacy of treatment should be studied. Addressing these areas has the greatest potential for improving the effectiveness and efficiency of the NHS. Secondly, statistically sound methods for analysing and monitoring the clinical practice of the NHS must be developed. A major database to collect information on patient demography, diagnoses, clinical findings, and treatments should be established. Thirdly, the attention of managers must be directed to applying and integrating research results. This would remove the hit and miss approach that often dominates the dissemination of important findings from research.*

To support these tasks she proposed:

> *Using this computerised database . . . to improve clinical practice in the NHS by:*
>
> - *Monitoring the introduction and standardisation of diagnostic methods and treatment modalities based on the results of randomised clinical trials to encourage the dissemination of state of the art medical practice*
> - *Monitoring selected adverse clinical events, such as postsurgical complications or readmission rates, and analysis of clusters of adverse events to determine management practice changes which may reduce the incidence rate*
> - *Detecting severely substandard performance by a doctor or hospital through monitoring of clusters of adverse events or single occurrences of a serious mishap*
> - *Monitoring access to care by detecting the occurrence of late stage disease at presentation for inpatient care, such as advanced breast or cervical cancer*
> - *Developing valid and reliable measures of patient outcomes, including physiological measures, and functional health status measures, such as ability to work and care for one's family, and patient satisfaction; measures that would constitute output measures for the NHS.*

While noting the commitment to medical audit, Quam's central policy conclusion was that:

> *This clinical effectiveness approach and the white paper proposals are incompatible avenues of reform.*

This conclusion may seem overstated in the light of the developments that have taken place, since this article was published, in the organisation and finance of research and development. But it could nevertheless be argued that the progress that has been made represents an overlay on the market structure which works in spite of it rather than because of it. Thus, *Research for Health* discussed by Angela Coulter below is a centrally inspired initiative not one emerging from the local purchaser provider/split or GP fundholding.

But Quam may not be right. Another perspective on the reforms is that at root they represent an attack on the power of the medical profession which reflects not simply an NHS perspective but also the broader aims of the Thatcher Government to shake up the professions and others seen as vested and self-serving interest groups. The complaints of the medical profession – as represented for example in Sandy Macara's speech to the 1994 BMA conference – might be seen as confirmation of that.

Leaving the Thatcherite rhetoric to one side, there is clearly a case for arguing that the effectiveness and outcomes agenda has only emerged and been accepted by the medical profession because of the wider threat they perceive of greater control over clinical practice. But even if this is right, then the question which follows is whether, now that it has emerged, the stimulus presented by the reforms is necessary to that agenda being actively pursued.

That question is tackled in the BMA's discussion paper *Future Models for the NHS.* It notes that one impetus to the reforms was the belief that professional staff made it difficult to bring about change but argues that within the present system 'the greatest dynamic in the new NHS that of GP fundholding has been led by clinicians, rather than managers'. Of the three models it considers, the first is a continuation of the present arrangements while the second and third represent some move back from it. Implicit in both of these is the belief that clinicians will retain a key role in moving the service forward, either through modified GP fundholding or through putting the management process out to tender, possibly to include consortia of clinicians. They do away with the current market mechanism but, recognising the need for contestability, rely on the 'creative tension' which exists in the changing boundaries between primary and secondary care as the principal dynamic for service development, obviating the need for a market solution to providing incentives for change and efficiency in the NHS.

The discussion paper requires more analysis than we can give it here: suffice to say that it bypasses the effectiveness issue with the affirmation that 'Measurable quality criteria will be built into all aspects of the service' without indicating the route by which they will be derived, how the knowledge on which they shall be based should be obtained, and what incentives or pressures must exist for knowledge, once obtained, to be applied.

There are alternative models to those discussed in the BMA paper. A Model 4 might be built up on the lines of the process used to produce the recent expert group report on Cancer Services and the subsequent announcement by the Secretary of State of a hierarchical structure for cancer care. This would be a centralised model, close to Quam's , which would not rely on a competitive process to improve standards of care. Rather, clinical practice across the whole of the country along with evidence from other countries would be monitored and when the evidence was strong enough to change current practice, the plans would be made accordingly. With the measures discussed by Angela Coulter in place, much of the structure required to underpin 'evidence-based planning' now exists. So, now that effectiveness is on the agenda, the issue is whether it is best maintained there by the forces that led it to emerge, or whether quite different mechanisms are appropriate to ensuring its success.

Whether the last few years have seen an improvement in the UK health care system as a result of the implementation of the 1990 Act is in one sense irrelevant. We are where we are now. Where we go next should not be a matter of looking at simple measures of activity or rejecting specific mechanisms. It should, rather, be a matter of trying to determine what mix of the policies that now appear feasible – many of which in 1989 would not have been – represent the best way forward. Whatever the merits of the 1990 reforms overall or at the level of the individual service or mechanism, they have at least had the virtue of opening up to debate nearly every nook and cranny of the health care system.

Part 4: CALENDAR OF EVENTS: 1993/94 IN BRIEF

April

13 **Patients Charter**
Plans announced for extension to include outpatient waiting times, waiting times for CABGs, hospital food and community nurse visits

14 **Consultants' Pay**
First annual report of the Advisory Committee on Distinction Awards. Awards range from £10,325 to £48,605
NHS Executive
Colin Reeves appointed new Finance Director of the NHS

15 **Equity**
Secretary of State sets out policy for treatment of elderly people

16 **Children's Services**
Increase in number of paediatric care beds announced

18 **Blood Supplies**
National Blood Authority takes responsibility for National Blood Transfusion Service from Regional Health Authorities
Access to Specialists
Government welcomes reports on direct referral for hearing aid services
Department of Health
Secretary of State sets out Department of Health goals for 1994 and beyond

21 **Drug Abuse**
Review of treatment services for drug misusers announced
Clinical Audit
Four progress reports issued

23 **Maternity Care**
Maternity Services Charter announced, offering choice, more control and better information

24 **Nurse Prescribing**
Pilot nurse prescribing protects announced in eight demonstration sites

26 **Accountability**
NHS Boards to be required to maintain a register of members interests.

29 **Consultants**
85 new posts announced under Part-Time Consultants Scheme

May

4 **Mental Health**
Leadership programme for top managers in mental health launched

10 **Maternity Care**
Membership of Advisory Group on Changing Childbirth announced
Prevention
Diptheria vaccine booster given to school leavers

11 **Complaints**
Report of Wilson Committee, *Being Heard,* published

13 **Health of the Nation**
New voluntary agreement on tobacco advertising

18 **Cancer Services**
Consultation document on organisation of cancer services published

19 **Drugs**
Guidelines issued for economic evaluation of medicines
General Practice
BMA agree changes in GP terms of service covering out-of-hours work

June

17 **Junior Doctors' Hours**
Progress in implementing New Deal announced

29 **Accountability**
First NHS Performance Tables published

July

11 **Prescribing**
Health authorities urged to ensure doctors prescribe effectively

15 **Role of NHS**
Secretary of State sets out purpose of the reforms

20 **Maternity Care**
Changing Childbirth pilot projects announces

14 **Dental Care**
Green paper *Improving Dentistry* published
Mental Health
Reports on high security pyschiatric and psychopathic services published

19 **Prescribing**
Regulations to tighten controls on hospitality and other inducements to GP prescribing announced

28 **NHS/DH Organisation**
Three reports published on organisation of NHS and the Department of Health, including Banks Review

August

3 **Patient's Charter**
Consultation Framework for Development of Local Community Care Charters published

5 **Continuing Care**
Consultation papers on regulation of residential and nursing homes issued

8 **Diabetes**
Standards of Clinical Care for People with Diabetes published

10 **Patient Records**
Draft Guidance issued on confidentiality of personal health information

12 **NHS Objectives**
Secretary of State sets out key objectives for the NHS

September

1 **Accountability**
Draft Code of Practice on Openness published

7 **Mental Health**
More secure psychiatric places announced

14 **Research and Development**
Report of Task Force Supporting Research and Development published (Culyer Report)

27 **Mental Health**
Mental Health in London: Priories for Action published

29 **Prevention**
Campaign against measles announced

October

4 **London**
Primary Care Support Force announced

6 **Organ Donation**
Register launched of people willing to donate organs

20 **Fundholding**
Expansion of scope of fundholding announced

21 **Resource Allocation**
New guidance issued on resource allocation

November

4 **Patient's Charter**
Framework for local community care charters published

10 **Department of Health Organistion**
Changes announced to structure of Department of Health and NHS Executive

23 **NHS Organisation**
Health Authorities Bill to abolish regional authorities and merge districts with family health service authorities published

29 **NHS Spending**
£1.3 billion extra announced for NHS in public expenditure settlement

25 **Junior Doctors' Hours**
Further progress announced on junior doctors hours

December

2 **GP Fundholding**
Changes to management allowances announced

6 **GP Fundholding**
Accountability framework for fundholders announced

12 **NHS Internal Market**
Guidance issued for development of internal market

15 **Research and Development**
New fundings arrangements set out following Culyer report

20 **General Practice**
Efficiency scrutiny to reduce GP paperwork announced
Nurse Prescribing

22 **Junior Doctors' Hours**
£64 million allocated for 1995/96 to support New Deal

January

12 **Hospital Doctors**
Report of Working Group of Hospital Locum Doctors published

16 **Prevention**
Measures announced to improve the NHS breast screening programme

17 **Doctors' Training**
Report of Working Party on the Unified Training Grade published proposing two specialist training grades

18 **Patient's Charter**
Extensions to Patient's Charter launched

25 **Fundholding**
Increase in number of pilot sites for total fundholding announced

February

6 **Professional Standards**
Review of Professions Supplementary to Medicine Act announced

9 **Pay**
Pay Review Bodies report

14 **Appointments**
Guidelines announced for appointment of chairs and non-executive members of NHS trusts and health authorities

22 **Prescription Charges**
Charge for prescriptions raised to £5.25

March

1 **Health of the Nation**
Results of 1993 Health Survey for England published

16 **Profesional Standards**
Hedical (Professional Performance) Bill published

20 **Organ Donation**
GPs encouraged to support Register

22 **Health of the Nation**
National Diet and Nutrition Survey published
Complaints
Acting on Complaints published, following Wilson Committee recommendations

28 **Childrens Services**
Consultation paper Child Health in the Community: a guide to good practice issued
Medical Training
Discussion document issued on future management of postgraduate medical and dental education

29 **Compensation**
Clinical negligence scheme for trusts launched

THE HEALTH OF THE NATION: THE WAY FORWARD

Mark McCarthy

In June 1991 the Communications Division of the Department of Health made a bold claim: that everyone in the NHS in England – almost a million people – would be briefed about the new consultation paper *The Health of the Nation* 'within 24 hours'. There followed a communications programme of equivalent grandeur. Rainbow-coloured consultation papers were produced in short, medium and long versions, with acetates and notes for speakers. Multimedia presentations were made to invited audiences by politicians and senior NHS managers, sometimes held in television studios to increase atmosphere. Other meetings for a wider range of NHS staff were held in luxury hotels to discuss handbooks, audio-visual materials, and other 'initiatives'. The top-down control of these supposedly participative events felt curiously paralleled by the books and films recalling the Chinese cultural revolution that were emerging during the same period.

The Health of the Nation has since become a significant force within the NHS. Its strength is the simplicity of its concept – the prevention of five major diseases. It has helped health authorities focus directly on health promotion, rather than only health services defined by age group (such as children's services) or function (such as pathology services). It has become an organising framework for local health planning: for example, many districts have established local *Health of the Nation* working groups, and annual reports by Directors of Public Health often follow *Health of the Nation* themes. It has even permeated the Department of Health's parallel initiative on Research and Development and the programme of the Medical Research Council.

But it continues to be hampered by two major difficulties: the health care professions and the public regard the NHS primarily as providing care rather than promoting health; and prevention has even more political implications than the rest of NHS responsibilities. This article reviews what progress has been made since *The Health of the Nation* was launched and makes a number of proposals for making its implementation more effective.

The Starting Point.

The *Health of the Nation* arises from the World Health Organisation's Declaration *Health for All* at Alma Ata in 1978. The Declaration commended organising health care at primary care level rather than the 'vertical', disease-specific, programmes that had traditionally been used to control some infectious diseases. It also commended increased equity in distribution of resources, greater participation at local level and an emphasis on prevention.

At first, *Health for All* was seen to relate mostly to developing countries. But, drawing on developments in North America during the 1970s, especially Canada's Lalonde Report, the European Region of WHO developed a set of 38 targets for *Health for All* in the European Region which were agreed and signed by all member states in 1985. Few countries appeared to take this commitment seriously: cost control was highest on the political agenda in the 1980s, as medical technology and population aging put increasing pressure on budgets. But along with a review of insurance systems, the Dutch government developed scenario planning based on epidemiological information, and within the United Kingdom, the Welsh Office introduced health promotion initiatives that were recognised as considerably better than those provided by the politically constrained English Health Education Authority.

The NHS reforms allowed a national public health programme to be developed. Responsibility for health became divided between the Department of Health in London, at its new headquarters opposite Downing Street in Whitehall, and the National Health Service Management Executive, which moved to Leeds. 'Policy' was led by the Department of Health, and the NHS Management Executive (as it was then) was required to 'operationalise' it. Within the Department of Health, the newly-established Central Health Monitoring Unit fed information on mortality and morbidity into the Department's policy processes, while academic epidemiologists were commissioned to review disease patterns to support needs-led purchasing by health authorities.

As with other parts of the 1990 NHS reforms, the policy for *The Health of the Nation* was developed during the consultation period. The initial green paper of June 1991 set out the intention of a public health strategy. Five criteria were proposed for priority areas, and against these were listed a mixture of diseases, behaviours and services: see Table 1. These were also summarised in three criteria for choices – a major cause of concern, scope for improvement and the ability to set targets. Following consultation, five disease groups

Table 1: Possible Key Areas

Area	Criterion 1 Major cause of concern	Criterion 2 Scope for improvement	Criterion 3 Ability to set targets
Coronary Heart Disease	Greatest single cause of premature death	Healthy living Effective treatment	Yes
Stroke	12% of all deaths 5% of deaths under 65 years	Healthy living Detection and treatment of raised blood pressure Rehabilitation	Yes
Cancer	25% of all deaths	Not for all cancers For some – healthy living Screening for breast and cervical cancers	Not for all cancers Screening targets for breast and cervical cancer + see smoking target
Smoking	Largest single preventable cause of death	Not smoking	Yes
Eating and Drinking Habits	Contribution to many aspects of health and ill-health	Healthier eating and drinking habits	Yes
Physical Activity	Contribution to many aspects of health and ill-health	More people taking regular physical activity	Not at this stage – further information needed
Prevention of Accidents	Most common cause of death under 30	Improvements in engineering, design, environment, etc Education, awareness Legislation and other controls	Yes
Health of Pregnant Women, Infants and Children	Key indicator of the nation's health	Wide subject – scope varies for different aspects	Yes
Diabetes	4-5% of total health care expenditure on care of people with diabetes	Effective treatment and care	Yes
Mental Health	20% of total NHS expenditure	Transition to a district-based service	Yes
HIV/AIDS	Greatest new threat to public health this century	Safe sexual and intravenous drug using behaviour	Not at this stage – further information needed
Other Communicable Diseases			
(a) preventable by immunisation	Potential for harm should immunisation rates fall	Immunisation	Yes
(b) hospital acquired infection	10% of inpatients have an infection acquired in hospital	Good practice	Yes
Food Safety			
(a) foodborne diseases	Cause of considerable degree of ill-health, though not many deaths Underlying rising trend in cases	Improvements in hygiene Increase in awareness Effective surveillance Regulation	Not at this stage – more needs to be known about incidence of poisoning
(b) chemical safety of food	Undoubted potential for harm to human health in absence of effective measures	Continued research and assessment. Regulation and other controls	Limited ability to set targets in terms of human health
Rehabilitation Services	Wide subject covering a variety of areas of concern	Scope for intervention varies	Yes – in specific areas
Asthma	Substantial morbidity – lost schooling and sickness absence	Effective treatment and care	Yes
Environmental Quality	Potential for harm to health if standards of protection are inadequate. Unrealised potential for promotion of health and well-being when standards are sufficiently high	Improvement in abatement technologies, stricter standards which are effectively enforced Mobilisation of public interest	Yes – in most areas

were identifed as the 'key areas', which subsumed the behavioural objectives but excluded some of the services areas: see Table 2 and 3.

One Year On

In November 1993 the Department of Health reported on implementation of *The Health of the Nation* in its first year. A network of government committees had been created. Cross-department working was to be encouraged through a Ministerial Cabinet Committee on Health, which receives progress reports on the whole programme twice a year. A junior minister for health was made chair of the Wider Health Working Group, which is a forum for advice from other government departments, industry, professional and voluntary associations and the media. The Chief Executive of the NHSE took the chair of the working group on implementation.

This report gave the first real recognition that responsibility for *The Health of the Nation* at local level doesn't lie with the health service alone. After the razzmatazz of launching *The Health of the Nation* to the NHS in 1991, local authorities were only advised formally two years later, in July 1993. The report recognised the contribution of *Healthy Cities*, the WHO European Region's programme of developing *Health for All* at sub-national level based on intersectoral collaboration. The UK had four founder 'cities' – Belfast, Camden, Glasgow and Liverpool – and has developed a national network of a further 100 cities. These *Health for All* initiatives have helped create the setting for local *Health of the Nation* action. Equally, Health Promoting Schools, developed by WHO and funded by the European Community, have led the Department of Education's response to *The Health of the Nation.*

The National Health Service response to *The Health of the Nation* has developed in several ways.

- During the first year the NHSME produced five key area handbooks which collected together ideas from focus groups on what might be done under each heading. The material was disparate, not scientifically based, and sometimes simply listed current practice, but it provided a useful starting point for local programmes.

Table 2: The Health of the Nation: Main Targets

Coronary heart disease and stroke

To reduce death rates for both CHD and stroke in people under 65 by at least 40% by the year 2000 (*Baseline 1990*)

To reduce the death rate for CHD in people aged 65–74 by at least 30% by the year 2000 (*Baseline 1990*)

To reduce the death rate for stroke in people aged 65–74 by at least 40% by the year 2000 (*Baseline 1990*)

Cancers

To reduce the death rate for breast cancer in the population invited for screening by at least 25% by the year 2000 (*Baseline 1990*)

To reduce the incidence of invasive cervical cancer by at least 20% by the year 2000 (*Baseline 1986*)

To reduce the death rate for lung cancer under the age of 75 by at least 30% in men and by at least 15% in women by 2010 (*Baseline 1990*)

To halt the year-on-year increase in the incidence of skin cancer by 2005

Mental illness

To improve significantly the health and social functioning of mentally ill people

To reduce the overall suicide rate by at least 15% by the year 2000 (*Baseline 1990*)

To reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 (*Baseline 1990*)

HIV/AIDS and sexual health

To reduce the incidence of gonorrhoea by at least 20% by 1995 (Baseline 1990),

To reduce by at least 50% the rate of conceptions amongst the under 16s by the year 2000 (*Baseline 1989*)

Accidents

To reduce the death rate for accidents among children aged under 15 by at least 33% by 2005 (*Baseline 1990*)

To reduce the death rate for accidents among young people aged 15–24 by at least 25% by 2005 (*Baseline 1990*)

To reduce the death rate for accidents among people aged 65 and over by at least 33% by 2005 (*Baseline 1990*)

Note: The 1990 baseline for all mortality targets represents an average of the three years centred around 1990.

Table 3: The Health of the Nation Risk Factor Targets

Smoking
To reduce the prevalence of cigarette smoking to no more than 20% by the year 2000 in both men and women (a reduction of a third) (*Baseline 1990*)

To reduce consumption of cigarettes by at least 40% by the year 2000 (*Baseline 1990*)

In addition to the overall reduction in prevalence, at least 33% of women smokers to stop smoking at the start of their pregnancy by the year 2000

To reduce smoking prevalence of 11–15 year olds by at least 33% by 1994 (to less than 6%) (*Baseline 1988*)

Diet and Nutrition
To reduce the average percentage of food energy derived by the population from saturated fatty acids by at least 35% by 2005 (to no more than 11% of food energy) (*Baseline 1990*)

To reduce the average percentage of food energy derived from total fat by the population by at least 12% by 2005 (to no more than about 35% of total food energy) (*Baseline 1990*)

To reduce the proportion of men and women aged 16–64 who are obese by at least 25% and 33% respectively by 2005 (to no more than 6% of men and 8% of women) (*Baseline 1986/87*)

To reduce the proportion of men drinking more than 21 units of alcohol per week and women drinking more than 14 units per week by 30% by 2005 (to 18% of men and 7% of women) (*Baseline 1990*)

Blood Pressure
To reduce mean systolic blood pressure in the adult population by at least 5mm Hg by 2005 (*Baseline to be derived from new national health survey*)

HIV/AIDS
To reduce the percentage of injecting drug misusers who report sharing injecting equipment in the previous 4 weeks from 20% in 1990 to no more than 10% by 1997 and no more than 5% by the year 2000

- The consultation paper proposed setting national targets for measuring achievement of *The Health of the Nation*, and the white paper defined these in relation to the chosen key areas. The NHS considered what targets were useful at local level. Many, such as child accident deaths were not, because of statistical fluctuations in the smaller district populations, others because the data were not collected in relation to defined populations. It also became clear that mechanistic 'tick in the box' monitoring of implementation at local level was unwise: more sensitive assessments were needed to understand how local perceptions and opportunities influenced choices and priorities.
- A sixth key area, health at work in the NHS, was introduced in association with the Health Education Authority. This initiative pointed health promotion towards NHS staff themselves and the NHS as employer. It was taken up by some NHS occupational health services, often a poor relation to other medical practice, and has developed into a broader concept of 'health promoting hospitals'.
- *The Health of the Nation* has probably had least effect on medical practice. Certainly, it has received much less management attention than, for example, GP fundholding or even clinical audit. The national-level *Wider Health Working Group* commissioned an excellent review of approaches to behavioural change in primary care covering four areas – smoking, diet, exercise and alcohol. A short booklet and a larger loose-leaf binder containing this information, entitled *Better Living Better Life*, was sent to every general practioner. However, it appears to have sunk without trace: it has not been mentioned in subsequent professional discussions of health promotion in primary care, nor in Department of Health guidance. This was disappointing, as primary care has the greatest opportunity of any part of the NHS for extending health promotion. In hospitals, specific advice to consultants and junior hospital staff was only distributed in 1995, three years after the launch, and it is not clear how much commitment will follow. Not actively engaging clinicians has implicitly reinforced the view that prevention 'is not really medicine'.

Monitoring and Targets

The 1993 review *One Year On* also provides a helpful analysis of trends in the epidemiological indicators chosen to monitor *The Health of the Nation* in England, and likelihood of reaching the agreed national targets. Some of the indicators are available from mortality statistics, and some from existing surveys. However, as part of monitoring *The Health of the Nation*, a new Health Survey for England and a Mental Health Survey have been set up, and support is being given through OPCS to developing local health and lifestyles surveys.

Coronary heart disease and stroke

Deaths in people under 75 have been falling for coronary heart disease since 1980 and for stroke since 1970. For both, the target lies on an extrapolation of the current trends – see Figure 1 – and is at least partly related to falling levels of smoking. However, other intermediate indicators are not so encouraging: population levels of fat consumption are static, alcohol intake is rising, while the proportion of the population overweight is increasing rapidly: from 1980 to 1991, the proportion of men above the recommended body-mass index rose from 39 per cent to 51 per cent, for women from 32 per cent to 41 per cent.

Figure 1a: Coronary Heart Disease

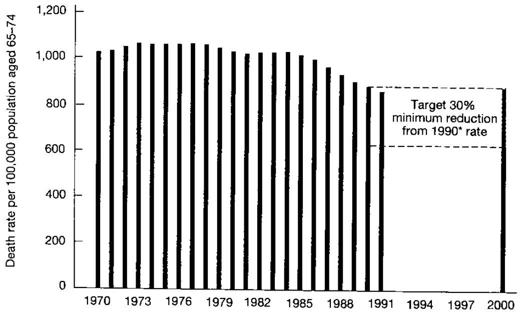


Figure 1b: Stroke

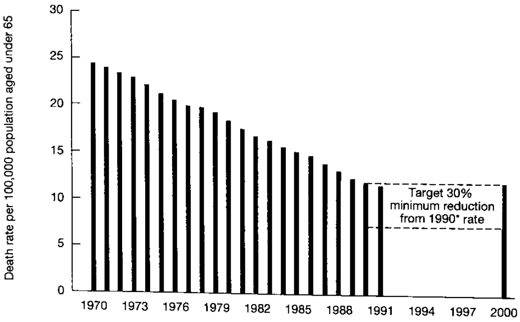
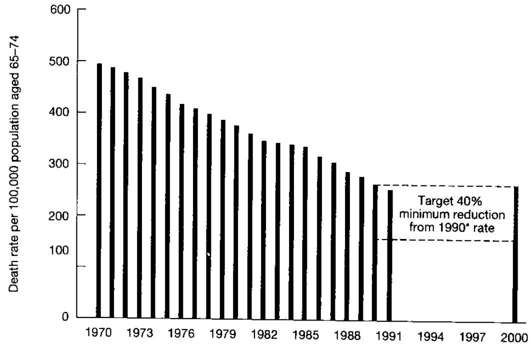


Figure 1c: Stroke in Elderly People

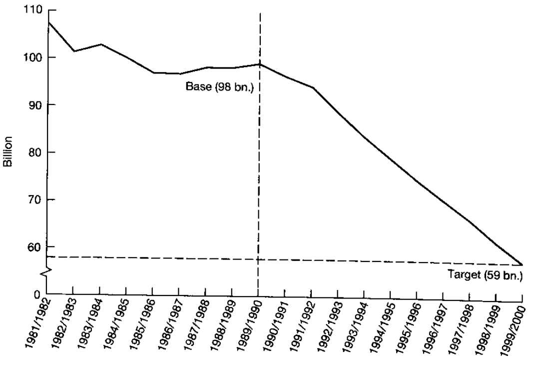


Cancer

The two main initiatives for cancer are breast and cervical screening, and smoking control. Breast cancer rates were roughly static during the 1980s, while the target is a 25 per cent drop from 1990 to 2000. There is scientific support for the view that the breast screening programme introduced from 1989 can achieve this reduction, but some scepticism over the likelihood, especially in deprived areas where population coverage has been poor. The cervical screening programme depends on general practitioners more than the breast programme, and has less uniform implementation. It is worrying, in terms of the effectiveness of the programme, that cancer rates are rising in younger women who are the most heavily screened.

Reducing smoking undoubtedly offers the single greatest opportunity for improving the health of the nation: smoking causes 90 per cent of all lung cancers, and lung cancer is the most frequent cause of cancer death. The present trends suggest that the target of a 30 per cent fall in lung cancer deaths in men will be readily achieved by 2010, but there is less likelihood of achieving the target 15 per cent reduction of deaths in women. However, while the number of people smoking has been falling, there is ominously little change in the total number of cigarettes sold, based on Customs and Excise data. This suggests that the remaining

Figure 2: Cigarettes released for Home Consumption



smokers are smoking more cigarettes and that current anti-smoking measures are not being effective: see Figure 2. This is particularly evident in smoking in young people, where the only *Health of the Nation* target set for 1994, of less than 6 per cent of secondary school children smoking, was not been reached and has had to be revised.

Mental illness

The Health of the Nation white paper included mental illness as one of the five key areas because of the size of the burden on the community: 10–15 per cent of people experience minor mental illness at any one time, and one to two per cent a major mental illness. However, the two other broad criteria for inclusion, of effective interventions and measureable targets, were not so clearly met. Mental illnesses arise from a complex interaction of genetic predisposition, childhood development and social and environmental effects. Prevention strategies are not well developed, and treatments of modest efficacy. *The Health of the Nation* proposals included 'development of comprehensive mental health services' – surely an objective of the NHS anyway – and specific attention to suicides. However, perhaps more systematic use of known interventions, especially in community settings, will be beneficial. An example of promise is the Royal College of Psychiatrist's *Defeat Depression* initiative, which seeks to improve the early identification and treatment of depression by general practitioners.

Reproductive Diseases and HIV

The underlying factor of concern for this key area is sexual behaviour. It was damaging to *The Health of the Nation* that Conservative prudishness axed the Medical Research Council's proposed funding for a national survey of sexual behaviour. The Wellcome Trust stepped in to save the survey, but neither national nor local data were available to set targets. Instead there are two proxy measures, teenage pregnancies and the incidence of gonorrhoea. The proportion of teenage pregnancies in the UK is among the highest in Europe: the conception rate for this age group rose by 20 per cent during the 1980s, and the likelihood of achieving the target 50 per cent reduction by the year 2000 is remote: see Figure 3. In contrast, the target on gonorrhoea, a 15 per cent reduction over 5 years, should be easily met as the clinic recording rates fell by 70 per cent during the mid 1980s: see Figure 4.

Figure 3: Conception Rates

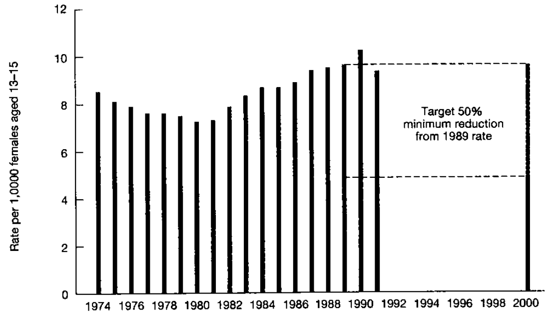
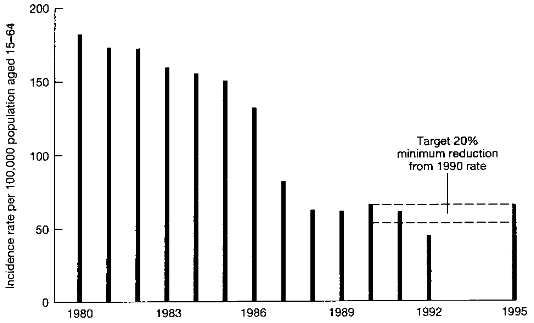


Figure 4: New Cases of Gonorrhoea



But it is of particular note that there is no *Health of the Nation* target for the most challenging area related to sexual behaviour, HIV infection. Measures exist for new cases of AIDS, laboratory HIV positive tests and from anonymous patient testing such as in antenatal clinics or accident departments; these latter are as accurate as population measures as are clinic gonorrhoea rates. But HIV rates are rising, and far more NHS money is spent on treatment of patients with AIDS than on prevention. Even in this new area of population ill-health where policies might have been different, funding has followed the demand for treatment from clinicians rather than the need for prevention through community-based programmes.

Accidents

The three targets chosen in the area of accidents were all defined in terms of mortality data, and the existing trends are likely to see the relatively modest target reductions being made: see Figure 5. However, it is not self-evident that this improvement will be due to prevention: techniques for intensive care support of people in accidents are improving, and may account for the decreasing mortality. On the other hand, risks are increasing through the ever increasing volume of traffic on the roads and the greater fragmentation of social

Figure 5a: Death Rate for Accidents: Children

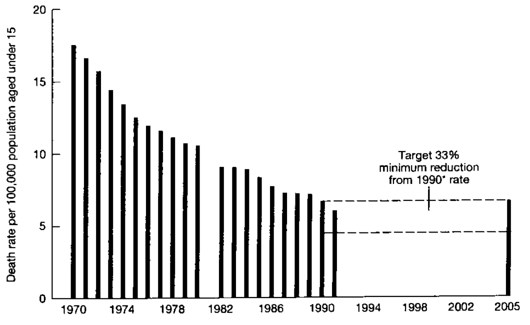


Figure 5b: Death Rates for Accidents: Young People.

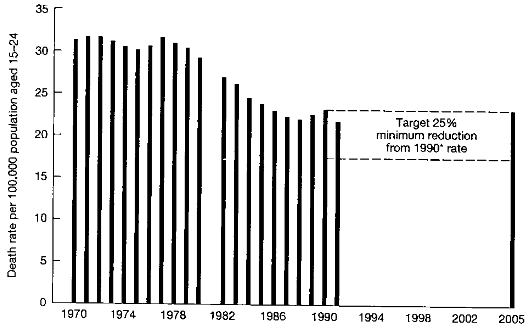
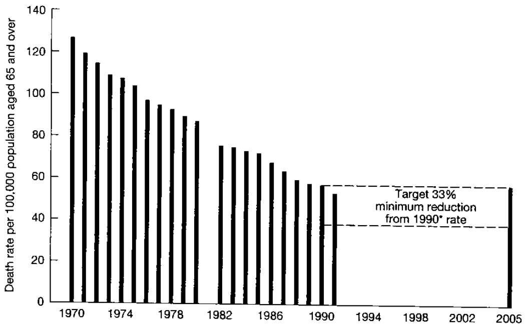


Figure 5c: Death Rates for Accident: Older People



support for elderly people. As Robert Davis has cogently explained in relation to traffic accidents (*Death on the Streets*, Leading Edge Press, Hawes, 1993) accident reductions do not necessarily mean greater safety: they may represent greater restrictions on 'vulnerable road' users. It's nice to go out for a walk, but in the City it's safer to stay at home!

Assessment: the Local Position

The 120 district health authorities in England are expected to deliver *The Health of the Nation* at local level. During 1994 the NHS commissioned a review using interviews with chief executives and directors of public health in a sample of 15 health districts. Among the findings were:

- a broad welcome for the policy; respondents supported the choice of the five key areas;
- little support for local targets, because of their variation within small populations; perhaps also districts are not used to working to the long agendas of health status in comparison with managerial objectives such as waiting times;
- while most districts could cite some examples of changes achieved with *The Health of the Nation* framework, they were usually small and marginal. Programme budgets had not been developed around key areas, and contracts were not seen as effective in achieving *The Health of the Nation* changes;
- patchy commitment of other local players: hospitals tended to regard the key areas from the perspective of treatment services, GPs showed a wide range of understanding;
- lack of direction from other central government ministries was seen as limiting local authority involvement;
- some of the continuing obstacles described included the need for greater investment in achieving population behavioural change; lack of wide ownership of *Health of the Nation* policies; and continued turbulence of the NHS managerial environment.

These points together add up to a sizeable gap between policy aspirations and field-level reality. *The Health of the Nation* is often relegated to be the (marginal) responsibility of the public health department, while the rest of the NHS gets on with the 'real' business – of contracts and balance sheets, hospital admissions and waiting times, and general practice consultations.

The managerial agenda for NHS districts in 1995/96 – mergers between district health authorities and family health service authorities and the development of primary care-led purchasing – continues to detract from delivering on health promotion. Reorganised staff will have to relearn about local needs and the contract portfolios; new local purchasing consortia need training; achieving short term Patient's Charter targets like waiting times, continued to take precedence over longer term health targets.

Assessment: the National Position

The Health of the Nation operates in two ways at central level. First, the Department of Health is responsible for ensuring the programme and achieving the targets. Second, other government departments are required to participate.

The Department of Health's approach to *The Health of the Nation* appears to have been publicity-driven. It is of note that the Health Education Authority, which is a formal health authority within the NHS, although almost completely funded directly by the Department of Health, was not expected to lead *The Health of the Nation*: responsibility has remained within the Department. To maintain visibility for the programme, the Department has developed a range of publicity tools, including newsletters, special themes, even prizes. Thus, in June 1993, the first aniversary of the launch of *The Health of the Nation* white paper, publicity was given to the Chief Medical Officers 'Challenge' of ten styles of healthy living. These were welcome in themselves, but were not followed through although they were revived, again for the one day, in June 1994. Similarly, in 1994 the Department initiated a competition, regionally and nationally, to award prizes to the best submitted examples of *Health of the Nation* alliances. Cynics wondered whether the Ministerial Cabinet

Committee on Health would be prepared to submit itself for scrutiny by a Department of Health judging panel.

The weakness of the Ministerial Cabinet Committee on Health is that, in common with other cabinet committees, it is surrounded by secrecy. Self-censorship is entirely understandable from the perspective of a civil servant: it may well be that greater action can come from internal than public debate. However, it is out of line with the Prime Minister's commitment to more open government and, without other evidence, can leave the impression that nothing is happening.

One example of progress in collaboration between departments that has emerged is a discussion paper from the Task Force on Nutrition. This group, chaired by a senior medical academic, is engaging with the complex field of nutrition policy and food retailing – territory closely controlled by the Ministry of Agriculture, Fisheries and Food. In previous years, working groups supported by the Health Education Authority have made recommendations on food policy, but have been opposed by powerful commercial interests. The new group takes an incremental approach, setting out a number of initial proposals and seeking to take the food retailing industy with them. The process strongly needs evaluation to understand how far health concerns can achieve primacy over commercial interests.

But what is happening elsewhere in government? In transport, where Britain has a poor record on child pedestrian accidents, the Department of Transport continues to plan for increases in motor vehicle traffic, ignoring widespread indignation by building new trunk roads and threatening social transport through privatising bus and rail services. In housing, new house building continues to fall, private rented accommodation remains empty, while provision for low-income families deteriorates. In economic policy, high levels of unemployment continue, income inequalities between social groups widen and the proportion of people in poverty increases. In education, specific funding for drugs education in schools has been abolished and parents are allowed to remove their children from lessons involving sex education. If these, and equivalent, policies have been debated by the Ministerial Cabinet Committee on Health, the decision would not appear to have gone in favour of *The Health of the Nation*.

Lack of policy leadership at national level matters on two counts. First, the health targets for a healthier population simply won't be achieved without national intersectoral commitment and action. Second, exhortation and PR from the Department of Health, without evidence that central government is fulfilling its responsibilities, creates cynicism within the NHS: 'If they don't want to commit themselves, why should we?'

Yet the Department of Health can be justifiably proud of establishing *The Health of the Nation*. It has been welcomed as an example of good practice by the World Health Organisation. It has been imitated by the Irish Government, and has spurred both France and Germany towards national health policies. It has been supported by the major health professional associations, by consumer associations, and by health promotion departments within the NHS. Its success or failure will depend on the degree of political commitment it can achieve.

Action Required

What action should be taken to enhance *The Health of the Nation* further? Why, indeed, has the response so far appeared half-hearted? Part of the answer to both questions is to maintain the cultural shift that was started by *Health For All*. People both inside and outside the NHS often tend to think of 'health' as created by health services. Only on reflection do the underlying factors of behaviour and the physical and social environment become apparent. The message from the NHS that health is sustained through health promotion and protection needs to be much stronger. The NHS spends billions of pounds on treatment and care and relatively little on prevention.

Yet the evidence for effective interventions is often sounder for prevention than for treatment, both because preventive programmes have to face higher levels of scepticism and because their basic science of epidemiology is more rigorous than clinical practice. As a simple example, holding the UK breast screening programme to the limit of women aged 50-64 is based on purely scientific epidemiological evidence, while clinicians, and some of the public, would wish to extend screening to other age groups. On the other hand, getting clinicians to implement proven preventive interventions is often very difficult: much more clinical effort and research funding has gone on studies of lung cancer treatment than on studies of clinical interventions against smoking.

Many of the options to enhance *The Health of the Nation* are in the hands of the Department of Health.

- In the face of further NHS organisational changes, the Secretary of State must maintain NHS commitment to *The Health of the Nation* key areas nationally and through district chairmen, health authorities and GP purchasers. District action programmes across primary and secondary care should be regarded as the top priority for judging performance. Conflicts in national policies – for example, inadequate taxation on tobacco, half-hearted approaches to sex education – need to be resolved. And locally, if programme budgets are developed for the key areas, allocations should be made specifically to address the areas of health services provision which have an impact on *Health of the Nation* targets.
- Management priorities within the NHS also need to be re-assessed. The NHS Executive should oppose the Treasury's demand for narrow so-called efficiency indices in the NHS. For example, in 1995/96 districts are required to achieve a 4 per cent increase in NHS 'activity' within the hospital and community services: yet the purpose of *Health of the Nation* is to invest to reduce health care, rather than increase it: to see fewer admissions to coronary intensive care, not more. Patient's Charter indices also appear more

concerned with efficiency than effectiveness. Most people would wish to see shorter waiting times for surgery; but what is the level of health gain from these operations? Indeed, how necessary are they if GPS and patients were previously prepared for a three or even four year wait? For several years now, special funds have been poured into surgical operations across the country to 'reduce' waiting lists, yet the lists have grown. This was never a *Health of the Nation* priority.

- There should be understanding of the place of targets. The original *Health of the Nation* targets were derived, at least in part, from the World Health Organisation's country-wide *Health For All* targets. For several *Health of the Nation* targets, no detailed local data were available: for one, on mental health, data were not even available nationally. There was also the difficulty of small numbers, for example a district might have only 5-10 child accident deaths a year, and the wide statistical variations make trend monitoring difficult. In practice, though, this should not be much of a problem. Health promotion programmes are set in place on scientific evidence, and monitored partly through coverage and quality of provision. Targets can be assessed as trends, and small numbers grouped as moving averages. Above all, health targets give a conceptual focus for action, they provide a rationale for priorities, and intermediate measures can be agreed for yearly monitoring of progress.
- A significant investment should be made in training. Senior and middle grade district health authority staff, especially in contracting and information departments, are poorly informed about the meaning of, and opportunities in, the five key areas. There will be no deep commitment to achieving *The Health of the Nation* at district level if the majority of staff do not understand the policy. Indeed, as the newly merged district and family health services authorities are increasingly being seen as leading the public health role within the NHS, all staff in these organisations will need extended public health training. Equally, the work brought together in *Better Living: Better Lives* needs to be implemented across general practice, and the new Authorities should be held accountable to ensuring implementation. As the scientific knowledge exists, it is untenable that the NHS should fail the public by not providing a well-resourced, effective preventive health care service.
- The central government departments that relate directly to local authorities, especially the Departments of Environment and Education, need to bring *Health of the Nation* targets explicitly into their guidance. Local authorities should have as strong a commitment to collaboration with health authorities for health promotion as they already have for community care. Staff in their environment, education, leisure and housing departments are often facing *Health of the Nation* issues – the links across into health authorities need to be established and developed. A larger vision for joint funding to cover social housing, leisure provision, environmental improvement, road traffic reduction, occupational health provision, community safety, health education, is one possibility, with the budgets held by stronger Joint Consultative Committees.

One of the current questions for *The Health of the Nation* programme is whether to expand the key areas. The original 16 topics identified in the consultation paper were reduced to five key areas for the programme. The key areas were all epidemiological disease groups – if teenage conception can be included in this term – but they also subsumed several behavioural objectives that were within the original list. Three areas – rehabilitation for physical disability, environment and food safety – that were not diseases were left out, and three disease areas – communicable diseases, diabetes and asthma – were also excluded.

There is pressure from some national associations to extend the five key areas. Diabetes and asthma continue to be advocated, and back pain has also been proposed. The St Vincent Declaration sets out a vision of comprehensive, locally-based diabetes services backed by appropriate prevention. Epidemiologists have suggested there is an increasing incidence of asthma. While the media have supported the common belief that this is due to external air pollution, most evidence, however, points to indoor air as the main factor. The quasi-independent Clinical Standards Advisory Group, established in 1991, reported in 1994 on back pain. They argued for more active management of acute back pain in primary care, and specialist, low-technology provision for the small proportion of cases requiring long term care.

While each of these diseases is of concern, it would not benefit *The Health of the Nation* to be extended to them. They affect fewer people than the existing key areas. As they have elements both of treatment services and prevention, they would deflect from the clarity of the existing programme. And they compete with other proposals – epilepsy, Alzheimer's disease, genetic disorders could all make claims. Policy makers for *The Health of the Nation* should not tinker with the content; they must seek to establish more clearly the programmes that will achieve the existing targets. At the present rate of progress only half or less will be achieved, and it would be foolish to move on to new objectives until the original ones are achieved.

Perhaps the three approaches most in need of development are intersectoral policy, behavioural interventions in clinical practice and reductions in inequalities. Intersectoral work – between health, social services, housing, environment, leisure, police, education – needs national policy guidance from the centre to local agencies, and needs to be promoted through local alliances. The Healthy Cities projects offer a successful model. Clinical behavioural interventions are most needed in primary care, seeking to achieve smoking reduction, alcohol control, increased exercise, stress reduction, better nutrition and weight through broad health promotion programmes for all ages. Economic, motivational and mental health factors influence the ability of individuals and social groups to respond, so attention must also be given, especially through national policies, to reducing underlying social and economic inequalities.

How will accountability be achieved? *The Health of the Nation* is the Government's programme, and the Secretary of State is accountable for it to Parliament. Parliament should give it as much attention as other areas of NHS activity – perhaps more. There should at least be an annual debate on implementation of the national programme and the progress towards targets, with presentations from all major Ministers describing how their departmental policies are contributing. Chairmen and their health authorities should be accountable for achieving specific intermediate *Health of the Nation* goals – for example, implementation of *Better Living: Better Lives* across all general practices and clear intersectoral programmes with local authorities. Finally, local people need to have a greater say, perhaps through regular fora for listening to local proposals for achieving *The Health of the Nation*. We need a Health Charter to complement the Patient's Charter.

The opening sentence of the 1991 consultation paper says: 'As we approach the next millenium it is timely to look forward to what we in England want to achieve by way of further improvements to our health.' *The Health of the Nation* has provided the vision: more action is needed.

RESEARCHING FOR HEALTH

Angela Coulter

In reviewing the state of medical research in 1988, members of the House of Lords Select Committee on Science and Technology were dismayed to discover that the NHS had minimal input to the initiation of research programmes, despite the fact that it is the principal customer for the results of research into health care. The DHSS, as it then was, funded several research units and some centrally-commissioned research projects, the total cost of which amounted to £20 million, one-thousandth of the health service budget. Regional Health Authorities had small budgets to spend on research projects initiated by NHS staff through the Locally Organised Research Scheme. Additionally the Service Increment for Teaching and Research, an allowance given to teaching hospitals to cover their extra costs, included an element to cover the service costs of research.

Most of this research was investigator-led rather than problem-led. Health services research, as distinct from basic biomedical science and traditional clinical research, was drastically underfunded. There was no mechanism for enabling the NHS to articulate its own research needs, for funding and organising research programmes to address NHS problems, or for ensuring that the results of research were disseminated throughout the NHS. The House of Lords committee concluded that it was high time that the NHS was brought into the mainstream of medical research.

This was the task faced by Professor Michael Peckham when he took up his post in January 1991 as the first NHS Director of Research and Development. His range of responsibilities included the development of a research and development (R&D) programme for the NHS in England, the establishment of Directorates of R&D in each Regional Health Authority, the continuation of the Department of Health's centrally-commissioned research programme, oversight of relations with the research councils and other funding bodies, and strengthening the interface with the health-related R&D of other government departments and the European Community. Similar R&D strategies were developed for Scotland, Wales and Northern Ireland.

The NHS R&D strategy, *Research for Health*, was launched with the aim of creating a knowledge-based health service in which reliable and relevant information would be available for decisions on policy, clinical practice and management of services. This would provide the basis for maximising the effectiveness, efficiency and appropriateness of patient services. The research to be commissioned was to be concerned with service delivery and organisation, and evaluative clinical research, focussing in particular on the outcomes of clinical interventions. It was to be problem-led, relevant to the needs of the NHS, and multi-disciplinary, drawing on research expertise and methods from diverse interests including hospital medicine, primary care, public health, dentistry, nursing, the professions allied to medicine, biological and physical sciences, epidemiology, statistics, economics, sociology and other social sciences.

The strategy had four key goals:

- **Knowledge**: to substantially increase the knowledge base required to evolve and apply effective, efficient and appropriate services. This includes knowledge arising from research and knowledge about scientific and technological advances.
- **Information**: to ensure that information about existing research and science-based knowledge is available and accessible for decision making, and that information about unmet needs for knowledge shapes the R&D agenda.
- **Implementation**: to promote the use of research and science-based information by decision makers in the NHS.
- **Culture**: to instil into the NHS a culture of evaluation, review and learning, so that information about knowledge is actively sought and applied intelligently in decision making.

Considerable progress has been made in establishing the infrastructure to carry forward this ambitious set of aims in the first four years of the programme's existence, but there is still a long way to go. The remainder of this article reviews progress against each of these four goals.

Establishing the Knowledge Base

This first goal requires three distinct elements to be in place:

- a means of identifying research needs;
- appropriate funding mechanisms;

- machinery for commissioning the agreed programmes.

Identifying Research Needs

A key goal of the R&D strategy is to engage NHS staff – both providers and purchasers of health care – in the formulation of research priorities. The aim is to create a 'needs-led' system for commissioning applied research, in contrast to the more traditional 'science-driven' method of allocating research funds in response to the interests and priorities of research investigators. While conceding that there should be a continuing role for responsive funding and curiosity-driven research, the main emphasis of the programme is to establish mechanisms for developing a systematic approach to identifying research priorities to improve the effectiveness and efficiency of health care delivery.

To achieve this a Central Research and Development Committee was established to oversee the development of the strategic framework, supported by a number of multi-disciplinary advisory groups. The advisory groups, with the exception of the Standing Group on Health Technology Assessment, are all time-limited and disbanded once they have reported to the Central Committee. The topics they have considered are set out in Table 1.

With the notable exception of the consumers group, each advisory group has conducted a wide consultation exercise to identify potential topics for research and then selected research priorities according to pre-agreed criteria. The groups' recommendations are passed to the Central Committee and, if approved, the research questions are refined, if necessary, and sent on for commissioning, as is explained below.

Table 1: Advisory Group Topic Areas

Disease-related:	mental health and learning disabilities cardiovascular disease and stroke cancer diabetes dentistry asthma nutrition
Management and organisation:	primary and secondary care interface implementation of research findings
Client groups:	physical and complex disabilities mother and child health
Consumers	
Health technology assessment	primary and community care pharmaceuticals population screening acute sector diagnostics and imaging methodology

It is a unique and relatively sophisticated approach to developing research priorities which has evolved and improved since it was first established. It depends on a considerable amount of voluntary effort on the part of large numbers of members of advisory panels and those who respond to the consultation exercises. Attempts have been made to ensure that the panels are multi-disciplinary and not dominated by sectional interests, but inevitably the keenest contributors tend to be those who hope to secure research funding once the priorities have been agreed. This ensures a level of expert advice, but maintaining the commitment of managers and professional staff with no research aspirations has been more difficult. Various attempts have been made to engage them through the consultation exercise, but resources have been limited and for the most part the advisory groups have had to depend on a combination of written submissions and their own knowledge of research needs. The system has been criticised for its apparently bureaucratic approach, although this seems a little unfair. The trick is to balance a genuine attempt to determine national research needs through consultation at all levels within the service, with speed of response in terms of high quality commissioned research producing relevant and useful output.

The system is mirrored at regional level where the eight Regional Directors of Research and Development have established their own research committees responsible for establishing local priorities and disbursing locally-derived funds, and for managing national research commissioning exercises on behalf of the Central Committee. The Regional Committees have often had greater success in engaging a wide range of NHS staff in setting research priorities, but accessing appropriate academic involvement has sometimes proved more difficult. This dual system of national and regional committees with separate funding sources, which has obvious dangers of duplication and miscommunication, will be simplified when the Regional Health Authorities are finally abolished in 1996 and the R&D strategy becomes the direct responsibility of the NHS Executive through its regional offices. It should then become easier to co-ordinate the work of the Regional Directors and thus lessen the risk of duplication.

Funding Research

There has always been a variety of sources of funding for medical research, by far the largest proportion coming from commercial sources, *ie* the pharmaceutical and medical equipment industries. Other funders include the Medical Research Council, other research councils, charities and university sources, as well as the Department of Health and the NHS, whose combined contribution in 1989/90 amounted to only about 15 per cent of the total. One of Professor Peckham's first acts was to establish a funding target of 1.5 per cent of total NHS expenditure to be earmarked for R&D expenditure by the NHS. It was argued that this proportion would be broadly in line with average expenditure on R&D in service industries and the NHS would need to spend this amount to ensure that its resources were used effectively to improve the nation's health.

This was not as great a planned increase as it first appeared, because the estimate of baseline expenditure had been uprated to include an estimate of the service costs of research. The SIFTR funding supplement, introduced in 1990 as an additional allocation to teaching hospitals and postgraduate institutions, was supposed to cover the additional costs of providing teaching and research facilities to the tune of 75 per cent teaching and 25 per cent research, but in practice these funds were not usually specifically earmarked for these purposes. In the pre-reform NHS the contribution of academic staff to NHS patient care and NHS staff's contribution to teaching and research were assumed to be balanced in a 'knock-for-knock' arrangement, with the true costs being opaque to say the least. Thus there was only a vague idea of the true expenditure on research support in NHS institutions, and very little control over what it was spent on.

It was obvious that the development of a comprehensive NHS R&D strategy would require much more careful targeting of research resources. Recalculation of the costs of research resulted in an estimated NHS R&D expenditure of about 0.9 per cent of gross NHS expenditure in 1989/90, or £225 million. By 1994/95 planned expenditure on R&D was estimated at £437 million, or 1.2 per cent of total NHS costs, an increase of 3 per cent since the R&D programme was established but still short of the 1.5 per cent target which would require an expenditure of £540 million.

Much of the expenditure was tied up in departmental support and not therefore immediately available to fund newly emerging research priorities. In 1994 an R&D Task Force, chaired by Professor Tony Culyer, was appointed to investigate ways of disentangling the complexities of the funding and support arrangements for NHS R&D. Its report, *Supporting Research and Development in the NHS,* recommends the establishment of a single funding stream to be levied from purchasing authorities on an annual basis. In response to repeatedly expressed concern that the purchaser/provider split was inhibiting the conduct of good quality research, the report argued that the direct, indirect and service costs of research should be made explicit and substracted from the sums allocated to purchasing authorities by means of an R&D levy.

Culyer's recommendations have been accepted by the Secretary of State for implementation in 1996/97. It is intended that the NHS Executive will become the main purchaser of research and funding arrangements will become much more transparent. Excess service costs arising from research will be separated from the costs of normal care and paid for out of the R&D budget. Purchasers will no longer be expected to bear the additional burden of research costs because they will not be reflected in provider prices. However, quantifying the indirect costs of research and separating the 2 per cent of SIFTR funding theoretically allocated to research from normal departmental costs will be no easy task. Much of the SIFTR money is currently supporting departments whose work is not focussed on NHS R&D priority areas, while some may even be being used to provide direct patient services. We can expect to see fierce resistance to the redeployment of these funds.

Another question not yet satisfactorily resolved concerns service development costs. For example, the cost-effectiveness of hospital-at-home schemes is a topic which has been highlighted as a priority for evaluation. It is not clear how the establishment and use of experimental schemes such as this will be paid for until such time as their cost-effectiveness is established. So far R&D funds have not been allocated to support innovative service developments, but purchasing authorities and GP fundholders may be reluctant to cover the costs of such innovations in the absence of evidence about their value. There may be difficult times ahead as Culyer's plans are implemented.

Commissioning Research

Once research priorities have been determined and appropriate funding earmarked, the next stage is to commission a series of research projects. These can include both original research and systematic reviews or secondary analyses of existing published research. The pattern established by the R&D programme is to advertise for bids to undertake specific research projects, either by placing advertisements in the press or by limited competitive tender. All bids are assessed by peer review, with funds being allocated to the best proposals. The Regional Directors of R&D play a key role, since they each take lead responsibility for managing one or more of the national priority areas.

The whole process rests on an assumption that there are enough experienced health services researchers available to fulfil the identified research needs. Due to the previously undeveloped and underfunded state of British health services research, this is proving to be a potentially serious barrier to the realisation of the strategic goals of the programme. Those academic departments with an established strength in the field have found they can attract considerable sums from the R&D programme. Health service research units are burgeoning and many new Chairs have been established. But this expansion of activity rests on shaky foundations. Although health services research has been carried out in the UK over the last fifty years, it has been a minority activity confined to a small number of specialist research units and a few academic departments of public health medicine, general practice or psychiatry. Very few NHS staff have had the opportunity to carry out high quality research or to evaluate the outcomes of clinical interventions. Since most of the work has been project based, theoretical and methodological development has been relatively neglected. Health services research still carries very low status in medical schools, in contrast to laboratory science, clinical research or epidemiology. As a consequence few clinical departments have concerned themselves with health policy or the operational research needs of those responsible for managing health services and very few evaluative studies have been carried out. There are signs that the situation is now beginning to improve, evidenced by an upsurge of interest in conducting randomised controlled trials of clinical interventions. But there is a real lack of relevant skills in most medical departments and the situation is even worse in nursing departments and among those responsible for training and career development in professions allied to medicine.

Many practitioners of health services research are not medically qualified, being trained for the most part in social sciences or statistics. Posts for such people, usually funded on short term contracts, are characterised by insecurity, poor pay and conditions and lack of career prospects. Turnover tends to be high and levels of experience low. Medically qualified researchers have better pay and conditions and greater job security, but very few have any experience in health services research. Not surprisingly, it has proved difficult to attract sufficiently experienced people to apply for the new posts and the quality of research proposals has not always been high enough to justify funding.

The need to establish training opportunities has been recognised by the R&D directorate and the regional offices and a number of fellowships have been funded. However more fundamental changes may be required if demand for good quality research is to be adequately satisfied. The best health service research is multi-disciplinary, requiring the collaboration of, for example, clinicians, statisticians, economists, sociologists, psychologists. The organisational structures of universities and service departments often militate against collaborative research and considerable commitment of time and resources is required to bring people with the relevant skills together. Organising community-based research, for example studies based in general practice, is even more problematic. Few GPs have research training or experience and academic departments of general practice are still at an early stage of development. The Government's intention to develop a primary care-led NHS has revealed the weaknesses of the knowledge base in primary care and has highlighted the urgent need to strengthen this area of research.

Recent initiatives by the Medical Research Council to establish a national centre of health services research based at Bristol University and the NHS R&D-funded Centre for Primary Care Research and Development at Manchester University should help to foster the collaborative research, training and methodological development that is so badly needed. Career prospects will improve if the demand for experienced researchers continues to grow. This in turn will depend on whether or not the first fruits of the R&D programme are perceived to be of value to those working in the NHS.

Disseminating Research Findings

Early on in the development of the NHS R&D strategy it was recognised that the need to commission new primary research was not the only priority. The need to make existing published research more accessible for decision making was arguably of even greater importance. Most researchers feel their job is finished once their findings are published. Dissemination usually goes no further than occasional conference presentations, usually to other academics, and publication in scientific journals. The output of academic researchers is judged solely by the number and quality of peer-reviewed publications. Most funding bodies have no brief for implementation and the question is seldom raised when research proposals are being assessed for funding. So it is not really surprising that the gap between research and practice is still so wide. The dissemination of research findings has to be carefully targeted so that purchasers and providers can access and use it. But this should not be a passive process. The producers of research findings and systematic reviews have to find ways of reaching audiences outside the traditional academic conference circuit.

The volume of literature published in scientific, medical and other journals aimed at health professionals throughout the world is enormous. It is now virtually impossible for any one person to absorb all the literature relevant to a single specialty, let alone the wider interests of people with generalist roles, such as GPs, public health professionals, nurses, health service managers and policy makers. The quality of published research is also highly variable and specialised skills in critical appraisal are required to extract information from well conducted studies from those that are unreliable.

This is particularly important when trying to determine the efficacy of health care interventions. The best way to evaluate a clinical intervention is to allocate patients to the treatment or a placebo alternative at random and to measure the outcomes – benefits and harms. Randomised controlled clinical trials have long been an established method of establishing the efficacy of new drugs and they are increasingly being applied to other clinical and even organisational interventions, such as surgical procedures, diagnostic tests and care delivered in different settings or by different professional groups. However, it is often dangerous to base a clinical policy on the results of one such trial, since the study may have been too small to eliminate chance effects and systematic errors or biases may have crept in to distort the results. Synthesis or meta-analysis of the results of a number of studies often produces more reliable findings, although this must be based on a systematic review of the literature incorporating all methodologically sound studies.

The Cochrane Collaboration was launched in 1993 as a major international effort to address this problem. Building on the work of Dr Iain Chalmers and his colleagues at the Cochrane Centre in Oxford, which was funded through the NHS R&D programme, the collaboration aims to review and synthesise the world literature, published and unpublished, of randomised controlled trials of health care. The output will include systematic reviews of the best scientific evidence on the risks and benefits of treatment options, which will be made available in electronic form (on computer disks) to clinicians throughout the world. Building largely on the work of committed volunteers, the ambitious aim is to transform medical practice to ensure that treatment decisions are based on sound research evidence wherever possible. By gathering together all the clinical trials and reviewing their findings, the gaps in scientific knowledge will also become more apparent and this in turn will inform the research agenda.

The Cochrane Collaboration reviewers choose the subjects they wish to develop into systematic reviews, the main constraint being the availability of published trials. In this sense the collaboration is investigator-led and therefore not directly linked to the R&D priority-setting process. The other new institution established as part of the NHS R&D information strategy – the NHS Centre for Reviews and Dissemination based at York University – adopts a problem-led approach to dissemination of research information. Using as their starting point clinical and organisational topics that are of particular pertinence in the NHS, they aim to produce or commission systematic reviews of the research evidence and disseminate them throughout the service in the form of accessible published summaries for use by purchasing authorities and health care providers. While working closely with the Oxford-based Cochrane Centre, the York team do not restrict their reviews to randomised controlled trials. Their dissemination products – the *Effective Health Care* bulletins, *Effectiveness Matters* and their database of systematic reviews – adopt a more eclectic approach to the types of study included in reviews, although they aim to be rigorous in their assessment of the quality of studies. The *Effective Health Care* bulletins have been generally well received by purchasing authorities who are beginning to use them to try to influence clinical practice, but at the time of writing less than ten have been published. If the dissemination programme is to do more than scratch the surface of the vast pool of published evaluations, activity and funding will have to be stepped up considerably.

The third element of the R&D information strategy is the development of a computerised register of all research projects funded by the NHS, including all those which attract service support but not project funding. Once established, this register should help to improve co-ordination of effort and reduce duplication. At present, considerable time, effort and financial resources are spent supporting many small scale studies which have little chance of producing useful results. This is particularly true of much clinical research, especially nursing studies. Greater co-ordination and collaborative effort could result in much better value in terms of payback for the NHS, but it will require more than the construction of a database to achieve this.

The investment in dissemination has been very small in proportion to the total R&D budget. The establishment of the centres at Oxford and York are very significant developments, but they employ only a handful of people. The R&D programme has been slow to develop a systematic plan for publicising its work and no communications specialists are employed in the directorate. This is disappointing because the familiar pattern of expensively commissioned research reports left to gather dust on shelves will not be broken unless those involved in R&D adopt a more professional approach to marketing their products.

Implementing Research Findings

There is little point in prioritising, funding, conducting and disseminating health services research, unless there is commitment to ensuring that the findings are implemented. And yet there is ample evidence that research findings often do not make the transition into clinical practice. For example, long after it had been established that thrombolysis could save lives of people suffering acute myocardial infarction (heart attack), many doctors failed to prescribe it; dilatation and curettage is still being carried out as a diagnostic test on many young women despite the fact that research has shown it is unnecessary; many women with breast cancer are still not receiving the most effective treatment regimes; and managers are still investing in expensive items of equipment after studies have shown they are not cost-effective.

Health care professionals are often resistant to attempts to persuade them to change the way they practice, or at least that is the way it seems to those who have tried to increase the uptake of research findings. Many of these attempts have been crude, based on a naive assumption that behaviour will change if people are simply provided with unsolicited written information. The guidelines production industry is based on this false assumption. GPs receive large numbers of unsolicited guidelines through the post, many of which go straight into the wastepaper bin. This may be the most appropriate place for some guidelines, since many are based on expert opinion or consensus rather than scientific evidence. Guidelines can have an important place in the promotion of evidence-based health care, but only if they are based on reliable research evidence.

Studies of influences on patients' behaviour, for example in relation to health promoting or health harming lifestyles, have shown that the relationship between knowledge, attitudes and behaviour is complex and subject to all sorts of extraneous influences. The same is true of clinicians' behaviour. Research into strategies for influencing clinical behaviour is at an early stage, but we know enough from other fields to know that passive receipt of unsolicited information is most unlikely to have an effect. The pharmaceutical companies have considerable experience of trying to influence clinicians through their marketing programmes, which are highly sophisticated. Those involved in trying to promote evidence-based practice would do well to observe the multi-faceted techniques adopted by the companies.

The R&D programme has highlighted research into implementation strategies as a priority area and studies of the effectiveness of various approaches to changing clinical behaviour are in the process of being commissioned. Different means of changing clinical behaviour which have been tried, all of which require further evaluation, include the following:

- Publication in professional journals
- Conferences and workshops

- Policy initiatives
- Continuing professional education
- Distribution of clinical guidelines
- Audit and feedback
- Marketing
- Press and media
- Opinion leaders or influential individuals
- Reminders and computerised decision-support
- Patient-mediated interventions (informed patients demanding better care)
- Contracts and service agreements
- Financial incentives
- Complaints and malpractice suits
- Individual performance review
- Academic detailing (educational outreach on a one-to-one basis)

Systematic reviews of the current state of knowledge have identified various levers which can be used to induce behaviour change. However most of these studies are north American and their findings may not be transferrable to the British context. There is often a need to target different audiences simultaneously, including clinicians, managers, patients and policy makers. Each group may need a different type of approach and there is some evidence that multiple approaches are more successful than any single method. There is certainly no magic bullet.

The findings of studies to evaluate the effectiveness of each of the levers for change will be very useful in planning implementation programmes, but those involved in R&D cannot afford to sit around and wait for the results. If the NHS R&D programme is to retain political support in the long term, it will need to be able to show that the investment achieves a reasonable level of payback. Despite the 'D' in the title, most of the activity to date has focussed on research rather than implementation and service development. Strictly speaking development should be a service responsibility. Most of the commissioned research is being carried out by academics. This is entirely appropriate, since they have the research skills, but they are not usually the appropriate people to implement changes in practice. Thus the success of the R&D endeavour must be judged on the extent to which it has been able to build bridges between researchers and practitioners to facilitate the transfer of research findings into practice.

Although there are signs that this is now being recognised as an imperative, the national R&D directorate has been slow to take initiatives in this direction. So far no central R&D funds have been earmarked for service development projects aimed at implementing research findings. Regional directorates have funded one or two implementation projects, for example the Oxford GRiP project (Getting Research into Practice), which takes specific clinical issues, such as treatment of menorrhagia, stroke rehabilitation, thrombolytic therapy, and uses a variety of interventions to change clinical practice. In the main though, practical attempts to implement evidence-based changes in clinical behaviour or the organisation of health services have been very few and far between.

This failure to take the initiative on implementation may have serious long term consequences for the R&D programme. It is likely that the programme will come under attack when purchasers realise that their budgets are being top-sliced to fund R&D and when providers find that they are losing control of part of their SIFTR funding. Those wanting to defend the R&D spend will need to arm themselves with examples to demonstrate the valuable output from the programme. Lists of publications in esoteric journals will not impress managers and practitioners looking for practical examples of impact. They will want to see evidence of real changes in clinical practice and uptake of cost-effective innovations. This will only be achieved if service development projects are accorded the same priority as primary research studies and systematic reviews.

Changing the Culture

A close alliance between R&D directorates, purchasers and providers will be necessary to achieve the breakthrough into service development. Although the purchaser/provider split has helped to clarify the need to consider the appropriateness and cost-effectiveness of health care interventions, the competitive culture is not always conducive to building alliances across the divide. Overcoming these barriers will require clear leadership from the top.

It would help enormously if policy makers were to demonstrate a firm commitment to using the knowledge base, yet research findings often get submerged under other political priorities. For example, the new contract introduced for GPs in 1990, required them to carry out urine tests in routine health checks, despite the fact that research showed that this conferred no benefit; and the Government has set its face against the body of research evidence which shows that a ban on tobacco advertising would reduce smoking rates and produce a beneficial effect on health. When the NHS reforms were introduced in 1991, the then Secretary of State for Health, Kenneth Clarke, refused to allow any evaluation to be commissioned by the Department of Health on the grounds that it would impede progress with implementation. A genuine commitment to evidence-based policy making would help to encourage a climate which was more conducive to the development of an evaluative culture.

As well as a clear lead from policy makers, there is a need to change the system of recognition and rewards in medical research. Far more kudos is attached to achievements in basic science and molecular biology, than is afforded to evaluation of treatments or organisational issues. There are no Nobel laureates in health services research. The old guard in the medical schools is confused about this activity and some feel threatened by its new ascendancy. They fear it will drain resources from the more traditional laboratory and clinical research activities on which most academic medical careers have been built. Professor Peckham's achievement in persuading a large number of distinguished clinical researchers to make important contributions to the R&D committees is evidence of his skill in building alliances. It will be crucial for the continued success of the programme to maintain a broad base of involvement among clinicians and academics.

The R&D programme has also aimed to engage the support and involvement of managers in its endeavours. Progress has been patchy in this regard. Unlike clinicians, few managers have a background in research and most of what is taught in management schools is very far from being evidence-based. Some of the regional R&D directorates have made considerable efforts to engage managers in their work with varying degrees of success. The different time horizons of academics and managers is particularly problematic. The timescale from priority-setting, through commissioning to production of results can be at least three to four years, but this can be very frustrating for those wanting evidence on which to base more pressing decisions. Many managers are keen to know more about the cost-effectiveness of alternative forms of provision, yet the small body of health economists engaged in health services research will find it particularly difficult to meet this demand unless their ranks are increased considerably.

The outlook is not all gloomy. There is far more interest now than ever before in developing the means to measure the outcomes of health care, and awareness is growing among NHS staff and the public that more intervention does not necessarily lead to greater health gain. Public interest in rationing decisions is intense and there are plenty of opportunities to use the press and media to raise questions about clinical effectiveness. The conditions are ripe for a culture change in the NHS, if those engaged in R&D are able to seize the opportunities presented.

ECONOMIC REGULATION AND THE NHS INTERNAL MARKET

Carol Propper

With the establishment of an internal market in the NHS came calls for regulation of this market. Commentators pointed to the existence of regulators in the newly privatised utilities and suggested that the NHS would also need its regulator. However, this conclusion needs to be tempered by two important facts. First, research on market regulation stresses the importance of industry-specific factors in determining whether regulation is likely to be of net benefit. Second, the NHS, and the UK health care market, in common with many other health care systems, is already heavily regulated. These facts suggest first, that if regulation is to be of net benefit, the precise regulatory arrangements will be specific to the market and second, the long term aim may be to decrease rather than increase the amount of regulatory activity. In this paper I therefore first examine whether economic regulation is likely to be needed. I conclude that it is. I then ask whether the present regulation of providers and purchasers is sufficient. I conclude that is it not. Given this, I then examine what kind of regulation is likely to be useful.

The Case for Economic Regulation

The traditional case for economic regulation is where weak consumers face a monopoly supplier. The supplier may charge higher prices and/or provide services of a poorer quality than in a market where competition is present. The supplier may be slow to innovate, protected from new ideas and challenges by its monopoly position. With respect to the NHS internal market, Julian Le Grand and Will Bartlett (*Quasi-Markets and Social Policy* Macmillan 1993) identified several potential sources of monopoly in the internal market: asymmetry of information between providers and purchasers, the existence of economies of scale in provision, and opportunities for providers to select patients and to 'cream-skim' – *ie* to pick those patients who are most profitable to treat. Given these, they suggested that regulation would be required.

However, some of these factors may be temporary. With respect to information, for example, while it is the case that information asymmetry between providers and purchasers was initially a problem, purchasers now have a better understanding of the information they need. In many cases they appear to be able to extract this information. Private firms have entered the market to help purchasers get information. If fundholders are able to get information more easily than DHAS as the number of fundholders spreads, so do information asymmetries decrease.

Economies of scale are widely believed to exist in hospital services. There are undoubtedly sunk costs in the creation of a new hospital which create barriers to new entry and protect those already in the market from competition. But evidence of economies of scale tends to be strongest for a limited number of 'high-tech' treatments in which effectiveness is a function of volume of activity and some evidence suggests that there may be diseconomies of scale as well. A large enough market may support more than one provider. And while entry into the provision of a whole new hospital may be difficult, entry into the provision of a single service for which the location of care is less important may be relatively easy. In the NHS system where health care is rationed by waiting list, there is evidence that patients may be willing to trade off travel distance against time to wait. And the sunk costs of entry into some services, particularly community based services may not be very high. In addition, there is believed to be excess capacity in the UK hospital sector. Reviews recently carried out of all large conurbations by the Department of Health have concluded that there is considerable excess capacity in hospital services. So, at present at least, the market is potentially competitive.

By way of support for this observation, I have estimated that only 8 per cent of a large sample of all acute service providers have no competitors within a 30 minute travel distance in the four important specialties of general surgery, orthopaedics, ENT and gynaecology. In addition, the specific nature of investment in, and the importance of location in the delivery of health care, means that long term contractual arrangements between purchasers and providers are likely to be the most efficient way of delivering most services. In other words, it is not necessary to have competition *in* the market for efficiency. Provided there is competition at contract renewal stage, long term relationships will be efficient.

But there are two factors which work in the opposite direction. While long term relationships have many benefits, they also carry with them the danger of bilateral monopoly or exploitation by the party with the greater bargaining power. And there is constant pressure on excess capacity in the NHS because investment is limited by constraints on public expenditure. Either and/or both of these factors may mean monopoly of supply comes to be a problem.

While monopoly on the supply side is the traditional area of concern for economists, in the internal market monopoly on the purchaser side may be as, or even more, important. Consumers in the NHS internal market do not directly choose their secondary health care. Instead it is chosen for them by purchasers acting on their behalf, as their agents. Those consumers whose GPs have become fundholders, often with little consultation of their patients, have their GP as their agent. Those consumers whose GPs are not fundholders have their local health authority as their agent. A consumer can only change their agent by changing GP. But because consumers have little choice of GPs they have little choice of purchasing agent. The extension of fundholding will not necessarily improve this. More fundholders does not necessarily give the patient greater choice of purchaser. In addition, the transactions cost of purchasing are such that fundholders may have an incentive to come together in larger groupings, so reducing the number of purchasing agents. The lack of choice of agent for the consumer of care gives the agent little incentive to be responsive to the consumers on whose behalf it purchases health care. In this situation, market forces cannot provide purchasers with incentives to act as good purchasers. Instead of seeking out the best deal for their patients or populations, purchasers will try to maximise their own benefits. This could result in collusion with, or lack of challenge of, poor providers, the outcome depending on the relative market power of the provider and purchaser. The result is monopoly exploitation of the end-user: a poorer service for a given expenditure of taxpayers' funds.

The Current Regulatory Regime

The discussion here suggests that that the NHS internal market is likely to be characterised by 'small numbers exchange' – the selling and buying of services by a small number of providers and purchasers in any one locality – and lack of competition for the purchasing role. In such a situation there is a case for economic regulation to protect the consumer and, since the NHS is funded from taxation, also the taxpayer. But with the exception of the recently issued NHS Executive guidelines on the regulation of the NHS internal market, *The Operation of the Internal Market: Local Freedoms, National Responsibilities*, there is little in the current regulatory regime that is likely to encourage providers and purchasers to respond to competitive pressures.

On the provider side, the NHS reform package promised greater managerial freedom for providers. In practice, the behaviour of NHS providers (Trusts) remains heavily regulated by the Department of Health. First, the financial regime regulates the prices NHS providers must charge to NHS buyers. Prices for such services must be set to equal short run average cost for each speciality. No cross-subsidisation between different buyers or services is meant to occur. Second, trusts have no clear savings mechanism. Trusts are supposed to have income that equals expenditure each year, and while there may be some flexibility at the margin, there is no automatic right to carry forward surpluses or make deficits. Third, investment is heavily regulated. Trusts are allowed to borrow from the private sector, but the requirement that was in force until mid-1994 that the cost of such capital must be no higher than the cost of borrowing from the government has severely limited the flow of private sector funds into the NHS.

The long term incentives for a such heavily regulated providers to respond to competitive pressures are very limited. In the absence of clear criteria for exit and limited incentives for entry, the 'no reserves' conditions imposed on NHS providers probably creates a bias towards current expenditure, decreases the incentives for long term productive efficiency gains and reduces the gains to any hospital of cutting margins.

In contrast, there is little regulation of private sector suppliers. The Department of Health has no direct regulatory role, and the activities of the private sector come under the competition acts which operate in the whole UK economy. Until recently, monopoly in this market has not been challenged, but in 1994 the Monopolies and Mergers Commission instituted an investigation *Private Medical Services* into pricing by medical suppliers.

On the purchaser side, the regulatory regime treats district health authorities, and fundholders rather differently. Districts cannot keep surpluses, and are regulated through the performance management actions of the NHS Executive. Because the Executive cannot observe all the actions of districts, the same problem that faces any regulator, monitoring is concentrated on the achievement of a small set of measures: currently, annual growth in activity, waiting times and targets for improvements in the health of certain groups in the population. GP fundholders are much more lightly monitored than districts. There is relatively little in these arrangement to ensure that patients' interests are met. Where there is no competition between agents for the purchasing role, monitoring of one set of targets will result in a reduction of other outputs. If the targets chosen are not the ones that the consumers of health care would give most weight to, monitoring will not increase consumer welfare.

The specific combination of market and existing regulatory incentives in operation in the NHS internal market suggests a case for reform of the present system of regulation in favour of more explicit market-orientated regulation. But while there may be a case for such regulation, regulation is not costless. Excessive regulation will stifle the incentives for innovation and change that a market can provide. Regulation may be ineffective because the regulator has less information than the regulated. Regulation may result in 'gaming' by the regulated and the eventual 'capture' of the regulator by the regulated.

The economics literature, theoretical and empirical, suggests that certain regulatory instruments may be more appropriate in certain cost and demand situations than others. Given this, the form of regulatory tools is important. I discuss below regulatory instruments which might have better incentive properties than those used to date.

What Form Should Market Regulation Take?

Regulatory activities can be separated into those to ensure as competitive a market structure as possible and those to limit the behaviour of monopolies. The first type are known as regulation of structure, the second type as regulation of conduct. In practice often the two interact. For example, controls on pricing – regulation of conduct – may limit the gains from entry, so making a market which is potentially competitive into one in which there is no competition. However, for ease of exposition, I consider the two types of actions separately.

Regulation of market structure

Until recently, Department of Health decisions on exit and mergers have been *ad hoc*. Provider exit has been dealt with through (forced) mergers but the criteria for such arrangements have not been made clear to market participants. More generally, the criteria for merger decisions have not been widely disseminated. Little has been done to promote entry, either in terms of loosening the constraints of the trust financial regime, or in terms of provision of information which may help purchasers choose new suppliers or help them choose contracts which may promote competition. The end result has been some confusion about the 'rules of the game' and some rather *ad hoc* decisions driven by short term financial pressures.

In December 1994 the NHS Executive announced in *The Operation of the Internal Market; Local Freedoms, National Responsibilities* that it is to replace the present *ad hoc* approach with a more rule-based approach to mergers, of both providers and purchasers, collusion and market re-configuration. The document defines the circumstances in which the Executive will intervene to limit the behaviour of market participants and attempts to make explicit the criteria it will use in deciding what regulatory actions to take. The framework reflects the underlying principles that trusts, health authorities, GP fundholders and GPs have primary responsibility for delivery of services. It states that there is a presumption against intervention, that actions of market participants should be limited only where they are shown to be likely to affect outcomes adversely, and that when the Executive intervenes it should be on the basis of explicit criteria.

For provider mergers and provider reconfigurations these ideas are embodied in the definition of a 'local decision limit'. This establishes those provider and purchaser actions which, *a priori*, are unlikely to adversely affect competition. The Executive Letter states that such actions, for example, small mergers, will be allowed to go ahead without the need for NHS Executive intervention, except in extraordinary circumstances. These decision limits are similar to the 'safety zones' used in regulation of the structure of the US health care market. These 'zones' are used precisely to give market participants maximum freedoms and certainty while seeking also to protect the public against the unnecessary development of monopoly.

At the time of writing there is no experience of the guidance in practice. Its success is likely to depend in a large part on the extent to which the NHS Executive is able to separate out its task as market manager from the many other functions it undertakes. One of its main other functions is to keep expenditure within the limits set by the Treasury. Pressure from the Treasury to limit public expenditure growth may mean that the NHS Executive returns to a wholly 'top-down' planned approach to the allocation of capital and other resources. In this case, there will be conflicts between the public expenditure control function and the market management function which emphasises a role for actual and/or potential competition. If this conflict is large, the regulatory rules may become opaque and difficult to enforce. The guidance also does not refer to GP fundholders, although the same principles as apply in the guidance to health authorities could be easily extended to this group of purchasers. From a regulatory point of view, it is desirable to treat the two types of purchaser equally, and so desirable to extend the purchasers merger rules to cover fundholders as well as districts.

Regulation of conduct

As it stands, the guidance deals less with the control of monopoly than the prevention of the development of monopoly. However, control of monopoly is as important if not the more important task facing the NHS regulator. Long term relationships, monopoly on the purchaser side, and a fair amount of monopoly on the provider side are likely. The NHS regulatory regime has so far failed to make sufficient use of the market, either in terms of the information provided by the internal market or by mimicking the information signals provided by a market structure. Market participants, be they buyers or sellers of health care, are regulated using tools which do not make use of relative performance information. In other markets, economists have advocated using comparative performance measures, which mimic the effects of competition when no direct competition is feasible, to regulate conduct. I consider some ways of doing this.

Conduct regulation of purchasers: One method of increasing the responsiveness of health authorities would be increase competition for the purchasing role through the introduction of franchises for the purchasing role. The franchise would be defined in terms of the population to be served, the time period of the franchise and the quantity and quality of services to be provided. Payment for the franchise could be determined by competitive bidding. Such an arrangement would reward good purchasers and penalise poor purchasers. It would allow successful purchasers to expand their activities and unsuccessful purchasers to exit the market without leaving the population without a purchaser. Bidding for the franchise could be open to both health authorities and GP fundholders, and possibly other non-current purchasers – for example, health insurance specialists.

For franchising to be useful, the regulator must be able to specify and measure the output the franchise holder must produce. If the output that the Department of Health desires is not the same as that desired by the end-user of the service, franchising will not necessarily increase the responsiveness of purchasing agents to end-users. If end-users value intangible outputs that, by definition, cannot be measured, or value outputs other than those chosen by government, then the choice of key dimensions of output by government will not improve end-user welfare. One policy would be to bring government objectives into greater line with those of consumers. One problem with this approach, which arguably the Government, in its use of Citizen's Charters, has followed, is that consumer wishes with respect to health care vary both across individuals and across the same individuals before and after the need for medical intervention. In general, franchising of production where the output is difficult to specify *ex ante* is associated with many of the same problems of service specification that occur in direct production.

An alternative policy which might overcome this problem would be to increase consumers' ability to choose between GPs, and to simultaneously increase the scope of the fundholding scheme. Greater choice between GPs should make fundholders more responsive to consumer wishes. The method of payment to GPs will need to reflect the trade-off between cream-skimming and cost reducing effort; a wholly capitation based scheme gives incentives to dump patients who are costlier than average while a full cost reimbursement scheme gives no incentives for cost reducing effort.

Conduct regulation of providers: The financial regime is very restrictive. At the very least, trusts need to be allowed to accumulate financial reserves. This would shift emphasis away from current expenditure, allow managers to make longer term strategic decisions and also provide a more robust indicator of financial performance to use in disinvestment decisions. If cost structures were such that price regulation was required (something which has not yet been established as the degree of monopoly in the internal market has not yet been properly established), it would be desirable to use comparative regulatory tools to allow trusts which increased their cost reducing effort above the average to gain, while those below average would be penalised. The DRG system for price setting used for Medicare has this feature. So would the use of an RPI-X type price-cap, widely used in utility regulation in the UK, in which the average increase in price across all services is limited to the growth of inflation minus an allowance for productivity increase (the X component). Setting RPI-X constant over a number of years allows firms to keep gains from cost improvements which are higher than X. To give incentives for efficiency gains, trusts which had such cost improvements would have to be allowed to keep (some of) the difference between the RPI-X price and cost. While this would raise issues about the role of savings for not-for-profit public bodies, a savings mechanism of some kind is necessary to promote dynamic efficiency. It is thus an issue that the Department of Health needs to address, as I suggest below.

More generally, one aim should be to reduce the extent of regulation of NHS trusts. The intention of the creation of a purchasing role and the introduction of competition on the supply ride was that the need for direct regulation of providers should fall. Competition should regulate behaviour; direct regulation would be required only where competition is not feasible, say in cases of economies of scale or scope. The current level and form of regulation on trusts is far heavier than that of private suppliers operating in the same market. Ultimately, much of the regulation of trusts stems from the fact that the assets are in public ownership. The tight control on trust financial behaviour is partly a product of the hard annual global budget constraint imposed on the Department of Health by the Treasury. Over- or under-spending at this global level is penalised; thus the regime set up for trusts seeks to minimise the collective under- or over-spend. The imposition of the not-for-profit constraint is partly a product of this budget constraint.

This discussion also highlights the importance of political constraints on the behaviour of any regulator where assets are publicly owned and finance is raised by taxation. Changing the pricing rules and investment rules opens up the debate on the role of the reforms in allowing profit from health care and privatising the supply side of the NHS. Allowing trusts to save runs the risk that the annual budget constraint with Treasury will be broken. Subjecting fundholders to the same performance targets as district purchasers questions the implicit contract between the Department of Health and an important medical care supplier. These issues are matters as much of politics as economics.

Perhaps one way of reducing political constraints would be to remove the market regulation function from the Department of Health. 'Regulator capture' – the identification of the regulator with the regulated rather than the public and the taxpayer – may be a particular problem for a regulator whose other functions include a great deal of negotiation with professional groups. It may be more effective to set up an independent regulatory body, an 'OFHEALTH', whose sole task would be to protect the user and taxpayer. If this were considered, lessons could be learnt by looking at the experiences of UK utility regulation and at regulation in other health care markets.

In conclusion, I have argued that the Department of Health has made a start in regulation of the internal market, but that there remains a need to review the regulation of conduct and in particular to look for mechanisms which give purchasers incentives to be responsive and efficient purchasers of health care.

HEALTH CARE FOR ALL? HOW TO TAKE EQUITY SERIOUSLY

Michaela Benzeval

Free and universal access to health care were the founding principles of the NHS. At the time the NHS was created there were substantial variations in the provision of health services between different parts of the country. One of the key objectives articulated by Aneurin Bevan, when he introduced the bill establishing the NHS to Parliament, was that it should 'provide the people of Great Britain, no matter where they may be, with the same level of service'. Initially, bringing hospitals and their staff into the public sector improved access to health care for many people. At the same time Bevan set up the Medical Practices Committee to equalise the number of general practitioners between areas. Since the 1970s there have also been systematic attempts to develop an equitable distribution of hospital resources at a regional level.

These efforts have resulted in much more equitable resource allocation – in terms of GPs and hospital resources – between areas than existed in 1948, although further reform is needed. For example, the distribution of GPs needs to be much more closely related to need. Moreover, Ministerial decisions to dilute the redistributive impact of the recent proposals by York University – to improve the allocation of hospital resources in relation to need – should be reversed.

However, a fair distribution of resources will not necessarily ensure that everyone has equitable access to appropriate services. Some social groups face significant obstacles to accessing care – in the form of geographic, cultural and economic barriers – that need to be overcome. The impact that such barriers have on access is hard to assess, as surprisingly little research has been carried out in the UK in this area. The commitment to a universal health care system has resulted in equity of access to health care being inappropriately taken for granted. However, what evidence there is suggests that disadvantaged social groups may receive less care relative to their needs than more affluent groups. Clearly if the NHS is truly to achieve equality of access, much more work is needed.

The objective of this article is to assess the degree to which the NHS has achieved equitable access to health care for all, and how this can be monitored more effectively and improved. First, it examines the barriers that different people face in using health services and reviews evidence about the distribution of health care utilisation between different social groups. Second, it examines how health services can be monitored much more closely in relation to equity issues. Finally, it considers how access to health care can be improved by making health services much more responsive to the needs and circumstances of different social groups.

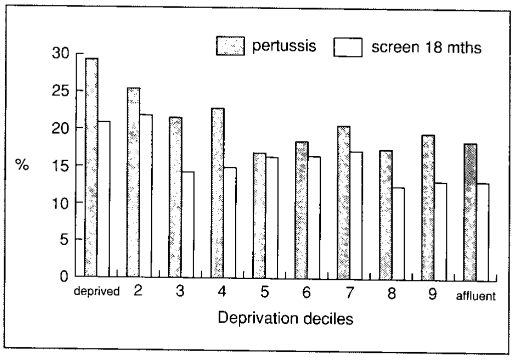
Barriers to Access

Although there is a universal and free access to health care in the UK, people still face barriers – geographic, cultural and economic – that prevent them receiving the care that they need.

- *Geographic* barriers arise when facilities are located in areas that are not easily accessible by those who most need them. For example, a number of studies have shown that health care facilities are often located in more affluent areas. Moreover, people living in disadvantaged circumstances are less likely to have access to a car and hence are reliant on public transport, which can be expensive, inconvenient and unreliable. People living in rural areas face similar problems, particularly those with the most need such as older people and people with disabilities. Graham Bentham and Robin Haynes (Journal of Rural Studies, 1:3, pps. 231–239, 1985) show that after adjusting for need, people in remoter regions receive less health care than comparable people who live closer to facilities.
- *Cultural* barriers often occur when users and professionals have different social and cultural backgrounds. Communication between professionals and users and the provision of information in the NHS are often perceived to be poor. This may be a particular problem for individuals who have different social or cultural backgrounds to the majority of professionals that they encounter. Ann Cartwright and Maureen O'Brien (in M Stacey, *The Sociology of the NHS*, University of Keele, 1976), have shown that people from manual backgrounds spend less time and exchange less information with their GP than those with non-manual occupations. Similarly, Isobel Bowler (Sociology of Health and Illness 15:2, pps 157–78, 1993) demonstrated that communication problems and cultural differences reduced the quality of care for minority ethnic groups.

Social Inequalities in Access to Child Health Services

Richard Reading and colleagues examined variations in the use of child health services between small geographic areas in Northumberland. The inclusion of patients' postcodes on health records enabled each child's enumeration district to be identified and linked to socio-economic information from the decennial census. Areas were then ranked by their score on the Townsend deprivation index and grouped into deciles. Utilisation rates for immunisation and surveillance screens were then calculated for each decile. The figure below shows the proportion of children who did not receive pertussis immunisation or screening at 18 months.



A clear picture emerged of lower use among children living in disadvantaged areas. For example, children living in the most deprived decile are 57 per cent more likely not to have been immunised against pertussis at 15 months and 54 per cent more likely not to have received their 18 month child health surveillance check than those living in the most affluent decile of enumeration districts.

Source: R Reading, S Jarvis and S Openshaw, Archives of Disease in Childhood, 68, pps 626-31 (1993).

Inequalities in the Treatment of Heart Disease

A number of recent studies which have examined variations in the treatment of heart disease, raise questions about age, gender and social inequities in access to health care for a major cause of death and illness in the UK.

Mark Petticrew and colleagues (British Medical Journal, 1 May 1993) studied hospital records of patients discharged from North and South West Thames regions and found that male patients with a principal diagnosis of either angina or chronic ischaemia were significantly more likely to undergo revascularisation than women.

Similarly, Frank Kee and colleagues (British Medical Journal, 26 November 1993) linked patient episode data in Northern Ireland to small area information from the 1991 Census for patients with a diagnosis of myocardial infarction. After standardising for age and differential admission rates women had lower coronary catheterisation rates than men.

A Elder and colleagues (British Medical Journal, 19 October, 1991) examined records from an Edinburgh hospital for patients suffering from angina. They found that older patients had experienced much more severe symptoms for a longer period prior to undergoing coronary angiography than younger people.

Yoav Ben-Shlomo and Nishi Chaturvedi (Journal of Epidemiology and Community Health, 49, pps 200–204, 1995) examined equity of access to coronary artery bypass grafts in North East Thames Region. They suggest that there may be some social inequalities in access to care for men.

- Direct *economic* barriers are minimal in the UK in comparison to some other countries such as the USA. However, certain user charges such as the sight test fee may inhibit use of services (see page 28 above). Perhaps more important is the high opportunity cost of using health services experienced by some people. For example, individuals paid on an hourly basis may be reluctant to attend clinics in working hours. A study by Ann Cartwright and Joy Windsor (*Outpatients and their Doctors*, HMSO 1993) demonstrated that those in work lost on average over two working days attending outpatient clinics. More significantly, people who are homeless or living in poverty may have so many pressing demands on their time that making an effort to obtain health care is not a priority.

These kinds of barriers do exist in the NHS, but there is mixed evidence about their overall significance in terms of access to care. At a highly aggregated level, Julian Le Grand (Economica, 45, pps 125–142, 1978) examined data in the 1970s and found that the middle classes received more NHS resources relative to need than those with working class backgrounds. In contrast, Owen O'Donnell and Carol Propper (Journal of Health Economics, 10, pps 1–19, 1991) investigated data from the 1980s, using a different methodology, and found that the NHS favoured lower income groups

This evidence is encouraging but not conclusive: a large number of small-scale studies have found inequalities in access to care between different social groups for a wide range of services. People from disadvantaged backgrounds have lower levels of uptake of immunisation, family planning, health education, health promotion and screening services. For example, the latest evidence about access to child health services is shown in **Social Inequalities in Access to Child Health Services**. Children from deprived areas are less likely to be immunised or to receive their regular health surveillance check ups.

There is also some evidence to suggest that people with disadvantaged backgrounds do not receive sufficient secondary care relative to their needs. For example, the latest evidence about the treatment of heart disease, shown in the **Inequalities in the Treatment of Heart Disease**, suggests that women, older people and disadvantaged socio-economic groups may not receive the same care as men, younger people and affluent groups respectively.

In summary, therefore, it would be unwise to assume that equity of access in the NHS can be taken for granted. However, perhaps what is most worrying is how little evidence there is about differential access to care. The clear implication of this is that the NHS should devote more effort to assessing the extent of inequalities in access to care. The next section suggests ways in which this might be done.

Monitoring Equity of Care

For a national health service that has equal access for equal need as one of its founding principles it is disturbing to note how little is known about whether the reality matches the aspiration. However, the new role of purchasers should enable and encourage them to focus more explicitly on equity issues. Purchasers are charged with assessing the health needs of their populations, contracting relevant services for them and evaluating the care received. Current evidence suggests that purchasers are focusing on monitoring efficiency and activity but not equity. It is vital that equity takes a higher priority in the monitoring process than currently appears to be the case. Fortunately, routine data are available that enables this to be done.

Medical records contain the age, sex and postcode of patients. In addition, all hospital units and all community health services will be required to record ethnic data from April 1995 and April 1996, respectively. As a result it will be possible to monitor service use and the outcome of treatment by people's demographic characteristics and by the socio-economic profiles of the areas in which they live. The studies highlighted in the boxes on child health services and treatment of heart disease use this approach to demonstrate social inequalities in access to some services in the NHS.

What is now required is for health authorities to monitor access to their services using these kinds of techniques much more systematically. Of course, the amount of work required to undertake equity audits should not be underestimated. Health authorities should, therefore, begin by agreeing with their provider units selected service areas where equity monitoring should be made a priority. Purchasers and providers will need to collaborate to improve the data specification and analysis required to monitor the equity of services, audit the appropriateness of care and feed the results back into the contracting process. For example, **Ethnic Monitoring in East London and the City** shows the patchy approach to ethnic monitoring found by East London and City Health Authority between and within the provider units it has contracts with. In response to this it recommends a clear management commitment by providers to monitoring and appropriate training for the staff involved. Such an approach should be adopted by other health authorities with their provider units and extended to monitoring utilisation by socio-economic and demographic characteristics as well as ethnicity. Public health departments could then make an assessment of access to health care a key topic for their annual health reports.

Equity audits are, however, mainly a question generating exercise. If a specific group is found to have

Ethnic Monitoring in East London and the City

There is poor information available on the use of services between different ethnic groups. As a result, national guidelines have been established to include ethnic data on all hospital records from April 1995 and all community health service records by April 1996.

A review in East London and City Health Authority found that few departments even within the same provider unit were collecting ethnic information on a consistent basis. Furthermore a feasibility study in the district showed that the main barrier to effective ethnic monitoring was a lack of managerial commitment and a lack of awareness and training among staff about its importance as part of an equal opportunities policy.

As a result a Black and Ethnic Minority Working Party was set up, which recommend ethnic categories for data collection that have subsequently been agreed by all parties. Its recommendations expand the 1991 Census ethnic groups so that they are relevant to East London and incorporate other language and religious categories that are important for accessibility purposes. The authority has set an objective of including a minimal level of ethnic data on the records of 80 per cent of specialities by 1995. In addition, wider monitoring was implemented with each provider unit in selected areas such as maternity, renal, mental health and cardiac services. The authority plans to assess the extent and quality of monitoring in provider units as part of the 1995 contract review and disseminate the results as widely as possible.

To achieve effective monitoring the authority argues that a senior manager in each provider unit needs to have designated responsibility for ethnic monitoring and all staff need to receive equal opportunity training.

Source: East London and City, *Health in the East End* Annual Public Health Report, 1995/96.

lower utilisation relative to its needs than other groups, further work will be required to understand why this is the case. There are a number of possibilities. Professionals may have treatment or referral patterns that are systematically biased against a group of patients. For example, Mildred Blaxter (British Medical Journal, 3 June, 1984,) examined data from the General Practice Morbidity Survey and found that people from manual social classes have lower referral rates per consultation relative to their need than non-manual groups. Medical education and peer review processes need to encourage professionals be constantly vigilant against such biases, which prevent all patients receiving the same high quality care.

An alternative explanation of low uptake among specific groups, is that the barriers to care, highlighted above, are significant obstacles to some people's access. In these circumstances purchasers will need to assess the location, timing and any associated costs of using their services, and the quality of communication between professionals and users. A number of questions need to be asked. Are health care facilities located in areas with high health care needs? Are there cheap and convenient methods of public transport from disadvantaged areas to health care facilities? Do clinic times make it easy for people who work to attend? Are health information leaflets, signs, etc, clear and simple to understand and available in languages relevant to groups who live in the area? By asking these kinds of question purchasers can begin to identify ways of reducing barriers to care. The next section considers how this might be done in more detail.

Improving Access to Health Services

To improve access to health care, purchasers and providers need to address the specific obstacles that people face, be these in terms of geographic, cultural or economic barriers to care.

Geographic barriers may be overcome by targeting resources on neighbourhoods with greater health care needs. This would imply that health clinics, GP's surgeries and even hospitals should be located close to disadvantaged areas. However, this is not as clear cut as it first sounds. There is an increasing trend, partly as a result of new technologies, for health care facilities to be concentrated in a smaller number of sites. Such concentration reflects arguments both about cost savings resulting from economies of scale and about improved clinical quality as a result of assembling a critical mass of specialities or professionals. This suggests that there may be a trade-off between efficiency, and perhaps even quality of care, and equity of access to services. How real this trade-off is in practice is not known. But where it does exist health authorities will need to work with their local communities to judge the appropriate balance to take, since ensuring equity of access to services may be more expensive and hence reduce the resources available for other services.

There may be ways of combining centralisation of specialities with satellite clinics to obtain the best of both worlds. For example, a nurse-run casualty unit in inner London has a communication link to an A&E specialist in a large acute hospital in Northern Ireland. Similarly, the use of branch surgeries can make the general practitioner more accessible in remote rural areas. Alternatively, purchasers may need to think more laterally and work with local authorities and businesses to develop cheap and convenient public transport systems to enable people to get to the centralised services more easily.

For many people, however, it is community-based services that could do most to improve their access to care and health status. Even at this level, it may be appropriate to provide outreach care to encourage the uptake of services among the most vulnerable groups. For example, many purchasers have health clinics in deprived areas in convenient locations close to shops and other facilities. The clinics are generally less formal and provide other services such as crèches or benefit advice. Such initiatives have also been used in relation to people who are homeless, by providing clinics in shopping centres, hostels and even on the streets.

Cultural barriers to care faced by minority ethnic groups have traditionally been reduced by employing linkworkers or health advocates to act as a bridge between the users and the health care system. For example, East London and City Health Authority have established a bilingual health advocacy scheme for Bangladeshi, Chinese, Turkish and Kurdish residents. An evaluation by MORI (*Evaluation of bilingual health care schemes in East London*, 1994) found that clients of the advocacy scheme received better information about services, were better equipped to access NHS care and health education, and felt more able to interact with service providers. However, coverage of the scheme did not match the need for it.

Economic barriers to health care are minimal in the UK and many of the poorest groups are exempt from paying prescription, dental and sight fee charges. However, the opportunity cost of attending health care facilities can still be substantial for some groups. In these circumstances the sorts of outreach services described above can be particularly helpful. Taking services to local areas or even people's homes can substantially reduce the problems associated with utilisation. Other, quite simple changes, can also improve uptake. For example, Margaret Whitehead and Göran Dalghren (The Lancet, 26 October 1991) report how health authorities in the Netherlands improved the uptake of immunisation rates among the babies of Moroccan and Turkish immigrants by changing clinic times and schedules to enable working men to accompany their wives and children to the clinics.

In some circumstances it may be helpful to provide supplementary services to people living in adverse circumstances. Extra support, although requiring additional resources, may enable people to overcome the barriers they face to change their behaviour or utilise services. For example, Hillary Graham (*When Life's a Drag: women, smoking and disadvantage*, HMSO, 1993) describes how the Newcastle midwifery project provides additional support and practical assistance to pregnant women living in disadvantaged areas, which successfully helped them stop smoking. Similarly, Allan Colver and colleagues (British Medical Journal 23 October 1982) conducted a case control study with families in parts of Riverside, Newcastle. In addition to health education information the study group also received extra visits from health visitors to help them change the physical environment in ways that could prevent child accidents. This resulted in a significant increase in the number of changes that were made by the study group relative to the controls.

These kinds of attempts to respond to the barriers of access faced by people in disadvantaged circumstances are commendable. However, most of the approaches described above are service-led. As such they may seem implicitly to be criticising people for 'failing to use services' or to ignore the priorities that users have themselves identified. A new approach is required to service delivery that empowers individuals and communities: to define their own needs, to design services that are appropriate to users' lives, and to specify outcomes that reflect their priorities.

Empowering individuals to enable them to take more control over their lives, can have positive health benefits. An evaluation of Newpin, a network and befriending scheme, by Anthony Cox and colleagues (Journal of the Royal Society of Medicine, 84, pps 217–220, 1991) showed improvements in the mental health and wellbeing of the women who took part.

Similarly, empowering communities to identify their own needs and priorities can help to improve the health of the local population. Many local health authorities are using rapid appraisal techniques to make this happen in a cost-effective way. Rapid appraisal is based on the formation of an inter-agency team that combines information about the area from official sources, interviews with community members and its own observations. The information collected by this process is used to identify areas of concern that are then fed back to the community to enable it to negotiate priorities for action. Such action often goes beyond the scope of the health care system itself. For example, it might aim to improve transport systems, housing and the local environment, and develop support groups and facilities for advice.

Conclusion

Equity of access to health care is a fundamental principle of the NHS. What little evidence exists in the UK suggests that more effort is required both to monitor existing patterns of utilisation and take positive action to ensure health care *for all* becomes a reality. The equity principle must become a central tenet of all planning and evaluation processes in local health care decision making.

SERVICE DEVELOPMENT: CONFLICT AND CONSISTENCY

Anthony Harrison

To those who believe that public policy should have, or should at least strive to have, a rational basis, consistency between different forms of policy intervention seems a self-evident virtue. But whether or not policies are mutually consistent is not always an easy matter to decide. To some, every policy initiative from the GPs' 1990 contract onwards has had an underlying consistency: they are designed to break up the NHS and eventually privatise most if not all of it. The increasing emphasis on financial incentives, efficiency, lower costs, higher performance, private finance and competitive tendering are all in this sense 'consistent'.

The Government, however, claims that these policies are consistent with the maintenance of the NHS as a universal system offering free care at most points of delivery. These policies, in the Government's view, are essential if a virtually universal, comprehensive and publicly funded service is to survive.

Such different interpretations of the same events stem largely from differences of political opinion. But their sharp divergence also rests on differences of view as to the precise objectives the new policies were promoting and what benefits they could be expected to bring about. These differences in turn stem from an underlying uncertainty about how they would affect the health care system they were intended to reform.

That system was and remains highly complex, and it is that complexity which largely explains why the Government was unable to forecast what the impact of the reforms would be. It had no forecasting model at its disposal to enable it to estimate the impact of particular measures on particular parts of the NHS nor to estimate the impact on the NHS as a whole. Still less could it take on board the impact of the related reforms introduced into local government by *Caring for People*.

The central argument of this article is that the reforms, both of the NHS and local government, have if anything underlined the need for policymaking to take the interactions between different parts of the health care sector into account. It begins by setting out the general reasons why this is so, and then takes two examples which demonstrate the argument in particular instances.

Both the general argument and the particular cases are based on considering the implications of interdependence between different parts of the health and social care system. We therefore consider a number of ways that interdependence between different parts of the health care system can be dealt with, which do not rely on the ability to understand and forecast the impact that interdependence may give rise to. It concludes by considering what alternative policies are available.

Growing Interdependence

In the world of the old NHS, the provision of health care could be reduced to a set of simple relationships, in which the three main elements, hospitals, GPs and community services, had different roles. Links to social services were limited. In this world, consistency meant that each knew and accepted what their role was for the majority of patients. GPs handled most of the work coming through their doors, referred patients on to hospitals as necessary and community services offered support if that was subsequently needed. Social services provided what was largely a parallel service.

These roles were, however, never very tightly defined, so that areas of work such as minor injuries might be handled by hospitals or GPs and patients might move from one provider to another as a result of personal initiative – the GP developing a diabetic service or the hospital consultant a new form of treatment. Although most of the NHS was subject to budgetary limits, the pressure to increase the level of activity – as well as to respond to other central policy initiatives – was modest. This relative tranquillity came to an end with the 1990 NHS and Community Care Act.

Within the post-1990 NHS, relations between GPs, community and hospital providers are now much more complex than they once were, and the circumstances within which each operate much more closely defined by financial constraints and activity targets which limit and prescribe what they should do. Hospitals, community services and GPs are simultaneously competitors and complements in the production of health care. Although this has always been so, the new arrangements, by virtue of the impetus they have given to innovation and change, have created the opportunity for new ways of producing health care, which have served to emphasise the inter-relationships between different kinds of care providers. Within the NHS itself, there are more free-standing providers than there once were as a result of the creation of separate hospital and community trusts: the role of GPs as independent purchasers and potential providers has led to new interrelationships never dreamed of in the old NHS.

Furthermore, although there always were other actors – patients themselves, voluntary organisations, private providers, and local authorities – they are now more significant, in part because of specific government policies such as the Citizen's Charter to enhance their status, and in part because their importance as partners has been increasingly recognised, *eg* in the case of local authorities, in relation to hospital discharge and more generally in the wider policy of care in the community.

These developments make for a more flexible health care system within which new forms of service can emerge and once impenetrable boundaries are crossed. But other developments are working in the opposite direction. The introduction of contracting, explicit activity targets for individual providers and, in respect of fundholding GPs, cash limits where none existed before, has meant that where boundaries were once flexible, they are now tightly policed and much of the 'slack' that existed has been eliminated.

To the extent that one aim of the 1990 reforms was to create scope for competition, overlaps between services are desirable, for in such areas competition can occur between different types of provider. A community trust may take on 'hospital work' and a GP can hire the same sort of staff as those employed by a community trust.

Widening the scope for combining the contributions of different types of provider and forging closer links with agencies such as social services are to be welcomed. Equally, the introduction of contracts, targets and more tightly defined budgets are in themselves desirable developments, contributing as they do to better cost control and greater accountability. Taken in combination, however, they lead to a health care system which is more difficult to manage than the one it replaced.

Those difficulties are likely to increase. The Government continues both to develop the reforms and take new policy initiatives, responding to pressures as they arise be it from junior doctors, new technology such as minimal invasive surgery, or the continuing pressure to get more out of limited resources. Pressures such as these will continue, if in new and different forms, requiring in turn further policy responses.

Consequences of Interdependence

Complexity and interdependence makes it hard to see if policies are consistent with each other. The impact of a policy initiative in one part of the health sector may be transmitted or 'shunted' to another: at the same time, the introduction of more explicit financial constraints and targets means that the incentive to transmit such impacts increases. Some examples of cost 'shunting' are:

- shorter lengths of inpatient stay may increase GP and community nursing costs;
- hospital prescribing restrictions may increase GP prescribing costs;
- reduced community nursing support may lead to more use of hospital beds.

In all three cases, the actions of one actor may pose financial or other problems for another and, as a result, what seems to be best, if just one part of the health care sector is considered, may not be if the overall picture is taken into account.

Interactions may, of course, produce favourable as well as unfavourable results:

- better organised asthma care in general practice can reduce hospital bed use;
- improvement in anaesthetics may reduce the need for aftercare.

Where one provider voluntarily makes a change which benefits another, the presumption can be that overall the change is still justified. But where the bulk of benefits 'spill over' in this way, the risk is that the change will not take place at all because insufficient benefits may accrue to the initiating provider. In other words, whereas with cost shunting the risk is the wrong policies will be adopted, where there are mutual benefits the risk is that the best policies, taking the overall picture into account, will not be adopted.

But interdependencies between the various actors in the health care system may extend well beyond simple cost shunting or benefit spillover. The Government is currently looking for higher levels of hospital activity, shorter lengths of stay and higher day case rates. But their targets do not take into account the impact of these policies on other parts of the health care system. If GPs get more work as a result of shorter lengths of hospital stay, they may work harder. Alternatively, they may cut down on health promotion, particularly in areas where they are not directly rewarded for it, or they may be more inclined to refer patients to hospitals for investigation, perhaps as emergency admissions, rather than take responsibility on themselves. If these reactions in turn reduce the capacity of the hospital to carry out elective work, it would be reasonable to conclude that the policy as a whole was inconsistent to the point where the original aims of one policy were being subverted by others.

How likely is such inconsistency to arise in practice? To illustrate the potential, we sketch out two examples of possible inconsistency which arise from recent service developments. The first is concerned primarily with the balance between different forms of care, but other policies apparently unrelated to this issue also come into play.

The second example draws on an analysis by Gerald Wistow which focuses on the relationship between the NHS and social services. His central argument is that the two main threads of government policy, the reform of the NHS and the reform of community care, were devised and implemented without any regard for each other and that, as a result, significant inconsistencies and conflicts have arisen.

Strategic Inconsistency in the Balance of Care

The 1990 NHS and Community Care Act was concerned with the framework for the delivery of health care: it was not designed to promote a particular division of resources between different types of service. Implicit in the introduction of the purchaser/provider split and the emphasis on analysis of health needs preceding the choice of services was the threat that financial resources would be shifted, but no specific changes were envisaged at the time.

Nevertheless, the new NHS has become associated with a policy of shifting the balance of care from hospitals to 'the community' or primary care. The reasons for this are not entirely clear. It appears to have arisen in part from the general policy of strengthening primary care which emerged before the 1990 Act and was embodied in the new GP contract, in part from the rapid spread of GP fundholding and in part from the diagnosis adopted by the Tomlinson enquiry in London, that the problems of London's hospitals turned in part on the weaknesses in primary care in parts of the capital.

In the light of the continued emphasis on reducing waiting times, and of some of the events of the year, to promote such a shift may seem rather curious. As far as acute hospitals are concerned, the pressure appears to be on them to do more rather than less. At national level, the pressure to reduce the longer waiting times continues, supported where necessary with funds from the Waiting Times Initiative: similarly the requirements of the Patient's Charter are becoming more demanding

A report by the Clinical Standards Advisory Group (*Urgent and Emergency Admissions to Hospital*) and a number of well publicised failings affecting particular institutions or individuals suggest that hospitals are finding it hard to cope with the levels of demand they are facing. Beds can be hard to find, and when patients are accepted, they may be subject to long waits within hospital A&E facilities before being fully admitted.

At the same time, however, other Government policies have been making it harder for hospitals to deal with the twin pressures on elective and emergency work. Since the New Deal, the Government has accepted the case for reducing the hours worked by junior doctors and there can be little argument with that. However, this policy, along with others relating to the medical labour force such as the requirement for continuing medical education, makes it harder for hospitals, particularly smaller ones, to provide continuous medical cover on a 24-hour basis.

Furthermore, the pressure to switch to day surgery, another measure which is itself largely welcome, has meant that hospitals have a smaller reserve of staffed beds to deal with sudden inflows of patients. It may not be desirable to cancel operations at short notice, a commonly used strategy for coping with variations in workload, but it may have been the lesser of two evils if a hospital was working at capacity. Reduction in the bed stock limits the scope of this option.

At the other end of the care spectrum, in GP and community health services, workload is growing as a result of changes in the hospital sector. The result may be, as suggested above, that both GPs and community nursing staff may refocus their efforts in ways which feed back in turn on to the workload of the hospital. Alternatively, if GPs do absorb more work, that may, in the medium to long term, influence the inflow of doctors into general practice – and there are signs of such an effect already.

Within this one example, a number of possible areas of inconsistency can arise:

- between the different demands being placed on acute hospitals;
- between some of those demands and intended developments outside the hospital;
- between policies towards the medical labour force and the maintenance of clinical standards as well as operational capacity.

Some of these might be regarded as matters which trust management should sort out: variable levels of demand might have to be met by new forms of staff contract. Some issues, such as the impact on hospital trusts of changes in primary care, purchasers might resolve. But others cannot be dealt with at this level; while trusts may employ their medical staff, they do not determine the main features of their careers – particularly training requirements – nor do they individually or together control the supply of medical staff. These can only be tackled at national level.

NHS and Social Services

In his inaugural lecture at the University of Leeds (*Aspirations and Realities: Community Care at the Crossroads*), Gerald Wistow points to a deep-seated conflict of values between the 'two cultures' of health and social services, the one concerned with a narrow definition of resource efficiency and cost effectiveness expressed in terms of rapid throughput, the other with needs-led assessments and allowing time for individuals to make their own choices. This observation arose out of study of hospital discharge arrangements. But he goes on to point out that, at the central government level, the reforms of social services announced in *Caring for People* did not take into account the changes taking place within the NHS and, even now, the social services side of the Department of Health has not adjusted fully:

> *Caring for People cannot be said to provide either that policy or implementation framework. Its immediate origins lay in the need to cash-limit social security spending on residential and nursing home care, and its central focus was on the boundary between residential and home-based care. It did not take into account the reshaping of acute services, or the boundary between personal social services and the acute sector. Hospital discharge was mentioned only once, and it was not until publication of the first Foster/Laming letter that it was defined as a key implementation task.*

Thus the main thrust of the reforms of social services has been to cope with long term disability of one form or another, which requires long term relationships with clients. But one implication of change within the NHS may be that a new form of need has been created which might require immediate response.

Leaving resources to one side, all that may be required is for local authorities to develop, as indeed some are doing, a new sort of service based on rapid response. That does not amount to inconsistency since if Wistow is right, local authorities could react if they recognised the need to. However, the changes which *Caring for People* has set in train may be leading to a genuine inconsistency. In particular, the concentration on complex care packages designed to prevent admission to residential care may be at the expense of lower levels of support to those remaining in their homes but not deemed to be at risk of entering care.

These policies may make sense within the social services environment but not within the wider context of the health and social care system as a whole. The residential home may be a more effective environment for keeping people out of hospital since it automatically provides a greater amount of support than is available in most households. Those remaining in their own homes but receiving a lower level of care may be at greater risk of eventual hospitalisation, an effect which may be exacerbated by the imposition of higher levels of charges for domiciliary care.

The potential inconsistency here stems from the difference between the local authority framework and that of the overall health and social care system. Within the former, a policy which concentrates on reducing admissions to residential care, appears to yield both cost savings and to offer benefits to individuals who are assumed to prefer to stay at home if they can. In the wider context, inconsistency may arise if these benefits are gained at the expense of greater costs within the NHS. Whether they do or not turns on the magnitude of increased hospital use resulting from change in the way in which social care is provided over which the NHS has neither control nor influence.

In this case, inconsistency may arise:

- between the objectives of health and social care providers at strategic level;
- between the different financial regimes operating on the two services;
- between their day-to-day operational practices and priorities.

As in the first example, some action may be taken locally to resolve conflicts as they arise. But the financial framework and the broad strategic direction are matters for national determination.

Dealing with Interdependence

If inconsistency is *prima facie* to be avoided, how should that be done? The first and most fundamental step is identification and measurement of the interactions which may give rise to it. If these were known, then in principle the implications of proposed policies, alone or in conjunction with others, could be assessed before they were implemented. That would mean, in the case of London for example, that the changes currently being proposed for the hospital sector were planned in the light of specific forecasts of the impact of expected changes in primary care and other health and social care facilities – and vice versa – as well as the broader economic and social factors which go to determine the use of health services.

No such forecasts have been attempted either in London or elsewhere. Most recent consultation documents issued to justify changes in acute services typically present no evidence bearing on the interactions between different care providers. Instead, in London as at national level, the need for them is ignored or it is implicitly assumed that other mechanisms will ensure that policies are consistent. What that amounts to is the first of the policy options we consider – 'taking the rough with the smooth'.

Taking the Rough with the Smooth

In the past, cost shunting has in effect been treated on a 'knock for knock' basis: although actors on the receiving end may grumble, they have not done anything about it. As far as benefits spillovers are concerned, the response has been the same, *ie* individual GPs or community units or hospitals have made changes in the way they deliver care for their own reasons and have not benefited from any favourable effect on other actors. Thus, in the case of diabetic care, the lead in creating community facilities was taken by pioneering GPs who were prepared to accept the consequences in terms of their own use of time and the switch in the burden of drug costs. As B. J Crump *et al* put it: (British Medical Journal 25 February 1995):

> *In some areas of care, such as the management of chronic renal failure, transferring the cost of prescribing from cash limited hospital budgets to the primary care prescribing budget (cost shifting) has become partly institutionalised. In this and other therapeutic areas shared care protocols have been developed so that general practitioners, who in signing the prescriptions accept clinical responsibility, become better informed about the need to monitor patients and side effects.*

Within the new NHS such informal arrangements have continued to operate. But if the degree of interdependence is growing, such informal arrangements may not be enough. The actions of the enthusiastic GP who introduces a community-based diabetic service will not be imitated. Other mechanisms must be used if the patterns of care they have pioneered are to become more common. Furthermore, as the pressure to produce measurable results from given budgets increases, then the scope for discretionary behaviour on which 'taking the rough with the smooth' depends becomes smaller. More fundamentally, where budgets are cash-limited and perceived by managers to be under pressure and where performance is monitored against explicit criteria, willingness to work on this basis will diminish.

Instead a different kind of behaviour will result: individual agents will attempt to move out of areas where responsibilities are confused, to focus on those which clearly fall to them and to off-load those which do not. In such an environment, two predictions can be made:

- services which do not have effective patient entry restrictions such as emergency services and mental health services will face pressure when other providers suffer budget cuts or increases in demand;
- services which straddle different providers will prove harder to co-ordinate.

Difficulties such as these are by no means new. Wistow's 'two cultures' point has often been made in relation to the development of care in the community over the past 10-15 years. What has changed is the financial and management context in which the two cultures have to work. Our analysis, like his, suggests that conflicts will increase.

The existence of interdependencies and the risks they pose have not gone unrecognised: a number of administrative and financial mechanisms have been introduced to deal with them. In the rest of this section, we briefly review each of them with the limited objective of showing that changes in these mechanisms are unlikely to be sufficient in themselves to deal with potential inconsistency.

Administrative Mechanisms

The existence of interdependencies and the risks they pose can be tackled through tighter role definition, which is essentially an administrative reaction of the type that might have occurred under the old NHS. Thus:

- in the case of hospital discharge, the Department of Health made it a condition of transfer of social security funds that local and health authorities got proper agreements in place;
- in the case of long term care, rules have been set out designed to curb off-loading of this form of care from the NHS to social services;
- agreements can be made locally which formalise in protocols the roles of physicians in general practice and hospital for the care of specific patient groups.

There are limits to what these processes can achieve. The discharge arrangements came unstuck because of budget shortages within local authorities in the financial year 1994/95 (see p 9). In these circumstances, formal arrangements are of no effect. In the case of shared care, protocols may be hard to agree in the absence of suitable financial arrangements which compensate those providers taking on more work. In the case of primary care, under present financial arrangements that is not generally possible.

More fundamentally, administrative role definition cannot be used to deal with some of the examples given above without subverting the essence of the new arrangements. If roles are rigidly defined, then there is no scope for competition; indeed, protocols or shared care would, in other contexts, be viewed as constraints on trade since they prevent competition for business.

Contracting Structures

The contracting function offers several ways of dealing with interdependence. In principle, contracts may be defined over all relevant services. That may involve defining a particular pattern of health care delivery and identifying the contributions of different providers within it. Examples might be:

- a programme structure based on user groups, such as children, which there is a case for managing as a whole
- a more focused analysis of particular areas of activity, such as orthopaedics which involve close liaison between hospital and community services.

As things presently stand, this approach runs up against a number of difficulties. Purchasers themselves do not have the capacity to manage the interfaces between providers, although they can encourage particular providers to take this task on. Furthermore, existing financial structures present boundaries within particular services – any service crossing the NHS and local authority boundary runs up against this difficulty. In principle, solutions are available, but in practice the political obstacles to exploiting them appear immense.

Finally, purchasers are not in control of some of the relevant factors. For example, they are currently having to cope with the implications of changes in junior doctors' hours, a policy which stems from central government and which purchasers, therefore, cannot directly influence themselves. In cases such as these, consistency has to be determined at a higher, *ie* national level.

A quite different route to dealing with interdependencies, particularly where there is cost shunting, is to tighten contracts so as to define away the grey areas of work which give rise to it. This is in effect the 'market' equivalent to role definition within an administered care delivery process. Clearly improvements can be made in this way, but it is not always easy to achieve, as the debates about the health/social care illustrate, be it at the level of the health or social bath, or continuing nursing care. Similarly experience in the US with cost per case contracts has underlined the scope for hospital providers to shed some elements of the care process by exploiting imprecisions in contract wording. But to eliminate such responses runs the risk of over-precision and inflexibility.

Financial Structures

An obvious answer to cost shunting is to create global budgets. Recent changes to NHS financial structures have seen moves in this direction from two directions at once, *ie* the merger of district health authorities and FHSAs and the creation of total fundholding on a pilot basis. Both solutions if taken to the extreme would reduce the scope for cost shunting and promote benefit capture. Under total fundholding, for example, GPs could in principle allow for any impact on their own services of the changes they require from hospitals. But to make such allowances would require more knowledge than the fundholder can be expected to have about the likelihood of such impacts.

Currently, there are two incomplete funding structures, neither of which deal with the issues identified across the board. The introduction of partial fundholding with capped prescribing makes the problems worse. As Crump *et al* put it in the article already cited:

> *This new responsibility has made fundholders re-evaluate their role in accepting the recommendations of hospital consultants. Previously, a consultant's prescribing recommendation for specialist care was accepted by most general practitioners, who valued this specialist knowledge. As purchasers, however, general practitioners increasingly recognise that they are responsible for the whole care of the patient and the optimal use of the drugs budget. They now question the appropriateness of some proposed treatment options when the health gain may be small. Fundholders need support to become confident in expressing these concerns to specialists and to draw up guidelines with them on use of such treatments. Neither can the ramifications of the degree of risk be ignored: a practice working methodically to stay within budget can be blown off course by such requests. Better risk management is needed.*

Crump and his colleagues put forward a number of solutions in respect of expensive drugs:

> *One option for change would be to make more financial provision to fundholding general practitioners who have patients receiving expensive treatments. Currently, general practitioners are not financially responsible for care given to an individual patient of above £5000 a year, though this provision extends only to the purchase of secondary care. This cut off point is currently under review and could be extended to the drugs budget. This would presumably leave health commissions to find the additional revenue and is likely to be seen as arbitrary in its effect. Also, general practitioners may not welcome the total clinical responsibility for patients receiving high cost treatments since their concerns about prescribing for these patients relate to more than just money. Although this option might preserve prescribing freedom, it is unlikely to help overall budgetary control, to enable more rational priority setting, or to encourage the collection of data on cost effectiveness.*
>
> *A second option would be to top slice funds from fundholder budgets (and, by implication, adjust indicative prescribing amounts) to set aside money to finance expensive drug treatments. The rules of fundholding are such that this pool could be created only from savings made on the drugs budget and that the savings would have to be allocated voluntarily by fundholders. Once a pool has been created new high cost medicines would not, at least initially, be prescribed by general practitioners. Access to these funds would be based on presenting a good clinical and managerial case for the introduction of a new drug to a group comprising professional advisers, general practitioners, and purchaser chief executives. The money would be given to purchasers, who would then have to pay the full costs of treatment because providers would not be able to shift costs to the primary care sector.*

The general implication is that if planned shifts in care are to be more common, then the basis of payment for GPs has to be reconsidered to allow for transfer of work to be paid for and not simply absorbed within the general medical budget. This might mean that capitation-based payments to GPs were reduced and payment for specific services such as emergency care increased. Alternatively it could mean the salaried GP, who in principle at least follows instructions. Either way, the loosely defined general medical contract which gives scope for independent action would have to go. At present, that does not appear likely.

In respect of local authority services, joint purchasing across the boundary may assist. But the indications here are not good: at present it seems to be more form than substance, essentially because it is an administrative device papering over fundamental differences in culture and behaviour as well as financial regime. Overall, the scope for financial innovation appears limited.

Providing Structures

In principle, a merger of all providers in an area would prevent cost shunting and avoid benefit spillovers. Currently, this is not on the cards. Indeed, with the rejection of combined hospital and community trusts, the Government went the other way. Merger of trusts with general practice is currently politically unthinkable.

However, even if such mergers did take place, they would only be of limited help, since within very large providing organisations the same issues can reappear within, as between, different organisations. That is, one part of the organisation can impose costs on the other in ways which internal budgeting procedures do not allow for. Such cost shunting can only be avoided if the same understanding of the strength and nature of interdependencies between different parts of the one organisation is available as would be necessary to find a solution between organisations.

In conclusion: the financial, contracting and organisational structures within which care is provided can be so arranged as to reduce the scale of cost shunting and benefit spillovers. But practical and political considerations rule out some of these arrangements, particularly between the NHS and social services and between primary and secondary care within the NHS.

Furthermore, political pressures to produce more care and at the same time maintain a tight cap on spending will tend to increase the incentive to shunt costs and reduce the incentive to collaborate on a give and take basis. Some unwanted side-effects may be removed or reduced by better contracting arrangements and tighter definitions of roles. But neither in themselves assist with forecasting in advance what effects have to be allowed for when different parts of the health and social care sector interact, nor do they contribute towards proving or disproving the importance of the various possible areas of interdependence identified in the two examples set out above. That must be based on knowledge of how the various parts of the health and social care system interact, knowledge which is currently lacking.

On this basis, it would safe to predict that inconsistency and conflict will not disappear: the question is what to do about it?

Other Options

One answer might be nothing. The Government has been criticised for 'making it (policy) up as it goes along'. But while this criticism may be accurate, it is easier to make than to respond to. The health and social care system is enormously complex, and hence any plan for change runs the risk of producing unexpected consequences. As the OECD remarked in its *1993/94 Economic Survey of the UK*:

> *Experience in other areas of policy suggests that shifting from 'command and control' to 'market-based' systems is not straightforward. In* UK *health care, the responses of various actors - especially the performance of the* GP *fundholders - were not entirely anticipated at the time the reforms were enacted. Given the complexity of the sector, unanticipated responses are not unusual, and there will no doubt be further surprises as the market for health services develops.*

This extract suggests two questions:

- if consequences cannot be anticipated, should policy proceed more cautiously?
- can anything be done to improve anticipation?

The OECD's remarks reflect experience in Eastern Europe where the issue of whether to proceed slowly or rapidly with the dismantling of the communist economic system has been hotly debated, and also in the United States, where health reforms introduced in the early 1980s to reduce costs produced unexpected side-effects which to some degree nullified the original aims of the reforms. Within the UK, the issue was raised at the time the reforms were being debated in the form of the proposal that they should be introduced in some parts of the country. This suggestion was rejected for what was then seen as the centre-piece of the reforms, the split at district level into purchasing and providing. In the case of GP fundholding, however, the initial stages were explicitly experimental but as far as the extension of fundholding is concerned, not to mention the expansion of the trust regime, enlargement of the Patient's Charter and tightening of waiting time targets, the Government has pushed ahead without waiting for evidence of success or otherwise to come in.

Whether it has been right to do so is a matter of broad political judgement. From the Government's perspective, the case for doing so has been compelling: to ensure that the reforms cannot be unpicked by a new government. At a less strategic level, a case for caution can be made as the two examples set out above indicate. In both cases, rapid change has posed risks: capacity may be removed which is then later shown to be necessary, or gaps between services appear because budgets unexpectedly run short. If such risks are to be reduced, the second question: can anticipation be improved? must be considered.

Perfect anticipation would require an ability to forecast accurately all the consequences of any particular intervention. To aim to do that would clearly be Utopian. But some progress may be possible.

A vast range of research and analytic work has a bearing on the issues discussed in this article. The particular gap it identifies is a better understanding of the linkage between different providers and between patients and providers. At present, both existing data and research tend to work within traditional boundaries. Thus, there is a vast quantity of data relating to the use of hospitals but none, with the exception of some small-scale studies, which links the use of hospitals to the use of other services. As a result, even simple descriptions of the links between services are impractical.

Good descriptive work would help to identify where, *prima facie*, interactions were important. It might include:

- patterns of service use across all providers. When in operation, the new patient number system should make this feasible;
- studies of particular interconnections, perhaps using pathway analysis for particular forms of treatment. Such studies can be carried out on a local basis possibly focusing on particular specialties.

Such descriptive studies do not in themselves provide the ability to anticipate the consequences of changes in policy, although they may help to identify critical areas. In the 1960s and 1970s, Government Departments supported large scale, expensive modelling work designed to cope with complex interactions. Perhaps because some of these efforts were too ambitious, and too expensive, they went out of fashion. But that experience need not rule out all work of this kind.

Given the massive size and complexity of the health and social care sector, one way forward is to select critical areas for modelling chosen because of their policy relevance. The analysis set out above suggests the following:

- the determinants of the use of emergency facilities: a good deal of descriptive data is being collected about patterns of emergency admissions into hospital but at present no capacity exists to estimate the impact of changes in GP services, or the pattern of social service provision, still less to estimate what the impact of new forms of provision might be;
- the overall performance of hospitals, taking into account the full range of policies which bear on them including performance targets and changes in medical staffing as well as the potential improvements resulting from changes in skill mix, admission and discharge procedures and other changes within the remit of management together with those policies over which they do not have complete control such as medical staffing.

The weakness of such partial studies is that they assume that 'all other things are equal' but they may not be. To take account of the wider context requires 'systems models' which in principle take all relevant interactions in to be considered at one and the same time. In the absence of the kind of descriptive data suggested above, work of this kind is unlikely to get off the ground, never mind succeed. But what might be valuable is the development of an overall framework of quantitative analysis which would allow 'what if?' questions to be considered. One such model is in use at the London School of Economics and the Institute of Fiscal Studies to estimate the impact of changes in the taxation and social security system. That is not a 'model of everything' but it does produce results which are of value in considering the implications of changes in social security benefits, personal savings levels and so on. A similar facility in the case of the health sector could provide the framework within which the available evidence on the relationship between the various actors within the health care sector can be systematically marshalled and research priorities identified.

The case for such a framework and the research to support it is well illustrated by the answer given by Dr Mawhinney to a Parliamentary Question on the relationship between primary and secondary care set out in the box.

The answer given by Dr Mawhinney amounts to a long-winded way of admitting that the evidence on the nature of the links between primary and secondary care has not been systematically examined. Nevertheless, broad policy statements continue to be made nationally and locally which assume the relationship is simple and self-evident

Primary and Secondary Care

Mrs Primarolo: To ask the Secretary of State for Health (1) if she will make a statement on the effect on the need for hospital beds of expanding primary and secondary care services.

Dr. Mawhinney: Developments in primary care are only one of the ways in which we can move services closer to the patient's home. These, together with clinical advances leading to shorter lengths of hospital stay and higher rates of day cases, have a significant impact on the number of in-patients beds required. Ultimately, it is for local health authorities, taking account of all these factors and the views of local people, to assess the level of services needed to meet the requirements in their area and to negotiate appropriate provision. We will be examining the changing pattern of service provision to ensure that patients continue to receive effective and high-quality care.

Source: Written Answers 22 June 1994

Conclusion

Our central argument is that the 'new' NHS presents, at national and at local level, a more complex management task than did the old one. The pressures it has given rise to and the freedoms it has created combine to make the health care system more difficult to understand and hence more difficult to control. At the same time, the pace of change appears to grow more rather than less, making the task even harder.

The suggestions set out here do not offer immediate or complete solutions. But they do offer a number of directions for research and analysis which would improve the chances of consistent policies being adopted nationally and locally.

CONTINUING CARE: WHO IS RESPONSIBLE?

Gerald Wistow

The nature and extent of NHS responsibilities for long term or continuing care leapt into public prominence during 1993/94. As last year's edition of *Health Care UK* correctly forecast, the publication in February 1994 of the Health Service Commissioner's special report on the subject provided the catalyst for a more open debate. Draft and definitive versions of guidance on the NHS contribution to continuing care prompted analysis and review of responsibilities at the boundary between health and social care services. Such technical processes were, however, a reflection of growing anxieties about the political consequences of elderly and disabled people being unable to secure 'free' healthcare when they needed it. Extensive media coverage of funding arrangements which compelled elderly people to sell their homes, thereby disinheriting their families, highlighted the acute political pressures which Ministers were increasingly having to face, not least from their natural supporters. A Daily Telegraph full-page article headlined 'The Great Betrayal' was indicative of the strength of feeling in such quarters. Perhaps unsurprisingly, therefore, a series of – it must be presumed – officially inspired leaks in the press during the spring of 1995 revealed that the Government was reviewing a number of novel financial arrangements to relieve the financial burdens of long term care on individuals and their families. At the same time, both the House of Commons Health Committee and the Joseph Rowntree Foundation have embarked on inquiries into the funding of long term care. By the end of 1994/95, therefore, a number of fundamental reviews were underway and should produce proposals for change in advance of the next general election.

Such an outcome seemed unlikely in August 1994, when the Government published its response to the Health Service Commissioner's special report. The report itself supported a complaint against Leeds Healthcare about the discharge to a private nursing home of a 55 year old man suffering from severe brain damage. His wife complained on the grounds that she had been obliged to pay for nursing care which should have been provided free of charge by the NHS. The Commissioner found that the Health Authority's failure to provide long term care was unreasonable and recommended that it should both make an *ex gratia* compensatory payment to the woman concerned and also review its policy of making no provision in similar cases. The case had been selected by the Commissioner from among a number of similar complaints as an exemplar of a general problem on which he had previously reported, though to little effect. He sought to ensure that the significance of his findings were not diluted by taking the unprecedented step of devoting a whole report to a single case. Subsequent events have justified this approach. The shockwaves which the report sent round the health service were reflected in the comments of the Director of the National Association of Health Authorities and Trusts who told the Health Service Journal (10 March 1994) that it placed 'a financial timebomb under the NHS'. This reaction was itself indicative of the extent to which the service had progressively withdrawn from long term care. The numbers of NHS geriatric beds, had fallen by 22 per cent between 1989/90 and 1993/94 notwithstanding the increase in the number of very elderly people.

The Government predictably sought to restrict the fallout from the report. In giving evidence to the Select Committee on the Parliamentary Commissioner for Administration of the House of Commons on the Leeds case on 9 March 1994, the then Chief Executive of the NHS argued that the service's responsibilities were limited to cases 'where the medical assessment is that care is needed . . . where it is clear that this is a medical responsibility'. Thus the intention appeared to be one of restricting the boundaries of the NHS to those cases requiring active medical involvement.

Draft Guidelines

The Department of Health subsequently issued its more considered response in the form of draft guidelines from the NHS Executive on 'NHS responsibilities for meeting long term health care needs'. An accompanying letter recorded that, having considered the implications of the Leeds case, Ministers had 'concluded that it would be appropriate for further guidance to be issued to remind health authorities of their responsibilities for securing long term health care'. The guidance was less than three pages in length and stated in its preamble that it:

reminds health authorities and GP fundholders . . . of:

- *their responsibilities for securing long term health care;*

- *the arrangements which should apply for discharging people from hospital with long term care needs;*
- *the importance of effective collaboration with local authorities in agreeing or changing respective responsibilities for long term care.*

The guidance further stated that it 'clarified' the nature of those responsibilities and required health authorities to agree with providers and local authorities eligibility criteria which would enable them to meet their responsibilities 'within available resources'. Such eligibility criteria were to be published in local community care plans. Most fundamentally, the twin emphasis on the clarification and restatement of responsibilities implied that the draft guidance represented no more than an elaboration of pre-existing guidance rather than a significant shift in policy. However, it was not interpreted in that way.

Its publication on a Friday in the middle of August, together with a consultation period of only two months, was inevitably open to criticism. On the other hand, the Department could perhaps equally argue that this timing reflected the seriousness and urgency which was now attached to the issue. The breadth of the consultation process was also open to criticism on the grounds that the range of organisations formally invited to respond was less extensive than it might have been. Regional health authorities and district health authorities were individually consulted whereas family health service authorities, community health councils, trusts and, local authorities were consulted only through their national associations. In addition, national voluntary organisations were separately consulted but the private sector was consulted only through an umbrella body.

Thus, the weight of responses from those organisations formally consulted necessarily reflected the views of NHS purchasers rather than providers and of health rather than social services interests. The private sector was also under-represented compared with the voluntary sector. Some district health authorities apparently consulted with their local authority counterparts in preparing responses but a notable feature of the process was the virtual absence of social services perspectives, apart from those supplied by the two relevant local authority associations and the Association of Directors of Social Services. In addition, the latter organisation's response expressed its concern about being consulted only 'a few days before the guidance was issued' notwithstanding the circulation of 'numerous drafts' to health professionals and managers in the preceding months.

A memorandum from the Department of Health to the House of Commons Health Committee published in March 1995 lists the total of 91 'invited' responses and 89 'non-invited' responses. There appears to have been a general welcome for the publication of the guidelines as a much needed recognition by the Department that an authoritative reply was needed to the 'Leeds case'. However, the responses appear to have been almost universally sceptical that the draft had succeeded in its principal objective of providing greater clarity about the nature of NHS responsibilities in this field. At best, confusion and uncertainty were expected to continue; at worst they might be exacerbated. Thus the Association of Metropolitan Authorities suggested that the guidelines could 'only be described as a fudge which fails to clarify the position'. The National Association of Health Authorities and Trusts was no less dismissive in its conclusion that 'the draft circular best serves as a basis for further examination of the issues to which it refers'. More particularly, it argued that the guidance lacked 'sufficient clarity . . . as to what constitutes NHS based continuing care . . . it will continue the confusion and undermine the concept of equity of access within a National Health Service'. Such conclusions rested on what were widely perceived to be three principal areas of weakness within the draft: its definition of NHS responsibilities; the arrangements proposed for hospital discharge; and the extent to which the draft represented a change in policy.

First, there was much criticism that key terms in the guidance were so imprecisely defined as to be open to diverse interpretations. Such terms included:

- complex or multiple healthcare needs;
- continuing and specialist medical or nursing supervision;
- the expectation will be that the *significant majority* of people who require continuing care in a nursing home setting are *likely* to have their needs met through social services (emphasis added).

The absence of any further elaboration of such terms appeared to leave ample scope for continuing disputes between health and local authorities about the boundaries of their respective responsibilities. In addition, their lack of precision would provide insufficient certainty for users and carers about what they could reasonably expect to receive from the NHS. Most fundamentally, the combination of ambiguous guidelines and a reliance on locally determined eligibility criteria would necessarily lead to wide variations in practice between localities inconsistent with the concept of a comprehensive National Health Service and its founding principle of equity of access. Accordingly, most of the national associations called for national eligibility criteria or minimum standards in order to ensure that access to care was determined by need rather than by an individual's geographical location. There was also significant support for the view that the references to NHS responsibilities gave insufficient recognition to the NHS role in rehabilitation, respite and palliative care.

A second principal area of criticism concerned the draft's references to discharge arrangements. Existing guidance on discharge had been issued in 1989 in circular HC(89)5 and an accompanying booklet. The latter contained the statement that 'no NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges'. In evidence submitted to the House of Commons Social Security Committee and published in its fourth report in October 1991, the Departments of

Social Security and of Health had stated that:

> *Health Authorities have a responsibility under the National Health Service Act 1977 to provide nursing care for those who cannot or do not wish to pay for it. Department of Health guidance is clear that people should not be discharged into private nursing homes when they have no wish to pay.*

In its report, the Committee recommended that 'this obligation should be properly enforced and ... health authorities should not evade what are properly their responsibilities'. It was the failure to fulfil this requirement which lay at the heart of the 'Leeds case'. However, the draft guidance created confusion and uncertainty by making no explicit reference to the 1989 circular. The clear implication, however, was that it would now be superseded by the draft's references to patients who had been assessed as not requiring long term care arranged by the NHS but who refused other options for long term care. In such circumstances, the guidance somewhat ominously advised that 'the health authority and hospital will need to take account of the needs of other patients in determining how long the person can continue to occupy an NHS bed. Individual cases should be handled sensitively . . .'

John Bowis, the Parliamentary Under-Secretary for Health sought to clarify the position in a letter to The Independent on 15 August 1994 in which he stated that 'if someone does not wish to be placed in a residential home where there will be a charge, he or she will continue to have the right not to be placed, and, instead, social services will see if a package of home care can be agreed'. Even so, many responses to the guidance questioned whether such provisions could in practice be implemented. For example, it was not clear what action the NHS could take to 'enforce' a reluctant discharge and a number of responses suggested the need for arbitration arrangements. Perhaps most significantly, the response from the Health Service Commissioner stated that he would be 'likely to criticise a hospital which discharged a patient without regard to the domestic circumstances or any proper discussion simply in order to release the bed for another patient'.

A third central issue raised by the responses to the draft surrounded the wider policy significance of the document and, most particularly, its implications for the extent to which health care would be provided free at the point of delivery. Indeed, it was this concern which generally underlay the criticisms of the continuing ambiguities in health and social services purchasing responsibilities and in territorial inequalities of access to health care. Such issues are of particular significance in the field of long term care since the definition of NHS responsibilities marks the boundary line between universal services, free at the point of consumption, and selective social care services which are wholly free only for those with resources of under £3000 and which must be fully paid for by the user if they have resources in excess of £8000. Accordingly, media coverage as well as formal responses to the guidance questioned whether it effectively represented a departure from a comprehensive 'cradle to grave' NHS. Mr Bowis's letter to The Independent was intended to rebut precisely that criticism. In addition, Mrs Virginia Bottomley, the Secretary of State, argued that the guidance had been misunderstood. In her speech to the Annual Social Services Conference in November 1994, she argued that it 'was *not* intended to and does not represent a change of policy. It is part of the fundamental purpose of the NHS to provide health care for people who need it on a long term basis' (original emphasis).

Faced with such a volume of criticism, the Department spent some months fundamentally re-writing the guidance. In addition, and before publishing a final version, it consulted with a number of national bodies on a revised draft. These consultations took the somewhat unusual form of meetings with individual bodies at which numbered copies of the revised guidance were distributed and comments invited. The drafts were collected at the end of the meeting. Although this process did not appear best designed to encourage a considered analysis and response, at least some of the participants in this process have indicated that observations made in the meetings were at least partially reflected in the published version.

Definitive Guidance

The definitive guidance, *NHS Responsibilities for Meeting Continuing Health Care Needs* (HSG (95)8/LAC(95)5), attracted a substantially more positive response than its predecessor when it appeared on 23 February 1995. Its essential elements are outlined in **Requirements of the Guidance**. The document contained a significantly more comprehensive statement of health service responsibilities, backed up by a more prescriptive framework for implementation and monitoring. Its starting point was an explicit commitment to continuing health care as 'an integral part of the NHS' (para 1). A requirement that purchasers should invest in further provision 'where they were currently failing to arrange and fund a full range of services' (para 3) signalled that this commitment was not merely a rhetorical one. Moreover, the guidance contained a timetabled action plan for bringing the new arrangements into effect by 1 April. Thereafter, health authorities are expected to report annually to the Executive on planned and actual levels of spending and activity, as an integral part of wider performance management processes in the NHS.

In evidence to the House of Commons Health Committee on 9 March 1995 both the Minister, John Bowis and the Chief Executive of the NHS, Alan Langlands, emphasised the high priority attached to ensuring that the guidance was appropriately implemented. This objective has since appeared as one of only six national priorities for the next three to five years in the Executive's *Priorities and Planning Guidance for the NHS, 1996-97*. The intention of the guidance was, therefore, one of making more explicit the full range of NHS responsibilities for continuing health care and associated activities such as rehabilitation and respite care. It was written in the spirit of seeking to extend opportunities for access to NHS care, rather than ratchet them down further, and of creating a framework for ensuring that such intentions could be delivered in practice. In what follows, we consider a number of issues which need to be resolved if those objectives are to be realised. In doing so, we employ the same three categories adopted in our analysis of the draft guidelines: clarity of responsibilities; discharge arrangements; and wider policy implications.

Requirements of the Guidance

The guidance requires health authorities and where appropriate GP fundholders and other agencies to undertake a significant programme of action during the course of 1995/96. This involves:

- developing, in consultation with local interests, policies and eligibility criteria for continuing health care which reflect the conditions set out in the guidance;
- agreeing those policies and criteria with local authorities and GP fundholders;
- reviewing current commitments to continuing health care and making the necessary investments in 1996/1997 contracts to fill significant gaps in services;
- ensuring appropriate information is available to patients, their families and any carers about how procedures for hospital discharge will work and about the local arrangements for continuing care;
- introducing arrangements to handle requests to review decisions on eligibility for NHS continuing care including arrangements for the operation of the independent panels.

Source: House of Commons Health Committee (1995) Supplementary memorandum from the Department of Health, NHS responsibilities for meeting continuing health care needs: Minutes of evidence, Thursday 9 March 1995, HC302-i, London, HMSO.

Extent and Nature of NHS Responsibilities

In a memorandum submitted to the House of Commons Health Committee, the Department of Health stated that Ministers had accepted the need for 'greater detail on the scope of NHS responsibilities'. Equally, however, they had rejected national eligibility criteria 'as infeasible, unlikely to fit local needs and circumstances and possibly stifling local flexibility and innovation'. In their place was offered 'a comprehensive national framework covering the full range of the NHS's responsibilities'. Accordingly, the guidance identified nine categories of services which health authorities and fundholders should arrange and fund in order to meet the needs of their local populations: see **Local Policies and Eligibility Criteria for Continuing Health Care**. The categories contained more detailed descriptions of the NHS role than the draft, as well as explicitly encompassing services - such as rehabilitation, respite and palliative care – about which the latter had been seen to be ambiguous. Health purchasers were expected to use these categories in drawing up local policies and eligibility criteria. As a result, therefore, the Department expected the guidance to 'lead to greater consistency between different parts of the country although the precise pattern of services will appropriately vary to meet local circumstances'. Another source of potential variation within – as well as between – localities is likely to be in the interpretation and application of criteria to individual cases. As the Minister repeatedly stressed in his evidence to the Health Committee, such decisions would be based on local clinical judgements made in the light of the changing needs of individual patients.

Local Policies and Eligibility Criteria for Continuing Health Care

- Assessment of need
- Balance of service and priorities
- Rehabilitation and recovery
- Palliative health care
- Continuing inpatient care
- Respite health care
- Access to specialist or intensive medical and nursing support for people placed in nursing homes, residential care homes or in the community
- Community health and primary care services for people at home or in residential care homes
- Specialist transport

Thus the guidance has sought to strike a balance between a national framework which is sufficiently flexible to meet variations in local needs and resources, on the one hand, and local eligibility criteria which produce unacceptably wide variations in access to health care, on the other. It moves the point of balance towards the former while the appointment of local review panels – explained below – should help to secure greater consistency in decision making within localities. Monitoring of local policies and criteria by the Executive should also reduce the extent of local variations, especially at the extremes.

However, and notwithstanding all these pressures towards greater consistency, the absence of national eligibility criteria necessarily implies the existence of some local variations in access to continuing health care. As a result, individuals in some authorities will receive 'free' care while, in others individuals, with the same or very similar needs will pay for it. Mr Langland's `only response' to this proposition, in his evidence to the Health Committee, was that `it is a little less likely under the new arrangement in the sense that there is now at least a national framework which I think is more explicit than it has ever been before'. The unresolved question is whether such reductions in the extent of local variations in access to `free' health care will be sufficient to be acceptable. In practice, the financial consequences for individuals and families of the application of eligibility criteria seem bound to make them a source of continuing controversy and potential political embarrassment. The extent of equity and fairness between individuals and localities will not only remain live issues, therefore, but may be reinforced by the greater transparency which the guidance will introduce into processes for service allocation. Such considerations will be most acute if patients in adjoining beds or neighbourhoods are subject to differing eligibility criteria because they live in different health authorities. Equally, however, as the Alzheimer's Society has already noted, it will be difficult to justify people with similar conditions having differential access to free health care because they live in `Bury, Manchester rather than Bury, St Edmunds'.

In this context, a crucial distinction is likely to be that between NHS-funded patients eligible for 'continuing inpatient care' in hospitals or nursing homes; and means-tested residents of nursing and residential homes eligible for access to 'specialist or intensive medical and nursing support'. Guidelines for the former include 'frequent, not easily predictable interventions . . . (requiring) specialist clinical supervision from the NHS on an on-going and regular basis'. They also refer to patients requiring 'routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff'. Conditions for the latter include 'occasional continuing specialist medical advice or treatment, specialist palliative care, specialist nursing care such as continence advice, stoma care or diabetic advice . . . (and) specialist medical or nursing equipment not available on prescription and normally only available through hospitals'. Mr Bowis resisted all attempts by the Health Committee to persuade him to provide examples of the kinds of patients who would fall within the continuing care category, or beyond its boundary, on the grounds that such matters depended upon assessments of individual cases based on the exercise of clinical judgement.

At this stage, it remains unclear how such conditions will be translated into eligibility criteria which are not only capable of being consistently interpreted by professionals but are also seen by individuals and families as having been fairly and consistently applied. Moreover, distinctions which are too fine may neither be readily understood nor acceptable to users or their carers. They will also impose heavy responsibilities on professionals conscious that the outcome of their assessments may be of fundamental significance to family finances. Similar considerations will apply in relation to, for example, the distinction between palliative health care received on an inpatient basis and specialist palliative health care provided to people paying for care in nursing homes as well as to respite health care arranged by the NHS and local authorities, respectively.

The definition and application of eligibility criteria will not take place in isolation from other influences. Indeed, the need to take account of variations in local service patterns is a principal element in the Department's preference for local, over national criteria. The intended relationship between resources and eligibility criteria is less clearcut, however. On the one hand, the guidance specifies that where health authorities and fundholders 'are currently not purchasing a full range of services, they must make the necessary investment in their 1996/97 contracts to address this' (para 9a). On the other, it indicates that they 'will need to set priorities for continuing care within the resources available to them' (para 12). Such statements could be reconciled by disinvesting from other services to meet the new national priority accorded to continuing care. However, they raise some important issues about the status of eligibility criteria developed under the terms of the guidance:

- Are they to be *absolute* in the sense that health authorities will be obliged to provide services to all individuals who satisfy the criteria, or are they contingent on resource availability?
- Are they *fixed* for the medium to long term or will they be refined annually on the basis of experience?
- Are they to be *varied* in year to bring supply and demand into balance like the parallel social services criteria?

Legal precedents suggest that the Secretary of State's duty to provide services is not absolute and can only be carried out within available resources. Bridgit Dimond argues (Health Service Journal, 14 April 1994, pp 24-25) that the courts `would draw a distinction between a situation where continuing care beds provided for specific conditions but priorities had to be made over which patients obtained care, and a situation where no provision was made at all'. If the existence of national conditions and local eligibility criteria for the receipt of services does not vary this position, scope would appear to exist for prioritisation between patients who satisfy those conditions and criteria. Redress would presumably rest on claims that health authorities had acted unreasonably in the exercise of such discretion, the implication of which might conceivably be that they would require a further set of criteria for prioritising within each set of eligibility criteria.

Underlying these questions is the more fundamental one of whether both the definition and the application of the criteria must be resource/supply rather than needs-led. The underlying philosophy of the guidance, like that of the community care reforms more generally, is to establish needs-led assessments and service packages. The Department has, in effect, specified conditions for the receipt of a range of services in the absence of information about levels of demand or their resource consequences. To that extent they are clearly demand/needs-led. However, there is a logical inconsistency in asking purchasers to draw up eligibility criteria in isolation from information about their cost implications. Indeed, health authorities may not have been funded at a level which enables them to meet the as yet unknown resource implications of the conditions laid out in the guidance. The question, therefore, is what happens when the rationing criteria are more generous than the resources being rationed. 'Normal' NHS rationing devices would seem to be inappropriate in this case. A waiting list for continuing inpatient care is not a feasible option if the individuals concerned are already occupying more expensive acute beds. Similarly, `hidden' rationing by professional decision making is less feasible when the criteria on which such clinical judgements are made have been published, after widespread consultation, and the judgements themselves are, in at least some respects, subject to independent review.

The above considerations suggest that while the fuller descriptions of NHS responsibilities contained in the guidance do provide greater clarity, they may still prove difficult to put into operation. To the extent that they do, they may form the focus for dissatisfaction about the lack of equity between individuals and for disputes between health and local authorities about their respective purchasing responsibilities.

Hospital Discharge Arrangements

The final guidance provides greater clarity about discharge procedures in at least four respects. First, it specifically states that it supersedes the 1989 circular on discharge. Second, it confirms that patients 'have the right to refuse to be discharged from NHS care into a nursing or residential care home' (para 27). Third, it balances this right with a re-affirmation that 'where patients have been assessed as not requiring NHS continuing inpatient care, as now, they do not have the right to occupy indefinitely an NHS bed' (para 27). Fourth, it provides greater detail about the procedures to be followed in such circumstances and introduces arrangements for reviewing their application in individual cases. More particularly, where patients refuse to be discharged, social services, hospital and community health staff should 'explore alternative options' with patients, their family and/or carer (para 28). Where such options are rejected, discharge may be implemented to the patient's own home or alternative accommodation 'with a package of health and social care within the options and resources available' (para 29).

This statement leaves open the possibility of patients being discharged home with levels of support which might be inappropriate to their level of need. While the individuals concerned could be said to have chosen a care option after being fully informed about the risks to which they might be exposing themselves, it is difficult to defend arrangements which drive them into such choices. Nor would such situations be satisfactory even from a narrow financial perspective if they lead to early re-admissions through the revolving hospital door. Ultimately, this tension between individual rights and the cost-effective utilisation of hospital services can be resolved only by the withdrawal of those rights, a relaxation in means testing or the guarantee of high intensity packages of home care.

In the meantime, however, the guidance provides a safeguard against the arbitrary or inconsistent operation of these procedures through a right to ask for the Health Authority to review individual cases 'as a final check before such a discharge is implemented' (para 30). The 'normal expectation' is that the Health Authority should seek the advice of independent panels in such cases. Although these panels will have no legal status and their decisions are not to be formally binding, 'the expectation would be that (their) recommendation would be accepted in all but very exceptional circumstances . . .' (para 33). The panels' key task is to assess whether the Health Authority's eligibility criteria have been correctly applied and thus they will apparently be required to review the clinical judgements of the professionals concerned. To this end they will have access to independent clinical advice. With the exception of rights of appeal under the 1983 Mental Health Act, this provision is a novel one. Moreover, it differs from the former in providing for a review of rationing decisions taken in the light of published eligibility criteria. It is, therefore, to be seen as a further development in the transparency of decision making about the allocation of resources. Indeed, it is not immediately apparent why, in principle, a similar right of review should not exist in other areas of the health service, especially if clinical protocols and eligibility criteria were to become more widely established. Whether the Department of Health intends to establish a precedent along these lines is, of course, improbable.

Underlying Policy Implications

The draft guidance was criticised for failing to address the more fundamental issues arising from the shift of historic NHS funding responsibilities onto the social security system which took place in the decade or so leading up to the community care reforms. The most extreme criticisms of the draft depicted it as the end of the 'cradle to grave' NHS. The final version continues to be devoted to the remedy of symptoms rather than the underlying question of the balance between state and individual responsibilities for meeting the costs of continuing care. However, in a letter accompanying the guidance, Mr Bowis takes up the issue about the boundary between health and social care as does the Department of Health's memorandum to the Health Committee. Both sources seek to make the point that a boundary has existed since the creation of the welfare state in 1948 between the responsibilities of the NHS and those of local authorities for arranging and funding continuing care. Both also argue that the guidance does not move that boundary. Thus, Mr Bowis argues that:

> *since the foundation of the welfare state, there has been a boundary between the responsibilities of the NHS and local authorities for continuing care. This guidance does not move that boundary but sets out a practical national framework which makes clear where the responsibilities of the NHS lie.*

The memorandum also makes the point that, while NHS care has been – and continues to be – free at the point of delivery, local authorities have had powers to charge for social care since 1948. On this line of argument, the purpose of the guidance may be described as simply seeking to restore the *status quo ante* through its requirement that the NHS should reinvest in areas where health authorities withdrew too far from arranging and funding continuing health care. It is, however, disingenuous to suggest that the boundary between health and social care has not shifted since 1948, as Mr Bowis effectively acknowledged in his evidence to the Health Committee: 'the boundary is not affected by this guidance, but the boundary has of course moved over the years since the founding of the NHS and the welfare state'. He further argued that:

> *the reason the boundary has moved since 1948 is because medical science and technology have moved on . . . people can have a hip operation, return home and lead a normal life which years ago was unlikely, much less back in 1948 . . . sometimes people do not have to leave home to have the treatments they would have gone to hospital for in the past and they certainly can return home much more quickly. In that sense the boundary has moved but this guidance has not moved it and it is not the same border as in 1948.*

This statement is important both for clarifying what would otherwise have remained a misleading impression and also for acknowledging that changes in the delivery of acute – no less than long stay hospital services – have shifted the boundary between 'free' health and means tested social care. By the same token, they have also shifted the balance of caring responsibilities from formal to informal carers. It follows, therefore, that increased activity levels and 'efficiency' gains in the NHS have, in part been dependent on higher direct expenditure (including charges) on social care services, together with indirect subsidies provided by the uncompensated contributions of informal carers.

However, the acceptance by ministers that changes in clinical practice have led to shifts in the boundary between health and social care provides only a partial explanation for the current situation. A more fundamental factor was the cost shunting from health to social security budgets which so largely enabled the boundary move to be funded. It was the new funding stream provided by the social security system that resulted in continuing health care being provided in means tested nursing home beds outside the NHS. This *de facto* shift in responsibilities away from the health service was statutorily underwritten by the 1990 NHS and Community Care Act. In an amendment to the 1948 National Assistance Act, the local authority duty to provide accommodation `by reason of age, infirmity or other circumstances' was extended to include `age, illness, disability or other circumstances'. The result of this amendment was two-fold.

First, it formalised the co-existence of `free' and means tested arrangements for providing 24 hour nursing care, arrangements which hitherto had been the unintended by-product of changes in the social security system. Second, and in consequence, it created the need for a clarification of the boundaries between those two systems, which the recent guidance seeks to meet. In this respect, a major source of difficulty is that the legislation was directed solely at redefining the responsibilities of local authorities in this field; those of the NHS were not formally affected. Indeed, the White Paper *Caring for People* argued that the functions and responsibilities of the health service as a whole remain essentially unaltered by its proposals (para 4.2). It further specified that health authorities should provide or arrange `continuous residential health care for those highly dependent people who need it' (para 4.21).

The potential for confusion and cost shunting arising from what appeared to be overlapping purchasing responsibilities on the part of health and local authorities was highlighted in, for example, evidence to the 1991 House of Commons Social Security Committee enquiry referred to above. However, neither the White Paper nor the 1990 legislation were generally seen as narrowing access to the NHS – and technically they did not do so. That outcome was the implied consequence of the amendments to local authority responsibilities rather than the direct result of a statutory re-definition of NHS roles and functions. The guidance is, therefore, best seen as an attempt to complete business left unfinished by the NHS and Community Care Act. While it represents a considerable advance in terms of providing a more detailed national framework for explicit local eligibility criteria, it does not deal directly with the question of why some nursing care is provided 'free' at the point of delivery and other nursing care is means tested. Ultimately, the issue to be addressed is whether all nursing care, in whatever setting, should necessarily be seen as an integral part of the NHS.

An affirmative response would not be the end of the matter in terms of clarifying responsibilities since it would open up debate about both the boundaries of nursing and also about whether accommodation costs might still be paid for. However, it is the outstanding point of principle which has yet to be fully debated and which underlies the disappointed expectations of the current generation of elderly people and their families. As matters currently stand, the community care reforms have had the effect of ending `universal access to nursing care, free at the point of delivery and irrespective of care setting' which the establishment of the NHS had apparently guaranteed. Yet, as the public disquiet about the contraction of NHS funded care increasingly demonstrates, the implied redefinition of NHS responsibilities which the community care reforms represent must still be considered unfinished business. A full-scale debate about the boundaries of `free' health care will be increasingly difficult for politicians of all parties to avoid.

Conclusion

Two sets of issues remain outstanding following the publication of the guidance: first, whether it offers a sufficiently clear and robust framework to withstand the pressures of implementation; and second, how the growing discontent with current systems of payment for long term care is to be defused this side of the general election. We have noted positive aspects of the guidance in terms of its restatement of NHS responsibilities, their clearer description and definition, the requirement to reinvest and the right to a review of individual cases against published eligibility criteria. Moreover, the consultation on draft policies and criteria will, themselves, contribute to public debate and awareness in an area where policy making by accident or stealth has been dominant.

At the same time, however, substantial uncertainties remain about whether the new criteria can be operationalised in ways which are comprehensible and do not lead to unacceptable levels of inequity between individuals and localities. Other uncertainties surround the role of fundholders who are expected to purchase within locally agreed policies and apply local eligibility criteria. It is by no means clear that the proposed accountability framework for fundholders provide the mechanism to ensure that they operate within a DHA policy framework.

A further potential implementation trap surrounds the question of retrospection. Mr Bowis confirmed to the Health Committee that individuals may ask for a reassessment when the eligibility criteria come into effect and that those not receiving free health care under existing arrangements could do so if their needs fall within the new criteria. A more difficult question is whether individuals might have a case for compensatory payments if it could be demonstrated that their health authority had inappropriately withdrawn from continuing care in the past.

Finally, the interface between this guidance and performance targets for the acute sector also needs to be addressed. A greater emphasis on rehabilitation, for example, might impact on throughput and thus the capacity to meet waiting list targets. So long as the principal performance drivers relate to the latter, there will continue to be a tension between priorities and sectors, which need to be seen as interdependent and complementary rather than separate policy domains.

The 1996/97 priorities and planning guidance recognises the link between re-admission rates, inappropriate discharges and arrangements for rehabilitation and recovery. It is, therefore, a welcome if still incomplete first step in the direction of recognising interdependencies between sectors.

The guidance also leaves open the issues raised by the shift in the balance between state and individual responsibilities for funding long term care and its impact on inheritance. Perhaps even more worrying for politicians is the probability that payment for long term social care is no more popular than that for nursing home care. The former requirement has existed, as we have noted, ever since 1948 but it has been of relatively little significance in a period when fewer elderly people owned their own houses. We have also noted that a number of funding reviews are now underway. As they proceed, it will be crucial for them to distinguish between the claims of current generations and mechanisms for meeting the costs of long-term care in the longer term (See: Gerald Wistow, Journal of Community Care Planning and Management 1995). Press leaks suggest that, in the short term, the Government is seeking to find ways of keeping capital from housing intact and available for inheritance while using income from that capital to contribute to the costs of care. However, the extent to which long term care is 'affordable' in the next century and how it can be paid for is a different issue which needs to be addressed separately.

Finally, amidst the growing preoccupation with responsibilities for funding long term care, less attention has been given to the nature of services to meet long term care needs. The guidance is important in this respect in requiring health authorities to develop purchasing policies for a wide spectrum of care and also in underlining the importance of rehabilitation and respite services. However, it will be important to avoid an over-emphasis on the provision of long term care beds, especially if the unit costs of intensive home care packages prove to be more expensive than those of nursing or residential care. Moreover, it is easy to ignore the fact that the vast majority of those with long term care needs currently not only live outside institutional settings but are often poorly supported by domiciliary services as research carried out by the Royal College of Nursing has demonstrated (B Wade, *The Changing Care of Continuing Care for Older People 1993*). The fundamental objective of *Caring for People* was to enable individuals to live in their own homes or where this was not feasible in 'homely' environments in their local communities. Meeting that objective will require an expansion in the range and level of primary and community services of all kinds for both users and carers. It is essential, therefore, that policies for long term care which health authorities are now required to develop will pay as much attention to service models as to eligibility criteria.

ATTITUDES TO HEALTH SERVICES 1983 TO 1993

Nick Bosanquet and Anna Zarzecka

The last decade has been one of continuing controversy over the NHS according to the 11th British Social Attitudes Report (Dartmouth/SCPR 1994) there was a peak of dissatisfaction around 1989 and some improvement between 1989 and 1993. The British Social Attitudes survey series began in 1983. Its aim has been to collect information about a range of societal values, how they have been changing over time, and on the extent to which different sections of the population vary in their attitudes and beliefs. The areas covered include subjects such as public spending, employment, health care, crime, gender, race and civil liberties. The information is gathered annually through interviews carried out by Social and Community Planning Research among a nation-wide representative sample of adults aged 18 or over living in private households.

People's values and attitudes towards health services are strongly related to their health-related behaviour such as seeking medical advice, compliance with treatment, or engaging in health promotion activities. They are also influenced by their past experience and satisfaction with these services, by the political climate and culture. 'Satisfaction' is a complex concept and measuring satisfaction with health services, although of prime importance, is a difficult task. People's responses can vary according to their understanding of the concept of satisfaction, their past experience as well as expected future events. Large differences in satisaction levels with a variety of public services have been previously found between various socio-economic groups; in the case of the health services, levels of satisfaction can be expected to vary according to geographical location, not only because of the actual variability in the services provided, but also because of regional differences in culture and social characteristics. Using special tabulations prepared for us by SCPR from the British Social Attitudes Survey, we can show whether or not such variations exist in practice.

We begin by looking at satisfaction with the NHS as a whole, GPs, NHS dentists and inpatient services. We then turn to findings on where respondents felt there is need for improvement in specific areas of the NHS – in the primary care setting and in hospital inpatient and outpatient services. We conclude with respondents' views on the financing of medical care.

Satisfaction with the NHS

In measuring the levels of satisfaction respondents were asked to note their level of satisfaction with particular aspects of health services on a scale from 1 (very dissatisfied) to 5 (very satisfied). The group means were calculated: the higher the mean, the more satisfied respondents were, as a group, with the services. Any value lower than 3 implies that most respondents were dissatisfied to a higher or lesser degree, and any value above 3 implies that most respondents were satisfied to a higher or a lesser degree.

Overall Satisfaction with the NHS

Question: All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?

In 1983 the average levels of satisfaction with the NHS were the same in all regions, at 3.3. On average there was no difference between regions at this time, but considerable differences emerged later. The levels of satisfaction with the NHS had fallen in 1989, to the lowest of 2.5 in London and the highest in Scotland at 3.0, and by 1993 had risen slightly again in all regions except in Scotland. London shows some rise but a smaller one than in the rest of the UK.

The proportions satisfied with the NHS in 1983, 1988 and 1993 was the highest in all years for Scotland, at 66, 49 and 47 per cent respectively, and the lowest in London at 43, 29 and 34 per cent. However the biggest rise in dissatisfaction also took place in Scotland, where the proportion of those dissatisfied more than doubled between 1983 and 1989: 17 per cent being dissatisfied in 1983, to 41 per cent in 1989 and 36 per cent in 1993. For London, there were most dissatisfied people with more than one in three (35 per cent) reporting dissatisfaction in 1983, more than a half (55 per cent) in 1989 and 44 per cent in 1993. Similar changes across the years were observed in other regions, with the South (excluding London) having more people dissatisfied with the NHS than in the North, Midlands and Wales, but less than in London.

Women reported slightly higher levels of satisfaction with the NHS than men. For both men and women, the level of satisfaction increased with age, with those in the youngest groups being least likely to report satisfaction, and those in the oldest – most, with differences of about 20 per cent in all years. The proportions of those reporting dissatisfaction were changing accordingly, with the highest levels of 53 per cent reported by the youngest males in 1989 and the lowest by the oldest females in 1983 at 19 per cent.

There is a clear pattern of change by social class. There was consistent movement from high initial levels of satisfaction to similar levels of dissatisfaction in 1989: but since 1989 opinion in the professional group has diverged, with continuing high levels of dissatisfaction, so that only a little more than one third of the professional elite is satisfied: see Table 1.

Controversy over the post-1990 reforms may well have dimmed memories of earlier controversies such as those over the funding of the NHS, but they clearly had a major effect on opinion. The last years of the old NHS saw a very distinct decline in public levels of satisfaction.

Satisfaction with GPs

Question: From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of these parts of the National Health Service runs nowadays: First, local doctors/GPs:

When asked specifically about their satisfaction with local doctors/GPs, as opposed to more general satisfaction with the NHS, the levels of satisfaction were much higher, with the great majority of respondents (about 80 per cent) being satisfied. As with the satisfaction with the NHS, Scotland had the highest proportion of those satisfied, and the income levels of satisfaction were the highest. Regional attitudes to general practice were similar in pattern to those found for the NHS as a whole, with distinctly lower levels of satisfaction in London, where 70 per cent were satisfied in 1993 compared with 83 per cent in all areas. In London they were at their lowest, but still much higher than for satisfaction with the NHS. South and North/Midlands/Wales respondents gave similar answers. The proportion of those dissatisfied with their doctors, at about one in five respondents, was the highest in London – this was more than double that for Scotland, where the proportions were below one in ten for all years.

The differences between years were slight for all regions and other groups, with the proportion of the total of those satisfied increasing from 80 per cent in 1983 and 1989 to 83 per cent in 1993. The proportion of those dissatisfied has decreased accordingly from 13 per cent in 1983, 12 per cent in 1989 to less than 10 per cent in 1993. Attitudes to family doctors have shown much less fluctuation than those to the NHS generally.

Proportionally more women than men were satisfied with their doctors, and they reported higher levels of satisfaction. Satisfaction was also rising with age for both men and women with about 10 per cent more respondents in the oldest groups reporting satisfaction

Table 1: Satisfaction and Dissatisfaction with the NHS

	% Satisfied			% Dissatisfied			Mean level of satisfaction		
	1983	1989	1993	1983	1989	1993	1983	1989	1993
All	54.5	36.6	43.6	25.6	45.5	38.0	3.3	2.8	3.0
Area									
London	42.8	29.1	34.1	34.5	54.7	44.2	3.3	2.5	2.8
South excluding London	52.9	35.6	42.1	27.3	45.3	38.7	3.3	2.8	3.0
North/Midlands/Wales	55.7	36.7	46.4	24.4	44.4	36.5	3.3	2.8	3.0
Scotland	66.2	48.8	47.1	17.4	41.2	35.7	3.3	3.0	3.0
Men									
18–34	45.2	27.4	31.6	30.7	52.8	44.3	3.2	2.5	2.7
35–54	51.4	31.1	38.6	32.8	50.8	42.1	3.2	2.6	2.8
55+	60.8	46.3	54.3	22.2	36.0	33.7	3.4	3.1	3.3
Women									
18–34	55.3	32.7	36.4	22.9	47.8	39.2	3.3	2.7	2.9
35–54	52.2	36.1	43.8	27.9	47.6	39.8	3.3	2.7	3.0
55+	60.8	45.8	57.7	18.9	38.6	29.2	3.5	3.0	3.3
Social class									
I – professional	52.3	35.8	37.7	30.0	45.7	44.3	3.3	2.8	2.8
II – managerial	51.5	37.8	46.6	24.2	43.7	33.6	3.3	2.8	3.1
III – non-manual	54.2	36.2	45.2	27.5	47.0	38.5	3.3	2.7	3.0
III – manual	59.3	37.2	44.2	23.2	46.2	37.2	3.4	2.7	3.0

as compared to the youngest groups, and the levels of satisfaction about 0.5 higher.

Differences across social class I were small and did not show differentiation between social class I and the rest found on other health service issues: see Table 2.

Satisfaction with NHS Dentists

Question: From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of these parts of the National Health Service runs nowadays: National Health Service Dentists:

In contrast to satisfaction with their doctors, which was high and on the increase, the proportion of those satisfied with their NHS dentists was lower, and dropped significantly between years 1983 and 1993. The proportion of those dissatisfied has doubled, with the South excluding London showing more than a three-fold increase in the proportion of those dissatisfied, Scotland and North/Midlands/Wales showing a two-fold increase. In London, where the numbers of those dissatisfied were already high in 1983 at 19 per cent, there was a fall in dissatisfaction to 13 per cent in 1989, and a rise to over 23 per cent in 1993.

The move towards greater dissatisfaction with NHS dentists took place after 1990 and was probably related to higher levels of charges. Differences in access to NHS dentists may have helped to create higher levels of dissatisfaction in London and the South East.

The pattern for age groups was also different than that for satisfaction with the NHS or doctors, with those in the oldest age group being least likely to report satisfaction, and their levels of satisfaction were also lower.

Those in social classes I and II were more likely to report satisfaction with their NHS dentist than those in other social class groups: see Table 3. These were the people who, in real terms, were least affected previously by the introduction of dental charges.

Table 2: Satisfaction and Dissatisfaction with GPS

	% Satisfied			% Dissatisfied			Mean level of satisfaction		
	1983	1989	1993	1983	1989	1993	1983	1989	1993
All	80.0	79.9	82.7	12.9	12.0	9.6	4.0	3.9	4.0
Area									
London	71.1	69.1	69.9	18.5	20.6	17.9	3.7	3.6	3.7
South excluding London	79.5	79.2	83.8	12.4	11.6	9.1	4.0	3.9	4.1
North/Midlands/ Wales	80.7	82.0	84.2	12.5	10.8	8.3	4.0	4.0	4.1
Scotland	87.4	84.4	87.1	9.4	9.7	7.5	4.1	4.0	4.1
Men									
18–34	72.5	70.9	73.7	17.8	15.7	14.5	3.7	3.7	3.7
35–54	73.4	75.3	80.0	17.9	14.5	10.2	3.8	3.8	3.9
55+	83.6	83.8	89.6	8.5	9.1	5.0	4.1	4.1	4.3
Women									
18–34	79.6	76.5	77.1	15.2	15.5	13.2	3.9	3.8	3.9
35–54	82.6	83.6	86.6	11.0	11.2	8.8	4.1	4.0	4.1
55+	86.6	87.8	89.0	8.2	7.0	6.1	4.2	4.2	4.3
Social Class									
I – professional	78.7	77.7	80.9	14.9	13.6	10.5	3.9	3.9	4.0
II – managerial	80.6	80.0	86.2	13.2	11.5	8.2	4.0	3.9	4.1
III – non-manual	76.8	81.1	83.3	13.6	11.5	8.9	3.9	3.9	4.0
III – manual	812.1	81.2	82.7	12.0	11.2	9.4	4.0	4.0	4.1
housewife/never worked	83.9	81.3	n.a.	9.1	10.9	n.a	4.1	3.9	n.a
other	78.1	74.0	70.5	17.7	16.2	15.1	3.8	3.7	3.8

Table 3: Satisfaction and Dissatisfaction with NHS Dentists

	% Satisfied			% Dissatisfied			Mean level of satisfaction		
	1983	1989	1993	1983	1989	1993	1983	1989	1993
All	73.0	70.2	58.0	9.6	11.0	20.1	3.8	3.7	3.4
Area									
London	63.2	66.8	51.2	18.9	13.2	23.3	3.5	3.6	3.3
South excluding London	73.7	70.0	51.2	8.6	11.8	26.1	3.8	3.7	3.2
North/Midlands/ Wales	73.0	71.2	62.6	8.7	10.7	15.7	3.8	3.7	3.5
Scotland	80.8	69.5	66.4	7.4	7.2	18.7	3.9	3.6	3.6
Men									
18–34	73.8	63.5	55.5	9.8	9.8	19.7	3.7	3.5	3.4
35–54	75.2	70.8	56.0	11.0	12.7	24.1	3.8	3.7	3.3
55+	64.3	61.1	52.9	13.5	14.9	21.9	3.5	3.4	3.2
Women									
18–34	81.0	75.9	66.2	10.0	10.3	15.1	3.9	3.8	3.6
35–54	81.3	79.6	62.6	8.2	10.9	21.6	4.0	3.9	3.5
55+	62.4	66.6	52.0	6.8	7.8	19.0	3.7	3.6	3.2
Social Class									
I – professional	76.0	71.7	55.3	9.4	11.2	23.5	3.9	3.7	3.3
II – managerial	75.5	75.4	59.2	11.5	9.2	19.7	3.9	3.8	3.5
III – non-manual	70.6	66.0	57.2	8.2	10.7	21.5	3.7	3.6	3.3
III – manual	71.1	67.4	59.5	9.9	14.2	18.3	3.7	3.5	3.4
housewife/never worked	75.0	69.8	n.a	7.3	6.2	n.a	3.9	3.7	n.a
other	63.6	67.1	63.3	18.0	4.3	11.8	3.5	3.5	3.5

Satisfaction With Being an Inpatient

Question: From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of these parts of the National Health Service runs nowadays: Being in hospital as an inpatient:

When asked specifically about their satisfaction with the service for inpatients, the respondents in Scotland were much more likely to report satisfaction, and those in London – least. There was a gradual decrease in those satisfied, with as many as 84 per cent reporting satisfaction in Scotland in 1983, 72 per cent in 1989 and 69 per cent in 1993. For London the corresponding figures were 66 per cent, 59 per cent and 54 per cent, and from mid-70 per cent to mid-60 per cent in other regions.

The levels of satisfaction have dropped in 1989 and remained on about the same level in 1993, for the total population from 3.9 to 3.5 and 3.6. The same pattern was seen in all geographical areas.

Interestingly, those who had a recent experience of being an inpatient or having a member of their family or a friend admitted to a hospital, reported higher levels of satisfaction than those with no such experience, and for those with experience the level of satisfaction has slightly risen very slightly between 1989 and 1993 from 3.7 to 3.8, as compared to those with no experience of hospitalisation whose levels of assumed satisfaction have remained similar.

The proportion of satisfied respondents with inpatient services has remained similar at 71 per cent and 72 per cent, but the proportion of those dissatisfied has fallen from over 18 per cent to 14 per cent. On the contrary, those with no experience were not only much less likely to report satisfaction in both these years, but there was also a much bigger drop in the proportion of those satisfied, from 65 per cent in 1989 and 56 per cent in 1993. The proportion of those dissatisfied for this group remained similar at 13 per cent in 1989 and 14 per cent in 1993: see Table 4.

Table 4: Satisfaction and Dissatisfaction with Inpatient Care

	% Satisfied			% Dissatisfied			Mean level of satisfaction		
	1983	1989	1993	1983	1989	1993	1983	1989	1993
All	73.7	65.4	63.8	6.6	15.4	14.0	3.9	3.5	3.6
Area									
London	66.1	58.9	54.0	12.2	23.1	20.5	3.6	3.3	3.3
South excluding London	74.1	60.5	62.0	5.6	14.8	14.2	3.9	3.5	3.5
North/Midlands/ Wales	73.0	71.2	62.6	8.7	10.7	15.7	3.8	3.7	3.5
Scotland	80.8	69.5	66.4	7.4	7.2	18.7	3.9	3.6	3.6
Experience									
yes	n.a	71.1	72.1	n.a	18.3	13.9	n.a	3.7	3.8
no	n.a	64.5	56.2	n.a	13.2	14.1	n.a	3.4	3.4

Improvements to Services

The 1993 survey included a 'shopping list' for improvements to GP and hospital inpatient services: we take these in turn.

Need for Improvement in GP Services

Question: From what you know or have heard, please tick a box for *each* of the items below to show whether you think the National Health Service *in your area* is, on the whole, satisfactory or in need of improvement.

Most respondents were satisfied with GP services, with over one in five thinking that the quality of medical treatment provided by GPs was very good. The GP appointment system was seen as the least satisfactory aspect of GP care, with over 40 per cent of respondents recommending some improvement to the system: see Table 5.

Need for Improvement in the Hospital Services

Question: From what you know or have heard, please tick a box for *each* of the items below to show whether you think the National Health Service *in your area* is, on the whole, satisfactory or in need for improvement.

Although a great majority were satisfied with the quality of medical treatment (67 per cent of respondents), and especially nursing care (75 per cent), certain aspects of hospital services were seen as requiring improvement.

In particular, the aspects of hospital service concerned with waiting times for consultant appointments, non-emergency operations and waiting to see a

Table 5 Improving GP Services

Is there need for Improvement in:	Yes, a lot	Yes, some	No, service is satisfactory	No, service is very good
		%		
GPs appointment system	10.4	30.6	44.1	13.7
Amount of time GP gives to each patient	6.8	23.6	53.4	14.7
Being able to choose which GP to see	7.5	18.7	52.3	19.3
Quality of medical treatment by GPs	4.4	18.8	52.3	22.2
Waiting areas in GP's surgeries	4.5	18.2	59.6	15.0

doctor in the out-patients or accident and emergency departments, were causing most concern, with 80, 79, 75 and 72 per cent of most respondents respectively wishing a lot or some improvement to those aspects of hospital care. About a half of all respondents reported the time waiting for an emergency ambulance as satisfactory or very good.

About 70 per cent of respondents were looking for improvements in the staffing levels of nurses and doctors, and more than half wanted improvements to hospital buildings and waiting areas: see Table 6.

Table 6 Improving Hospital Services

Is there need for improvement in:	Yes, a lot	Yes, some	No, service is satisfactory	No, service is very good
Time		%		
Waiting lists for non-emergency operations	37.1	42.2	16.3	1.2
Waiting time before getting appointments with consultants	40.8	39.4	15.1	1.6
Time spent waiting in outpatient departments	29.2	46.0	20.3	1.2
Time spent waiting in A&E departments before being seen by a doctor	31.2	40.5	21.8	2.6
Time spent waiting for an ambulance after a 999 call	13.8	29.3	40.6	10.3
Surroundings				
General condition of hospital buildings	15.9	37.8	35.4	8.9
Waiting areas for out-patients	14.1	35.7	41.1	6.1
Waiting areas in A&E departments	19.0	38.0	34.8	5.2
Staffing				
Staffing levels of nurses	26.0	41.5	25.2	4.6
Staffing levels of doctors	25.9	41.7	25.1	4.0
Quality of Treatment/Care				
Quality of nursing care in hospitals	4.7	18.1	50.1	24.5
Quality of medical treatment in hospitals	5.8	25.0	52.1	14.9

Political Attitudes

We conclude by presenting the results of two questions which were directed at people's broad political attitudes to the role of the NHS and the finance of health spending.

NHS for Those on Low Income Only

Question: It has been suggested that the National Health Service should be available *only to those with lower incomes.* This would mean that contributions and taxes could be lower and most people would then take out medical insurance or pay for health care. Do you support or oppose this idea?

When asked whether the NHS should be for those on the lowest incomes, 29 per cent supported the idea in 1983 as compared to 22 per cent in 1989 and 21 per cent in 1993. 64 per cent opposed it in 1983, 74 per cent in 1989 and 75 per cent in 1993.

In both 1983 and 1989, the higher the social class, the stronger the opposition to the idea. In 1983, 70 per cent of those in social class I, and 79 per cent in 1989, opposed it, and 23 per cent and 18 per cent gave their support for it respectively. In contrast, over 60 per cent of manual and non-manual class 3 in 1983 and over 70 per cent in 1989 opposed it. The higher rates of opposition were also related to higher earnings, with those on lower incomes less likely to oppose it than those on higher incomes – particularly in 1983.

Taxes and Spending

Question: Suppose the government had to choose between the three options on this card. Which do you think it should choose?

Reduce tax and spend less on health, education and social benefits, keep taxes the same, or pay more and spend more on health, education and social benefits.

There was a two-fold increase between the years 1983 and 1993 in the number of respondents who wanted to increase taxes and spend more on these three areas of public spending – from 32 per cent in 1983 to 63 per cent in 1989. The numbers of those who wanted to keep taxes the same or decrease them have gone down almost by half. In 1989 less than 3 per cent of respondents opted for lower taxes and spending, as compared to 8.6 per cent in 1983 and 4.4 per cent in 1993: see Table 7.

Table 7: Preference for Taxes and Spending

	1983	1989 %	1993
Reduce tax and spend less on health, education and social benefits	8.6	2.7	4.4
Keep taxes and spending the same	54.3	36.8	28.5
Increase tax and increase spending on health, education and social benefits	32.2	56.2	63.1

First Priority for Extra Government Spending

The majority of respondents chose health as their first priority for extra spending in both 1983 and 1993, although the figure has risen in the latter year (38 per cent and 45 per cent respectively). This was followed by education (24 and 27 per cent), housing (7 and 9 per cent), social security benefits (6 and 5 per cent), police and prisons (3 and 4 per cent) and defence (4 and 1 per cent).

There were some differences in priorities choice according to age and sex. For example, older people were more likely than younger groups to choose health, social security benefits, or defence as their first priority, and younger people education. There was strong sex difference, with males being more likely to support spending on defence, especially in 1983. Housing attracted most attention in the youngest and oldest groups.

Conclusion

For a long period the NHS was a consensus programme with wide and uniform support across regions and social groups. From 1983 to 1989 dissatisfaction showed a strong increase which was slightly reversed from 1989 to 1993. But within this general pattern there are some important differences.

- People in London are much more dissatisfied than respondents in the rest of Great Britain.
- Professionals in social class I are now much more dissatisfied with the actual performance of the NHS, although they remain most committed to the principle, showing least support for restriction of NHS services to people with low income.

The typical crisis in the 'old' NHS involved controversy over national funding levels concentrating on the Summer/Autumn public expenditure round. Local crises were related to local pressures, as hospitals which increased activity found themselves running up against budgetary limits. The new NHS will have humanitarian crises over access to services: it may also have new local differences in perception of service quality as some trusts gain stronger reputation for local care. The detailed results show greater differences between services and region than in the past. The impact of the 1990 reforms in the long term might well be to increase differentiation between regions. The 'motor' of change in attitude might be local service quality, rather than national political attitudes.

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by David Taylor
The nation's dental health is improving and so is the pattern of care provided. But changes need to be made to ensure that all sections of the population benefit and that services are provided in the most efficient manner.

Inter-Agency Collaboration: Can Care Management Fix It? 104
by Bob Hudson
The Government are banking on care management to produce packages of care combining elements from many different services; an assessment of the evidence suggests that its promise may prove greater than actual performance. But steps can be taken to improve the chances of its success.

Discharging Patients or Responsibilities? Acute Hospital Discharge and Elderly People 113
by Linda Marks
Discharge of elderly patients from hospital has long proved far from 'seamless'; what is needed to make it work properly and what are the implications of the Government's plans to contain social security spending on residential and nursing home care?

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In the second half of the 1980s, arrangements for the external audit of the NHS have been greatly strengthened. Can we now be confident of their effectiveness?

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by Morton Warner
Major changes are required in the way that services are planned and provided; five key areas where change is needed are identified.

The European Community and UK Health and Health Services 136
by Chris Ham
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Health Policy, Competition and Professional Behaviour 142
by Frances Miller
With the Government intent on introducing competition to the NHS, the general framework of competition law is becoming increasingly relevant; as a result, the medical profession may have to re-think its standards of acceptable behaviour.

HEALTH CARE UK 1992/93

Health Policy Review 1992/93 1

PART 1 MAIN EVENTS
A critical account of the main policy changes during 1992/93

1.1 Implementing the National Health Service and Community Care Act 3
The Government continued to develop the 'new' NHS, creating more trusts and GP fundholders, and putting yet more emphasis on support for purchasing. In London, the first moves towards tackling 'over-capacity' in the acute sector were made.

1.2 Community Care 11
The Government began the (delayed) process of implementing the community care provisions of the Act; we set out the series of measures taken during the year and the issues they give rise to.

1.3 Public Health Strategy 16
The Government followed up last year's green paper, *The Health of the Nation*, with a white paper confirming the general approach. It also began a series of measures to realise it. We point out the significant obstacles which remain.

1.4 Serving the Consumer 19
The Government continued to develop the Patient's Charter, announcing plans for extending it and making the first steps towards introducing it for social services. We contrast the approaches in health and social care and then look at some of the wider issues which a consumer orientated policy entails.

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The health and social care sectors remain divided, and the 1990 Act introduces new divisions. Nevertheless, the Government is committed to seamless care; we discuss whether the new mechanisms, contracts and care management, can overcome those divisions sufficiently well.

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Both these services have recently been reviewed, paediatrics by the Audit Commission and maternity care by the House of Commons Select Committee on Health: what evidence have these reviews produced on the scope for shifting the boundaries of care?

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Services for Elderly People 64
The share of hospital beds occupied by the elderly has been growing and will grow further. If the objective is to contain or reduce the use they make of hospital facilities, a large range of measures could be taken to alter the balance of care. But existing organisational and financial arrangements present serious obstacles.

Elaine Murphy

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Mental Health Services 77
The aim of shifting the balance of care for the mentally ill from hospital to community is far from new and the evidence presented here confirm the case for such a shift. But it is more difficult to define, on the basis of existing research, just what the pattern of replacement services should be. Here too there remain substantial obstacles in the way of major change.

Matt Muijen

Pathology Services 88
Most large hospitals comprise a pathology department: is that inevitable, or can pathology services be provided as efficiently in ways which break that link?

John Stilwell

The New NHS

The gradual introduction of the 'new' NHS continues to raise new issues. The following group of articles considers some broad questions which the new arrangements pose.

The Mysteries of Health Gain 99
The notion of health gain is now common currency in discussions of health policy: but what exactly does it mean and what are the obstacles which lie in the way of applying it?

David Hunter

Purchasing, Priorities and Rationing 106
The creation of purchasing authorities charged with the task of meeting the health needs of their residents within limited budget, raises the question: how should they go about determining how best to use the resources at their disposal. Economic techniques provide part of the answer.

Ray Robinson

Accountability and Control in the NHS 117
The accountability of the NHS has always been contentious. The introduction of the reforms, particularly the introduction of free-standing trusts, has served to emphasise the weaknesses in existing arrangements but, at the same time, has created opportunities for new forms of accountability.

Bill New

The NHS: Church or Garage? 136
The NHS is now more than 40 years old: have its goals changed within that period? In many respects they have not, but during the 1980s new goals have appeared which are hard to reconcile with the original ones.

Rudolf Klein

Reshaping the NHS: From Radical Reform to Continuous Change 141
What changes can be anticipated in the next five years to the NHS and the context in which it operates? The short answer is, a great many, so many indeed that the NHS seems set for a period of continuous change rather than one-off reform.

John James

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Part 1 Main Events 1

A critical account of the main policy changes during 1993/94

1.1 Creating the New NHS 1

Further steps were taken to develop the 'new' NHS with the creation of more trusts and more GP fundholders while in London the process of shifting the balance of care from hospital to other services began to take shape.

1.2 Community Care 7

At long last, the main provisions of the community care part of the Act came into effect. There have been both negative and positive reports about its immediate impact. In the field of mental health, however, a number of incidents suggested that changes should be made to the existing policy framework.

1.3 Public Health Strategy 12

The process of implementing *The Health of the Nation* continued, and the first reports of progress towards the targets set in it appeared. But, at the same time, the complexity and magnitude of what the policy involves became even more apparent. It also emerged that, in some parts of the country, existing preventive programmes had been poorly implemented.

1.4 Serving the Consumer 15

The Patient's Charter was extended into primary care and the first monitoring information on the degree to which its targets were being met or missed became apparent. Furthermore, criticism of the NHS' response to complaints led to the appointment of a committee to recommend changes to existing procedures.

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Part 2 Commentary 20

A discussion of long term issues raised by events during the year.

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The Government continued to try to extract more care per pound from the NHS by pressing purchasers and providers to raise their level of so-called efficiency. The means employed however might have the opposite effect. It also continued directly and indirectly to limit the scope of the NHS: what principle if any can be found to justify that process?

2.2 Accountability 31

Investigations by the National Audit Office revealed corruption, and mismanagement in two Regional Health Authorities. The Government responded with new measures to ensure the proper conduct of public business. But other measures may be necessary.

2.3 Equity 36

There were numerous reports during the year suggesting the patients of GP fundholders were getting better access to hospital services. Whether true or not, the debate raised more general issues about equity within the NHS and its relationship to the introduction of an internal market. In some respects market process might improve equity. But a specific commitment to equity in provision would mean a 'nationalisation' of the Service.

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by Howard Glennerster
The introduction of fundholding has been a success in terms of greater efficiency and responsiveness to patients. Objections on grounds of equity are misplaced. The present scheme should be expanded and improved.

Purchasing for Health: The Development of an Idea 50
by Joan Higgins and Jeff Girling
The introduction of the purchasing function was poorly prepared. In practice, the most interesting developments have taken place at local level. To put purchasing on a proper footing, an explicit ethical dimension needs to be introduced, based on the fundamental principles underlying the NHS.

Community Care One Year On: An Implementation Deficit? 57
by Bob Hudson
The community care element of the 1990 Act provoked little fundamental disagreement, but it presents formidable problems of implementation, the brunt of which will be experienced by fieldworkers and, if the reform fails, by users. Whether it will succeed or fail remains far from clear.

Health Care Markets: Abstract Wisdom or Practical Nonsense? 63
by Sean Boyle and Adam Darkins
The internal market as it now stands is far from being a genuine market. If it is to become one changes are necessary to allow new agents to enter the market to provide the key functions of co-ordination and innovation.

A New Blueprint for Hospitals? 72
by Anthony Harrison and Sally Prentice
The present Government has issued no general policy statement on hospitals, but economic, technological and other factor~~s are~~ changing the way that hospitals function, leading to suggestions that the present pattern of provision based on the district general hospital it out of date. Is a new Hospital Plan needed or should area go its own way?

Will Patients 'Be Heard'?: Improving NHS Complaints Procedures 81
by Michael Solomon
The review committee on complaints in the NHS has just put forward a series of measures designed to improve on existing arrangements. While good in themselves, they have not gone far enough.

The Accountable Professional in the NHS 94
by Jane Lightfoot
Professional have traditionally been accountable to their own professional bodies by virtue of entry and other quality controls. But the drive to greater efficiency has imposed a parallel line of accountability through general management: how if at all can the two strands be reconciled?

Changing Clinical Behaviour: Do We Know How to do it? 102
by Nicholas Mays
Experience shows that the results of research are often not translated into clinical practice. That process can influence in a number of ways but none guarantee success. Nevertheless ways of making it more effective can be identified.

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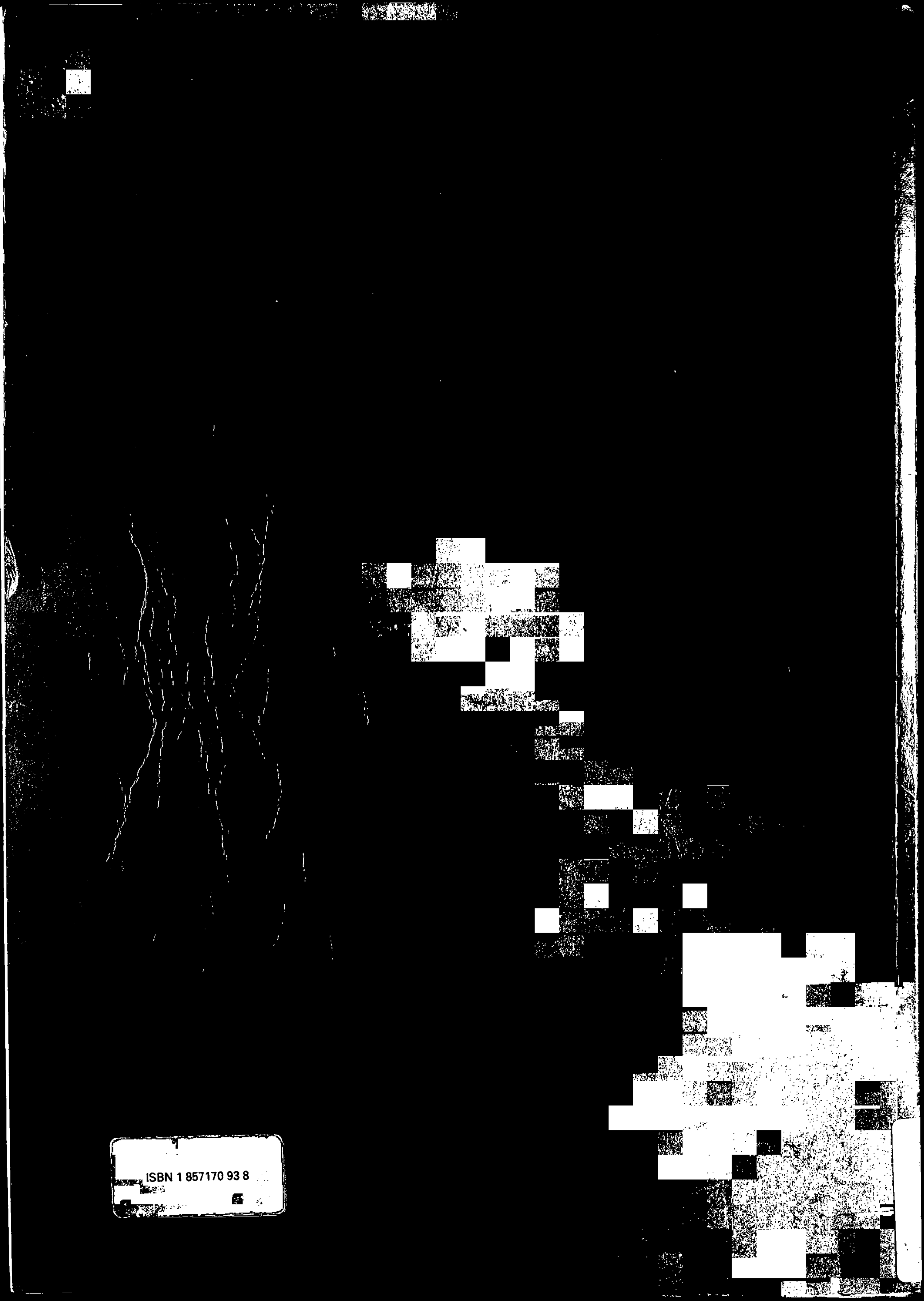

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