# *Health needs assessment in the contemporary NHS*

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# HEALTH NEEDS ASSESSMENT IN THE CONTEMPORARY NHS

## HIGHER DEGREE THESIS

## PRESENTED FOR THE DEGREE OF M.A.

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## ABSTRACT

***Working for Patients***, published in January 1989 and the subsequent NHS and Community Care Act 1990, introduced the most major and complex reorganisation of the NHS since its inception. One of the outcomes of this re-organisation has been the separation of the purchasing and providing functions and the creation of an internal market in health care in Great Britain.

District Health Authorities shed their responsibility for providing health care (this responsibility passing to acute and community NHS Trusts) enabling them to concentrate on their wider role of purchasing health care services which maximise the health of their local population.

The thesis is about health needs assessment for the planning and purchasing of health services, where decisions about priorities and the allocation of resources are based on an assessment of health need.

At the inception of the NHS, 'need' was purely medically defined. In the 1970s formal planning systems and a formula for allocating resources were the mechanisms through which 'need' was identified. The post 1990 reform of the NHS is the focus of the thesis, where health need assessment is undertaken within an internal market in health care.

The Case Study analysis in Chapter 4 considers the practical process of health needs assessment by one regional and two district health authorities using the published Annual Reports of the Director of Public Health.

In the conclusion the point is made that further restructuring of the purchasing process and the increase in the number of GP fundholders is likely to lead to more tensions within the health needs assessment process than there are at present.

# HEALTH NEEDS ASSESSMENT IN THE CONTEMPORARY NATIONAL HEALTH SERVICE

## CONTENTS

## GLOSSARY OF TERMS

| | |
|---|---|
| ACHEW | Association of Community Health Councils for England and Wales |
| AHA | Area Health Authority |
| AIDS | Acquired Immune Deficiency Syndrome |
| BMA | British Medical Association |
| CHC | Community Health Council |
| CHD | Coronary Heart Disease |
| D & C | Dilation and Curettage |
| DH | Department of Health |
| DHA | District Health Authority |
| DHSS | Department of Health and Social Security |
| FHSA | Family Health Services Authority |
| FPC | Family Practitioner Committee |
| GP | General Practitioner |
| GPFH | General Practitioner Fundholding |
| HIV | Human Immunodeficiency Virus |
| HMOs | Health Maintenance Organizations |
| HNA | Health Needs Assessment |
| HCNA | Health Care Needs Assessment |
| ICD | International Classification of Diseases |
| LA | Local Authority |
| LMC | Local Medical Committee |
| NAHA(T) | National Association of Health Authorities (and Trusts) |

| | |
|---|---|
| NHS | National Health Service |
| NHSME | National Health Service Management Executive, renamed 1994 to National Health Service Executive |
| NRHA | Northern Regional Health Authority |
| RHA | Regional Health Authority |
| RAWP | Resource Allocation Working Party |
| SS | Social Services |
| SMR | Standard Mortality Ratios |
| WHO | World Health Organisation |

## LIST OF FIGURES, TABLES AND APPENDICES

## INTRODUCTION

The National Health Service Act of 1946 rested on the principle of collective responsibility by the state for comprehensive health services provided on the basis of equal access for all. The central aim was to provide free medical care to the whole population, and as Aneurin Bevan MP put it

> *"medical treatment and care ... should be made available to rich and poor alike in accordance with medical need and by no other criteria"* (quoted in Carrier & Kendall 1990, p 11).

The Act was the enabling legislation for the creation of the National Health Service (NHS) on 5 July 1948 and was crucial in establishing the pattern of health care in the UK for the following 40 years. The provision of health care by the state on the basis of need has been taken as the theme of this Masters thesis. The title of the thesis 'Health Needs Assessment in the Contemporary NHS' aims to show clearly where the focus will lie.

The thesis will analyse the concept of health care need, and the ways in which assessment of health needs have been perceived and conducted within the NHS since its inception by adopting a chronological approach to developments and consideration of the political environment within which changes have occurred.

The terms 'health needs assessment' and 'health care needs assessment' are used loosely and often interchangeably within the NHS and in this thesis. The premise adopted in the thesis is that although health needs assessment (HNA) is carried out by the NHS, other agencies have a responsibility to respond to, or meet the health needs of the population by, for example, the provision of clean air and water and safe working conditions, so that people are not subjected to hazards and risks which result in ill health and the need for health care. Health care needs assessment (HCNA) is that element of the health needs assessment process which the NHS has control over, and not just influence on; which is to ensure the provision of health care services which meet the needs of individuals and populations, and services which seek to prevent the occurrence of ill health and medical needs. This will be returned to in more depth in Chapter 1.

This thesis is specifically about health needs assessment for service planning, purchasing and contract setting, where the outcome of the assessment of need is used to decide priorities and allocate resources. It is the assessment of the population's health needs which are of interest in the planning and purchasing of health care services to meet them. District Health Authorities as purchasing organisations are the focus of this thesis. General Practitioner Fundholders as purchasers have not been specifically addressed.

The assessment of the population's need for health care in the 1990s has been given a higher profile by two parallel developments which took place in the late 1980s. The first was the review of public health in the form of ***Public Health in England*** (HMSO 1988), and the second was reform of the National Health Service proposed in ***Working for Patients*** (HMSO 1989). The former report recommended that directors of public health be appointed to be responsible for assessing the needs of their local populations. The latter report suggested that such assessments should be part of the priority setting process and a core function of purchasers in a newly reformed NHS. Within both of these publications the underlying view of the concept of need was that it would be used to decide on priorities and allocate resources. This priority setting exercise would be undertaken within financial constraints and in the belief that needs for health care are infinite and cannot all be met. Priority setting would thus become the rationing of services.

The thesis will address a series of questions intended to identify how a reformed NHS is carrying out its new functions of assessing the population's health needs and purchasing health care services to meet them. This will be done through a case study approach using the Annual Reports (and other documents where available and relevant) of a Regional and two District Directors of Public Health within the Northern Region.

Four particular issues will be considered in this case study exercise:

1) the way in which national policies are dealt with at the regional and local level

2) the process of health needs assessment adopted at the regional and local level and the interface between regional and district authorities

3 the results of this health needs assessment exercise in terms of prioritisation of health care services purchased at the local level

4) the extent to which explicit rationing of services is being considered by the authorities.

In Chapter 1, **"Exploring the Concepts"**, 'need' is discussed in general and in the context of health and health care. This chapter will seek to clarify the concepts and definitions used in assessing needs in order to provide a framework within which health needs assessment can be discussed.

In Chapter 2, **"Reviewing the History of the NHS from a Needs Assessment Perspective"**, a chronological approach is adopted to discuss the history of needs assessment in the National Health Service from its inception in 1948 to the publication of the White Paper ***"Working for Patients"*** in 1989. The variety of different approaches to needs assessment not only relates to the dominance of the medical professionals involved in this, but also reflects historical concerns. The period of rational planning in the late 1960s and 1970s left a legacy of the idea of a comprehensive review of services. During the period of the RAWP (Resource Allocation Working Party) review and subsequent policies (1974 onwards) the focus of attention was on the differences between localities, which although useful for reforming the distribution of funds between localities said little about what sort and level of service was actually required. The agenda for needs assessment in the 1990s is expressly about defining the nature and level of services required to care for and improve the health of a population.

Although there is inevitably some overlap of the periods chosen, the opportunity has been taken to discuss the developments and changes which have occurred over the past 40 years and identify where the concept of need and needs assessment has featured in this evolutionary process.

The three periods covered in this chapter are 1948 to the 1960s, subtitled "Establishment and Growth" ; the 1960s and 1970s, subtitled "Planning and RAWP"; and the 1980s, subtitled "Managerial Ascendancy". This last section will conclude with an introduction of the White Paper ***Working for Patients*** in 1989 and the structural changes to the NHS which were proposed and subsequently enacted.

The pressures within the NHS and the reorientation of welfare state policies during the 1980s leads us to the subject of Chapter 3, **"Health Needs Assessment in the Internal Market".**

This chapter considers four aspects of the NHS reforms: the introduction of a market philosophy in health care, touching on the likely consequences; the purpose of health needs assessment in the reformed NHS; the techniques for rationing in an internal market; and the relevance for the process of health needs assessment of the Government's priorities as contained in ***Health of the Nation*** and ***The Patient's Charter.***

Chapter 4 **"Case Study Analysis",** presents a discussion of the Annual Public Health Reports produced by two District Health Authorities and a Regional Health Authority and examines the processes and criteria by which Health Needs Assessment is being carried out on the purchasing side of the NHS.

Reference has been made in this chapter to supporting documentation where this is available and relevant. The Annual Reports analysed span the years 1989 to 1993.

Although Case Studies cannot 'prove' anything, their purpose in this thesis is to illustrate how the process of health needs assessment and its outcome is being driven forward within one specific locality, the guidelines which have been produced to inform this process, and the interface between the various authorities responsible for carrying it out.

Chapter 5, **"Conclusions"**, provides a view on the future of Health Needs Assessment within the NHS.

## CHAPTER 1 EXPLORING THE CONCEPTS

This chapter will explore and seek to clarify the concepts and definitions of need, health and health care need in order to provide a framework within which a discussion of health needs assessment can be undertaken. The relationship between needs, wants, demand and supply, and the definitions of health and social care will be outlined.

### (i) Concept of Need.

> *"it is often from a misunderstanding of the nature and imprecision of need that many of the NHS problems have come ...*
> *needs are those demands which in the opinion of the doctor require medical attention. That is, they are an expert's view of our health state"* (Cooper 1975, p 20).

Whilst the Beveridge Report of 1942 (regarded as the precursor to the 1946 NHS Act) refers to conquering the five Giant Evils of Want, Disease, Ignorance, Squalor and Idleness, by the post war period the emphasis had shifted to 'meeting needs.'

The health service at the time of its creation in July 1948 was, ideologically at least, dedicated to the concept of meeting need; 'to each according to his need'.

According to Iliffe, the meaning of the word need had been assumed, not analysed, so that in practice it shaded into consumerist 'wants' on the one hand and into professional judgements of priority on the other (Iliffe 1983).

In 1948 there appeared to be nothing confusing about the term "need" as applied to the National Health Service. The aim of the newly created NHS was to satisfy, or at least respond to, medically defined need. Although as Iliffe suggests, the concept of need was never defined, it was interpreted as an ability to benefit from the use of the NHS. A need for medical care existed when an individual had an illness or disability for which there was an effective and acceptable treatment or cure. The medical profession would have the task of determining need in individual cases and preventing abuse of the system by those not genuinely in need.

However, the medical profession soon found that health care needs were not finite (or at least that resources fell far short of meeting those needs) and thus they found themselves fulfilling the role of assessing relative needs and rationing scarce health resources amongst them (Cooper 1975, p9). The purpose of health needs assessment has, from the inception of the NHS, been linked to the rationing of resources or services, this rationing initially falling to medical practitioners who exercised value judgements in deciding who would benefit from the health care available. The circumstances in which judgements were made were open to numerous influences; from the doctor's medical interpretation of the relative need, to the patient's ability (or otherwise) to articulate his or her needs, to the availability of the services to meet the need. As A J Culyer suggests ,

> *"The making of value judgements lies at the heart of medical care delivery in general, is crucial to the concept of the NHS and is the very essence of establishing the meaning of the word need"* (Culyer 1976, p 44).

Although the concept of need is central to the NHS, there is a continuing difficulty in arriving at an agreed view of what constitutes need which can be operationalised in a way that is useful to the planning of services.

Per Erik Liss in a philosophical study of health care needs, identifies three senses of need: need as a difference, need as a tension and need as an object. Need as a difference - the teleological need - is, he suggests, the most basic concept and the one discussed in this chapter. It is defined roughly as the difference between an actual state and a goal. He summarises the significance of the goal of need in the following way -

*"a) a goal (G) is a necessary condition for there to be a need*
*(b) the thing needed is a (necessary) means to G and therefore,*
*(c) what someone needs is determined by G*
*(d) G is the justifying component in the concept of need"* (Liss 1993, p46)

In other words, need is instrumental. There is a need for health care when there exists a difference between an actual state and a goal, and health care is necessary to reach the goal.

Liss goes on to suggest that the definition of need is open; it is an abstract concept of need that is defined. The openness or abstraction is due to the unspecified goal and the difficulty in using need in social policy and planning is due to this openness.

Similar sentiments on the difficulties of the use of need for policy and planning purposes are expressed in the writings of influential economists such as A J Culyer and his colleagues. Culyer felt that the word 'need' was an 'incubus' on the back of any serious student of the NHS or of health problems in general and argued in 1972 that

> *"... the word 'need' ought to be banished from the discussion of public policy, partly because of its ambiguity but also because ... the word is frequently used in 'arbitrary senses ... indeed ... in many public discussions it is difficult to tell when someone says that 'society needs' ... whether he means that he needs it, whether he means that society ought to get it in his opinion, whether a majority of the members of a society want it, or all of them want it. Nor is it clear whether it is 'needed' regardless of the cost to society"* (Culyer, Lavers and Williams 1972, p67).

Alan Williams, seeking to abandon the language of 'needology' (a term he was responsible for coining) and introduce instead the language of 'priorities' (not 'rationing' although this would fit well with economic theory), says

> *"We are in the business of making judgements about the relative values of different potential benefits to different potential beneficiaries and we are not helped in that difficult intellectual and political task by thought-stopping terms like "need" which incite 'on-off' thinking rather than 'more-less' thinking"* (quoted in Bradshaw 1992).

Jonathan Bradshaw suggests that need is a modern concept and points out that it is a word having no equivalent in ancient Greek or Latin (Bradshaw 1992).

Twenty five years ago he devised a classification of need which is still widely referred to in discussions of health needs. This classification distinguished between four types of need for a service:

1. Normative Need - defined by experts, professionals, doctors, policy makers. Often a standard is laid down and compared with the standard that actually exists.

2. Felt need - want, desire or subjective views of need which may or may not become expressed need. This can be assessed by asking the population whether they feel they need a service.

3. Expressed need - felt need translated into (action) i.e, demand

4. Comparative need - obtained by studying the characteristics of the population in receipt of a service. If there are people with similar characteristics not in receipt of a service then they are in need.

A classification system is a useful tool in planning services where the concept of need is introduced for the purpose of allocating resources or deciding priorities; in Liss's terms, classifying needs in accordance with the importance of the goal. However, Bradshaw's classification was never intended to be used to prioritise services. He did not imply any hierarchy of different types of need. What it can do is to lead us to look closer at the complicated relationship between needs, wants, demands and supply which is the subject of the next section.

### (ii) Health, Health Needs and Health Care Needs.

Moving from a discussion of the general concept of need to a more specific discussion of the concepts and relationship of health, health needs and health care needs, the thesis continues with Liss's argument that there is a need for health care when there exists a difference between an actual state and a goal, and health care is necessary to obtain the goal, the goal being improved health. Health, however, is subject to many interpretations. In terms of understanding the implications of health needs for health policy and planning, some reference to the debate on the definition and concept of health is required. It is, however, acknowledged that this cannot be dealt with in any depth or very extensively in this thesis. The discussion therefore will be limited to a brief exploration of the two models of health which Bradshaw distinguishes and a consideration of these in the light of the World Health Organisation's (WHO) definition of health. In 1946, WHO defined health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity" (WHO 1948) a definition which is still widely used. In 1985, the WHO further widened the definition to

> "*the extent to which an individual or group is able on the one hand to realise aspirations and satisfy needs and on the other hand, to change or cope with the environment. Health is therefore seen as resources for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources as well as physical capacities*" (Health Promotion 1986, p114)

These definitions have been criticised not only for their all-inclusiveness, but also for the difficulties in using them in any measurable way.

Bradshaw distinguishes broadly two models of health - a social model and a medical model - each, he argues, having rather different consequences for the understanding of health needs and their implications for health and social policy (Bradshaw 1992).

The social model of health, as exemplified by the 1985 WHO definition, not only encompasses curative medicine but also prevention, recovery and rehabilitation. It also focuses on the interaction between health and the social structure. In this model

> "*need is not an absolute state, not just an untreated condition, not just an impairment or a disability but also an absence of well being or quality of life ... meeting need is not just the treatment of disease but whether the quality of life is enhanced as a result*" (Bradshaw 1992 p 7).

Bradshaw lists a number of problems associated with the social definition of health and the resulting priorities for the health service.

> *"First the agenda for the health service would become hopelessly ambitious if it aimed to deal with the wider definitions of health ... second, there is the argument that the association between poverty and ill health is not sufficiently well understood to plan effective interventions ... third, there is the argument that ill health is not entirely the consequence of structural factors which might be adapted by social policy"* (Bradshaw 1992 pp8-9).

The medical model of health views health as the absence of clinically ascertainable disease. "Need" in this context would be the presence of disease which is treatable. The medical model emphasises cure rather than prevention, disease rather than promotion of health and welfare, and the treatment of the individual rather than intervention in social conditions. Mooney quotes the observations of Kosa and Robertson, that to most medical doctors, the question of defining health and ill health is of little if any relevance.

> *".The practising physician ... tends to regard health, illness, disability and death in their concrete relevance ... definitions of health and illness appear to him as matters all too abstract and removed from the current problems"* (Mooney 1986,p 22).

The current problems are presumably those presented by the individual patient seeking advice and treatment. The perspective of the doctor here is with the medical needs of the individual which may seem, and may be, far removed from the task of improving the health status of the population. This may be a more manageable model of health, but with advances in medical technology, it will still be associated with potentially huge needs for and demands on health services.

Not only is there continuing debate on the definitions and conceptualisations of health, there are also different views on the concept of health care need. Liss puts forward four categories of health care need - the ill health notion, the supply notion, the normative notion and the instrumental notion.

The characteristic of an ill health notion is that a need for health care is identical with a deficiency in health that is perceived to require medical attention. Such a need exists irrespective of whether or not there is any acceptable treatment for the deficiency.

A J Culyer advances the supply notion of health care need (which Liss quotes) with the following definition of 'need for health care' :

> " *A need for health care exists when (1) the potential for avoidance of reductions in health status exists; (2) the potential for improvements in health status above the level it would otherwise be exists ... the definition is a quasi supply concept; a need exists only if a procedure has a positive expected outcome"* (Quoted in Liss 1993, p33).

The existence of acceptable treatment is a necessary condition in the supply notion. If there is no acceptable treatment there is no need. Liss points out however that in 1991, Culyer had accepted the idea of an unmet need (Liss 1993).

Also quoted by Liss is a similar view of health care need advanced by G K Matthews. Matthews states

> *"A need for medical care exists when an individual has an illness or disability for which there is effective and acceptable treatment or care"* (Quoted in Liss 1993, p 33).

The above views are summarised by Liss as -

> *"A need for health care exists when (i) the individual has an illness or disability and (ii) there is effective or acceptable treatment or care for this illness or disability ... the supply notion of health care need* (Liss 1993, p 40).

Liss argues however that the proponents of this view fail to distinguish between 'there is a need' and 'the need should be met'; and that there can be a need for health care even if the need (for whatever reason) cannot be met.

The 'normative' view of health care need considers the beliefs and opinions of the assessor as a defining characteristic. According to the normative notion, a need for health care exists when the 'assessor' believes that health care ought to be provided. Magi and Allender define need for medical care as

> *"The type and amount of medical services an assessor believes ought to be utilised for a particular health related condition"*
> (Quoted in Liss 1993, p35)

Liss identifies two categories of assessor, the affected individual and the physician (provider); but increasingly there is a third category in the NHS today and this is the manager as either a purchaser or provider. The role of the manager is an issue which will be discussed in Chapter 2.

The normative view of health care in Bradshaw's taxonomy (that which is defined by experts) has held sway since the inception of the NHS. However, this has not been an unchanging expert view for as Cooper suggests,

> *".. need is in any case a medical opinion not a medical fact ... collectively the medical profession re-assesses its conception of need in line with actual levels of provision"* (Cooper 1975, p 23).

The normative notion comprises the idea that health care need is a matter of opinion. The identity of the assessor is included in the definition and whether a health care need exists or not depends on the beliefs of the assessor.

Liss's fourth category of health care need, the instrumental notion (where need is the difference between an actual state and a goal), is characterised by the idea that the health care is needed to reach a desired state. He quotes MacStravic's view that health [care] needs can be defined as

> "*The manpower, equipment and facilities determined by organisations and communities to be requirements for maintaining and improving health" (*Quoted in Liss 1993, p 39).

Liss makes three interesting points regarding this definition.

> *"First, health needs refers to the thing needed, not to, for instance, a deficiency in health ... second, the assessor of the health needs is an organisation or community - not a client or a provider... third and most important the health care (manpower etc) are requirements for something - for maintaining and improving health"* (Liss 1993, p40).

Before looking in more detail at the Need, Demand, Supply relationship and definitions of health and social care needs, it is necessary to consider further the distinctions to be made between health need and health care needs.

The Department of Health in May 1991 produced a paper entitled **Assessing Health Care Needs** which contained a section on terminology. In discussing the terminology used in the growing debate on health needs assessment, the report made two distinctions. The first distinction between the need for health and the need for health care, and the second distinction between Need - Demand - Supply. The following definitions were offered.

> *"The need for health is a broad term typically measured by health questions in health surveys, surrogate measures such as deprivation indices, and relative measures such as standardised mortality ratios - all measures which do not easily translate into what can or should be done to improve health. The need for health care is much more specific. It is dependent on the availability or potential availability of health care and prevention services to respond to the disease or risk factors and to secure an improvement in health, ie the ability to benefit from effective health care or prevention measures".*
> ( NHSME 1991, p4).

This definition is attributed to A. J. Culyer. Culyer, as suggested previously had some difficulty in coming to terms with the concept of need, but was finally convinced that *"it {is} an indispensable and profoundly useful tool of both analysis and policy"* (Culyer 1976, p1).

The new health care purchasers (in this thesis the focus is on District Health Authorities) have to measure the population's need for health care at the local level. According to Stevens and Raftery, the question to be resolved by health authorities concerns not so much who is needy, ie the need for health, but who needs what services, i.e. the need for health care. Frankel (quoted in Stevens and Raftery 1994) suggests that the unnecessary confusion surrounding the use of the terms health need and health care needs should be dealt with by labelling the need for health care as 'health care requirements'.

Health economists suggest that an approach to needs assessment which equates need with ability to benefit offers a clear advantage over an approach which equates need with illness, (Liss's ill-health notion). They suggest that the way forward in needs assessment for the NHS is that the defining criteria should be ability or capacity to benefit, a definition which will feature in the following chapters.

Mooney refers to a *"defined but ill specified relationship between health (however defined) and health care"* (Mooney 1986, p 22). The capacity to benefit from use of the NHS leads us to agree that a service cannot be 'needed' if it has no capacity to benefit patients, or alternatively a service is needed only in as much as it can improve the health status of patients and ultimately populations. Conversely, Liss's view that there can be a need for health care even if the need cannot be met either through inability to treat because of the current state of health care knowledge or because of resource constraints, produces a difficult dilemma for the NHS. What is to be done with the patient whose condition can only be relieved, where the benefits are only marginal or short term, but perhaps at considerable cost? Changes in technology, diagnostic procedures and advances in drug therapies will over time enable an even wider range of needs to be met which at present may not be capable of being met. Central to the discussion of the differences between health needs and health care needs is the effect of extraneous influences on health status - air pollution, unsafe working conditions, poor standards of drinking water, low road safety standards. Remedying the ill effects of these influences falls to the NHS but eradicating the causes of the resulting ill health is not within the remit of the NHS. This point is central to the issue of the difference between health needs and health care needs.

The need for health care is much more specific than the need for health. The population's ability to benefit from health care depends on the potential of preventive or treatment services to remedy (or alleviate) health problems. Those problems can be risk factors, diseases or disabilities and handicaps.

Stevens and Raftery produced the following explanations to show the importance of individual components of the definition of need.

> *"Components of the definition of need*
>
> ** the population's ability to benefit from health care equals the aggregate of individuals' ability to benefit. For most health problems this will be deducible from epidemiological data, rather than from clinical records*
>
> ** the ability to benefit does not mean that every outcome is guaranteed to be favourable but rather that need implies potential benefit which on average is effective*
>
> ** the benefit is not just a question of clinical status but can include reassurance, supportive care and the relief of carers. Many individual health problems, especially infectious diseases and long-term disabilities, have a social impact via multiple knock-on effects or via a burden to families and carers. Consequently the list of beneficiaries of care can extend beyond the patient*
>
> ** health care includes not just treatment, but also prevention, diagnosis, continuing care, rehabilitation and palliative care"* (Stevens and Raftery 1994, p5).

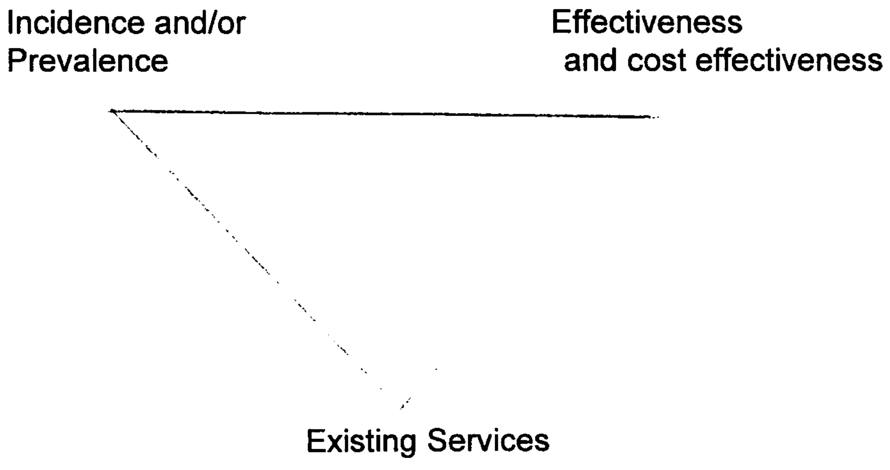
Population health care needs assessment thus includes both components of incidence and prevalence on the one hand, and the efficacy and effectiveness of whatever the health (or other) services can do for them on the other.

Besides information about incidence and prevalence and effectiveness, Stevens and Raftery add a third component to the needs assessment process which is information on the services currently provided. Changing provision for the better necessitates knowledge of the existing services, both to know which services ought to change and to identify opportunities for the release of resources to enable the change to happen.

These four components, incidence and prevalence, health service effectiveness and knowledge of existing services form the basis of Stevens and Raftery's "triangulation" of needs assessment, whereby purchasers can determine the policy directions they wish to pursue. These three components will be discussed in more detail in subsequent chapters.

**FIGURE 1 - TRIANGULATION OF NEEDS ASSESSMENT**

Source: Stevens & Raftery 1994, p6



### (iii) Need - Want - Demand - Supply

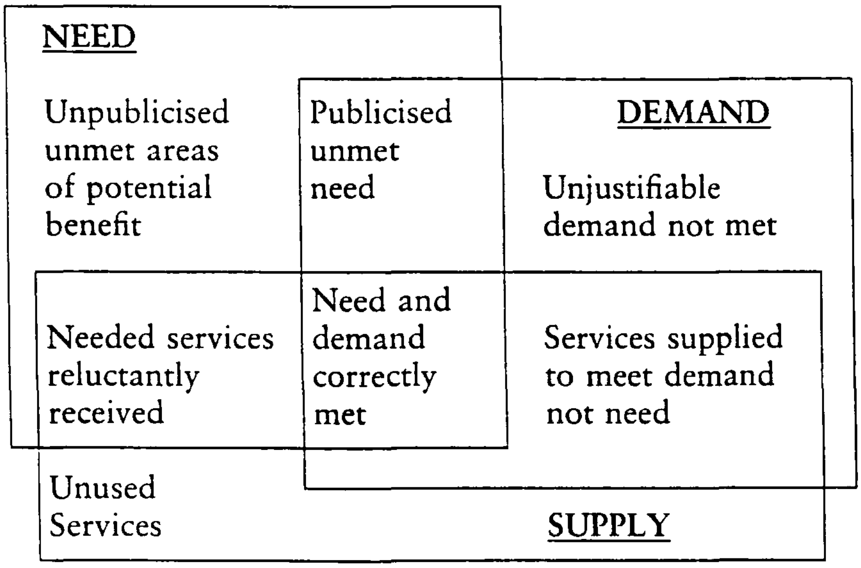
For the NHS the framework within which health authorities operate is determined by the DH or the NHSME. In the 1991 discussion paper previously referred to, the NHSME set down the ground rules for health authorities' approach to health needs assessment. This document made the distinction between need, demand and supply thus -

> *"Need - what people could benefit from*
> *Demand - what they ask for (or in a market place are prepared to pay for) or what their health professional prompts them to ask for; and*
> *Supply - what is provided"* (NHSME 1991, p4)

In diagrammatic form the relationship is -

**FIGURE 2 - NEEDS, DEMAND AND SUPPLY RELATIONSHIP**

Source: NHSME 1991, Assessing Health Care Needs.



In seeking to clarify this relationship, the discussion paper suggests that

> *"The significance of the distinction between need, demand and supply is that it focuses attention on two points. The first is in the difference between services which are demanded and those which are needed. The difference is in the appropriateness and effectiveness of the service, as for example in the prescribing of antibiotics for viral upper respiratory tract infections (demand) on the one hand, and for bacterial infection on the other (need) ...The second point about difference between need, demand and supply is that it clarifies the interpretation of routine (and non-routine) information sources. ... service utilisation rates ... are usually about supply, not need - except in demand led conditions for which there is a proven effective treatment such as for fracture ... and waiting list information is about demand, not necessarily need"* (NHSME 1991, p5).

Alan Mordue, a public health doctor working for the Northern Regional Health Authority produced a discussion paper on Needs Assessment in October 1990 for district health authorities ( NRHA, Mordue 1990).

Mordue used three overlapping circles, depicted in Figure 3, to show the relationship between needs, demand and supply, which he explained thus:

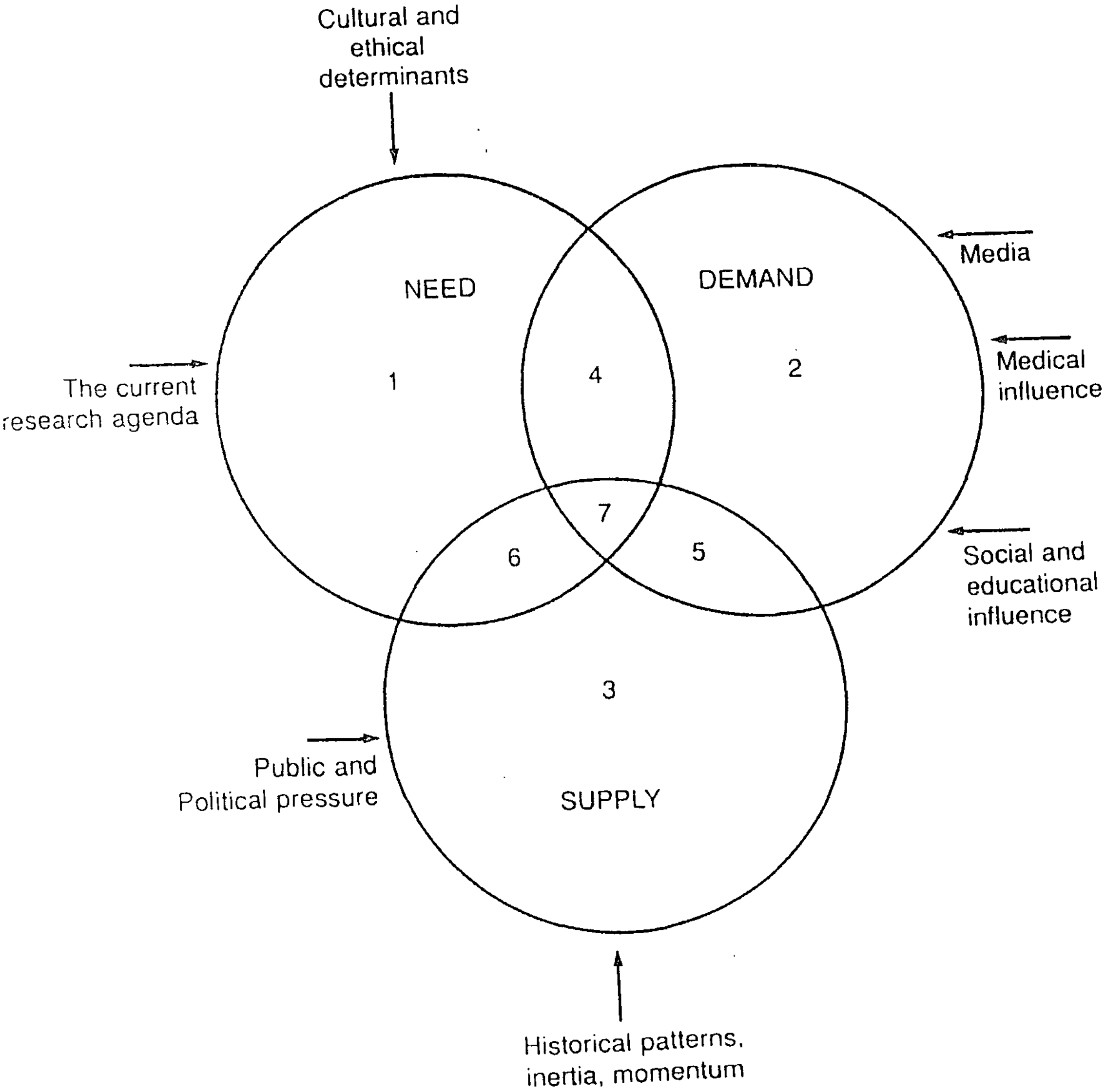
> *"Taking the example of hernia operations, there will be in the community (if we can measure it) ) a certain 'need' for this operation, in other words a certain capacity to benefit from it. There will also be a certain demand expressed in terms of the number of patients "listed" by surgeons for the operation. Finally there will be a current level of service provision or supply of hernia operations. Some people will need the operation, demand it and it will be supplied (area 7 of Figure 3 ), others will need it, demand it but it will not be supplied and they will remain on a waiting list (area 6). Still others will not present to the surgeon, so that no demand will be made, and no operation will be supplied, although they "need" it (area 1) and so on"* (NRHA, Mordue 1990).

In Mordue's opinion the ultimate aim of the assessment of health needs can be expressed very simply in terms of maximising area 7, that is the overlap between need, demand and supply. In advancing some views of need he suggests

> *"... need will involve, for example, examining treatment or consultation rates between different populations* (Bradshaw's comparative taxonomy) *whilst normative need would involve, for example a health care professional such as a manager or clinician defining an appropriate level of need which would obviously incorporate his or her value judgements"* (NRHA, Mordue 1990).

**FIGURE 3 : NEEDS - DEMAND - SUPPLY : Overlaps and Influences**

(Source: Stevens and Raftery 1994, p10)



The inclusion here of the manager's values in what would previously have been a clinical/medical decision is an example of the extent to which the professional monopoly of clinicians in this area has been eroded and is an issue which will be returned to later.

The external influences on the need, demand, supply relationship are self-explanatory. For example doctors' perceptions of benefit will reflect the basis of the current research agenda, which is in turn related to the cultural and ethical determinants of the day. Stevens and Raftery, quoting the Hall and Butler report, refer to the doubts cast on the usefulness of the need for child developmental surveillance which had been accepted since the 1940s. Much of the developmental surveillance formerly regarded as a job which could only be done by trained professionals is now recognised as normal parenting (Stevens and Raftery 1994).

Demand is also subject to medical influences, with doctors affecting patient preferences. The social and educational influences on demands for services are well documented in studies on equitable access to services and inequalities in health across the social classes.

Influences on the supply side, which are often the result of public and political pressures, cover such issues as the raising of public funds for the provision of CAT scanners, to the political pressures associated with the introduction of national screening programmes.

Cooper presents a different relationship which is that between wants. demands and needs. This is presented in diagrammatic form as revised by Mooney who argues that there is a source of need which is independent of either want or demand.

**FIGURE 4 - COOPER'S WANTS, DEMANDS AND NEEDS**

**Revised by Mooney**

Source: Mooney 1986, p.83.

| **WANT** | | **DEMAND** | | **NEED** |
|---|---|---|---|---|
| **An Individual's own assessment of his health state. His 'want' for better health** | → | **Those of his wants that the individual converts into demands by seeking the assistance of a medical practitioner** | → | **A state of health assessed as in need of treatment by a medical practitioner. Not all needs will find expression demands** |

According to Mooney, need may be

1. Demanded and wanted
2. Undemanded and wanted
3. Undemanded and unwanted

There is perhaps a fourth grouping of need not included in Mooney's diagram and that is need which is demanded but unwanted. Patients normally initiate the use of resources, i.e. make demands, by requesting advice or care or treatment . This may not be true of patients compulsorily detained in mental hospitals or re-settled into the community. For such patients, demands for treatment may be made by the medical profession or society collectively, which the patient does not want, does not demand but in the judgement of others may need. A recent example highlighted in the media is the debate as to whether continuing treatment and medication of schizophrenic patients living within the community should be enforced.

The way in which Mooney reconciles need with demand is through an 'agency relationship' in which the doctor acts as the agent of the ill informed patient. Without empirical data, Mooney says, there is no way of ranking the priority that the medical practitioners will attach to the three types of need he has identified (Mooney 1986). The medical profession is clearly seen as the prime assessor of the health care needs of the patient. Whilst as individuals we may initiate our entry into the system, as patients we place our reliance on the doctor (the expert) to perform two roles on our behalf - one to make a diagnosis of what is required, and two to arrange for the provision of the necessary services (Mooney 1986). The role of the assessor as previously suggested, is therefore an important one.

The principles of allocating health care in accordance with need is increasingly being seen as too vague and fails to allow the adoption of a rational approach to resource allocation or planning of services. If there is a general acceptance that it is impossible to meet every need when allocating scarce resources (assuming one accepts the view that resources for the health service are scarce) then it becomes necessary to assign priority to certain categories of need, or alternatively to meet every need only to a certain degree. The practical problems of setting priorities for health care are numerous as priorities can be determined by means of various criteria. Whilst one would expect the principles to be based on the type of need or health problem, it is possible, Liss suggests, to follow the principle "first come first served" or the principle of lottery. The individual's age, social worth, achievements, degree of responsibility for his illness are examples (cited by Liss) of other types of criteria which could be used (Liss 1993).

The medical profession is more ready to question treatment for heavy smokers, the general public question health service expenditure on drug abusers or the victims of HIV and AIDS; a physiotherapist ends treatment on an elderly patient because of the dubious benefit the treatment is said to give. These are all examples though small in number, of health service issues which have featured recently in the national press. They may reflect changing attitudes amongst professionals and the public on how 'worthy' different groups of patients are of health service provision, which could be a spin-off from the 'victim blaming' approach to health care of the mid 1980s. What they do reflect is the opening up of the wider debate on the issue of rationing of health services and the questions of who gets what services.

A further dimension to the debate on needs assessment was introduced by the White Paper "***Caring for People***" published in 1989. This contained a requirement for health authorities and local authority social services departments to define the terms 'health care' and 'social care'. There were two principal reasons for requiring such definitions. Firstly to establish responsibility and accountability for the provision of particular services, and secondly to indicate budgetary responsibilities for the provision of the services falling into these two categories.

A Working Group established by NAHAT in 1992 (***Care in the Community: Definitions of Health and Social Care - Developing an Approach***) chose to approach the definitions of health care and social care by looking at the tasks undertaken for clients (patients) in a range of settings. The tasks were then categorised as health care, social care or both/either, dependent upon which service (health authority or local authority) was seen as being responsible or accountable for the task. The conclusion reached was that the work undertaken did not allow for the type of definition "health care is ...", or 'social care is .....", and in any event, any such definition was likely to be of limited help in practical terms.

What did emerge from this work was a swathe of 'grey areas' which could be seen as the responsibility of both or either statutory authority. Whilst the emphasis is that service provision for the client should be seamless, ***Caring for People*** brought an added consideration for health authorities in their task of needs assessment, in that they would be redefining some of the services they currently provided in terms of health care or social care. One example of this is the provision of personal hygiene services (e.g. bathing) in the past carried out by district nurses but often now following appropriate training, carried out by home helps employed by social service departments. Another much broader example of this redefining of care revolves around the question of continuing care for elderly people. Can the care currently provided by the NHS be redefined because it is essentially meeting a social need rather than a health need and should, therefore, be provided by Local Authority Social Services or through private residential or nursing home care?

Social services departments have lead responsibility for assessing and meeting the needs of individuals within the community and for those awaiting discharge from an acute hospital. Packages of care are put together involving health and social services (and occasionally the private, voluntary and not for profit sector) to enable the individual to remain in or be discharged back to their own home. Hunter (quoted in Titterton 1994) suggests that for local authorities strapped for cash it will be in their interests to give most attention to people in need of support who are already living in the community, rather than attend to the needs of those individuals who are in hospital but who may be better provided for in the community. Local authorities may take the view that if such people are in hospital then they are at least getting some form of support and care which will not be the case in respect of those living in the community who are lacking any support. Difficult decisions will need to be taken in respect of priorities and the allocation of resources, which the NHS will have to be closely involved with.

***Working for Patients*** has forced health authorities to embrace health needs in a systematic way and develop models which they will use in their need assessment process. These models will have to accommodate the health and social care divide, the relationship between need, demand and supply to see how the three can be made more congruent, information on effectiveness and public perceptions of services. The outcomes sought from such a model are to move from historical patterns of service provision and spending to services which are effective, meet the assessed health and health care needs of the population and lead to health gain. The case studies will endeavour to identify the models which district health authorities are developing.

# CHAPTER 2

## REVIEWING THE HISTORY OF THE NHS FROM A NEEDS ASSESSMENT PERSPECTIVE

### Introduction and Summary of the Chapter

This Chapter will cover three overlapping periods of NHS development and will attempt to link each period with the concept of need and needs assessment prevalent at that time.

During the period of 'establishment and growth' (1948 to the 1960s), the model was that of health care needs of the population being met by the state through a comprehensive range of free medical care available to all on the basis of "medical need".

This is followed by an era of 'rational planning' starting in the early 1970s which, in trying to meet the health care needs of the population, alighted on a formula which was intended to produce a more equitable allocation of financial resources to Regions and Districts. Needs assessment in this period was based on global measures of health and surrogate measures, such as data on mortality and socio-economic deprivation, to compare the needs of different places and populations and consider the distribution of NHS resources in the light of these.

Our third period, 1980s - 'Managerial Ascendancy', is one where managers are clearly seen as agents of the Government in delivering policy and objectives, and playing a key part in the challenge to the dominance of the medical profession and of solely medically-defined need in the service. At the end of this decade we see the introduction of market principles into the NHS which are intended to make the service more efficient and lead to the more effective use of resources based on a systematic assessment of need, which, according to the rhetoric, will also deliver choice to the users of the service.

## (i) 1948 TO THE 1960s - ESTABLISHMENT AND GROWTH

July 5th 1948 saw the culmination of a prolonged debate on the nature, organisation and scope of the future provision of health care. On this date Britain became the first country in the world to offer free medical care to its entire population, through the creation of a National Health Service (Carrier & Kendall 1990). It was an acknowledgement of the state's responsibility for its citizens; a Health Service which was based on the rational and planned provision of services according to need (Morgan et al 1991). A number of assumptions were made which took on the property of myth, one of them being that the absence of the price barrier would ensure that those in need would come forward and seek treatment, and those providing the care would know what was required and would provide the best treatment to meet the medical needs. A further assumption that there would be no conflict of interest between the patient and the professional who could adopt a collective orientation untainted by self interest, has been somewhat undermined by the practice of the professionals who see their allegiance to the individual patient. The conclusions reached from these assumptions were that the professional knew just what resources were required to treat individuals, the administration would ensure that these resources were available, and the organisational arrangements would be made to facilitate the professionals activities (Carrier & Kendall 1990).

However, the debate taking place prior to the passing of the NHS Act 1946 was not about the concept of need but about how the service was to be organised and financed. If we look at the situation which the newly created National Health Service inherited, we find that {from an organisational perspective} hospitals and medical practitioners were unevenly spread across the country. The war had left the local authority and voluntary hospitals under-equipped, suffering from bomb damage and with no obvious source of finance to correct this. Health care provision available in hospitals and in primary and community health care was fragmented and haphazard.

Generally speaking, the population was one in which it was becoming more common to reach old age, in which fewer children were being born but more children were reaching maturity than at any previous time. Measles, whooping cough, and diphtheria were still major dangers for children and in early adult life tuberculosis was the principal cause of death. The systematic provision of immunisation and vaccination, still relatively new services, would contribute to the further reduction (if not eradication) of these early deaths.

The introduction of a National Health Service, with the state as primary provider, was seen as continuing and extending the state's responsibility for promoting the health of the people, a practice dating back to the Public Health Act of 1848, which was a major landmark signifying acceptance by the state of a responsibility for public health issues. The new National Health Service was to be universal, egalitarian and collectivist.

Margaret Whitehead suggests that the NHS was built up of at least eight components that could be said to be equitable or fair.

> *"Universal entitlement : Everyone is entitled to health care. There are no eligibility hurdles or means tests to overcome before being able to claim that right. Being universal also means there is no stigma attached to using it, as there sometimes is with systems designed just for the poor. ...*
>
> *Pooling of financial risks : Funding of the system through general taxation means that financing is linked to ability to pay, ...*
>
> *Free at the point of use: Detaching the use of the service from the ability to pay for it, removed financial barriers to access. Coupled with the pooling of financial risks it also removes the fear of being burdened with overwhelming costs if serious illness or disability occurs. ...*
>
> *Equality of access to a comprehensive range and geographic spread of services:...*
>
> *The same high standard of care for all : The notion of a two-tier service - basic for the poorer sections of the population and a superior level for those with more power and influence - was rejected...*
>
> *Selection on the basis of clinical need: This recognises that publicly funded services should be available to all on the basis of need, rather than social or financial status and that when resources are scarce allocation will be on an equitable basis.....*
>
> *The non-exploitative ethos of the service: The high degree of integrity and altruism of those working for the NHS has been*

> *noted...The perception that they do not have overt financial incentives to exploit patients for profit can provide health professionals with a source of pride in their work ...*
>
> *Bevan's 'feel-good factor': Some go further and suggest that a benevolent feel-good factor is important in continued popularity and public approval of the NHS ... first articulated by Aneurin Bevan "Society becomes more wholesome, more serene and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but all their fellows have access, when ill, to the best that medical skill can provide" (*in Robinson and Le Grand 1994, p 208-209).

Whilst one would expect the above ideals from a Labour Party elected with a large majority, the framework for the 1946 Act and the debate surrounding it had taken place well before the election of a Labour Government.

The forerunner to the 1946 NHS Act was the Beveridge Report of 1942 (a war time best seller) which laid down the axiom that a health service must be universal, that the needs of the rich and poor are alike and should be met by the same means.

Beveridge's vision of conquering the five Giant Evils on the road to reconstruction - Want, Disease, Ignorance, Squalor and Idleness - were at the heart of the welfare reforms introduced by the wartime coalition Government and the post-1945 Labour Government which were to provide Britain with in some respects, the most comprehensive social security safety net in Europe. Labour's "Citizen's Charter" of abolition of the means test, national insurance, family allowance, retirement pensions, access to affordable, good quality housing and a National Health Service, offered a combined approach to achieving improvement in the health of the population.

> *"Restoration of a sick person to health is a duty of the state ... prior to any other",... a comprehensive national health service will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary or institutional, general, specialist, or consultant and will ensure also the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents"* (quoted in Klein 1989, p28).

Beveridge clearly had a vision of a unified health care provision which integrated what was then being provided by local government, voluntary agencies and the private practices of the medical profession.

The over-riding fear of the professionals - particularly the General Practitioners - was the wholesale nationalisation of medicine by a Labour Government. The vision of the state owning, controlling and directing the medical services caused the medical profession to take fright. The risk of general practitioners losing their independent status and becoming salaried (and they believed probably poorly paid) staff ensured that they closed ranks in an effort to protect their 'clinical freedom', and their influential position within the system of health care provision being devised. Hospital Consultants, on the other hand, accepted a salaried service but ensured that they retained their ability to practice privately, and that as part of a national health service, they would not be managed by local government. For all the posturing on both sides the dispute was not about the aims of a National Health Service, which were the provision of a preventive, curing and caring service to all, but about the means of achieving them.

The structure which emerged in 1948 was one of administrative and political compromise and according to Klein (1989), represented a victory for the values of rationality, efficiency and effectiveness; it was designed to be the instrument of national policies for delivering health care in a rational, efficient and fair way across the country.

The tripartite structure which was adopted was a monument to the influence and power of the medical profession. The nation ended up with a split rather than unified service, free, but with private practice and General Practitioners retaining their independent status, clinical freedom and, although constrained, a choice of where they would practice. The medical profession also retained their representation at all levels in the planning and delivery of services. The most controversial aspect of the legislation was the decision to vest almost all hospitals in the Minister of State for Health; in effect the nationalisation of the hospitals which was to perpetuate the division between general practitioners and specialists.

However, a rational model according to Morgan et al would have been one of regional services developed in accordance with local needs, financed by and accountable to local government (Morgan et al 1991). The case for local government control was based on a view of the world -

> *"anchored in the values of localism, a view which stressed responsiveness rather than efficiency, differentiation rather than uniformity, self-government rather than national equity"* (Betts 1993, p55).

The Local Authority public health tradition was well established. By the time of the outbreak of the second world war, local authorities had developed responsibility for a large part of the hospital service, public health services and a range of community health and personal social services. Local authorities were the only part of the health service which had developed a specific responsibility for the prevention of disease, and preventive and social medicine was controlled almost entirely by local authorities through Medical Officers of Health and their departments (Betts 1993)

The decision not to place all health services under the control of the local authorities was at least partly due to the opposition of general practitioners and hospital doctors to control from local authorities, as they were then and still are, primarily concerned to maintain their status as independent contractors. Also there was a need to bring the organisation of the hospitals under central control because of the financial problems of voluntary hospitals and the lack of overall planning. It may also be the case that medical officers of health had a poor reputation amongst hospital doctors and general practitioners, and they were loathe to be managed by them (Betts 1993).

The NHS Act of 1946 took hospitals out of the hands of the voluntary sector and local authorities and their administration was taken over by regional boards (except for teaching hospitals which were to be administered by boards of governors) and hospital management committees; GPs and dentists came under the control of executive councils while environmental and personal and community health services remained in the hands of local authorities.

Local authorities retained responsibility for the provision of health centres, maternity and child health services, midwifery services, public health nursing (health visitors) home nursing, vaccination and immunisation, and ambulance services (Betts 1993). Most of these services were already technically provided in part or whole by local authorities. Local authorities would no longer be the main authority in treating ill health, although through their direct provision of services such as housing, environmental health and those listed above, they still remained the most important authority in preventing ill health and maintaining good health. According to Betts, it is essential to recognise that without the involvement of local authorities even though it was uneven, the major improvements in health that took place in the late 19th and early 20th century would not have happened (Betts 1993).

The medical profession and its model of health became dominant and health and health services were viewed as separate from those services provided by local authorities. Less recognition and importance was attached to the role of local authority services for maintaining and improving health. With the transfer of medically oriented tasks to the NHS it came to be viewed as the major provider of health services and health care came to be seen in terms of the medical model of health. The models on which health and local authority services developed reflected their different approaches to solving health problems. The development of health services in the NHS was based on an individualistic approach, while local authorities emphasised collective action. Medical services were increasingly seen as the primary way of meeting health needs. In terms of the focus of this thesis, it is important to emphasise that health needs were equated with health (or medical) services.

There has been a permanent tension in the relationship between the politicians and the medical profession. According to Klein, implicit in the structure of the NHS was a bargain between the state and the medical profession. Central government controlled the budget, doctors controlled what happened within that budget. Financial power was concentrated at the Centre with politicians making decisions about how much to spend; and clinical power at the periphery with doctors making the decisions about which patients should get what kind of treatment (Klein 1989). The clinical autonomy of the medical profession cushioned the policy makers, who could claim that decisions about treatment were not political issues but reflected clinical judgements.

Although individuals usually took the first step of approaching the health services, need was primarily professionally defined at the point of contact between medical practitioner and patient and then translated, if felt to be appropriate, into demands on the service. The General Practitioners, although providing directly the care and treatment for most people coming to them, also acted as the gatekeepers to secondary services. In a perverse way, they became instrumental in ensuring that the acute side of the service retained its supremacy in terms of resource allocation. Being the first port of call for the patient, the GP's assessment of the patient's needs was crucial for the further development, financing and administration of health policy. If a GP, on the basis of medical need, referred his or her patient to a hospital specialist or for diagnostic testing, this carried substantial resource implications. Although there have always been large variations in referral rates amongst general practitioners, there is no indication that GPs restrained their referral to these services, even though the costs of the NHS continued to increase. Klein makes the important point that consumer demand (as measured by contacts between patients and general practitioners) has fallen during the years the NHS has been free at the point of contact (Klein 1989). What has increased dramatically is doctor determined demand (Allsop 1984). Whilst doctors had the clinical freedom to act on behalf of their patients they did not have complete financial freedom and they had to make rationing decisions about which patients could benefit most from additional use of a service if they were referred on. Such judgements cannot be value free. Allsop quotes from a study on the choice of patients for renal dialysis and transplantation which found that recipients were likely to be between the ages of 15 to 45, without other health problems, married with children rather than single. Others were likely to be refused treatment (Allsop 1984). The professional expertise and subjective judgements of the medical profession went largely unchallenged. How they were selecting their priorities for treatment was often based upon what services were available to meet the specific needs of the patient who presented, and the qualitative judgement they made about whether the patient would benefit from the use of the service. The ethos of medicine encouraged doctors to concentrate on meeting the needs of the individual in front of them rather than seeing the larger population as the starting point for achieving improvements in health status.

Beveridge had taken the view that improvements in health status would lead to a drop in demand for services and thence a reduction or at least stabilisation in the levels of finance. However, others foresaw that the actual costs of the NHS would depend on how people behaved when the service became available, the amount of unmet need there was within the population, and the changes in the definition of need.

Whilst medical need remained the guiding principle in theory, the practical problems of finance and organisation were again the focus of debate in the 1950s and early 1960s. There was a failure of resources to expand sufficiently fast to keep pace with the rising demands on, and cost of, the services being provided. In May 1953, the Conservative Government set up the Committee of Enquiry into the cost of the National Health Service. The Committee had the following Terms of Reference -

> *"To review the present and prospective cost of the National Health Service, to suggest means, whether by modifications in organisation or otherwise of ensuring the most effective control and efficient use of such Exchequer funds as may be made available, to advise how, in view of the burden on the Exchequer, a rising charge upon it can be avoided whilst providing for an adequate service; and to make recommendations" (*Quoted in Watkin 1978, p34).

The Committee's Report (the Guillebaud Report) was critical of the current system of allocating resource funds for its lack of a consistent long-term objective. However, the Committee's principal conclusion on the NHS overall was that

> *"The Service's record of performance since the Appointed Day has been one of real achievement. The rising cost of the service in real terms during the years 1948 - 1954 were kept within narrow bounds; while many of the services provided were substantially expanded and improved during the period. Any charge that there has been widespread extravagance in the National Health Service, whether in respect of the spending of money or the use of manpower, is not borne out by our evidence*" (quoted in Watkin 1975, p35).

The Committee saw no need to recommend drastic changes in the organisation or financing. The Report offered a realistic description of what kind of health service the nation could expect.

> *... "in the absence of an objective and attainable standard of adequacy the aim must be, as in the field of education, to provide the best service possible within the limits of the available resources ... It is still sometimes assumed that the Health Service can and should be self-limiting, in the sense that its own contribution to national health will limit the demands upon it to a volume which can be fully met. This at least for the present, is an illusion. It is equally illusory to imagine that everything which is desirable for the improvement of the Health Service can be achieved at once"* (quoted in Watkin 1975, pp35-36).

The important point to recognise here is that the Committee identified very clearly that need for health services was likely always to outstrip the resources available. Needs were not finite, and the working off of a backlog of ill-health would do little, if anything, to reduce demands on the service.

During the course of researching the Report's findings, the Guillebaud Committee had found that the information they needed was not available. Their final recommendation was that the health departments should set up a Research and Statistics Department which would consider what information was lacking as to the working of the NHS and how it might best be produced.

This lack of relevant information is an issue which occurs time and again in discussions of the NHS and is a problem for public health physicians and others when they come to embark on a systematic process of health needs assessment in the 1990s.

Having assuaged the fears of the medical profession, stilled the voices of political opposition and established a creditable reputation amongst users, the health service entered the decade of the 1960s in a relatively strong position as a successful example of social democratic welfare provision.

### (ii) THE 1960s AND 1970s - PLANNING AND RAWP

The early 1960s saw expenditure on the NHS increase substantially, and debates about the high cost of the service temporarily faded into political memory. In 1960, total expenditure on the NHS as a proportion of the UK gross domestic product was 3.8%; in 1974 this figure had risen to 5.3% of a larger GDP. Expenditure on services, according to Brian Abel-Smith, appeared to be keeping pace with demand, a situation made possible by a more favourable economic climate. Taken as a whole, the population was receiving a vastly better service than when the NHS started in 1948 (Abel Smith 1978).

This period, described by Abel Smith as one of growth and development and by Rudolf Klein (focusing on the years 1960 to 1975) as one of 'technocratic change', is a period I have chosen to label "Planning and RAWP" as these were major features of these years. It was an era of attempting to improve the matching of need and supply through better planning mechanisms, and without doubt it was also a period of striking medical advances on a number of fronts. New drugs and new diagnostic and surgical techniques were introduced, which, although they resulted in growth in the numbers treated in hospitals, also produced corresponding increases in unsatisfied demand, reflected in, for example, waiting list sizes.

An early attempt in this period to get to grips with the planning of services can be found in the Hospital Plan, published by Enoch Powell, then Minister of Health, in 1962. That plan marked the start of a 10 year rolling plan of hospital construction and attempted to lay down uniform criteria for assessing the need for hospital care for the whole country. It was aimed at the equalisation of service provision through a programme of capital allocation. Hospital provision was so expensive that it dominated all thinking and the emphasis was placed on targets for achieving a certain number of acute hospital beds per 1000 of the population.

The Hospital Plan set the pattern for attempts in the 1970s to introduce national norms of provision and could be seen as the assertion of central authority (albeit heavily influenced by the medical profession) to bring about nation-wide standards. The Plan was based on a comprehensive review, region by region, of the country's hospitals and on a series of estimates of the appropriate ratios of beds to population in the main specialties. The Ministry felt the country had too many hospital beds overall (although there were wide regional variations) and what was required was fewer beds but of a better standard, in the right places and better used. (This view of too many hospital beds is prevalent in discussions of health services for the 1990s and beyond). The outcome was to be a decrease in the number of hospital beds from around 470,000 to 430,000 and the closure of some 1250 hospitals. From the trends then emerging it was estimated that mental illness beds would drop from 3.3 to 1.8 per thousand by 1975; and the requirement for beds for mentally handicapped patients was provisionally put at 1.3 per thousand (Abel Smith 1978). Such a programme of rationalisation raised many questions, not least of which was how the criteria for number of beds was to be arrived at; what functions should be incorporated and where new hospitals should be located.

The new hospitals had an effect on the distribution of finances, as allocations had previously been based on historic spending figures. The revenue costs of this new building programme began to surface in the 1970s and it became evident, according to Abel Smith that the cost of new hospital construction had been seriously underestimated (Abel Smith 1978).

In an attempt to move away from historic allocations, a method of allocating money (to the English regions) was developed in 1970, known as the "Crossman Formula". Half of the money allocated under the Crossman formula was based on the population served and a quarter each on the basis of the number of beds and the number of cases treated. The decision was to move in annual steps towards "fairness" as defined by the formula on the assumption that it would be reached over a period of ten years.

The formula made no allowance for the fact that different regions had different levels of ill health and thus need for services. Although it was criticised for this, at the time there was no agreed method of assessing need on this basis. The transitional period injected an element of caution to ensure that no-one should actually lose resources and would give the opportunity for those 'over-provided areas' to reduce their bed numbers, without any objective methods being available to decide what was over provision.

We can see here the origins of the trend which culminated in the recommendations for the allocation of funding of the NHS contained in the 1989 White Paper ***Working for Patients.*** This White Paper laid down that District Health Authorities would be funded on the basis of their resident population (i.e. an identified population to be served) weighted for population characteristics and the money would follow the patient to wherever he or she was treated.

The 1974 reorganisation of the NHS brought an explicit commitment to deal with the historical inequalities in the distribution of resources in the NHS both geographically and between the acute and chronic sectors; introduced a system of planning and tackled the administrative separation of the hospital, general practitioner and local authority health service.

The particular arguments put forward for the NHS planning system introduced formally in 1976 included the view that such a system would lead to better informed and more considered decisions and contribute to the removal of inequalities and inequities in the provision of health services and in health itself (Lee and Mills 1982).

Under the 1974 NHS reorganisation local authorities lost community nurses, health centres and nearly all their role in health education to the NHS. Environmental health services remained with local authorities, thus separating personal and environmental public health services for the first time. The post of medical officer of health ceased to exist and the role of looking after the health of the local population passed to the community physicians employed by the NHS. The important role of local authorities was only emphasised in terms of their coterminosity with AHAs. There was little recognition that they had a role as providers of health services or in maintaining the health of the population.

Organisationally, the 1974 changes injected a degree of democratic participation by the creation of Area Health Authorities which included elected councillors nominated by their local authority, and Community Health Councils which were established to act as the patient's representative within the NHS. However, Klein suggests that the re-organisation set the 'voice of the expert' into the concrete of the institutional structure even more firmly than Bevan's design had done.

Doctors and, for the first time, nurses obtained representation on the regional and area health authorities and importantly, at the basic unit of management, the District Management Team, the medical profession had the power of veto. As they were the people who in practice determined who got what, it appeared logical to build their participation into the decision making machinery.

In contrast to the 1991 reforms which seem to equate the NHS with acute hospital services, the theme of integration was the hallmark of the 1974 re-organisation, and a recognition of the fact that health care had to consist of more than merely hospital services.

Area Health Authorities, the lowest tier of statutory authority and geographically based, were also self-governing planning units responsible for providing

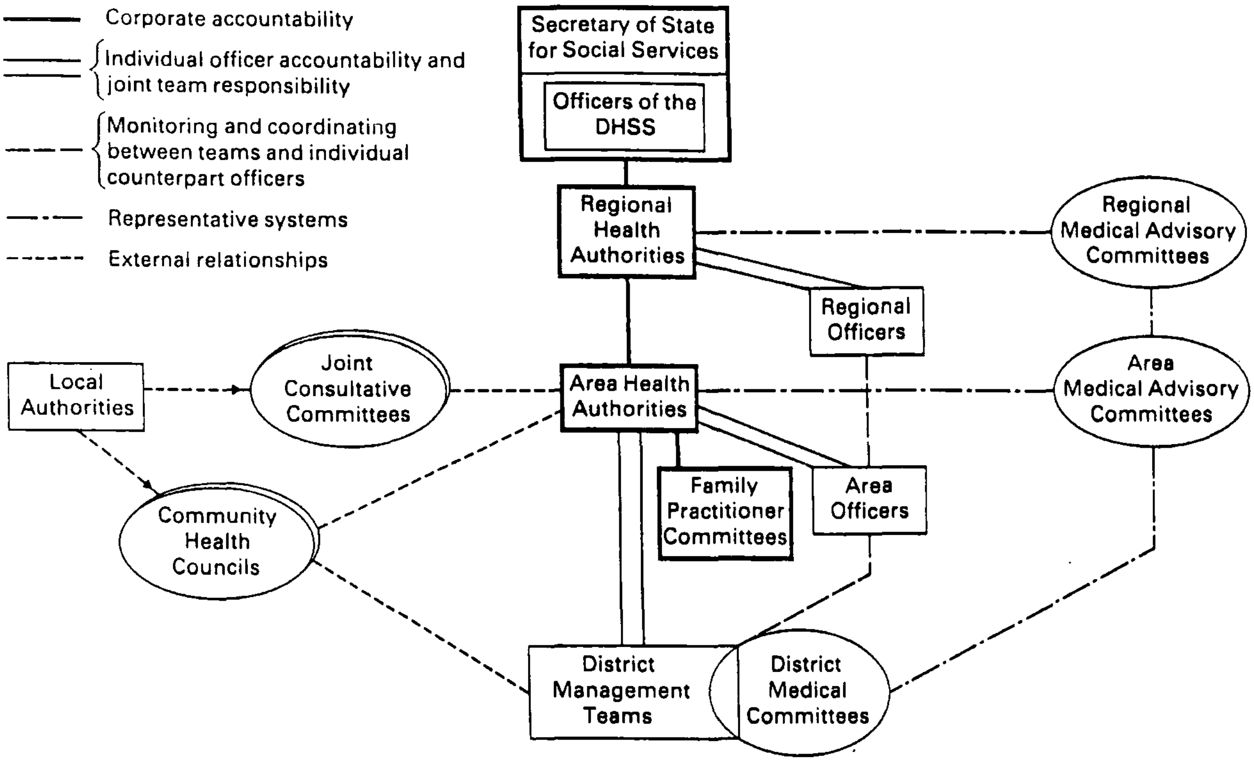
> *"... comprehensive health services designed to meet the needs of the communities within its Districts".* (Mays 1987, p24).

This re-organisation established two types of planning teams at District level, one a multidisciplinary team which would bring together workers in hospitals, community and social services to plan co-ordinated services for those people in the priority care groups. A second team would embrace general and acute hospital services, primary care, and maternity services.

The 1974 reorganisation produced the following structure.

## FIGURE 5 - STRUCTURE OF THE NHS POST 1974

Source: Health Policy and the National Health Service (Allsop 1984, p 62)



Source: Kings Fund Library Information Service.

Community Health Councils, divorced from any management responsibilities and with a membership comprising 50% local authority nominees, 35% elected by voluntary organisations and 15% appointed by Regional Health Authorities, would provide community views on health need and service provision.

Lee and Mills advance two views about the rationale for a health service planning system. One is that planning was seen as the means by which health authorities could learn about the needs of the population to be served and create strategies whereby priorities could be balanced and put into effect within available resources. The alternative view was that planning procedures had more to do with developing a system of management and financial control than with identifying health care needs (Lee & Mills 1982). They suggest that it was possible to see health planning in the UK from the late 1970s as strongly influenced by the government's attempt to come to terms with the rationing dilemma posed by the mismatch between health care needs and resource availability. Hence, planning was seen as an explicit and centralised rationing and control procedure. They go on to say that in terms of the economic aspects of health planning, two particular factors assumed considerable importance; the containment of overall costs and obtaining better value from a given health care expenditure. Which of these two factors assumes prominence within a country at any point in time will depend crucially upon political concerns and economic considerations.

The general approach adopted for the planning of services was through 'care groups' which classified the need for services for different types of patient. The planning system introduced in 1974 provided the mechanism for interagency (ie local authority/health authority) collaboration through the establishment of Joint Consultative Committees (Allsop 1984). Health and local authorities were expected to develop a range of services in the community rather than in residential institutions. In 1976 the consultative document ***Priorities for the***

***health and personal social services in England*** and ***The Way Forward*** published in 1977, outlined targets in terms of spending and service development for the priority services (these being services for the elderly, mentally ill and mentally handicapped people) with relative reductions in the acute hospital services. According to Klein, the general presumption was that it was desirable to lower the unit costs of treating each acute patient (since this was a sign of increased efficiency) and to increase the unit costs of caring for long-stay patients (since this was a sign of improved quality as measured by the input of staff). Klein suggests that although this became DHSS policy doubts remained. What if lower unit costs in acute beds led to lower quality; what if higher costs in the chronic care sector reflected not better quality for patients but more leisure time for staff? (Klein 1989).

Judgements of adequacy or quality, it was thought could not be derived from statistics but had to be based on expert opinion. The DHSS Priorities' documents set out desirable objectives expressed in norms of inputs (beds or nurses) for particular client groups (eg elderly, mentally handicapped). Similarly a programme budget showed the desired shifts in expenditure patterns between different client groups. But these, because of the existing diversity, could not be imposed by the Centre.

> "*Local priorities will naturally be affected by a range of factors - demographic, social and practical - peculiar to individual areas, and it is accepted that local plans will often not correspond to the order of national priorities proposed here {the DHSS 1976 Priorities Document}*" (Klein 1989, p128)

In practice the language of norms and objectives turned out to be merely a vocabulary of exhortation (a very different situation to the post 1989 White Paper where local plans are required to embody national priorities and local targets set for meeting them). The assumed needs of these priority groups were therefore tied up with shifts in spending on these groups and expressed in terms of largely input based targets (Allsop 1984).

The Resource Allocation Working Party (RAWP), also set up in 1974, alighted on a formula that was intended to provide the missing component in measuring need. The RAWP formula only covered the RHAs of England and was based on seven criteria by which the relative need for health care could be established:

*population size
*age and sex structure of the population
*mortality (as a proxy for morbidity or illness) of the population
* cost of providing care
*cross boundary flow of patients betwen health authorities
*cost of medical and dental education, and
*distribution of buildings, plant and equipment (Harrison, Hunter et al 1990)

Except insofar as already reflected by mortality, the formula did not reflect the effect of social deprivation or the need for hospital and community services. It was criticised for this on the grounds that factors such as poor housing, unemployment and poverty have a greater effect on health than other conventional measures included in the formula. Ameliorating social deprivations associated with ill-health was the task of other programmes as a long term objective, not of the National Health Service (Mays & Bevan 1987). The innovative feature of the formula was the attempt to measure the relative needs of regional populations for health service resources and to ignore historical legacies.

> *"In order to use the mortality statistics to relate regional variations in morbidity to the actual need for health care for non-psychiatric inpatient services, RAWP chose to group the causes of death according to the seventeen chapters of the ICD (omitting chapters with very few deaths) and calculated the demand for health care generated by each chapter using the national age/sex hospital bed usage rates for each chapter"* (Mays 1987 p44)

The original objective of the RAWP formula was to equalise progressively the allocation of resources to Regions with similar needs.

For a variety of reasons use of SMRs was not universally accepted. The relationship between mortality and a need for resources was not proven. High SMRs might indicate a need but not necessarily for health care services. It is known that the availability of health service resources is not associated with noticeable reductions in mortality, whereas changes in lifestyle and environment may have more impact (McKeown 1979). The decision to employ SMRs allowed, for the first time, use of factual evidence in place of political judgement to decide which parts of the country were in need of more health care.

Whilst RAWP allocated resources based on some criterion of need, there was no mechanism for assessing the type of services which were needed. In addition, the RAWP formula could not control the resources allocated by ensuring that they were spent on meeting those needs within the districts. This was supposed to be the function of the planning process. What invariably happened in practice was that planning recommendations were interpreted and judged by managers, doctors and health authority members who all had their own agendas. Culyer, as already noted, argues that

> *"the making of value judgements lies at the heart of medical care and is crucial in the concept of the NHS ... It is a question of major importance as to who should be making these value judgements"* (Culyer 1976, p43).

Such judgements had until then largely been made by the medical profession and were rarely explicit. What began to emerge was the involvement of others in this process, and a weakening of professional medical dominance.

The introduction of the 1974 reforms and the adoption of the RAWP formula coincided with a declining economic situation. Whilst the previous 15 years had, relatively speaking, been years of growth and development in the NHS, from 1975 onwards spending increases continued, but at a slower rate, in a very different climate. By 1976/1977 cash limits had been introduced into major parts of the NHS and overspending in any year was taken back the following year. RAWP was left re-distributing a diminishing cake which meant the removal of more resources from previously 'favoured' parts of the country than was intended.

This lack of growth in expenditure coincided with a change in emphasis in health policy with more recognition being given to the promotion of health and prevention of ill health. A recognition that medical intervention was increasingly costly, and the limited impact there had been on mortality rates had prompted policy makers to adopt other strategies. During this period attention was being turned to individuals and the effect of their behaviour on health status. There was a growing belief that health depended increasingly on the behaviour of individuals, a view reflected in the 1976 publication ***"Prevention and Health - Everybody's business":***

> *"Much ill health in Britain today arises from over indulgence and unwise behaviour. The individual can do much to help himself (sic), his family and the community by accepting more direct responsibility for his own health and well being".* (DHSS 1978, p )

In this document a heavy emphasis was placed on the responsibility of individuals for their own health. At its most extreme the position adopted was the crude 'Look after yourself' message, whether that was in terms of diet, smoking or keeping warm. The more sophisticated view adopted the approach that health education for individuals was only one part of a more comprehensive strategy which involved health promoting policies at national and local level. Reducing the effects of the material and social environment on health was no longer seen as a major challenge. This view was in stark contrast to the policy emphasis of the 1940s which identified and attempted to deal with those social, environmental and economic determinants of health which required collective political solutions. At that time the NHS was perceived as an integral part of the newly emerging welfare state apparatus, and a political recognition that the way in which society was organised, and the levels of employment had as much to contribute to improving the population's health, as did the availability of health services.

Any strategy for maximising health requires health promotion, the prevention of disease, the treatment of illness and incapacity and the development of a society which offers a useful and rewarding role for all its members regardless of any impairments from which they may suffer (Jacobson et al 1991). According to Jacobson et al, it is increasingly recognised that harmful environmental influences are continuously changing and are not easily controllable and that individuals' actions are influenced by *"...the social, economic and political environments which lie beyond their control"* (Jacobson et al 1991, p12). The logic of prevention is the transformation of society. It suggests that the imperative of public policy should be the creation of an economy, a society and a working environment conducive to the production of good health as distinct from the production of ill health. If such a policy were adopted, all public policy making would be assessed in terms of its contribution to the promotion of health. A political strategy which embraced the range of determinants of health would suggest the relegation of the NHS to a peripheral role, unless the scope of the NHS was widened to take this analysis into account.

The views of Thomas McKeown had been influential in drawing attention to the importance of personal behaviours as determinants of health. He concluded that the importance of medical intervention in contributing to the substantial decline in mortality had been over emphasised, and identified the main determinants of the decline in mortality from the mid 19th century as being the improvement in nutrition, environmental measures and limitation in family size. His analysis thus identified social, environmental and behavioural changes as forming the major influence. (McKeown 1979)

Taking the view that external influences and personal behaviours form the predominant determinants of health, McKeown advocated a shift in the balance of resources from curative medicine to caring for the sick and disabled and the prevention of disease. Whereas in the past the predominant health needs were associated with poverty in the form of malnutrition, defective hygiene and bad living and working conditions, he suggested the main causes of preventable mortality in modern industrial countries were chiefly those associated with affluence. He thus regarded changes in personal behaviours (in relation to diet, exercise, tobacco, alcohol drugs etc.) as being more important than non-personal measures (e.g. combating food deficiency, environmental hazards) in preventing disease. He placed emphasis on education and increasing knowledge as a means of preventing disease through changing personal behaviours. The argument here is that an individual's health status is largely their own responsibility, and challenges the notion that health needs can be equated,or are even related, to needs for health services.

Thus, from the mid 1970s there was a disillusionment with the dominance of the medical profession, a perceived failure to improve the general health status of the population and a need to contain expenditure. Value for money, efficiency and effectiveness were to become the criterion against which public services including health would be measured in the following decade.

To sum up, four approaches were adopted to provide health services on the basis of need which had been arrived at through a system of rational planning:

I. Resource allocation which was not instrumental or historical but based on a formula agreed by the Resource Allocation Working Party (RAWP);
2. Management structures which would bring efficiency and effectiveness. Consensus management through multi-disciplinary District Management Teams would translate resources into service provision based on objective data;
3. New health authorities and patients' organisations which would be able to articulate the needs of local communities and would inject a degree of democratic participation;
4. DHSS Priorities document which set targets for spending and development of services for particular client groups.

It was not long, however, before the assumptions about service delivery made on the basis of planning and resource allocation were being challenged by a questioning of the efficacy and relevance of the health services provided. Such questioning was increasingly coming from the direction of health service managers.

## (iii) 1980s - MANAGERIAL ASCENDANCY

This decade began with a Green Paper ***"Patients First"*** published in the early months of 1979 and ended with a White Paper ***"Working for Patients"*** published in January 1989.

In ***"Patients First"*** the emphasis was on patients (not yet consumers) and the District Health Authorities were identified as the bodies responsible for determining policy to suit local needs. By 1989 the talk was of internal markets and consumer choice.

The 1979 general election brought into office a Conservative government determined to end what they saw as British decline and the crisis of state authority. An ideological shift from social democratic consensus to market solutions and consumerism in the public sector was to be used to bring about the desired change.

> *"The dominant feature of British society in the 1980s has been Government determination to expand the role of the market, to re-organise the state, and reconstitute the system of social relations ... cumulatively and gradually the NHS has been subjected to processes which have attempted to transform its structure, management and rationale"* (Flynn 1992, p4).

Throughout the 1980s the Government actively sought to cultivate an entrepreneurial orientation within all sectors of British society. According to Maxwell it was somewhat surprising that the NHS, a centrally planned public sector service providing universal access largely free of charge at the point of service, had escaped most of the 1980s relatively unscathed (Saltman and Von Otter 1992).

The Government's overall strategy was one of welfare pluralism and privatisation which required the offloading of as much state provision of services as possible onto the private, voluntary and informal sector. The 'New Right' had linked issues of social welfare to arguments about culture and morality and in so doing had offered explanations of social problems and an agenda for reconstructing the welfare state, the ideological elements of which were market mechanisms; competition between providers; consumers enabled (encouraged) to opt out of state provision; individualism and individual choice taking precedence over collective choices and planned provision; and state provision kept to a minimum.

This philosophy underpinned Government initiatives throughout the 1980s as it sought to 'roll back the frontiers of the state' and diminish the state's role in meeting people's needs. At its simplest, the slogan 'private good, public bad' sums up the approach. For the Government market mechanisms offered flexibility, responsiveness and choice, which enabled them to respond more quickly and more sensitively to 'needs' or at least, to demands.

The range of initiatives introduced into the health service since 1979 have been many, all of them, it is suggested, supporting the above agenda. The 1982 re-organisation of the NHS theoretically devolved decision making to the lowest tier of the organisation. Area Health Authorities were abolished and their constituent districts re-arranged into 192 district health authorities. Fourteen regional health authorities were retained as a strategic planning tier. The professional advisory machinery was pruned and the planning system simplified, although the composition of health authority and management stayed intact.

From September 1983, health authorities were instructed to engage in competitive tendering for ancillary and domestic services, a strategy designed to decrease the influence of organised labour and improve 'value for money'. Cost Improvement Programmes were introduced from the early 1980s with the aim of reducing waste and inefficiency. Districts and Units were instructed to achieve specific target savings. Finally, the hoped for entrepreneurial culture was assisted by the active promotion of income generation schemes.

Saltman and Von Otter suggest that during the 1980s there were three precursor innovations which provided the political and administrative context for the 1988 review of the NHS. These were the introduction of general management in 1984 following publication of a 1983 Inquiry into NHS Management by Roy Griffiths (managing director of the Sainsbury group); the simultaneous introduction of performance indicators and management budgeting and the 1988 report into Community Care (Saltman and von Otter 1992).

The main features of these three initiatives are briefly discussed.

### Introduction of general management

The Government in June 1984 announced its intention to implement the proposals for the NHS contained in the 1983 Griffith's Report. Roy Griffiths headed a Management Inquiry Team which reported in October 1983. His report concluded that the NHS suffered from 'institutionalised stagnation'. It was an organisation where change was difficult to achieve and where there was a lack of clarity about objectives. The NHS could not display a ready assessment of the effectiveness with which it was meeting the needs and expectations of the people it served.

The Griffiths proposals called for a full-time NHS Management Board at the national level and for the replacement of District Management Team based on consensus management (a feature of the 1974 re-organisation) by a more business-like system of regional, district and unit general managers who would be 'in charge'.

The shift in management structure was, according to Saltman and von Otter intended to create conditions for more flexible, entrepreneurial decision-making at the authority level. As part of the effort to encourage entrepreneurial behaviour, general managers were to be hired on short term contracts that would be subject to performance appraisal. The stated objectives of the changes were to achieve increased efficiency and value for money (Saltman and Von Otter 1992).

Built into the general management structure was the 'requirement' for the personnel in these posts to behave as agents for the government. In 1982 Accountability Reviews between Ministers, civil servants, regional health authority and district health authority chairs had been initiated and after 1985 this was extended to General Managers down to the local unit. This review system was evidence of the Government's determination to ensure the full implementation of its policies through the inter-relationship of hierarchical controls.

If one views the Griffiths Reforms in a wider perspective which includes the 1989 White Paper ***Working for Patients*** and the likely changes during the 1990s, the introduction of general management becomes very much a 'strategic reform' in that it was a necessary step in creating the preconditions for a shift from a 'planned' system of health care to a competition driven 'managed' delivery of health care. ***Working for Patients*** in 1989 confirmed general management as a mechanism through which decision-making autonomy and entrepreneurial initiative at the unit and district level could be introduced. Saltman and von Otter suggest that the 'strategic reform' interpretation of the Griffiths proposals views general management as a necessary precursor to the creation of 'planned markets'. The general management reforms became a cornerstone in the Government's efforts to generate flexibility at the operational level within global budgets and political constraints (Saltman and von Otter 1992).

The Griffiths report was to symbolise the post 1982 policy for managing the NHS. It represented a diagnosis of the problems of delivering health care through a publicly-funded service and spelt out a solution acceptable to Conservative politicians. Within two years of publication of the Griffiths Report new management structures were in place in District Health Authorities. General Managers had been appointed at Regional, District and Unit level, many coming from outside the NHS. The potential for greater managerial control over doctors had been created, with the intention of challenging over 30 years of professional medical domination of the NHS. Medical consultants were to be challenged by a new alliance of Government, Ministers and Managers attempting to 'shift the frontiers of control' (Harrison 1988).

## Performance Indicators and management budgeting

The concept of performance indicators (PIs) involved the generation of comparable statistics on service outputs and resource consumption broken down into the functional categories of clinical activity, manpower, finance and estate management. An important way in which managers have attempted to evaluate health care has been through the use of performance indicators. These consist of routinely collected statistics about various aspects of health service provision, most commonly rates of specific activities, such as hospital admissions, lengths of stay, throughput per bed. These are all input rather than output measures. There are only a few indicators that can be interpreted as outcome measures and these normally refer to mortality rather than morbidity (Davey 1993). They were introduced progressively and supplied to health authorities by the DH in computerised form so that local managers and others could get information relevant to them, for example by finding out how their authority compared with others on a specific performance indicator. Table 1 shows where Coventry DHA stood in 1989-90 in relation to the national picture for a number of performance indicators relevant to gynaecology (Davey 1993). Their purpose was not to provide the basis for specific decisions but rather to be an information warning system which could identify potential problem areas for future investigation, especially by identifying variations (Saltman and von Otter 1992).

### Table 1: Health Service Performance Indicators relating to gynaecology in Coventry 1989-1990

Source: Davey et al 1993 (p61)
*Derived from 1989-1990 Health Service Indicators package, Department of Health.*

| | National Average | Coventry Average |
|---|---|---|
| Gynaecology day cases for people aged 16 - 64, expressed as a percentage of what would be expected given national rates | 100 | 121.7 |
| Hospital day-case episodes for people aged 65+ concerning gynaecology, expressed as a rate per 1 000 people in the population (national or district) | 0.450 | 0.660 |
| Cervical cancer annual SMR for females aged 16 - 64 | 99.6 | 171.5 |
| Average length of hospital episodes for gynaecology (days) | 2.5 | 2.45 |
| Number of patients awaiting admission for gynaecology, per 1000 people in the population national or district) | 4.75 | 7.03 |
| Number of gynaecology consultants per 100 000 people in the population (national or district) | 3.02 | 2.28 |
| Number of women aged 35 - 64 who have had a cervical smeal in the last 5.5 years, divided by the number of women in the population national or district) | 68.21 | 85.37 |

The performance indicators generated overly simplistic data since they were not adjusted for case mix or other structural variations among districts, nor were they linked to the quality of outcomes obtained. Rather than simply providing warning signals the data generated were used directly for managerial decision making, particularly to identify areas for cutbacks to achieve nationally and/or regionally mandated cost reductions. In effect, unadjusted raw data were used not to improve management efficiency but to cut back levels of service.

Difficulties in interpreting performance indicators do not however mean they are useless. Armed with a set of indicators a local manager or doctor can begin to enquire into the local conditions that cause variation. Performance Indicators are also potentially useful to managers who wish to influence clinical decision-making

> *"doctors when confronted with evidence that local performance is markedly different from the national average, normally feel constrained to consider why".* (Davey 1993, p 62)

The concept of management budgets (subsequently called resource management) is that medical specialists, by being given responsibility for budgets, help to select and then enforce limitations necessary to achieve maximum benefit from a fixed level of funding.

> "*Since specialists authorise an overwhelming proportion of hospital expenditure one way to increase value for money is to harness these physicians to the achievement of explicitly managerial goals"* (Saltman and von Otter 1992, pp 27-28).

Six pilot sites were chosen to develop the resource management initiative.

However, hospital specialists were not subject to performance appraisal nor had performance linked salaries. Whilst they became more willing to enter into resource related discussions, it was recognised that the financially oriented, rather than clinically and/or outcome oriented information system, and the dominant interest by managers in improved financial results, could dissuade these specialists from future participation in the setting and management of budgets.

Saltman and Von Otter contend that these initiatives (performance indicators and resource management) were not designed as elements of a planned market strategy. In effect they were concepts adopted from the private sector and introduced into an organisational decision-making environment that remained hierarchical in both structure and function (Saltman and Von Otter 1992).

Community Care -

The third precursor innovation is the 1988 Griffiths (the same Roy Griffiths) report ***'Community Care - Agenda for Action'*** which put forward proposals for a mixed market of social care service providers to include private, voluntary and not for profit sectors, as well as publicly operated provision. This conceptual framework for a mixed economy of provision was to be extended one year later to the entire health service.

The Report proposed replacing the collaborative planning machinery of Joint Consultative Committees as the basic mechanism for achieving a co-ordinated local authority / health authority service provision for community care with a market based set of organisational mechanisms and solutions. Local Authorities were to be given a budget and the responsibility only to ensure that care was provided, with the actual service delivery determined via competitive tenders and contracts with the public, private and voluntary sectors. The Report followed the logic of public finance for private provision further by suggesting that local authorities should create voucher systems to allow patients to choose among different providers and in so doing seek to 'maximise choice and competition' ( Community Care - Agenda for Action, HMSO 1988).

This precursor to ***Working for Patients*** contained planned market elements although the scope was limited to the provision of social care through social services departments. It made little provision for resolving the health care/social care divide or for accommodating the planning mechanisms needed to cope with the delivery of services by the private, public and voluntary sectors (Saltman and von Otter 1992).

Flynn suggests that both the 1974 and 1982 organisational changes in the NHS can be seen as stages in a long process of bureaucratisation and rationalisation. Corporate planning and centralised control were introduced and extended to cope with an almost open-ended and professionally dominated health system. As a consequence of general management there had been a fundamental change in attitudes and values and in practices and procedures. The problems for the government in the past had been to obtain greater local conformity with ministerial goals and priorities and greater consistency between different regions. The managerial changes of the 1980s strengthened central control over the NHS and ensured that comprehensive health services, universally provided on the basis of medically defined need, and the organisational and professional structure to deliver them was no longer sacrosanct (Flynn 1992).

After 1985 managers were instructed to become more assertive and directive as agents of government and the "frontiers of control" between doctors and managers shifted in favour of managers (Harrison et al 1988).

Klein reinforces some of the points made by Flynn in his identification of four themes which he suggests were clearly visible from 1983

- sharp turn towards centralisation
- revival of faith in managerialism and bureaucratic rationality
- continuing expansion in private sector and contracting out of NHS services
- growing emphasis on primary care and prevention as part of a wider strategy designed to stress the role of the consumer in exercising choice and responsibility

all of which, according to Klein, can be seen as a response to the NHS problem of money (Klein 1989).

The proposals for a market led system of health care which it was claimed would deliver services based on the health needs of the population and at the same time increase choice for the patient, was launched in the form of a White Paper "***Working for Patients*** in January 1989.

***Working for Patients*** was the outcome of a review of the NHS announced by Prime Minister Margaret Thatcher in January 1988. The background to this review, it is important to remember, was growing concerns about underfunding of the NHS highlighted in the media by crises in large teaching hospitals, notably in London and Birmingham, and a government increasingly on the defensive about the politics and financing of the NHS.

During the course of the review there had been vociferous advocates for radical reform of the NHS. The Institute of Economic Affairs Health Unit advocated a full privatisation model embracing both finance and provision. The preferred model which finally gained the upper hand was one which preserved public financing whilst introducing competition in supply. The Review however had a political genesis and purpose influenced by the right wing of the Conservative Party and was, according to Butler an ideology in search of an application (Butler1992).

There had been no coherent analysis of the underlying problems of the NHS; the diagnosis made by the government at the outset was one of "*chronic system inefficiency resulting from a dearth of market competition*" (Butler 1992, p48).

***Working for Patients*** was published in January 1989 amidst what can be described as an unprecedented propaganda campaign to sell the proposals to all levels of the NHS workforce and, through the media, to the general public.

The White Paper set two objectives :-

> *"to give patients, wherever they live in the UK better health care and greater choice of the services available; and*
> *greater satisfaction and rewards for those working in theNHS who successfully respond to local needs and preferences".*
> (Working for Patients, 1989, pp3 - 4)

Seven key measures were proposed to achieve these objectives which included -

> *"...to make the health service more responsive to the needs of patients as much power and responsibility will be delegated to local level ...*

and

> *...to enable hospitals which best meet the needs and wishes of patients to get the money to do so, the money required to treat patients will be able to cross administrative boundaries ..."*
> (Working for Patients, 1989 p4).

The Prime Minister in her foreword to the White Paper re-affirmed that the NHS would maintain the principles on which it was founded. It would continue to be available to all, regardless of income and to be financed mainly out of taxation.

Klein argues (1989) that the proposals in ***Working for Patients*** fell into two categories. They represented firstly a consolidation of the move towards tighter managerial control and secondly a move towards competition between providers within the framework of the NHS. Tentatively they marked the assertion that public financing of health care, need not necessarily be equated with public provision.

The search for better management again dominated the reforms proposed in this White Paper. The managerial problem in the NHS, according to Harrison et al (1990) fell into three separate though overlapping areas of concern:

> *"attempts to set priorities nationally which can then be made to stick locally; the distribution of resources at a micro level' ... and the management approach deemed most suitable to achieving the first two"* (Harrison et al 1990 p61)

The structural changes to the NHS were threefold. The first was to separate administratively and managerially within every DHA the responsibility for obtaining health care on behalf of residents, from the responsibility of providing the (actual) service components of that care - **the purchaser-provider split.** The second was the encouragement to develop existing hospitals and provider units as organisations for which no district health authority was responsible - **the self governing hospitals or trusts**. The third was to encourage and facilitate the capacity of some general practitioners to make direct arrangements for the supply of and payment for certain clinical services as direct contracts between themselves and provider units - **the establishment of General Practitioner Fundholders.**

The method of generating the market springs from these changes. In such an arrangement the state moves from primary funder and provider to being only primary funder (the health insurance industry still covering only a small part of the population for some of their health care). The provision of services is through a mixed economy of welfare comprising the statutory (self governing trusts both hospital and community), voluntary and private institutions provided through a contractual arrangement with purchasers.

The language of the White Paper insisted that the district health authority's duty would be to

> *"buy the best service it can from its own hospital, from other authorities' hospitals, from self-governing hospitals or from the private sector"* (Working for Patients 1989 p33).

The following statement defines the term best

> *"Health Authorities carrying out their new role as purchasers rather than providers of care will buy in services from the private sector if it offers a better deal than is available from NHS hospitals".* (Working for Patients, 1989 p68)

These organisational changes, however, would not be imposed from the top as in the 1974 and 1984 re-organisations. The Government had altered the incentive structure within the NHS to get change from the bottom (Holliday 1992). General Practitioners could gain autonomy, status and financial reward (such as substantial grants towards the cost of new computer systems) if they opted to become fundholders. Similarly, hospitals and other parts of the secondary care sector could gain independence and become self-governing units able to exercise a range of freedoms including setting their own priorities for service provision if they opted for trust status (Holliday 1992).

A consistent theme of government policy throughout the 1980s was a belief in the superiority of the private sector. A major part of this belief was that it is the competitive environment within which private sector organisations operate which provide the necessary initiatives for achieving greater efficiency. This provided the stated rationale for successive privatisation programmes in different sectors of the economy during the 1980s (Le Grand 1993, p.24) .

This White Paper according to Saltman and von Otter brought the decade long debate over the future of the NHS to a critical juncture. The proposal was to establish a mixed public/private market for the provision of health services, accountable to district health authorities which would be responsible for running this new market on a bid and contract basis. Whilst tax-based finance of the health service was to be retained, a variety of market mechanisms were to be adopted as the means to achieve central governments objectives. Although its content reflected political compromise, the White Paper's intentions were nonetheless to steer Britain's publicly operated health service into uncharted "planned market" waters (Saltman and von Otter,1992, p31).

Prior to 1990, according to Donaldson (1994) it was never entirely clear who was responsible for health care priority setting. As a result of the 1990 NHS and Community Care Act, responsibility for purchasing health care for communities was placed firmly in the hands of health care purchasers, such as health authorities (health boards in Scotland) and GP fundholders. This responsibility will inevitably involve such purchasers in deciding which needs will or will not be met and to what extent. The managerial agenda of the

1980s has, using Harrison's terms, shifted the frontiers of control from the medical profession to managers acting on behalf of central Government, within a new market environment of buyers and sellers of services.

The next chapter continues the discussion on the internal market and its influence on the health needs assessment process.

# CHAPTER 3 HEALTH NEEDS ASSESSMENT IN THE INTERNAL MARKET

The introduction of an 'internal market' in health care with identified purchasers and providers was the central theme of ***Working for Patients.*** Within this internal market health authorities are required to carry out a health needs assessment of their resident population and translate those needs into health service provision. Faced not only with the difficulties of grappling with new concepts of contracts and purchasing, Health Authorities were also directed to meet the national objectives defined by the Government in two publications published in 1992, these being ***Health of the Nation*** which outlined a national health strategy and ***The Patients Charter*** which addressed some of the concerns of individuals using the health service.

This chapter will address four aspects of the NHS reforms which have influenced the health needs assessment process. Part 1 will discuss the introduction of a market philosophy in health care; part 2, the purposes of health needs assessment in the reformed NHS; part 3, the 'rationing' debate and the techniques for rationing in an internal market and part 4, the relevance for health needs assessment of Government priorities in ***Health of the Nation*** and ***The Patients Charter***.

### (i) Need and a market philosophy in health care

The internal market was the phrase adopted by Alain Enthoven, Professor of Public and Private Management at Stamford University, California, (1985) to show that he was proposing a model compatible with public sector provision, "internal" referring to the fact that the suppliers (in the main) are NHS institutions. It was the "creation" of a competitive market on the supply side where providers - public and private - competed for the budgets of largely publicly financed purchasers (Williams 1988).

Enthoven's model drew inspiration from the United States of America, in that DHAs were seen as capable of adopting some of the incentives of the USA health maintenance organisations (HMOs). The key trend in USA health care, suggests Paton (1992), had been the replacement of weak and politically subverted planning in the 1970s by an allegedly pro-competitive strategy in the 1980s.

In the United States, HMOs were developed to reconcile the incentives confronting the provider and the insurer (purchaser) by merging them into one organisation. The HMO received an annual premium for its enrolled patients and in turn was responsible for providing all necessary care to them either directly or through sub-contracting. Competition had been promoted as planning had declined, with its proponents arguing that managed health care organisations could promote managed competition that suited the American culture better than planning.

Paton (1992) argues that there is no intellectual evidence which supports the view that British planning had failed and that competitive markets were needed in Britain. Provider markets were seen by the Government as a means of maintaining public finance at the same time as escaping from what they saw as the bureaucratic system of planned provision. According to Hunter, in an article in the Health Service Journal, comprehensive rational planning had its roots in a public sector ethos, whereas 'managed' competition belongs to the philosophy of the market place, and is presented as the unifying focus by which the traditional values of the NHS can be harnessed to the alleged virtues of the market (HSJ 2 Feb 1995).

The purpose of introducing a market mechanism into the NHS was to improve efficiency and responsiveness. It also created a new role for DHAs (and those GPs who opted to become fundholders) as purchasing agents for their local (or practice) population. The internal market can also be seen as a new political attempt to contain costs and manage the effectively unlimited demand for health service interventions (Harrison et al 1990).

There are six broad categories of players in the internal market - patients, purchasers, providers, regulators, central policy-makers, and GPs (fundholders and non-fundholders). A central idea of the reforms was to tip the balance of power in favour of patients so, logically, if the internal market is to make health care services more responsive to patients, priority should be given to finding out what patients value or want or need. This role is to be carried out by their 'agents', the purchasers (DHAs or GPFH), who will endeavour to meet these needs, wants or values.

This appears to raise two problems. First there must be agreement on who defines the needs of patients and at present several parties are accepted as having a role in defining needs - the DH and NHSME in laying down national targets; regions in setting regional priorities; district purchasers through their needs assessment work; fundholding and other GPs and the patients themselves.

What is not clear is how these different views of needs are to be balanced and whose views are expected to dominate in each set of circumstances. For example when it comes to the allocation of resources there is a trade off between pursuing the national targets of the ***Health of the Nation*** and those of ***The Patient's Charter*** and pursuing locally identified targets. How is this trade off to be made?

The second linked issue concerns who is best placed to identify patient needs and to use the information provided by patients.

> *"To the extent that priority is given to patients' needs as they define them themselves, general practitioner-based purchasing arrangements are likely to produce more responsive markets than arrangements based on larger and more distant agencies. However if patient needs are defined in terms of the health needs of local populations, and public health specialists are the arbiters of those needs, purchasing authorities are likely to be judged better able to contribute to efficient and responsive markets".* (Hopkins 1994 p9)

According to Clive Smee, Chief Economic Adviser to the Department of Health, how the market develops will depend on the categories of purchaser which become most common. He suggests that several underlying types of purchaser behaviour may be identified and labelled thus

> *"protectionists (or cosy relationists): these appear to be primarily concerned to maintain the status quo so far as local providers are concerned*
>
> *autarkists : these appear to be primarily concerned to establish local self sufficiency in as wide a range of services as possible, usually on the grounds that this will minimise patient travelling time*
>
> *monopsonists : these tend to concentrate on driving prices as low as possible disregarding the effect on innovation and potential market entrants*
>
> *furniture movers: these spend so much time changing the organisational structure of purchasing, or talking about it, that they do not get round to any active purchasing*
>
> *catalysts (sometimes called destabilisers): a term commonly used to refer to fundholding GPs who have used their freedoms to shake up the local mould of provision*
>
> *relational activists: those who are trying to build up longer-term relations, but only after carefully surveying the alternatives and identifying providers, including new entrants to the market, who can meet their demanding standards"* (quoted in Hopkins 1994 p12)

Smee's guess is that at present many purchasers fall under the headings of protectionists, autarkists and furniture movers. An efficient market, he suggests, requires that many more develop roles as catalysts and relational activists, and are willing to encourage new entrants to the market to create contestability.

Smee also suggests that any kind of market is possible so long as it is managed or regulated. He sees competition as a means to an end and its opposite is monopoly and not planning as some commentators have suggested. The question which the reforms have to address, he suggests, is how can competition be used to promote efficiency and responsiveness without adversely affecting other public interests of improved health, equity, choice, access and patient influence over decisions. Smee's answer is that in the new internal market, the main way in which these other public interests can be met is through line management of purchasing. In their commissioning role, health authorities remain in a line relationship with the Centre (Hopkins 1994).

The logic of competition between providers is likely to lead to increased fragmentation, with market level units (the trusts) being regulated but not directed by upper tiers of the NHS. It is somewhat ironic that the Reforms have returned the secondary care sector to the uncoordinated state of pre 1948 albeit within a different purchasing structure.

According to Holliday (1992) the 'new' NHS is currently being created through progressive fragmentation and disintegration of the old. In the process, a new set of internal dynamics is being established in Britain's health care system as the balance of power within that system shifts. One aspect of this changing power relationship is discussed in Chapter 2 'Managerial Ascendancy'.

Marketisation is the managerial mechanism currently being employed to undermine professional medical autonomy in the name of choice, efficiency and responsiveness. Whilst there is always a temptation to idealise the 'old' NHS, it never delivered equality of access (the Black Report of 1980 claims that it increased inequalities in this regard, with the well off and articulate securing more benefit from the NHS than the poor and disadvantaged) and it never was unified (Holliday 1992).

Holliday (1992) identifies three strengths of the marketised NHS which are considered below in terms of their link with health need.

- increased choice and autonomy for patients
- increased responsiveness to meet changing public demands (and needs)
- increased efficiency

According to Le Grand (1994) a concern for choice underlay much of the Government's motivation for the reforms. ***Working for Patients*** referred to the importance of giving patients 'greater choice of services available'. The rhetoric of consumer choice in the reformed NHS is somewhat flawed in that an individual's health care is purchased on their behalf by managers of a DHA or a GP, who it is assumed will act in the best interests of patients.

Hunt (quoted by Hudson 1994) defines patient choice as

> *"the freedom of those who are or might become ill to select from a range of meaningful and genuine alternatives in some aspect(s) of treatment and prevention".*
> (Hudson 1994 p53).

On this definition Hudson believes that the likelihood of the quasi market in health care expanding patient choice is slim. The internal market empowers DHAs and GPFHs to purchase health care on behalf of users. However, the system of block contracts placed by DHAs which decide where patients should be treated may lead to less choice than previously existed.

The concept of "cream skimming" was openly discussed as a possible adverse outcome of the reforms and a potentially serious problem in circumstances where purchasers and providers have incentives to be selective about the kinds of cases and social groups with which they deal. For example, there was concern that GPFH's might choose to select cheaper patients and to exclude, if they could, expensive ones. The incentive for provider trusts in dealing with block contracts would be to avoid accepting patients with conditions that required expensive treatment. Under cost per case contracts, providers would have an incentive to avoid patients for whom there was a risk that the marginal treatment costs would exceed the price agreed in the contract. In these circumstances, treatment becomes inversely related to need, rather than directly related as a needs-related interpretation of equity would require (Le Grand 1994).

Freeing health authorities from their responsibility for providing and managing services would enable them to concentrate on measuring needs and determining service requirements. In this way health services would become more responsive to the needs of 'customers'. Measures of responsiveness include knowing how long people with specified conditions had to wait for treatment; or whether hospital patients found the food palatable; or whether doctors and nurses took the trouble to explain to patients the nature of their conditions and what was being done for them (Harrison 1990). These measures of responsiveness form part of the ***Patient's Charter*** which will be discussed in Section (iv) of this Chapter.

Underpinning much support for the 'new' NHS are the claims of increased efficiency which will be generated by it. To the extent to which the internal market becomes purchaser-driven, provider prices, in theory, should be forced down by the pressure of competition and the efficiency of hospital provision should be increased by purchaser power. There is however a problem with this argument when one considers that the location of provider trusts, especially if mergers take place, will restrict the choices available to purchasing organisations.

Holliday (1992) views the weaknesses of the 'new' NHS, as a switch from need to demand; the potential the reforms have introduced to move towards 'top up' payments for services (a voucher system) and a loss of social justice.

A voucher system, with all citizens provided with a voucher to cover the cost of basic NHS services, funding for themselves any provision above this basic level, is completely at odds with the basic distributive principles on which the NHS was founded (***Community Care - Agenda for Action*** suggested voucher systems to allow patients to choose among different providers, see p72). It may however be the only feasible way of increasing overall health spending in future years. The Conservative Party have already toyed with the idea of a voucher system in Education. Although in health the idea has been strongly rejected by Government Ministers, as a logical extention of the internal market it cannot be ruled out for the future.

The switch from need to demand as the main determinant of health outcomes will, Holliday suggests, emerge if the internal market becomes purchaser driven. (He is here making the assumption that demand has not been equated with need in the past). An alternative vision for purchasers is that as they become more expert, their needs assessment outcomes will displace provider produced demand, to be replaced by services which are purchased to meet assessed need.

In the 'old' NHS access to health care was regulated centrally and regionally and administered locally. In the 'new' NHS the situation is fundamentally altered as the old unitary system is fragmented into a series of independent and (semi-) autonomous agents by the creation of GPFH. Psychologically, this fragmentation undermines the notion of a unified service and it enables GPFHs to make innovations in primary care. This increases the likelihood of diversity in primary care, not necessarily a detrimental development but one which could well impact on equity. In addition general practitioners still operate within an illness or disease model, so a major shift will be needed to integrate these fragmented providers (who are now also purchasers), into a coherent health care system (Health Services Journal, 2.2.1995).

It appears that the trade-offs to be faced in the reformed NHS are those of increased efficiency, choice and autonomy for decreased equality and social justice. Le Grand makes the point that ***Working for Patients*** was relatively weak on the language of equity and social justice (Le Grand 1994), whereas social justice was one of the main motivating factors behind the establishment of the NHS.

According to Holliday, (1992) judging between these competing sets of values is extremely difficult. The Government's argument deployed against those whose judgements conflicts with its own, consists of the claim that increased efficiency generated by a quasi-market solution in health will produce gains for all. In this way, everyone will benefit from the reform programme, even if some will benefit more than others. The standard Conservative conviction that efficiency is produced by markets rather than strategic planning is in evidence.

In considering the ideological interpretation of values, we should not forget the political genesis of the reforms which as Chapter 2 shows were clearly ideological. Ideological issues in the provision of health care have been dissected by Alvedi Donabedian (Williams 1989). He polarised attitudes around two viewpoints A and B, which may be loosely termed the 'libertarian' and the 'egalitarian' respectively, illustrated in Figure 7.

In the libertarian view access to health care is part of the society's reward system and people should be able to use their income and wealth to get more or better health care than their fellow citizens should they so wish. In the egalitarian view access to health care is every citizen's right and this ought not to be influenced by income or wealth. Each of these broad viewpoints is typically associated with a distinctive configuration of views on personal responsibility, social concern, freedom and equality.

The implications of these ideologies for priority setting in health care point to a willingness and ability to pay as the dominant ethic in the libertarian system of health care provision, which can best be accomplished in a market orientated 'private' system. On the other hand, equal opportunity of access for those in equal need would be the dominant ethic in the egalitarian system of health care provision. .

The essence of a public service is that it involves some degree of redistributive justice. Unbridled consumer choice in health care expressed through individuals with varying influences and wealth could lead to an unacceptable and unfair distribution of resources. Those in most need might have little purchasing power under such a system. The right of the individual to choose the best health care available as against the rights of other consumers not to be disadvantaged by this choice is the tensions between these two viewpoints

## FIGURE 6 ATTITUDES TYPICALLY ASSOCIATED WITH VIEWPOINTS A AND B

| | Viewpoint A (Libertarian) | Viewpoint B (Egalitarian) |
|---|---|---|
| Personal Responsibility | Personal responsibility for achievement is very important and this is weakened if people are offered unearned rewards. Moreover, such unearned rewards weaken the motive force that assures economic well-being, and in so doing they also undermine moral well-being, because of the intimate connection between moral well-being and the personal effort to achieve. | Personal incentives to achieve are desirable, but economic failure is not equated with moral depravity or social worthlessness. |
| Social Concern | Social Darwinism dictates a seemingly cruel indifference to the face of those who cannot make the grade. A less extreme position is that charity, expressed and effected preferably under private auspices, is the proper vehicle, but it needs to be exercised under carefully prescribed conditions, for example, such that the potential recipient must first mobilise all his own resources and, when helped, must not be in as favourable a position as those who are self-supporting (the principle of "lesser eligibility"). | Private charitable action is not rejected but is seen as potentially dangerous morally (because it is often demeaning to the recipient and corrupting to the donor) and usually inequitable. It seems preferable to establish social mechanisms that create and sustain self-sufficiency and that are accessible according to precise rules concerning entitlement that are applied equitably and explicitly sanctioned by society at large. |
| Freedom | Freedom is to be sought as a supreme good in itself. Compulsion attenuates both personal responsibility and individualistic and voluntary expressions of social concern. Centralised health planning and a large governmental role in health care financing are seen as an unwarranted abridgement of the freedom of clients as well as of health professionals, and private medicine is thereby viewed as a bulwark against totalitarianism. | Freedom is seen as the presence of real opportunities of choice; although economic constraints are less openly coercive than political constraints, they are nonetheless real, and often the effective limits on choice. Freedom is not indivisible but may be sacrificed in one respect in order to obtain greater freedom in some other. government is not an external threat to individuals in the society but is the means by which individuals achieve greater scope for action (that is, greater real freedom). |
| Equality | Equality before the law is the key concept, with clear precedence being given to freedom over equality wherever the two conflict. | Since the only moral justification for using personal achievement as the basis for distributing rewards is that everyone has equal opportunities for such achievement, then the main emphasis is on equality of opportunity; where this cannot be assured the moral worth of achievement is thereby undermined. Equality is seen as an extension to the many of the freedom actually enjoyed by only the few. |

Source : Williams (1989)

when considered in terms of health care. Klein observed that the creation of the NHS

> *..."represented the rejection of the market principle in favour of a collectivist solution ... [which assumes] that there is a collective interest in the provision of health care over and above the self-interest of individual members of society"* (Klein 1989 p 153).

The ideological divide epitomises the 'old' NHS with its egalitarian ethos, and the 'new' NHS which springs from the libertarian mould of 1980s Thatcherism.

Recent guidelines produced by the NHSE on the future regulation of the internal market - ***"The Operation of the NHS Internal Market - Local freedoms, national responsibilities"*** claim that competition stimulates hospitals and community health services to be efficient and respond to patients' needs. They also suggest that the internal market cannot be expected to pursue such important goals as equity of access, quality assurance, public accountability and patients rights. Markets are also seen as weak in securing strategic aims, such as effective teaching and research. For those reasons it is made clear that the internal market will be expected to complement other mechanisms such as professional self regulation, codes of conduct and accountability and the ***Patient's Charter.***

The whole question of whether competition in the NHS is desirable has been somewhat skirted by most writers. Whilst it may be agreed that competition is not an end in itself, but a means, the question as to where, or whether, it is an appropriate means is avoided. There is still talk of collaboration and co-operation in the NHS, but self governing trusts and general practice fundholding increase the problems of coordinating provision with financing, and a co-ordinated delivery requires agreement on priorities and services to be delivered. The architects of the reforms saw the demand for health care as similar to the demand for any other commodity and public expenditure as inherently harmful to the economy, whereas Beveridge saw health care as an investment. It is of no public concern if Marks & Spencer discontinue a particular line, the assumption in the market being that the customer will then go somewhere else and find a substitute. However, if a purchaser of health services were to discontinue a particular line - for example a very expensive service - there would surely be an element of public interest (Hopkins 1994).

In the next section the thesis will consider the purposes of health needs assessment in the reformed NHS.

### (ii) Purposes of Health Needs Assessment in the Reformed NHS.

The purpose of health needs assessment in the reformed 'marketised' NHS is to prioritise service provision, to decide **who** gets **what** at **whose expense**. The **who** refers to different sorts of people, the **what** refers to different sorts of health care, the **whose expense** is however less straightforward. According to Alan Williams, (1989) on a financial analysis the 'whose expense' is who pays the bill and in Britain it is the Government and the taxpayer. In the context of an economic analysis, the 'whose expense' is based on the notion of opportunity cost rather than on the notion of expenditure. It means who is to go without health care in order that others shall have it. There is a reluctance for politicians, clinicians and managers to make explicit the implication that there are some 'low priority' people in the health care system, which means their health care services may be withdrawn (Williams 1989).

Prioritising services on the basis of a more comprehensive assessment of health needs could, suggests Hudson (1994), allow DHAs to target the more disadvantaged groups; adopt innovatiive community health strategies such as Health for All 2000, and actively monitor the health status of the population which would speed up the generation of meaningful outcome data to inform choices and priorities. This will however require a huge cultural and organisational change involving a more central role for previously marginalised specialties such as public health and epidemiology and health education.

District Health Authorities, the organisations which are the main subject of this thesis, were required to appoint Directors of Public Health following the recommendations of the Acheson Report ***Public Health in England,*** (DH 1988) and to produce annual reports on the local population's health. It was this report rather than ***Working for Patients*** which contained the detailed discussion on how health authorities would carry out their new role of identifying the health needs of their local population. The provision of health services was to be informed by an assessment of the population's health needs combined with an evaluation of the extent to which the services provided successfully tackled those needs. The health needs assessment role was not therefore originally linked with the purchaser - provider split introduced in ***Working for Patients***.

The concept which ***Working for Patients*** did introduce was that of contracting between NHS purchasers and providers of care. Contracting, however, was not new to the NHS for there had been competitive tendering for ancillary services since 1983. What ***Working for Patients*** and the reforms did was to increase the scope and significance of contracting. Needs assessment is important in the reformed NHS because contracts between purchasers and providers will specify what is to be provided, the amounts of care to be provided, where it will be provided, at what cost and at what quality of service.

The puchasing remit for DHAs should reflect the public health responsibilities contained in the Acheson Report which were

> *"to review regularly the health of the population for*
> *which they are responsible and to identify problems.*
> *To define objectives and set targets ... to deal with the*
> *problems in the light of national and regional guidelines...*
> *...to relate the decisions which they take about the*
> *investment of resources to their impact on the health*
> *problems and objectives so identified ...*
> *... to evaluate progress towards their stated objectives ...*
> *...to make arrangements for the surveillance, prevention,*
> *treatment and control of communicable disease ...*
> *... to give advice and seek co-operation with other*
> *agencies and organisations in their locality to promote health"*
> (Public Health in England 1988, p19).

Expectations of the ability of public health departments and others to undertake health needs assessment might have perhaps been over optimistic. Bie Nio Ong (1991) suggested that health needs assessment was severely underdeveloped within health service planning and the skills available within public health departments to assess health needs were in short supply.

However, the purpose of health needs assessment was not only about the assessment of health of the population and the needs they have in relation to improving their health but also about

- an assessment of the effectiveness of different policy and service options for meeting those needs, and
- devising ways of allocating resources efficiently to meet identified need.

These are potentially the most beneficial aspects of the Reforms in relation to social inequities in health care. The assumption made by DHAs was that they would be changing health care priorities in line with this process and the outcome of consumer research which they were expected to undertake.

Dr B Mawhinney, then Minister of State for Health made a series of speeches during the first half of 1993 under the umbrella of "'Vision for Purchasing". These speeches set out seven key 'stepping stones' to effective purchasing and were an attempt by the Government to reorient the focus away from Trust status and provider units to the purchasing role of health authorities (NHSME1993).

Whilst purchasers may claim to appreciate the complexities and pressures of their new purchasing role, Malek et al suggest that

> *"purchasers may not fully appreciate, nor want to acknowledge the incremental, highly political and psuedo-scientific nature of priority setting ... priority setting is neither pure science nor clear cut nor wicked politics. It is a highly political proces where values, science, data and argument collide ... if community-based health needs assesment is to be the cornerstone of the new purchasing activity, there must be a much more honest dialogue about the nature, purpose and potential of purchasing"* (Malek 1994 p27).

The purchasing decisions made by health authorities would increasingly be directed towards achieving health gain, defined by Ranade as achieving reductions in mortality and morbidity or improvements in quality of life (Ranade 1994). In the purchasing context, health gain has three dimensions:

> *"the improvement of life expectancy, the improvement in health related quality of life, and the quality of the experience of being a patient"* (Malek 1994, p 32)

In Chapter I, the three components of the population health care needs assessment process were given as incidence and prevalence, health service effectiveness and knowledge of existing services.

The epidemiological approach to needs assessment carried out by public health departments will provide information on incidence and prevalence. Research into effectiveness and cost effectiveness of service options has been assisted by the Department of Health with the publication of a number of "Effectiveness Bulletins" which have provided outcome measures for a range of interventions and treatments within different specialties. These effectiveness studies will begin to impact on contracts in that they provide the medical justification for either ceasing to offer particular services or interventions, or they will prompt authorities to purchase services which previously were not routinely available.

In a similar initiative, the UK Clearing House for Information on the Assessment of Health Outcomes has been set up at the Nuffield Institute in Leeds to establish a Research Centre on outcomes assessment materials, as well as acting as a focal point for information exchange and training on the subject.

Whilst the purpose of health needs assessment is becoming clearer, the status accorded to the health needs assessment function of Public Health Departments by health authorities is not clear (Robinson and Le Grand 1994). There have been massive injections of funds to develop financial and activity information systems but only modest resources have been allocated to work on assessing health needs outcomes.

A study in the Northern Region in 1992 documented perceptions of what is happening in this field at the local level (see Robinson and Le Grand 1994). A qualitative interview survey of chief executives, directors of planning and contracting and directors and consultants of public health in eight purchasing organisatons was carried out. This showed that the assessment of health needs and how it related to other functions of purchasing authorities was perceived as problematic for many respondents. There were divergent stances taken on the subject. At one extreme, a director of contracts dismissed the activity altogether:

> *"I leave all that health needs nonsense to public health ...*
> *it's irrelevant ... I just place contracts and try and get more*
> *out of them than they are giving us at the moment"*
> (Le Grand in Robinson and Le Grand 1994 p227).

Others were said to use it just as a 'fig-leaf' to justify cuts in services. On the other hand, in another district an active project was underway to survey the needs of a very deprived area - assessing health needs in broad terms, rather than from a narrower health care perspective. Another district was working closely with GPs to help identify needs in the population.

The study concluded that progress and attitudes towards health needs assessment were linked to the financial position of the organisation. Those with development money were sometimes using it in innovative ways, but in organisations which had been allocated a reduced budget, there was little prospect for development work and a much more restricted view of the value and relevance of health need assessment - a luxury they could ill afford (Robinson and Le Grand 1994).

What this study demonstrated was that on the one hand, the purpose of health needs assessment was to enable DHAs to purchase services for health gain and to focus on effective interventions which improved health. On the other hand, for those districts facing pressure to meet short term targets, for example those stemming from the ***Patient's Charter,*** and pressure to balance the books with a shrinking budget, the DHA may focus on quick and easy benefits that could be achieved with sections of the population, or on easier to treat conditions, to demonstrate that they have delivered health gain, for example by meeting the targets for hip and knee replacement operations. Groups for whom improvements may take longer to achieve, or require more finance, may be seen as worthy of less priority and little attention.

No matter how DHAs carry out their health needs assessment process, what they are doing is rationing services, and the concern is that health care needs assessment within an internal market will increasingly become a tool by which the rationing of health care is justified. Rationing health care (or prioritising services) has a high profile within the reformed NHS and the next section will address this increasingly important issue.

### iii) The Rationing Debate

There is 'rationing' in all health care systems and it is, in Klein's words "a universal phenomenon" (Klein 1989). Appleby in Light et al (1993) suggests that although rationing and priority setting are often combined it is useful to view rationing as distinct from priority setting. Rationing, he suggests, is the mechanism for allocating health care according to the principles purchasers have set and the guiding or core principles they have adopted. The latter may include notions of equity, commonly formulated in terms of equality of access.

Hunter has argued that to protect politicians from the consequences of their resource allocation decisions, priority setting decisions have largely been invisible and rationing has relied on the four "D" words -

> *"<u>Deterrence</u> - patients are discouraged from making their demands known or effective, possibly through the activities of behaviour of 'street level operators' or gatekeepers like receptionists and deputising services in general practice, and through various other eligibility rules that are put in the way of access to care.*
>
> *<u>Deflection</u> - patients are referred to other agencies via a form of cost shunting eg from health to local authorities, if their needs are assessed to be primarily social.*
>
> *<u>Dilution</u> - this involves a reduction of standards to cope with excess demands; services are spread thinly to ensure everyone gets something rather than concentrated on the most needy cases.*
>
> *<u>Delay</u> - through waiting lists and times and queues"*
> (Hunter, NAHAT, No 8 1993 p 11).

Klein (1989) refers to the all pervasive nature of priority setting in health care systems reflecting the complex interaction of multiple decisions taken at various levels of the organisation. He contends that there is no self-evident set of ethical principles or of analytic tools which allows us to determine what sort of decisions we should take at different levels in the organisation. Firstly, the Secretary of State and officers in the Department of Health bear the responsibility for directing national policies and allocating resources to different areas of the health sector, having decided how much of the nation's wealth should be allocated to the NHS. Secondly, there appears to be a fundamental conceptual problem at the heart of the current priority setting process, in the belief that in some way there is a technical solution which could provide a neutral formula to deliver a definable and scientific list of priorities. In practice, the process will be shaped by dominant ideologies, implicit market oriented values and the political impact of key professionals and pressure groups. There are no perfect solutions or right answers.

Given that resource constraints mean that purchasers cannot purchase all they may like to purchase, the two key questions which health authorities have to face are: What should we purchase? and: What should we forego?

Evidence from a large scale study of districts' published purchasing strategies has clearly indicated that in the first two years of the reforms, DHAs did not really get to grips with setting priorities. Redmayne and Klein found that the most common approach to priority setting, one which was really a continuation of pre-reforms policy, was essentially to make everything a priority. In resourcing terms this translated into 'spreading the money around', however thinly (Redmayne and Klein, 1993).

Whilst one might expect 'prices' to feature in the market relationship, in the NHS they are not allowed to act as a rationing device, as they do in most markets. Public sector providers (Trusts) are restricted in the amounts they are allowed to make on the sale of their services to a 6 percent return on assets. In effect, prices are reflections of costs and cannot vary in the usual market way to restrict excess demand or discourage excess supply.

If price is not an option, what other rationing techniques are available? A traditional rationing mechanism has been waiting lists, but the ***Patients' Charter*** standards are now constraining the extent to which this can be used.

A superficially simple option is to decide not to purchase a service or treatment. But apart from a very narrow range of services (for example in vitro fertilisation, tattoo removal, various forms of cosmetic surgery) very few health authorities have so far explicitly restricted access to defined services or treatments (Redmayne and Klein 1993).

In the "old" NHS access to health care was neither equal nor particularly open, but it was not, says Holliday (1993), a contentious issue - few people seemed to bother about or even notice this aspect of the service (Holliday appears to have forgotten the recurring problems of lengthy waiting lists and waiting times). In the marketised NHS inequity in access has become a more visible aspect of the service, partly because access is a feature of the ***Patient's Charter.***

Two techniques for rationing are discussed in this section: the 'scientific' solution, involving QALYs, and the 'Oregon' solution, with involvement of the public in the decision-making process.

## The 'Scientific' solution.

Mooney (1992) suggests that viewing health needs assessment as part of the priority setting process in the reformed NHS has given rise to two problems. First, it has led to some confusion about the precise purpose of needs assessment within the context of priority setting and second, the assumption has been made that assessing total needs is a 'good thing' seemingly essential to planning health care. Expressions of need synonymous with illness or disease are normally related to total needs and based on an epidemiological assessment of incidence and prevalence of disease in a particular population. Mooney suggests that this has a certain appeal in priority setting as it seems natural that a big killer should be given priority, but it is in most instances a false logic. He advocates the more sophisticated approach to needs assessment, which involves equating need with ability to benefit (the Department of Health definition). Such an approach is reflected in the Quality Added (Adjusted) Life Years (QALY) league tables. Put simply the costs of a health care treatment or programme are compared with the benefits obtained.

The concept of QALYs was one of the tools developed by York University Centre for Health Economics, although it was devised in the late 1970s by the United States Office of Technology Assessment. They are a form of health status measurement which allows life years gained to be brought together with changes in quality of life in a single index. The principle is that if the quality of life can be measured on a scale 0 (dead) to 1(perfect health) the impact of different interventions can be charted.

The following example, based on a heart transplant patient and a patient with leukaemia, shows how QALYs can be used to evaluate different kinds of treatments. The heart transplant patient expected to live for at least 10 years in perfect health, is given a weighting of l; which represents a full quality of life in each of those 10 years. Therefore: 10 x 1 = 10 QALYs.

The leukaemia patient, expected to live for 10 years with only half the quality of life that perfect health would give because of illness and frequent hospital trips, is given a weighting of one half, therefore: 10 x 0.5 = 5 QALYs.

But before decisions can be made on these figures, the cost of treatment must also be taken into account. Suppose £100,000 will provide one heart transplant. Each heart transplant patient has been allocated 10 QALYs. So this sum will provide 1 x 10 = 10 QALYs. Suppose also that £100,000 will pay for five leukaemia treatments. If the sum can provide five of these treatments each giving five QALYs, it will provide a total of 5 x 5 - 25 QALYs. In this case, leukaemia treatment generates two and a half times more benefit than a heart transplant. This does not mean that doctors should not ever perform heart transplants, but it does give some idea of which treatments may be given priority and could be used by purchasing authorities and clinicians to make decisions about the types of treatment that are more effective and give the best value in terms of quality of life.

In Britain the Department of Health has gathered a range of data and produced a QALY league table for nearly 500 interventions. This league table has been presented at conferences (eg the 1993 Conference of NAHAT) but has not yet been published (Malek 1994).

There are many criticisms of the QALY approach; not only technical doubts about measurement but also on moral and political grounds. For example, individuals and groups of the population do not always agree on the valuations of particular health status, raising the question of whose valuations should prevail. The approach does not take account of the number of dependents a patient has, although many would claim that this could be relevant in making rationing decisions. (Davey 1993) Some people have doubted whether there is obvious merit in making all decisions explicit and coherent, arguing instead that idiosyncratic and opaque decision making by doctors may be more humane and democratic (Davey 1993).

In the future however it seems inevitable that decisions in health care will become more publicly visible. The QALY framework is one possible tool available to managers and doctors to assist them in making difficult decisions. The NHS however was founded on the belief that every life has the same value; the concept of QALYs could undermine this.

### The Oregon Solution

A somewhat different dimension to the rationing debate is provided by a public participation experiment embarked upon in the State of Oregon in the United States of America. The 'Oregon Experiment" is described by Davey (1993) as the "*most extreme application to date of an explicit rationing system for health care*" (Davey 1993, p 41). The aim of the Oregon project (which applied only to Medicaid - the public insurance scheme for those on low incomes) was to provide a list of health services ranked in priority from the most important to the least important, representing the comparative benefits of each service to the entire population served (ie the poor). The Commission overseeing the project (consisting of five physicians, a nurse, a social worker and four consumers) had consulted the public by conducting 47 community meetings, 12 public hearings, and a telephone survey of 1001 people. Fifty provider organisations and more than 200 healthcare professionals also took part. After the list had been costed it was passed to the State government which chose to guarantee to pay for all treatments up to line 587. Table 2 gives some examples of the kinds of conditions that appeared at the top and bottom of the list (Davey 1993).

**TABLE 2: Health Priorities in Oregon** (Source: Davey 1993 (p41)

| Top ten health priorities | Bottom ten health priorities |
|---|---|
| pneumococcal pneumonia, bronchopneumonia, influenza with pneumonia | gynaecomastis (benign swelling of the breast |
| tuberculosis | kidney cyst |
| peritonitis (an inflammation of the abdominal cavity) | terminal AIDS-related disease (with less than 10% survival rate at 5 years) |
| foreign body in pharynx, larynx, trachea, bronchus, oesophagus | chronic pancreatitis (untreatable inflammation of the pancreas) |
| appendicitis | superficial wounds without infection |
| ruptured intestine | constitutional (inherited aplastic anaemia) |
| hernia with obstruction or gangrene | prolapsed urethral mucosa (a minor urinary tract condition) |
| croup syndrome or acute laryngitis (upper respiratory ailments) | central retinal artery occlusion (blockage) |
| acute orbital cellulitis (inflammation of tissue around the eye) | extremely low birthweight babies (under 1.3 pounds) and under 23 weeks gestation |
| ectopic pregnancy (embryo implanted outside the uterus) | anencephaly and similar conditions in which a child is born without a brain |

The Oregon Health Service Commission sought to induce an explicit public debate about prioritisation. Indeed the strength of the experiment was said to lie in its concept of public accountability, even though consultation with the public had been limited. Out of a population of 2.5 million, 3,500 people had been contacted representing 0.14 per cent.

The Commission soon found however that the knowledge base for their work was absent, and this lack of knowledge led to the replacement of analysis with intuition. The Oregon priorities are determined by 'guesses' about effectiveness and social judgements about what the Commission calls "reasonableness" (Malek 1994)

In a NAHAT Briefing Paper (January 1992) Hunter questioned whether explicit rationing of the Oregon kind would be a good thing for Britain. He expressed concern that it would distract attention from issues of under-funding and lack of provision and lead to invidious situations where those making the decisions about resources for health care endorsed treatment for conditions arising from certain lifestyles and not others. He also suggested that it enabled the educated well off to express their views whilst keeping the less well off chronic sick in the background, and that it created the illusion of fairness through the use of figures whilst not reflecting the realities of life.

The critics of Oregon dismiss it as being

> " *dangerous nonsense which could lead to a form of 'health fascism' in respect of middle class elites determining priorities on behalf of the poor sections of the community who may well have greater need of health care provision and who do not have the option of going private in situations where public provision is of poor quality or non-existent. Such a development, if it occurred, would be a particular manifestation of the 'inverse care law' in operation, whereby those in greatest need of care received less of it*" (NAHAT No 8, 1993, p5).

The Clinton Administration has given Oregon a waiver from the Federal Medicaid legislation and the scheme has been implemented during 1993-1995 with full evaluation.

Public participation is increasingly seen as an essential component of health authorities' strategy for developing effective priority setting and resource allocation. A somewhat sceptical view would say that by embracing public participation it will enable health authorities to claim that changes in service provision have been legitimised by the opportunities provided for public participation in the decision making. The NHSME in January 1992 published ***'Local Voices'*** and a NAHAT research paper with the same title gave examples of innovative thinking and good practice, providing case study illustrations from DHAs on their approach to involving users in decision making.

One example contained in ***Local Voices*** was a report on City and Hackney (now East London and City) Health Authority which conducted several consultation exercises as part of a research exercise funded by the King's Fund (an exercise which has similarities to the Oregon experiment). One was a large scale consultation process exploring health service priorities within 39 community groups and tenants associations in the District. Another was a postal and interview survey of a random sample of 454 people registered with GPs, taken from FHSA lists, and a third was a postal survey of all 121 general practitioners, 197 hospital consultants and seven public health doctors in the district.

Respondents were asked to list 16 areas of health service provision on a scale of priority ranging from essential to less important. Most of the public seem to have valued high-technology surgery and life saving treatments as the number one priority. For instance, high technology surgery and procedures which treat life threatening conditions, for example heart and liver transplants were ranked number 4 by members of the public, but number 12 by general practitioners, consultants and public health doctors. There were three categories which came at the bottom of the list for all four groups of respondents and these were cosmetic surgery, treatment for infertility, and complementary/alternative medicines. The two services where there appeared to be most disparity was firstly in the provision of services for people with mental illness, where the public ranked this as 8, with the three professional groupings scoring 2, 1 and 1, and secondly in community services/care at home where the public ranked this number 11 as against the professional rankings of 1, 3 and 1.

This survey was telling the health authority that local people valued life-saving treatments at the expense of what they saw as luxury or peripheral services. There was some exploration of people's reasons for their ratings and it appeared that the majority of people emphasised quality of life rather than length of life in terms of treatments. The survey also revealed that people could hold contradictory views, since many people had prioritised as very high those high technology, life-saving procedures that may or may not enhance quality of life (NAHAT No 8, 1993).

Whilst there are various ideas for finding out the public's views there is little evidence as to how these have been used to prioritise services or change or enhance services in those Districts, or how well they stood up against other aspects of the needs assessment process. To counteract any unpopular consequences of the market place and the rationing debate, the central attempts to regulate service provison are through the ***Patient's Charter*** and the National Health Service priorities and targets set in the ***Health of the Nation.*** These are the 'public' faces of regulation, the less public documents are the corporate contracts between DHAs, RHAs and the DH, which to seek to ensure that objectives set locally and regionally are met.

The next section looks at the influence of the ***Patient's Charter*** and ***Health of the Nation*** on the health needs assessment processes undertaken by district health authorities.

### (iv) Influence of the ***Health of the Nation*** and the ***Patient's Charter*** on the Health Needs Assessment Process.

The ***Health of the Nation*** was published in July 1992, following a consultation exercise during 1991, and was, suggests Ranade, the first real attempt to adopt a national strategy for health which provided a set of public health targets (Ranade 1994). It was however greeted with disappointment in many quarters because the issue of tackling social inequalities in health had been practically ignored.

The prior consultation paper had discussed a number of key areas which could be selected as national health priorities and a total of 16 priority areas were discussed. Out of this list five initial priority areas were included in ***Health of the Nation.*** These were Coronary Heart Disease and Stroke, Cancer, Mentally Ill people, HIV/AIDS and sexual health, and Accidents, and a set of national health targets were provided (reductions in suicides, coronary heart disease, accidents and cancers) which had been chosen partly on a needs-assessment basis, which purchasers were encouraged to build into their purchasing strategies.

**TABLE 3: Health of the Nation - a summary of key areas and main targets:**

Source: Ranade (1994, p144)

1. Coronary Heart disease and stroke - by the year 2000

    * to reduce deaths from CHD in under-65s by at least 40 per cent;

    * to reduce deaths from CHD in 65-74s by at least 30 percent and deaths from stroke by 40 per cent;

2. Cancer - by the year 2000

    * to reduce deaths from breast cancer in the screened population by at least 25 per cent ^;

    * to reduce cervical cancer by at least 20 per cent;

    * to reduce deaths from lung cancer in under 75s by at least 30 per cent in men and 15 per cent in women;

    *to halt deaths from skin cancer by the 2005

3. Mentally ill people - to improve significantly the health of mentally ill people and by the year 2000

    * to reduce suicides by at least 15 per cent;

    *to reduce suicides among severly mentally ill people by at least 33 per cent;

4. HIV/AIDS and sexual health

    *to reduce gonorrhoea by at least 20 per cent by 1995;

    * to reduce conceptions by under-16s by at least 50 per cent by 2000 ^^;

5. Accidents - by the year 2005

    * to reduce deaths from accident among children under 15 by at least 33 per cent

    * to reduce accidental deaths among 15-24s by at least 25 per cent; and among over-65s by at least 33 per cent

(All baselines 1990 except ^ 1986 and ^^ 1989)

Previous attempts to impose priorities and create priority groups had made little impact on the distribution of resources. ***Health of the Nation*** embraces explicit priority setting in that the priority areas and targets attached to them were to be the core overall objectives of the NHS, and the performance of health authorities in meeting these objectives would be monitored by regional health authorities. District health authorities in their corporate contracts and business plans would be expected to demonstrate they had developed plans and committed the resources to meeting the targets set.

The ***Health of the Nation*** and the preceding Acheson Report ***Public Health in England***, suggests Holliday (1992), make it clear that British public policy was moving in the direction of a more public health stance.

Health needs assessment is viewed by the Department of Health as essentially epidemiologically based. At the local (district) level public health physicians will be identifying the total needs of the population - the size of the health problem locally - in the context of the five target areas identified in ***Health of the Nation.*** The epidemiological assessment of the public's health needs at the local level will either endorse this national strategy or identify other health needs as being more important. Convincing evidence is likely to be required from Districts for choosing a local public health need as a priority over the key targets in ***Health of the Nation.***

The ***Patient's Charter*** introduced in November 1991 as part of the Government's 'charter' initiatives appears to be an afterthought to ***Working for***

***Patients.*** Ten charter 'Rights' for patients were announced, seven of which re-iterated existing rights of NHS patients with three new ones introduced from April 1992. In addition nine charter standards were announced and health authorities were asked to produce local charters setting more specific local targets for, amongst other things, outpatient clinic waiting times.

The ***Patient's Charter*** provides basic standards against which patients can judge the services they received. A two year inpatient waiting list target to be achieved by April 1992 was given a high priority and extra finance was made available to health authorities to help them achieve it. Some clinicians have argued that this has led to people with more urgent clinical needs being pushed aside (Davey 1993). Apart from finance for this waiting list initiative, no extra resources were released to meet the costs of implementing the charter standards, although meeting the standard for outpatient waiting times could be at the expense of seeing fewer patients and a lengthening list for a first appointment.

According to Paton (1992) the ***Patient's Charter*** is a superficial initiative and an example of centralist regulation which is opposed to the competitive philosophy of ***Working for Patients.*** However, the origins of the ***Patient's Charter*** stem from the consumerism and emphasis on invidiual choice which was the dominant political ideology of the 1980s, although the rights and standards in the charter are more about responsiveness of the service than about patient choice.

The ***Patient's Charter*** shows the Government's determination to ensure that the NHS performs in line with the strategic objectives which have been set nationally and is viewed by some as one of the regulatory mechanisms necessary in an internal market to safeguard equity and access to services.

Insofar as health needs assessment is concerned, the ***Patient's Charter*** presents purchasers with short term targets which they are expected to meet, whereas the ***Health of the Nation*** sets longer-term targets which have to be planned for and resourced. The ***Patient's Charter*** offers opportunities for the public views to be heard as to whether or not services are meeting patients needs, whilst ***Health of the Nation*** targets with their focus on disease and risk require professional knowledge as to whether needs are being met.

The implications for purchasers is that both publications may consume a disproportionate share of resources (finance and staffing) available for achieving improved health. The importance attached by purchasers to these publications will be explored in Chapter 4.

# CHAPTER 4 - CASE STUDY ANALYSIS : HEALTH NEEDS ASSESSMENT AND ITS IMPLEMENTATION

This chapter will address the issue of health needs assessment by adopting a case study approach. This will involve examining the Annual Reports of Directors of Public Health, and supporting health authority publications, at the level of a regional health authority and two district health authorities in the North East of England.

The use of case studies will enable a comparison to be made of the health needs assessment process adopted by the health authorities, and whether or not it has resulted in that authority making changes in service provision or priorities.

Four particular issues (or criteria) wil be considered in this case study exercise in an attempt to evaluate the ways in which health needs assessment has been interpreted and undertaken by these authorities in the reformed NHS.

1. the ways in which national policies are dealt with at the regional and district level
2. the interface between the authorities and the process of health needs assessment adopted at the regional and district level
3. the outcome of the health needs assessment exercise in terms of prioritisation of health care services purchased at the district level
4. the extent to which explicit rationing of services is being considered by the authorities.

The main documents informing the case study are -

Northern Regional Health Authority, Regional Director of Public Health's Annual Reports for 1990, 1991 and 1992

Northumberland Health Authority, Director of Public Health's Annual Reports for 1989, 1990, 1991 and 1992

North Tyneside Health Authority, Director of Public Health's Annual Reports for 1989, 1991 and 1992/1993

Reference will be made to relevant publications of other health authorities, Department of Health and NHS Management Executive, and where available, the business and purchasing plans produced locally which are essential to the analysis being undertaken.

The first publications analysed, dating from 1989 to 1991/1992, are the initial attempts and early responses by the authorities to their new tasks. By 1992/1993 there is a change in the publications in terms of content and format and this will be noted in the discussion.

Moves were afoot from 1990 for the establishment of joint DHAs and FHSAs. Two sets of documents were published in 1990 and 1991 which set the NHS the key task of achieving greater integration of primary and secondary health care. These were "**DH Mission, Goals, Priorities Aims and Objectives 1990 - 1991 to 1993-1994** (DOH 1990) and "**Integrating Primary and Secondary Health Care"** (NHSME February 1991).

This greater integration of primary and secondary health care is of relevance to the health needs assessment process because it is about integrating the purchasing of services by creating the structural framework for involving general practitioners (particularly GP fundholders who, it is asserted in this thesis, purchase care largely on the basis of individual need) into the purchasing process. The views of GPs in needs assessment are increasingly important if health authorities are to retain a strategic view of need and the primary and secondary care services which are required to meet it.

The bringing together of DHAs and FHSAs within a unified management structure accountable to Regions and the NHSE, was a precursor to establishing by statute merged authorities which will provide the structural framework for integration of primary and secondary health care. New Joint Authorities will be in place by April 1996.

Amidst this background of organisational change and the formidable agenda of new tasks given to DHAs, the first year of contracting (1991-1992) was constrained by the 'smooth take-off' , 'steady state', ' no surprises' philosophy dictated by the DH.

During the course of the research and writing up of this thesis, new organisational structures have been implemented, the result of which is a new Northern and Yorkshire Regional Health Authority from April 1994 and a joint DHA and FHSA management structure in Northumberland. In North Tyneside the health authority has merged its management structure with its coterminous FHSA and its neighbouring DHA and FHSA in Newcastle on Tyne to form a new Authority, North Tyne Health. There have also been changes in the provider structures, with the merging of NHS Trusts and the creation of new ones.

## NORTHERN REGIONAL HEALTH AUTHORITY

The Northern Region was one of the largest of the 14 English health regions, covering an area of 6,000 square miles across five counties, extending from Cleveland through County Durham and Tyne and Wear to Cumbria and Northumberland and up to the Scottish Borders. Its three million inhabitants are dispersed in widely contrasting communities which range from very remote rural areas and isolated villages to small market towns and the major conurbations of Tyneside, Wearside and Teesside.

The RHAs Mission Statement, adopted in July 1990 is

> *"To work on behalf of the people of the Northern region*
> *to enable them to achieve levels of health comparable*
> *with the best in the world, and to ensure that they have*
> *access to a choice of high quality services responsive to their needs"*
> (NRHA 1990)

This is a mission statement which encompasses both health needs of the population and health care needs.

The Regional Director of Public Health acknowledged that accomplishing this desired state would not be an easy or straightforward task, nor was it a task for the NRHA and other HAs in the Region alone. It required the involvement and commitment of the widest possible range of organisations and individuals across all sectors in the region as well as that of the people themselves.

The 1990 and 1991 Annual Reports were lengthy, both numbering some 50 plus pages whereas the 1992 report was different in both style and content, being 12 pages in length and produced as a glossy broadsheet.

The 1990 Annual Report, the first one published by the Regional Director of Public Health, illustrated the major determinants of the patterns of health, disease and death by addressing a series of major health issues within four periods of life - childhood, adulthood, later life when the effects of ageing begin to have their impact, and the final years before the end of life which are often associated with physical and mental frailty and the onset of dependency (NRHA 1990). It was published in the spring of 1991 and contained some of the themes which would be reinforced at a national level later that year in the Green Paper ***Health of the Nation.***

The 1991 Annual Report focused on six main issues: childhood accidents and deaths, strokes, births and perinatal mortality, physical activity and fitness, control of communicable diseases and the promotion of a healthier environment.

The 1992 Annual Report, which in its style and appearance is probably best described as 'user friendly' reviews progress on the six issues highlighted in the 1991 report and sets out a new series of challenges for action in the form of posing a series of 'Why don't we?' questions.

The thesis will discuss firstly the content of the 1990 and 1991 Annual Reports which provided the parameters for viewing health needs and health care needs in the Northern Region, before considering the 1992 Annual Report .

## 1990 and 1991

These two reports feature certain key areas which are identified epidemiologically as constituting large health problems in terms of premature mortality or morbidity or both. The Northern Region has one of the highest levels of premature death attributed to coronary heart disease and stroke of any of the 14 English regions which makes these diseases key targets for improvement. In Mooney's terms coronary heart disease and strokes have been identified as 'big killers" and as such given a top priority, which in his view is a false logic (see p 109).

The importance of lifestyle, for example, smoking, lack of exercise and poor diet, which help to produce this poor health status is a feature of both reports.

A discussion in the 1990 Report on the introduction of national breast screening programmes for breast and cervical cancer has no supporting epidemiological evidence on the number of deaths or size of the population at risk in the Northern region.

> *"The UK breast cancer screening programme was one which was carefully evaluated before being introduced on a national basis by the Government following a decision taken in 1989"* (Annual Report 1990).

There have been doubts expressed about whether breast cancer screening is capable of impacting on mortality rates. Women in the age group 50 to 64 years are screened, but deaths from breast cancer are disturbingly high amongst younger women who are not routinely screened. This gives us an example of health needs being dictated politically at a national level where the effectiveness i.e. the ability of the screening programme to reduce mortality, is apparently not yet proven.

Lung cancer has taken the place of breast cancer in accounting for more deaths of women in the Northern region than any other form of cancer. Cigarette smoking is clearly seen to be the main risk factor causing the majority of these deaths. The proportion of women in the "unskilled manual" socio economic groups who smoke is 39%, which is twice as high as women in professional groups (Annual Report 1990). Although advertising is cited in the Report as a powerful channel for cigarette manufacturers to increase their sales and income, there is no indication that the RHA will bring its influence to bear on the Department of Health in the campaign waged by others to persuade the Government to introduce a ban on cigarette advertising.

The risks of smoking are reiterated in the 1991 Report, where the association between smoking and low birthweight is highlighted together with a suggested higher risk of cot death in the babies of mothers who smoke during pregnancy. Low birthweight is given as the most important factor which is linked to perinatal death.

The 1991 Report encourages all DHAs to set targets for the key areas identified in ***Health of the Nation,*** ie CHD, cancers, mental illness, HIV/Aids and Accidents. By highlighting them in the Regional Annual Report, Districts are given an added impetus to include them in their Business Plans and in their Corporate Contract with the RHA.

This Report outlined the management action required across these key areas, which was to be incorporated into corporate contracts (for RHAs, DHAs, FHSAs), purchasing contracts, provider business plans or implemented in the primary health care field.

Cataract and hip and knee replacement operations are discussed in the Annual Report for 1990 in terms of the increased quality of life which such operations can offer. They are examples of the 'ill health' category of health care need discussed in Chapter 1 and of services where there have been historically long waiting times and waiting lists for admission to hospital for treatment. Although there is no routinely available data to show the extent of the need for this intervention, it is a requirement of the ***Patient's Charter*** that a maximum waiting list time for these operations is adopted.

Reductions in waiting times in accordance with the targets and standards to be set locally and nationally under ***The Patient's Charter,*** are to be given a high profile for both hip and knee orthopaedic and cataract operations, which district health authorities will be expected to reflect in their contracting arrangements. The 1991 Annual Report indicated that reduction of waiting times in all specialties for hospital admission continued to be a major priority.

Dementia is the final health care issue identified in the 1990 Report. Again this is an area where there is no routinely available information about the number of sufferers in the population of the Northern Region or other parts of the country. A broad estimate is that between 5% and 7% of people aged 65 years or older will have dementia or early signs of it; whilst the population of the over 85s falling into this category is 20%. DHAs and FHSAs were to be responsible for assessing health needs and securing appropriate health care, whilst from April 1993 local authority social services departments would be responsible for assessing social needs and securing the appropriate care from a range of sources. The prevailing view within the NHS was that NHS long-stay institutional care was no longer appropriate for this group of people. There is little indication that the RHA believes that the health service should have a continuing role to play. Health authorities are withdrawing from the provision of continuing care for elderly people who are frail, confused or suffering dementia, often on the grounds that hospital environments are unsatisfactory. The argument used is that the needs of these confused elderly people (and indeed elderly people without dementia) are 'social' rather than medical and thus can be better met outside the NHS. The decision to withdraw this service from the NHS does not appear to have been made on the basis of an assessment of need which includes the views of users and carers.

This decision does however reflect the Government's thrust towards a mixed economy of care, the containment of public expenditure and the agenda set out in ***Caring for People.*** The division of needs into health need and social care need is briefly referred to in Chapter 2, and is an issue which will be returned to in the conclusion.

Health inequalities and the link between deprivation and ill health are addressed in both reports. Reference is made in the 1990 Annual Report to a study in 1986 (unnamed but probably a follow-up study to the Black Report entitled 'Shortened Lives' by Phillimore et al) into differences in local communities. This study demonstrated a strong link between material deprivation and poorer health experiences within the Northern Region. With very few exceptions those wards shown to suffer from greater material deprivation also experienced poorer health.

> ..."*the explanation for this clear association has been debated widely but remains uncertain and could include housing and other environmental influences, unemployment, levels of income, lifestyle, access to services and cultural factors*" (Annual Report 1990 p 36).

Health inequalities by social class are evident in the mortality statistics reproduced in the 1990 Annual Report. Within social classes IV and V in the Northern region there are higher levels of SMR for adult males, higher levels of infant mortality and higher levels of cervical cancer compared to social classes I and II.

The discussion of disadvantage and inequality is picked up again in the 1991 Annual Report in connection with childhood accidents and deaths involving road accidents, where the relationship between disadvantaged communities and the risk of death from head injury is explored. Although the numbers are very small, children living in the most disadvantaged electoral wards in the Northern Region had a death rate from head injury which was 14 times greater than for those living in the least deprived wards (Annual Report 1991).

A section on dental health in the 1990 Report refers to the fact that the extraction of teeth in the Northern Region is more common than elsewhere in England and Wales. The key to improvement, according to this report, is the fluoridation of water supplies (a non-NHS responsibility) and more effective dental health promotion programmes to ensure children and families take responsibility for maintaining high standards of dental hygiene. There is, however, no mention of the detrimental effect which the introduction of increased dental charges may have on the dental health of families where the costs of treatment will increase in stages until full costs are met or as important the serious potential threat posed by the withdrawal of dentists from NHS practice.

'Old Foes Unvanquished' is the title of a chapter in the 1991 Report dealing with communicable disease control. The diseases which have in recent years featured prominently in the media have concerned food hygiene issues such as salmonella in eggs and listeria in soft cheeses, in addition to Legionnaires Disease and AIDS. The latter poses perhaps the most important public health problem in the last decade of the 20th century. Tuberculosis, a disease of poverty in the late 19th and early 20th century remains as a cause of serious illness although more rarely now of death. TB had been declining each year in England and Wales reaching a low in 1987. Since then there have been increases of 1.5% in 1988 and 5% in 1989. Within Britain the Northern region is in the middle of the range for tuberculosis occurrence. The highest rates are reported from areas with high proportions of residents of Asian ethnic origin (Annual Report 1991). However, nothing is said in this report about whether this disease is still linked to poverty.

In evaluating these two annual reports against the four issues outlined at the beginning of this chapter, it is clear that the 1990 and 1991 reports identify health needs and health care needs through a combination of epidemiological information which is available on mortality and morbidity, top down priorities in ***Health of the Nation*** and ***The Patient's Charter***, evidence about lifestyle which is known to be associated with ill health, and distinctively through the link between disadvantage and ill health where proposals for health promotion initiatives are prominent.

The themes running though both reports are a commitment to wider definitions of health and the need for multi sector collaboration in achieving improvements in health. There is a clear recognition that the NHS cannot by itself meet the health needs identified in these reports. At the end of each topic an Action Plan is produced which sets out the role of health authorities, professionals, people, educational/local authority and other organisations in achieving the targets set or improvements sought. These also provide the mechanism for measuring how far the district health authority, or family health service authority has progressed in adopting the recommendations at the local level.

In purchasing terms, the action expected of health authorities will have financial implications. For example, there may be a need to resource the development of networks for multi-sector collaboration; the involvement of users of services has cost implications; the costs of additional health promotion initiatives which are targetted on particular groups will have to be balanced against continuing to purchase existing services. In terms of identifying success, the actions to be taken are not easily measurable, often being of a long term health promotion/prevention nature, making it all the more difficult to assess what priority it should be given.

The 1992 Annual Report appears to adopt, almost at random, eight issues against which to pose "Why don't we?" questions, designed both to stimulate thought and discussion and to bring about action, which suggests a move from the prescriptive approach of the two previous reports. These eight issues relate to the management and treatment of high blood pressure to reduce the incidence of heart attack or stroke; the prescribing of generic medicines which would bring financial savings with no loss of quality of care; helping more patients to avoid the need to stay in hospital by treating them as day cases;

increase the uptake of a new Hib vaccine to protect against meningitis; save the lives of more premature babies by giving steroids to women in premature labour; agree on the best way to treat patients by developing guidelines on appropriateness and effectiveness of treatments; end the misery of tooth decay by the introduction of fluoridated water; and finally pay more attention to the impact of housing on people's mental health.

Looking at these eight in more depth, some are related to effectiveness; some to the prevention of ill health and one to the overlap between health and housing needs. The prescribing of generic medicines is linked to financial savings and the Government's intention to reduce the national drugs budget. The introduction of fluoridated water is seen as the single most important thing that will help to win the battle against tooth decay and was highlighted in the 1990 Report. A programme of fluoridation is continuing in the Northern region at the same time as the NHS dental service for adults is in crisis, with practitioners in some parts of the country (and the region) withdrawing from providing NHS treatments.

The clear sign is given in this 1992 Annual Report that the effectiveness of medical treatments and clinical practices is under close scrutiny, as the first stage of withdrawal from services which do not have a 'demonstrable benefit '. Two are singled out for particular mention; operations for "glue ear" in children and D& C operations on women under the age of 45 years.

The switch to day case surgery is seen in terms of saving money to spend on other areas of health care and is made possible by advances in medical treatments and anaesthetic techniques. *"Estimates suggest that day surgery can save a district health authority as much as £1.27 million a year"* (Annual Report 1992 p 9), and would bring substantial reductions in hospital waiting times. This (and other reports) speaks authoritatively about patients not wanting to stay in hospital after treatment although there is a lack of systematic information which supports this. This is one aspect of NHS service provision which could benefit from the input of user views. Peoples perceptions of NHS treatment and operations have been built up over 40 years and health authorities have an educational function to fulfil to explain these changes in clinical practice as well as a responsibility to listen to the population's/patients' views.

In translating health needs into health care contracts, district health authorities have been given a mix of ***Health of the Nation*** and ***The Patient's Charter*** targets to fulfil which could well become the identified priority areas. This is a time when there are few, if any, development funds available and for those authorities who under the new rules are capitation losers, the situation is even more problematic. There appears to be an expectation in the Regional Annual Reports that these nationally set targets will be at the top of a District's priority list.

## NORTHUMBERLAND HEALTH AUTHORITY

The County of Northumberland includes large rural areas in the north and west (bordering Scotland and Cumbria respectively) which are relatively sparsely populated and areas in the south east which have more industry and are more densely populated. The total population in Northumberland is currently estimated at around 301,500 and is predicted to expand to around 312,000 by the year 2005 before beginning to decline. The most striking demographic feature is the doubling in the number of people aged over 85 years during the period 1985 to 2010.

Although outside the period of the case study , since April 1994, the FHSA and DHA have been pre-occupied with moving towards a merged management structure servicing two Authorities. The Health Authority had directly managed responsibility for its acute and community services until April 1994 when both the acute service and the community service achieved trust status. There have been two other trusts in Northumberland since 1993; the Northgate Trust , which merged with another unit in April 1994 to become the Northgate and Prudhoe Trust (providing services for people with learning disability), and the St George's Mental Health Trust. The configuration of services in one part of the District, Tynedale, is under review in the form of a detailed appraisal of options for hospital services arising from the need to replace the Hexham General Hospital which, since April 1994, has been part of the RVI Trust Hospitals. A new District General Hospital in Ashington opened in 1993, with a second phase being re-considered. There are six community hospitals in the District with a mix of acute, general practitioner and long-stay beds.

The above indicates the extent of organisational changes taking place locally with which the health authority had to contend at the same time as developing its new purchasing role.

## ANNUAL REPORTS OF THE DIRECTOR OF PUBLIC HEALTH FOR 1989, 1990, 1991 AND 1992

Four Annual Reports have been analysed. The main issues of each report will be put forward in turn, before making reference to supporting documentation.

### **1989** - The content

This was the first Annual Report which District Directors of Public Health are required to produce as a result of the Acheson Report and as such is broadly based containing much information on the health of the population. It is clearly written and understandable to a wide range of people with an interest in health issues. The aims are identified at the outset:

> *" ... to collect and present relevant data on the health of the population; provide an analysis of this information and make appropriate recommendations ... achieving these aims, the Report should perform a number of functions* ***it should identify health needs,*** (emphasis added) *... it should inform and educate its audience, ... it should influence health policy and stimulate appropriate service developments,... it should monitor outcomes"* (Annual Report 1989 p 7) .

The Director of Public Health in discussing the NHS reforms, suggests that this new Annual Report can fulfil a useful role if

> *"it provides the basis for* ***assessment of need and ordering priorities for the Health Authority in its new role as purchaser and*** ***. . .*** (emphasis added) *is seen by those with a wider interest in health in Northumberland as a way of identifying areas to work together to improve health and as a means of monitoring progress"*
> (Annual Report 1989 p9)

The Report makes the link between poverty and ill health with the social, economic and environmental determinants of health clearly seen as beyond the direct influence of the NHS. The need to co-operate with other agencies with an interest in health to meet health needs is expressed throughout the Report and attention is paid to the issue of healthy environments, healthy lifestyles and health related behaviour. For example,

> *"infant mortality often reflects the social and economic circumstances of the new-born and its family rather than the quantity or quality of potential* {health} *care"*
> (Annual Report 1989, p42).

Northumberland Health carried out a survey in 1985 of 3,000 adults in the South East of the County, through general practitioners. Questions were asked on height, weight, diet, physical activity, alcohol consumption, and smoking habits. Respondents were asked for their views on behaviours and lifestyles which produce ill health. The fact that this study was carried out before either the Acheson Report or ***Working for Patients*** suggests that Northumberland

Health Authority had a well developed public health function, was collecting data on lifestyles at an early stage, and had a sufficiently good working relationship with general practitioners for them to collaborate in this work.

The major causes of death in the adult population identified in the Report are coronary heart disease, strokes, lung cancer, accidents and chronic respiratory disease.

When looking at what information will be available to assist the health authority in deciding what, how much and where to buy services, the

> "*decision to purchase will depend on how great is the need for the service, how much money is available, the cost of the service, the quality and effectiveness of the service".* (Annual Report 1989 p 113 )

Whilst the Report acknowledges that much detail is available about the nature and quantity of activity in acute services, there is very little information which is collected routinely on quality or effectiveness of services. There is a role for CHCs to be involved in developing methods of assessing consumer reaction to the outcome of care and treatment. This is an example of Northumberland Health's willingness to adopt a 'consumer' dimension to service provision through its links with the CHC.

Three themes run through this Report: the need to adopt a multisectoral approach to improving health, the role of health promotion in reducing and tackling inequalities in health and the need for reliable, accurate and more appropriate health information systems.

**1990** - The Content

A chapter on the assessment of need for the provision of health care for children picks up some of the issues raised in the previous Report. Five areas of major interest were identified for attention.

1. Assessment of inequalities in child health
2. An evaluation of pre-school vision screening
3. A strategy for dealing with the problems of childhood asthma
4. The consumers view of services for pre school children with special needs
5. An integrated approach to preventing children's accidents. (Annual Report 1990 p 49)

In considering three of these areas, it is noted that

- a series of investigations were undertaken into the extent of child health inequalities. Information on low birthweight babies born to mothers from areas with different socio economic characteristics was available. This showed that in the most deprived areas *"over 16% of babies weighed less than 2.8 kg compared with only 6.8% in the most affluent areas"* (Annual Report 1990 p 50) echoing views expressed on infant mortality in the 1989 Report.

- childhood asthma is identified as a priority need, although there is little evidence presented on why, nor is there any evidence that it is, or is not, a condition linked to the socio economic status of the family.

- an integrated approach to children's accidents in Northumberland is suggested as many accidents are predictable and follow recognisable patterns. The risks of accidents are not evenly spread, and it is clear that the children of parents from Social Class V are far more at risk than their peers in Social Class 1.

Linking in with the Regional DPH's recommendation to establish a regionwide task force on accident prevention, a working party was in the early stages of establishment to provide a lead in reducing deaths from accidents. Whilst there is clearly a need for improvement in low birthweight, childhood asthma and children's accidents, the Report does not give any clear idea of the priority which should be afforded them.

In deciding where to start the process of assessment, the DPH suggests that early topics as part of a rolling programme of assessment should be judged against three criteria - basic epidemiology, existing costs and political considerations. These early topics could be focused round a condition, for example stroke, or a client group (physically disabled people), or a form of treatment, (hysterectomy).

It is stated that to start with

> *"contracts will be based on historical patterns of service. However, over time, the results of assessment of need and judgement of effectiveness of interventions may be expected to alter the balance of service provision through contracting."* (Annual Report 1990 pp88-89)

In the process of assessment the following questions were to be addressed :

> *"Is the condition important in terms of number of people affected and/or severity of the condition?*
>
> *Is the condition costly to the NHS or the lack of service costly to those who need it?*
>
> *Is the issue to be addressed seen as important to consumers, purchasers and providers?*
>
> *Has it really been considered in detail whether within the District or elsewhere?"* (Annual Report 1990, pp88-89)

The first steps of the health needs assessment process were seen as to define clearly the problem to be addressed. A range of questions were posed, for example

> *"How does the condition present itself ... how common is it .... is the cause known... how does the condition affect the patient"*. (Annual Report 1990 p 89)

The answers to these questions will, it was suggested in the Annual Report, be gathered from a variety of sources including patients and their relatives, local professionals and national expert guidance. It is thought that from these answers a whole range of locally defined needs will start to emerge.

The next stage of the process was to transform the assessed need into recommendations for a range of services required. This necessitates a further series of questions to be addressed. For example

> *"Is it possible to prevent the condition.... what sort of treatments are available .... how effective are the treatments ... are there some who will.... require some form of continuing care... what services are already available and what needs to be developed".* (Annual Report 1990 p 89)

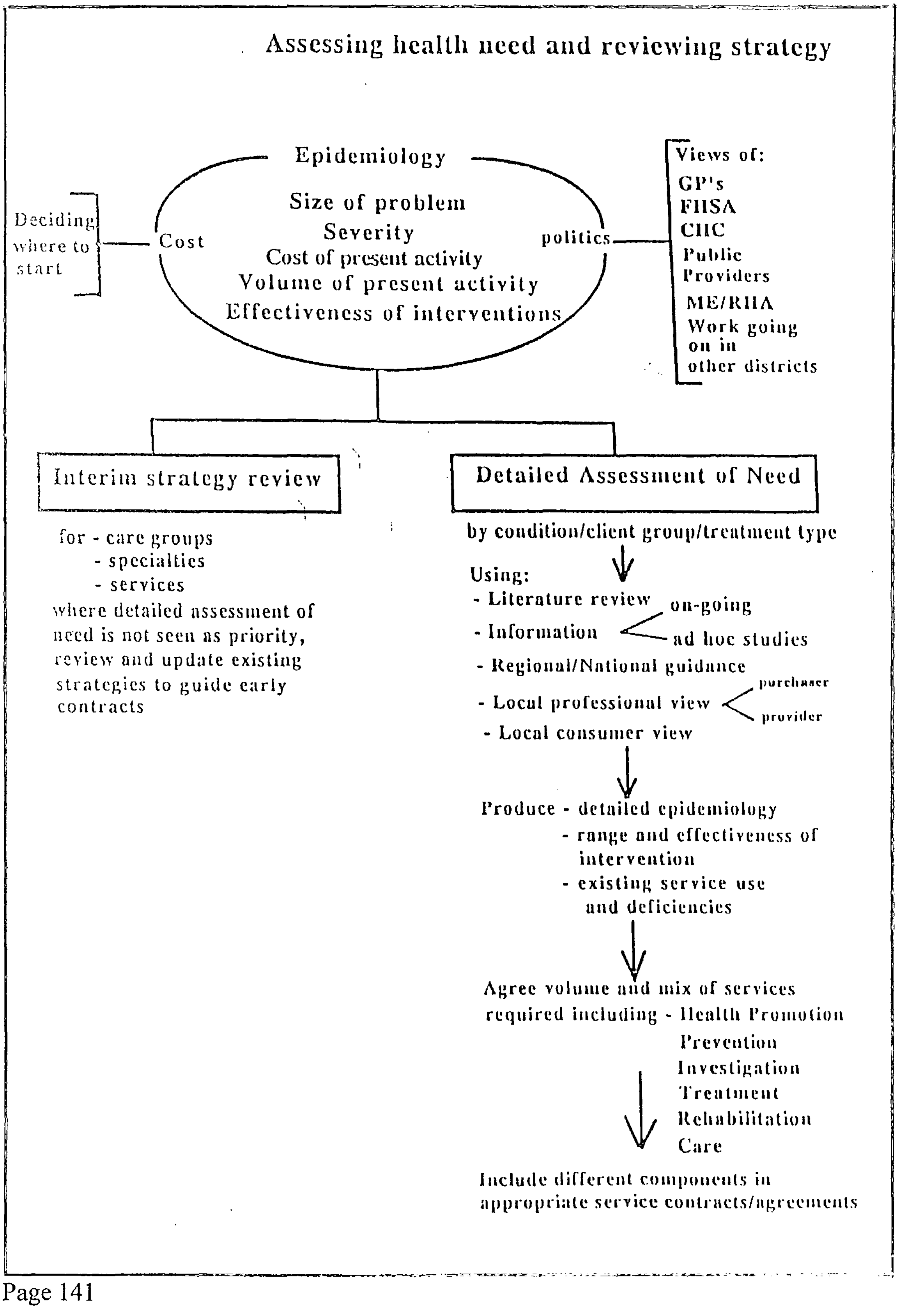
The complete process as summarised by the Director of Public Health is represented here as Figure 8. There is, however, no practical framework within which this process will be undertaken; how or who will provide the answers to the questions posed, and there is a feeling of fragmentation about the exercise. Much of the work suggested, if carried out, will provide a large amount of detail and information. The failure is in clarifying how this information will be turned into coherent health programmes or contracts for services, or indeed identifying the finance required to achieve them.

Several themes have emerged which provide the basis for sets of recommendations.

Firstly, the need for appropriate health information, with a recommendation that the health authority should work on this with the FHSA and general practitioners to develop mutually useful and appropriate indicators of health in primary care; secondly a systematic approach to public health, the recommendation being the adoption of objectives in public health medicine with a system of monitoring and review; thirdly, consumer involvement, the recommendation being to give due recognition to the importance of public participation in the development of all health promotion programmes; and finally, intersectoral collaboration to improve health and a recognition of the health implications of general policy development.

**Figure 7: The process of Health Needs Assessment**

(Source: Annual Report, Northumberland Director of Public Health 1990, p90)



## 1991

This again is a very detailed report spanning a number of issues some of which are specific to Northumberland. A chapter on Rural Issues in Northumberland, seeks to identify the specific problems that rural communities have in terms of service provision, particularly those of access.

A chapter on Primary Care concentrates on activity based in primary care for two main reasons.

> *"Firstly in recognition of the importance of primary care as the population's main point of contact with the health service and secondly its potential to inform the needs assessment process."* (Annual Report 1991 p 27)

During the year covered by this Report, progress had been made on the provision of morbidity data from primary care which would supplement data currently accessible on mortality and hospital based activity to support the needs assessment process.

The NHS changes are the subject of a chapter but in this report a little more attention is given to the community care objectives in ***Caring for People*** and joint working with the local authority social services department.

In looking at the progress made on assessing health needs the point is made that in the second year of contracting there is pressure to show that the contracting system works and that choices can be delivered. For those facing the difficult choices on service provision, assessment of need is seen to hold the answers but not yet.

> *"Some progress has been made over the year but it will take several years before the results of needs assessment can substantially assist contracting".*
> (Annual Report 1991 p 74)

Reference is made to the national networks which have been established to carry out work on the effectiveness of various treatments and on assessing prevalence and incidence which can be made available to all purchasers. A major barrier to progress locally has been identified as deficiencies in information systems

> *"particularly ... information on morbidity in the population .. details of the mix of local treatments available ... detailed reliable costings".* (Annual Report 1991 p 75)

> *"Local priorities have to be set following review of local prevalence and perceived importance. It is at this level that the services of epidemiologists and health economists need to merge with, influence and be influenced by local players such as general practitioners, providers and consumers so that the decisions of purchasers are fully sensitive to local needs".* (Annual Report 1991 p 75)

The ***Health of the Nation*** targets are prominent in this Report with a chapter devoted to them.

The major causes of death in the adult population in Northumberland are coronary heart disease, lung cancer, accidents and chronic respiratory disease, which to a large extent, match the five ***Health of the Nation*** priority areas. The DPH Annual Reports set a lot of store on local priorities, for example the child health issues which have been identified. Given this local emphasis, some reference to the balance between meeting national and local needs might have been expected, together with criteria which could be adopted. This balance - or trade-off - between national and local needs is not really being tackled.

In a concluding section, the Health Authority declares a commitment to setting up a dialogue with the public, to be clear about the purpose of this and identify how to achieve it. The aims of the dialogue should include -

> *"... (to give) an honest explanation of what is happening within the health service in Northumberland ... seek the views of the public on health promotion and health needs .... empower consumers by giving them through the Patient's Charter a clear indication of what they should expect from health services ... seek feedback from consumers of health services on both good and bad experience so that the quality of service may be improved ... empower people within the community to improve their own health by giving them information on health and health risk... in recognition of the limited resources available for health (to) seek public participation in deciding on priorities"*
> (Annual Report 1991 p 91)

However, whilst there may be a commitment to user involvement, there is a lack of clarity about how this will be put into practice and what use will be made of the outcome.

## 1992

The Annual Report for 1992 is changed in format and style, being much shorter,( 8 pages compared to the 50 plus of the previous reports reviewed) The hope is expressed that it will be read by a wider audience. The messages in this report focus on ***The Health of the Nation*** and are directed at other authorities and organisations with which the health authority wishes to work, to bring about improvements in health, and to individuals living in Northumberland who can make changes to their own lifestyle. Action to be taken to secure these improvements is suggested. There is also a review of progress made on the 1991 recommendations.

These four reports provide information on those issues identified as health priorities in Northumberland. These are CHD, strokes, mental illness, cancers, accidents and HIV/AIDS and sexual health. Other themes which have been raised over the course of the four reports include issues in child health and inequalities in health but largely the priorities identified locally mirror those of the ***Health of the Nation*** . Whilst these provide evidence of 'total needs' there is no framework or criteria from which a list of priorities will emerge.

Public participation in the health authority's decision making process is considered to be at an early stage of development, as is the use of research based evidence on effectiveness of interventions and treatments. Professional opinion however is well developed through the links which the health authority appears to have with general practitioners, particularly in the development of information systems. The use of economic techniques for health needs assessment is raised only insofar as a role for health economists is mentioned in the 1991 Annual Report.

From these Reports there is no impression that there have been year on year changes in the development of the health needs assessment process, or in obtaining any definitive outcomes from this. At the start there did appear to be a clear recognition of what action on health needs assessment was required and a systematic approach suggested for health needs assessment of the local population. The difficulties and problems of doing this soon led to acknowledgements that it would take several years before the results of needs assessment could substantially assist contracting.

**Supporting documentation**

The documents available for analysis are the Business Plans for 1991/1992 (which contain a contracting framework) and the Business and Purchasing Plans for 1992/1993. Business Plans are essentially for the internal use of the organisation to set out their objectives for the year and how they are going to achieve them. The point is made in the 1991/1992 Business Plan that fundamentally, the process of business planning is about the direction of change and priorities which the Health Authority needs to address .

Key service objectives, dealt with at length in this Business Plan, were identified including:

*** agreeing the process of assessment of health needs, and a programme for the systematic review of service effectiveness.**

A key element of needs assessment work was to be the development, with others, of information bases for assessing health needs and monitoring outcomes. A group of officers from the DHA and FHSA were given the task of agreeing methodologies for ascertaining the health needs of local populations and to suggest areas for priority consideration which might be topic or condition based or aimed at producing geographical profiles which include needs and service provision. A Needs Assessment Group was established led by the Director of Public Health. Work with the Local Authority Social Services Department on care management and assessment procedures and obtaining feedback from patients on services in a way which can influence future planning and contracting are identified as areas for action.

and

***To develop a purchasing strategy which identifies the potential for changes in contracting arrangements.**

The policy priority was the maintenance of existing services. The purchase of additional cataract operations using non-recurring funds was to be pursued (this being through the RHA waiting list programme) with orthopaedic surgery and ophthalmology important options for improvement being discussed with providers.

The Business Plan recognised that it would take some time for a strategic review of services to be completed. but it indicated to providers the importance attached to a range of service issues, 19 in total, which were not given in any order of priority and which were not costed (Business Plan 1991/1992 p 14).

In so far as health needs assessment was concerned, the principal action to be taken in 1991/1992 was to

> ..."*assist in developing a conceptual framework to guide work on assessment of health needs within the Northern Region by April 1991. .... Establish an information base for assessing health needs in the field of primary care by September 1991. ... By September 1991 agree with the FHSA a work programme identifying priority areas in health needs assessment. ...*" (Business Plan 1991/1992, p 16).

All of the service issues that had been identified should have been seen within the context of health needs assessment. It is almost as if health needs assessment is a separately identified activity which can be completed and ticked off; rather than seeing the process as part of the ongoing work of the authority from which all policy decisions will flow. The adoption of a health needs assessment process suggests an assumption in the reformed NHS that decision-making will be a rational undertaking, in the sense that it will be informed by a systematic evaluation of the pros and cons of conflicting alternatives flowing from the process.

Turning to the Purchasing Plan produced for 1992/1993, this is described as a public statement of the Health Authority's purchasing intentions indicating the changes and associated benefits in the services which the health authority currently secures. This plan is expected to form the basis of discussion with providers and to lead at the turn of the year to the formal negotiation of contracts. (Purchasing Plan 1992/1993) The point is also made that

> *"health care needs assessment work is relatively under-developed and the health authority will need inevitably to base decisions about service change largely on established strategies, proposals from providers and the views of general practitioners"* (Purchasing Plan 1992/1993, p3) .

There is no mention here of CHCs, the public's views, or those of the Local Authority being included.

Having had regard to the views of general practitioners and proposals from service providers, the Authority had attempted to establish a balance between maintenance of and improvement in agreed levels of service, the development of new services and recognition of regional and national priorities.

There were 19 priorities for service change or development in the Purchasing Plan, nine of which referred to the development of particular services; two referred to reduction in waiting times for Radiotherapy inpatient services and a number of acute specialties which were not identified; two to reviews of particular services (community nursing and services for elderly frail and mentally infirm); the other six were extension of ENT services to the population of Tynedale; resettlement in the community of mentally handicapped residents; reduction in working hours of junior doctors; arrangements for contracting directly with general practitioners; provision of a locally based mental health service for the north and east of the country; redirection of patient flows with the opening of the new district general hospital.

These were not listed in any order of priority and were not the result of an assessment of health needs. Much of the developmental work was probably ongoing. Historical concerns featured in the list where there was a need to address existing inequality in service provision within the county; the remainder arose from national requirements, ie the resettlement from long stay institutions and reduction in junior doctors' hours.

It is somewhat difficult to judge which of these priorities specifically complement or relate to the priorities outlined in the Annual Reports of the Director of Public Health. Whilst they reflected a change to the contracting framework of the previous year, which was concerned with workload activity and maintenance of existing services, they were not translated into contracts for services with providers.

The Business Plan for 1992/1993 is reviewed here to follow up just one of the issues contained in the 1991/1992 Business Plan, that of agreeing the process of assessment of health needs and a programme for the systematic review of service effectiveness and what had happened to the priorities outlined in the 1992/1993 Purchasing Plan.

Referring to the difficulties with a systematic assessment of need the Authority acknowledged in the Business Plan, as it did in the Purchasing Plan (see page 152) that decisions about service change would be based largely upon previously established strategies, proposals from providers and the views of general practitioners.

Six strategic themes were adopted in the 1992/1993 Business Plan which explained the Authority's philosophy and included the need to ensure equity of provision across the county, and due emphasis to primary health care. A summary of existing service strategies was produced together with a financial framework for the year. Within this latter, the RHA guidelines are much in evidence (partly because of the uncertainty over the revision of regionwide baseline funding which would affect the Authority's position against capitation and the subsequent level of growth funding). Out of a total of £97 million available to the Authority in 1992/1993, £90.7 million was to be spent on service contracts to cover current workloads, with £970,000 available for uncommitted expenditure. Some of this uncommitted funding would go on priorities for change which were identified in the Purchasing Plan for 1992/1993 and which appeared in this Business Plan broadly in order of priority, some of which had been costed. The list now totalled 20 priority areas (19 in the purchasing plan) costed at a sum of £818,000 .

The Business Plan for 1991/1992 was some 40 pages long with 33 pages of appendices. The Business Plan for 1992/1993 was 45 pages long with 66 pages of appendices . Whilst one can only be impressed by the quantity of information they purport to contain and the difficulties of the health needs assessment process, there is little evidence as to how health needs assessment will influence the contracts for services. It is difficult within such large and detailed publications to identify those processes which are informing the contracting arrangements. In particular how the joint FHSA/DHA Needs Assessment work will feed into and begin to shift the emphasis from maintenance of existing services and tackling historically perceived inequalities, to purchasing services based on agreed needs. For some geographic areas or specialities this shift in emphasis may mean a reduction in service provision, but the Health Authority gives no clues as to how they are going to persuade those previously well provided areas to give up some services or resources to benefit those areas less well provided for.

There is no evidence of a developing strategy for the systematic involvement of users although reference is made to the importance of this. General Practitioners continue to be a main source of influence on the pattern of service provision. Regional requirements are taken on board for increased purchasing of ophthalmology and cataract operations. The need to reduce waiting times as part of the ***Patient's Charter*** initiative is accepted.

The FHSA Business Plan for 1992-1995 entitled, "A Focus on Primary Care' provides an insight into primary care services in Northumberland. The local priorities include the need to

> *"meet health need identified through a structured process of assessment both general practice based and county wide ".* (pp2 -3)

Two aspects of this report are important to the health needs assessment debate. The FHSA are involved in two projects on the collection of information. The MEDICS project - Morbidity and Epidemiological Data Interchange and Comparison Scheme is

> "*designed to collect structured morbidity data from general practitioners for use in planning services and to provide practices with feedback illustrating the position of their own practice in relation to county averages, consequently highlighting local health priorities* " (FHSA 1992-95 pp22-23)

The second project COPC - Community Oriented Primary Care - is an

> *"initiative currently being piloted as a collaborative venture with the Kings Fund and supported by the DHA. COPC is a framework for the delivery of primary care based on the epidemiologically assessed needs of the practice population"* (FHSA 1992-95 pp22-23)

These are two initiatives which offer a real possibility of providing morbidity data by general practice and are probably the outcome of the Director of Public Health's recommendations for improved data collection on morbidity in the primary care field. It would have been interesting to see some reference as to how these are to be used in the needs assessment process and contracting in the DHA's publications analysed. The reference to joint working suggests that the FHSA effort will be focused towards obtaining and using general practice held morbidity data, whilst the DHA is concentrating on epidemiological issues and effectiveness studies (the research based evidence). A framework for bringing the data together and putting it to some practical application is not provided.

Whilst the DHA takes a cautious approach to service changes, the FHSA Business Plan envisages a substantial move away from providing services based upon the underlying demands of the population (which the Report suggests are generally reactive based and result in expensive, inconvenient and painful treatment) to meeting the identified needs of the population served.

## NORTH TYNESIDE HEALTH AUTHORITY

North Tyneside is a mixed urban/residential area and the DPH Annual Reports highlight the striking contrasts between the material and social deprivation in areas where there was formerly much heavy industry, with the much better-off residential areas. The population of 192,700 at mid 1989 is declining slowly but steadily, and according to the 1989 report a relatively low birth-rate is being only partially offset by inward migration.

The Health Authority has had disruption at the senior management level with the secondment of their Director of Public Health to the RHA in 1991; the unexpected resignation of the Chief Executive in early 1992, the appointment of a temporary Chief Executive who made way for the new Chief Executive appointment in August 1992. Although outside the period of the case study the authority was preparing for a merged management structure to serve two district health authorities and two familiy health service authorities in 1994 .

## ANNUAL REPORTS OF THE DIRECTOR OF PUBLIC HEALTH 1989,1991 AND 1992/1993

Three Annual Reports are analysed; 1989, 1991 and 1992/1993. There was no Annual Report for 1990.

### 1989 - The Content

The 1989 Report (the first one produced following publication of the Acheson Report) provides an overview of the District's responsibilities and the task it has of assessing the health care needs of the population of North Tyneside and commissioning hospital and community services in accordance with those needs. There is no evidence as to how this process of assessment will be tackled.

Any potential criticism of the 1989 Annual Report's brevity (a total of 23 pages) is met by the statement

> "*we have consciously aimed for a report which is short and targeted towards the key indicators of health rather than seeking to compile a mass of figures resembling a railway timetable*" (Annual Report 1989 p 0.2)

There is no mention that the brevity might have something to do with the under-development of the public health function in North Tyneside (referred to in the Business Plan for 1992/1993).

This Report provides an analysis of the links between deprivation and health in North Tyneside. The conclusions reached in this report on the link between deprivation and health are that the burden of ill health and premature mortality is greater in North Tyneside than in the country as a whole, although levels are about average for the Northern Region, and

> *"the effects of ill health and premature mortality*
> *are concentrated disproportionately in the most deprived*
> *areas of North Tyneside; given the wide variation between*
> *the best off and worst off areas in the District, this is a*
> *major factor in determining the health of the resident population"*
> (Annual Report 1989 p. 4.6 )

Future action according to the Report will be concentrated initially on the areas of prevention (of ischaemic heart disease and cancers) and on finding ways to counteract the effects of deprivation on health.

### **1991** - The Content

In the 1991 Annual Report the ***Health of the Nation*** strategy and the five key areas where improvements in health have been targeted are discussed. The point is made that only one target is the specific and sole responsibility of the NHS, which is for the health authority to make sure that people have access to high quality health services. Two minor reservations about the strategy are voiced.

> *"Firstly, it does not give adequate weight to the association between ill health and disadvantage ie the effect of low income, unemployment, unsatisfactory housing and the other adverse social circumstances on health. Second, it does not address the issue of ability to choose, change and achieve a different lifestyle for those people whose lifestyle is considered to be putting them at risk"*
>
> (Annual Report 1991, p.1.2)

The health care issues considered in some detail are coronary heart disease, cancers in women, mental health, sexual health, injuries in children and children with 'special needs'. The 1991 Annual Report suggests that coronary heart disease is clearly the local priority and is the major single health problem in North Tyneside accounting for 25% of deaths in the district, which follows the 'big killer' approach that Mooney criticises.

One of the action points for achieving ***Health of the Nation*** targets is to agree local targets aimed at reducing inequalities in health. Developing relevant health promotion programmes for reducing inequalities in health requires the

> *"Health Authority and Local Authority with the FHSA (to) produce a joint strategy for health promotion in North Tyneside focusing on selected key areas and working to achieve targets that are locally relevant. This joint health strategy should address all of these key elements"* (Annual Report 1991, p8).

Prevention is seen as the key issue. Two key settings where health promotion strategies should be put in place to contribute to the aim of reduction in deaths from coronary heart disease are schools and work places. This approach is termed 'primary prevention', aimed at reducing the risk factors in the community.

Secondary prevention of coronary heart disease, requires the identification of individuals with significant risk factors or symptomatic heart disease in order to help them change their behaviour or to treat their condition appropriately. Action here includes identifying, with the LMC and FHSA, ways of carrying out health promotion for CHD in local settings and the adoption of a systematic audit of the investigation and treatment of people with symptoms or history of heart disease.

Tertiary prevention is explained as involving a process known as cardiac rehabilitation, which aims to restore patients who have had heart attacks to their optimum physical and social status and to maintain that status.

However, patients do not attend coronary heart disease services but attend services in the primary, secondary or tertiary care sectors which deal with different aspects of the disease. How the work done in schools and workplace is tied up with the services which overall may reduce the levels of CHD in the district, is a stage in the process still to be addressed.

**1992/1993** - The Content

This is the first Annual Report produced by the merged authorities and is published under the title "Working Together for Health". Whereas the 1992 Annual Report of the Regional DPH, and Northumberland DPH were 'new' in both content and format, this 1992 Report for Newcastle and North Tyneside appears to go over what could be considered 'old issues'.

Volume 1 contains three sections. Section I deals with 'Commissioning Health Care' which is discussed in terms of assessing need and is related here to housing, physical disabilities, designing health programmes (which is to do with the development of primary care and contracting for health services); dealing with priorities and rationing; and the current issues around provision of hospital beds.

Section 2 deals with Health Promotion, young people and sexual health and fluoridation of water supplies and dental decay.

Section 3 addresses issues of monitoring around communicable disease control and the registration and inspection of nursing homes.

Volume 2 of the Annual Report contains statistical details about the population of Newcastle and North Tyneside in terms of size, gender and age distribution, statistics on births and deaths and figures which indicate that the major causes of death are cardiovascular disease and coronary heart disease.

For the purpose of this thesis, attention is focused on the sections dealing with assessing need and contracting for health services.

Two very different issues are addressed in the section on "Assessing Need". Firstly, the relationship between housing and health is discussed and reference made to the Black Report on Inequalities in Health (published in 1982) which revealed that inequalities in health existed not only between different occupational classes but also between the major types of housing tenure within each class. The DPH had been working with Newcastle City Council Housing Department on medical criteria for allocation of housing. Flowing from this work, a second project in collaboration with Newcastle City Council was established to tackle the concerns about housing services for the mentally ill. This project would work with communities in the design of initiatives and intervention strategies to secure improvements in the housing needs of people with mental health problems, and to monitor the effects of housing on health.

Secondly, assessing the needs of people with a physical disability addresses the issue of dependency levels and the problems associated with the provision of physical disability services. A joint approach with other agencies was seen as a means of overcoming some of the problems, through joint planning and the provision of joint services which support integrated service provision. There was also seen to be a need to identify effective ways of involving users and carers. The provision of services to this group of users posed one of the key health care/social care issues to be resolved by both statutory authorities to ensure a seamless service with the financial boundaries clearly agreed.

The section on Contracting for health services addressed the difficult choices to be made in prioritising and rationing of services. The point was made that the

Department of Health and Regional Health Authority do not give advice or guidance on which services should be given low priority. The fundamental problem, according to this Report was that the demand for health services exceeded the resources which individuals, or governments can supply.

The following four methods were suggested and discussed in the Report for bringing demand and supply into balance:

> *"Increase the supply - In the NHS this is constrained by the amount of revenue allocated to health authorities. ...The UK spending on health represents a lower proportion of GNP than most other developed nations.*
>
> *Reduce the demand -... by increasing the price ... not possible in a health service free at the point of delivery, or by making the service inaccessible or unpopular - not an acceptable approach in the NHS.*
>
> *Create a queue or waiting list - limited applicability now that waiting times for surgical procedures and outpatient appointments have to be reduced.*
>
> *Develop rules about who gets what or how much"*
> (Annual Report 1992/1993 p36).

The new capitation policy has meant a loss of revenue in Newcastle and only a small increase in North Tyneside. Four options to reduce the pressures this capitation policy had created are discussed and include -

> *"(iv) The final option would have to be to ration services explicitly by*
>
> *- encouraging a policy of 'wait and see' for some conditions where the timing of elective surgery is not critical*

> *- concentrating on the provision of effective services which are only available from the NHS (i.e. 'cure and repair' rather than 'caring' services);*
>
> *- defining more clearly the services to be excluded from the NHS. For example, give consideration to such services as long-stay care, cosmetic surgery, infertility, reversal of sterilisation, gender identity, etc;*
>
> *- not providing services which are given a low value by the public. This is unlikely to be an uncomfortable experience as studies elsewhere show that the public have different priorities to clinicians and "policy makers"*
> (Annual Report 1992-93 pp 37-38).

There is no mention here of the health needs assessment process driving priority setting. Rationing here would be finance driven. However, in being explicit about the services which it purchases the health authority intends to take a number of actions which would include a statement that the health authority cannot meet all expressed and unmet needs within available resources; initiating discussions with the CHC and local authorities about priorities; holding public discussions which would enable detailed debate on the issue; discussing with general practitioners and hospital consultants to identify services of doubtful or low clinical benefit and vigorously exploring the various efficiency and pricing issues which were around.

**Supporting documentation**

The Business Plan for 1991/1992, produced soon after the 1989 Annual Report was published, addresses health needs assessment thus:

> "*It seems to DHA directors that there are two methodologically distinct starting points for an assessment of the need for health services ... on the one hand there is the traditional epidemiological approach based on descriptive statistics of morbidity and (principally) mortality for the population. On the other hand there is an approach based on an evaluation of current services ...*"
> (Business Plan 1991/1992, p10).

At this time health needs assessment is more of an 'either / or' approach rather than being a synthesis of a range of inputs.

The choice was made that the starting point would be an evaluation of current services through a systematic analysis with each GP in the District of referral patterns and preferences and service quality issues. Rather than adopting the line of action recommended by the DPH (ie prevention and finding ways of counteracting deprivation), the health authority took the line of initially maintaining the status quo by contracting for the current service delivery and at the same time using the general practitioners to identify a manageable number of issues on which to seek improvements. There is no mention of other agencies, for example the Community Health Council or the Local Authority being invited to influence the contracting process by highlighting issues or areas for improvement. The Local Authority is an important agency to work with in countering deprivation through its housing, leisure and education policies.

Out of this consultation process with general practitioners, seven areas were apparently consistently identified as showing scope for improvement and these were chosen as the priorities for health care needs. Only three could claim to have any underlying data which could tentatively support them being classed as priorities, these being orthopaedics, ENT and Ophthalmology waiting times which failed to meet the new Patient's Charter standards. The remaining priorities were based on the professional opinion of general practitioners.

The DHA Business Plan for 1992/1993 suggests that the Authority in making improvements in health and heath care for residents, plans to direct its efforts to four key result areas.

> *"1. to assess health need and opportunity for health gain*
>
> *2 to encourage healthier lifestyles and avoidance of risk taking behaviour*
>
> *3 to attain synergy in health and social care through collaborative working with other statutory voluntary and professional groups*
>
> *4 to achieve greater effectiveness in service provision through direct management and the contracting process" (*Business Plan 1992-3, p4).

These are a restatement of what under the reforms is now expected of health authorities. In directing its efforts to those four key areas, it fails to give any indication of what the outcome is expected to be, the timescale, and the likely effect on service provision. The spending balance between the essentially strategic key result areas of number 1 and 2 (above) and the operational ones numbered 3 and 4, has necessarily emphasised the latter with the need to improve services and quality and maintain the movement towards a community setting for the provision of certain priority services.

Reference was made to the fact that the strategic aspects of the purchasing function had not made the progress hoped for last year (ie 1991/1992) and the view expressed that with a full-time DPH not yet in post it would have been inappropriate in 1992-93 to allocate larger sums to a department which was considerably under-staffed.

The FHSA Business Plans for the years 1991/1993 (a two year plan) identified its top three priorities for health needs and planning as

the high incidence of lung cancer
high perinatal mortality rate
unacceptably high level of prescribing costs

whereas by the 1992/1993 FHSA Business Plan "*The strategic target areas for action by all of the NHS in 1992/1993 are coronary heart disease, still births and infant deaths*" ( 1992/1993 Business Plan p12).

There was little evidence of a strategy for tackling these priorities. The 1991/1993 plan and its aims and objectives was more concerned with setting out the FHSAs image to the public and other agencies with which it would be working and with managing the internal mechanisms of contracts and functions. The 1992/1993 Plan tackled a number of additional issues including explaining the role of the FHSA in the NHS and the proposals for the integration of primary and secondary care. The FHSA foresaw a growing role in supporting the development of DHA purchasing plans, the ultimate aim being for FHSA service strategies to become an integrated part of local purchasing plans.

## MAKING COMPARISONS

The earlier reports produced by the Directors of Public Health (perhaps with the exception of North Tyneside), including the supporting documentation were wordy and descriptive, paying much attention to the setting of objectives and the processes for health needs assessments. By 1992/1993 the Public Health Annual Reports were becoming more focused on the difficult issue of making choices in service provision with Newcastle and North Tyneside Health openly referring to the problem of rationing of services.

For the first three years of the reforms, the DHAs have struggled to get off the bottom of a 'learning by doing' curve in relation to health needs assessment, with Northumberland Health perhaps slightly ahead of many in the field because of its previous work with, and knowledge of, local communities and the relative stability of its senior management team and public health function. In comparing the two public health departments, it appears that North Tyneside Health Authority has never had a full complement of public health staff, which has perhaps delayed the progress the Authority has made with health needs assessment. What we cannot tell from these published documents is the status accorded to the health needs assessment function within the two organisations. Northumberland Health (reported in the 1991/1992 Business Plan) carried out a SWOT analysis of its organisational functions, presumably to identify deficiencies, although the results of this are not mentioned in any detail in subsequent reports.

The Regional Health Authority clearly sees its role as the successful delivery of the policies laid down by Ministers acting as agents of the Centre to secure compliance with national objectives, except for the emphasis which has been put on inequalities in health in these reports. 'Hard' epidemiological data on patterns of mortality and morbidity are utilised as the measures of health need within the regional and local populations. The need to reflect ***Health of the Nation*** targets leads to a large degree of unanimity across the three authorities as to what constitute the major health issues within the Region and Districts.

Coronary heart disease, stroke and cancers are the major causes of deaths and high levels of morbidity. Each of the reports concludes that the strategy to be adopted in reducing mortality and morbidity from these major causes, should be a preventative one and as such have a high priority. Such a preventive strategy will be multi-agency because there is a clear recognition, albeit expressed in slightly different ways, that the population's ill health cannot be solved by the NHS alone.

In Northumberland the 1989 Annual Report acknowledged the link between poverty and health, but also acknowledged that the social, economic and environmental determinants of health are beyond the influence of the NHS. North Tyneside's Director of Public Health supports the view that some factors fall outside the remit of the NHS. There is also a more critical recognition in the DPH report for North Tyneside that the effects of low income, unemployment, unsatisfactory housing and other adverse social circumstances may deny to some sections of the population the opportunity to choose, change and achieve a different lifestyle to the one which may be putting them at risk.

Co-operation, multisectoral participation and changes in individual lifestyles are the means through which it is envisaged improvements in health will be achieved. This participation will revolve around preventive measures and effective interventions in those areas of need already identified as priorities for action which are coronary heart disease, strokes and cancers. Other ***Health of the Nation*** targets are variously addressed in the Annual Reports; from the setting up of child accident prevention panels to increasing uptake in screening programmes and improving access to mental health services. There is no concern expressed that meeting national priorities in ***Health of the Nation*** will in any way affect how local priorities are dealt with.

If the thesis adopts Redmayne and Klein's analysis of distinguishing between 'aspirational' and 'funded' priorities (see NAHAT 1993, Research Paper 11) we can see that our two District Health Authorities have some difficulties. The Business Plans for neither authority contain detailed expenditure plans linked to their priorities or key service objectives, although Northumberland's 1992/1993 Business Plan attempts to link expenditure to priority developments. The purchasing intentions in North Tyneside's Business Plan for 1991/1992 indicated the very small amounts of money available for developments or to meet locally identified needs.

The detailed financial information which is available is confined to the cost of the acute sector provision and the activity currently contracted for by specialty and provider unit. In terms of contracting intentions there are no specific proposals for the purchase of agreed levels of service from specific providers in those areas where change is sought. For example the coronary heart disease programme which districts aim to follow, contain no specific funding allocations for prevention, secondary and tertiary care provision, or for care provided in the primary care sector.

Health Authorities are still searching for ways in which the public can participate in health needs assessment and of the two Districts it is Northumberland which conveys the impression that this is an issue which is under serious consideration. At this stage however, general practitioners continue to dominate any consultation process with which the authorities are involved. There is a danger in this approach to confirming the 'accident of history' pattern of referrals to services. This should not be the case in Northumberland as the two information systems being pioneered by the FHSA, MEDICS and COPC should in the future provide relevant information on health profiles of practice populations, though this is still a long way from using the information to determine service provision..

It is disappointing that by the time of publication of the second District Annual Reports there has been little progress on assessing the health care needs of the local population in terms of equity and access to services and acute versus community health services. There seems to be an acceptance that the ***Health***

***of the Nation*** and ***Patient's Charter*** requirements will drive the Districts' service provision and purchasing. The underlying view (not expressed) appears to be that the achievement of the targets in these national reports is not open to negotiation. This will mean the allocation of resources to ensure that these targets and standards are met which is perhaps not too problematic whilst local needs are still being identified and prioritised.

From the documentation considered, only the new authority of Newcastle and North Tyneside Health is at the stage of contemplating explicit rationing of a service, either through the withdrawal or limiting of availability in ways other than through waiting lists. This latter is likely to happen through the contracting process by health authorities contracting at lower levels of activity relative to demand, provided they continue to meet standards in ***The Patient's Charter.*** It is also likely that some services will slip off the agenda of health care (for example tattoo removal) just as continuing health care for elderly people appears to be moving off the health service agenda.

There is no evidence that either DHA at this stage has the confidence and skills to use their buying power to substantially change the balance of service provision. The importance is to maintain the current levels of service provision, the majority of which is in the acute sector. For the time being it is incremental, marginal changes in the overall balance of service provision which are being made by health authorities.

Looking forward, one can foresee that as the DHAs become more competent in the various areas of health needs assessment, not least of which is in the growing areas of outcomes/effectiveness of treatments, change may come more quickly, and firstly, within the acute sector of service provision.

The rhetoric may continue to be that of addressing the needs of their resident population and purchasing the services required to meet them, but in reality DHAs know that in the short term at least they will be spreading the finite resources available to the service in ways that are tolerably fair and productive of reasonably good results.

The difficulties in the practical application of needs assessment and the scale of the task, coupled with the very tight contracting timetables, has meant that the pressure to get contracts specified, signed, sealed and delivered has provided virtually no time to carry out proper epidemiologically-based or other forms of needs assessment (Light 1993). As our case studies show, the work that has been done, the public meetings, the study of the population's health status, do not appear to have had a direct or significant impact on the districts' purchasing decisions.

Neither of the Districts have adopted explicit rationing techniques although Newcastle and North Tyneside is being explicit about the levels of services they will purchase. The outcomes and effectiveness studies have had only marginal effects, but in the longer term these could well be influential as districts move more towards the economic notion of 'capacity to benefit' in prioritising service provision.

There is one area across the authorities where policy making has lacked any debate and has been implemented almost by default. This is in the area of health authorities reducing their responsibility for funding long term continuing health care for confused and elderly people. The health care - social care needs boundary in this area of provision has been redrawn without consultation and should cause disquiet.

What is lacking in the case studies is an unequivocal identification of those health problems within the local population in which resources will be invested and contracts for services (if necessary) are placed. Both District Health Authorities refer to the ***Health of the Nation*** targets and the preventative actions required, but neither stipulate the investments the Authority is prepared to make in these areas to secure improvements or give a criterion which allows improvement to be quantified if mortality rates are not used.

Health Authorities have available professional opinions (ie, general practitioners and consultants) on service issues, some research based evidence on outcomes which has been produced nationally, and the top down targets which they have been set. The supporting health authority documentation fails to bring this information together in a way that enables it to be interpreted for purchasing services.

There is no evidence of QALYs or economic techniques being seriously considered although they are mentioned, possibly to indicate that there is an awareness within Districts that this is an option open to health authorities, which they may in future turn to if they do become more explicit in their priority setting.

After three years, it appears that the service content of the Reforms is still being driven nationally through the top down requirements of the ***Health of the Nation*** and ***Patient's Charter.*** However, the relaxation of the 'steady state' approach, the NHSE's intentions to strengthen the purchasing function and the shifting of purchasing power from DHAs to GPFHs indicate that the agenda for health authorities is still large and will be subject to continued change in the future.

# CHAPTER 5 CONCLUSIONS

Working for Patients set out a vision of a health service in which the philosophies and structures of the market place would be blended with the traditional principles of the National Health Service - equity, equal access and services free at the point of need. It was also, suggests Butler, the ambitious product of a political environment that preferred private to public domains, markets to bureaucracies, competition to patronage and individual choice to social equality (Butler 1992). Yet ***Working for Patients*** retained the concept of need and indeed argued that needs would be better assessed and better met in the 'new' NHS.

The subject of the thesis is heath needs assessment in the contemporary NHS. It has focused on the role of District Health Authorities and the requirements for them to assess the health needs of their local population and purchase (or commission) health services to meet those needs, and the political climate within which this is has taken place. There has been no attempt to analyse the whole spectrum of purchasing and therefore an important aspect of the NHS reforms, the creation of General Practice Fundholding, has not been addressed. The implications of this omission has meant that no attention has been paid to the role of primary care services in identifying and meeting individual's and practice population's needs; the relationship between GP fundholders and the district health authority; or the effect which increased numbers of GP fundholders will have on the purchasing role of health authorities.

The thesis is also constrained by considering a small number of reports published by three health authorities which give only a glimpse into needs assessment and which tell us little about the realities of the process. Little attention has been paid in the thesis to linking health needs assessment with resource allocations although this is very important in the contracting for services particularly where, like Newcastle District, authorities are capitation losers. High levels of need may be identified but the pursuit of effective purchasing strategies to meet them faces the recurring problem of insufficient resources.

In the thesis there are four significant points arising from the reforms insofar as health needs assessment is concerned. These are:-

the concept of need
consequences of an internal market for health needs assessment
the process of health needs assessment
the rationing debate.

**The concept of need**

In Chapters 1 and 2 the concept of need was addressed philosophically and in a practical sense through a consideration of NHS developments since 1948.

Chapter 1 suggested that the concept of need has always been problematical for the NHS. In 1948 medical or clinical need was the guiding principle, with the medical profession largely responsible for interpreting this. Need was also seen to some extent in 'absolute' terms, but the belief that demand for services would decline as the population became healthier has not been realised. Despite the philosophical difficulty of definition, underlying the concept of need is a general acceptance that capacity or ability to benefit from health care is the accepted interpretation of need within the NHS.

Whilst the scope of the NHS in 1948 encompassed all those in need, the process of health needs assessment in ***Working for Patients,*** it now seems clear, was to be undertaken in order to better prioritise (or ration) services to meet the criteria of "ability to benefit". This shift in emphasis reflects not just a different political and economic climate but also the recognition that resources will never be sufficient to meet ***all*** need.

Chapter 2 discussed two principles operating within the NHS during the 1970s which were used to define and meet needs. These were strategic planning mechanisms to identify health care needs and the principle that finance should be allocated on the basis of a formula related to need. The chapter concludes with a discussion of developments in the NHS prior to ***Working for Patients*** in 1989 and addresses some of the proposed changes in this White Paper.

### Consequences of an internal market for health needs assessment

The introduction of a market philosophy into health care at the end of a 'revolutionary' decade of politically right-wing economic thinking brought together proposals formulated by the Centre for Policy Studies, the Adam Smith

Institute and the Institute of Economic Affairs. An American health care expert, Alain Enthoven pioneered the concept of the purchaser-provider distinction in the NHS, this being a key innovation in the health service reforms.

The Reforms of 1991 emphasised the Government's view that efficiency in the NHS would be produced by competition rather than by the bureaucratic strategic planning which was a feature of the public sector in the 1970s. A NHS market, alongside other reforms such as the introduction of general management, would break the medical hegemony in the NHS, bring increased choice for patients and, some argued, paved the way for the privatisation of the NHS at some time in the future.

## The Health Needs Assessment process

The whole process of health needs assessment and health care needs assessment is the gathering together of information from a range of sources (the inputs to the process) which include epidemiological information on incidence and prevalence of disease; the effectiveness of treatments and services; data on existing service provision; and the public's views on both their own health needs and on the health care needs within local populations. Judgements on the basis of this information are made by health authorities which in turn inform their purchasing decisions.

These inputs to the health needs assessment process are well understood by health authorities. As the case studies show, DHAs are identifying the health experiences of their whole population in terms of mortality and morbidity. This essentially epidemiological exercise has provided them with a developing data base on the nature, or at least the patterns, of ill health within their population.

Less in evidence, however, is the extent to which other inputs to the process have developed. Knowledge about the effectiveness of interventions and treatments, and the views of users on the services provided are at an early stage of development. During the 1980s, health authorities have been amassing more detailed knowledge of existing service provision and its costs; they have little knowledge of how users view these existing services and are not clear about how to use the information obtained from users to influence future service provision.

The health needs assessment process reflected in our case studies show that health authorities are not yet in a position to use this process to any significant extent to determine what services should, or should not, be purchased.

## The rationing debate

Rationing, as Chapter 3 shows, has always occurred in the NHS. Waiting lists have long been used as a rationing device. However, since the Reforms were introduced rationing has received more attention. During 1994, there has been a series of media reports on the denial of care to elderly people, the shortage of intensive care beds and the limited provision of infertility services within the NHS. It could be that the debate within the NHS in the future will not be about need versus demand, or services provided on the basis of need, but services openly rationed according to whether the acknowledged need is a priority or not. The health care needs assessment process in future could be used to legitimate decisions to restrict or deny some services to some sections of the population. This is one reason why the input of the user's voice into the health needs assessment process is so important to heath authorities who will need the support of the local population as they take unpopular decisions.

If this is the case in the future , the decision-making process within the NHS must become even more transparent and plans made by health authorities must set out the competing demands, the options available and the reasoning behind the final judgements made about service provision, the financial constraints and the effect such decisions will have on local providers of services as well as on patients. The Health Authorities in our case studies are not yet at this stage of openness.

## Looking Ahead

The strategic role of RHAs and DHAs highlighted in this thesis, of taking health care decisions on behalf of their populations, is likely to be undermined in the future largely because much of the cash for meeting the priorities identified will not be in their control; it will have passed to GP fundholding.

General Practice Fundholding (not addressed in any detail in the thesis) looks set to expand (January 1995) with the publication of a NHSE Letter EL(94)79 -

Developing NHS Purchasing and GP Fundholding - Towards a Primary Care Led NHS.

This EL indicated that subject to parliamentary approval DHAs and FHSAs will be replaced by a single new authority at local level accountable to the Secretary of State through the NHS regional offices which will replace regional health authorities.

> *"These new health authorities will be responsible for implementing national health policy. They will have overall responsibility for assessing the health care needs of their local populations and for developing integrated strategies for meeting those needs across primary and secondary boundaries. ... The new health authorities will continue to have a significant direct purchasing role, for example for those services requiring a broad population base and for services outside the fundholding scheme. As fundholding develops however, general practices will become increasingly important as purchasers in their own right. Health Authorities should support this move towards primary care led purchasing and ensure that it works for the benefit of individual patients and the local population as a whole"* EL(94)79, p 2).

In the light of this new guidance, it is difficult to judge at this point in time how strategic decisions following health needs assessment exercises will be implemented. Clearly there will have to be closer working arrangements with general practitioners (something which the districts in our case studies are developing). This could be problematic because general practitioners are still independent contractors providing services and, as fundholders, are working as autonomous purchasing agents on behalf of their practice populations.

On a more positive note the GPs' purchasing function is likely to stretch across the entire spectrum of secondary, community and primary care in the future which could generate the kind of integration between different branches of the health care system which has eluded past re-organisations of the NHS.

The political objectives of the ***Patient's Charter***, appear to have been more important than clinical considerations in the development of a policy on waiting lists and times. As the case studies demonstrated, health authorities are required to ensure that targets for waiting times for particular services are met. The requirement for the new health authorities to implement national health policy has been clearly spelt out in the new EL letter referred to earlier.

Whilst the 'old' NHS was widely believed to be socially just (despite evidence of inequitable access and benefits from services), the fragmentation and new pattern of incentives and resource allocation which have occurred with the introduction of the Reforms, including the creation of Trusts and GP fundholding, undermines the notion of a unified service and increases the diversity of provision across the country. Such a situation could, according to Holliday (1992), lead to a system in which top-up payments become acceptable. This would lead to everyone having a basic level of service provided and people would fund for themselves anything over and above this. This is a situation in line with the tenets of a market system and is a way of increasing funding within the health service. It is not however in accord with the basic distributive principle on which the NHS was founded. The notion of social justice could therefore be a major casualty of the NHS reforms.

The rationing debate will almost inevitably become more explicit involving a larger and more politically sensitive role for health needs assessment. However for a Government which has accepted formal responsibility for the heath of the nation, there is a need to develop a national strategic approach to health policy. This could be through the identification of core services, as in Oregon, or some other method which will produce guidelines or protocols on priorities. Newcastle and North Tyne Authority made the point in their DPH Annual Report (1992/93) that there was no guidance on priority areas. The NHS is at a crossroads. Either policy will increasingly depend on the vagaries of those operating the market, or the Government could embark on a consultation process aimed at developing a set of principles which will guide the purchasers' decision making on priorities and choices. Such a set of principles should seek to remove the tension between meeting nationally set priorities based on nationally defined need (as in the ***Health of the Nation***) and those needs identified at the local level which because they may not be of the 'big killer' type (eg cancers etc) will receive less attention and less resources. If this is not done at the national level, health authorities will be left to do this by default, further increasing the fragmentation of service provision across the country and undermining any concept of a *national* health service.

The act of purchasing health care services to meet the health needs of local populations was at the core of the NHS reforms, and it is this which will drive continued change in the future. The increase in the number of general practitioner fundholders and the declining purchasing role of health authorities, may see health needs assessment and health care needs assessment interpreted in different ways, with new tensions emerging. In the future the tensions may include not only national versus local needs, but population's versus {GP} practice needs.

Health authorities will not only have to concentrate on their new roles of strategy, monitoring and support but also develop the needs assessment process to the extent that they not only know the health needs of their local population but can convincingly identify the health care services required to meet them.

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