COMMENTARY

Priorities and the problems of planning

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The publication in 1976 of the Department of Health and Social Security's consultative document on priorities[1] was a landmark in the history of the National Health Service. It was, incredibly enough, the first attempt to devise a national strategy for the NHS and the personal social services: to translate the logic of a *national* service into an explicit set of targets applicable to all health authorities. Previously the DHSS had frequently exhorted the health authorities to improve services for particular groups of the population, while evading responsibility for stating at whose expense such improvements should be carried out. In its 1976 document, however, the DHSS accepted responsibility for the unpopular choices in giving priority to some to the detriment of others. If the NHS could not "generalise the best"—Aneurin Bevan's rhetorically hopeful phrase—at least it might be possible to generalise the acceptable minimum: to ensure that everyone in Britain would get the same basic package of health care, irrespective of where they happened to live.

Inevitably, the DHSS's first priorities document prompted much criticism. Indeed, its declared objective was precisely to provoke a debate. The publication of the DHSS's revised national strategy—*The Way Forward*[2]—therefore provides an opportunity to see both how the Department has reacted to criticisms and how it is adapting its strategy. Have the priorities been changed? What progress is being made towards achieving the hoped-for standards? And, given that the whole planning system is still at an experimental stage, what is being learnt about the problems of trying to implement a national strategy?

Unfortunately, *The Way Ahead* seems to be designed to make any comparison with the 1976 consultative document an exercise in cryptography. The presentation is different. The figures are not precisely comparable.

Regular exchange

Much of the detail given in the 1976 document about the allocation of resources to the various programmes and client groups is missing in the 1977 version. The attempt to express priorities in terms of specific growth rates for particular services has been dropped without explanation. It is almost as though the Department was ashamed to admit that it is concerned in a learning process where mistakes are inevitable. Yet *The Way Ahead* claims that its aim is to continue "the debate which is to become a regular exchange between central and local government, the health authorities, the professions and the staff providing these services, and the public." If there is to be such a "regular exchange," then clearly it does not help if one of the protagonists insists on changing the vocabulary from year to year and it becomes necessary to break the code of civil service prose as a preliminary to joining the discussion.

In fact, the Department does appear to have responded to criticism. In particular, ministers have accepted that it is unrealistic to increase geriatric provision by restraining additional spending on acute services—since the objectives of policy, to rehabilitate the elderly, may equally be achieved by providing appropriate treatment in general medical or surgical beds. As it is, 50% of beds in general medicine and 39% of those in general surgery are occupied by the over-65s, and it is therefore self-evidently counterproductive to try to improve the care of the elderly by starving the acute services of extra resources. In total more than twice as many over-65s are treated in general medical and surgical beds than in geriatric ones. So, as the 1977 document sensibly recognises, the best way of giving priority to the elderly may be to organise the acute services so as to meet their needs.

Planning by the stars

The precise resource implications of this policy change are not, however, made clear. The 1976 consultative document suggested that the share of the acute and maternity services in NHS expenditure would fall from 43·1% of total NHS and personal social service spending in 1975-6 to 40·7% in 1979-80. The equivalent figures in the latest document are 40·9% and 39%, respectively. The difference stems partly from the fact that the 1977 document, unlike its predecessor, excludes the costs of administration, which are shown under a separate heading. But it also reflects the fact that the 1976 document seems to have based its calculations on an overestimate of the actual amounts spent on the acute and maternity services in 1975-6, and that the figures have subsequently been revised downwards. Perhaps this helps to explain why *The Way Ahead* is so reticent about giving precise percentage figures of planned spending targets. Given the problems in making any sense of expenditure statistics, these may convey a spurious impression of precision and suggest that the DHSS has an accurate set of maps and up-to-date navigating instruments when, very often, the planners appear to be steering by the stars and a large measure of guesswork.

Again, it is not clear to what extent the DHSS expects any increase in the resources available to the acute services to be made possible by a fall in spending on maternity care. The 1976 consultative document's proposition that savings should be made by closing underused and inefficient maternity units is reaffirmed. Provision should be concentrated, the 1977 document emphasises, in "better equipped units with enough staff with relevant training." This is expected to bring about a reduction in the cost per case, but it is not clear whether savings are to be used for improving the maternity services—in particular, the preventive aspects—or whether they are to be diverted to other sectors of the NHS.

Turning to the social work and domiciliary services, *The Way Ahead* becomes even less precise—even though these are an essential part of any coherent strategy, particularly for the elderly. It reiterates the DHSS's current strategy of cutting back on expensive residential provision and of giving priority to support in the community. "Taking the national picture for the next decade," the document states, "the hope is for a slightly higher rate of growth of field work and domiciliary services than was envisaged in the consultative document." That statement comes in paragraph 2.10. But paragraph 3.12 smartly whips the carpet from under this optimistic assertion. It emphasises that the figures given in *The Way Ahead* "are not based on any detailed information about the intentions of authorities nor do they take account of the most recent work connected with the rate support grant on personal social services which suggest that social work and home help services are likely to grow less than the projections envisage."

This is hardly encouraging, given that the projections for 1979-80—even assuming that they deserve any credence at all—suggest that provision at the end of this decade will still fall far short of the standards laid down in departmental guidelines. Thus, while DHSS guidelines envisage 12 full-time home helps—or their part-time equivalents—per 1000 elderly, the projection for 1979-80 is 7·1 (as against 6·5 in 1975-6). And this despite the fact that the number of available residential places per 1000 elderly is expected to fall from 18·1 in 1975-6 to 17·9 in 1979-80—so that the guideline target of 25·0 per 1000 seems to be ever-receding. Similarly, for the community health services, there is expected to be a fall in the relative provision of day places for the elderly (from 1·1 per 1000 in 1975-6 to 1·0 in 1979-80 as against a guideline target of 2·7), partly balanced by an improved nursing service.

So not surprisingly the recurring theme of *The Way Ahead* is that improvements in services depend largely on the more efficient use of existing resources. This, of course, is incontrovertible, given the present constraints on the budgets of the NHS and the personal social services. Similarly, it would be foolish to deny the vast scope for greater efficiency. Anyone working in the NHS will be able to expand on the document's shopping list of possible savings, which range from cutting out waste in food to shortening lengths of stay.

But although *The Way Ahead* is strong on exhortation, it is singularly weak on suggestions about how to bring about the hoped-for economies. What are the obstacles in the way of implementing change in the NHS? What incentives could be offered to those who successfully innovate or introduce economies? The DHSS document neither identifies the obstacles nor proposes any incentives. Implementation, it seems, is the problem of the field authorities at regional, area, and district level. There is no recognition that many of their problems stem from circumstances which could be changed only by national policy decisions. For example, the NHS as at present designed has in effect—if not in intention—multiplied the ability of various groups to veto or obstruct change. Not only the medical profession but the trade unions and the community health councils have the power to delay or prevent the reallocation of resources or the introduction of new patterns of work. Consequently, the NHS is in danger of becoming a stalemate organisation,[3] with an inbuilt bias towards the status quo. If the DHSS's exhortations are to carry credibility, therefore, they ought to be accompanied by policies designed to make the implementation of change easier. This, surely, ought to be the Department's first priority.

How to strike a balance

But the difficulties of overcoming organisational inertia is only one of the problems of trying to introduce a national strategy. *The Way Ahead* also underlines an even more fundamental problem—how to strike an appropriate balance between imposing a national strategy and yet to allow for local circumstances and discretion. Throughout the document warns that its figures are illustrative only: that they merely provide indications of the national "long-term direction of strategic development," not "specific targets to be achieved by declared dates in any locality."

In making this point, *The Way Ahead* identifies the central dilemma of planning in the health and personal social services. If the central planners insist that their guidelines figures should be taken as targets, then they risk imposing a national blueprint even in circumstances where it may be inappropriate or where it may simply be incapable of achievement given local constraints. If, on the other hand, they treat their guidelines simply as a general but not binding indication of what is desirable, then there is a danger that national planning may simply become a rhetorical exercise in persuasion.

It remains to be seen whether there is a sensible middle way: whether, in fact, the health and personal social service authorities will assess their own plans in the light of the national strategy, and whether the DHSS will in turn adjust its strategy to take account of their views. Certainly, current DHSS planning tactics seem to be based on the assumption that a process of mutual adjustment will produce a movement in the desired direction, and that the planning system will result in the gradual convergence of central policies and local views.

This view of a national strategy as a kind of mirror in which those responsible for planning health services at the point of delivery can see their own shortcomings has the advantage, at least, of recognising the limitations of knowledge at the centre. But it does leave some worrying questions unanswered. How much divergence from the guidelines is the DHSS prepared to accept, and on what grounds? And what criteria exist for assessing the all-round adequacy of services provided for any specific population?

Resource-centred approach

At present, the DHSS takes the view that adequacy or equity—whether in terms of overall provision, as in the RAWP formula, or services for specific groups—can be measured only in terms of resources. But the care provided reflects both the level of resources and the way in which they are organised and used. Moreover, as the DHSS recognises, there is great scope for substitution between different kinds of services—between acute and geriatric beds, between residential places and community support.

This resource-centred approach to planning may, at present, be unavoidable, given the lack of other techniques. But its deficiencies limit what can sensibly be done, and perhaps further explain the reluctance of *The Way Ahead* to commit itself to translating its priorities into specific figures. So, perhaps, the DHSS's second priority ought to be to instigate more work on the development of population-based criteria for assessing Health Service priorities: the long-term aim ought to be to express these priorities in terms of what they mean for the population concerned—as measured, in particular, by the availability of access to medical or social care for specified conditions and in particular circumstances.

Indeed, the current emphasis on developing a planning system and strategy ought, more generally, to be seen as a long-term investment rather than as an immediate useful tool of management. Given current economic constraints, there is little scope for manoeuvre, and any adjustments are bound to be marginal tinkering. The real test will come if the gush of North Sea oil releases a flow of extra funds for the health and personal social services. There would thus seem to be a strong case for the DHSS to prepare a consultative document now setting out its priorities for distributing any extra resources that may become available. If an extra £200 million, £300 million, or £400 million a year were to be added to the DHSS's budget, how should the money be spent? How much should be spent on better salaries to improve morale? How much should be devoted to new buildings as distinct from hiring more staff? How much should go to the NHS as distinct from the personal social services? What benefits, and for whom, would flow from different spending priorities? Any national strategy for the health and personal social services must, surely, concern itself with such questions. Any debate about priorities which excludes them is bound to seem more about incremental adjustment than strategic choice.

References

1 Department of Health and Social Security, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.
2 Department of Health and Social Security, *The Way Ahead*. London, HMSO, 1977.
3 Klein, R, *New Universities Quarterly*, 1977, **31**, 161.

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Fees

Increase

The General Whitley Council has reached an agreement on a revision of the day and night subsistence rates, the late night duties allowance, and the public transport rate of mileage allowances for hospital and community medical and dental staff. The subsistence rates and late night duties allowance apply from 1 July and the public transport rate from 1 August 1977. The revised rates and the appropriate paragraph in the Handbook of Terms and Conditions of Service are shown here:

Subsistence (Section XVIII)

Paragraph 3(*a*)(i)	
First 30 nights:	
London	£19·77
Elsewhere	£17·37
After first 30 nights:	
Married officers—London	£7·70
—Elsewhere	£7·55
Other cases:	
Non-householders—London	£5·05
—Elsewhere	£4·45
Householders —London	£5·90
—Elsewhere	£5·35
Paragraph 3(*a*)(ii)	
5-8 hour absences	£1·22
Over 8 hour absences	£2·58
Paragraph 3(*b*)(i)	
First 30 nights:	
London	£14·60
Elsewhere	£12·13
After first 30 nights:	
Married officers—London	£6·75
—Elsewhere	£6·30
Other cases:	
Non-householders—London	£5·05
—Elsewhere	£4·45
Householders —London	£5·90
—Elsewhere	£5·35
Paragraph 3(*b*)(ii)	
5-8 hour absences	£0·95
Over 8 hour absences	£2·24

Late night duties

Paragraph 8	£1·00

Public transport rate (Section XVII)

Paragraph 11	5·7p per mile

Decrease

General practitioners who do part-time work for local authorities have, from 9 August, had their mileage allowances reduced from 12·5p per mile to 12·3p per mile. The revision follows the reduction in petrol tax.

Correction

In the paragraph on fees for part-time service in the report from the CCCM (1 October, p 912) a speaker was reported as saying that general practitioners had received an increase of 33% in their fees for local authorities. In fact, the increase of 32·27%, which the Price Commission agreed with effect from 1 April 1977, was for Category D recommended fees and other negotiated fees (*except* those from public sources, which are deemed to come within pay policy).