

Making policy in the dark

One of the most predictable conclusions to emerge from almost any research project is that more research is needed. The two latest research studies prepared for the Royal Commission on the National Health Service are no exception. The first, produced by a team at Warwick University, examines the structure of financial control in the NHS.¹ The second, written by Martin Buxton and Rudolf Klein, analyses the recommendations of the Resource Allocation Working Party (RAWP) and their implementation.² Both argue that present policy in the NHS is based on inadequate information and that better data are needed if there are to be improvements in the strategy for using and deploying resources—a depressing finding, given that as long ago as 1956 the Guillebaud Committee³ drew attention to the need to improve the information system of the NHS. At that time the Ministry of Health had just appointed its first statistician. Now the DHSS has a whole army of statisticians and economists; yet the same cry goes up.

Yet if policy makers will always ask for more facts it becomes all the more important to decide on priorities. What extra information is essential, as distinct from being merely desirable? The question is all the more crucial, given the costs of collecting data—a cost measured not just in the salaries of any extra staff that may be required but in the time of busy clinicians and other existing staff who have to supply the raw material. Here the Warwick paper rightly warns against collecting information merely because this seems to be useful to the managers. The history of Hospital Activity Analysis is a case in point. This expensive system is much underused and, as the Warwick paper points out, is frequently inaccurate—which in turn helps to explain the lack of interest shown in it by many of the clinicians who are supposed to be able to use HAA to analyse their own performance. Information requirements need to be assessed in the setting of specific decisions and of specific policy problems.

Starting from the requirements of the individual clinician, the greatest weakness of the present system of NHS budgeting is that it is almost impossible to get information about the costs of dealing with individual patients or using specific procedures. Here the Warwick team argue for moving towards a system of specialty costing which, though still fairly coarse meshed in terms of individual treatment costs, would at least provide consultants with a picture of their total expenditure pattern. Indeed, the next move would be to adopt specialty budgets, so that consultants could use their resources within a given total. This seems a promising development and certainly a feasible one, to judge by the results of some of the experiments that have already been carried out. But moving in this direction would be sensible only if, in turn, consultants were given freedom to make their own decisions within their budgets. If such a system were seen as a means of strengthening administrative control, as distinct from enhancing clinical freedom, within fixed financial limits, it would certainly not obtain the required degree of co-operation from clinicians.

In general, the Warwick paper argues that at present clinicians do not participate sufficiently in decisions about resources. No evidence supporting this assertion appears in the report, which is generous with opinions and parsimonious of facts, and is peppered with such phrases as “We have been told . . .” and “We have heard . . .” But to argue for more medical participation is in any case to beg the question of whether the present environment of the NHS is such as to encourage it, or indeed even to permit it. Improving financial

information—or even the committee structure—is not going to bring about more participation by consultants and others if their clinical work load is excessive. If the Royal Commission were to decide that more medical participation in decision-making in the NHS is desirable it should also spell out the implication. This is a larger medical establishment, in particular more consultant posts, to reflect the administrative as well as the clinical work load.

The case for investing in specialty costing is, however, further reinforced by the Buxton-Klein paper on RAWP. This concludes that the RAWP formula was probably the best that could be devised, given the lack of adequate indicators of morbidity as a basis for Health Service planning. But it underlines several weaknesses in applying the formula. One of these is that, given the cross-boundary payments by health authorities to reflect patient flows, better financial information is urgently required. As it is, teaching and other specialist hospitals which import the more difficult or severe cases are likely to lose money, since payments are based on estimated average case cost by specialty. A realistic system of specialty costing should permit accurate prices to be charged. This change is essential if health authorities are not to discriminate against high-cost patients. Similarly, the authors point out, the lack of any allowance for day patients and outpatients crossing administrative boundaries—reflecting lack of data about costs—is a strong deterrent to the effective deployment of resources.

More fundamentally, Buxton and Klein emphasise that the RAWP formula and DHSS policy are based on a questionable assumption—that redistributing resources is both necessary and sufficient for bringing about the objective of the whole exercise: to equalise opportunities of access for patients throughout the country. It may not be a necessary condition, their paper argues, since access for patients living in underprovided areas could be increased by “providing transport, subsidising the travelling costs of patients and their relatives, or by improving the flow of information about the availability of spare treatment capacity.” It may not even be a sufficient condition, since in practice two health authorities with the same level of resources may provide quite different patterns and levels of service. If we accept this argument, it follows that perhaps the most urgent information need for the NHS is to develop indicators of access—population-based measures of who gets what in the way of treatment for specific, clinically defined conditions.

There are more problems about this approach than Buxton and Klein seem to recognise. Measuring “need” in the population—a necessary precondition for measuring access—is notoriously difficult. Furthermore, such an exercise would be prohibitively expensive if carried out on a national scale. But the Royal Commission might be wise to recommend a trial experiment in a few areas of the country designed to evaluate methods and to monitor the effects on access of redistributing resources. For unless we can be sure that the RAWP exercise is succeeding in its aim and that access can be shown to be improved as a result of the redistribution of resources, it is questionable whether the consequent dislocation and strain can be justified.

¹ Royal Commission on the National Health Service, Research Paper Number 2, *Management of Financial Resources in the National Health Service*. London, HMSO, 1978.

² Royal Commission on the National Health Service, Research Paper Number 3, *Allocating Health Resources: a Commentary on the Report of the Resource Allocation Working Party*. London, HMSO, 1978.

³ Committee of Inquiry into the Cost of the National Health Service, *Report*, Cmnd 9663. London, HMSO, 1956.