TALKING POINT

Observations on SHAPE—Scottish priorities for the 'eighties

J A FORD

The report on *Scottish Health Authorities Priorities for the Eighties* (SHAPE)[1] makes recommendations for the Scottish Health Service until 1986 and replaces the existing guidelines in the 1976 document, *The Way Ahead.*[2] Produced by a working party of the Scottish Health Services Planning Council, SHAPE is an extension of *The Way Ahead* and its successor, the report on *Scottish Health Authorities Revenue Equalisation* (SHARE).[3] The latter made 26 detailed recommendations. It was based on complicated calculations that, in considering revenue allocation to individual health boards, took into account weighting factors based on national utilisation data for the population of the 15 health boards. These factors included age, sex, cross-boundary flow of patients, supra-area services, teaching, and other special commitments. As a result of these calculations and in order to progress from 1977 to 1982 the annual percentage of financial allocation to the largest of the health boards, such as Glasgow (−0·53), was to decline, while for the smaller boards, such as Ayrshire and Arran (+6·9), it was to increase. The SHARE report therefore operated within the existing cash limits with a small (1½%) inbuilt growth rate and simply equalised revenue allocation between the boards.

There are several problems inherent in this approach. Firstly, statistics concerning morbidity are—and have been since 1948—lacking, and the report acknowledges that there is no method available for their collection. It is doubtful whether mortality statistics used on a proxy basis accurately reflect morbidity. Secondly, in terms of development of new services revenue equalisation can only have an inhibitory effect. In an era of high technology further advances will have occurred and the cost correspondingly increased by the time a planned service has come into operation. The major health boards will be reluctant to introduce innovations. Thirdly, there is no clear attempt to end the spending sprees by most health boards towards the end of the financial year. At present a health board automatically loses unspent allocations in the following financial year. This is a positive disincentive to good housekeeping and must be stopped, especially if the new "unit management" is to be encouraged.

The SHAPE report must be studied against this background. Fundamentally, such economic philosophy means redistribution of resources favouring the poorest and disabling the richest. This approach has already been applied to the Scottish educational system, with deleterious results.

Self-inflicted ill health

The SHAPE report divides priorities into three separate categories—A, B, and C. Category A is prevention. In the foreword the Secretary of State points out that much of the ill health of the Scottish people is self-inflicted by smoking and excessive drinking. Having made the justifiable plea for better morbidity data, the report states that, out of 24 countries, Scotland is the fourth and second worst respectively for male and female life expectancy while about average for infant mortality. Prevention is therefore an admirable goal. But there are so many factors and influences concerned—the mass media, the educational services, taxation on tobacco and alcohol, the inability of MPs to pass legislation on the compulsory wearing of seat belts, flouridation, and law enforcement. So it is difficult to see how setting this goal will make any impact on the utilisation of the Health Service. The remaining groups in category A are those that were accorded high priority in *The Way Ahead* and include the elderly, the mentally ill, and the mentally and physically handicapped. Many outside factors—local authority housing, home helps, meals on wheels, voluntary groups, society's attitude to the extended family—are equally relevant. Even so, if revenue is to be diverted to the community-based services on the assumption that outside provision will be readily available then there is a danger that the acute services with fewer resources will have to struggle on with the existing work load.

None of the recommendations in category A except perhaps the development of the community nursing services are likely to have much impact on revenue allocation (as described in SHARE) in the Scottish health service. Their successful implementation will depend more on changes of attitude in society than on the financial compliance of the already besieged local authorities and the good will of voluntary organisations. It would have been encouraging to see provision made for positive financial incentives to families to keep their elderly or handicapped relatives at home.

Category B lists primary dental services, maternity services, general medical services, and general ophthalmic services. The report emphasises again that more attention should be paid to preventive work. So far as the general ophthalmic services are concerned there should be more domiciliary work directed towards the elderly and the handicapped. Maternity services have commendably been raised from low to medium priority because of the increasing number of births. SHAPE recommends that the Walker Report on the standards of perinatal care[4] should be implemented to reduce perinatal mortality and the social class differential. It is encouraging that the SHAPE report gives special mention to the implications of neonatal care both special and intensive, not only on survival but also on long-term handicap. In the light of these preventive implications the development of the perinatal services should have been placed in category A. It is suggested that the costs of the improvements will be partially offset by reducing the mean stay in maternity hospitals from seven to six days, achieving a bed occupancy of 80%, and closing little-used beds. Nevertheless, the report emphasises that the maternity services should be given additional resources.

Category C lists child health, the acute hospital services, and the general pharmaceutical services as having the lowest priority, where programme expenditure should be static and any improvements self-financing. As for the pharmaceutical services, like the family practitioner services they are outside the control of health boards, though the point is made that more economic prescribing habits may lead to a reduction in costs. The report does acknowledge the argument that improvement in child health and prevention of handicap is an investment for the future. But it sees this as a selective rather than a global expansion in the services, concentrating mainly on prevention, screening, and outpatient

Rutherglen Maternity Hospital, Glasgow G73 2PG, and Royal Hospital for Sick Children, Glasgow G3 8SE

J A FORD, MB, MRCP, consultant paediatrician

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services with the closure of small inpatient units. It seems, therefore, that in keeping with the failure of the Government to act on previous reports such as *Fit for the Future*[5] the child health service is to remain a Cinderella service.

The low priority given to acute services engenders most misgivings among the medical profession in Scotland. The general philosophy of the report is to develop the least cost-intensive services listed in category A. It is a major act of faith to assume that prevention will reduce mortality and morbidity and that the newly developed community services will cope with a substantial proportion of the present acute-service work load. Nevertheless, in a recent circular to all consultants in the Greater Glasgow Health Board it was made clear that patients from neighbouring Lanarkshire should have reduced access to Glasgow facilities. Yet even in a new district general hospital in Lanarkshire theatres cannot operate full time because of an acute shortage of nurses, and the maternity services are so near to breaking point that it has been suggested officially that general practitioners should undertake more home confinements. The implication is that by adopting this policy Glasgow will be able to reduce its acute beds. This shows an incredible belief in the cross-boundary accounting methods of the SHARE document and takes little notice of supra-area services.

Need for collaboration

SHAPE's final chapter turns to programme objectives. The authors state that the assumptions concerning growth rates are vulnerable to outside factors such as inflation, etc, and emphasise that if recommendations are to be successful there must be collaboration between health boards and local authority services at every level. It seems that we have come full circle and are now to develop a pre-NHS policy of almost conterminosity.

The report recommends that national guidelines on capital expenditure should be issued every five years, that the Secretary of State should begin a review of the major building programme in 1980, and that boards should review both their major and ordinary building programmes and consider whether the division between the two categories is correct. Other than improving the geriatric facilities for the over 75s (to be partially offset by the projected reduction of the client group aged between 65 and 74), all capital expenditure related to categories A and B is to be minimal. So far as category C is concerned money for development of orthopaedic, oncology, and pacemaker services must be found from within revenue savings. Furthermore, it is implied that where new beds are required this will often entail switching beds from one specialty to another and a more flexible use of beds between specialties. This happens already, and in some specialties numbers of beds and personnel are so stretched that there is little room for flexible usage.

In dealing with programme objectives in the health and community services not requiring major capital expenditure the report lays out its assumptions on three possible growth rates—nil, 1·5%, and 3%. Nil growth results in simply redividing the allocations in favour of category A; a 1·5% net growth should result in all the extra money being diverted to categories A and B; and if a 3% growth is achieved then the further additional funds should go to increase capital expenditure incurred mainly in category A. Whatever option is adopted the outlook for the hospital service is gloomy and holds little hope for anything other than a diminution in the services provided.

So far as general practice is concerned, the report welcomes the commitment expressed by the National Medical Consultative Committee for General Practice to prevention but then suggests that this may lead to an examination of the present contract for general practitioners. Coupled with the emphasis laid on primary health care teams, the report will have done little to inspire general practitioners. One important point to emerge, however, is the value of the independent nature of the general practitioners' contract. In considering programme objectives the report has omitted any consideration of general practitioner services as "they are demand led and the method of financing them is different." There is a lesson here for the whole profession, and general practitioners must continue to guard jealously their status against such hints to re-examine the nature of their contracts.

Like its predecessors, the SHAPE report contains some laudable sentiments that would, I believe, be supported by the profession. The means of attaining them, however, evoke different responses. The policy is an all too familiar one of robbing Peter to pay Paul.

References

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PLAB: 1980 report

Pass rate of 43% for tests

The 1980 report of the Professional and Linguistic Assessments Board shows that 15 tests of knowledge of English and of professional knowledge and competence were conducted during the year. There were 2710 attempts made to pass the full PLAB test. Several candidates took the test on more than one occasion. Forty-three per cent (1160) passed the full test. Of those who passed, eight were graded by the examiners as "excellent," 107 as "good," and 1045 as "adequate." The percentage pass rate during 1980 was similar to those of previous years—1979 (38%), 1978 (42%), 1977 (32%).

The test was introduced in June 1975. By September 1980 the number of individual attempts made to pass the test had reached the 10 000 mark, and by December 1980 the figure had increased to 10 924.

The board and its panels have continued to review the results of the tests and remain satisfied that doctors who have passed the test have sufficient proficiency in English and professional knowledge to engage safely in employment in a British hospital in the grade of senior house officer. Since June 1975 the GMC has monitored the performance in hospital appointments in the United Kingdom not only of doctors who have passed the test but also of those who have gained exemption from it. In both categories the council has received adverse reports in less than 2% of cases.

During 1980 the board continued to conduct special tests of knowledge of English for doctors who qualified in another member State of the EEC and who have obtained full registration in the United Kingdom as a national of an EEC member State. The board has continued to admit to this special test doctors who have obtained outside the EEC a qualification which is recognised by the GMC for the purposes of provisional and full registration. During the year the board tested the knowledge of English of 71 EEC candidates, of whom 63 passed. Over the same period it tested the knowledge of English of 470 candidates who held qualifications obtained outside the EEC. Of these, 285 passed.

In October 1980 the Government announced its intention to abolish the existing statutory requirements that EEC doctors must satisfy the GMC, as a condition of their continued registration, that they had the necessary knowledge of English for the practice of medicine in the UK. It had been proposed that the requirements would be replaced by arrangements whereby authorities in the NHS would have a responsibility for satisfying themselves that EEC doctors possessed the knowledge of English requisite for the particular employment offered to them and that, for this purpose, the PLAB English test might continue to be used.

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