position to manage their own services, provided the resources are somewhere approaching adequate. One of the most important resources is information: without it we grope in the dark and have fair reason to blame the system when things go wrong; with it we can begin to make rational decisions, develop a more effective service, and assume a greater degree of responsibility.

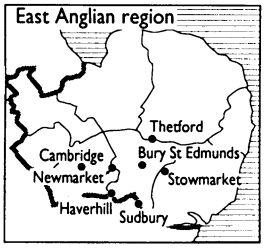
A curious aspect in which a hospital information strategy is potentially constrained is the separation of funding for medical audit and resource management. Our belief is that the two go hand in hand, especially when clinical staff are being encouraged to take responsibility for managing their clinical services. Our experience in developing clinical management teams at the ward rather than directorate level suggests that this can lead to far better teamwork between doctors and nurses than might otherwise be the case. Since both professions are managing the same patients this must be to the patients' advantage. Encouraging separate investment in medical audit and nurse management systems does not help this and seems set to perpetuate professional rivalries. Both professions currently capture similar patient data in their respective manual records, and both initiate separate care plans for the same patients—often without reference to each other. Perpetuating this division of labour in hardware and software makes little sense.

Perhaps the greatest problem is that although hospitals are being encouraged to develop their own strategies, their room for manoeuvre is limited. Guidelines—initially supportive in intent—become increasingly prescriptive and seemingly less relevant. Funding is earmarked for specific system developments whether or not they eventually form part of a carefully developed strategy. It is as though a great scientist having initiated his experiment and impatient for the results begins to write them up while turning a blind eye to the actual outcome.

A simple approach to an information strategy would be to ignore the clinical coalface, devolve hardly at all, and ensure that contact minimum datasets and other externally required information are delivered by installing central contract and case mix systems fed by the traditional army of clerks. Boxes could be ticked and paymasters kept happy—for a while. This would, however, be an extremely short term view and would do little to ensure the continuing good will and involvement of those who actually treat the patients.

I am especially grateful to Stephen Ranger, of OASiS, for his indefatigable support and for ensuring that our thoughts did not completely transgress the bounds of possibility, and to David Feeney and Guy Fitzgerald, of Templeton College, Oxford, for useful insights and advice.

The New NHS: first year's experience



West Suffolk: a changing world

Jane Smith

You might expect West Suffolk to have ridden the first year of the reforms well. As a predominantly rural district with one main general hospital, comprehensive community services, and good general practices, its potential for chaos was always much less than that of places like Newcastle upon Tyne (4 April, p 907) or East Birmingham (described in next week's *BMJ*). And, indeed, the district and its two directly managed units (the acute unit based at West Suffolk Hospital in Bury St Edmunds and the community health unit), have ridden it well. Contracts have been met, waiting lists have been reduced, no extracontractual referrals have been refused, both district and units ended the year in financial balance, and both units have applied to become trusts. Nevertheless, two events have overshadowed the first year of the reforms and will continue to do so: the possibility of West Suffolk district merging with East Suffolk and the change of use of Newmarket Hospital.

The merger

One of the main lessons learnt by the health authority during the first year has been that it isn't big enough to do its job properly. As Jane Rutherford, director of planning and personnel, explained, West Suffolk is only just big enough to set up the framework for purchasing—to establish contracts, monitor them, and measure activity. "There is no extra capacity to maintain a dialogue with general practitioners and to set up teams to delve into particular aspects of care.... We are only just surviving."

The merger may be seen as inevitable by district officers, but others have mixed feelings. Many people remember with suspicion the old Suffolk Area Health Authority. They felt then that East Suffolk's bigger hospital in Ipswich sucked in more than its share of resources and they fear the same again. So much so that Grant Elliott, now director of finance of both authorities, has pledged himself, if appointed director of finance of a new authority, to ensure that the people of West Suffolk receive their fair share of resources.

The effect of the merger has been most dramatic at West Suffolk Hospital: it has swung the consultants behind the hospital's trust application. "The cosy relationship [with West Suffolk Health Authority] will go, and then it'll all come down to cost," said one. Some years ago there was a proposal to concentrate ear, nose, and throat surgery at Ipswich; the consultants fought hard to prevent it and would do so again. If ear, nose, and throat surgery goes, they reason, other services will follow and the hospital will be left simply providing outpatient services for Ipswich and Addenbrooke's. "We'll become an irritant to Ipswich just as Newmarket has become an irritant to West Suffolk," another said.

Neither general practitioners nor district officers think that is likely. Bury St Edmunds' natural communications are with its hinterland, the small towns on roads that radiate from it, and the "purchasers" think that patients simply would not go easily to Ipswich. "The people of West Suffolk wouldn't stand for it," said Dr Ted Cockayne, a general practitioner in the east of the district, nearest to Ipswich, but who nevertheless refers nearly all his patients to Bury.

Newmarket

Newmarket Hospital has been a "problem" for the past nine years, and without the reforms some reckon that it would have been for a good few more yet. Instead the internal market has forced a decision.

Newmarket Hospital is a small acute unit with high costs and a reputation for friendliness that has

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WEST SUFFOLK NEWSPAPERS

Newmarket Hospital: a victim of the market

fallen victim to CEPOD (Confidential Enquiry into Perioperative Deaths) and the agreement on juniors' hours. Health authorities who used to use the hospital have shifted patients elsewhere, thus forcing costs even higher. The district last year proposed its redevelopment as a community hospital but with outpatient and diagnostic services. The local general practitioners and the community health council opposed this plan, so the decision went to the minister for health, who delivered his verdict in February. He approved the change of use to a community hospital but also asked the district to explore the possibility of a minor casualty department, a general practitioner maternity unit, and day surgery.

Newmarket is on the border of West Suffolk and Cambridge districts and its patients and consultants come from both places. To decide its future a working group of both districts together with the West Suffolk acute unit (which currently runs Newmarket) and Addenbrooke's Hospital in Cambridge has been set up to work out affairs collaboratively rather than competitively. West Suffolk Hospital needs to know how much of the workload it will be taking on in order to provide for it. But, according to Dr John Calvert, a Newmarket general practitioner, the local general practitioners have not been able to get out of Addenbrooke's general manager a clear answer on whether consultants based at Addenbrookes will continue to hold outpatient sessions at Newmarket.

Perhaps the most immediate effect of the Newmarket decision has been the decision of two practices in Newmarket and one nearby in Cambridgeshire to apply to become fundholders in 1993. They have done this, explained Dr Calvert, one of the general practitioners concerned, because it is the only way they can exert real influence to get the hospital at Newmarket that they want. This was obviously a decision that Dr Calvert had taken reluctantly, but he thinks that "money might talk in a way that simply expressing preferences to managers may not."

The district health authority

At district level the main lessons of the first year for Jane Rutherford have been simply about learning what the process is and where patients go. Some activity levels have turned out wrongly, not because a provider underperformed or overperformed but because the original information was wrong. "We now have a much better baseline."

She also knows more about where patients are going. For example, in the first year she had picked up an unexpected amount of respite care, often done through extracontractual referrals. That had highlighted a need, and the authority had therefore put more resources into providing it locally and improving its quality. She had also discovered a small flow of tertiary referrals to London and of convalescent patients to the Norfolk coast. In the first case she had identified a similar service near by and at less cost. She had asked the consultant concerned to check out the service and if he was happy with it then she would make a contract. In the second she had made a contract with local nursing homes. The only other significant change in contracts this year was to increase the numbers of coronary artery bypass graft operations bought from Papworth Hospital.

Changes at the margins apart, Jane Rutherford sees her job as contracting largely "for the nature of things"—existing general practitioner referral patterns, which reflect patient convenience and waiting lists. Some of the general practitioners interpret this more cynically as the district just not having any spare money, but she points out that the only major problem raised by general practitioners has been orthopaedic waiting lists—a national problem and one she hopes will be eased locally by the provision of an extra theatre at West Suffolk Hospital.

CONTRACTS

Contracts for 1992-3 will be a little more refined than last year's, but not much. There will be more block contracts with upper and lower limits on activity, and a few more cost and volume contracts. Some small contracts will not be renewed but instead handled as extracontractual referrals. The district has signed letters of agreement with some providers which allow them to do extracontractual referrals up to a certain limit without prior authorisation. Developing more sensitive measures of activity is clearly a major concern. Both the district and the hospital are moving towards case mix for acute activity, but no one yet seems to have solved how to measure accident and emergency, outpatient, and community activities.

West Suffolk's philosophy is to work with providers, but "at the end of the day there is a contract, and we'll wield it if necessary," said Jane Rutherford. She conceded that the district wasn't known as an aggressive purchaser, but it had taken some providers by surprise in its insistence on inspections. The district's nurse adviser has visited all its providers to monitor, for example, waiting times in outpatients, the quality of the food, and the information patients receive. According to managers at West Suffolk Hospital these inspections can last up to five hours and include authority members as well as officers. One benefit of this approach is the comparative element: the inspector can put one hospital in touch with another to spread good ideas.

At present quality largely consists in broad brush requirements like ensuring that medical audit is in place (with a mechanism for implementing the results), that patients are asked about what they want, and that regional guidelines on prescribing are followed, but much of it consists in ensuring that providers are doing the things they said they would do.

THE ANNUAL REPORT

The shape of future contract requirements lies in the director of public health's annual report. For the first time Roger West has identified priorities for action, concentrating on ischaemic heart disease, lung cancer, diabetes, and dementia. For heart disease, for example, the report recommends that health promotion should be built into most contracts, that thrombolytic treatment should not be withheld on grounds of cost, and that outcome measures for heart disease should include the proportion of patients who return to normal

activities after treatment. Though most of these recommendations will inform next year's purchasing rather than this, the authority has already earmarked funding for a health promotion coordinator and for extra coronary artery bypass grafts.

Roger West likes to think that the reason there are no fundholders in West Suffolk is because general practitioners are pleased with what the health authority does for them. That view is partly confirmed by Dr Ted Cockayne. His practice initially flirted with fundholding but decided against. They have always managed to get the services they wanted from the local hospital and the first year of the reforms has not changed his view. In the autumn he was concerned about bed closures and raised at the district medical committee the difficulty of getting patients admitted, but the problem had not recurred. He worried, however, about the loss of Newmarket Hospital; it acted as a safety valve when beds got tight.

The hospital

West Suffolk Hospital now charges visitors to park and boasts advertising panels in the main corridor. It would be wrong to say that not much else has changed, but there is a feeling that waiting for the Newmarket decision has held back a lot of action and a commensurate feeling that the hospital has only about a year to catch up and show it can compete within a larger district.

Nevertheless, Bob Jones, the general manager, has a list of achievements. Like the district, he and his team have a much clearer idea of who they are treating and feel they have responded to the pressure to deliver care. They have met their waiting list targets and in the process cleaned up the waiting lists and rewritten their waiting list management system. They have established a system of clinical service areas and lead consultants (West Suffolk's version of clinical directorates), appointed business managers to work with the consultants, and started to devolve budgets to clinical areas. As a result, for example, the radiologists used money for clinical assistants to fund an extra radiographer.

They have started to plan to take on work from Newmarket. But because of capital charges "the last thing you do is provide extra facilities unless you're absolutely sure you will get that service," commented John Foreman, unit director of finance. He cites the maternity service at Newmarket. When it closed everyone thought that half the patients would go to Addenbrooke's and half to West Suffolk. In fact 75% went to Addenbrooke's, though that figure has fallen to 60% since the West Suffolk's maternity services manager started running seminars for general practitioners. The other development that capital charges is making them wary of is their day surgery unit. They need to be sure they can get the contracts to cover the costs, and to minimise those costs they have commissioned a space utilisation survey.

QUADRAPHONIC FLAK

Bob Jones feels that the dialogue between consultants and managers is better now, though he confesses that he found agreeing consultant job plans a negative experience and would do away with them if the hospital becomes a trust. Humphrey Piggott, general surgeon and chairman of the medical advisory group (the lead consultants group), thinks that the consultants remain demoralised because they can't see where the reforms are leading. He thinks he sees a glimmer, though confesses to feeling a bit like a conscripted private subjected to quadraphonic flak. In the end he thinks the good outweighs the bad. "It disciplines us and we know more about what we do—and that's good."

What bothers him is whether he and his colleagues have the capacity to do everything. This year the hospital will have to take on work from Newmarket and cope with the capital charges for the day surgery unit. Also they've been invited to provide outpatient sessions at Haverhill, on the edge of the district, but he's not sure whether they can do this and meet the requirements of the patients' charter. He worries about how they are to reduce junior doctors' hours when the hospital runs on one of the lowest levels of junior support in the region. Most of all he worries about the amount of time management takes from clinicians. He had taken on his job as chairman "as an intellectual exercise and to find out what is going on.... If it got in the way of my doing surgery—which I think it is beginning to do—then I should give it up."

Other consultants confirm Humphrey Piggott's surmise that they are feeling blackmailed. Some think that things are being done at the expense of patients rather than for them: they cite the manipulation of waiting lists and the push to day surgery. Though the reforms have made them look at costs there's a credibility gap when data are obviously inaccurate.

The community health unit

The major change to the community health unit over the past year was its reformation to include mental health as well as community services. That has brought an influx of doctors, and Chris Stevens, the new unit manager, has set up a medical advisory committee as one means of involving doctors in managing the unit. He is also anxious to engage doctors, nurses, and therapists in contracting. He doesn't want to see a token clinician on a contracting team ("that's not a good use of their time") but he does want contracts to reflect what they have committed themselves to.

He sees the relationship between purchaser and the community unit very much as a partnership and cites the example of the health promotion coordinator post which he is currently discussing with Roger West. "It's an example of how purchasers and providers can work together on strategic change."

Chris Stevens has been much impressed with the work of the unit that he has just taken over, including the good relationships with social services and the family health services authority and he wants to see those develop. "When an issue is fundamentally common to more than one agency joint discussions should go on from day one.... It may take more time initially but the result is better."

The community unit doesn't plan to become predatory when it becomes a trust: it doesn't, for example, want to take over East Suffolk's community services. That would make the unit too big to maintain local contact and also negate what he sees as his unit's role in protecting services for the people of West Suffolk. But Chris Stevens does want to use this further year of a protected market to show any potential purchasers and fundholders that his unit can provide those services better than anyone else.

He has already had a potential success with the general practitioners of Newmarket, some of whom have been using West Suffolk's mental health services for their Cambridge patients. These had to be done as extracontractual referrals; none were refused but the general practitioners spent time negotiating them, particularly when they wanted West Suffolk's community mental health team to follow up an initial consultation and several were deferred. Both the general practitioners and the community unit would like Cambridge Health Authority to have a contract for these services. So far Cambridge has proved reluctant, but it has agreed a level of extracontractual referrals within which the unit should expect authorisation. The

unit is still trying to develop an agreement that approval should be for a "package" of care rather than a single consultation.

Problems for the future

Doctors who sit on the district medical committee say that the first year of the reforms don't seem to have produced much benefit to patients, largely because there seems to be no real money for developments. The general practitioners also complain that the hospitals have been preoccupied with waiting lists. The consultants at West Suffolk produced business plans last year, but Bob Jones admits that not much has come out of them: "They have established a base to build on in the future." The urologists managed to persuade the district to fund a transurethral microwave therapy machine because it allowed patients to receive outpatient treatment and increased throughput.

That emphasis on throughput bothers Roger West. There is pressure on purchasers to account for developments in terms of measurable gain over the "lifetime of a manager's contract." Many provider developments, he points out, are qualitative. For example, the authority has approved the appointment of a consultant in accident and emergency medicine and is currently discussing the need for a chemical pathologist (because the royal college is threatening to remove approval for junior posts). "You can't measure in activity terms the effect of either a chemical pathologist or an accident and emergency consultant." Similarly, Bob Jones and Humphrey Piggott worry that reducing juniors' hours will cost money but not deliver more activity.

Measuring activity presents another problem: investing in information technology. Grant Elliott, district finance officer, agrees that the nuts and bolts of contracting have gone well this year, but he concedes that the West Suffolk Hospital has an antiquated computer system and badly needs a new one. He recognises the dilemma of spending money on information technology rather than patient care, but thinks that a purchaser has to support one of its main providers in acquiring the capital and revenue to provide both parties with the information they need on costs and activities. His other main concern is capital charging. East Anglia region plans to put all capital charges into weighted capitation next year, and some providers will have real problems. "We need to be careful that fear of capital charges means that there will be no capital developments at all." He is a firm believer in making assets work but thinks that the capital charging scheme is ill thought through and shouldn't have been introduced at the same time as the internal market.

Capital charges also raise the question of how to value non-measurable outcomes—patient convenience, for example. Since the authority will have to support West Suffolk Hospital in its bid for a day surgery unit it will have to put a value on patient convenience. Otherwise it might be cheaper to send patients to existing units in Ipswich or Cambridge—and then the consultant's fears about becoming simply another Newmarket might really come true.

For Debate

Public health heresy: a challenge to the purchasing orthodoxy

Paula Whitty, Ian Jones

The purchaser-provider split introduced by the NHS reforms[1,2] has been enthusiastically embraced by public health physicians.[3] This reaction was in marked contrast to that of the rest of the medical profession and was exploited by the former secretary of state for health as support for the changes.[4] Directors of public health argue that the reforms fully embody the recommendations of the Acheson report on the future of the public health function.[5] Public health's role in purchasing has since attained the status of a new orthodoxy, without there being reason to believe that the necessary investment of its resources will have any impact on the public's health. This paper questions the acceptability of such a role, thereby raising considerable doubts about the future of public health medicine.

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Purchasing and the Acheson report: indistinguishable?

The essential components of the public health function as laid down in the Acheson report[5] are tripartite: to survey the health of the population; to promote and maintain health; and to ensure that the means are available to evaluate existing health services. The enthusiasm of public health physicians stems from the belief that purchasing clarifies and fulfils the role given to public health in the Acheson report[4] and moreover anchors the public health specialty firmly within the NHS management structure.

But the assessment of health care needs is already dominating the assessment of the health status of the population. Although this situation is difficult to avoid in the face of purchasing pressure, it represents a profoundly regressive shift for public health physicians.[6]

Quality monitoring has focused on the "humanity" dimensions of care, such as the improvement of hospital surroundings.[7] Only rarely has a health authority tackled the monitoring of formal patient outcome[8]; therefore public health skills are presently redundant in this aspect of the public health role.

As for Acheson's third component, "promoting and maintaining health," there is a growing misconception that "purchasing for health gain" is the process by which this will be achieved.[8-10] This assumption completely disregards the evidence that the state of the population's health is fundamentally determined by social and economic factors,[11-13] as has been emphasised in the recent past by the widening of social inequalities[14-17]; therefore the impact of purchasing health services on the population's health would be expected to be minimal. Rather, the promotion of the population's health requires governmental and societal action.[18] The response from advocates of purchasing has been that they might buy non-NHS services,[9] but this is clearly nonsense in the face of an NHS that most people consider is underresourced. Instead, the public health professional has a hope of improving health by appraising and lobbying on relevant economic and social policy issues[19]; coordinating local intersectoral action on health related issues[20]; and, in a more limited way, by organising disease prevention programmes, such as immunisation and screening.[19]

The confusion over purchasing and health gain has