TALKING POINTS

Planning health care in Scotland*

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Planning health care is essential if the National Health Service is to provide the wide range of costly and complex services that modern society expects, particularly if it must attempt to do so in the face of the restrictions of a limited economy.

Health planning may be easy in theory but it is not in practice. It is a gradual and cumulative process. Impartial health policies are not readily formulated at national or at local level. Too often planning has to overcome the inertia, if not the outright opposition, of vested interests. Local decisions about developments may be influenced by the strength and persistence of the advocate, sometimes well placed as a member of the decision making committee, rather than by the strength of the case. At national level party and professional politics may prevail over impartial advice. Administrative apathy or antipathy can frustrate the best of plans at any level.

In the NHS politics, both party and professional, are central to decisions about policies and priorities, and somehow or other the different aspirations for the NHS of the politicians, the professionals, and the public have to be reconciled. So it is important that the advice given to the government is as authoritative and impartial as possible. Such advice will always come best from an autonomous policy planning and development agency. This agency should be independent but work closely with the central health authority. The principal NHS planning body in Scotland is the Scottish Health Service Planning Council. No such body exists in England. The earlier Scottish Health Services Council was not as broadly based and was not able to fulfil a planning role successfully.

The planning council was set up as an independent advisory body under the NHS (Scotland) Act of 1972 as re-enacted by the 1978 Act. It advises the Secretary of State on the exercise of his functions under the Act, whether at his request or on its own initiative. For the purpose of performing this duty it is obliged to keep under review the development of the health service in Scotland as a whole and in the various parts of Scotland. The Act provided for the setting up of a secretariat for the council and for the establishment of

national consultative committees of the health care professions. The statutory function of the national consultative committees is to advise the planning council on the provision of services under the Act.

The membership of the council is given in the box, and the modestly staffed secretariat, under a secretary drawn from the NHS, consists partly of NHS and partly of Civil Service officers. The council is not part of the Scottish Home and Health Department but has close links with it.

which, like the Resource Allocation Working Party report south of the border,³ allocated resources.

Does health planning work?

Planning is a useless and time wasting activity unless it achieves something. Has the present system of planning produced useful guidance? The report on priorities was accepted as a sensible document advocating a

Membership of planning council

- Chairman, appointed by the Secretary of State from outside the Scottish Home and Health Department.
- One member appointed by each of the 15 health boards (in practice the chairman).
- The chairman of the Common Services Agency (appointed by the Secretary of State).
- Six senior officers of the Scottish Home and Health Department appointed by the Secretary of State.
- One member appointed by each of the four Scottish universities with medical schools.
- One member representing local health councils (similar to community health councils in England and Wales) appointed by the Secretary of State.
- The chairmen of the national consultative committees (at present seven) attend meetings of the planning council as assessors.

The committees and working groups of the planning council can be divided into three broad categories: firstly, those concerned with programmes of health care for particular client groups; secondly, those concerned with the services provided by the different professions; and, thirdly, those concerned with the planning of scientific, technical, and non-clinical services. In 1975 a working party on health priorities was established to give an overview of the health service in Scotland. Ad hoc working groups have been established from time to time—for example, on NHS supplies, on information for health service management, etc. Multidisciplinary programme planning groups are constituted, as required, to deal with specific client groups.

The most important report has come from the working party on health priorities. *Scottish Health Authorities Priorities for the Eighties* has been endorsed by the Secretary of State and ranks priorities into three categories—namely, high, medium, and low priority.¹ It emphasises prevention, services for the deprived, community nursing, care of the elderly, and of the elderly with mental disability, and care of the mentally ill, and of the mentally and physically handicapped. It breaks new ground by showing what can be achieved with different growth rates in NHS funding, and it complements an earlier council report, *Scottish Health Authorities Revenue Equalisation*,²

practicable and feasible policy for the development of the NHS in Scotland, and on specific topics the council has offered guidance on the advice of its advisory groups and working parties. Sometimes it has pronounced on controversial issues like the location of units for cardiac surgery: the recommendations of a fully representative and expert working party enabled the Secretary of State to justify in parliament the decision that cardiac surgery should be developed only in centres in Glasgow and Edinburgh. In 1981 the planning council foresaw the consequences to the clinical services of the NHS of the economies imposed by the University Grants Committee on the medical schools. As a result it was able to initiate the replacement of university posts with NHS funded ones where the clinical services were likely to suffer most.

It is too soon to say whether the priorities document has produced any results. Through its own planning unit the Scottish Home and Health Department is monitoring the implementation of the Shape guidelines, and health boards have been asked to prepare priority statements indicating their plans and reporting progress. Although the boards are quasi-autonomous bodies, they recognise the overriding priority of policies promulgated by the planning council and endorsed by the Secretary of State.

The planning council could be improved.

*Based on a presidential address given to the Chartered Society of Physiotherapy, 19 September 1983.

The initial concept was novel, and some streamlining of committees and procedures has already been achieved. Initially, the consultative committees tended to work in isolation, and it has taken time for them to learn that cooperation and cross representation are likely to achieve a more acceptable result much more speedily than a report based solely on the deliberations of a single discipline. This stricture also applies within the larger consultative committees.

Some general lessons

As its programme of work for the first five years came to fruition and the results were published the planning council had to cope with the criticism that it was generating too much paper and that the reports would merely add to the frustration caused by inadequate resources before joining the backlog of other unimplemented reports in dust laden pigeon holes. Clearly, the economic as well as the political climate had changed in the later 1970s, and in some quarters there was a nostalgia for a laissez faire ethos.

Health planning should not be abandoned because the political climate is inclement. In hard times we require to lay our plans for better days ahead so that we are fully prepared to take advantage of any improvement in the economic climate. Otherwise, we are caught napping and indulge in wasteful panic planning and ad hoc decisions when such improvement occurs.

In the present time of economic difficulty and financial stringency the planning council has decided that it is sensible and expedient to concentrate its immediate efforts on studies that are likely to ensure that the best value for money is being obtained through the more efficient use of resources. We have completed studies on out of hours and emergency health care, on supplies, and on information for planning, and are about to embark on the second stage of a study on waiting lists. A working group to examine current developments in the paramedical professions, and their manpower and training implications, is projected for the near future. The council is also now reviewing other areas of health care provision in pressing need of study.

Future of the NHS

The NHS is not unique among national health services in its financial problems. Nowhere does expenditure on health care, by whatever method it is provided, meet needs, far less expectations or demands. The biggest cost to the NHS is the wage bill. There has been a steady expansion in the numbers of most categories of NHS staff. The total health care budget has continued to increase in real terms. Yet we are told that the NHS is on the verge of collapse. I find this puzzling. The increased numbers are only partly explained by shorter working hours or by the more intensive staffing of highly specialised units. Are we admitting, therefore, that more staff do not mean a better service, or are we saying that our work practices are becoming increasingly inefficient? Or is it people's expectations that have outstripped what the country is willing to pay for or what it can afford? If it is the latter we have to consider how far we should educate the community in the need to ration health care. These questions require political

decisions that cannot be taken in isolation from a consideration of other pressing claims on the gross national product.

Progress in the NHS is now heavily dependent on political decisions on what the country can afford; and cost limits have become a major factor in management. Making the best use of resources means adopting a critical attitude to the obsolescent as well as to the innovative, and it means looking at the development of the health service over a longer time scale than has been our previous practice.

I take an optimistic—and realistic—view of the future of the NHS. But the best use of health care resources, particularly under conditions of economic stringency, will be achieved only if the right policies and priorities have been planned and agreed in advance, if the services provided in the light of these policies and priorities are managed efficiently, and if they are effective.

Role of management

Better management should certainly contribute to better value from the resources available. If the experience of industry and modern business methods are wisely applied they should improve the efficiency of the NHS and thereby make it possible to extend the range and improve the quality of care that it provides. Presumably, these methods are most applicable to activities like the purchase of supplies and other non-clinical services, which can be measured in terms appropriate to commerce. Clinical practices, however, differ from industrial practices, and clinical skills and management skills are not identical. While managers may have something to teach clinicians about the organisation of their work, the direct relevance of their experience to clinical performance is questionable. What ultimately determines the quality of care that the patient receives is the standard of practice of the health care professionals. It may be tempting to those with a business background to regard clinical care in trade terms. There is much more to health care and its provision than commercial practice and sales talk; the patient is paramount, not the product, its producer, or his profit. In an ideal world forces other than market ones would determine the availability of health care, but in the real world the financial restrictions imposed by a straitened economy cannot be ignored. Better management in the NHS, through employing and deploying staff with the requisite skills where they are most effective, might lessen the impact of these restrictions. It will take time to assess its full clinical benefits. I can see no good reason why clinicians who are confident of their professional standards should oppose attempts to improve organisation and management in the NHS. Quality assurance studies in health care in America have shown that the vast majority of failures in treatment or care are due to organisational, rather than professional, factors.

The Griffiths recommendations on the effective use and management of manpower in the NHS are the outcome of a request by the Secretary of State for Social Services for advice.⁴ The Secretary of State for Scotland has not yet indicated how he proposes to apply the recommendations in Scotland, though there is every indication that he has accepted the principles of management embodied in the Griffiths report. One pos-

sibility is that the NHS in Scotland could be supervised by a health service supervisory group and managed by a health service management team, identified as such in the Scottish Home and Health Department structure.

All these attempts to improve the efficiency of the NHS do not diminish the need for the informed and impartial advice that the council can provide. As the forum through which advice reflecting the views of all the health professions, the health boards, the universities, and the local health councils is channelled to the Secretary of State the planning council is appropriately constituted to fulfil its statutory role, and would, a fortiori, be appropriately constituted to fulfil that role, should it evolve into the advisory policy planning and development agency that I have mentioned above. Should the Secretary of State establish a health service supervisory group or some equivalent body it will be desirable, if not essential, that the views of the planning council can be directly voiced, preferably by its chairman, at group meetings.

Distinction between the managerial and planning function

The management of a service, including the implementation of the policies devised and accepted for it, is a function that is quite distinct from the strategic planning one. In a complex service such as the NHS past experience shows that these functions are best kept separate. The numerous, diverse, and urgent problems that the manager has to cope with on a day to day basis leave him little time to stand back and take a long term look at the service. He is a tactician, skilled in implementing plans to achieve preselected objectives, rather than a strategist who formulates the policies or plans that are necessary for the future and advises on their respective priorities. Clearly, the strategists (the planners) and the tacticians (the managers) must interact. There must be arrangements for satisfactory liaison between the officers of the planning council and the officers of the health service supervisory group and the health service management team or their equivalent.

The propounding of a fresh dogma of management and the creation of additional central agencies to give effect to its theories will count for little or nothing unless progress is made in implementing well thought out health policies. Presumably, the new agencies will seek a *modus operandi* with established bodies, each will have its individual role, and collectively they will be required to make common purpose and pursue agreed goals. It will take skilful leadership to determine acceptable interrelationships, fine judgment to apportion resources agreeably, and experienced management to ensure proper coordination.

Conclusion

The NHS is a costly service, largely because it is labour intensive but also because sophisticated technology is often now inseparable from up to date medical care. The idealism behind the conception of the NHS has to accommodate itself to the financial facts of life. The services that the NHS provides must be delivered in a manner that

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Further developments in psychogeriatrics in Britain

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In 1981 we reported the rapid recent growth of psychogeriatric services, a major new development in the National Health Service.¹ Recent publications such as *The Rising Tide*,² *Care in Action*,³ and *Mental Illness in Old Age: meeting the challenge*⁴ emphasise the increasing needs of the elderly mentally ill and the efforts required to meet them. Two new chairs in old age psychiatry have been created, at Guy's Hospital and at the Institute of Psychiatry. We now report further developments in this field with special reference to numbers of consultants and opportunities for higher training. Our earlier survey described the position at the end of 1980; reported here is the position as surveyed at the end of 1983.

Over 200 consultant psychiatrists were identified as being likely to be working specifically in old age psychiatry. One hundred and fifty eight of these replied to a questionnaire, from which a "core group" was identified of 126 psychiatrists providing well defined special services for old people ("psychogeriatricians"). Forty of these had started to work as consultants in this specialty since the previous survey. Allowing for others known to be doing this work but who did not respond in 1983, we estimate that at the time of the survey there were 150 consultant psychogeriatricians in the United Kingdom, an increase of 25% on our 1980 estimate of 120.

In 1983 one third of the services concerned more than one consultant, compared with only one quarter in 1980. The proportion of consultants giving the whole of their time to this work had increased, from just over a third to almost one half. In addition to the increase in consultants, respondents who replied to both surveys showed a net gain of 67 sessions devoted to psychogeriatrics (equivalent to six more full time posts). Over 100 districts (or their equivalents in Scotland and Northern Ireland), however, were without an identified psychogeriatrician. The age distribution of consultant psychogeriatricians is shown in the figure.

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Ages of consultant psychogeriatricians at 31 December 1983 (118 valid observations; mean age 44.1 years).

Senior registrars

The Joint Committee on Higher Psychiatric Training requires senior registrars training for special responsibility posts in psychogeriatrics to spend between one year and 18 months in higher training posts in which psychogeriatrics forms the main part of the work. Although we identified 28 established senior registrar placements, only 14 of them met the joint committee's criteria and were available at least two years in every three. This is equivalent to 12% of the number of current consultant posts, which compares with ratios in general psychiatry and in the other major medical specialties of between 19% and 26%.⁵ Seven senior registrar posts temporarily established for training in this subject in 1979 account for one half of the satisfactory posts available. This shortfall has only partly been offset by a small number of determined senior registrars who obtained elective posts in psychogeriatrics; but the development of higher training clearly is not keeping pace with the rapid expansion of consultant posts. Between 1979 and 1982 the Royal College of Psychiatrists provided assessors for an average of 26 consultant psychogeriatrician appointment committees a year, and in 1983 for 33 (personal communication). Although direct information is not available, our inquiries suggest that about two thirds of these committees made an appointment.

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gives the best value for the money spent: they must be managed efficiently. Policies must be based on a long term, consistent, and coherent strategy, albeit one that is flexible enough to take account both of changing demands and of scientific advances. The NHS should be a patient oriented service. All the different professions, disciplines, and other groups involved in it must give first priority to agreed objectives for improving health care.

Good management does not absolve the government from ensuring that its policies and priorities for developing the health service are well conceived and are adequately funded through wise economic and fiscal policies. As politics are nothing more, according to Virchow, than medicine on a large scale, politicians may have something to learn from the physician about the rehabilitation of the body politic when it becomes sick. In emergencies or crises in which there is no alternative treatment radical and hazardous measures may be justified; but, even in such circumstances, the wellbeing of the whole patient is paramount. The physician must judge how much of his treatment the patient can endure.

Over the next few years we can expect many new posts to be advertised as health districts without a psychogeriatrician strive to obtain one, and as larger districts create further posts. Our earlier survey showed that although most posts were filled by senior registrars, some were filled by established general consultant psychiatrists "converting" to old age psychiatry; there is thus a wide age range among existing consultants.¹ Although flexible retirement options for psychiatrists make prediction difficult, it is likely that, in addition to expansion, there will be four to five consultant vacancies a year from retirement.

At present there are not enough senior registrar posts to meet the combined needs of new posts and retirement vacancies. A doubling of the number of satisfactory training posts should help to provide sufficient properly trained candidates for the new posts. In the absence of official manpower statistics on "psychogeriatrics," which is not distinguished from general psychiatry, further surveys such as ours will be needed to monitor developments and to measure continuing needs.

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No matter how promising it may be in theory, its side effects in practice must not be so adverse that existence for the patient becomes intolerable. Sensitivity, judgment, and compassion are all important. In the prescription of its remedies for the body politic including those measures directed at the NHS, the government requires to exhibit similar sensitivity, judgment, and compassion.

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