Oregon revises health care priorities

Continuing its efforts to control health care costs while establishing a programme by which everyone in the state of Oregon is eligible for at least some basic health care, the Oregon Health Services Commission has released its revised prioritised list of about 800 basic health services.

The first list, issued last May, aroused almost unanimous criticism because of "significant errors" in gathering raw data and cost-benefit analyses by computer. It ranked such services as office visits for phenylketonuria higher than prenatal care.

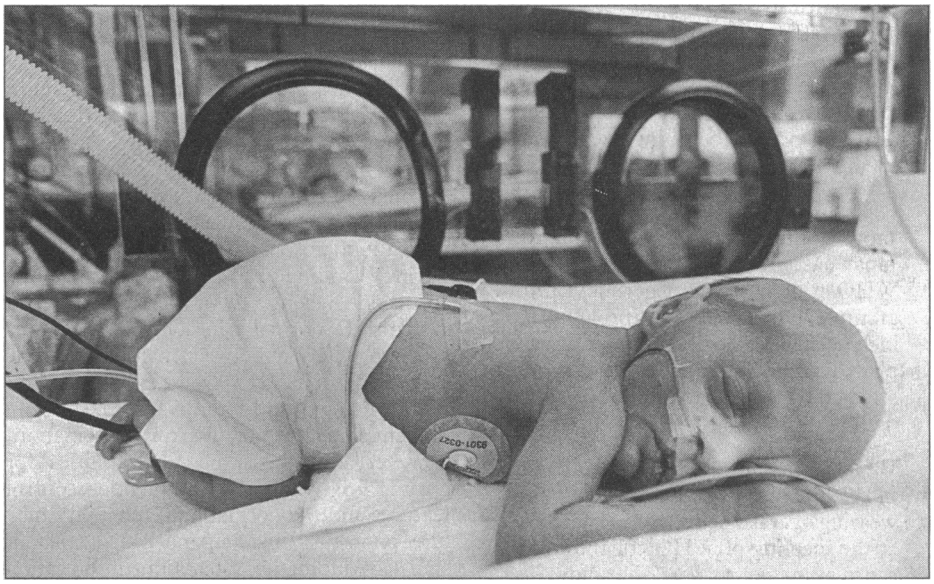
So the 11 member commission, which comprises five doctors, four consumer advocates, one medical social worker, and a public health nurse, started again. They defined condition and treatment pairs and then ranked them according to cost, improvement in quality of life (based on the quality of well-being scale developed by Dr Robert Kaplan of the University of California at San Diego), and treatment effectiveness, including duration of benefit. Information on effectiveness came from published studies or consultations with experts. In addition, condition and treatment pairs were grouped into categories that were ranked, such as preventive care for children, maternity care, and lifesaving treatment for injury or sudden illness.

Public values were also integrated into the decision making process. At about 60 public meetings around the state people voiced their opinions on health care priorities, such as quality of life, ability to function, and prevention of illness. (One criticism, however, is that only some 600 people attended these meetings and over half worked in health care.) A telephone survey of 1000 randomly selected citizens was also conducted to learn their health care values.

Finally, commissioners exercised not only collective but individual judgments in prioritising the new list of health services. Final approval was unanimous. The list is to be updated every two years.

To illustrate the urgency of the situation the programme notes that in 1989 Oregon spent an estimated $6bn on health care, and the United States as a whole spent $604bn. That cost is expected to triple by the year 2000.

Furthermore, an estimated 450 000 Oregon residents, 41% of whom work full time, have no health coverage. They may be poor but "too rich" (a family of four earning $541 a month) to qualify for public insurance (Medicaid), may not be covered by their employers, may be too poor to afford private insurance, or may be unable to purchase it because of pre-existing medical conditions.



NETWORK

Treatment for extremely low birthweight babies (under 1·3 pounds) is one of the lowest of the 800 priorities

John Kitzhaber, physician, president of the Oregon State Senate, and chief author of the Oregon plan, said, "The current system in this country systematically rations care to the poor by making people a low priority. We want to make sure everyone is covered and decide what should be covered to ensure basic health."

The next step is for actuaries to determine the rates necessary to cover the costs of services on the list. Then the Oregon legislature will determine how much of the list it is willing to fund, which will define the basic health care package for all Oregon residents.

Two other laws in the Oregon plan cover the working poor by mandating that employers provide their workers and dependants with the basic health care package and establish a programme for those denied insurance because of pre-existing conditions.

Finally, to implement its plan, Oregon will seek waivers of several standard Medicaid provisions either from the Health Care Financing Administration or from Congress. Congress would grant approval for the Secretary of Health and Human Services to issue the waiver if he believed basic health needs were being met and after a public comment period.

And there will be comment. However innovative and enterprising the Oregon programme might be, there remains the spectre of health care rationing for the poor and a two tiered health care system. —GAIL McBRIDE

Health priorities in Oregon

Top 10

- Pneumococcal pneumonia, other bacterial pneumonia, bronchopneumonia, influenza with pneumonia
- Tuberculosis
- Peritonitis
- Foreign body in pharynx, larynx, trachea, bronchus, oesophagus
- Appendicitis
- Ruptured intestine
- Hernia with obstruction or gangrene, or both
- The croup syndrome, acute laryngotracheitis
- Acute orbital cellulitis
- Ectopic pregnancy

Bottom 10

- Gynaecomastia
- Kidney cyst
- Terminal HIV disease with less than 10% survival rate at five years. (Note: treatment for earlier stages of HIV disease and comfort care for terminal stage are listed much higher in the list)
- Chronic pancreatitis
- Superficial wounds without infection and contusions
- Constitutional aplastic anaemia
- Prolapsed urethral mucosa
- Central retinal artery occlusion
- Extremely low birthweight babies (under 1·3 pounds) and under 23 weeks' gestation
- Anencephaly and similar conditions in which a child is born without a brain

Headlines

Random breath tests defeated: The government imposed a three line whip to ensure that an amendment to the Road Traffic Bill that would have introduced random roadside breath tests failed by 265 votes to 157. Roads and traffic minister, Christopher Chope, reminded the Commons that the police had powers to stop motorists if they suspected that they had been drinking or had been involved in an accident or offence.

Japan joins Chernobyl programme: Japan has agreed to contribute $20m to WHO's international Chernobyl programme. Objectives of the programme include epidemiological monitoring and providing health care to populations affected by the accident in 1986.

WHO to promote crash helmets: An international initiative to promote the wearing of crash helmets was launched at the meeting of WHO collaborating centres in February. The move is aimed at reducing head injuries from road accidents, a serious problem in developing countries, where people tend to buy motorcycles rather than cars.

Twin research: A national research unit has been set up by the Institute of Psychiatry and King's College Hospital to carry out research on twins. Five thousand identical and non-identical twins are already on registers, and the unit hopes to enrol an additional 10 000 pairs for further research.

MRC to review dairy product and heart disease findings: The MRC has convened a panel to peer review the results of a study from its epidemiology unit in south Wales, which showed a decreased risk of heart disease among people who drink milk and eat butter. The study's results have so far appeared only in a progress report from the Welsh unit. The MRC hopes to give a verdict of its review within the next month.

New team to tackle waiting lists: Looking at 80 waiting lists in 30 district health authorities, Qa Business Services will investigate the causes of long waits and experiment with different solutions. Qa will build on similar studies carried out by Inter Authority Comparisons Consultancy, which quit its Department of Health funded work last month (23 February, p 432).

Air crashes and human error

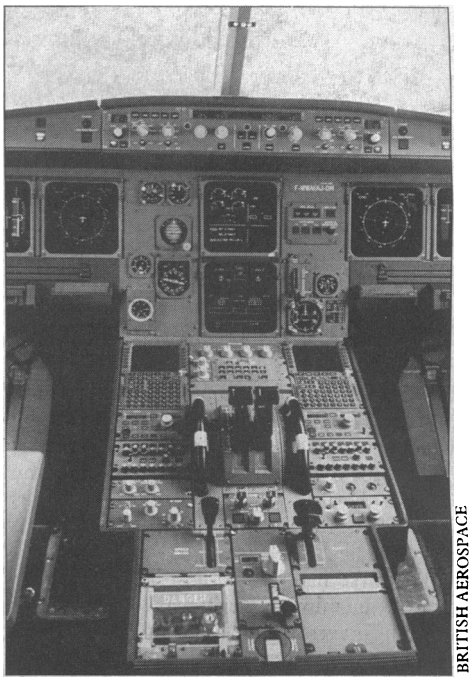
Air crashes usually happen because people rather than machines fail. This was the theme of the conference "Pilot error in perspective" held by the Parliamentary Advisory Council for Transport Safety. In the early 1960s the accident rate declined steeply and then plateaued. Only one in a million commercial aircraft is lost, but the chances of surviving a crash have not improved in two decades. Flight crew errors contribute to around 65-85% of all accidents, but if all crew members are included human error plays a part in almost all. Thirty per cent of accidents have been found to occur during take off, 26% during landing, and 21% during the approach—when crews rather than aircraft systems are normally in control. What was called the interface between man and machine is the weak point.

Technology and technical "fixes" can prevent some but not all error. Automation, however, introduces new possibilities for error. For example, automatic control features and the normal high reliability may lure pilots into placing too much trust in signals. Automatic systems put information together for them and even shift the balance of decision making from man to machine. The problem was thought to be getting worse with the second generation of "glass cockpit" aircraft (that is, with cathode ray displays and a high degree of automation); as one speaker put it, to the question, "What's going on?" the answer might be, "Don't worry, the machine knows." The pilot, it was said, should be included in the design of a system at the earliest stage instead of being fitted in at the end, with sophisticated technology "used and not just watched." A survey showed that pilots liked automation but regretted the degradation of their handling skills.

The ability to provide large quantities of information was agreed to have outstripped the ability to assimilate or even present it clearly. Humans are poor at prolonged monitoring yet much of flying now, it was pointed out, is just this. In the Kegworth crash, when the wrong engine was shut down, information was both misread and missed. Displays and instrumentation in general, it was agreed, should cater for "the below average pilot on a bad night" and must be both designed and tested more scientifically. "It is staggering," said one speaker, "that after 20 years glass cockpit displays have not been scientifically evaluated."

Traffic control still depends on people talking to each other, and misunderstandings have caused several accidents. More standardisation was thought to be needed. More broadly, it was suggested that good communication called for social skills training to make it easier for crews to "come clean" about doubts and uncertainties.

Unless the accident rate is cut now, increasing air traffic will lead to increasing accidents. Some crucial needs were agreed to be:



BRITISH AEROSPACE

The "man-machine interface" needs to be the main focus of attempts to reduce flight crew error

- Better understanding of human factors in man-machine interactions
- A more scientific approach to design and evaluation
- Attention to design deficiencies in instrumentation and display in existing aircraft
- Training to cater better for recent technological developments and for the increasingly important "cockpit management skills" focusing on the team.—DAPHNE GLOAG

Root and branch reform of prisons

In the 1970s a group of prison governors wrote to the then Home Secretary, Merlyn Rees, saying: "If the present trend continues there will be a serious loss of control [and] a probability of both staff and prisoners being killed." In 1982 another Home Secretary, William Whitelaw, called British prisons "an affront to a civilised society and a continued threat to law and order." The first 25 days of April 1990 saw the worst riots ever in British prisons—at Strangeways (where 147 members of staff and 47 prisoners were injured and repairs to the prison will cost £60m), Glen Parva, Dartmoor, Cardiff, and Bristol.

In response to the riots the Home Secretary asked Lord Justice Woolf to investigate why the riots happened and what might be done to stop them happening again. To these questions Lord Justice Woolf added two further ones: "Why did the riots not happen earlier?" and "Why were the consequences of those riots not even more serious?" The resulting inquiry—published last week in a 600 page report—broadened into a proposal for root and branch reforms of the prison service. Lord Justice Woolf was helped in the broader aspects of his report by Judge Stephen Tumim, the chief inspector of

prisons, who has already established a reputation as a radical critic of the prison service (12 January, p 64).

The Home Secretary responded to the report by calling it "a remarkably coherent set of recommendations" and "one of the most significant reports on the prison service ever published." It will form the basis of a white paper that "will be a blueprint for the prison service into the 21st century."

In many ways the report supports humane containment, a philosophy that has three basic principles: sending as few people to prison as possible; using as little security as possible within the prison; and making prisons as "normal" as possible.

The report's first set of proposals address the central question of diverting people from prison. It wants greater coordination across the criminal justice system and proposes a national forum and local committees to encourage coordination. In particular, more hostels should be created for offenders with drink or drug related problems and for the mentally handicapped, and various initiatives are suggested for keeping mentally disordered people out of prison. But the report recognises that prisons will inevitably contain mentally disordered people, and the prison service "should recognise the special responsibility it has for those in its care who are mentally disordered." The report also wants a better deal for sex offenders and specifically calls for another prison like Grendon, the "psychiatric prison."

Within prisons the report wants life to be as normal as possible and to that end it calls for community prisons so that prisoners can be held in the community where they have their closest links. Otherwise, prisoners should be held in units of about 50-70—and no prison should hold more than 400 prisoners.

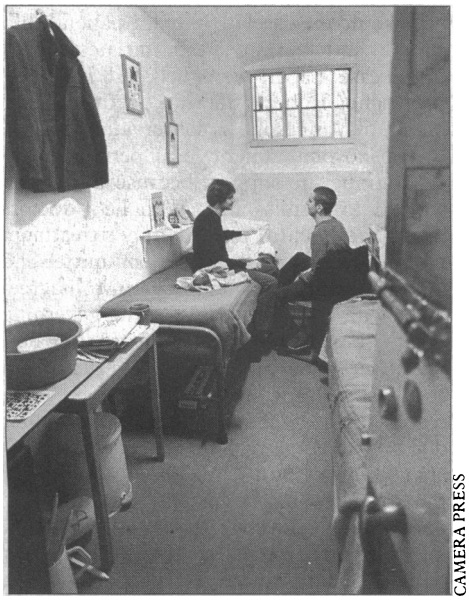
Prisons should be required to meet accredited standards; no prison from the end of 1992 should hold more than its certified number of prisoners except in exceptional circumstances; all prisoners should have rooms to themselves if they want; and all should have access to integral sanitation—"standards of hygiene should be commensurate with those in the community." Prisoners should be able to work as long as in the outside world, and education should be given equal standing to work. Mail should no longer be censored, and prisoners should have access to phones and the Samaritans (the latter at public expense). Prison officers' uniforms should become less militaristic and "peaked caps should be phased out."

On a broader canvas the report wants visible and publicly answerable leadership of the prison service by a director, who would "contract" with ministers. More responsibility should be delegated to governors, and they in their turn would contract with prisoners, setting out the prisoner's "expectations and responsibilities." The report says little about medical services but notes a considerable body of evidence that the service fails to reach a standard comparable with that in the NHS. It also observes that the efficiency scrutiny of the prison medical service (20 October, p 892) is in accord with its general approach.

The report also carries proposals on dealing with prisoners possibly infected with HIV—in particular, phasing out "viral infectivity restriction," as suggested last month by the Prison Reform Trust (16 February, p 371). Some idea of the effort and range of the inquiry can be sensed by reading the sentences on the circumstances of prisoners infected with HIV in Wandsworth prison. "The inquiry visited a small, dingy and airless basement unit . . . which contained a number of inmates who either had HIV, or who were awaiting the result of HIV tests. Apart from an hour's exercise, visits to the library, and some classes, they were confined to this small area. They had a television and a small amount of weight lifting equipment."

In his response to the report the Home Secretary, Kenneth Baker, promised that he would end slopping out by the end of 1994, abolish routine censorship of letters, increase the level of visits, and make several other family related improvements.

It may well be that last year's riots and this year's report will finally transform the British prison system.—RICHARD SMITH



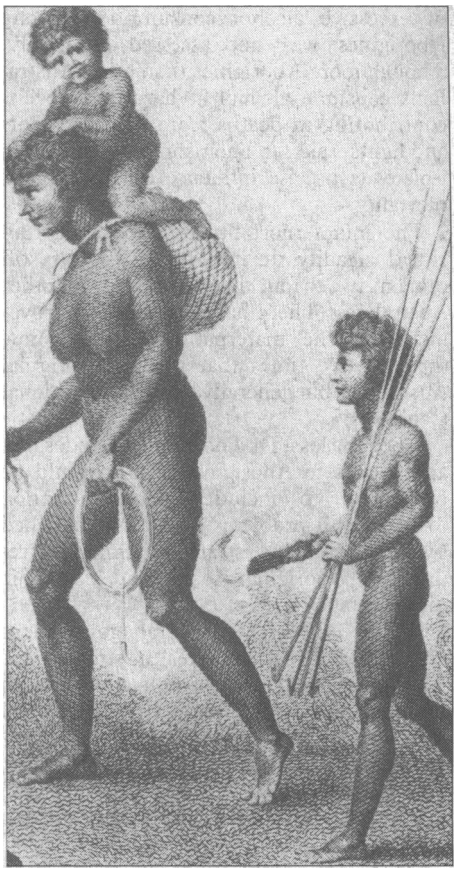
CAMERA PRESS

Slopping out to end by 1994

Increase in death rate among young Aborigines

A thorough review of all sources of data on mortality among Australian Aborigines has shown a disturbingly high rate of death.

Dr Neil Thomson, head of the Aboriginal and Torres Strait Islander Unit of the Australian Institute of Health in Canberra, says that the mortality is "unacceptably higher than that for non-Aboriginal Australians." A paper by him in the *Medical Journal of Australia* (18 February, p 235) shows that, though the overall health of Aborigines has probably improved slightly over the past two decades, there is evidence of a rise in death rates among the young and middle aged.



At the same time as William Blake was portraying the Australian Aborigines as Noble Savages, they were being decimated by diseases brought to Australia by the First Fleet. Two hundred years later they are suffering disproportionately from the "disease of civilisation"

Census data in 1986 put the population of Australian Aborigines at 206 104, and of Torres Strait Islanders (the people indigenous to the islands between the northern tip of Queensland and Papua New Guinea) at 26 541. The total is 1·4% of Australia's population. About 40% of Aborigines are under 15 and only 4% are over 60, compared with 23% and nearly 15% respectively of the total population.

After standardising the death rates in his study Dr Thomson found that the Aboriginal rates were between two and four times those of the total population. Variations existed among regions—in the mid-1980s the standardised mortality for male Aborigines in the Kimberley region of Western Australia was 1·6 and for those in the northern territory 3·7 (females 2·4 and 4·2 respectively).

In addition, the study shows that the best expectation of life at birth for Aborigines is 12 to 15 years less than that for other Australians. This level of life expectancy for Aborigines, says Dr Thomson, is comparable with that in Colombia, Mongolia, the Philippines, and Thailand. The worst levels are about 20 years less than overall Australian figures, comparable with life expectancies in India, Haiti, Ghana, and Papua New Guinea.

Disease of the circulatory system was the leading cause of death for Aboriginal men and women—2·2 times more common than expected for men and 2·6 times more common for women. The second commonest cause of death in men was "external causes of injury and poisoning" which was third commonest in women. The much publicised problem

of excessive alcohol consumption among Aborigines was not assessed separately. Though more Aborigines than other Australians consume alcohol at hazardous levels, contributing to deaths from road accidents and fights, said Dr Thomson, it is difficult to isolate its precise influence on disease and mortality.

The infant mortality for Aborigines declined steadily during the 1970s but still remains two to four times above that for other Australians. There have also been improvements in the maternal death rate, now three to five times that in non-Aboriginal Australians but generally low by international standards.

None the less, Dr Thomson concludes that approaches to Aboriginal health should be broadened to include greater attention to the health problems of adults, "matched by broad ranging strategies aimed at redressing Aboriginal social and economic disadvantages."

In December the federal government announced a national health strategy for Aborigines and Torres Strait Islanders worth $A232m in federal support over five years. These funds will be largely devoted to improvements in living conditions (housing, water supplies, etc), and negotiations are proceeding with the six state governments to provide matching funds.

Aboriginal organisations expressed deep disappointment at the level of funding, which, even if matching state funds are obtained, falls well short of the $A2·6bn over 10 years that was recommended last June by a joint meeting of federal and state ministers for Aboriginal affairs.—PETER POCKLEY

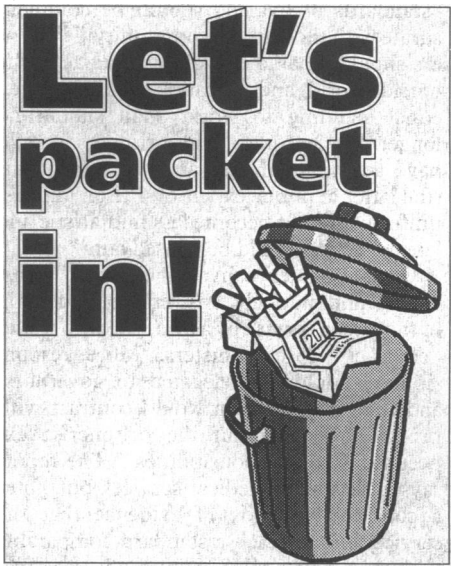
No Smoking Day 1991

A new initiative to stop women smoking during pregnancy has been launched by the Department of Health. At present only one in 12 women who smoke give up during pregnancy, and 65% of those go back to cigarettes after the baby is born. The junior health minister, Virginia Bottomley, described the new measures at a press conference announcing this year's No Smoking Day, 13 March.

Women who smoke during pregnancy are twice as likely to have a low birthweight baby and have a greater risk of premature delivery, bleeding during pregnancy, and premature and prolonged rupture of the membranes. Recent research also suggests that as many as one in six ectopic pregnancies may be due to smoking in pregnancy.

Two of the six new health warnings on cigarette packets will relate to children: "smoking when pregnant harms your baby" and "protect children—don't make them breathe your smoke."

March 13 will be the eighth No Smoking Day. Fourteen voluntary and professional bodies are involved, including the Health Education Authority, the Royal College of Nursing, Action on Smoking and Health, and the BMA. Posters, stickers, tee shirts, and caps will carry the "Let's packet in" slogan accompanied by a picture of a dustbin and a crumpled cigarette packet.



Slogan for 13 March

Responding to criticism that bullying tactics run contrary to civil rights, the organisers of No Smoking Day emphasise that it is aimed at helping people who want to stop smoking. Studies have shown that more than half of smokers—and in some series up to 90%—want to give up.

Statistics from last year suggest that over a million smokers will succeed in stopping for the day; 72 000 will still have stopped three months later, and after one year 50 000 will remain free from cigarettes. Since the first No Smoking Day in 1984, 300 000 smokers have stopped for good.

These figures must be set against the few hundred new smokers each day in Britain. Increases in the price of cigarettes fall behind the rate of inflation, and the government receives an estimated £6bn a year from the sale of cigarettes.—FIONA GODLEE

Hospital sues to remove life support

An issue of life versus death is again before the American courts. This time, in contrast to the "wrongful life" case of last year (28 April 1990, p 1095), Hennepin County Medical Center in Minneapolis is seeking the court's permission to discontinue life support for an 87 year old woman who has been in a persistent vegetative state since May 1990.

On 14 December 1989 Mrs Helga Wanglie fractured her right hip. She underwent surgery at a local private hospital. Next month she had difficulty breathing and was transferred to Hennepin County Medical Center, where she was placed on a respirator. She stayed there for five months fully conscious and alert.

In May she was weaned off her respirator and transferred to Bethesda Hospital, St Paul, across the river from Minneapolis. Within a week she went into cardiac and respiratory arrest. By the time she could be resuscitated she had suffered severe brain damage, and she was returned to Hennepin County Medical Center in a persistent vegetative state. She is unresponsive and is unaware of when her husband visits her.

Mr Oliver Wanglie, 86, a retired lawyer, said the hospital first raised the question of discontinuing life support late in May, but the family objected—largely on religious grounds, Mrs Wanglie being the daughter of a Lutheran minister. Quality of life was not a consideration, nor was finance (Mrs Wanglie's hospital care was covered almost entirely through her health insurance). Mr Wanglie told the doctors that his wife of 53 years would have wanted to live and that everything possible should be done to sustain her life. She had told her husband, "Only He who gives life has the right to take life."

In a telephone interview Mr Wanglie alleged that one of the doctors had threatened to turn off the respirator whether the family agreed or not. After his wife was transferred to Bethesda Hospital on her doctor's recommendation she was taken off the respirator but developed respiratory problems and cardiac arrest. He claimed that the transfer was against the family's wishes; the doctors told him she would receive better care there, but he found there was no intensive care unit at Bethesda. Mr Wanglie said that he had sent a letter to Dr Michael B Belzer, medical director of Hennepin County Medical Center, explaining that he had talked about the end of life many times with his wife. If anything happened to her she had said that she did not want her life snuffed out but wanted to live until the Lord took her home. However, she had put nothing in writing. He had made a commitment to her that he would never let her life be snuffed out.

Dr Belzer explained that after many discussions with the attending physician the family had refused all options offered to them. These were that Mrs Wanglie should be transferred to another institution; that the family should apply for an injunction forcing the medical centre to continue life support; or that the hospital should begin a legal action to appoint a guardian ad litem or a conservator who would then seek to have the patient's life support system removed. In the latest moves in the case, papers were filed on 8 February proposing Robert Sherran, retired chief justice of Minnesota, as conservator.

The hospital sought legal permission to discontinue life support because the family wanted to dismiss Mrs Wanglie's doctors unless they yielded to the family's treatment wishes. The hospital's ethics committee and the medical director had been in full agreement with the doctors. Also, the governing body—the elected county board of commissioners—had approved taking the case to court. Dr Belzer concluded by saying that the real issue for the court to decide was whether doctors should be obliged to render inappropriate medical care. The fact that this is the first case where a hospital is trying to get permission from a court to turn off a patient's life support system against her family's wishes is sure to set an important legal precedent.—FRED B CHARATAN

The management executive in 1992

Lean and rigorous and living in Leeds—this is what the NHS Management Executive wants to be in two years' time. This vision of itself has emerged from a review of its activities and organisation published last week and endorsed by the NHS chief executive, Duncan Nichol.

The review starts from the fact that the executive is not currently organised to manage the NHS to meet its three strategic goals: to improve the health of the population through the NHS; to ensure that services are provided effectively and efficiently and in accordance with patients' wishes; and to ensure that the NHS is structured to support staff in carrying out their jobs and develop their careers. It has identified eight core functions (see box). The management executive itself should therefore comprise the chief executive and the heads of the directorates (plus a medical director and a nursing director if not already in charge of a directorate, although the review suggests the medical director head the health care directorate). Other functions carried out centrally are not core functions of the executive, and the review suggests that they should be performed by separate agencies. One of these (estates) becomes an agency on 1 April; the status of the others (information, purchasing, and NHS superannuation) is being considered.

Core functions	*Directorates*
1 Research and development	Research and development
2 Defining strategic framework for NHS	Corporate affairs
3 Developing health care operation policy	Health care
4 Objective setting and performance review	Performance management
5 Support for ministers	Corporate affairs
6 Resources and resource management	Finance and corporate information
7 Organisation and people development	Personnel
8 Corporate management	Corporate affairs

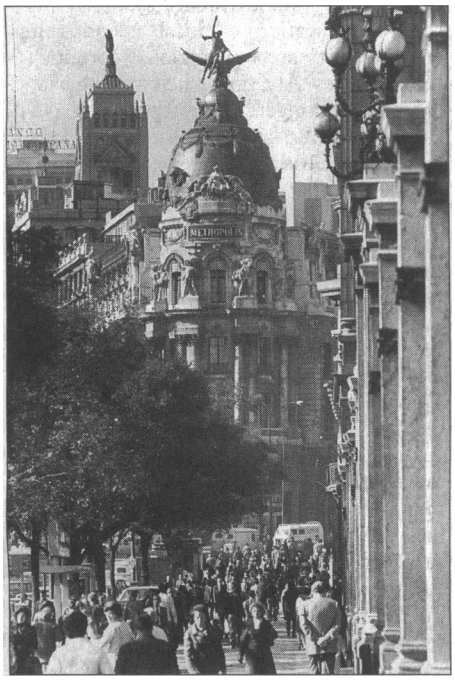
The management style that the executive wants emphasises shared goals and objectives, with clear targets and personal accountability for them; it wants to be rigorous on outcomes but to leave to the NHS how they will be achieved. In pursuit of credible leadership, the review recognises that the executive must contain people with clinical experience in the health service—notably a doctor and a nurse. On the other hand, in pursuit of leanness, it suggests that there should be no separate hierarchies for professional and non-professional staff within the executive, though doctors and nurses with line accountability to a non-professional manager would also have professional accountability to the professional directors.

The authors of the review have had to make some concessions to the politics of the Department of Health and the NHS. For example, though the corporate affairs directorate will take on the main responsibility for supporting ministers, they acknowledge that all directorates will play a part in this. The review also emphasises the fact that some work—for example, on health care policies—straddles the boundaries between directorates and the remaining policymaking staff of the Department of Health. The biggest area of untidiness, however, is medical staffing. Logically part of the personnel directorate, work on medical manpower and juniors' hours currently rests with the medical director, and the review suggests that it should remain there "to maintain the confidence of the medical profession" and to facilitate liaison over undergraduate medical education (the responsibility of the permanent secretary) and postgraduate and continuing medical education and the work of the General Medical Council (the responsibility of the chief medical officer).—JANE SMITH

NHS Management Executive. *A Review of the Functions and Organisation of the Management Executive*. London: NHS Management Executive, 1991.

Spanish judges propose drugs be treated as medicines

About 50 Spanish judges and professors of criminal law met last month in Seville to propose the legalisation of the sale of drugs as the only means to avoid the damage caused by the traffic of drugs and the social problems that emerge from drug dependency.



CAMERA PRESS

Most Spaniards want the sale of drugs prohibited

These professionals believe that stupefacient and psychotropic drugs should be included in the new medicine law currently being debated, which would mean that the distribution and sale of these drugs would be under the control of the state. The only drug activities that would be penalised would be illegal production, distribution, and sale. The text of the new law would be changed to include drugs affecting mental and bodily wellbeing, along with the traditional therapeutic indications for medicines. Cannabis should have the same controls as tobacco and alcohol, say the judges, while heroin and cocaine should be more tightly controlled. No publicity would be allowed for any of them, including tobacco and alcohol.

The Seville proposal was just one more event in a fairly long campaign for the legalisation of drugs that has gone on in Spain for the past two years, sponsored mainly by lawyers and intellectuals. In Barcelona, just a few weeks before, the official association of lawyers asked for legalisation of the traffic and consumption of drugs. Three hundred young lawyers said the same in November last year.

Recent successes in the war waged by the police against drug traffickers have not changed the belief of many lawyers that traditional punishment of offences by drug misusers is no solution, as most traffickers and corrupt officials go on with their illicit trade untouched by the law.

Another campaign in Spain asks for sanctions against the public consumption of drugs. Spain is the only country in the European Community where drug taking goes completely unpenalised. The government has announced administrative measures (mainly fines) for people who take drugs in public and those who leave syringes lying about that can be a health hazard for children and passers by. Most patients with AIDS in Spain are drug addicts. The measures announced will be similar to those already in force in relation to smoking.

Recent private surveys indicate that Spaniards think drugs are the third most important problem in the country, after unemployment and terrorism. The figures indicate that more than three fifths of the population surveyed want total prohibition of the sale and consumption of drugs.—MAGDALENA RUIZ

This week's contributors include:

Fred B Charatan, psychiatrist, Long Island
Daphne Gloag, staff editor, *BMJ*
Gail McBride, science writer, Chicago
Peter Pockley, science writer, Sydney
Magdalena Ruiz, science writer, Madrid
John Warden, parliamentary correspondent

The new culture

When the whistle blows on 1 April it is meant to signal something more than a new way of running the NHS. To the true believers in Richmond House the reforms are the vehicle for a whole new culture of health care in Britain. The motive is to be patient friendly and bureaucratically benign. It is all about decentralisation and devolved management.

As a concept it requires an act of faith even by the initiated. In that case it must have been dispiriting to reformers from the Department of Health last week when they found themselves having to educate members of parliament in the first principles of the new culture. It happened when Duncan Nichol and his NHS management team answered to the Commons public accounts committee.

The committee had before it the recent National Audit Office report on NHS outpatient services (23 February, p 435). This described the bad old days of 1989 with wide variations in general practitioner referral rates and extended waiting times of up to 72 weeks for first outpatient appointments. That was unacceptable and something would be done about it, Mr Nichol said. From now on authorities would set target times for first appointments according to local conditions.

The culture clash came when MPs insisted on chapter and verse about waiting times in specific units or even districts. But that is not the way that Mr Nichol means to run things from the centre. Labour's Mr Terry Davis at the point of exasperation demanded to know if it was still a *national* health service. It became clear that the emphasis he used did not chime in with the language of the new culture. "We are not going for sameness or exactness," said Mr Nichol. "That is totally contrary to the concept of giving flexibility to districts to assess their own needs for themselves. We provide the framework."

Ignorance of the new culture was not confined to Labour MPs. Mr Nichol had to straighten out his Conservative inquisitors as well, explaining that the whole thesis of the reforms was that health needs should be assessed at local level. "We will do some sampling, but I do not have a system that requires them to report in," he said.

And as the frustrated MPs demanded more and more information from the department's files Mr Nichol flatly refused to allow his headquarters to become "a factory of paper" with districts sending up detailed reports. If that made it uncomfortable for him as a witness, which he confessed it did, then it was the price of the new culture.

What the episode illustrates is that the reforms will not eliminate the classic dilemma over NHS accountability to parliament. Bevan's complaint that if a bedpan was dropped anywhere in the NHS he was expected to know about it can just as well be echoed by his successors. The trouble is that on issues like waiting times MPs see the NHS from the bottom up. After this month ministers will be viewing it from the top down.

Apart from waiting times, the other big variable is referral rates from general practitioners to outpatient departments—from as low as three to as high as 12 per 100 patients. This vexed the auditors, who were unsure if it signified overuse or underuse of resources. Either could be wasteful. The new culture provided no ready answer. Mr Nichol could only speculate about why Dr A might refer twice as many patients as Dr B.

He put it down to individual experience, interest, and enthusiasms, as well as the sense of wanting to be independent. There was no particular correlation, such as a link between referral rates and prescribing patterns or doctors' ability to carry out their own investigations. "There is a very personal threshold here," said Mr Nichol.

Looking to the future, Mr Nichol said that family health services authorities would be able for the first time to require general practitioners to submit information about their referral practices that could be challenged. In time there would be more comparative information in the system which general practitioners would be able to study.

Meanwhile, fundholding general practitioners would have an incentive to limit referrals, while the extension of clinical audit in general practice might indicate better ways of doing things. Plainly, the new culture will not be defeated.—JOHN WARDEN

The Week

One of the classic episodes of *Yes, Minister* concerns a hospital being administered to perfection—because it has no patients. To say that the NHS is heading in that direction would be unfair, but moves towards better information and the rhetoric surrounding "efficiency" are in danger of becoming ends in themselves, divorced from treating patients and promoting their health. Clinicians are particularly galled to see the ease with which administrative jobs are approved and filled at a time when beds are closed and operating lists cut.

They are also puzzled because one of the government's principal targets over the past few years, particularly at party conferences, has been the "administrative tail" of the NHS. In fact the NHS is already lean, its administrative costs running at around 4% of the overall budget. This is small compared with health systems in other developed countries (6-7% in western Europe, 12% in the United States) or with large commercial companies.

Two reasons for this administrative efficiency have been the absence of billing and paying in the NHS and the low cost of running a centralised system for negotiating pay and conditions for most of the NHS's 900 000 staff. Servicing the General Whitley Council and the two health review bodies costs just over £625 000 a year.

Now both these elements will change and the cost of administering the service will rise. A survey published in *BMA News Review* this week confirms that a whole new bureaucracy is coming into being. Over six months in late 1990 on average about 300 new administrative, finance, and management posts were being advertised in the *Health Service Journal* each month—worth just under £7m a month in salaries. A follow up survey in January confirmed that recruitment was continuing at similar levels.

The government has always admitted that its reforms will cost money, particularly in the first year, but nearly all these posts will continue. Already they cost over £80m a year, not including clerical and support posts (which are not usually advertised in the *Health Service Journal*). Without new funds the money will have to come from budgets currently allocated to patient care: cynics claim that the money squeezed from efficiency savings should just about cover the costs.

The health service may need better management—indeed, if it is to carry through the reforms successfully it undoubtedly does—but this massive recruiting drive may lead simply to more rather than better management. Better information may ultimately lead to better patient care, but invoicing systems and the multiplication of local negotiating arrangements are not obviously productive activities. At a time when waiting lists are getting longer, many districts have cash problems, and thousands of beds have been closed it seems extraordinary to doctors that money can be found to establish all these posts.

If the government is intent on breaking up centralised but cost effective negotiating machinery and on increasing the administrative tail then it will need to devote more money to the health service if it is to protect funding for patient care. Two years ago the debate about the funding of the NHS led to the review and the current reforms. Now, with thousands more employees in administration and management, perhaps it is time to stimulate the debate again. Perhaps, as the secretary of state hopes, these staff really can produce the information to convince the Treasury that its money would be well spent on the NHS.

HART