Priorities in Medical Care

EDITED REPORT OF A CONFERENCE HELD AT THE COLLEGE, MARCH 1985.

Welcoming the participants, the President, Sir Raymond Hoffenberg, said the aim of the conference was to bring together doctors and experts in other fields to discuss one of the wider medical issues. The problem of priorities in medical care was urgent, as there had to be a limited expenditure on health care. Good housekeeping could save some money but sooner or later there would not be enough money to pay for all resources. There was implicit acceptance that some form of rationing was inevitable. Rationing could occur without planning but there could be an earnest attempt to rationalise the rationing.

The financing of medical care would be addressed by Mr A. Harrison, co-editor of Public Money and by Mr D. W. Pace, Regional Treasurer of the South West Thames Region. The adequacy of medical care would be dealt with by Professor R. E. Klein, School of Humanities and Social Sciences, Bath. The moral and ethical problems would be discussed by Canon G. R. Dunstan, Department of Theology, University of Exeter, and Professor I. McC. Kennedy, Professor of Medical Law and Ethics, King’s College, London. Finally, how we manage would be discussed by Sir Douglas Black, Mr R. Nicholls, formerly President of the Institute of Administrators and Dr June Crown, District Medical Officer, Bloomsbury Health Authority.

The Financing of Medical Care

Mr Harrison said that rationing was inevitable in the system of financing health care in this country. The overall priorities were set by a small group of people meeting in Downing Street, the people that picked up the bill were the tax-payers, those who used the money were the professionals within the NHS and all were liable to be clients or users of the service but not necessarily as taxpayers at the time. So there were four groups of people, each of which might have their separate views on what the overall priority should be, and there was no reason to suppose that the views and priorities at the global level would coincide. In 1984 Social Security Planning Research carried out a large-scale survey of public attitudes and showed that people were prepared to pay more for more and better social services. Many people had put the NHS as their first or second choice of where extra government expenditure should go. So there was already tension in that people wanted more health care than the government was ready to provide, and further tension between the providers and the consumers who might be refused care that they knew could be available.

The present system of public finance by which the NHS was funded acted as a constraint on what could be done. Was the pressure induced by that constraint likely to relax, increase or stay the same? One view held that there was no real problem about public spending in the medium term. If the government was to hold the line right across the public sector, then a little bit of growth in the economy would make money available for public spending and it could be diverted to health if this was the first priority. If the government wished, provided it held the line on other spending programmes, it could divert large extra resources to the NHS or it could reduce taxation by an equivalent amount. With the present government, a reduction in taxation was more likely than an equivalent sum being given to the NHS. However, it would be difficult for any government in power to devote a vast amount of extra resources to health care. Nearly anything any government did, be it for health, the arts, defence or social security, became more and more expensive. Real costs tended to rise, partly because of advancing technology and partly because many services were labour intensive and their costs rose with a general rise in incomes. The case for social security was a little different, but if those receiving its benefits were to be kept more or less in line with the incomes of the rest of the community there was a built-in cost increase. Ten years ago there did not appear to be a public spending problem if the line was held. However, programmes had expanded in real terms, with higher standards as well as costs. It was unrealistic to expect any government to hold the line on all its spending programmes and give priority to a particular one. Pressures of all kinds would build up for the spending of money on all fronts and not just one. Therefore it seemed unlikely that the financial rationing of the NHS would be relieved by much.

There were other financial strategies that might make the problem of rationing easier for those who had to manage resources within the NHS. The charges could be increased, but only by a modest amount if the concept of the NHS was not to be subverted. This was a limited method of choking off demand before it entered the system. Fiscal measures could be used to influence behaviour. As an example, the cost of road accidents to the NHS was estimated to be about £100,000,000. An attempt to reduce the pressure of those costs would be for the insurers to be charged for the full amount. Insurance premiums would then be so high for high-risk road users that they would not be able to afford to drive and so the number of road accidents should drop. In the same way it
had been suggested that industries that were particularly
dangerous to their workers should pay extra National
Insurance charges, giving a built-in incentive to reduce
the industrial risk. However, these policies would only
make a minor contribution to the NHS.

There were sources of income other than tax which
could supplement the resources available to the publicly
financed services. Very small amounts, in comparison to
the total NHS budget, came from charitable sources,
together with some gifts in kind, such as equipment. But
in the wider field of caring rather than treatment the
contribution of charity was enormous but unquantified; it
probably ran into the small billions. It had been argued
that if the welfare state was doing what it ought to do,
charitable finance was irrelevant and outmoded. But
another view was that it was reasonable to top up what the
state was willing to do with charitable resources. How-
ever, if large amounts were involved, the state might well
start withdrawing its funds, thus undermining the whole
basis of the public contribution to health care. The same
argument could apply to the private sector of health care.
There was, of course, the great debate over whether the
private sector diminished or complemented the NHS. Mr
Harrison thought that if the private sector was to double,
the pressure to supply public money would diminish and
the total available resources would not necessarily in-
crease.

He did not think that within the present system of
public finance there was a way of matching the financial
decisions with the service itself and its consumers. There
were other ways of organising things. One method was
hypotheication, or earmarking of finance. That was the
best way of describing how the BBC was funded; a
specific licence fee went to that particular institution and
the particular fee was argued about in its own right. A
long time ago such a principle was adopted to finance
expenditure on roads and the road fund was set up. How-
ever, the fund was soon absorbed into the exchequer
because the Treasury did not accept the principle of
earmarking. The same was the case for the so-called
health element in National Insurance. That just went into
the general pool of taxation and was, in no sense, earmarked.
In other countries there were hypotheicated taxes related to specific services such as education. As a
concept earmarking was a viable option. Its merit would
be that health expenditure would be debated separately
and would not be involved in the general debate about the
level of taxation in the economy as a whole.

Another possibility in trying to match the providers
and users of the resource was the local option. Local
government was supposed to have the merit of marrying
up local political preferences with what was spent so that
there could be divergencies from the national view. A
scheme could be sketched out that reverted somewhat and
put health in the local sphere. There could be a special
health tax, linked with the hypotheication argument. The
amount spent on health would vary with local preference
and it would tighten the link between those who made the
tax decisions, the tax-payers and the outcome. The
scheme might produce more or less but it would tend to
ease the strain of rationing that now had to take place
within the service itself. However, the present govern-
ment had made it clear that local authorities were not to
be allowed to set their own limits on expenditure.

Mr Harrison said that economics had come to be
known as the dismal science due to predictions that
resources would increase arithmetically and demands
geometrically. The various possibilities he had discussed
were not really practical and the constraint on resources,
with the very awkward decisions that had to be taken on
certain forms of care, would not disappear quickly. The
need for self-conscious rationing processes would grow
rather than diminish. Going back to his original point he
said that, with the present system, the overall priorities
were determined by the Cabinet, and other people then
had to work out the implications of those decisions.
Central government sent out through the DHSS various
messages as to how it wanted resources to be used. These
priority messages were not closely linked to the financial
system. With minor exceptions, the finance within the
NHS was not earmarked, so rationing decisions had to be
taken all down the line. He thought that if the pressure on
public finance was to continue to be as tight as it was now,
the principle of earmarking should start to apply within
the NHS itself and there should be earmarking of certain
funds for the care of the mentally ill or handicapped or for
other groups.

Mr Pace said he would go on from the theory as
outlined by Mr Harrison to the practical experience of the
last few years. Two things were under discussion; the
volume of resources to be spent on health care and the
value achieved from those resources. He thought the
NHS was suffering from culture shock at the moment,
coping with so much change in the approach to its
financing.

When he started work in the NHS it was virtually
inflation-proofed and looked for a steady growth of
between 1 and 3 per cent per annum. Life was a more
question of how to apply next year’s increment, rather
than examining existing activity and costs. The 1975 oil
crisis had changed all that and had led to the introduction
of cash limits. These cash limits heralded the intro-
duction of real financial management into the NHS because until
then there had been no real discipline to planning, and a
change of approach was needed if value for money was to
be achieved. Cash limits had brought with them other
policy changes in the last 10 years, which had moved the
NHS from a rather insulated, inward-looking service into a
quasi-commercial one. For a start, cash limits now
contained a pre-set sum to cover inflation, of both pay
and prices, but in addition, the right to sell assets and to
apply for planning permission for the use of land had
been gained. Additionally, any income produced was
now retained, so all income from pay beds and charges
made for prescriptions and the like was retained within
the service. With cash limits came the ability to manage
cash flow, so if in one year a lump sum was needed to
produce a decent pay-back, the cash could be manipul-
ated a little. Creditors would not like the fact that bills could
be slightly delayed in order to make cash available, but it
was now a tool for use.

So the NHS had moved from a situation pre-1975 of
being fairly insulated to one which was almost into the market-place. The trouble was that simultaneously with this change many had started to question whether there was enough money to carry out the task. He had listened with interest to what Mr Harrison had said about the possibility of producing more money from within the service and if successful, the Treasury might say, ‘Oh, good, now we don’t need to provide it’. He thought that this was happening on the capital front already; looking at the capital projections for the next few years there was the suspicion that they would have been higher if it were not for the successful sale of land, and though charges and other methods of increasing resources might be successful in the very local and the very short term, there was a danger that they might become merely part of the national package and then the same constraints would apply to them.

Mr Pace thought it was a healthy sign that a start had been made on looking at the way health services could be financed, not just from public expenditure, but by encouraging the population to start making some of its own provision. This was merely recognising that the state could not provide everything. There had been something of the order of a £300,000,000 expansion of the private health sector over the last six years in real terms. That was new money coming into the system with people putting it in from their own pockets, either through personal expenditure or through insurance policies, or maybe through their companies taking up executive insurance policies and so on. But the effect in real terms was about half a per cent real growth in the cash going into health care. However, there had to be differentiation between the volume coming in and the value going out. Mr Pace was interested in seeing the maximum amount of money coming into health care, either in the private or the public sector, in order to deal with the job in hand.

Charges, and the income from them, had always been a two-edged sword because charges, once introduced into the NHS, tended to be applied to a relatively small section of the people using the service. Many people in the wards and out-patient departments were in fact those who would be given exemption from any charge that might be introduced, and the moment there were exemptions there was bureaucracy.

The growth of the health insurance market was uneven nationally. Some work done had pointed to the fact that the people who were covered by health insurance in the UK tended to live in the better-off areas of the country, and the better-off areas of the country were already those that were seen under the national resource criteria as being ‘above target’. Thus the additional resources were going into those regions that already had a fair amount of resource. Whatever the method of raising resources, the amount of money spent on health care would come back to what the country could afford. Of course, the top level of government had the fundamental option of deciding what proportions of total expenditure went to individual programmes. Probably, until the late 1970s, the NHS had really done quite well at the expense of defence and education but now the corner had been turned and health was being caught by pressure from every angle.

Mr Pace accepted the view that the amount of money would not increase at any great speed, either in the NHS or in the private sector, or in the country as a whole. What it really came down to in the end was managing what was given with much greater efficiency and making sure that the money was put into the places that actually needed it.

The amount of money being passed down to regions by government was enormous by anybody’s standards. His was a comparatively medium-range region yet spent £650,000,000 a year and employed 50,000 people. No ordinary sized company was in this league. An era was beginning in which the money was taken at the very top level and an attempt made to specify the businesses of the NHS. The NHS was not one business but many different busineses, some high level, high tech, high intensity services and others very low level, the care and custody sort of service. Additionally, there were problems in the business where it interfaced with the social security and social services. The NHS was having and would have difficulty in trying to bridge the pressure on local authority expenditure. The social security side, too, faced complications in carrying out the government’s policy of moving people from inappropriate hospitalisation back into the community. There was a fair degree of tension between those particular guidelines and available resources. The government would say that the local authorities, within their total funds, could spend more on dealing with these particular problems rather than on other parts of their programmes.

The NHS was indeed a multi-faceted business. At regional level, the one thing missing in the past was clarity in the division of the £650,000,000 received. Which services should it be put into? What was expected to be done with the money? How would its effectiveness be judged? What were the units of work, the values, and so on? At the moment measurements of performance were lacking. Splitting resources between businesses was dealing with the management of change and in this context consultants posed a problem. An average consultant appointed in his late thirties or early forties could look forward to 25 years of work in one specialty and probably at one location. This was a major constraint on planning change and a way of moving those consultants in their fifties who were approaching retirement to posts in which they would better serve the interests of the NHS had to be found.

If splitting the total resources between ‘businesses’ was a regional or national process, rationing between services was very much a practical, down-the-line exercise. Mr Pace was interested in government initiatives in this rationing process. If the government provided £10,000,000 for a specific purpose within a regional programme already costing £90,000,000, there was a danger that the region, while spending the £10,000,000 as designated, would cut back on the rest of the programme so that the total spent did not come up to the full amount of £100,000,000. It was probably true that central intervention without a very careful monitoring of the total expenditure was virtually sterile. If policy was not clearly identified, the small-scale interventions, pump-priming...
though they might be, tended to run into the sand at some point.

Mr Pace thought it curious that there was almost a common view that the NHS was being cut. The strange thing was that any cuts had not been significant at the national level. The amount of money going into the NHS had not been reduced significantly and yet there was a fairly clear public view that the NHS was being attacked, and all sorts of things were going wrong. He believed that one main reason for this view was the increasing pressure faced by the service. The demands were growing all the time and therefore the press would always concentrate on new treatments that were not being implemented, and new pressures that were not being met. Additionally, the culture of cuts was fuelled by the redistribution of resources in the NHS, which meant very variable local situations. Those in a Thames region facing resource reduction or in a metropolitan district in a gaining region, were all likely to see their real resources reduced. That meant that a quarter of the NHS (four regions) was in a perpetual state of giving money away to other parts of the country. In the other ten regions, the teaching districts were in the position of giving resources to the other districts. It was not surprising that, although the total sum of money was not being cut dramatically, the effects on individual districts were serious. This was particularly true of places like Guy’s Hospital, and the coverage by the press was a classic example of what tended to follow.

Probably only two real cuts had been made over the last seven years; one was when VAT was under-funded and moved from 8 per cent to 15 per cent in 1978, and the other was in 1984 when 23 per cent of the total cost of the wage award was met from savings in the service, thereby, in real terms, cutting the cash. The service had not been significantly cut; it was just facing pressures from a change in the style of the service, changes in what the medical profession could actually deliver and also redistributional change.

Faced with the fact that the amount of money was constrained, a government could only squeeze more value out of what it provided. The whole of the Griffiths’ management initiative and everything else going on at the moment should be seen in that light. How could a sleepy service that had never really concentrated on the commercial or industrial type of management be shaken up and brought into an environment in which it could start to get better value for money? Griffiths’ view was that the NHS had forgotten the consumer and that it was a service industry; it was beginning to become slack and not give full value for money. So even within the value-fornoney debate there were problems in microcosm. Faced with pressure on resources, the NHS had started to move the money that it should spend on equipment and buildings into employing manpower to meet patient expectations and so had found itself in the poor situation of staff looking after more patients in a deteriorating environment. Unless this circle was broken at some stage health authorities would finish up using far too high a percentage of their resources on manpower.

Mr Pace suspected that capital and revenue investment was out of balance in the NHS. About 7 per cent of total resources was being spent as capital, a 1:14 ratio of capital to revenue that was probably too low. However, the government had said that no more resources were available and therefore there must be a question as to whether the balance between revenue and capital was right. If it was not corrected the practice of medicine would continue in unsatisfactory conditions for the next 30 years. As well as the imbalance between capital and revenue there was also a problem about the ratio of manpower to non-manpower costs.

Proper control of manpower and its costs was a central factor in an efficient NHS. How could this be achieved? Testing costs through a tendering process was one possibility. Many people were employed in delivering hotel-type services. If they were delivering them economically a tendering exercise should not, in theory, be a problem to them. The profit element should enable them to beat off any outside tenderer against a common specification. During the present exercise there had been suspicions that one or two companies had initially tendered low in order to remove in-house opposition to any future tender and certainly there was evidence that the second round of tenders produced significant price increases. But as a general principle, the services provided in the hotel should be provided at the lowest, most efficient, cost; this was something that had to be grappled with.

In addition to initiatives seeking better value for money on the staff front, the government was expecting better performance in the purchasing of supplies. The NHS was an enormous purchaser, but not yet adept at using its power in the market-place. Successive reports had said that the service could and should do better. To be fair to suppliers staff, there were internal difficulties in the sense that consultants and administrators at local level did not want central imposition of purchasing procedures. The consultant liked to have the piece of equipment he wanted or the syringe he felt comfortable with and was very reluctant to accept standard solutions which could be cheaper. It would be for the greater good of all if these particular issues were solved, the consequent savings being made available for developments in care. The considerable power of the NHS in the market ought to be used.

By far the most significant factor in value for money was productivity. It was necessary to achieve the best return on each pound of the tax-payers’ money received. Productivity was a difficult term to use in relation to patients. But why was it that some consultants kept their patients in hospital for 14 days and others in the same specialty kept them in for eight? This subject needed to be grappled with more effectively. The figures in the Public Expenditure White Paper showed a considerable drop in the number of patient-days, but the number of cases dealt with had significantly increased. Consultant numbers had increased and productivity in relation to the number of doctors, the number of cases and the number of patient-days seemed to have reached a fair degree of equilibrium, but it was uncertain whether the productivity of consultants had increased or remained fairly stable.

The government had pursued other initiatives in the search for value for money. Sir Derek Rayner had been
brought in by the Prime Minister to look at Civil Service efficiency and had later undertaken to examine the NHS as well. It was decided that the NHS could benefit from Rayner ‘scrutinies’ and a number had been undertaken, with some success. One on transport showed that the services could be much improved. Another on residential accommodation showed that far too much residential accommodation was not being used properly. An advertising scrutiny showed that too much was spent on competition within the NHS for scarce staff. The latest scrutiny on income systems suggested improvements in debt collection; and this, associated with the apparent failure to collect income related to consultants’ private practice, meant that less cash was available for services. The most recent initiative was the restricted drug list. All of these initiatives were designed to achieve better value for money and were inevitable in the present financial climate.

Mr Pace said that everyone was faced with enormous pressure on resources. Government policy necessitated increased expenditure on community-based services for the mentally ill, the mentally handicapped and the elderly. At some stage the community might have to decide whether or not there was a place for people to serve that community by making use of their extra leisure time and their unemployed time and perhaps working for nothing. Their ability to contribute to the high-technology side of care was probably limited because highly trained staff were needed in that area. The acute sector of the NHS was being squeezed in order to move resources to community care where, in an ideal world perhaps, the ‘family’ should bear greater weight in looking after old people. If facilities were located close enough to where the community lived they could be given greater opportunity to contribute. Unless alternative sources of resource could be found, the only way of pursuing the government’s policy of care in the community would be to reduce expenditure still more on the acute services, which much of the population believed was what the NHS should be providing at an improving level. There would never be enough money to do everything and a much more efficient job had to be done with what was available.

Discussion

Dr A. K. Thould said that value for money as judged by an accountant was not the same thing as quality and standard of care. He was concerned with the rapidly ageing population around Truro where he worked. The demand that the elderly made on the NHS increased exponentially so that merely counting the number of patients dealt with left out a very important part of the equation which was the amount of input per patient. He had looked at community problems for years and suspected that the real cost of community care was far higher than usually thought. The costs of hospital care were known. In his hospital the drug bill was only 1 per cent of costs and it was the hotel costs that constituted the major proportion and needed the most attention when it came to savings.

Mr Pace said that, first of all, the planning had to be right so that the money went to the place where it had been decided to spend it. A lot of money got wasted because it never got to the right unit. In terms of the unit, getting value for that money depended on the consultants and the managers discussing the inter-relationship between their services. One point about the elderly as high consumers of health care was the need for psychogeriatric care. The NHS was beginning to become a social service as well as a health service and was trying to meet some of the problems of local authorities.

Lord Ennals said that as Secretary of State from 1976-79 he agreed with all that had been said about value for money and the necessity of cash limits to force people to fit within the constraints of a budget because there would never be enough money to meet all demands on the service. He questioned Mr Harrison’s view that the constraints would be the same whatever government was in power. The different political parties did give different priorities, in health as opposed to other aspects of their policies, and in terms of different aspects of public expenditure in relation to taxation. He also wanted to point out the profound effect that rate-capping and the abolition of metropolitan authorities might have on the ability of local authorities to provide more community care in order to relieve pressure on the NHS.

Mr Harrison replied that the scale of the problem in terms of pressures from patients and from escalating costs within the service was something that no government could alter very much so that the scope for expressing party political preferences was very limited. Lord Ennals’ comment on local authorities raised the question of whether the total resources going to the NHS and social services should be earmarked for particular services. The overlap area between the NHS and local authorities was growing in importance and very difficult to handle financially. In answer to Dr Thould he said that it would be a mistake just to focus on the growing number of the elderly. It had been calculated that this demographic change would need an annual increase of half a per cent in resources to maintain services. The pressure of demand for services spread right across the population with its increased expectations of what should be provided.

Dr D. G. Williams, speaking as a renal physician at Guy’s Hospital, said that the renal unit, in common with others all over the world, had become much more efficient and successful in renal transplantation. The patients were now surviving into relatively old age, so that whereas ten years ago his unit had a pool of 40 patients it now had 280 patients to be looked after, using the same number of beds. As a consequence of increased efficiency the unit was now in deep financial trouble. How could such efficiency be penalised with the penalties now being handed out?

Mr Pace replied that the government had said that renal transplantation was a high priority service that it wished to see expanded. In the very short term the extra resources for this service could come from squeezing money out of other services by making them more efficient. But once efficiency had been achieved there was no further saving to be made in this way and the pressures were back. In the end the population at large had to
decide whether they wished to spend 10X on one patient in a particular specialty or 1X on 10 patients treated for other things.

**Dr Tudor Hart** took up Dr Williams' point about being penalized for efficiency. In Glyncorwg, South Wales, he had looked after much the same people for 23 years, a population of 1,700. There was no residential care for mental defect or psychiatric illness, no long-term geriatric care and they had not got any major drug dependence. The percentage of males with no jobs (unemployed or sick) was 48 per cent for ages 16 to 64 and 60 per cent for ages 14 to 16. The local economy was devastated; in the Port Talbot area more than 50 per cent of householders qualified for rate relief. Despite this he said that Glyncorwg was operating very efficiently. Families looked after their own patients, though with the number of children leaving the area this was becoming more difficult. It should not be supposed that because a community operated efficiently and quietly it could take a further beating. There should be local budgeting for community health services which should include primary care services. That meant the end of independent contractor status for GPs, as they could not be budget-holders without some local accountability, which he thought must come from the local population and to some extent from local peer groups; no one would want accountability to some central agency. Some new structures for democratic answerability were needed if doctors were to think about their work more intelligently.

**Mr Pace** replied that he thought of community care in terms of the community rather than of individual families. The unemployed might be able to help in community care as a free resource. He agreed that for better performance the resources should be put locally so that the people were aware of them and could get better value from them. However, those who wanted a resource never wanted to lose the facilities of the other resources. There was always a conflict between the urban centre of a region and its rural communities, as well as conflicts between different specialties and between consultants and GPs. These indicated how diffuse problems became when dealing with a number of agencies looking after local problems.

**Dr J. Lister** wanted to know whether the different proportion of the gross national product spent on health in Britain as compared to the USA indicated that the NHS was really under-financed or that the USA was not so efficient in delivering health care. If more was to be spent on health it was necessary to indicate what was for health care and what was for medical care.

**Mr Harrison** quoted the opinion recorded in *The Painful Prescription* that the way limited funds had been allocated in Britain was sensible. But the problem was the loose connection between the providers of finance and the users with their preferences. An economist was used to people who wanted more money putting up plans that detailed what would be done with that marginal increment of resource. The DHSS did not know what the return at the margin was. It needed an information system, accounting in the broad sense, before it could say what would be gained from an extra sum or what would be lost if that sum was not available.

Mr Pace added that more had been spent in the USA on the environment of health care. In Britain some wise decisions had been made in concentrating the high specialty centres and not replicating equipment throughout the system. In America facilities could stand vacant waiting for users to come along. In Britain there was never an ounce of over-provision.

**Sir Henry Yellowlees** said that he had always been mystified by the concept of a gross national product so could not attempt to judge whether or not a fair proportion had been allocated to health. It was better to talk about the proportion of public expenditure which actually rested with health and social services. The government had planned for the year 1985/86 a total public expenditure of £130.21 billion, of which £16.5 billion (12.5 per cent) went to health and personal social services. In real terms, against the base of the previous year, the planned expenditure on health and social services was £15.1 billion for 1985/86. This seemed to be a better way of expressing the size of the cake.

If, as had been suggested, earmarking of funds was a way of making better use of what was available and made better relationships between those who made the financial decisions and those who had to live with them, it was important that there was absolutely full consultation between all those concerned. He was worried by what seemed to him to be a deterioration in consultative processes.

Turning to medical manpower, Sir Henry asked if the doctors made too many financial decisions and whether the cost and size of medical manpower ought to be looked at especially. For the first time ever the January 1985 figures showed a reduction in training grades of 1.2 per cent and a rise in consultants of 2.3 per cent. After years of striving for some such result he found it a consolation that it had occurred a year after he had left the DHSS. The junior grades had enthusiastically supported efforts to get to grips with the problem of manpower; the BMA and negotiating committees had been cautious but gradual co-operators, the deans and universities had been interested but mystified and the Royal Colleges had been entirely courteous and extremely kindly in their total obstruction.

**Mr Pace** said that the relative inflexibility in medical manpower worried him when regions were planning major resource shifts and changes in service between different styles and locations. Other markets around the world were more responsive to change than this one, which had to be changed in a sensitive way. He would expect government to be talking to consultants in a constructive way about changes in where consultants delivered their services. There was a lot of planning on change which could be frustrated by the unwillingness of consultants to accept and co-operate with it.

### Adequacy of Care

**Professor Rudolf Klein** said that the level of expenditure on health services in the UK had not been cut; in real terms they had increased. However, levels of expenditure were meaningless unless related to adequacy of health.
care. The basic question about the NHS, or indeed any health system, was how to assess whether the health care being provided was adequate. What benchmarks or criteria should be used to evaluate 'adequacy'? He would not answer that question for the simple reason that he was unable to do so. But he would try to explore the various dimensions of the concept of 'adequacy'.

The Royal Commission on the NHS had defined objectives for the health service, listing, among other things:

1. To provide equality of entitlement to health services.
2. To provide a broad range of services of a high standard.
3. To provide equality of access to these services.
4. To satisfy the reasonable expectations of their users.

These objectives raised as many questions as they answered. They did not indicate how broad the range or high the standard of the services should be or define what was a reasonable expectation. The latest (1984) annual report of the DHSS was of little help. The report stated that the objective of the NHS was 'to provide effective and appropriate treatment and care where necessary'. But there was nothing about who should decide what was appropriate and what was necessary. If existing resource constraints were taken as a limiting factor then the way that priorities were defined could be questioned. If the notion of adequate standards was accepted the acceptability of the constraints themselves could be questioned. Could constraints be compatible with what the NHS should be trying to do by way of providing adequate health care for everyone?

Professor Klein then proposed a framework for thinking about adequacy in the following terms—inputs, activity, process and outcomes.

**Inputs**

In the sixties and early seventies it was fashionable to consider adequacy in terms of inputs, i.e. so many beds, so many doctors and so many community nurses, etc. This assumed economic growth and that improved input of resources improved the adequacy of care provided. When the economic growth to underpin this concept did not happen the popularity of the concept faded.

**Activity**

This was a more recent fashion of thought that reflected pessimism about economic growth and laid stress on the numbers treated or on waiting lists for operations. The more phrenetic the activity the more adequate the service, appeared to be a conclusion.

**Process**

This gave a qualitative dimension to statistics. It also had a technical dimension. The maternal death inquiry was an example of finding out the adequacy of care. It was about how individuals were treated rather than inputs. One should know if the individual was treated with proper respect and dignity as a human being.

**Outcome**

The emergent style of thinking defined adequacy in terms of the impact of health services not only on individual patients but also on a given population. It revolved around the effects on the population and not on what happened within the NHS. In considering outcome there had to be a distinction between adequacy of treatment and adequacy of care.

The adequacy of treatment posed familiar questions about whether everything possible was being done to save life and prevent disability. Was the quality of treatment adequate to achieve the desired result and its quantity sufficient to ensure that all who could benefit did so? Was its distribution such that there was equality of opportunity (for equal needs) of actually getting it? Hence the interest in monitoring the quality of medical treatment, in achieving an equitable distribution of resources and in analysing use by social class. Hence the controversies about queues for specific procedures such as arthroplasty and dialysis. Hence the big question of whether the notion of adequacy was, like poverty, indefinitely expandable in line with technological development. Did the adequacy of a health system have to be defined by its ability to meet the demand for all procedures that could prolong life (heart transplant) or lessen disability (coronary bypass surgery)? Professor Klein stressed that, because those were familiar questions, adequacy should be thought in terms not of medical treatment but of health care provision. Care described what any health system did to improve the quality of life of those who could not be cured and to make inevitable disability more tolerable. However, the definition of adequate care was more difficult than that of adequacy of medical treatment, which could be tested by the criterion of effectiveness. It was difficult to judge what was an adequate environment for the mentally handicapped or what was an adequate supply of home aids and physiotherapy for the disabled.

Professor Klein asked who should define adequacy, whether it meant the necessary, desirable or optimal in any given situation, and whose definition should prevail, that of health service producers or that of the health service consumers. He considered that the concept of adequacy was both a technical and a social one, involving technical procedures and the environment in which these procedures were carried out. The relationship between the two involved value judgments whose implications required analysis and debate. He wished to guard against defining adequacy in terms of technical optimality, an approach characteristic of American medicine. He wanted to settle for 'acceptable', somewhere between what was necessary and what was desirable. Medical technology was international but national incomes were not and Britain needed to guard against an infinite technologically-driven expansion of the definition of the 'desirable'. Adequacy should not be defined exclusively in medical terms, which might be the easiest to measure, for there was always the danger that the measurable and dramatic would drive out the desirable. Headline news was made by those denied life-saving treatment but not by old ladies who, for lack of aids, could not do housework or shop.
Any definition of adequacy that left out the old ladies and adopted an exclusively medical focus was likely to be mischievous and misleading.

Discussion

Dr J. W. Todd said that for most patients who sought advice for minor self-limiting illnesses and minor psychiatric disturbances the highest standard of medical care was a visit to a GP who would listen to them and advise but do no investigations, give no prescription and not refer the patient to hospital. There were many unnecessary investigations done in hospital and unnecessary admissions solely for investigation. There were also some dubious hospital treatments such as cholecystectomy for symptomless gall-stones and vast quantities of inappropriate chemotherapy and radiotherapy for cancer. Armies of old patients repeatedly attended out-patients quite unnecessarily. Doctors did have it in their power to make enormous improvements in health care by getting rid of this shocking waste.

Sir Kenneth Robinson wanted to emphasise one aspect of adequacy in the NHS: its accessibility. In that respect the NHS compared very well with the health services of any country, however wealthy. There was accessibility to hospital treatment for urgent cases, albeit at the price of unacceptably long waiting lists for the non-urgent. But the real jewel in the NHS was the accessibility to primary care and the family doctor service. This should never be forgotten.

Dr S. D. Horsley was worried that, if outcome measurements were not developed soon, proxy financial indicators would be used instead. The use of performance indicators that had no output could lead to the absurdity of it not mattering that many patients had died provided a large number were going through the service. There had to be some outcome measure that included the quality of care element.

Dr H. E. Thomas said that he had been taught to think of value as having two meanings, the value for exchange and the value for use. He thought that the financial speakers had not understood this difference. Value for use in the medical context could only be determined by one’s peers. A system was needed to judge the best value for use.

Professor Klein agreed that the performance indicators used to measure many things did not measure the adequacy of care. They might well distort perception of what was happening by defining adequacy in terms of activity. A lot of activity might not only be useless but harmful. There was also the danger, seen in America, of monitoring the quality of care provided by using process criteria; e.g. it was assumed that the care of a patient was better because he had 342 X-rays taken and not just one. Partly this was defensive medicine but it also indicated a confusion between technical optimality and adequacy. If the two were equated, spending on the health service would be doubled and untold suffering inflicted on the patients.

He agreed with Sir Kenneth Robinson that the NHS had a very good record of accessibility but he had begun to wonder whether that might be measured by the ability of the medical profession to damp down total demand. In the issues of resource rationing and priorities, most of the demands, certainly the expensive ones, were made by the doctors. For years the rate of patient/general practitioner consultations had remained constant at 4.2 a year. What had persuaded the patients that this was an adequate rate and did it have anything to do with the rather long wait in the surgery?

Moral and Ethical Problems

Canon G. R. Dunstan said he had brooded long over the relevant literature on medical care and was aware of the polemics of the resources debate, with one interest group after another staking its claim against the cost of Trident. He was also aware of the tedious and often spurious counter-claims of high technology medicine versus traditional operations or of one specialty (e.g. the renal lobby) against others within the allocated funds. He was aware of the claims of disease in poverty-ridden countries of the Third World against such things as special infertility units in the UK and of the economies predicted of preventive medicine, keeping people well as opposed to treating them expensively when ill. He did not wish to discuss the literature but instead proposed to recall seven foundation maxims of medical care as a basis of claims and, if those claims conflicted, he would leave others to adjust them. The maxims, mostly from the past, would not be expressed in their original terms (still less in their original languages), as it was necessary to wrest them from the thought forms of their times and express them in today’s terms.

His first maxim, established by Aristotle out of the oldest and most essential exercise of a disciplined curiosity, embryology, was that the basis of human nature is animal nature. Humans were biochemical products or random genetic factors. His second maxim, also from Aristotle, stated that imposed upon, or rather animated in man’s animal nature was a rational nature which enabled man to speculate upon his animality and ultimately to exercise a measure of control of it. But granted the random factor in human genetic make-up and so its ultimate unpredictability, understanding and explanation could not guarantee total control. So good medicine stood on observation, understanding and making experiments (i.e. innovation) but although one could learn from the past, the past could not be relied upon. To cut back on research (unless it be cutting out the bad or unthought-out research) was to cut at the root of medicine.

Human rationality also had a moral dimension, reason exercising itself in moral judgment. One such judgment found the random activity of biology fundamentally unjust; it forbade the sentimentiality of ‘nature knows best’, except in certain restricted fields. It used words like victim for some of nature’s products, implying that they ought not to be as they are and that their marred conditions exercise on man a certain sort of moral claim.

Canon Dunstan’s third maxim, from Aquinas out of Aristotle, stated that man was a social being with affectional and willed affinities to add to his biological species
grouping. Man used this rationality to organise them into politics or ways of living. Man had self-awareness, especially for pain, disadvantage and injustice, which gave him a sympathy for the victims of biological injustice; he found a moral imperative to look for remedies and had the capacity to create and organise institutions of care. The Jewish and Christian religions, to look no further, added a motive to this moral imperative. Therefore medicine was an art, grounded in a reasoned application of curiosity and compassion and organised as a social institution within diverse kinds of polity—cities, communities and now nations, all of various sorts. In moving quickly from the embryo to the nation state Professor Dunstan said that tension was to be expected and that the ethics of priorities in medical care were the ethics of tension.

His fourth maxim came from the Greeks and stated that medicine had its ethics and so did politics. He believed that the major confusions in the resources debate stemmed from a confusion of these two, from the temptation to escape from the contingent tensions of medicine by ignoring or wishing away the essential tensions of politics. So primary duty had to be discovered and done within the contingently possible. A secondary duty might be to move into the political realm to enlarge the economic basis of possibility. It was important to recognise what was primary and what was secondary in these two ethical obligations.

His fifth maxim was that medicine created polities of its own, adapting variously to the local wider polities of the times, be they the city state, the kingdom (ancient Levantine or feudal European) or the modern nation state, welfare, capitalist or socialist. Throughout history doctors had varied in social status from slaves to the confidants of kings and had had various systems of rewards for good service and penalties for bad. But doctors had always organised themselves into guilds, fraternities, colleges and, latterly, into a profession. This organisation entailed the corporate possession of knowledge and skill and interest in social and material reward and a corporate obligation to offer a service that was ethically governed.

Within these ethics of medicine and politics the doctor had to serve both rich and poor but might take from the rich to pay for both. The basic injustice of biology should not be compounded by economic injustice. Herein lay the foundation of modern provisions for health care based on mutual insurance, a service financed out of taxes with or without voluntary contributions. Thus a maxim of medical ethics was to provide for those who did not or could not generate wealth from the wealth of those who could. This took medicine into the realms of politics to state and maintain its claims by ethical means. Means were limited, as spending could not exceed production. Granted the historical facts of a wide variety of economic relations between medicine and the political community, Canon Dunstan thought it would be the height of political unwisdom to intrude a political dogma which made the interplay of public and private funding as difficult as possible.

His sixth maxim applied to both systems of ethics, medical and political, and formulated the principle of consent. Aquinas had used it in relation to surgical intervention, but monastic communities had developed it in relation to government by consent and then to representative government. This concept was now somewhat overwhelmed by loud voices that clamoured for conflicting rights. However, the principle of consent was as fundamental to the body politic (and its provision of health care) as it was to the care of the body human. One priority in medicine might be to come to grips with the preoccupation with rights and forestall what might happen to medicine and society if an ethic built on consent were to be replaced by an ideology of conflict.

His seventh maxim came from Hippocrates and stated that it was unphysicianly to treat those for whom there was no possibility of cure. This maxim was a gift to those who gave a low priority to high-technological procedures. But medical advances had not been achieved by holding back and a balance had to be found between the new untried and the established. The established could be improved to some extent by learning from the untried, provided that the learning be disciplined, controlled and not 'free range'. How far a trial should go for any individual patient was another question but there was nothing unphysicianly about allowing men properly to die.

These seven maxims had not offered clear-cut solutions to anything but Canon Dunstan stressed that it was not the moralist's job to provide the solutions to technical problems, especially when those problems occurred in the exercise of other men's professions, and that solutions which did not pay attention to the maxims he had quoted might not be worth very much or last very long.

Professor I. Kennedy said that he wanted to put forward a logic flow, a series of ideas not unlike the maxims set out by Canon Dunstan. As a lawyer he was aware of the real world where solutions had to be reached. His theme was from principle to practice and his brief concerned the moral and ethical problems in the financing of medical care and in the limitations of the facilities provided. Such terms as efficiency and cost containment had been referred to as appropriate concepts to use in the analysis of priorities. Efficiency merely meant 'productive of the desired result' and gave no moral guidance. If we wanted to be efficient we had to ask what we wanted to be efficient about. Equally, talk of cost containment, the argumentative flavour of the month in the USA, begged a series of questions, in that decisions had already been made about choices that had to be contained or not contained. It was those decisions and choices that had to be wrestled with. There was no simple way of avoiding the analysis of the allocation of a scarce resource by making it appear as a value-free exercise, pursuant to the rules of economics. Economics was more a matter of political philosophy than anything else, although it might masquerade as no more than statistics. The question was not could we, but should we, afford X or Y, under what circumstances and with what arguments for and against. The criteria for choice between X and Y were central and had to be morally defensible.

There were three levels of problem. The first problem
for the moral philosopher was how much of the total resources of the nation-state should be allocated to health and medical care as compared to other sectors using money, time, human and material resources (such as defence, education, transport). Once a sum had been allocated to health and medical care, the second level of problem was how to split up the allocation. The third level, once funds had been split up, concerned who should get the treatment, particularly if that treatment were, by definition, scarce.

Professor Kennedy pointed out that to say that these problems were not amenable to moral or any form of rational analysis would imply that the criteria for decision-making were not amenable to rational debate and so the decision-makers could not be held accountable. As such decisions were taken in the community and affected everyone’s livelihood, accountability seemed a very important factor but could not be discussed unless it was agreed that the criteria for decision-making could be analysed. There was a counter-desire in central and local government to fudge the criteria in order to dissipate responsibility and accountability so that no one was clear as to why one unit was closed and another open. Alternatively there were cries of professional freedom or territoriality that might or might not be rationally defensible. If there were no stated reasons on which decisions were made, the public surrendered power to the decision-makers who would then be immune from accountability. Therefore the question was what was the moral agenda on which resources in society were allocated for health and medical care, and who would set the agenda. Professor Kennedy did not agree that the moral agenda for the practice of medicine should be allocated only to those who practised medicine or delivered health care. It could not be any particular group who set the moral agenda. It was necessary to be aware of the rhetoric of power which held that those with certain technical knowledge were blessed with moral superiority in making decisions. The moral agenda for the allocation of scarce resources had to be set within political institutions because this would guarantee some political answerability from those with power.

The first principle on the moral agenda should be the notion of justice, of behaving with a sense of what was just. Other principles would include respect for life and respect for people’s dignity. Such principles should not intrude too much into respect for freedom of choice and the people’s right to make up their own minds. There were various theories as to what was just in a community and Professor Kennedy agreed with Canon Dunstan’s view of the mutual care for those less able by those who were more able which was the egalitarian view. This was the notion of caring for each person as being of equal moral worth (not factually equal) and equally entitled to an opportunity to enjoy the sum total of society’s resources. Another, fashionable, view of justice was that ‘What I have I should be entitled to hold’, so that if the individual could negotiate more medical care for himself that was just. This was the theory of entitlement. The theory of utilitarianism suggested that just decisions were those made for the greatest good of the greatest number, a cost-benefit analysis much beloved by some because it appeared to be a factual exercise. This was not true because it depended on both cost and benefit being functions of the starting position.

Professor Kennedy thought that the egalitarian view of justice should be our inspiration as it was claimed that we lived by it. The question of whether the healthy should look after alcoholics and drug users needed to be answered. They should not be looked after if it was believed that the well-off were not obliged to look after the less well-off. Similarly, the view of how resources should be allocated at all levels depended on the answer to that question. As a matter of policy in the sharing out of money to the NHS and other health care institutions the aim should be to insure that each person had an equal opportunity to enjoy health within the context of the sum of society’s resources and the need to do other things. For instance, health might be improved by removing motor cars but this would diminish very important deemed needs such as the need to get around. But within this context the proportion of gross national product to be allocated to health could be decided. While a great deal of GNP was allocated to medical care, a great deal of economic energy was spent on anti-health production so that the two sometimes cancelled out. It was not efficient to allocate money to medicine and also take it away, thereby denying certain people the opportunity of equal access to health care. The Black report gave examples of what might be called injustices in the decisions taken as to the amount of resources, human and material, allocated by the tax-payer.

In dealing with the tensions that necessarily exist in the competition for limited resources Professor Kennedy offered a two-stage analysis. The first stage was to set up a norm of ordinary care, to cater for what every urbanised developed society could provide in health maintenance and medical care. This ordinary care should be so organised that everyone had equal access to it. It would clearly be unfair if it was available only to those who could pay for it or lived in the right place. Hence the organisation of revenue spending would be wrong unless justice has been traded for some other notion of freedom (although that would probably be unjust and wrong).

After the provision of ordinary care according to international norms would come the provision of unusual or special care. This type of care would make a greater than usual demand on resources, and would have to be set on a sliding scale. The choice between heart transplants and intensive care units should not depend on arm-twisting but on a considered moral analysis. The factors should include the consequences of not providing the treatment (the cost of continuing care if it was not provided) and the effect of the treatment in terms of total or partial recovery or degree in reduction of handicap. There also had to be some research and development potential. A check-list of priorities and preferences could be built up which would have moral credibility and not merely be the response to loud noise. Such priorities would have to be drawn up after proper debate, which would have the advantage of educating the public as to the limits of medicine. It would need centralised planning and articulation of relevant criteria.
Professor Kennedy did not think that a rare resource should be dissipated all over the place, although the principle of equality of access required that the source should be sited so that all people should be able to get to it. Distribution of a resource was a problem. The decision as to who should use it was another, as limitation of resource meant that not everyone could be treated. The traditional method was the queue, a rationing system largely morally indefensible. A waiting list was not a method of selection that respected life. A lottery system, as used when polio vaccine was introduced, was unsatisfactory for the same reason, as it depended on the chronological fact of date of entry. Claims had been made for the use of objective medical factors only in choosing patients for renal dialysis but usually more than technical criteria had come into such schemes. It was necessary to work out what was morally defensible, not only for the benefit of society, but also for the benefit of those who practised medicine and who had to live with these hard decisions each and every day.

Discussion

Answering Sir Douglas Black, Professor Kennedy said that his lottery did not apply to clinical trials and their ethics. He had applied the term only to the clear example of where there were enough candidates for a treatment but not enough resources. Patients could be admitted in turn from a waiting list or chronology could be defeated by pulling their names out of a hat. He did not think this lottery was fairer. A better way had to be found of allocating a bed to one of ten candidates knowing that the other nine might be harmed as a consequence of the choice.

Taking this example Sir Raymond Hoffenberg asked if it was fair that the decision was often left to one doctor. Professor Kennedy replied that it was not fair to doctors who were often in the position of being damned if they did and damned if they didn’t. It was the obligation of those who commented on these matters to develop the appropriate moral guidelines which would help rather than confuse. He had argued that these matters were of such complexity and importance that it behoved government to set up a standing advisory committee to discuss the issues one by one, taking appropriate evidence and then issuing guidance papers which would attempt to offer the four corners of moral propriety within which doctors were entitled to act.

Dr I. Munro said that the legal ethicists with whom he had conflict from time to time in his role as a journalist would seek to lay down a code of ethical practice that was too general. The analysis of individual instances of resource allocation and of other ethical judgments in medicine was a reasonable way of advancing people’s thought, particularly doctors’ thought. Making a general pattern based on rather vague concepts of right and wrong led to difficulties. He, like Professor Kennedy, was a pragmatist and would not favour an attempt to lay down a code in very sweeping terms, but each decision should be judged much more carefully than hitherto.

Professor Kennedy thought that the notion that one could respond to individual cases as they occurred was only tenable if the response was by reference to a set of moral principles. Answers to specific individual problems did not pop up from the problems themselves. They popped up from the perception of how the problem fitted within a moral taxonomy. Medical scientists, engineers and everyone else had a taxonomy of analysis to indicate the kind of problem. There was room for that in applied moral philosophy. He agreed that it would be wrong to think in terms so general that they did not particularly direct the mind to anything. Facts had to be learned and matters had to be talked about in the context of real life. Categories could be built up, say of severely handicapped neonates, which took account of morally relevant facts. Any sensitive code would operate by examples and would properly leave the doctor discretion in his choices, as it was the right and responsibility of a professional to use his professional discretion within the four corners of what was indicated as morally tolerable.

Sir Raymond Hoffenberg quoted the case of two renal physicians in Birmingham who had been faced with the dilemma of having to turn down patients for renal dialysis because they had exceeded their allocated budget and had been told that if they persisted in spending more money by taking on more patients they were depriving other sectors of finance. In his view they had rightly argued: ‘It is not for me to make the decision about accepting or refusing a patient. I cannot send Mr Jones away because I haven’t got the resources.’

Professor Kennedy replied that some claimed that a doctor had a duty to serve the group as well as the individual. By treating X here, he neglected the group over there. Others said that the doctor could solve his problem by addressing himself to his patients and his patients alone. That did not resolve the problem, it solved it by opting for one group instead of another. In the battle for resources, decisions that should have been made and enforced politically (to the extent that they could be), had been allocated to be fought out by different lobbying groups within the medical profession in a way whereby no one benefited. He was persuaded that if, for good reasons, society had decided to spend a certain sum on renal dialysis in a certain unit then that was the answer.

Canon Dunstan could not suggest any way out of the dilemma; once the limit was reached that was the limit. Those turned away could be provided with alternative forms of care. They were not simply being rejected, some appropriate management had to be found for them. Sir Raymond Hoffenberg said that they were indeed being rejected and deprived of live-saving treatment.

Miss J. Turner thought that doctors who had to turn patients away had some sort of duty to the public to make known what they had done. They could appeal to the public more directly and with more public understanding in the high-technology specialties than in the low. She wondered whether it was really enough for doctors to make difficult decisions and be quiet about them. She wanted to hear of the duty to speak out. Canon Dunstan said this came within his definition of secondary duty. To enter into the realms of politics to secure needed resources would be using the ethics of politics and not specifically
medical ethics. **Professor Kennedy** agreed and added that if a doctor thought the cut of the cake was improper or morally wrong he was entitled to enter the debate, his only special qualification being his great technical and specific knowledge but with no greater standing on the moral and political decisions on resource allocation.

**Dr A. K. Thould** thought there would be little in the way of resolution of problems by public debate on television. The emotive problems would be debated, as they made good news, but the equally important non-emotive problems would not, as they did not have news value. It was of equal importance that those needing renal dialysis should get it and that the disabled should get the required occupational therapy. Society normally resolved problems by putting them in the market-place. If there was a need for X, someone would manufacture it and those in need would buy it at a price. To be fair to those who required it, the NHS had been taken out of the market-place, which had produced enormous problems of choice. In the last resort the choices had to be made by politicians, who should have the courage to have a public debate so that people who used the services could say what they wanted.

**Dr T. Brewin** said that decision theory could be used to look at both public and individual decision-making. The application of this theory in medicine, to both individual and public policies, often resulted in finding out that there was still a problem. However, the process itself, whether done in private or in public, illuminated the problems and might dispel anxiety.

**Canon Dunstan** said that he was all for applying in appropriate spheres a theory of decision provided it was validated and workable. He would not let himself be bound by it absolutely as some day there would be a case to which the theory did not apply.

**Miss K. Whitehorn** said Professor Kennedy had been provoked to talk of the doctor as a doctor and as a political animal. She wanted to know about the patient as a patient and as a political animal. The doctor, in turning down a patient for dialysis, might think that he would be more comfortable with the explanation that his condition was not suitable for dialysis rather than being told: ‘Sorry, old chap, we haven’t got the resources’. On the other hand, the shroud waved most effectively was one’s own. Might not the doctor consider it his duty to say: ‘We aren’t dialysing you because we haven’t got the resources so go and tell the local paper and maybe we can whip up some support’. She wanted some thoughts on this doctor’s extra dilemma.

**Canon Dunstan** knew what the doctor must not do; he must not use his patient as a political pawn in any way which might be to the patient’s disadvantage. After that it was a matter of the doctor’s judgment of his patient’s capacity to enter with him into a consensual agreement on the course to be followed. This was consistent with the principle that the patient was also a moral agent.

**Professor Kennedy** agreed, and added that the doctor’s duty was first and foremost to his patient. What was in the best interest of the patient was usually defined by the patient and therefore if the patient became a willing partner in the doctor’s desire to point out some political difficulty, that might gratify the patient and be an act in his best interest. To use a patient as a means to an end would be inappropriate behaviour.

**Dr T. Brewin** felt that there should be public debate on the big decisions on priorities, on how much should be spent on health and what sort of health. The minor tactical rationing decisions of day-to-day care were taken best by an experienced doctor who had learnt from his mistakes. He would not make better decisions if there was a committee at his elbow.

**Professor Kennedy** made it clear that he did not advocate that decisions should be taken by committees. He repeated that he wanted doctors to exercise proper discretion within the context of what was deemed morally tolerable by the community. The determination of what was morally tolerable was not at the behest of the medical or any other profession. It might be that some form of committee could work out what was appropriate in the case of resource rationing and the doctor would be obliged morally to live within that framework.

**Canon Dunstan** said that over such a wide range of decisions it was necessary to work out means of decision relevant to the locus of authority for that decision. Whatever the consultative processes and committees concerned with the allocation of resources, in the end the minister would decide. Similarly the clinician, whatever advice he took, had to decide about his patient. No one would advocate one vast principal consultation by committee for such a wide range of potential decisions. Professor Kennedy thought it was begging the question to talk of the locus of authority. The doctor had the decision-making capacity because he and no one else had to make the decision. What mattered was the moral context in which his decision was made.

**How Do We Manage?**

**Sir Douglas Black** said that, like the other speakers, he had no intention of answering questions but would embroider on them, beginning with a double tribute to Dr David Owen. Dr Owen had said very plainly that need could never be really met even by the utmost superfluous of resources. There would never be a complete equation between need, which in theory should evoke demand, that in turn would lead to supply. Dr Owen also had the bright idea of finding out what were the main burdens on the NHS and then dividing the transferred sums to the MRC proportionally to the main burdens. Sir Douglas and Mr David Pole, then economic adviser to the Department of Health and Social Security, had been given the task of measuring these burdens. First they looked at the International Nomenclature of Disease with its 900-1,000 items. They thought that categorisation in these terms would not be useful for anyone, let alone those commissioning programmes for the MRC. Instead they made groups of about 50 items and then devised five indices of burden on the NHS—in-patient days, outpatient referrals, visits to GPs, sickness benefit and loss of expectation of life. The use of loss of life expectancy rather than mortality rates loaded the index in favour of children, which seemed sensible and fair.
In terms of in-patients (Table 1) more than half the burden on the NHS was accounted for by mental disease and handicap. But the burden in terms of out-patients (Table 2) was quite different, with a much more varied picture and neurological disorders at the top of the list.

Table 1. Burden on the NHS. In-patient days [1].

| Disease                  | % of total burden |
|--------------------------|-------------------|
| Mental illness           | 31.31             |
| Mental handicap          | 15.19             |
| Cerebrovascular disease  | 4.36              |

Table 2. Burden on the NHS. Out-patient referrals [1].

| Disease                        | % of total burden |
|--------------------------------|-------------------|
| Neurological                   | 9.82              |
| Accident and suicide           | 7.84              |
| Bone and joint (not arthritis) | 6.87              |
| Digestive disorders            | 6.72              |
| Skin disorders                 | 5.90              |
| Urogenital disorders           | 5.50              |
| Arthritis and rheumatism       | 3.96              |

The burden indicated by visits to GPs showed respiratory infections at the top of the list (Table 3). Indeed, each index gave a different set of priorities. The precise problem of what weighting should be given to each priority had been evaded by all politicians. Table 4 showed a partial index in that it related only to those employed who were absent from work through sickness.

Table 3. Burden on the NHS. GP consultations [1].

| Disease                        | % of total burden |
|--------------------------------|-------------------|
| Respiratory infections         | 16.03             |
| Mental disorders               | 7.73              |
| Bronchitis and asthma          | 5.07              |
| Skin diseases                  | 4.84              |
| Accidents and suicide          | 4.63              |
| Digestive disorders            | 4.05              |
| Arthritis and rheumatism       | 3.99              |
| Heart disease                  | 3.06              |
| Other bone and joint disease   | 2.79              |

Table 4. Burden on the NHS. Days of sickness benefit [1].

| Disease                        | % of total burden |
|--------------------------------|-------------------|
| Bronchitis and asthma          | 11.46             |
| Mental disease                 | 9.55              |
| Accidents and suicide          | 8.81              |
| Arthritis and rheumatism       | 7.22              |
| Respiratory infections         | 7.17              |
| Ischaemic heart disease        | 5.73              |
| Digestive disorders            | 5.73              |

Table 5. Burden on the NHS. Mortality (loss of life expectancy) [1].

| Disease                        | % of total burden |
|--------------------------------|-------------------|
| Ischaemic heart disease        | 21.51             |
| Neoplasms                      | 20.63             |
| Cerebrovascular diseases       | 10.88             |

Table 6. Burden on the NHS. Simple average of previous indices [1].

| Disease                        | % of total burden |
|--------------------------------|-------------------|
| Mental illness and handicap    | 13.60             |
| Respiratory diseases           | 13.47             |
| Ischaemic heart disease        | 6.59              |
| Bone and joint diseases        | 6.38              |
| Accidents and suicide          | 6.25              |
| Neoplasms                      | 6.08              |
| Digestive disorders            | 4.56              |
| Neurological disorders         | 4.11              |
| Cerebrovascular disease        | 3.74              |
| Skin disease                   | 2.55              |
| Urogenital disease             | 2.31              |
| Total                          | 69.64             |

The importance of mental disorder and respiratory disease was clear. Loss of life expectancy (Table 5) concerned only three conditions, with arterial disease accounting for almost a third of the loss. As ischaemic heart disease came late in life it was under-estimated in this table, whereas diseases like leukaemia that were prominent in childhood were over-estimated. By taking a simple average of the five indices some idea of important conditions in terms of burden could be found (Table 6).

Sir Douglas felt that such an exercise was more relevant to service provision than to the allocation of money for research and that research on a group of diseases depended more on appropriateness and availability of people with the necessary interest. As a pragmatist he wanted to put resources into things that saved life or demonstrably improved the quality of life. In terms of outcome, resources deployed in this way might be better than putting them into the so-called Cinderella diseases, although they also needed resources.

Of other indices that formed a possible approach to management would be one based on the quality of life. By that criterion hip replacement would come way above most life-saving measures. The worst possible way of determining priorities was to listen to pressure groups in which the still small voice of reason could not be heard. But the concept of burden was inadequate as shown by the fact that deafness, which severely impairs the quality of life, gave a burden of about 0.5 per cent; yet Mr. Jack Ashley managed to elevate research into deafness to a top priority.

Turning to the role of management Sir Douglas thought that such things as the hotel side of hospitals and
appointment systems were susceptible to improvement by management but that the worrying point as to whether in the NHS things were being done that need not be done and others that should be done were being left undone could not be ‘managed’ away. Such items were firmly based on professional skills.

Sir Douglas said that the NHS and medicine in general were for patients and not to provide employment for doctors and managers. The term patient had to be widened from the person who came to the doctor who then did his utmost for him to the potential patient for whom disease could be prevented. There should be no diminution of the emphasis on prevention, which needed additional resources, not resources taken from the acute services. It was also important to ensure that doctors were adequately trained to take the sort of decisions discussed in the conference. It was equally important that doctors, nurses and all who worked in the NHS should be caring people. He did not think that the ways of ensuring this were fully known but they had to be found.

Sir Douglas was sure that the health service had a great future, but that future was dependent on the advancement of knowledge and nothing in the narrow pursuit of economy should be done that threatened either the training of future doctors or the advance of medical knowledge.

Mr R. Nicholls said that he wanted to emphasise the need for sound management in the NHS and to give some examples of managerial activity, largely from the regional point of view. Management had only recently become a respectable word in the NHS vocabulary and there was some way to go before a management culture was developed in the service. Given that management was about achieving results from limited resources, it was clear that a lot of it had been going on in the NHS. Some would say that management was doing well. There were high and rising patient activities in the health system which took one of the lower proportions of GNP of any country. The score on the few available health outcomes was also good. Surveys showed a high level of satisfaction with the services provided and the NHS had shown remarkable resilience and productivity despite a series of crises, some of them self-inflicted. Yet the politicians, the media and some workers in the NHS were extremely critical of the failures and inadequacies of the service. There were real problems such as barriers and delays to access, wastage of some key resources and a rather fixed use of medical manpower. Perhaps consultants, like general managers, should have short-term contracts. In particular the NHS had been criticised for its slowness in implementing plans and priorities which had been set out by the elected government that continued to fund 90 per cent of the resources. There was also the criticism, highlighted in the Griffiths’ report, of NHS attitudes to and communications with its customers.

He underlined the need for good management by showing the tendency of all Western health care systems to absorb ever-increasing resources yet continue an apparent decline. The demographic trends in his region illustrated this. There would, in the next ten years, be a spectacular rise in the number of those aged up to 75 years old and an apparent increase in those aged up to four years. These two groups were the biggest users of the health services, particularly the acute services. The overall demand for acute services was expected to rise in his region by over 10 per cent in the next decade. The use of facilities by the elderly was expected to rise by 15 per cent. This was against an expected resource gain of 1.5 per cent p.a. This did not take into account what might happen to pay settlements or demands from the rise in medical technology and the ability to do things or the demands from the customers and other services that might be called priority. Clearly there was a shortfall and the region had to consider what could be obtained by cost improvement programmes. These, traditionally, had been about raising efficiency, and saving on heat and hotel services. These savings had been running in the region, as elsewhere, at about 0.5 per cent p.a. More important were transfers to the community, which meant that cost improvement involved a change in priorities. If the objective was to move resources to the community, its achievement could be counted as cost improvement. There was also the increasing productivity in the acute services and the region’s declared priority for the Cinderella services and prevention. He thought that management needed to make targets if anything was to happen.

He suspected that management of the NHS had been rather like the weather was to Mark Twain, everybody talked about it but not a lot was done about it, at least at the corporate level. Individual clinicians, used to managing their resources, might think the debate to be rather old hat, but resources were now being looked at on a district, regional and even national basis. There had been many central initiatives trying to cope with choosing between competing claims for the limited resources available. Until recently the emphasis had been too much on structural reform. There had been central initiatives designed to improve the efficiency of the service, including the 1982 system of reviews, first by ministers of the regions, then by regions of their districts and, increasingly, by districts of their units. This was an important logical management initiative. There was no point in planning a priority system if there was not a way of reviewing achievements at all levels. Health authorities had had cash limits for some time and they were now accompanied by annual manpower targets. These initiatives had been designed to put the NHS under the DHSS microscope but they suffered from two major weaknesses. First, they had focused too narrowly on efficiency, diverting managerial effort away from broader issues like quality, effectiveness and priority. Second, they had undervalued the considerable achievements of the NHS and created the impression that all its problems could be solved by better management. Even the Griffiths’ report had been seen in this light initially.

Mr Nicholls considered that when the rather ghastly process of appointing general managers was over, the concept of general management would allow the NHS to address more effectively some of the issues that faced it. Two key recommendations by Griffiths were that the establishment of a supervisory board with the ministers and the heads of the professions at the DHSS and the setting up of
the NHS management board. These should give a sense of strategic purpose within the NHS, in terms of the proper role of the health care system and targets to be achieved in the next decade. The government was a signatory to WHO’s Health for All 2000 but its targets had not been widely promulgated in the service. The central requisites also gave the opportunity for selectivity and more certainty in operational planning for one or two years ahead. They should help the management of the service to be somewhat distanced from the inevitable oscillations of politics. Politics had a vital place in developing criteria for priority decisions and for setting broad policy objectives, but management needed freedom to get on and implement.

At regional, district and unit level Griffiths had recommended the development of a general management culture throughout the service, a commitment to corporate objectives, the accountability of individuals for achieving results and the development of information and management budget systems to involve clinicians more closely in management; the use of resources was to be maximised, with responsibility placed on individuals at each level for planning implementation and control. If properly developed, general management could bring about delegation of decision-making and give a much needed sense of direction and corporate purpose to the whole organisation.

General management would not happen overnight and would need considerable effort and sensitivity from all those involved. The NHS’s management’s main task was to make hard choices about using scarce resources in such a way that clinicians and the public at large had confidence in the way these were made.

It was clear from the review system that the Secretary of State held regions to be accountable for the overall management of the health service throughout their territories and for implementation of agreed plans and priorities. Given that regions had to work largely through districts, which were separate statutory accounting and employing authorities, and through consultants whose contracts they held but whose work they could not easily monitor, there was plenty of room for tension and different operational models. In addition to their traditional role of producing strategic planning guidelines and sharing out resources between districts, regions were now setting specific targets for districts to achieve in the use of resources and within agreed time-scales. Regions were also implementing plans by a variety of methods, including specific agreements with districts on tasks, and helping to solve problems which might delay implementation. Regional powers were being used in a more purposeful way.

Mr Nicholls recalled the remarks on the earmarking of funds and said that at central or even regional level, earmarking had a pretty dismal track record. Earmarking was not comfortable for politicians, it raised too many questions about the criteria for priorities. He thought that the creative use of available resources was the essence of management. His region had found that, for the mentally handicapped, it could provide better care for less money. Much of what had been spent was tied up in overheads and hotel services. By transferring to community care with support for the carers, advantage could be taken of other fiscal measures, notably the payment through the other branch of the DHSS of social security for people living in their own or group homes in the community. Another use of resource was the sale of lands, which would release millions of pounds.

In dealing with the projected 10 per cent rise in demand over the next decade due to demographic changes, his region had asked its districts to see how they could achieve an annual cost improvement of 2 per cent over the decade. This was a tall order but there were improvements in performance to be made. Reduction of turnover interval to two days and providing day places would achieve nearly a 5 per cent increase in productivity. Things were not quite so simple and consultants working in the districts were being asked to look at the performance and appropriateness of particular treatments, admissions and use of out-patient departments. There was also scope for saving by improving communications using the new technology for computed and automated offices, scans by telephone and videos for staff training and health education.

Lastly Mr Nicholls remarked on the appointment of clinicians as general managers, particularly at unit level. The commitment to management would be not less than seven sessions a week and he thought that few clinicians would wish to abandon such a high proportion of their clinical work. In most cases clinicians were wanted as clinicians, although involved in management through their professional advisory machinery, as accountable for the resources they commit and, in some instances, as budget-holders for clinical departments. What was important was that all doctors should be helped to understand more about the organisation and its costs. First exposure to management should come at the undergraduate stage and certainly in the early postgraduate years.

Dr June Crown said she would talk about the approach to problems rather than how to solve them, as she did not think satisfactory solutions had been achieved. She wanted to put into concrete terms the effects of limited resources within a health district, to set out the choices that had to be made and describe their effects on patient care.

The Health District of Bloomsbury was a very mixed area of London. It contained five main-line railway stations and included the College of Physicians and the slums around King’s Cross. There were many homeless, a large ethnic minority of Bengalis, Cypriots and Chinese, a large daytime population of commuters and many visitors. The local residents included the highest proportion in the country of elderly people living alone. The District had five predecessor authorities; two districts, each with a District General Hospital that was a distinguished undergraduate teaching hospital, and three groups of postgraduate hospitals. Among the various supporting hospitals were two that differed from the rest in that their future had not been settled through the normal planning procedure. The Elizabeth Garrett Anderson Hospital had been rebuilt after direct ministerial intervention and provided gynaecological services by
women doctors. The Royal Homeopathic Hospital housed homeopathy as well as some other clinical activities.

Bloomsbury was obviously not a ‘typical’ district but the principles of determining priorities were the same for all districts, whether they were resource gainers or losers. All districts had to provide care for local residents and take account of demographic change. All had to ensure that services not available locally were available and accessible somewhere for their residents when they needed them. All had to try increasingly to take account of outcome measures in the planning of services.

There could be little doubt about the value (outcome) of vaccination and immunisation programmes for children. Questions raised about cervical cytology programmes in relation to their effectiveness were being taken account of in future developments. The very serious questions about some cancer therapies were still to be addressed. It was necessary to have the courage to stop services that did not adequately meet clinical needs in order to make space for the development and innovation so essential in medicine.

Bloomsbury District’s present annual revenue was about £110,000,000. The District was well above its Resource Allocation Working Party (RAWP) target and by 1993, £14.1 million had to be provided for RAWP distribution. Much of this saving ought to be achieved by redistribution of services and a considerable reduction in the number of sites of operation. This would have clinical advantages in that work done in the undiscipline hospitals would be transferred to sites with a full range of diagnostic and therapeutic services. To achieve this would require a considerable capital expenditure on upgrading buildings for, like many inner-city districts, the more modern buildings in Bloomsbury were over half a century old and none had had the necessary modernisation required for the adequate practice of twentieth century medicine. Most of the money for this work would have to come out of the district’s revenue budget. However, the district budget included various components (regional specialties and postgraduate hospitals) that were protected and so limited flexibility in achieving savings.

In such a difficult situation the health authority responsible for the district’s services had been clear and open about its view of priorities. It intended to:

1. Provide first class services for its local residents. In common with many other inner city districts, Bloomsbury’s community health services suffered from many inadequacies as described in the Acheson Report (1981). Priority services which worked to a catchment area and by definition served local people (geriatric, mental illness and handicap) had not been well developed and required more investment.

2. To sustain the regional and supra-regional services offered in the district’s hospitals. Some of these, such as cardiac surgery and radiotherapy, were formally recognised and had protected funding. A reduction in the level of these services would result in a reduction in the level of district funding.

3. To continue to support the teaching of health professionals—medical, nursing and paramedical students—an important part of undergraduate and postgraduate hospital activity. It was necessary to provide teaching staff and patient services that were satisfactory in range and quality. The district’s responsibilities in this area with regard to medical and dental students were recognised by an adjustment to the RWP target of the Service Increment for Teaching (SIFT).

4. To improve the environment in which patients were treated and in which staff had to work. This meant the improvement and modernisation of buildings.

During the first two years of the Bloomsbury District’s existence the revenue budget had remained stationary, which meant a reduction of funding in real terms of about 5 per cent (due to inflation). Nevertheless, the authority had decided to transfer £500,000 annually (slightly less than half a per cent of the revenue budget) into priority services. This was an arbitrary sum but, despite problems in finding sites for new health services in Bloomsbury, innovative schemes could be implemented, each being subject to evaluation to demonstrate the extent to which the project met the objective.

Revenue savings were met in part by increased efficiency and in part by reductions in general acute services. Such reductions were consistent with the authority’s declared priorities because a significant proportion of the patients treated in some of the general acute specialties were coming into Bloomsbury for treatment which could and should have been provided for them locally. It was not thought that Bloomsbury should provide curettage for ladies from St Albans or grommets for the ears of children from Chelmsford.

Between April 1982 and January 1985 the number of beds for local acute specialties (excluding those in the postgraduate hospitals) in Bloomsbury was reduced from 1,059 to 859, a loss of 200 beds. During that period the management of patient care was improved so that the work load was little reduced (from 12,609 deaths and discharges in the second quarter of 1982 to 12,464 in the last quarter of 1984).

The authority had also agreed to withdraw acute services from two supporting hospitals and concentrate them on the University College and Middlesex Hospital sites. By April 1985 there would be a further reduction to 714 acute beds in the district. This concentration of acute services should lead to further efficiency and would have the advantage of making the full facilities of the main hospitals available to more of the patients who needed them.

The authority’s declared service priorities had been widely supported within the district. The choice of service changes had not been painless but had been logical and reasonable; it had been possible to reorganise undergraduate teaching to fit in with the changes.

The end of resource reduction was not near; there was a long way to go to meet the RWP target and much other work needed support in the district. As opportunities for more saving through measures of efficiency became progressively harder to achieve, it was clear that further reductions in services were inevitable if the authority was to keep within its cash limits. The problems were confounded by the fact that planning was increas-
ingly finance-led and it was important to identify changes that could be implemented quickly and easily.

The authority had to address itself to the priorities of the following problems:
1. Should it abandon the protection of the priority services for local people? This would mean even longer waits for the elderly to receive proper support in their homes and longer waits for residential care for the demented elderly and for any locally based services for the mentally handicapped.
2. Alternatively, should it abandon certain specialties so as to preserve the rest? This path had already been embarked upon and it was a question of how far it could be followed before the teaching function and quality of clinical services of other specialties were seriously prejudiced. Dispensing with regional specialties that had protected funding might constitute an ‘own goal’ in trying to meet financial targets.
3. Should the use of revenue for capital works be stopped? This, as an effort to maintain services, had obvious short-term attractions but meant that long-term targets would be even more difficult to attain. Premises would become even more out of date and depressing. Moreover, it would not yield sufficient savings and would have to be coupled with further reductions in services.
4. Should the reduction of general acute services be continued? This would appear to be an attractive choice and consistent with the district’s declared aims. However, the point would soon be reached when the viability of certain highly specialised services would be threatened. These services went under the banner of ‘general’ medicine or surgery but were really regional or supra-regional services, such as the investigation and treatment of children with growth problems, specialist gynaecological endocrinology and gastroenterology. If these services, receiving patients from great distances, disappeared from Bloomsbury they were not available elsewhere. Careful evaluation of these services had been carried out and outcome measures did exist to demonstrate their efficiency.

Dr Crown said that as a Community Physician she could attempt to measure the need for the various services, relate that need to demographic change and population projections and then try to calculate the proper size and balance of future services. As a practitioner in a shortage specialty she had to identify her own priorities. It was difficult to justify prolonged detailed work on such issues in the district when history had shown that decisions would be made on a political rather than on an epidemiological basis and that financial imperatives would prevail. As District Medical Officer with responsibility for medical manpower she had to look at the implications of the choices for medical staffing. To reach financial targets would mean considerable cuts in medical staff budgets. Further choices came into this, such as should the consultant grade be reduced (which could not be done by natural wastage) or should training posts be eliminated, although these were often part of rotation schemes that were highly regarded as providing a balance of academically orientated and apprenticeship training.

However, Dr Crown said that as a community physician she had considerable reservations about the RAWP formula that was one of the bases of current problems. No voice had been raised in Bloomsbury against the principle of RAWP despite its harsh effects on clinicians. Everyone supported the development of services in peripheral districts and acknowledged that Bloomsbury was over-funded and that considerable savings could be made. The RAWP formula had been introduced in 1975 and since then there had been great advances in information technology. It would now be possible to consider amending the formula to take account of cross-boundary flows and their reimbursement. Under the present arrangements a child who came from outside Bloomsbury to receive very expensive growth hormone therapy was credited to the district at the average cost of a general hospital paediatric case. The detailed information available from the 1981 census was of particular relevance to health care in inner cities and could be used to incorporate deprivation weightings into the RAWP formula. The application of RAWP was a positive disincentive to the development of community and out-patient care. In Bloomsbury some major departments, like rheumatology, gastroenterology and genito-urinary medicine, treated large numbers of patients but had relatively few in-patients.

There was also the apparent total dislocation of RAWP-losing movements of money from RAWP-gaining developments of service, and the inconsistency of RAWP losses in inner cities which were at the same time receiving money from government departments through ‘inner city partnership’ and other schemes. The teaching and other RAWP-losing districts were facing a downward spiral (Fig. 1). As revenue was reduced, services were cut and so cross-boundary flow diminished, which lowered the RAWP target. Then more service reductions became necessary, reducing teaching capacity. Students would then have to be taught in other districts so SIFT would be transferred, leading to further reduction in the RAWP target. It meant constantly chasing receding targets.

The priorities being defined and preserved in Bloomsbury would inevitably lead to some service losses. The special services, although representing the interests of the doctors concerned, had developed in response to patients’ needs. It was essential that the medical profession and the Royal Colleges should participate in decisions on priorities in clinical services. They should aim to ensure that the decisions taken were robust and did not destroy services for which there was a clear need and demonstrable value, and which would be difficult to replace.

Discussion

Dr J. W. Todd, commenting on the phrase ‘finite resources, infinite demand’ pointed out that the one and only demand the man in the street could make was to see his GP and get his advice. Everything beyond that was demanded or underwritten by some doctor. He instanced a man with chest pain investigated with ECGs and coronary arteriography only to be passed to the orthopaedic surgeon to exclude orthopaedic causes for the pain and then to the neurologist to exclude neurological causes
and ending up with the psychiatrist. He emphasised that this enormous demand came from doctors and not from the patient.

Sir George Godber said that without doubt the level of funding of health care in the UK was, as a proportion of resources, much lower than that of any other country. Leaving out Scotland, which gave over 8 per cent, the level was under 6 per cent of GNP whereas no other country in the West was putting in less than 8 per cent and many put in over 10 per cent. Sir George thought there was a need for some precise indications of what should be done and cited the Standing Medical Advisory Committee's notes on choices of treatment for spina bifida, which had been accepted and used without problem. He deplored the way that so-called shroud-waving, particularly on television, had obscured various issues. It seemed to him that there must be selection, as not everything could be done, and that it was necessary to scrutinise more closely the efficiency (not in terms of cost) with which things were done. The profession as a whole had not applied itself enough to forming judgments on the efficiency of its work, and ways of judgment should be built into the organisation of all medical work. The Cogwheel system had been supposed to be about this and he was sorry that this aspect had not been developed.

There was wastage in the NHS, which should be eliminated as far as possible. But there was also a great deal of short-fall in the provision of service. Waiting lists, which were one way of absorbing some of the problem, were far too long. He knew that some managed without waiting lists but in some countries there was no provision for treatment. He quoted a recent statement of the American Hospital Association that there were 35 million Americans without health insurance cover, which meant that a lot of them went without the health care they needed. At least this was not the case in Britain but there were gaps and delays that ought to be eliminated. Much of the prevention needed was to prevent premature death from chronic conditions later in life. It would be a long time before there was financial advantage from this. Preventive services would not in the short run do something wonderful in reducing the cost of the health service. It should not be saving that was looked for, as the longer old people lived the more care they would need. What was needed was a change in the pattern of practice as indicated for general practice by Dr Tudor Hart in his recent George Swift lecture. Sir George would have liked to see more of that type of thing coming from the specialist sections of the profession. Specialist groups were apt to suggest what should be the minimum service in a particular field but not to think about the extra expenditure involved. There was no free lunch; money put into something had to come out of something else and there was not enough debate about what should be surrendered or whether it should be surrendered in order to do other things.

Sir Douglas Black thought that what Sir George had said was very important but considered that the waiting list was not a satisfactory index of need because it was so readily manipulated.

Dr Crown thought it was vital that clinicians, community physicians and managers should get together and see what could be done about the whole area of clinical efficiency. Savings were clearly required and greater efficiency was a matter of urgency, otherwise finance-led decisions would prejudice many vital services.

Mr Nicholls thought that the matter of clinical efficiency should be addressed at the local level, but the strategic lead should come from the Department. Politicians should be well advised by central mechanisms so that a
framework for making choices was set. Then districts, management and clinicians could share the business of making sense out of those choices, but direction would have to be given by the elected government of the day, as it provided the majority of the finance.

Sir Raymond Hoffenberg commented on clinical audit, which had been used in his own unit in Birmingham for several years. A regular weekly clinical audit meeting had proved highly successful, with an immediate downward curve in the number of investigations and prescriptions ordered and a tremendous improvement in patients’ notes. He was disappointed that clinical audit had not been taken up by other units in the hospital, and little audit appeared to be going on in the country as a whole. It might be argued that audit had saved money and increased efficiency but had not produced the hoped-for improvement in outcome. But outcome was difficult to measure.

Dr R. C. King was glad that the question of evaluation had been raised but for him the big question was who was to do the evaluation. It might be that clinical budgeting would provide the answer and that people on the ground would be able to take the decisions needed. However, he thought it would only be done at the central level. Much money was wasted on needless chemotherapy and on the GPs’ drug bill. There was tremendous room for savings in these areas but savings would not be made unless someone in the Department was to say how they could be achieved. He instanced GI endoscopy as a topic for evaluation, as the use of the technique had not reduced the mortality from upper GI haemorrhage, except in a small group of gastric ulcer patients over 60 years old. There was a pressing need for intensive clinical evaluation which should be done both locally and centrally with some guidance from the Department.

Dr J. J. A. Reid appreciated the presentations because Sir Douglas Black had given a strategic view, Mr Nicholls a view of the Region and Dr Crown had spoken about one particular district which demonstrated that in the end things had to come down to the local level. But the particular problems of Bloomsbury were specific to Bloomsbury and any attempt at a higher level to say how they could be dealt with was not likely to be successful. One issue he wished to take up was that of the earmarking of funds. Clinicians said that they wanted no central control of direction and wished to be given maximum freedom. But in relation to their own speciality or super-specialty they wanted some form of earmarking to take place. A balance had to be found. Central government was concerned first with broad guidelines and second with facilitating local innovation. This could be clinical innovation or in relation to audit. He cited the current national perinatal mortality study from which no models were drawn but the results were available for clinicians to study and decide what sort of deductions should be drawn in terms of their own practice. Lastly he drew attention to the ‘health for all’ targets, an unfortunate journalistic term invented for the WHO. But there were a series of specific targets which European countries were pledged to try and achieve. These got away from the type of incremental planning that was a thing of the past. These targets, if better known, should prove useful tools in the health service.

Dr L. B. J. Stuyt, formerly the Dutch Minister of Health, said that there was a great difference between the British and the Dutch health services. The Netherlands did not have a health service, but there was free health insurance and everyone could choose his own insurance company. He was impressed that in Britain the NHS could realise its assets, something that could not be done in The Netherlands. The Dutch government would claw back any money as unused. He also remarked that the discussions on ethics would have been difficult to hold in The Netherlands, where the view on medical ethics was different. The Dutch view was centred on the system outlined by Canon Dunstan and made a great distinction between the ethics of government against the insurance system, the health system and individual doctor’s decisions. What he had missed was any mention of the natural end of every patient’s history, which was death. To him one of the most important aspects of medical ethics was the decisions involved in the treatment, or stopping of treatment, and care of the dying.

Dr Howard Hiatt, formerly Dean of the School of Public Health at Harvard University, stressed that the fraction of resources that went into a health system was not necessarily an index of the return. It was true that the USA was committed to a per capita expenditure of twice the fraction of its GNP as was the UK. Despite the seemingly unlimited resources available for health services in the USA there was increasing talk of cost containment. This was producing a kind of discipline into the practice of medicine that was not unhealthy. Technology assessment was being used to see how resources were used. Disease prevention did not represent an area in which large savings could be made. In fact, most preventative programmes cost more than they saved but there were compelling reasons, other than financial, for emphasising disease prevention.

There was growing awareness in America that many of the issues were not solely medical (although medical considerations were critical) but involved patients and society as a whole. He considered that the physician was first and foremost his patient’s advocate. But decisions on resource allocation were not for physicians alone. It was important that physicians contributed to these decisions by making the facts known. It was clear that, with advances in medical technology and an increasingly elderly population, demands for health services would increase and become more sophisticated. The kind of discipline now introduced into the medical area was less well developed in other areas such as housing, transport and defence. The total fraction of world resources devoted to arms had increased about fivefold since the Second World War. The whole issue of trade-offs should extend to these areas, and citizens of the world should know how much more could be done with the world’s resources.

In winding up the discussion, Sir Douglas Black pointed out that the area between different funding authorities was important because it was the first casualty when funds became short. He added that high technology, properly employed, was cost effective. The big
waste came from poorly applied routine low technology. Dr Crown said that evaluation could not be done without manpower and investment in information, so it was a resource. The procedure needed clinical involvement and she thought that the good offices of the Royal Colleges could be used to approve some of the training posts, for at least some months of their tenure, as time to be spent on evaluating a problem within a specialty. Mr Nicholls referred to the continued debate of centre versus periphery and thought that for evaluation there should be more central activity. Performance indicators had been called inadequate but were improving. The review system which he had mentioned could be used for open debate at various levels. Finally, he thought that cost containment was not such a valuable term as cost awareness.

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Book Review

_Psychosocial Stress and Cancer_, by C. L. Cooper. John Wiley & Sons, Chichester, 1984. 265 pages. Price £17.

The possibility that emotion might affect the onset, or influence the progress of cancer has intrigued physicians since the time of Galen. Walshe and Snow, both nineteenth century physicians, are quoted in the introductory chapter as including depression and reversal of fortune among the events that may lead to cancer. The idea is not new, but has been largely overshadowed by more modern attempts to define external agencies. Although this approach has been partly successful, and environmental hazards such as smoking tobacco, asbestos and certain industrial chemicals are now recognised, much remains unexplained, and review of the evidence for the role of psychosocial stress in causing malignant disease and affecting its course is timely.

This book serves this purpose very well. It is a multi-author work by a number of distinguished contributors who maintain a properly critical attitude throughout. The book starts with a history of the subject, and then a careful examination of the methodology is followed by an account by Eysenck of the relationship between stress-prone personalities and lung cancer. The relationships between life events and cancer are critically reviewed by Paykel, and possible avenues for further research discussed. This is followed by a consideration of how the mind may affect the body’s propensity to develop malignancy, and consideration is given to how established cancer may be affected by management of the psyche. Finally, there is an excellent summary of the various approaches that have been used in more than 30 studies on the subject. There is enough evidence to recommend that as far as aetiology is concerned, more sophisticated studies are justifiable to confirm or refute the apparent relationship between emotional disturbance and cancer and its progress. There is no doubt that much greater care will be necessary to define the types of cancer, construct proper controls, and classify the types of emotional stress and, if possible, quantify it. Nobody would, I suspect, have much difficulty in accepting this suggestion, but I found the recurring theme throughout the book, which attempts to explain the mind–body interaction on the basis of perturbation of the immune system (the friendly _zeitgeist_ of the alternative medicine lobby), wholly unconvincing. A few experiments showing transient suppression of subsets of the lymphocyte population in patients with emotional stress seem to be a quite inadequate basis for advancing such a hypothesis. Immuno-suppression and ‘immunosurveillance’ are now seen as unlikely to be relevant as factors in the cause of common cancers, and indeed may be wholly irrelevant.

The subject is so complicated that one is easily led into such remarkable conclusions as that of a very logical Frenchman, M. Tanchou, who is quoted as saying in 1843 that since cancer was a disease of civilisation, and since the incidence of cancer in Paris was four times that of London, ergo the French were four times more civilised!

This book is concerned with the possibility that people with certain personalities may be more prone to cancer than others. While we accept that smoking tobacco and cancer are related, are we yet prepared to accept that those patients who show a higher degree of neurotism are less likely to develop carcinoma of the bronchus? After all, it has not been difficult to accept that personality types are associated with a higher rate of cardiovascular disease. We come back to something we have known all along—that the soil is as important as the seed.

I think you would enjoy reading this book.

J. S. Malpas