Editorial

What colour is your health service organization

This may have been the best year for National Health Service (NHS) patients, but next year will certainly be the best for many years for public health interventions, with a ban on smoking in public places. So, to think positively, the structural changes in the English NHS, coming to a head next month, may be a time to think about the colour of our health service organizations, that is, what type of values and what strategy do they have; do they want?

All healthcare organizations provide a spectrum of possibilities but have a central tendency towards one approach. Each type inevitably has its own set of good and bad points. I guess the trick is to make the best of the good ones and try to work around the bad. Some of the options are:

(i) The health for all approach, with health defined as a ‘sense of complete mental, physical and social well-being’. This tries to cover the whole population with interventions with many fields beyond the traditional health areas. It tends to be a politicized approach, with attempts to reduce the health differences between rich and poor in the area. This can cause clashes with other services, especially social and housing services, about whose budget should pay for different things. People talk a great deal about determinants of health and inequalities. The present government refers to much of this work as broader public health. The problem is that the approach needs good joined-up work between the private sector, providing jobs, housing, education, social services and tax system that encourage financial equality. Health is probably not the lead service for this model.

(ii) The health promotion approach with healthy living seen as being a taught discipline. There is an emphasis on research evidence for the avoidance of disease. The ideas rely on population data and are geared to the whole population. There is some politics involved. Health education specialists have clashed heavily with the government in the United Kingdom on the promotion of information about sex, drugs and tobacco. The public, if asked, tend not to appreciate this model of service, as a high proportion of people believe that smokers and drinkers should reap their own rewards; some victim blaming. Well-off people respond well to this model, with the result that it may increase the gap between rich and poor.

(iii) An emphasis on health services for providing reassurance for patients. There is an emphasis on screening for diseases and for the general population, giving encouragement to many people that they are ‘normal’. The approach tends to believe in open access to services, with a tendency for the worried well to clog up the system. With luck, they may be less worried afterwards. I have suggested, in the past, that reassurance is the main benefit that most services can hope to achieve at the present time; for harder outcomes are too contaminated by other factors.

(iv) Another approach is for health services to give ‘cradle to the grave’ care, though this was originally coined by Beveridge for the Welfare State as a totality, not simply its health component. It has a paternalistic feel to it these days. Advocates of this approach included many of the great and good, notably Nye Bevan and Archie Cochrane. The latter suggested that ‘all effective services should be free’. This diverts attention towards deciding what is effective; not always an easy task, especially for uncommon diseases. There is also a need to define ‘health care’ as distinct from ‘social care’.

(v) Health services for ‘health gain’. Those in need of health care are defined as those who will gain appreciably in terms of mortality and morbidity by receiving health services. The approach tends to get into trouble when deciding what to do for people who are not going to get better or when marginally effective treatment for very serious diseases is made unavailable. The main problem for these services is to try to be even-handed in relation to improvements in health gain. This is a very difficult exercise when comparing, say surgery for babies with heart defects and a small chance of survival with surgery for old ladies with arthritic hips and a high chance of improvement. The approach leads inevitably to using health economics to compare services. The model has the benefit of being popular with the public, until the choices are made explicit. Most health authorities in the United Kingdom keep them implicit for this reason. The National Institute for Health and Clinical Excellence (NICE) is using an explicit approach for new technologies and its guidelines and gets into regular bust-ups with the Daily Mail, so what hope have the rest of us.

(vi) Acute health interventions only. There is a need to define what services provide acute medical care. Others are seen as social care and taken out of the remit of the health service. The argument about whether the NHS should provide
long-term care for elderly people is constantly in trouble with this approach, the English and Scottish governments having intervened to force health and social services authorities to provide such services free. Further battles have been fought over the rights of infertile couples to be given treatment on the NHS. This approach is sometimes overturned by the intervention of the odd government minister.

Whatever colour your health service, most are short of cash. It looks as if there is likely to be less money available for the NHS in the next few years, suggested by Alan Maynard as being the ‘seven years of famine after the seven years of plenty’. In passing, it is a little depressing to note that Roberts in 1952 suggested that ‘no nation on earth can afford any longer to finance all the aspirations of its medical practitioners or satisfy the expectations that these create in the minds of the people’.

So we need, once again, to prioritize different services with the colour of the service we have. For day-to-day decisions on priorities, there are no completely accepted models for legitimate and fair priority setting, despite the work coming from the National Service Frameworks (NSFs) and NICE. Traditionally, approaches from health economics are used for priority setting across different health boundaries, using cost-effectiveness analysis, program budgeting of different types and marginal analysis. Studies of actual priority setting show that these tools often have a limited influence on decision-making. Cost-effectiveness analyses are useful, but other values important to priority setting include equity, the health of individuals as against communities, the ‘rule of rescue’ and democratic decision-making.

For the new individual authorities, it may be an approach, such as that used by the old Oxfordshire Health Authority; a ‘priorities forum’ might be useful. Now, as the government is in ‘lumping’ rather than ‘splitting’ mode, it may be time to expand such initiatives, in the hope of a bit more rationality in the structures and decisions we make. The advent of practice-based commissioning (did I say lumping?) and including those general practitioners (GPs) in the forum may be an important priority in itself to keep everyone in the area singing from the same song sheet.

Norman Vetter
Editor, Journal of Public Health

References