Regions for Health

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Leading Edge

Health and Social care in 2010: A New Vision from the United Kingdom

Marcus Longley, Chris Riley
and Morton Warner

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HEALTH AND SOCIAL CARE IN 2010: A New Vision from the United Kingdom

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TARGET 33
HEALTH FOR ALL POLICY DEVELOPMENT

By the year 2000, all Member States should have developed, and be implementing, policies in line with the concepts and principles of the European health for all policy, balancing lifestyle, environment and health service concerns.

- PRIMARY HEALTH CARE - trends
- DELIVERY OF HEALTH CARE - trends
- SOCIAL WORK - trends
- UNITED KINGDOM

Foreword

The aim of the Regions for Health Network (RHN) is to bring about health gain at the regional and local level across Europe. One way of doing this is through a rapid exchange of knowledge between the regions. For this purpose, the RHN has launched the LEADING EDGE series.

These short papers present some of the interesting initiatives in our Member Regions, and will cover a wide variety of issues. They have been written in an easily readable form, which we are sure will stimulate discussion.

We hope however that they will do more than that, and that they will encourage collaboration between regions throughout Europe. This is why on the last page you will find the names and telephone/fax numbers of people to contact, if you are interested to learn more about the initiative presented here.

Do you think that what we present here would work in your region? Are you already doing something similar and would like to exchange experiences? Then go ahead, give them a call, you may find just the answer you are looking for! This is what the Regions for Health Network is all about.

Anna Ritsatakis, Ph.D.
Regional Adviser for Country Health Policies
and Equity in Health
Regional Office for Europe
World Health Organization

Health and Social Care in 2010: A New Vision from the United Kingdom

"If you aim at nothing you'll hit it every time"

Sitting Bull

"They are ill discoverers who think there is no land when they see nothing but sea"

Francis Bacon

Few would disagree with the sentiments of Sitting Bull and Francis Bacon. But predicting the future is an inherently risky business. Since earliest times the fate of the false prophet has been particularly ignominious. Yet a shared view of the future is essential if health policy makers are to make the best decisions where to invest limited health resources. This is no easy task. Health care systems worldwide are in a period of unprecedented change. They are beset from all angles by apparently incompatible demands, and there is growing uncertainty about how they can survive in the midst of this maelstrom.

In deciding how health care must respond to change, the policy-makers first challenge is to develop a clear vision of the future that engenders ownership by health professionals, the community and politicians alike, yet retains sufficient flexibility to avoid disputes over the detail.

This challenge formed the basis of a study in the United Kingdom, led by the Welsh Health Planning Forum, a World Health Organization Collaborating Centre for Regional Health

Strategy and Management Development in Europe[1]. The task was to consider how the British National Health Service (NHS) could remain true to its basic principles and build upon its strengths, in the fast changing circumstances of the next 10 - 20 years. The result is a new vision for health care for the early part for the next century.

Modelling the Future

The Welsh Health Planning Forum began work on the Health and Social Care 2010 project in 1992[2]. The aim was to discover the key elements of what might be both a *desirable* and an *achievable* future for health and social care.

The assessment of desirability was to be made against a statement of common core values - the key features of a *desirable* health care system (Figure 1) - which would be relevant both now and in the foreseeable future.

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1 The Welsh Health Planning Forum advises the Health Service and Government Department in Wales on strategic issues relating to health and health services, and is also a World Health Organization Collaborating Centre for Regional Health Strategy and Management Development in Europe.

2 Further details on the project are contained in Welsh Health Planning Forum *Health and Social Care 2010: A Report on Phase One* Cardiff: WHPF, 1994.

Figure 1: Common Core Values

Choice - ***the users of services should be able to exercise maximum control over their health and the treatment and care they receive:***

- *Services should support and encourage people to maintain and improve their*
- *Users and carers should influence the development of services*
- *As far as possible, all users should have equal access to the best available care*
- *People should have information to enable them to make real choices about the care they receive*
- *Whenever appropriate, services should be provided in or near the home, or in a homely setting*

Quality - ***quality should be judged from the point of view of the person using the service:***

- *Services should strive to provide the most effective treatment and care possible*
- *Care should be geared to the user's needs and not organizational convenience*
- *Staff should be responsive to users and carers*

Value for money - ***the maximum possible benefit should be extracted from every pound spent:***

- *Investment must be in what is effective in meeting the needs of users and clients,*
- *Everyone entrusted with resources should ensure that services are managed cost-effectively*
- *Staff should have a level of skills appropriate to their job*
- *Day-to-day management control should be devolved as close as possible to where care is given*

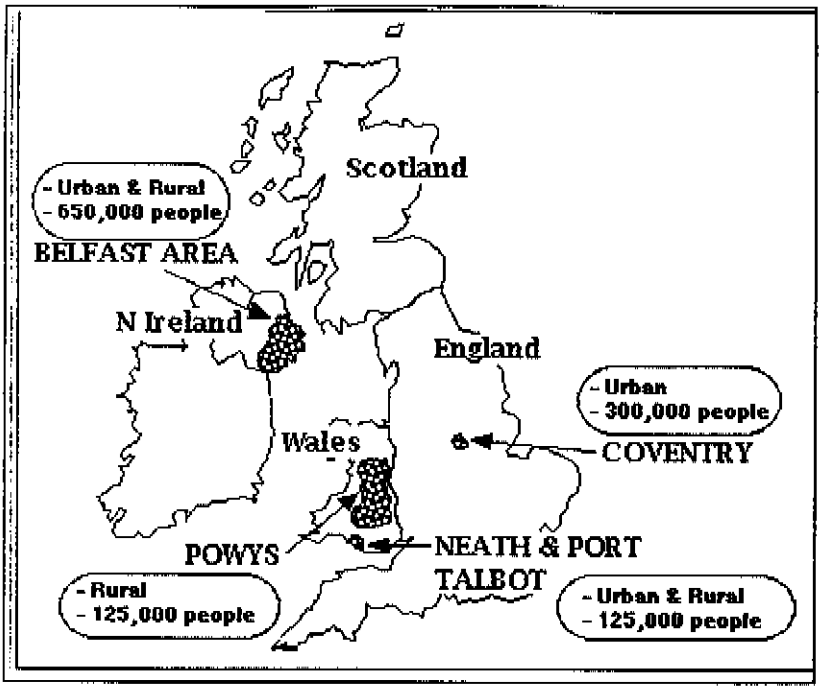
The Forum then developed nine 'Assumptions' about the nature of services in the future (Figure 2), which were to be tested in the pilot sites. They were not targets or predictions, but projections. They were drawn from all areas of health care - from health promotion to long-term care - and also crossed the somewhat artificial divide that currently exists in the UK between 'health' services - provided by the NHS - and 'social' services - provided by local government. They were designed to reflect both the possibilities and the potential dangers inherent in the various forces for change described above. Each, therefore, had the potential of improving the quality of services available. The year 2002 was chosen as being a point sufficiently far distant to allow for the possibility of substantial change, whilst still being (just) within the bounds of people's imaginations.

Figure 2: Assumptions for testing

By 2002:

- *Health promotion targets on smoking, physical exercise and weight are met.*
- *For each local community there are arrangements in place for the pooling of NHS and local authority funds to provide local access to minor surgery, a minor accident service, certain specified diagnostic services, therapy services and social work assistance.*
- *All mental illness and mental handicap hospitals that were open in 1985 are closed.*
- *Everyone over 85 has a keyworker.*
- *Referrals from GPs to specialist medical services have been reduced by 20%.*
- *40% of outpatient consultations with specialist medical staff occur in locations other than a DGH.*
- *80% of surgical interventions are by minimal access.*
- *60% of surgery is by day case.*
- *Acute beds in DGHs have been reduced by at least 40%.*

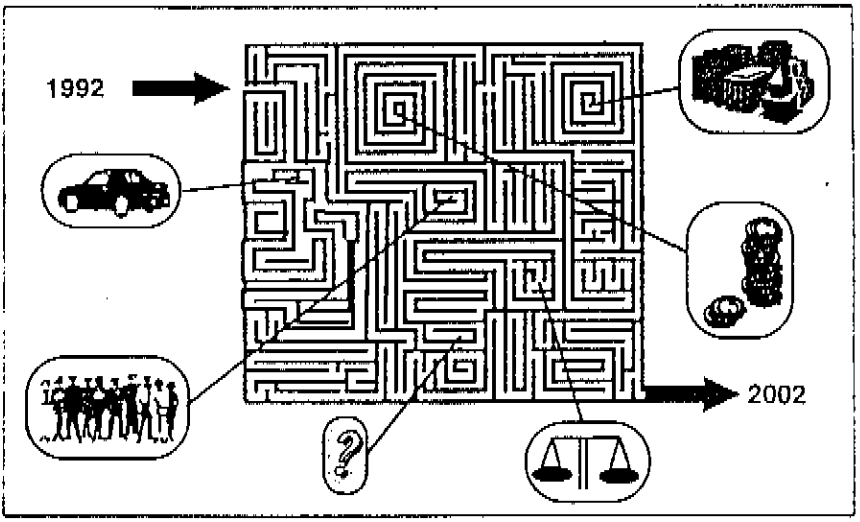
Four pilot sites worked with the Forum (Figure 3).



Each faced a very different mix of circumstances and different patterns of service which had developed over many years. In each site, a hundred or more people came together to consider how they would achieve the Assumptions. They represented all of the key stakeholders locally - primary and secondary care physicians, other health professionals, social services staff, managers, voluntary groups, and representatives of the general public.

They were confronted with a maze (Figure 4).

Figure 4: The Assumption "Maze"



Starting in the year 1992, they had to get through to the Assumption for the year 2002. In between, there lay many obstacles to achievement - lack of finance, inadequately trained staff, inappropriate buildings, and possible ways through which ran counter to the set of common values. The first task, therefore, was to find a way through this maze. Having done that, they were then asked to make an assessment as to whether the benefit gained from attaining the target outweighed the costs of doing so.

They were encouraged to be as imaginative and innovative as possible, but certain parameters were set at the start:

- *public expenditure on health would not increase in real terms;*

- *the methods of financing health and social care would not change dramatically;*
- *local government would continue to provide social services, with the NHS providing health care;*
- *there would be a continuing emphasis on services closer to where people live, where this is appropriate and acceptable to patients and users.*

Some results

Three of the pilot sites have produced detailed reports[3], which discuss the implications of achieving each of the nine Assumptions. In general terms, several themes emerge:

- *people will in some ways be looking after themselves better - fewer people will be smoking, for example;*
- *there will be greater co-operation between health and social services - some of the boundaries between them will have become blurred;*
- *mental illness and learning disability services will be based in the community;*
- *several aspects of acute hospital services will be available nearer to home - more specialist consultations and treatment will take place in dispersed settings, greater use will be made of day case treatments resulting in shorter hospital stays, and various 'hospital-at-home' initiatives will develop;*

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3 Eastern Health and Social Services Board. *Framework for Health and Social Care 2010. Progress Report.* Belfast: Eastern Health and Social Services Board, 1992.

Powys Health. *Health and Social Care 2010. The Powys Response.* Brecon: Powys Health, 1992.

West Glamorgan Health Authority/West Glamorgan Family Health Services Authority. *Health and Social Care 2010. The West Glamorgan Response.* Swansea: West Glamorgan Health Authority, 1993.

- *some specialist services, however, will be concentrated on fewer sites;*
- *the number of beds required in hospitals by the acute specialties will decline, largely - but not entirely - as a result of reductions in the surgical bed complement.*

These changes can be summarized in terms of five types of *substitution.*

First, *new technologies will substitute for old.* This clearly is not a new phenomenon, but it seems likely that the pace of change in this area will accelerate, particularly as the results of the Human Genome Project (which seeks to identify the function of the c.100 000 human genes) are used to develop new diagnostics and therapies.

Second, *new locations will substitute for old.* As the possibilities for moving care closer to home develop, and as the clinical imperative to centralize other services becomes more insistent, the function and nature of hospitals and community care will change rapidly and profoundly. This is partly a function of the opportunities afforded by new technology - it will no longer be necessary to confine a patient to bed in a high technology (and high cost) hospital. But it will also be driven by popular demand.

Third, *new staff and new skill requirements will substitute for old.* Many of the boundaries between professions, and those within professions, will increasingly look anachronistic. Thus one may expect generalists and specialists, nurses and doctors, and many others to question their roles and to seek to redefine their ascribed functions. Whole new categories of staff may also emerge. These changes will in turn demand a re-evaluation of initial and on-going training, particularly to reflect

the powerful new opportunities afforded by the new information technologies.

Fourth, an emphasis on *efficiency and effectiveness will substitute for the current concern with efficiency alone.* There has already been a shift at the national and international levels towards more systematic evaluation of effectiveness, and the pressures of budgetary constraint and patient demand are likely to ensure that this continues.

The fifth substitution takes forward the central thrust of *Health for All 2000* and looks beyond the rather narrow confines of health and social *services* and brings the debate back to the fundamental issue - how should society organize itself to ensure that everyone enjoys the best possible state of health? There is a discernible, if very slow-moving trend towards an acknowledgement that health and social services are probably only minority players in this broader arena. Their role certainly is to provide high quality, cost effective prevention, diagnosis, treatment and care - a role which Thomas McKeown memorably summarized as

> *'to assist us to come safely into the world and comfortably out of it, and during life to protect the well and care for the sick and disabled'.*[4]

But it is more than that. Health and social services professionals have an important role in championing the cause of *health.* Their position of specialist expertise and high public esteem confers on them the responsibility of encouraging all those in society with an influence of people's health to examine their own practices - to be 'healthy' in the widest sense. This will require the forging of 'healthy alliances' with employers, other branches of national and local government, planners,

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4 McKeown T *The Role of Medicine - Dream, Mirage or Nemesis?* Oxford: Basil Blackwell, 1979 p192

schools, the media, food retailers, car manufacturers, and many, many others, to try to ensure that they are not unwittingly undermining the general drive to improve health.

This is a role which currently may lack some 'legitimacy'. After all, many taxpayers or insurance policy holders probably still regard the function of professionals involved in these services as being to care for them when they need it, and not to devoting a part of their energies to the rather nebulous task of persuading others to act differently. The challenge, therefore, is one of public education as well.

The New Strategic Agenda

The work of the pilot sites clearly showed that this process of enormous change requires *management* - one cannot simply sit back and trust everything will come out all right in the end. Those responsible for services must therefore begin *now* to address the key issues.

This suggests that the following items should be considered when compiling the new strategic agenda:

- ***Equity*** *- continue to ensure equal access to high quality care*

- ***Public acceptance*** *- obtain public understanding and acceptance of the vision outlined above*

- ***Integration of organizations*** *- get the various different organizations involved to deliver care to their clients in a 'seamless' way*

- ***Information systems*** *- develop systems which can identify the health and social care needs of the population, and measure the impact of services provided*

- ***Resource shifts between sectors*** *- ensure that locational substitutions are matched by appropriate resource shifts, without undue disruption of care in the process*

- ***Training at all levels*** *- ensure that staff and skills are remain matched to the tasks to be performed*

- ***Best use of buildings and facilities*** *- use health care facilities appropriately in a changing service*

This is an agenda for policy makers and managers on a scale to match the enormity of the change that lies ahead.

Acknowledgements

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For further information, please contact:

Professor Morton Warner
Welsh Institute for Health and Social Care
University fo Glamorgan
Glyntaff Campus
Pontypridd, Mid Glamorgan CF37 4BS, Wales
United Kingdom

Tel.No. (44) 1443 48 30 70
Fax: (44) 1443 48 30 79