PROBLEMS AND PROGRESS IN MEDICAL CARE
THIRTEENTH SERIES *ESSAYS ON CURRENT RESEARCH*

MATTERS OF MOMENT

MANAGEMENT · INNER CITIES MATERNITY · COLLABORATION

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Editorial

The common theme of this collection is health services research which is a subject to which many of the Trust's publications have been devoted because it is fundamental to the Trustees' policies to implement the Trust's purposes (1).

The memoir from Dr. R.H.L. Cohen reviews recent (mostly unfavourable) comments on the research management arrangements centred on the DHSS from which he retired as the first Rothschild-style Chief Scientist in 1972. But, as Professor W.W. Holland, the Director of a Social Medicine and Health Services Research Unit which is a leading 'contractor' in the Rothschild sense (2) to DHSS 'customers' and is internationally renowned for its outstanding record of achievement, shrewdly points out in his Postscript and PPS, that the intent and hopes of the Rothschild reforms have not been fulfilled. Indeed, had they been there would now be an efficient mechanism for an overview of research, either within or outside the DHSS with a gearing to a general strategy intended to relate research to priorities with 'customers' at the operating level as well as those in the DHSS, and to a policy on the staffing of research units designed to create an effective force of 'contractors'. Instead the lack of an effective mechanism as a basis to policy drives combined with the recent confusion (3) (now happily cleared (4)) about the role of the Medical Research Council in the future, has resulted in lowering of morale among the scientists engaged in health services research (5). As long as there is no firm statement of policy or evidence of a mechanism for overview to relate research to priorities and service, the problems indicated in

the three essays emanating from other distinguished research units, which deal with major issues currently facing those concerned with making Health Services effective and efficient viz with getting value for money, and with the better co-ordination of services, not basically medical but closely associated with health care, are unlikely to be solved. Above all, it is unlikely that without a planned transmission system the results of such important research will be fed into the administrative machine at the right time. Thus, the trends in maternity care indicate the facts which add up to a lesson which ought to be heeded if there is indeed other than token concern about the optimum deployment of resources in a period of economic restraint, during which the selection of priorities should be pre-eminent. Both the other essays are involved with quite different aspects of collaboration between Health and Social Services. Both draw attention to the fact however that while there is much lip-service given to the requirement for close co-ordination between those services administered by local authorities and those which are the responsibility of Health Authorities, there seems to be no effective link between the observed need and the research required to meetit. Thus, the way to achievement of effective comprehensive services, particularly for the most vulnerable client groups in the population is not facilitated.

The faults in the system are not however too difficult to diagnose from the essays from Dr. Cohen, and the commentaries by Professor Holland. Nothing can hide the fact that the mechanism for the development of a strategy for commissioning appropriate research tied to approved service priorities, does not exist in the DHSS. It is an extraordinary commentary on the planning of the machinery of government that for a vast enterprise like the NHS there seems still to be no rational approach to the important issue of research as a necessary complement to requirements for efficient service and the deployment of resources.

1. See Complete List of books published by or for the Trust 1941-80 and discussion on pp. 26/27 of the Tenth Report of the Trust 1980.

2. The Organisation and Management of Government R.& D. (Rothschild Report) HMSO 1971.

3. Editorial, Commissioning Research, Lancet 1981 i. 312-3.

4. Buller A. and Gowans J.L., Medical Research and Funding of the MRC, Lancet 1981 i. 550.

5. See also Kogan M., Korman N., Henkel M. Government's Commissioning of Research. A Case Study. Department of Government, Brunel University 1980.

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The DHSS and the MRC

The first Chief Scientist looks back

Between 1974 and 1978 the Nuffield Provincial Hospitals Trust issued four publications concerned with medical and health care research, the three most recent of which dealt also with the changes following the Rothschild proposals. First in 1974 came Positions, Movements and Directions in Health Services Research, The Papers and Proceedings of a Meeting held at Hertford College, Oxford. This was followed by Drew Kay's Rock Carling monograph for 1977, Research in Medicine, Problems and Prospects, and in 1978 by two further publications. The first of these, Five Years After, a review of Health Care Research Management after Rothschild, 1973-7, was the result of a 'running seminar', convened by the Trust, in which a group of DHSS unit directors, together with the Trust's Secretary, met to discuss 'matters of principle and mutual interest concerning the promotion and direction as well as the logistics of such research'. Their report was in two parts: a preliminary historical review by Tom Whitehead of the origins, content, and effects of the Rothschild proposals, and a complementary essay by the group as a whole described in the Secretary's introduction as being 'concerned with the development of ideas'. Finally there was Colin Dollery's Rock Carling monograph for 1978, The End of an Age of Optimism, Medical Science in Retrospect and Prospect, a wide-ranging essay containing in its Chapter 5 criticism

of the organisation and activities of health care research in their post-Rothschild form.

I worked at MRC headquarters from 1948 till 1962 and from then and until 1973 at the Ministry of Health and to me much that is said by all these authors seems strangely wide of the mark. However, although the notes which follow are intended partly as a corrective to their accounts, my main purpose is a more personal one: to tell the story from the point of view of a participant who had a close familiarity and sympathy with both bodies and owes to each an almost equal debt of gratitude.

Relationship between MRC and Ministry

Anyone who wishes to understand the way in which health services research arose and developed or to form a rational judgment of the merits of the Rothschild proposals must start by considering the relationship of these two bodies over the years and their ability to adapt their policies and working arrangements in response to the changes that were taking place in the social and scientific world outside.

Spring 1948 to mid-1962, RHLC at MRC

The key to the relationship in this period is the close and spontaneous identity of interest that existed between the two bodies. These were above all the years of one advance after another in the control of communicable disease. The Ministry's priorities were for the quick, safe and effective introduction of the new remedies. The MRC's were to do the research to bring this about. The principal activity of the National Institute for Medical Research in the 1950's was the search for new chemotherapeutic agents and this was also the era of the great series of MRC clinical trials in communicable disease, of streptomycin and BCG, of whooping cough vaccine, and Salk and Sabin vaccines against poliomyelitis. In addition, during this period the MRC continued to run the Public Health Laboratory Service and the Common Cold Research Unit on behalf

of the Ministry, and to look after Biological Standards, it ran the Blood Group Reference Laboratory as agent for the Ministry, and it set up the Radiological Protection Service jointly with the Ministry.

The second large area of collaboration was in clinical research. Himsworth had become Secretary of the MRC in 1949 with the intention of developing clinical research on a major scale, and on his initiative a joint committee of the MRC and the Ministry's Standing Medical Advisory Committee was formed which recommended that a Clinical Research Board should be set up for this purpose, formally as a committee of the MRC but with half its members nominated by the Ministry and something of the air of a joint enterprise.

All this meant close collaboration and in some cases co-ordinated financial arrangements.

Mid 1962-Spring 1973, RHLC at Ministry

Pre-Rothschild

Collaboration in this coming period was to be less simple. Till then the Ministry had continued to see its needs for research mainly in terms of its traditional responsibilities for public health, and had been content for the expansion of clinical research to be developed by the MRC along its own traditional lines. It had been pre-occupied in the first decade of the NHS in getting the organisation established and in creating a specialist service throughout the country as a whole. It was only very gradually that the Ministry began to have brought home to it some of the implications of the new obligation to generalise modern medical care throughout every region and every specialty. By mid-1962, however, it was beginning to experience the first impact of the pressures that would be generated by this obligation, in conjunction with an unprecedented explosion of medical advances, instant mass publicity, and unrealistic professional and public expectations. The first test came over population screening for cervical cancer. On the advice of SMAC, and after consultation with the MRC which did

not consider preliminary research in this country to be necessary, the Ministry concluded that it would be unethical not to introduce this service forthwith. Doubts have since been fairly widely expressed about the wisdom of this decision. The Ministry was aware at the time of the shortcomings[1] in the evidence and it did restrict the scope of the screening for which it would pay. But the real importance of this sequence was as a lesson for the future; the advice, the action, and the subsequent criticism, together illustrated a dilemma that was bound to recur again and again in one form or another and which epitomises the tensions between the demands on service and the need for research in the peculiar conditions of a national health service.

It might seem strange in retrospect that the Ministry and the MRC took so long to recognise that the creation of a national health service would be bound to have major and novel implications for research, if one did not bear in mind the urgency of the other claims on their attention. By the early 60's, however, the Ministry was fully alive to the problems looming ahead and to their new national dimension of scale and urgency, and it began to appear, especially to George Godber who had become CMO in 1960, that if the resources of the NHS were to be developed and used rationally and effectively the Ministry must be able to rely on a research facility devoted to its needs and problems over the whole range of health care. This was an orientation different from that of traditional medical research and there was never any question then or later of the MRC's accepting responsibility, either alone or in partnership, for the new field as a whole, though individual items of such a programme might be expected to attract its interest and be undertaken by it on its own terms. I do not know whether any consideration was given at

[1] In anticipation of the series of difficult decisions that would be needed about screening, Max Wilson then an SMO in the Ministry had been given responsibility for the subject and had visited the USA and Canada to examine the evidence. Later, he and Gunnar Jugner were the joint authors of a WHO Public Health Paper, 'Principles and Practice of Screening for Disease', published in 1968. This was the first full-length general review of the subject outside the US and is still in many ways the best.

the time to the alternative of setting up some quite new body, independent of the health departments and the MRC, such as has since been canvassed in some quarters, but I should have expected the idea, if entertained at all, to be rejected because the heart of the difficulties that were now facing the Ministry was the inadequacy and insecurity of arrangements which separated service and research responsibilities and left the Ministry wholly dependent on research resources outside its own control. It was a classic case of responsibility without power.

The Ministry's eventual decision to set up its own research facility was fully endorsed by Himsworth and generally welcomed by the MRC. But this could not in itself be more than a partial solution. There is no sharp division between health services research and other forms of medical and social research and the problems of the NHS overlapped too considerably with MRC activities, and were themselves on too large a scale, to be satisfactorily tackled without the regular and active support of the MRC's resources.

Naturally, there continued to be a good deal of shared activity. Portfolios for Health 1 and 2 show that there was always DHSS work being done in MRC units or with MRC help. The DHSS, for its part was sometimes able to give initial help, in some cases over several years, until the MRC felt the work ripe for its own support. This was true, for example, of the work under Griffith Edwards at the Institute of Psychiatry which developed into the jointly supported Addiction Research Unit, of the work under Albert Kushlick, which developed into the jointly supported Mental Handicap and Geriatric Research Unit, of Bagshawe's work on choriocarcinoma and, later, childhood leukaemia, and of the work on automatic pattern recognition which paved the way for the MRC unit under Rutovitz. Towards the end of the period there was a promising experiment in more intimate collaboration, which owed its origin to the initiative of Malcolm Godfrey at MRC HQ, when the joint MRC/DHSS Epidemiology and Medical Care Unit was set up under Tom Meade at the MRC's Clinical Research Centre at Northwick Park.

However, the shared activity tended to be incidental and intermittent and largely dependent on long established personal contacts. It is perhaps this that misled Tom Whitehead in Five Years After to use the unhappy phrase 'increased friction' to describe relations between the two bodies at this period. This, however unintentionally, gives the impression of bad blood. The truth was the very reverse. For many years the feelings on both sides had been those of good will and friendliness and, when Himsworth became Secretary of the MRC and as one of his first acts invited the two CMO's of the Health Departments to become assessors to the Council, the friendliness ripened into friendship; communication between the two offices could not have been easier. On the other hand, I cannot in honesty subscribe to Kay's belief that 'a partnership between the research councils and the executive departments was evolving' if he means, as he seems to, that they were working together to ensure that their combined resources and experience would be used to the best advantage in the interests of both or that this objective was being gradually attained in the natural course of events. On the contrary, it seems to me that the research priorities of the two bodies were beginning to diverge and that a conscious and positive effort would have been needed to counteract this. The MRC's attention was increasingly focused on the spate of new opportunities in basic science, of which molecular biology was only the most conspicuous example, and on preparations for the Clinical Research Centre; the Ministry, for its part, was more and more concerned with what was needed to help the NHS to run efficiently and effectively. Kay, in the passage from which I have quoted, seems to be equating Ministry and NHS needs with 'short term investigations of immediate practical relevance', of which as an example he later cites hyperbaric oxygen. But these in my experience from both vantage points had never been a source of difficulty. The novel and serious problem for Council and Ministry alike was what to do about developments such as organ transplants or screening for breast or cervical cancer, with their enormous and long term

demands on research and service resources and the impatient professional and public pressures to which they give rise; as Kay says 'it is significant that after twenty years we are still unable to determine whether the latter (cervical cytology) leads to real benefit'. A rather similar misconception seems to underlie Pickering's[2] reply to Zuckerman's criticism of the research council system in Beyond the Ivory Tower: 'Requests for help were, so far as I know, never refused'. In my view the time had come when persistence in dealing with problems piecemeal threatened to become a permanent handicap to progress.

What was needed by now was a far more active collaboration. The roles of the MRC and the Ministry in research had remained formally as defined in the original concordat when the two bodies came into existence almost simultaneously some fifty years before. Since then the practice of medicine and the organisation of medical care had both been revolutionised. The creation of the National Health Service over twenty years before had been a social change of major historical importance, meriting in itself a reexamination of research priorities and organisation. But there was never any thought of developing a unified policy over the large area of common concern. Perhaps it was impossible for either party to think of changing a traditional relationship which had been fruitful in many ways over so many years. But someone coming to the subject from outside and with a fresh eye was almost bound to ask himself why such a unified policy did not exist and was more than likely to conclude that this was what was required. Indeed, partly because of the scale on which all the research councils were now operating, they had for some time inevitably been coming under closer governmental scrutiny. A Minister for Science had been appointed in 1959 and the first of several official enquiries into their affairs, which culminated in Rothschild's some ten

[2]Quoted in Landsborough Thomson's Half a Century of Medical Research. Pickering adds 'And I believe there is nothing to prevent these relationships becoming closer given goodwill and understanding on both sides' but he does not particularise.

years later, had been set up under Zuckerman. All this reflected a continuing unease in government circles about the research council system. The Ministry, however, never lost sight of the value to itself and government as a whole of the independence of the MRC and emphasised this whenever its opinion was asked. The question was whether this overriding necessity was really incompatible with some change in the current arrangements.

Health and Personal Social Services Research[3]

Research resources

The Ministry of Health (as it was known in the years I have been concerned with so far) had had a distinguished record in research in its previous incarnation under the Local Government Board. The establishment of the Medical Research Council transferred the main influence elsewhere and, later, the remaining research role in communicable disease was taken over by the Public Health Laboratory Service. Health services research in its present connotation started from scratch in the Ministry in the 60's and got properly under way in 1963-4. For nearly fifty years medical research in this country had been rooted in the Haldane/Addison principle that it should be separate from an executive department as a guarantee of scientific independence. In the face of such a successful tradition and developing, as we were, a hybrid form of applied research that had not

[3]If I write in this section largely in the first person it is to show that I speak only for myself. I am too much out of touch with most of my old colleagues to be sure how far I can speak also for them. But the work was essentially the joint effort of a few people who worked closely together as a team whatever their formal affiliations in the Department. The permanent members in addition to myself were Max Wilson, John Cornish, and Leslie Best; in addition, each for several years and some on specialist aspects, Wulf Rudoe, Mike Heasman, Bill Berry, Gill Ford, Catherine Dennis, Marjorie Simpson and Graeme Matthew. There were other for shorter periods whom I do not name. The originator of our enterprise and its constant inspiration was George Godber the CMO during the whole period and we also had the encouragement of successvie Permanent Secretaries. In an executive department, research is entirely dependent on the value accorded it by the chief service officers; it is they who must provide staff of high quality and with as much continuity as this will allow. We ourselves were very lucky in this respect.

yet proved its worth, we felt that the trust of research workers, and outside confidence in their results, would only be won if we established from the outset unassailable credentials of quality and scientific independence. This in itself would have been enough to lead us to place the early work extramurally in departments of acknowledged reputation.

The academic base of health and personal social services research, as Douglas Black has written, does not lie within the traditional disciplines of medical schools but rather within the newer discipline of social medicine, and more broadly within the social sciences generally. Fortunately, in community medicine and epidemiology, and indeed in medicine more generally, there existed research workers with a spontaneous interest in practical health service questions. We had the good luck, for example, very early on to attract the interest of Archie Cochrane, Director of the MRC's Epidemiology Unit, and his help remained throughout a mainstay of our activities; later, a number of our larger programmes were undertaken in Richard Doll's department in Oxford. In a very few years it proved possible to set up, in different parts of the country, a number of research units and long term programmes, mainly based on epidemiology and community medicine, with broad or more specific terms of reference. Under these arrangements we were able to concentrate a variety and quality of thought on what research could do for the problems of the NHS which I do not think we could have enlisted so quickly in any other way. Thus, from the start, ideas for research arose from interaction between Departmental staff with responsibility for service and research workers in the health care field.

In the social sciences it was more difficult to develop research and it was inevitable that the Department's early projects should have been largely medically orientated. The SSRC had not yet been set up, academic departments were relatively new, an interest in health and welfare had yet to be awakened, research techniques were less well established and were difficult to apply in our field.

Nevertheless, Portfolios for Health 1 and 2 show that a good deal of progress, largely due to John Cornish, had been made by the end of the decade; in particular there were by then a number of multidisciplinary units and programmes.

Although DHSS was able to play a useful part in remedying the shortage of workers in the relevant fields of research, especially epidemiology and community medicine, and had reasonable success in recruitment and training, it was dependent on other bodies when staff reached the stage of needing security of tenure. The issue was only just coming to a head in my time and then only in a very few cases, partly because our work was mostly still only developing, and partly because it was then still not too dificult, after negotiation, to make reasonably satisfactory ad hoc arrangements with universities or once or twice with the MRC. However, the fact that no regular or guaranteed arrangements existed was bound in the long run to lead to a damaging sense of uncertainty and restlessness among the staff. The numbers involved were always likely to be small and I believed that they could be absorbed by the universities and MRC without embarrassment to either. This seemed indeed the only satisfactory solution and it is good news to learn from Gordon McLachlan's introduction to Five Years After that agreement with the universities may now be in sight. A similar agreement with the MRC was one of the major benefits that I hoped would follow from the new Rothschild relationship.

In this connection I find it disconcerting that Whitehead can write in Five Years After that 'There is no doubt that certain medical research workers looked upon the Department's research activities as those practised by second class scientific citizens'. I first met this particular manifestation of intellectual arrogance many years before at the MRC, in the attitude of some laboratory research workers towards their clinical research colleagues. I thought then that it was best ignored. But it cannot really be shrugged off as just another innocent academic foible. It is a nasty expression of a destructive impulse which can only too easily undermine

the self-confidence of the young who still have their way to make and it should surely not have been given currency, without rebuttal, in a publication under the names of six DHSS unit directors. Again, could there be a more effective way of deterring the young from taking up applied research than by telling them, as both Whitehead and Dollery do, that such work does not attract the 'best' scientists? This may be true of those few who are highly creative, though they too seem to have taken pride in their practical role in war-time. But the less creative who must form the bulk of even the most elitist organisation are both more useful and usually happier if a good part of their work is with a discernible practical purpose. It is no service to them or to society to lead them to think this beneath them.

Research programme

We did not start with a 'master plan'. Our approach, like that of the MRC in developing biomedical research, was empirical. Nor did we theorise in advance about the definition of health services research. We were prepared, for a beginning, to initiate or support any sufficiently useful project or programme with 'a precise and practical relevance to the operations of the NHS, that is to better care of patients or better use of resources, within a time scale of the next five to ten years' as well as 'a limited number which could be expected to be particularly fruitful in the development of research methods, though more theoretical and taking rather longer to yield practical results' (Portfolio for Health 1). We did not expect that our results would normally be the deciding factor in policy; as I wrote at the time, service research is 'like a pair of spectacles offering clearer and longer vision and not like a magic wand to conjure up ready-made solutions and decisions'. Our interpretation of what constituted 'research' for our purposes was practical and included at one extreme basic research needed to attack specific problems and, at the other, working prototypes of health services or new

service developments, some with only a small element of research in the strict sense but requiring to be evaluated under central control and scientific oversight before a decision was taken to encourage their general introduction. Our range of interest stretched from the medical sciences through epidemiology to sociology and economics.

Health services research, like other forms of applied research, needs to be ready to respond to current problems and unforeseen opportunities, whether they fit into a pre-conceived plan or not. This indeed is the basis of Dollery's justified plea for more adequate arrangements for collecting intelligence. A great deal of effort in the early years, for example, was put into defining the general principles on which decisions about screening should be taken and in investigating the pros and cons of screening for particular diseases, including an early cost/benefit analysis by a small inhouse social science unit in DHSS of the Rotherham multi-screening experiment. Similarly, research and experiment were needed for the rational and economic introduction, under scientific guidance, of renal dialysis and transplantation. In the case of another major innovation, intensive coronary care, for which the degree of benefit in relation to the use of resources was in question, the Department supported, through a special committee under Robert Platt, a large programme of research including Gordon Mather's project for a trial of home versus hospital treatment, which was the first attempt in the world to examine scientifically the value of this new and expensive form of care. Equally, there were opportunities to be taken advantage of. The so-called Best Buy hospitals at Frimley and Bury St Edmunds made it possible to try out different patterns of hospital and community care; the Oxford Board's prototype community hospital led to a large programme of research to determine its best content and functions; and the Wessex Board's new units for the mentally handicapped allowed the experimental evaluation of different forms of residential care. These are all examples of necessary and important responses to urgent current problems or opportun-

ities which would have had to be undertaken whether they fitted in with our major interests at the time or not.

It was not very long, however, before the fields of interest and research activity became well enough marked out for it to be seen that the bulk of the work was being concentrated on a relatively few dominant themes of high priority. The classification which we used is no doubt somewhat arbitrary but it does provide a logical framework within which the bulk of our work can be viewed: Studies of Service Need, Demand and Utilisation; Evaluation of Services and Quality Control; Studies and Experiments in different Patterns of Hospital and Community Care; Manpower Studies, especially in Nursing Services and General Practice; Nutrition Surveys and Studies of Specific Medical Conditions, often by randomised controlled trials; Prototype Services and Special Service Developments; Management, Organisation and Economics Studies. Special attention was given to improving the care of the so-called dependent groups whose need may be as much for help from the social as the medical services. It is true, I think, that these themes gradually emerged and took shape in our minds, as a result of a multiplicity of informal contacts, rather than that they were the outcome of a 'conceptual rationale'. Of course we were working at the dawn of health services research, fishing as Max Wilson said in well-stocked pools where it would be difficult to avoid hooking a worthwhile catch. But I remain sceptical of master plans and should be content for our record to be judged by the foresight shown in capturing what appear in retrospect to have been the most important issues; and I am reassured to find from Kay's Rock Carling monograph for 1977 that he, as Chief Scientist for Scotland, seems to be setting out on much the same paths.

Clinical Trials: 'The major strength available to Britain which should have been capitalised' writes Dollery in his criticism of DHSS research policy 'was in the conduct of randomised controlled trials and clinical experiments generally—it is surprising how little they have been exploited to investigate the problems of the last decade'.

Looking through the lists in Portfolios 1 and 2 which cover the years 1963-73 I find RCT's, some in collaboration with the MRC, completed or in progress on: glaucoma, diabetes, moderate and mild hypertension, coronary care, coronary prevention, multiphasic screening in general practice, hernia, varicose veins, haemorrhoids, physiotherapy in low back pain with sciatica, aversion therapy on cigarette smoking, methods of rehabilitation for disabling disease, calf vein thrombosis after hip replacement, conditioning procedures in chronic schizophrenia, supplementary milk in mothers and infants, duration of hospital stay, home versus hospital treatment, out-patient versus in-patient treatment, admission and discharge policies, 'biochemical profiling'. I should be surprised if there were not as many in the MRC's programme.

Intelligence: There is more substance in Dollery's complaint of the lack of any formal arrangements for collecting intelligence on new developments that affected the delivery of health care. Although we were often successful in getting early warning of impending new developments, largely through Godber's wide personal contacts at home and overseas, as in screening and renal dialysis, we knew quite well that the informal arrangements on which we and the MRC had been accustomed to rely were no longer adequate. The MRC and DHSS, for example, both learnt almost accidentally of the improved treatment for childhood leukaemia only some seven years after it was first put on trial in the US and, similarly, we were both four years behind over l-dopa. This was a symptom of the reluctance of the MRC and DHSS to reassess or combine their roles; for collecting and disseminating intelligence on clinical developments was one of the duties explicitly laid on the CRB when it was set up and it would have been absurd to set up a separate organisation for developments in health care. This was pre-eminently an area for collaboration.

Rothschild

This, then, was the position when the Rothschild proposals became known. It was clear that they must profoundly affect not only MRC/DHSS relationships but also the Department's own domestically controlled health services research.

I have not concealed my belief that a new initiative was needed in MRC/DHSS relations and that, for understandable and honourable reasons, it was unlikely to be taken by those of us within either body, who were all too much prisoners of the respect we felt for the traditions we had been brought up in and the successes that had been achieved. I therefore welcomed Rothschild as the nearest contemporary equivalent to a deus ex machina, the outside intervention that would persuade or compel all concerned to lay aside ingrained inhibitions and face and resolve present issues. His recommendation that the essential independence of the MRC should be maintained but that a quarter of its annual grant-in-aid should be transferred to DHSS for 'applied' research and used, as far as possible, for commissioned work in the MRC's research establishments on a customer/contractor basis, accorded very closely with our own estimate in DHSS that some quarter of the MRC's existing programme was already applied research in the Rothschild sense and potentially of direct relevance to DHSS needs but was too often planned and carried out with little or no reference to the service implications. The Rothschild proposals seemed therefore to offer an opportunity, which should not be missed, to plan together in partnership on the basis of new and more realistic principles of association.

The pre-condition for the new relationship was to be the appointment of a Chief Scientist and the creation of a Chief Scientist's organisation in DHSS.

Although the Rothschild proposals in their original form were not explicitly concerned with research under the DHSS's own direct control, it was clear that the Chief Scientist's organisation provided a welcome opportunity for uniting service needs and scientific oversight in a way that had not hitherto

been attempted. The current phase of DHSS research interest was of recent and unusually informal growth. In its early years the few of us closely concerned had been fully stretched in building up a research resource able to respond flexibly to different and changing needs, and we had deliberately avoided setting up any formal controlling organisation at that stage. However, if research was to become a stable and fully integrated activity of the Department, and to win for itself an accepted place in the estimation of the scientific world, it needed to be given a properly constituted and permanent status. The Chief Scientist's organisation, under the Rothschild proposals, seemed likely to bring this about.

'Thus, essentially', as I wrote in Portfolio 2, 'the DHSS was faced with four main tasks: to set up a 'customer' function to define the needs for research and implement the results; to bring together the various research management branches into a coherent system for formulating, commissioning, and monitoring a realistic research programme; to establish the new relationship with the research councils and evolve, in partnership with the MRC, mutually satisfactory arrangements for administering the transferred funds both in the transitional phase and in the longer term; and, fundamental to the success of all these activities and playing a key role in each, to introduce the novel figure of a Chief Scientist, with the necessary authority and independence, and create the supporting machinery, both within and outside the DHSS, to enable him to function effectively'.

Customer and Chief Scientist Organisation[4]

So a powerful scientific influence had to be introduced into the Department and blended with the

[4]At this point when the new organisation was due to be drawn up we were joined by Ken Stowe as Under Secretary and Robert Maxwell then a member of McKinsey the consultant management firm taking part in the forthcoming re-organisation of the Department in preparation for that of the NHS. In addition, after his nomination as my successor, Douglas Black took part as often as his professorial responsibilities allowed. I hope that what I have said in this section does not conflict too much with their views and memories.

existing administrative machine to form the 'customer' organisation. We were never in any doubt that the scientific influence should operate at all stages of the research process. The organisation which we had in mind would be in three tiers corresponding to three stages in the framing of the programme but with responsibilities much wider than this.

1. RLG'S and Specialist Committees: The initial stage would be to examine customer needs, section by section, in the light of research practicalities. For this purpose research liaison groups would be set up covering different aspects of the NHS and other Departmental responsibilities; they might, for example, deal with the so-called client groups, children, the elderly, the mentally ill and so on, or with any other of the main Departmental interests, for example general practice or the nursing service. In the early years research in the Ministry had been too much isolated from the service divisions and, though later their influence had become increasingly important, there had never till now been formal arrangements to bring the administrative machine as a whole into the preparation of the research programme. This seemed the right place for them to air their problems and examine whether research could be of help. The RLG's would bring together in regular session, and for the first time on research, Departmental staff, professional and lay, and outside scientists both from the Chief Scientist's research committees and DHSS research units. Together they would act as a forum, at the right level and with the right combination of experience, to prepare the ground for the Chief Scientist and the Chief Scientist's Research Committee and enable them to build a balanced and realistic programme over the whole range of NHS needs.

On the same level and performing a similar function in particular fields would be three specialist committees responsible for Equipment Research, Computer Research, and Operational Research, whose work it had then been decided,

rightly as I still think, should come under the authority of the Chief Scientist.

2. The CSRC and its supporting committees: The functions of the CSRC as outined in Portfolio 2, were 'to give strategic advice to the Management Board on R and D in the field of Health Care, Personal Social Services, and Social Security, covering the objectives of the R and D programme; the balance, in terms of cost and effort, within the programme between one field of research and others; and the adequacy of the arrangements for managing and evaluating the research programme and for implementing its results'. The CSRC was intended, therefore, in Dollery's words, to function as 'the centre-piece of an effective research organisation'; it was to be a multidisciplinary body of medical and social scientists under the Chief Scientist as chairman and its recommendations would be the final stage in the preparation of the programme which would go forward to the Management Board for approval.

The CSRC was itself to be assisted by three scientific committees:

(i) The Health Services Research Board was intended to perform for health services research much the same functions that the MRC's Clinical Research Board does for clinical research. We wished to expose the content and quality of the work to the influence of a wide range of outside experts and we felt that the health services research programme, including operational research and special service developments, needed to be supervised in more detail than the CSRC would have time for. Above all, the HSRB would be concerned with quality. Moreover, no small part of the loyalty and good feeling among the clinical research staff of the MRC had been due to the close relationship they enjoyed with members of the CRB; it seemed to us that health services research was more likely to prosper in the long run if similar feelings could be fostered by the HSRB.

(ii) The Personal Social Services Group whose functions in their field would be similar to those of the HSRB.

(iii) The Panel on Medical Research was to look

after commissioned biomedical research and the use of the transferred funds. The idea of the transferred funds had been received with great hostility by large and influential sections of the medical and scientific community and though, as Whitehead says, 'negotiations between the MRC and the DHSS were conducted with complete co-operation from both sides', and indeed with the utmost friendliness, in parts of the scientific world outside deep resentment persisted. The PMR, as a scientific body with representatives from both sides, would have been needed, if for no other reason, to ensure and to demonstrate that the transferred funds would be used sensibly and in genuine partnership; and there is good evidence that the promise that it was to act in this way had, at least in advance, a reassuring effect.

But, of course, the PMR's functions went far beyond this. One problem that had to be settled was what should be included within the formula of 'applied research'. Rothschild never intended, I believe, to exclude suitably orientated basic research if asked for by the customer. It is, of course, true that 'a contract to work on cancer' (Whitehead's example) would not have been acceptable to him—or indeed to us—but one to work on cancer immunology would have been, provided DHSS regarded this as a step necessary for progress. In fact this was his own example at a later stage of the discussions. I had always taken for granted that such broad commissions were covered by the Rothschild formula and should not have thought the new relationship with the MRC or the transfer of funds feasible without them. Although we at DHSS foresaw increasing scope for specific commissions, as experience in working the new arrangements was gained on both sides, we expected that broad commissions would remain a major and very likely predominant factor. Indeed we took it for granted that for the first few years most of the money would be spent not so much on new work as on buying a stake in the existing work of relevant MRC units, so that it could be adapted to include the social, economic and organisational aspects of importance to the Department but

which the MRC would not normally take into account. Once informal access to MRC units had been obtained, and an interaction between service and research interests could be developed, planning on new work likely to be useful to both parties could begin in earnest. We did not see any benefit in trying or pretending to move faster or further than was practicable along the line of more detailed customer control.

It seems to be generally agreed that this middle tier of scientific advisory committees did not work in practice and Kogan and Korman have analysed the reasons for its failure. But the reaction seems to have been to diminish or even largely eliminate the independent scientific influence rather than to rechannel it into more practicable working arrangements. I think this was a mistake in principle. The reasons that led us to attach so much importance to outside scientists can be summarised as follows.

(a) We did not believe that the Chief Scientist's organisation could ever be strong enough scientifically to carry out its Rothschild functions unless it was supported by a strong infusion of outside advisors actively engaged in scientific and professional work.

(b) It seemed to us that the Management Board should not reach its decisions on the basis of advice from Departmental staff alone but that policy recommendations were best hammered out in open discussions in mixed groups with different backgrounds, experience and skills. The scientists' contribution would be not only as experts on research methods but also as professionals in daily contact with a wide range of other professionals and working in the field where the results of Departmental policy are experienced.

(c) A wide range of scientific experience would be needed in selecting research workers, stimulating and vetting projects, and monitoring progress. It seemed to us that this would be best done by scientists who understood and believed in the Department's research policies and priorities because they had themselves taken part in formulating them.

(d) In research under the direct control of a government department, when results must often

disappoint the expectations of both the public and the health professions, the known presence and influence of independent experts seemed to us indispensible as a guarantee that the planning and conduct of the work were above suspicion.

3. The ultimate authority as customer for research, whether DHSS controlled or commissioned, would be the Management Board, the group of top officials, lay and professional, responsible for the planning, policy and management of all DHSS activities. The Chief Scientist was to be a full member of this for all purposes, on equal terms with its other members. It was not intended that the Management Board should exercise detailed control over the research programme. Its function would be to decide priorities in broad terms and allocate funds with the advice of the Chief Scientist, who in case of serious disagreement would have the right of direct appeal to the Secretary of State. In his more restricted field the Chief Scientist would therefore carry an authority and responsibility similar to the CMO's. Within his budget and the agreed framework of priorities he would himself decide how and where the money was spent.

Individuals and ideas vs problems and needs

Dollery, who is not himself a supporter of the laissez faire point of view, quotes a Secretary of the MRC as once having said that 'no government edict was required to persuade him that it would be a good thing to discover a cure for heart disease and cancer; the problem was to discover a researchable idea that had some prospect of success'. I suspect that this may be apocryphal, as well as anonymous; certainly no Secretary of the MRC that I have known would have cared to be caught shooting at such a sitting duck. The fallacy in such reasoning is that the prospect of success is easily overlooked if it is not actively sought for and the attitude of mind attributed to the Secretary is one of the best ways of ensuring that such an omission takes place. An early post-war MRC report to Parliament makes by implication this very point when

it describes the rich harvests that had been gathered in both world wars as a result of its scientists concentrating their attention on immediate practical possibilities; and was not something of the same sort in John Squire's mind when, as Director Designate of the Clinical Research Centre he told the MRC that he intended to concentrate the work there on subjects of social importance? The laissez faire doctrine that 'ideas and individuals are much more important than problems and needs' is a false antithesis, a truism in so far as it means no more than that the bright are likely to do better research but, in so far as it seeks to disparage problems and needs, having no warrant in either history or recent experience. If one thinks of the major advances in medicine in the last fifty years, one finds that, however much they were dependent in their origin on previous basic research or the 'prepared mind', few of them would have come to fruition without the further stimulus provided by problems and needs.

Five Years After and a Bit

A Postscript to Dr. Cohen's review

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Five Years After and a Bit

A Postscript to Dr. Cohen's review

This postcript is written by one concerned with directing a research unit and who has been involved in the field during the period of growth described by Dr. Cohen. I feel that if Dr. Cohen's principles and description of practice were being followed at this time, few of our current difficulties would now exist.

The development of this research field, described in his Introduction, particularly in the assessment of screening, shows clearly how research in this applied area was encouraged and fostered. Perhaps it is nostalgic to look back to that era and to recollect that few if any of the hopes of the actors in the drama have been realised in the form originally envisaged. To take an example; Cohen suggests that the research resources required would be covered by the development and attraction of suitable research workers. This has occured to some extent, but in spite of repeated pleas, nothing has been done to develop an avenue for formal training. One of the great strengths of the Medical Research Council (MRC) has been its training fellowships which have enabled many, including the present writer, to be trained in the appropriate field. Many of us are extremely grateful for the opportunity of being introduced into a field which was, at that time, novel to clinical research. This training has continued to be developed and fostered by the MRC in

specific areas, particularly in biomedical research, although the MRC has continued to have training fellowships in epidemiology and in sociology as applied to medicine. However, as Cohen described, much of Health Services Research (HSR) is multidisciplinary and involves difficult and taxing training first in the separate disciplines. This specific training in sociology, economics or epidemiology is available; but, multidiscplinary work in addition requires a discipline to pull all the subjects together. This is an art in its own right. The failure to appreciate this is evident when one examines some of the applications for grants in the field of Health Services Research. In spite of this deficiency, few if any training capabilities have been created in the past ten to fifteen years, even though some fifty to sixty units have been recognised by the DHSS as research units. Unfortunately, many of these do not meet the criteria of the Medical Research Council which has always specified that a research unit must be capable of providing training facilities. This is sadly lacking in many of the Health Service Research Units. An exception is the very great development of one particular aspect of HSR—economics. A unit at York University is responsible for providing the majority of specifically trained health economist researchers now working in this country. However worthy, this development is insufficient. Part of the problem concerning development is tenure (1). In spite of the repeated pleas by workers in HSR and the many promises made to them, this has not been granted. Tenure is a difficult problem. It implies that an individual is given security of employment for a long period of time and once a particular researcher is 'burnt out', difficulties in trying to obtain suitable employment will normally ensue. In addition, it is difficult to decide at what stage an individual should be considered for tenure. A number of meetings have been held about this and the research unit directors referred to earlier, considered that to foster Health Services Research, a few individuals of proven calibre should be given tenure. The number was estimated by Opit (2) at one

stage to number about fifty or sixty in England. However, the difficulties of providing tenure are considerable. The Universities are currently facing great problems because a large number of people were granted tenure in the 1960s when they were expanding; but Universities are now contracting. However, the total number involved in HSR is relatively small when compared to the total manpower resources of the National Health Service. Also, the disciplines involved in Health Service Research, epidemiology, the social sciences, statistics, are disciplines that are required for the appropriate running of the National Health Service and it should not be impossible to create a suitable scheme which would enable individuals of proven calibre to be given security of tenure, if necessary by arrangment with the NHS. In this way, even if they no longer produce original research, they could at least provide a service function.

Cohen comments on the problem of Health Services researchers being considered 'second rate'. Unfortunately, this is only too true of HSR workers and perhaps the difficulty is fostered by the Department of Health who seem unable to consider Health Services Research as equivalent in status to medical or biomedical research(3). Medical and biomedical research workers are given tenure but Health Services researchers are not. Unless tenure is granted, HSR workers cannot but feel that they are regarded even by their employers as intellectually inferior to researchers in basic sciences. It is small wonder then that too few scientists are attracted to the field of HSR.

Cohen raises a further point; that of the interaction between the researchers and the Department of Health. Unfortunately, the ideal circumstances no longer exist as described by Cohen when, in the mid-60s to early 70s, Departmental Officers knew the policy of the Department and were able to negotiate directly with researchers for appropriate work to be done. Pressure on Departmental members and changes in the economic climate have greatly altered the situation. The increases in size and responsibilities of the Department of Health have also not

helped. The creation of Research Liaision Groups has certainly aided in an interchange between administrators and researchers in certain fields. Many of the HSR problems however, are of a very much broader nature and cannot be confined to only one care grouping. It is now difficult for the Department to respond to requests for research to be done in wider areas. This is because RLGs are naturally 'lobbied' for research to cover their particular field of concern. In addition, Research Liaison Groups also only cover a limited series of activities within the Department of Health and they are more concerned with the activities of the Department than with those of the National Health Service.

Furthermore, although the Research Liaison mechanism of client groups may have been of great help to the Department at a time when resources were growing, when resources are restricted or contracting, the mechanism is incapable of coping. An RLG concerned with one client group will naturally be concerned with developing the services of that particular client group, and it will therefore tend to foster research to cope with needs which in view of the resources now available, probably remain unmet. It is difficult for this type of organisation to reorient itself to the rationalisation of services or to be concerned with research indicating priorities for different client groups or examining the needs of more than one client group. In addition, this form of organisation does not lead to the development of choice between groups. To be able to consider a problem over a very much wider area, which is also not possible with RLGs, may enable one to discern more easily areas requiring development, contraction or rationalisation (4).

Perhaps the most difficult problem at this time is that of providing advice to the Chief Scientist and of the Chief Scientist providing advice to the Health Department. It is difficult to see how, using the RLGs and no other advisory group, rational choices can be made between competing areas of research and development. Furthermore, although it is clear, standing from outside, that the CSRC and the HSRB were not very effective, and that the major

function of these advisory groups should have been to provide advice on work done elsewhere which might be applicable to the solution of our current probblems as well as to advising on areas of necessary research and development at this time, the abolition of such committees still left no organisation able to counsel the Office of the Chief Scientist on these areas. Also, it has left the Office of the Chief Scientist unsupported, so that it is difficult to understand how that Office provides advice to policy makers on all areas of research that has been done or needs to be done. It is not easy to discern where such advice is obtained (5)(6).

Similarly, the review mechanism of research units has been of uneven quality and on a number of occasions this has given rise to great concern. For example, the units are supposed to be assessed on the basis of scientific excellence by the appropriate peer group. The customer view is added separately. Units have little, if any, knowledge of what the customer has said about their work, despite the fact that the customer is usually the major initiator of a particular research programme. The difficulty of the customer-contractor relationship is also evident if it lies in an area outside that of any individual Research Liaison Groups. For example, customers could be considered as the National Health Service or particular clinical groupings, and yet the customer view of a particular research unit can only come from within divisions of DHSS who may or may not agree with a particular line of research which threatens some of their policies. Similarly, the scientific assessors do not always know the precise customer view so that it is difficult for them to make a reasoned assessment of the ideas for research.

Clearly, this is a difficult area for a research unit director to write about, since he is one of those involved in both being assessed and being an assessor. Nonetheless, my own disquiet and uncertainty about this procedure has been growing in recent months mainly because of the ambiguities in the present situation and the difficulties that I have seen and experienced at this time. The problems

of assessment in a field such as Health Services Research should not be underestimated. It is relatively simple to make an assessment of a specific research project in the biomedical or basic natural science field. The experiment or investigation has either been appropriately designed and analysed or it has not; commonly accepted rules apply. In a field concerned with practical application and encountering a large variety of constraints, both human and material, it is often not appropriate to use the best known method of investigation; often one has to be satisfied with a second-rate one. Naturally, one of the prime concerns is whether researchers understand these constraints and the ensuing problems of arriving at valid conclusions, but it is difficult to discover a suitable method of assessment in this area and one can only conclude that the present method gives rise to disquiet.

Dr. Cohen states that the Chief Scientist's Organisation could never be strong enough to carry out its function unless it was 'supported by a strong infusion of outside advisors actively engaged in scientific and professional work'. It is this area that should perhaps be examined the most critically. Sadly, it is still relatively rare for a researcher to be included in discussions concerning Health Service policy. He makes an uncomfortable bedfellow for Health Service administrators, civil servants and clinicians. His presence on many committees is not considered at all since it is often felt that he is remote from the delivery of a service. This is perhaps one of the most important oversights that has occured in recent years. Not only can the researcher bring to such committees knowledge of work done in the field of concern in this country, but also he is usually far more knowledgeable about work done in other countries than are those concerned with service. His method of training involves reviewing all available evidence. There is however a second difficulty. Many of the problems considered by various policy committees are in areas of uncertainty and require research. If the researcher is included in such policy discussions, it is more likely that he will

become involved in undertaking such research. In this way the researcher can choose the direction of his research and feel that he has done so, as much as the policy maker considered that he is responsible for the direction of research. Further, the researcher with his specialist knowledge of Health Services is the only one capable of advising administrators and politicians on which areas are or are not researchable and whether or not present available knowledge can be relied upon in the event of research proving worthwhile.

What is needed evidently is a much closer dialogue between the two 'camps'. The Research Liaison Groups have undoubtdly improved the climate in some areas but wider dissemination and consideration of far greater input than can be given by Research Liaison Groups is required. In addition, it should be clearly understood that where communication between the researcher and policy maker is difficult, or the civil servant, NHS bureaucrat, or clinician is causing problems, experience and patience is required. There is probably a place for intermediaries; the research analyst or facilitator is essential in this process. Moreover, this dialogue must extend to those who implement the recommendations, that is to the clinicians and administrators. To these people the Health Services Researcher may be an equally unwelcome colleague: Health Services Research is concerned with evaluation, and it may therefore consider certain areas that the clinician or NHS administrator wishes to develop as inapropriate.

If it is accepted that one of the major problems is lack of communication between central policy makers, and administrators and members of Health Authorities, clinicians and researchers, then clearly some effort is required to develop improved methods of communication. Although a major meeting was held at Hertford College in 1974 this experiment has not been repeated. This particular symposium, which resulted in a publication. (Positions, Movements and Directions in Health Services Research) was a very successful one in that it provided an opportunity for researchers involved in work both in this country and abroad to demonstrate to their 'Custom-

ers' the limits to what their research could provide, what opportunities they had of doing particular types of work, and what the constraints of that work were. On the other hand, administrators and others were able to describe the constraints they had found in arriving at decisions on policies and in indicating to researchers the questions they considered vital. Unfortunately, this useful experiment has not been repeated; there have been two further meetings between those concerned with Health Services Research and those concerned with directing Health Services Research from the Department. Neither of these meetings however, led to publication, and therefore there was little, if any, public debate on the issue. Furthermore, in contrast to the scientific approach of the Hertford College meeting, the two subsequent ones were largely of an informative nature although they may have helped to bring researchers and policy makers together. This lack of communication between those concerned with policy, with clinical and administrative practice, and with undertaking research in Health Services is currently one of our greatest short-comings.

Although researchers publish the findings of their research freely and widely, this is not necessarily the case with policy makers. The Department puts out numerous green or other coloured papers, but these do not make an adequate contribution to the debates taking place in any policy making group. Awareness of the constraints and issues are essential if adequate research is to be done. The open publication of proceedings of such meetings as the Hertford College symposium helps such awareness and perhaps influences others to take up their interest in this particular type of research.

As many have said (7), those involved in HSR have not been able to develop their own constituency in the same way as a GP or heart specialist has and this perhaps is one of the major problems that we now face. Health Services Researchers must develop a relationship with those responsible for the Service, with policy makers and with the public who are the consumers of the Service. This lack of rapport is perhaps one of the greatest deficiencies of HSR.

Central policy makers and administrators find this relationship complex. Researchers have problems both in penetrating the administrative framework and seeing their work applied. The Rothschild principles, which I support, are difficult to apply. It is often difficult to identify clearly just who the customers for a particular research are, or are likely to be. A division within the DHSS is rarely an appropriate customer for some of the work being undertaken. The DHSS being a separate administrative body to the NHS, is divorced from practical operational responsibility and therefore cannot conceive some of the problems needing investigation. Devolving responsibility for the maintenance of research below DHSS, eg to Regions, as has been suggested by some, could lead to other types of problems since very frequently much of Health Services Research can only be done in certain geographic locations which may or may not be within the Region that would be supporting a particular unit or project. This particular argument however needs further development which I feel is inappropriate here.

I believe that the continuation and development of research in Health Services is crucial to the evolution of our Health Service. I believe that such research is likely to be of a long-term nature and must therefore be divorced from day-to-day political decisions. For even though some decisions in Health Service policy have to be made relatively rapidly, their implementation can take from five to ten years, during which time they can be modified in the light of long-term research results. Therefore, those involved in it must have some degree of security so that they can conduct their work independent of society's winds of change, for the fruits of their research are bound to be manifested long after the Minister involved has left office. Furthermore, merely because a decision has to be made tomorrow, it does not necessarily mean that research cannot be undertaken to question the relevance and appropriateness of that decision. The time interval between the implementation of a decision in Health Services and the making of a decision is quite long enough for most of the research that I know.

Health Services Research must be considered equivalent to all other forms of medical research in status and in its method of assessment. There is no reason to suggest that status should be judged by other criteria than those used for other sciences. However, the method of assessing HSR is of greater complexity than that used for the basic natural sciences since the ultimate outcome of HSR is action. In order to foster the improvement and continuation of HSR a closer dialogue between those concerned with practice, policy and research must continue to be evolved—not necessarily on the basis of the organisation of Research Liaison Groups, but more on the basis of discussion of mutually important issues. There can be no doubt that HSR is more supported and more successful in this country than most others although a number of major problems remain (8)(9). In spite of my dismay, at many of the current trends and policies—I remain optimistic that the vision that Cohen and his colleagues had—can be realised in the not too distant future.

PPS.

A recent Finnish publication (10) has noted that health services research has been awarded top priority in all the regions of WHO (Europe). Every effort should be made to improve its standing both in the scientific community and the health care systems and researchers and policy makers should acknowledge their common interest. This line of research is growing in urgency as it becomes clearer that health policy will not meet its challenges through the uncritical application of increasingly sophisticated capital and labour intensive technology, the effectiveness of which has often not been proved. The burden of proof is on those who demand the application of such technology. It is disappointing to see how little effect this had had on policy in the UK which has so far led the way in Europe.

My postscript was written some months ago. Since that time the Department of Health has announced that the funds transferred to the DHSS as a result of the Rothschild proposals would now be returned to

the MRC ('New Arrangements Between Health Departments and the Medical Research Council' October 1980), which encouraged the MRC to develop Health Services Research. In addition, the DHSS is willing to support Health Services Research undertaken by the MRC from its own funds. It has also clearly stated that up to £2 million extra may be spent in any year within the next five years to increase the amount of Health Services Research funded by the Medical Research Council. This, of course, is to be welcomed but a recent editorial in the Lancet (11) has indicated that the situation has since become even worse. The Lancet emphasised that researchers have become increasingly less sure of their understanding of the policies of the DHSS which, through resource constraints, has found it more difficult to define its needs. The Lancet clearly indicated the demoralisation that has occurred in the field of Health Services Research and underlines the dissipation of goodwill which has come about.

It is unfortunate that the Department of Health appears unable or unwilling to listen to those who have been involved in this field over the years, has narrowed its perspective and has not appreciated the real conflict that exists in a field where it can only set guidelines and the NHS authorities are responsible for the delivery of service.

The researcher is usually much nearer to the field than the central government administrator. This distance and lack of understanding have been exacerbated recently and unfortunately little attempt has been made by those who control the resources to understand the problems of those who do the work. My optimism has been greatly dampened since writing my original article as a result of the apparent unwillingness of the Department to accept its responsibilities for the support of research and its emphasis that all that is required and all that it can do is to answer 'customer' questions. The inability of the Department to accept that to be able to undertake the research necessary to do this requires the creation and the maintainance of a stable base is beyond my comprehension. Many of us are beginning to feel that we are metaphorically banging our heads against brick walls.

The creation of resources by the MRC and the ability of the MRC to support Health Services Research is clearly welome, but the separation of the MRC from the DHSS in the past does not inspire optimism i.e. that this new arrangement will lead to the development of the field. It is possible and the MRC's ability to fund long-term research may help. However, although it supports three units the spread of workers and the ideas from these places has been relatively trivial compared to the spread of knowledge and experience from units supported by equivalent funds from the DHSS. This therefore does not augur well for the future. The optimism of my last piece has now been tempered by more gloomy thoughts provoked by the Lancet editorial.

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Health and the Inner City Partnerships

An experiment in collaboration

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Health and the Inner City Partnerships

An experiment in collaboration

Introduction

During 1977 seven Inner City Partnerships were set up: Birmingham,Liverpool, Manchester/Salford, Gateshead/Newcastle, and, in London, Docklands, Lambeth, and Hackney/Islington. After tracing the background and history of partnership this paper describes the experience of the ten Area Health Authorities involved; it examines the relationship between this policy of concentrating resources in the inner areas of selected cities and the simultaneous health policies of redirecting resources from historically well-provided to historically deprived localities, and from acute hospital medicine to psychiatry, geriatrics, and community services; and finally it describes a number of general issues which are illustrated by this experiment, and which stem from the barriers to collaboration both centrally and locally.

PART ONE

THE BACKGROUND AND HISTORY OF PARTNERSHIP

1. Urban policies 1968-77

In the decade prior to partnership there were a series of government initiatives to reverse urban

decline and alleviate the associated social problems. In 1968, announcing the Urban Programme in the House of Commons, the then Home Secretary, James Callaghan, referred to the pockets of severe social deprivation in a number of cities, many of which included concentrations of immigrants, and faced acute social problems in the fields of health and welfare, education, and housing. Although expanding social programmes, particularly in the fields of education and housing, were making an impact, the urban areas required 'special help to meet their social needs and to bring their physical services to an adequate level' (1). The purpose of the Urban Programme was 'to supplement the governments other social and legislative measures and to ensure that all citizens had an equal opportunity in life' (2). Under this programme, which was administered by the Home Office until 1976, local authorities were given loan sanction and a grant of 75 per cent towards the capital cost of approved social projects, particularly those aimed at ethnic minorities, including a number submitted by voluntary organisations. The revenue costs of the schemes were guaranteed initially for five years, and subsequently for a further five years—an arrangement which left few funds available for new schemes in the latter years of the programme.

Subsequent initiatives included a number of Community Development Projects (CDPs), the Inner Area Studies in Lambeth, Birmingham, and Liverpool, and the Comprehensive Community Programmes (CCPs) in Gateshead and Motherwell, Scotland.

The Community Development Projects were mounted in 1969 by the Home Office and financed partly from the Urban Programme and partly by the participating local authorities. Emphasising citizen involvement, community self help, and the close coordination of the various statutory and voluntary social welfare agencies, they aimed to discover the means by which the particular social problems of a locality could be identified and resolved.

In 1972 the Department of the environment commissioned firms of planning consultants to carry out the Inner Area Studies; they were to 'look at the needs

of the study area as a whole from the point of view of the people living in them, and derive lessons on powers, resources, and techniques' (3). In their brief they were instructed to discover a better definition of inner areas and their problems, to investigate through action research the social and environmental measures that could be taken to improve conditions, and to examine the concept of area management and its implications for the local authority. The findings of these studies, published in 1976 (4), heavily influenced the proposals contained in the 1977 White Paper 'Policy for Inner Cities' (5).

The Gateshead and Motherwell Comprehensive Community Programmes, inaugurated in 1976, were to 'consist of a description of the state of deprivation in the authority's areas, an appraisal of the effectiveness of existing central and local government policies, and .... an annual programme of action drawn up in consultation with the various departments and agencies concerned' (6). The CCP's were the forerunners of the partnerships, but they differed from them in that their focus was not limited to a defined inner area but was authority-wide, and in that they had no specific financial allocation, so that all their proposals had to be met from the redirection of central and local government main programme expenditure.

2. 1977 - The recast urban programme

In September 1976, Peter Shore, the then Secretary of State for the Environment, announced a major review of urban planning policy, involving the limitations of New Town growth and the concentration of available development resources in inner city areas. Speaking in Manchester he claimed that the government initiatives of the past decade had dealt only with the symptoms and not the causes of urban decline. City centres 'shared common problems of the most daunting kind', which stemmed largely from the major and unbalanced loss of population (7). The government dispersal policy had contributed to inner city decline, partly because the overall population

increase had been far less than originally forecast, and partly because 'the planned efforts to decentralise and decongest the inner cities had been accompanied by a voluntary movement of people much greater than anticipated by the planners' (8).

The details of the new urban policy are contained in the 1977 White Paper 'Policy for the Inner Cities' in which the government committed itself to 'give the inner areas an explicit priority in social and economic policy, even at a time of particular stringency in public resources' (9). This document contained an analysis of inner area decline and a statement of government proposals to reverse it.

Although the precise mix of problems and the linkages between them differ in each city, according to the White Paper the inner areas are characterised by a combination of economic decline, physical decay, and social disadvantage. They contain high proportions of unskilled and semi-skilled workers, and a mismatch as developed between the skills of the residents and the available jobs. The loss of jobs in the traditional industries has not been compensated sufficiently by investment in new manufacturing industry, and unemployment is high. The high density old housing, the vacant land, the lack of amenities and public open space, and the generally drab environment combine together to make the inner areas unattractive, both to many of the residents and to new investment in business, industry, and housing. There is a concentration of the poor, the homeless, and those with personal problems such as drug addiction or alcoholism. In addition there is 'a collective deprivation which affects all the residents ....and arises from a pervasive sense of decay and neglect which affects the whole area. This collective deprivation amounts to more than the sum of all individual disadvantages ....it is an important argument for tackling inner city deprivation on an area basis, and for discriminating in favour of the inner areas in the working out of public policies and programmes' (10).

The government proposed a package of measures to assist the regeneration of these areas: first, the main policies and programmes of government were to

be given an inner area dimension; second, the Urban Programme was to be transferred from the Home Office to the Department of the Environment to secure a more unified approach to urban deprivation, it was to be increased from £30 million to £125 million a year (1977/8 Boutturn prices) and extended to cover industrial environmental and recreational provision as well as specifically social projects; and finally the government was to enter into special partnerships with a limited number of local and health authorities, and these partnership areas were to be given priority in the allocation of funds from the increased Urban Programme.

The March 1977 budget allocated £100 million to aid the construction industry whilst assisting with inner city problems. This 'construction package', which Shore described as 'launching aid' for the partnerships (11) enabled certain schemes, including a number of health schemes, to be started in advance of the preparation of the first partnership programmes.

3. The Partnerships 1977-9

The partnerships are a new form of organisation embodying a number of inter-related concepts drawn from the variety of previous initiatives:

i) Coordination: vertical coordination between the policies of central and local government, and of county and district councils; lateral coordination at the national level between central government departments, 'the activities of central government have been over compartmentalised', (12) and at the local level between local government departments, Area Health Authorities, private industry, and voluntary organisations, 'a unified approach will be required in which the various local policies and services within these areas are closely concerted (13).

(ii) Positive Discrimination: in the concentration of Urban Programme funds in selected cities, and in the requirement that the inner area be given priority in the main programmes of participating authorities.

(iii) Citizen Involvement: 'involving local people is .... a necessary means to the regeneration of the inner areas' (14).

Partnerships were offered initially to Liverpool, Birmingham, Manchester/Salford, Lambeth, and the London Docklands. The selection was not based on objective criteria, which, it was claimed, were not available in a comparable form for different areas, but it was justified on the grounds that the inner area problems of the major cities were the most serious because of their 'sheer scale' (15). As a result of local pressure, partnerships were also offered to Gateshead/Newcastle and Hackney/Islington in November 1977.

In each of the partnership areas the appropriate Area Health Authorities were brought into the local machinery in order to 'help the hospital and community health services play the wider social role required of them', and to 'reinforce their links with other services' (16).

Each partnership has a partnership committee consisting of government ministers, local authority leaders, and AHA chairmen, a steering group consisting of senior officers from central and local government departments and the AHA and a number of topic working groups. The partnership committee sets the broad aims and direction of the partnership, and is ultimately responsible for approving and monitoring the programme. The officer steering group acts as the main advisory group of the partnership; it examines proposals and bids in the light of local priorities before making its recommendations to the partnership committtee. The working groups study the needs of specific client groups or particular services; they consist of officers from relevant statutory authorities and voluntary organisations, and vary according to the priorities of the different partnerships; examples of those on which the health interest is represented are the under-fives (Lambeth), primary care (Hackney and Islington), the social environment (Liverpool), Health and Social Services (Birmingham and Gateshead/Newcastle), and Language and Translation Services (Hackney and Islington).

In Lambeth and in Hackney/Islington there is also an Inner City Unit within the local authority to coordinate the partnership activities and assist in the devlopment of the programme. These are staffed by local authority officers and by seconded officers from the GLC, ILEA, and the DOE.

The administrative machinery of the Docklands partnership differs slightly from the others. In place of the partnership committee there is a Docklands Joint Committee through which the GLC, ILEA, and the London Borough Councils of Greenwich, Lewisham, Newham, Southwark and Tower Hamlets work in cooperation with government departments. Although health is not represented health schemes are eligible for funding.

The first Inner Area Programmes, to run from 1 April, 1979 have now been produced, and those from 1 April, 1980 are in preparation. The programmes are based on a diagnosis of the problems of particular inner areas, and list schemes to be funded from the redirection of main programmes, as well as Urban Programme schemes. According to E. P. Bell, the chairman of the Docklands Joint Committee, the partnership programme will lead to the eventual transformation of the inner area 'not by a radical change of its unique character or a sweeping away of its traditions, but by replacing despair with hope, and decay with prosperity' (17).

PART TWO

HEALTH POLICIES IN THE PARTNERSHIP AREAS

1. Characteristics of Inner City Area Health Authorities

In 1974 the NHS was reorganised into three administrative tiers: Regional Health Authorities (RHA's), Area Health Authorities (AHA's) and Health Districts. It is the AHA, whose boundaries are coterminous with the corresponding local authority, which is represented on partnership committees, although the partnership activity might relate to only one of a number of health districts. In London, the City and

East London and the Lambeth, Southwark and Lewisham authorities both belong to two separate partnerships, the former to Docklands and Hackney/Islington and the latter to Docklands and Lambeth. Reorganisation was justified on the grounds that it would integrate all the health functions within a geographical area under a single administration and thereby assist the provision of a coordinated service attuned to local needs. The AHA's took over the functions of the Hospital Management Committees, the Boards of Governors of Teaching Hospitals, and the local authority Health Departments; the Family Practitioner Committees, which are coterminous with the AHAs, took over the function of the general practitioner Executive Councils.

Although the facilities inherited by each AHA differed, those in the urban centres share common characteristics. They are well provided with acute services, all except Gateshead being major teaching centres; and, especially in London, expensive facilities are often duplicated in separate hospitals—Lambeth, Southwark and Lewisham contains three teaching hospitals each with a renal dialysis unit. However, there are often serious gaps in psychiatric and geriatric services. Community health facilities are inadequate, there are lower than average health visitor and district nurse staffing ratios, and vacancies are difficult to fill (18). GPs tend to be older, to have large practice lists, to practice single handed and to live some distance from their practice—all factors which encourage the use of commercial deputising services (19). The Royal Commission observes 'GPs, nurses, health visitors, social workers, receptionists, and secretaries are no more likely than anyone else to want to live and work in unattractive urban areas' (20), and it concludes that the NHS is 'failing dismally to provide an adequate primary care service' in declining urban areas (21).

The inner area health services are a product of history. The teaching hospitals were originally founded in populous working class districts near to the city centres, where there were sufficient patients to justify the existence of a large and

expensive hospital. Lunatic asylums and mental deficiency hospitals were built in rural areas away from the cities where their inmates could be segregated safely from public view. During this century the distribution of hospital services has failed to respond adequately to demographic and medical trends. The patients have moved away from the city centre to the peripheral suburbs but the city hospitals have not followed; up until the mid seventies, many, denuded of the surrounding population, were still undergoing extensive modernisation and rebuilding, the notable example perhaps being the newly opened Royal Liverpool Hospital. Neither health nor local authorities have made appropriate local provision for the mentally ill and handicapped, even though 'community care' has been the motto of the psychiatric services for the past twenty-five years. Along with the effects of selective migration this has led to a serious mismatch in inner areas between health service provision and the needs of the local popultion. The migration of young skilled workers has left an unbalanced population structure with a high concentration of the poor, the old, and of vulnerable groups such as single parent families, the psychiatrically disturbed, the homeless, and those addicted to drugs or alcohol. Amongst this residual population, illegitimacy rates, stillbirth perinatal and infant mortality rates, the incidence of VD and the prevalence of mental illness are all high (22).

The take up of available services is low; attendance at family planning, antenatal, and child welfare clinics is poor, and the casualty department of the local hospital is traditionally used in preference to the general practitioner (23).

The inner city health authorities are in an ambiguous position, they are fulfilling regional and sometimes national functions in providing expensive high technology medicine to patients from outside their boundaries and in training medical students and junior doctors, but they are failing to provide the primary care, the geriatrics, and the psychiatry needed by their local population. Since reorganisation they have been under particular pressure

because of the governments attempts to redistribute resources geographically between authorities and functionally between patient groups, and also because of the desire by authorities on the conurbation periphery to become self-sufficient in acute services.

2. Health Policies Since 1976

(i) Geographical Redistribution

In May 1975 the Resource Allocation Working Party was appointed to review the distribution of NHS capital and revenue and to recommend 'a method of allocation responsive objectively, equitably, and efficiently to relative need' (24). Since 1948 local revenue allocations had been calculated on the basis of the previous years expenditure plus the running costs of new capital developments (RCCS), with any remaining development money being distributed on a pro rata basis according to the size of existing budgets. The working party argued that this incremental method 'tended to reflect the inertia built into the system by history' (25). It recommended a new system based on a formula designed to secure 'equal opportunity of access to health care of people at equal risk' (26).

The new method, introduced nationally in 1977/8, first calculates 'target' allocations for each AHA according to criteria of need, and then, in the division of annual funds, moves each authority nearer to its target. In practice, the pace of change is modified to ensure that no region receives an allocation less than that of the previous year, but the running costs of new developments are no longer protected. The formula is based on the size of the resident populations, weighted by age, sex and standardised mortality ratios (SMRs) to reflect differential morbidity, and adjusted for cross boundary flows and the number of undergraduate students.

The Regional Authorities use a similar system, with the details altered according to local circumstance, to distribute funds to the Areas and

Districts. In this process the Inner London AHAs have emerged as overfunded Areas in overfunded Regions, and Birmingham and Liverpool as overfunded Areas in underfunded Regions. Manchester, Salford, Gateshead and Newcastle are all below their 'Target'; but Manchester, Salford and Newcastle are well provided relative to other districts in their Region; only Gateshead is deprived by both national and regional standards.

The formula is disadvantageous to the inner areas in a number of ways. The basic figure to which the weightings are applied is reduced as the population declines. There is no measure of adverse social conditions, even though these may put pressure on hospital beds by lowering the threshold of admission and increasing length of stay. (The working party aimed to secure equal access for populations of equal need, rather than to discriminate positively in favour of areas of multiple deprivation, on the grounds that it was inappropriate for the health service to compensate for such things as poverty or bad housing which should be attacked by economic and social measures). Standardised Mortality Ratios are used as a proxy measure for morbidity, while the Infant Mortality Ratio is probably the more sensitive measure in urban areas. No account is taken of the quality of GP services. Average costs are applied to the cross-boundary flows, even though the importing hospitals claim to be doing the high cost work within each specialty (27). The per capita increment for students is based on the median excess cost, an arrangement which penalises the London Areas but favours the others.

During the late sixties and early seventies substantial capital developments were planned in all the inner areas, on the assumption that the necessary revenue would automatically be provided. The West Midlands, the North Western, and the Northern Regions have all continued to protect RCCS at least in part, thereby easing the commissioning of new hospitals such as Freeman Road in Newcastle, and the redevelopment of existing hospitals such as Hope in Salford. The Thames Regions and the Mersey Region discontinued the provision of RCCS, with the result

that the commissioning of major redevelopments at Guy's and St Thomas's in London, and of the Royal Liverpool Hospital has involved substantial overspending by the responsible authorities.

(ii) Functional Redistribution

The hospital and community health services were integrated under a single administration in 1974 to facilitate the provision of coordinated and well balanced facilities in accordance with the needs of local populations. The Conservatives had found suggestions to unite health and local government services impracticable, but this had not altered Sir Keith Joseph's view that, 'in a perfect world the answer would be to unify health services within local government' (28). Although the boundary between health and social services was drawn on the basis of the skills of the providers rather than the needs of consumers, Sir Keith Joseph argued that the government wanted 'to get as near as possible to the advantages unifications brings. They aimed at parallel and interacting structures in health and local government' (29). Health and local authority boundaries were to be coterminous, the two authorities were to be under a statutory obligation to collaborate, and Joint Consultative Committees were to be established to plan services of common concern.

In the 1976 consultative document 'Priorities for Health and Personal Social Services in England' the government emphasised the importance of prevention and argued for the redistribution of funds from the acute to the community and long-stay sectors (30). The growth in Public Expenditure would be limited and the development rate of general acute and maternity services should be curtailed to allow the enhanced development of previously neglected services for the mentally ill and handicapped and the increasing number of old people. The Secretary of State stressed the crucial importance of joint planning by health and local authorities of provision for the priority groups, and promised to make available a sum of money, rising to £27 million

by 1979/80, for the financing of joint schemes (31). The joint monies, which are distributed to the AHAs on the basis of population, can be used to finance a scheme that has been agreed by the JCC, provided this is a personal social service or primary care function and falls within broad government policy guidelines. Usually the collaboration money will finance 60 per cent of the capital cost of a project, although in exceptional circumstances it may provide 100 per cent of the capital. After seven years the local authorities must assume responsibility for the full running cost of any scheme so financed. The joint-funding and the inner city monies are both intended to encourage the collaboration which should already be established between separate authorities in the planning and provision of services, and to facilitate the redirection of government monies towards stated government priorities.

In inner city areas the escalating cost of acute medicine and the preemptive demands of the hospital sector on curtailed budgets limit the development of priority services. Even the gaining RHAs, who can afford to be more sympathetic to the problems of their relatively well provided authorities, tend to favour the acute sector in the provision of specific monies; the protection of RCCS facilities the commissioning of hospitals at the expense of the community: in Newcastle AHA(T) for example, all extra revenue is consumed by the new DGH despite gaps in non-acute services; the protection of funds for specific purposes, for example the development of regional specialties in the North West and medical equipment over £5000 in the West Midlands, is often advantageous to the teaching Areas, but again it is the acute sector which tends to benefit.

The losing Regions cannot afford to offer any financial protection to city health authorities, whose budgets must be strictly limited to allow for growth in peripheral Areas. In this situation the inner city authorities face a dilemma; they can only develop priority services by closing acute beds, but schemes to minimise length of stay and transfer care into the community have little change of success in

districts which lack adequate GP services and where housing is old, overcrowded, and without basic amenities. Opposition from consultants, trade unions,CHC's, and local pressure groups make closures difficult to implement, and even if beds are reduced the cost of the acute sector will not decline proportionately: the cost of heating, lighting, and maintaining underused buildings may be unaffected, and the annual cost per bed will rise as medical techniques develop and the average length of stay decreases.

The joint funding arrangements have given an impetus to joint planning with local authorities and they have facilitated the building and staffing of facilities, particularly for the mentally handicapped, which might otherwise have been granted low priority. However, the requirement that local authorities assume responsibility for the full running cost of any scheme after seven years leads them to favour 'once off' expenditure such as fire precautions or additions to their stock of aids and appliances, rather than additional facilities and services. Health authorities complain that the money is often used to subsidize schemes already in the social services capital programme, rather than for genuinely collaborative projects. Both health and local authorities often regard the earmarking of funds for particular projects at a time of limited resources as a constraint on the effective planning of their respective services.

(iii) Self Sufficiency

The hospital services in each authority are planned on the basis of bed/population ratios. In the densely populated conurbations where there are no clear demographic boundaries the key issue has been the definition of a population for each Area to which the bed norms can be applied. In 1974 health boundaries were drawn so as to be coterminous with those of the local authorities, without consideration of the natural catchment populations of existing hospitals. The RHAs are now under pressure from the newly created authorities surrounding the city

centres to plan capital developments on the basis of predicted resident populations in order to disperse the acute services in the inner area. As a result of such pressure the North Western Regional Authority are to build a new DGH in South Trafford, even though South Trafford residents are already well served by Wythenshawe hospital which is easily accessible, although now just over the boundary into South Manchester. In the West Midlands Region the strategy until recently has been to concentrate services for the conurbation in Birmingham, with the overspill population to the east of the City being served by East Birmingham DGH to which it is well connected by transport routes, but now this population is to be served by a new DGH over the boundary in Solihull. Perrin observes that many officers have confused their duty to plan a comprehensive service with the physical provision of that service within the boundaries of their own authority, and have equated the RAWP principle of equal access with district self-sufficiency (32). The inner city authorities, whose services are threatened by developments in their neighbouring districts, argue that it is uneconomic to disperse efficient and accessible services, and unrealistic to expect general practitioners to change their established referral patterns.

To summarise, since 1974 all the inner city health authorities have been penalised by differing extents by the cumulative effects of RAWP, government priority guidelines, and the new planning system. The recent limits on public expenditure together with the effects of increased VAT and salary awards are imposing additional strain on budgets which are already overspent.

PART THREE

Discussion

The partnership and joint-funding arrangements provide the inner city AHAs with a means of funding

developments in priority services in a time of limited growth. Neither scheme has operated without problems and a certain amount of conflict, although all the participating authorities have used the opportunity offered to fill gaps in their service. An inquiry into the experience of each AHA involved in the partnership activity has highlighted a number of issues.

1. Conflicting Government Policies

The basic problem from which all others stem is the conflict between the DOE policy, announced in 1977, of concentrating central and local government expenditure in the inner areas of selected cities, and the DHSS policy, introduced in the same year, of redistributing resources from historically well provided to historically deprived localities. A number of central government departments each receive annual Public Expenditure Committee allocations which they then allocate to smaller geographical areas using different criteria of need. The 1977 White Paper deplored overcompartmentalism in government activities and recommended concerted action which would 'lead to a more efficient use of resources by avoiding duplication or conflicts of effort and .... be more sensitive to the needs of the public who do not see problems in departmental or agency terms' (33). The White Paper recognised the difficulties or coordinating activities which are organised on a functional basis: 'Government departments are responsible for specific fields of policy, and local authority departments with the provision of specific services. This is sensible and efficient for the most part. Where, however, it is necessary to adopt an area-based approach to public sector activities, as it is in inner city areas, it requires special efforts of coordination and joint working which cut across established practices. These efforts are needed within both central and local government and in their relationships the one with the other' (34).

Despite this stated commitment to coordinate their activities the government proceeded to announce, in

the same year, two conflicting initiatives, the partnership policy which required the re-direction of public funds into the inner areas, and the RAWP policy which reallocated resources away from these areas. Health authority revenue allocations, based on historical figures, are reduced as the population migrates, an arrangement which ignores the efforts of the partnership to halt and reverse population decline. Bed numbers are planned according the OPCS population predictions, which assume continued migration on the scale of recent years despite the deliberate limitation of New Town growth and the discontinuation of overspill developments. There is no recognition in either the resource allocation or planning systems of the contribution made by hospitals in inner areas to primary health care, despite the statement in the Inner City White Paper that 'this role (will) not be overlooked when the detailed reallocation of resources takes place' (35). The only evidence of the government giving priority to the inner areas in its health expenditure was the small sum earmarked for this purpose in the 1978 budget.

Without an inner area dimension to DHSS policy the RHA's and in turn the AHA's have found it virtually impossible to meet the partnership requirement to redirect their expenditure towards the partnership districts. The Lambeth, Southwark, and Lewisham Authority, before its recent suspension and replacement by commissioners, faced a typical dilemma: if they followed RAWP they would be drastically cutting services in St. Thomas's and Guys, both in the inner area; if, in filling gaps in psychiatry and geriatrics, they gave priority to Lambeth, a partnership district, they would be penalising Lewisham, a non-partnership district without a single psychiatric outpatient clinic, day hospital, or bed. It is unrealistic to expect AHA's to exercise positive discrimination in the provision of local services when there is no similar discrimination in central government policies.

2. Procedural Confusion at the Local Level

Collaboration between AHAs and local authorities, whether through the JCCs or the Partnership Committees, frequently suffers from mutual misunderstanding of the differing structure and organisation of the NHS and local government. Health authority officers do not fully comprehend local government sensitivity to the local electorate, and local authority officers do not appreciate the principle of consensus management nor the constraints imposed by the hierarchical structure of the health service. The Hackney council members have withdrawn from the City and East London AHA(T) as a protest against the authority's decision to work within its revenue allocation as assessed by the Region, which they regard as a rejection of its responsibilities to Hackney people. An officer of one of the Inner City Units in London observed that the health representatives on the partnership were not sufficiently adept at political manoeverings, they did not appreciate the value of trading off one bid in order to secure another of higher priority, and they did not act quickly enough to capitalise on unanticipated opportunities. On the other hand, an AHA administrator complained that the non-local government representatives ie. health, trade union, CBI and voluntary organisations were unable to follow the procedures or to understand the jargon used; and an AHA treasurer remarked that local authorities favoured big capital schemes that would win votes rather than additions to community staff which would be more cost effective.

Administrative confusion has arisen from the different financial structure of the two organisations. Local authorities receive loan sanction and a grant of 75 per cent towards the cost of any scheme. The AHAs are not entitled to receive monies directly from the DOE and they have no powers to raise the 25 per cent balance, therefore an administrative procedure is employed whereby the full cost of any approved health scheme is deducted from the total DOE allocation and added to that of the DHSS, and then passed down through the RHA to the Area as part

of the capital allocation. Despite representation on partnership committees the DHSS was slow to clarify the details of this arrangement, thus generating considerable apprehension amongst Health authorities, who were unsure whether partnership monies would be added to their current expenditure in assessing distance from revenue targets, whether unspent partnership monies would form part of their permitted carry over at the end of the financial year, and whether they would eventually have to assume responsibility for revenue funding. It is now established that partnership monies are included in the permitted carry-over, but they are separately identified allocations which are disregarded for RAWP purposes. The Gateshead Council insisted that the AHA obtained the formal written assurance of the DHSS on this last issue before they could agree to the funding of health schemes. The matter of revenue funding remained unanswered until the second year of partnership negotiations (1979/80 - see postcript).

3. Conflicting Local Criteria

In theory each partnership sets criteria of selection between bids according to its diagnosis of local problems. In practice, because of the influence of government ministers on partnership committees, very similar lists of criteria have been produced. The overriding priorities of each partnership are the regeneration of the economy and the stimulation of local employment. Health services have been of peripheral interest, which has led some health authorities to describe themselves as 'junior partners', although one Area Medical Officer, stressing the relevance of social and environmental measures to health services, readily admitted that the smoke control programme which had been carried out under the construction package would do more to improve local health than the partnership health schemes. Although the partnerships have arrived at differing criteria for health bids, all favour primary care and community services rather than hospitals, with an emphasis on psychiatry and geriatrics rather than acute services, and on projects designed to increase

local take-up of available services. Individual partnerships have given priority to specific groups: Lambeth is concentrating resources on children and young adults as an investment for the future; Hackney is favouring schemes aimed at ethnic minorities in order to redress its past neglect in this field.

The partnership allocation is intended to act as a catalyst to attract private investment and to divert the strategies of public organisations. Except in exceptional circumstances the partnerships will not support schemes that would normally be funded from the main programmes of participating authorities. The allocation is 'intended for pump priming, experimental and innovatory projects; voluntary sector schemes; activities for which main programmes scarcely exist; and, finally, activities which would normally be funded udner main programmes in cases where, even after the scope for reallocating funds between and within such programmes has been exhausted, some additional contribution is needed' (36).

Innovative health schemes include, in Liverpool, a comprehensive service for problem drinkers aimed primarily at homeless alcoholics, and a centre for people suffering from drug dependance; and, in Newcastle, the provision of a bus to transport children to the dental hospital. The partnerships vary in their interpretation of what constitutes a main programme scheme. Although health centre bids have been rejected for this reason, a number have been accepted on the grounds of the priority given to the development of primary care services in inner areas. Hospital based schemes are generally unacceptable: the Birmingham Partnership refused to provide the revenue necessary to open an ophthalmology unit or to support the expansion of maternity services at Queen Elizabeth hospital despite the very high perinatal mortality rate; on the other hand the Gateshead Partnership agreed to fund the reorganisation of maternity services and they provided the capital to upgrade an occupational therapy unit in a psychiatric hospital which serves the inner area population although situated several miles from the city.

The partnerships have failed to grasp the nature

and extent of cross boundary flows in the health service. Hospital schemes in the inner areas have been rejected because the authority has been unable to restrict access to local residents, and others, of prime benefit to the inner population, have been opposed because they were not located in the defined partnership area.

The partnership initiative was intended to increase employment, to redress the effect of selective migration and improve the social class mix, and to provide local facilities of which the population could be proud. Current health policies conflict with all these aims. The large city centre hospitals are a major source of employment. The combined effects of geographical and functional distribution together with the trend towards self-sufficiency will lead to a sizeable reduction in the number of hospital beds and a comparable loss of employment not only for doctors, nurses and paramedics, but also for domestic and anciliary staff. With the exception of Hackney/Islington the partnerships have ignored the employment potential of the NHS and have concentrated on attracting commerce and industry. In Hackney/Islington, the City and East London AHA(T) have secured partnership funding for a work experience scheme intended to stimulate local recruitment: school leavers will spend two days a week in college learning such things as numeracy, literacy and home economics, and three days in a local hospital working as a porter, as a domestic, or in CSSD etc.

Partnerships have rejected proposals to build medical and nursing accommodation near to hospitals even though inexpensive, good quality housing might have persuaded professional staff to live in the inner area. They have funded schemes in the primary care and community services but many authorities are unable to fill vacancies in these sectors where staff recruitment is difficult. The prestigious hospitals which attract high quality staff have traditionally compensated for inadequate GP services and poor social conditions. It might be appropriate to recognise this role in an increased bed complement and the provision of a salaried, hospital based, primary care service.

Several partnerships give priority to capital schemes in order to avoid the preemption of funds in subsequent years. An Area Administrator, arguing that the employment of additional staff was more important to health service provision than new buildings, pointed out that his partnership district was having difficulty funding established posts and therefore would be unlikely to fund new staff for Urban Programme developments. Only Lambeth has specifically avoided major capital development, preferring to esablish good basic services, and to support local community initiatives which would be self-sustaining after the partnership had dissolved.

Despite the emphasis on citizen involvement and community self-help the CHCs have generally played a peripheral role in partnership activity. The City and East London CHC has been closely involved in the submission of two voluntary sector schemes: one in connection with the Hackney Council for Racial Equality, the other with a Local Tenants Association.However, the Birmingham CHC failed in its attempt to secure a seat on the Partnership Committee.

4. Distortion of Local Priorities

Many administrators doubt whether the cost of partnership in time and effort brings commensurate benefits. Often the earmarked partnership and joint funding monies are substantially larger than general health development monies: in 1979/80 Gateshead AHA received £130,000 for general health development, as compared with £180,000 for joint funding, and £440,000 for partnership schemes. Health authorities tend to resent the distortion of their local priorities in this way. An Area Medical Officer explained that funds were urgently needed to provide the basic district services without which the innovative schemes favoured by the partnership would be wasted: services in his authority were hospital dominated but because of RAWP it was impossible to direct resources into the primary care sector where they were needed.

5. The Inner City/Outer City Conflict

The partnership initiative is aimed at economic and social regeneration, but its focus is limited to defined areas of selected cities: these are usually the inner zones, although the whole of the London Boroughs of Hackney and Islington are included, and the Newcastle/Gateshead Partnership contains a detached area on the outskirts of the city. The existence of the partnership penalises the deprived areas in the outer city. The overspill housing estates often have the same health and social problems as the inner areas from where their population originated. A map of perinatal mortality in Liverpool shows an area of high values in the centre and a ring with similar values on the periphery. These outer areas are discriminated against: they are ineligible for partnership money, the expenditure of statutory authorities has been diverted towards the inner zone, and local authority disposable income is reduced by its obligation to meet 25 per cent of the revenue costs of partnership schemes.

6. The Partnership: A Wholistic Approach or Another Source of Finance?

The partnerships are a new form of organisation, embodying principles from a series of previous initiatives, designed to achieve collaboration between central and local bodies in their efforts to halt urban decline and relieve the associated social problems. They are a device to ensure vertical co-ordination between the policies of separate central government departments, and between the variety of statutory and voluntary local organisations.

Dean is pessimistic about attempts to break down the institutional barriers between Departments at Whitehall. Writing in the Guardian he comments: 'The rocks on which corporate planning in Whitehall has foundered are large, and old, and jagged' (37). In 1975 the joint approach to social policy was introduced in an attempt to reduce policy contradictions, promote government monitoring, and improve the Cabinet's coordinating function with 'forward looks'

at impending policy decisions (38). JASP has now died, neither its ministerial committee nor its permanent secretary committee has met for over three years. Social policy expenditure accounts for about one quarter of the GNP, of which 40 per cent is spent by the local authorities who relate to the DOE; the annual expenditure of the DHSS is £28 billion, six times the annual turnover of ICI, Britain's biggest industrial concern (39). Yet the expenditure of the DOE and the DHSS is unrelated. Both get Public Expenditure Committee Allocations which they reallocate to smaller geographcal areas according to separate and unrelated formulae. The financial barrier between individual PESC allocations has been bridged in recent years by the joint funding arrangements and the procedure described above for Urban Programme funding of health partnership schemes. However, the health authorities' experiences of the partnership activities is a classic example of the failures in coordination and communication between the two departments. Despite the commitment in the White Paper to give an inner city dimension to the policies of all relevant government departments the DHSS introduced in 1972 a formula for redistributing health resources which explicitly disregards the effects of urban social deprivation and conflicts with the criteria of the inner city partnerships introduced in the same year. Despite the emphasis on vertical communication the DHSS were slow to inform the AHAs of the details of the agreement they had reached with the DOE over the mechanism to be employed to fund health schemes, with the consequent misunderstanding and apprehension described above.

At the local level the Partnership and Joint Consultative Committees have worked best in areas where day-to-day joint working at officer level was already established. In one city the AHA, whose extra resources were consumed by the redevelopment of its teaching complex, were unable to restore a small district hospital. Relationships between officers of the health and local authority were good, and when the Partnership was established it was agreed that the first phase of the restoration

would be funded from the 'construction package', the second from the partnership allocation. However, after the completion of the initial phase, the estimated cost of the remaining work soared from £200,000 to £300,000, and furthermore, it became evident that the intended content of the building (accommodation for undergraduate teaching, nurse education etc) did not accord with the partnership criteria. After local consultation the health authority rearranged its plans so that the restored building would house health education, a VD clinic, contraceptive advice to teenagers etc., and at the Partnership meeting the submission was approved. The final content of the scheme had been decided on the grounds of political expediancy rather than inner area priority, but ironically the Minister chairing the committee commended the health authority for bending their strategy to meet the needs of the inner area residents.

In Gateshead/Newcastle the partnership negotiations were hampered by the long established political revalry between the local councils. Eventually after informal consultation, the DOE chief officers came to an agreement with the two local authority chief executives that the partnership allocation should be divided before the submission of schemes. Newcastle and Gateshead Council were each to receive £2æ million, and the Tyne and Wear County Council £2 million. Gateshead local authority then unilaterally decided to allocate the AHA between £400,000 and £500,000. The Area Medical Officer who represented the AHA on the officers steering group explained that local relationships in the close-knit community south of the Tyne had always been good; furthermore he had been MOH before reorganisation and worked well with his former local authority colleagues. The health authority finally gained partnership approval for schemes totalling £440,000, including £180,000 to rearrange the maternity services, and £70,000 to provide occupational therapy facilities in a psychiatric hospital in rural Northumberland: both submissions which might have been rejected as main programmes schemes. In contrast, within Newcastle, where there was no similar understanding between

local officers, the AHA secured relatively little from the city's share of the allocation.

The Hackney/Islington Partnership decided at the outset to allocate five per cent of the budget to each of the AHA(T)s. Although the first list of schemes submitted by the City and East London Authority was totally inappropriate this did not jeopardise its allocation: the health authority rewrote its submission and received its five per cent. On the other hand in other partnerships where there was no initial carve-up of the allocation the rejetion of unacceptable proposals involved the loss of comparable funds. Arrangements such as these may be an effective means of procuring resources, but they hardly fulfill the partnership ideals of collaboration between central and local organisations and corporate planning between health and local authorities to meet the inter-related needs of inner area residents.

The NHS experience in Inner City Partnerships clearly illustrates the dilemma posed by the existence of separate systems for health and local authority services in Great Britain: how is the government to bridge the gap between the two organisations to ensure coordinated provision for their common clients, and how is it to enforce priorities and redistribute resources at the same time as protecting local democracy?

Postscript.

A major uncertainty facing health authorities during partnership negotiations in 1978/9 concerned the possibility that eventually they might have to accept responsibility for the revenue consequences of schemes funded through partnership monies. At the outset of the second round of negotiations in 1979/80 it emerged that partnership revenue monies could only be guaranteed for three years, and the possibility that health authorities would have to accept extra financial responsibility themselves had become a probability. The effect in one partnership was dramatic. Two health authorities were involved.

In the first year of the partnership one had successfully negotiated health programmes totalling £450,000, in the second round the authority deliberately restricted its proposals to schemes costing only £50,000, and limited to the three year duration of guaranteed funding. The other authority, which had not secured as much in the first round as might have been expected, seemed to be unaware in the second round of the subtlely changing ground rules and negotiated more ambitious programmes likely to be regretted later, given probable restraints in the health budget. The point perhaps illustrates the importance of recognising that public planning systems are complex but have to be managed, and the process of management reveals differential management skills.

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Trends in Maternity Care in England and Wales 1963-77

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SUMMARY

The aim of this essay is to review developments in the maternity care system in England and Wales during the past two decades, with emphasis upon changes in demand, in resources, in the pattern of care, in outcome and in costs. It is shown that the total number of births fell by about one-third and that changes in the pattern of fertility have led to a more viable population of births. Concurrent with this reduction in demand there has been a slow increase in the total resources available to the system and a major shift in the pattern of confinements from home to hospital. The available information about mortality rates is reviewed and several aspects which give cause for concern are discussed. Recent trends in the costs of various parts of the maternity service are considered and anomalous features of current policies are underlined. An alternative to the existing pattern of development of maternity care, which would result in a more effective and a more efficient allocation of resources, is put forward.

1. Introduction

During the past two decades fundamental changes have taken place in the pattern of maternity care in Eng-

land and Wales. Over the same period there as been a steady decline in maternal, perinatal, neonatal and infant mortality. Although it is widely accepted that the outcome of delivery reflects many factors in addition to the circumstances of the current pregnancy, there is a natural tendency to interpret these parallel trends as evidence of a casual relationship. This argument is sometimes extended even further to embrace each separate aspect of change. The purpose of the present essay is to review the way in which the maternity care system in England and Wales has developed over recent years to determine the extent to which the service has taken advantage of the opportunities presented by changing circumstances and conditions.

The evidence to be considered is derived from three main sources. First, is the vital statistics system for England and Wales, which produces complete and reliable information on a very limited basis about each birth, based upon the registration of births, still births and deaths. Second is the system for notifying births to local health authorities, which provides more detailed medical data and is summarised in the annual LHS 27/1 returns to central government. Third are a variety of local and national ad hoc studies designed to investigate particular aspects of the health care system. It is an unfortunate, but perhaps inevitable, feature of maternity care in England and Wales that information is not available on a consistent basis from routine statistical sources about all aspects which are of interest to the student of the system.

The National Health Service (NHS) provides a comprehensive system of medical care in England and Wales which is free at the point of delivery and is used by the great majority of the population. The first stage in the delivery of NHS maternity care is the confirmation of pregnancy, which is normally carried out by the mother's general practitioner (GP). At this stage a decision (which may later be modified) is taken as to whether the patient should be referred to a hospital consultant unit (CU) for assessment and/or continuing care during the pregnancy. The options in terms of ante-natal care

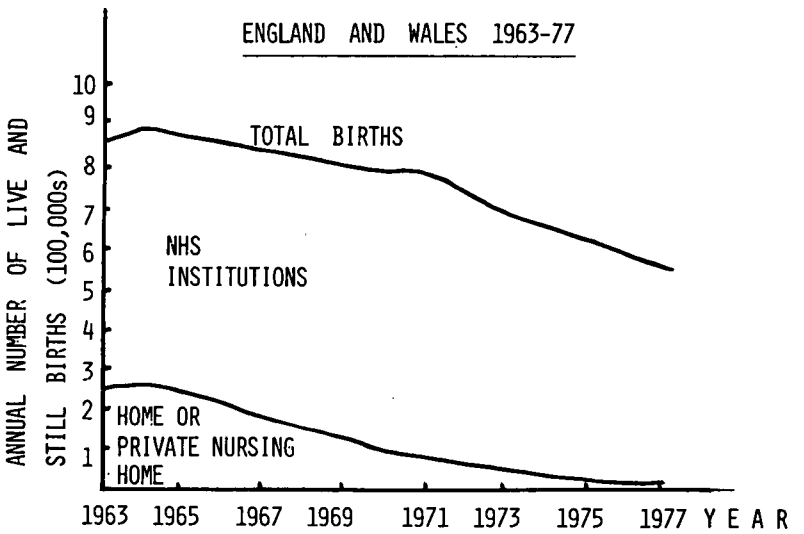
concern the relative roles of the GP and the CU and involve the timing, frequency and nature of ante-natal contacts with the patient. A second main aspect of maternity care is the selection of the place of delivery. An initial booking is normally made soon after the confirmation of pregnancy, but many patients are eventually delivered at places other than the one at which they were originally booked, either as a result of an obstetric emergency or for other reasons. The available place of delivery belong to four main classes: CU's, general practitioner units (GPU's) situated in close proximity to a CU, GPU's remote from any CU, and home. A small minority of mothers (about one per cent) are delivered at private (non-NHS) nursing homes. The physical facilities and levels of skill of the staff vary widely between different places of delivery. Following delivery in hospital, the length of stay reflects pressure on resources and social circumstances as well as purely clinical considerations. Average lengths of post-natal stay are high by international standards, but there are wide variations from hospital to hospital. Pregnant women are also admitted to hospital prior to delivery for care, observation and rest. After discharge from hospital or home delivery, continuing care for mother and child is provided by the domiciliary midwifery service. Thus, the available pattern of maternity care embraces a wide variety of options in terms of ante-natal, delivery and post-natal factors. Clinical responsibility is shared between GP and CU and decisions reflect not only clinical considerations, but also the wishes of the patient and the availability of resources.

2. Demand

In contrast to most other sectors of the health service, the demand for maternity care is well-defined and reliable statistical data are available at least in quantitative terms from the vital statistics system. Recent trends in the numbers of live and still births in England and Wales are summarised in Figure 1. The main feature of these

FIGURE 1

TRENDS IN NUMBERS OF LIVE AND STILL BIRTHS



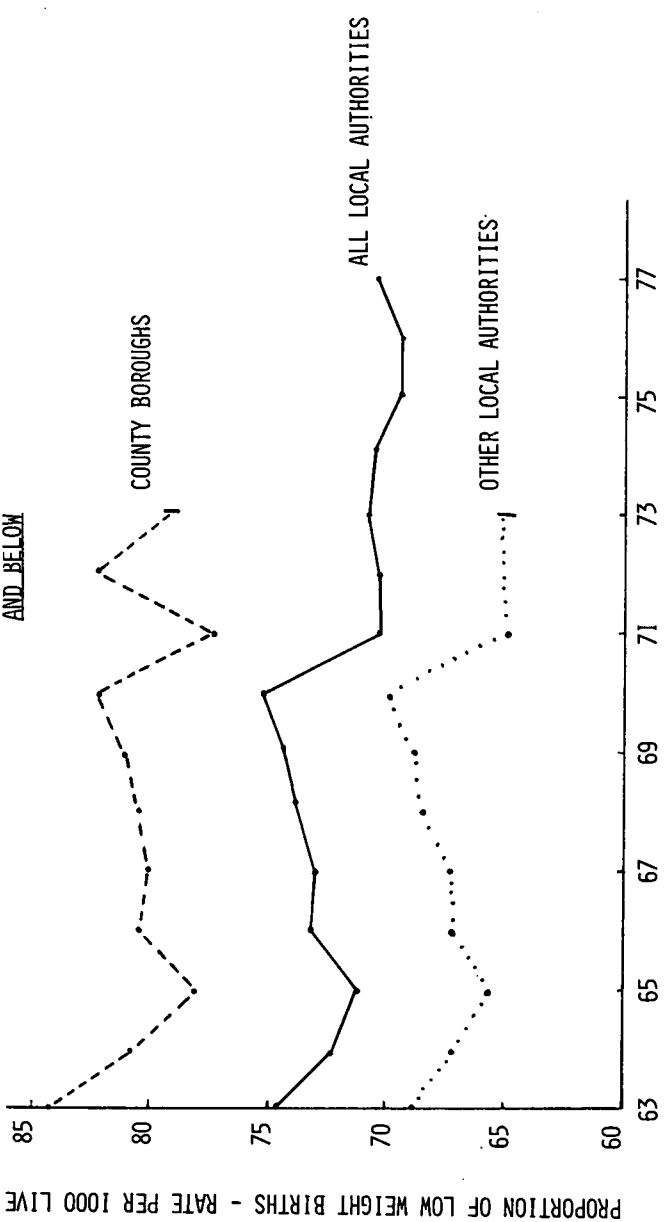
results is the steady decline in the load on the maternity care system. From a peak of 890,000 births in 1964 the numbers have declined steadily year by year and by 1977 had fallen below 600,000. Indeed, the latter year was the first occasion in time of peace since records were first kept in which the number of deaths in England and Wales exceeded the number of births. This fall of more than one-third in total numbers of births over a period of thirteen years represents a major change in the demand for care, which has affected to a greater or lesser extent the operation of the maternity services in all parts of the country.

Detailed statistical information about the population of births in terms of factors such as social class and parity is not available on a regular basis. However, some qualitative indication of the nature of the requirement for maternity care can be obtained in terms of the distribution of birthweight. Figure 2 summarises recent trends in the proportion of low weight (ie. 2,500 g or below) births, both for the country as a whole and for

FIGURE 2

TRENDS IN THE PROPORTION OF LOW WEIGHT BIRTHS - ENGLAND AND WALES

RATE PER 1000 LIVE AND STILL BIRTHS WEIGHING 2500g AND BELOW



county boroughs (more urban) and other local authorities (less urban) separately. The latter subdivision serves to separate in general terms the city dwellers from the remainder of the population and is only applicable up to 1974, when the geographical boundaries for local government were changed to bring together both the urban and the rural parts of the same locality. For the whole population the proportion of low weight births increased steadily from 71 to 75 per 1,000 between 1965 and 1970, fell sharply between 1970 and 1971 to about 70 per 1,000 and has remained at or about that level subsequently. There is a clear distinction between the birthweight distributions in the county boroughs and the other local authorities. For the former the proportion of low weight births has remained at or about 80 per 1,000, whereas for the latter the corresponding result fluctuated between 65 and 70 per 1,000. This analysis suggests that, on average, there has been a reasonable degree of stability as regards factors affecting birthweight. The sharp difference between county boroughs and other local authorities confirms that considerable variation does exist between different geographical areas. In addition to the contrast between urban and rural populations, there are also continuing differences between the north/west and the south/east of the country (Brimblecombe et al, 1968).

Two special studies have been carried out of variations in the characteristics of the population of live births. The more recent of these covered the period between 1970 and 1975 (Ashford, 1978) and the results are summarised in terms of legitimacy, parity and social class in Table 1. Between 1970 and 1975 the proportions of low social class and high parity births fell very sharply but there was a small increase in the proportion of illegitimate births which were registered jointly by the mother and the father. Hellier (1978) has studied the changes in the distribution of maternal age, parity and social class amongst legitimate singleton births between 1950 and 1973. These results also show a decrease in the proportion of low social class and

TABLE I

CHANGES IN THE STRUCTURE OF THE POPULATION OF BIRTHS ENGLAND AND WALES 1970-75

PERCENT OF TOTAL BIRTHS IN YEAR

(A) LEGITIMATE LIVE BIRTHS

PARITY	SOCIAL CLASS			
	I AND II	III	IV AND V	ALL*
0	7.5/10.1	18.4/18.5	7.5/7.3	34.9/37.8
1	6.6/9.3	16.0/16.9	6.5/6.1	30.1/33.8
2	3.2/2.8	7.6/6.0	3.7/2.8	15.0/12.1
3 OR MORE	1.4/1.2	6.0/3.5	3.6/2.3	11.2/7.1
ALL	18.8/23.5	47.9/44.9	21.2/18.5	91.7/90.9

* INCLUDES SOME BIRTHS OF UNKNOWN SOCIAL CLASS

(B) ILLEGITIMATE LIVE BIRTHS

JOINT REGISTRATIONS	OTHERS	TOTAL
3.6/4.4	4.6/4.6	8.2/9.1

NOTE: THE FIRST AND SECOND FIGURES IN EACH CELL REFER RESPECTIVELY TO 1970 AND 1975.

SOURCE: PEARCE AND BRITTON (1977)

high parity births over this more extended period. In terms of maternal age, the 1973 population included a higher proportion of births to young mothers, the rise being particularly marked for the twenty years and below maternal age group. In general these results indicate that there have been substantial changes in the structure, as well as the size, of the population of births in England and Wales.

3. Resources

The resources available for maternity care may be separated into two parts: physical and human. Information about the physical resources is provided by the numbers of hospital beds in (consultant) obstetric units and in general practitioner units. Reference to Figure 3 shows that the numbers of

TABLE 2

CHANGES IN THE STRUCTURE OF THE POPULATION OF BIRTHS

ENGLAND AND WALES 1950-73

PERCENT OF LEGITIMATE SINGLETON BIRTHS IN YEAR

(A) MATERNAL AGE (YEARS)

<20	3.9/8.6
20-24	27.3/33.4
25-29	33.1/37.7
30-34	19.9/13.9
35-39	12.0/5.1
40-49	3.6/1.3
45 OR MORE	0.3/0.1
TOTAL	100.0/100.0

(B) PARITY

0	38.1/40.8
1	31.9/35.8
2	15.5/14.1
3	6.9/5.4
4	3.2/2.1
5+	4.3/1.8
TOTAL	100.0/100.0

(C) SOCIAL CLASS

I AND II	PROFESSIONAL & MANAGEMENT	16.4/24.9
III	SKILLED	56.5/52.7
IV AND V	SEMI-SKILLED AND UNSKILLED	27.1/22.4
TOTAL		100.0/100.0

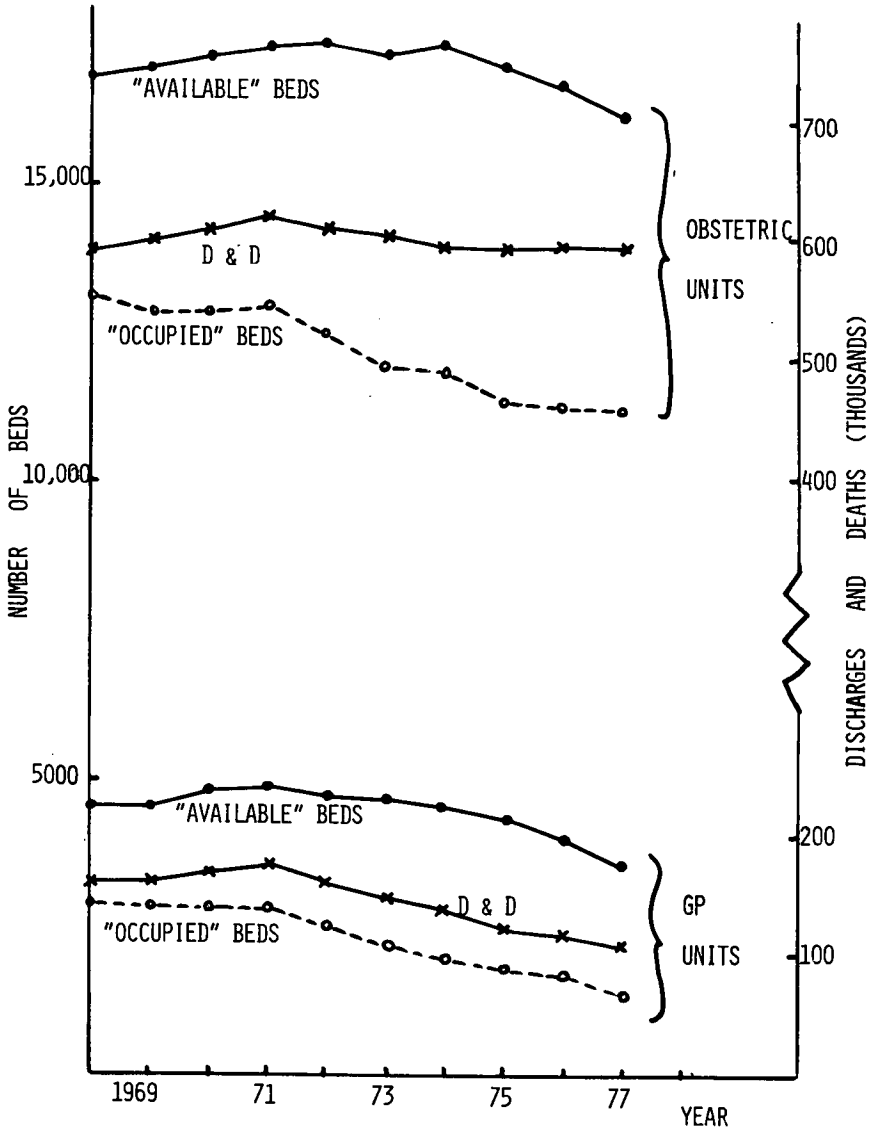
SOURCE: HELLIER (1977)

NOTE: THE FIRST AND SECOND FIGURES IN EACH CELL REFER RESPECTIVELY TO 1950 AND 1973

'available' beds in obstetric units have remained at about 16,000 between 1968 and 1977, whilst the numbers of 'available' beds in general practitioner units have fluctuated between 4,000 and 5,000. In contrast to the sharp decline in the overall demand for care, the numbers of beds of each type have fallen to a very limited extent, and only since 1973-4. The proportion of hospital beds assigned to general practitioners has remained at about thirty per cent of the total throughout the period.

FIGURE 3

TRENDS IN AVAILABILITY OF "MATERNITY" CARE, ENGLAND AND WALES, 1968-77.



Recent trends in the numbers of medical and nursing staff concerned with maternity care are summarised in Figure 4. Between 1966 and 1975 the total number of midwives has remained at a level of about 20,000. Within this group there has been a continuing increase in the numbers of hospital midwives and a continuing decrease in the numbers of community midwives. Reference to Figure 3 shows that the numbers of 'occupied beds' are considerably lower than the numbers of 'available' beds, which underlines the fact that spare capacity exists within hospital maternity departments. It is interesting that the total number of 'occupied' beds in obstetric and GP units is approximately equal to the total number of hospital midwives. The numbers of hospital doctors in the gynaecology and obstetric specialty, who are concerned in part with maternity care, have increased steadily between 1969 and 1976, as have the numbers of hospital paediatricians.

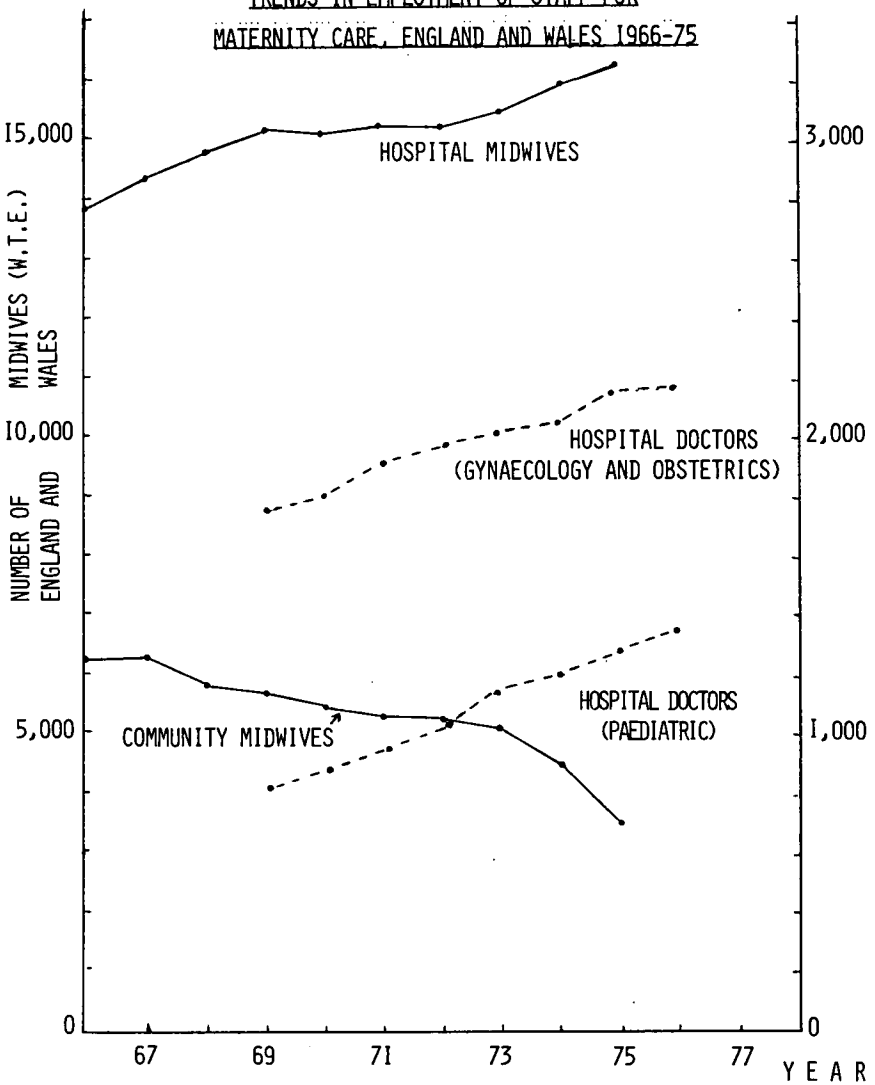
It is unfortunate from the point of view of the study of the maternity care system that no information is generally available about the distribution of hospital maternity beds in terms of size of unit, facilities available, staffing or other hospital specialties sharing the same building. An analysis of the position in 1976 suggests that the majority of consultant obstetric units are situated in multi-specialty hospitals, whereas many of the GP units are located in buildings allocated solely to this purpose or used also for convalescent or geriatric patients. A substantial proportion of GP units are situated several miles from the nearest consultant obstetric unit.

4. Use of Resources

Reference to Figure 1 shows that there has been a major change in the distribution of the place of confinement. The numbers of live and still-births delivered at home or in private nursing homes fell from 270,000 (or 1 in 3) in 1963 to 12,000 (or about 1 in 50) in 1977. Despite this very great reduction in the numbers of domiciliary deliveries, the numbers of births in NHS hospitals had, by 1977,

FIGURE 4

TRENDS IN EMPLOYMENT OF STAFF FOR MATERNITY CARE, ENGLAND AND WALES 1966-75



fallen by about 50,000 from the peak reached in the late 1960's.

When the proportion of home confinements was substantial, a deliberate policy was adopted of selecting 'high-risk' deliveries for hospital care, on the

grounds that the more effective facilities should be reserved as far as possible for the mothers who are more likely to need them. As the proportion of home deliveries has fallen, the emphasis has shifted to the selection of 'low-risk' cases for home delivery. The current position is that, although the home-confinement system has been preserved as a matter of policy, in many parts of the country the mothers who deliver at home have chosen to do so for personal reasons in the face of strong advice in favour of hospital delivery from doctors and midwives. Recent trends are illustrated by Figure 5, which shows the proportion of deliveries at home or in private nursing homes, both for the whole population of births and for low weight births separately. The results up to about 1973 indicate that the selection process for hospital delivery was successful in that the proportion of low-weight (and thus higher risk) births at home or in private nursing homes was considerably lower than that for all birthweights. Since 1974, however, the two sets of figures have converged, which indicates that the selection process is breaking down.

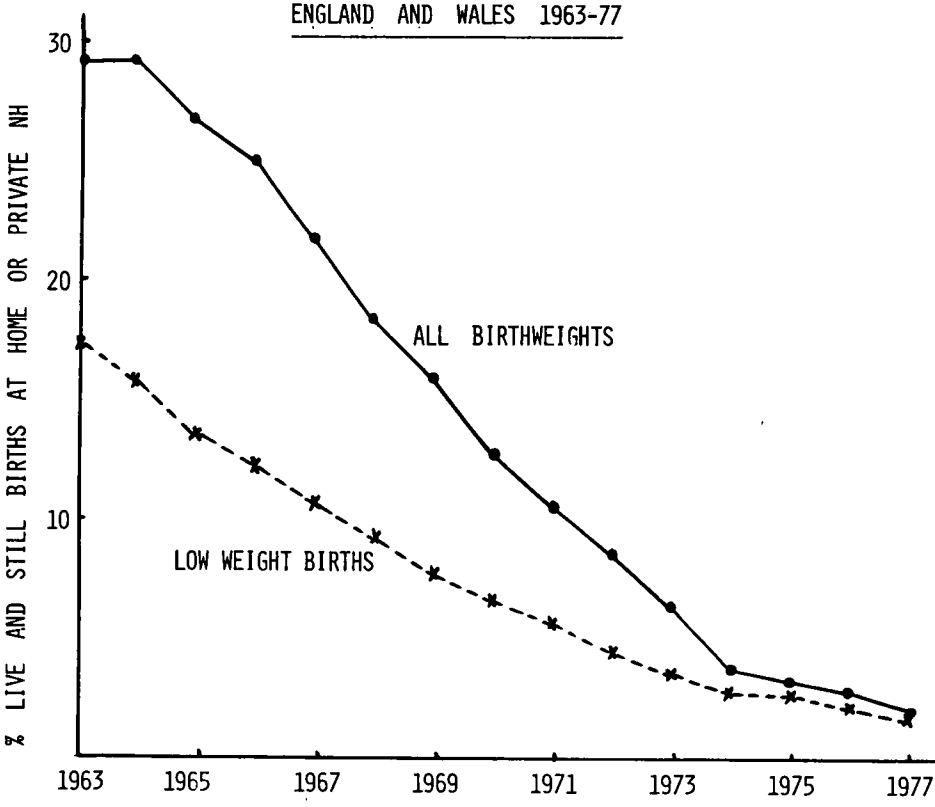
The attitude of the NHS to home confinement (and the proportions of such confinements) has always varied markedly between different parts of the country. Figure 6 shows the distribution of the 98 Area Health Authorities (AHA's) in terms of the proportion of domiciliary confinements during the period 1974-7. This confirms that in the majority of AHA's the proportion of home-deliveries was extremely low, and the maximum was less than one in ten over this period.

The ratio of occupied to available beds provides some indication of the usage of hospital resources. Reference to Figure 3 shows that the occupancy rates in the consultant obstetric units have been of the order of 60-70 per cent. In the GP units the pressure is considerably less, and occupancy rates of below 50 per cent were very common towards the end of the period. Average lengths of post-natal stay in hospital have changed little during recent years, with typical figures of six days for consultant units and four to five days for GP units. The

FIGURE 5

TRENDS IN PLACE OF CONFINEMENT

ENGLAND AND WALES 1963-77

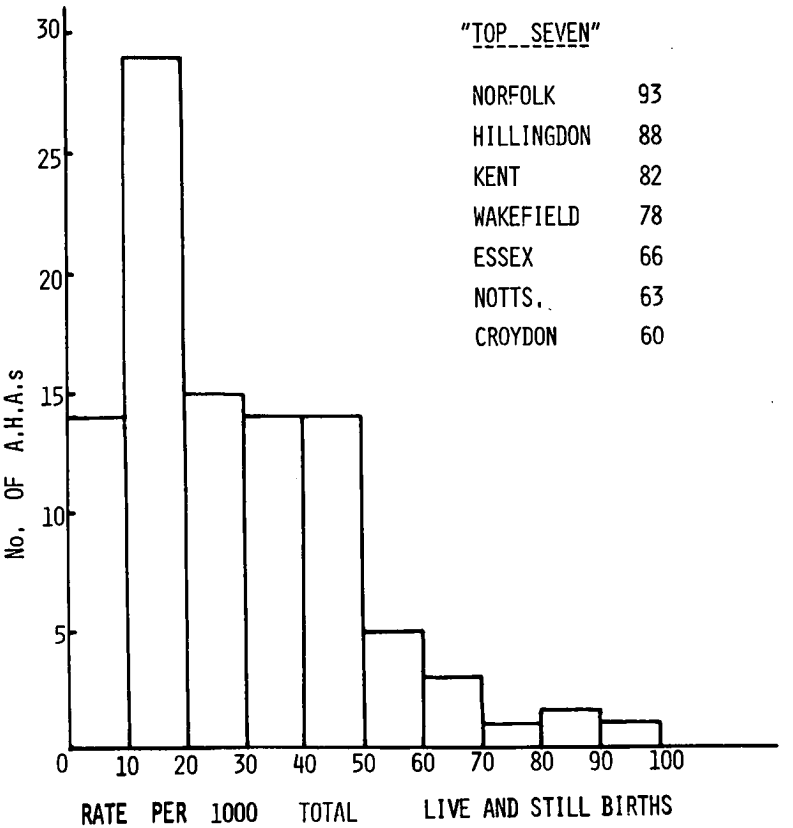


total number of discharges and deaths has remained fairly constant at about 700,000, in relation to a total number of hospital deliveries which has fallen from just over 700,000 in 1968 to less than 600,000 in 1977. The discrepancy is accounted for by an increasing number of pre-natal admissions.

Little quantitative information exists on a general basis about the pattern of ante-natal care and it is therefore necessary to rely on the results of specific local studies such as the one carried out by Ferster and Jenkins (1976) in three districts in the North, the North West and the South West of

FIGURE 6

DISTRIBUTION OF PROPORTION OF DOMICILIARY CONFINEMENTS IN THE A.H.A.s OF ENGLAND AND WALES 1974-77

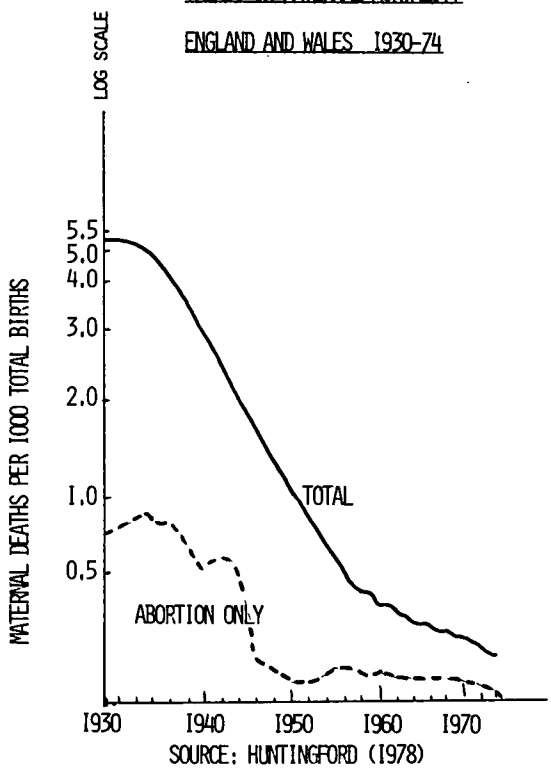


England. In both the North and the South West about half the mothers eventually delivered in the CU had paid their first ante-natal visit to the GP by the seventh week of gestation and virtually all had done so by the sixteenth week. The higher social classes tended to report to their GP for confirmation of pregnancy several weeks earlier than the lower social classes. Marked differences were found in the use made of the CU for ante-natal care. In the

FIGURE 7

TRENDS IN MATERNAL MORTALITY

ENGLAND AND WALES 1930-74

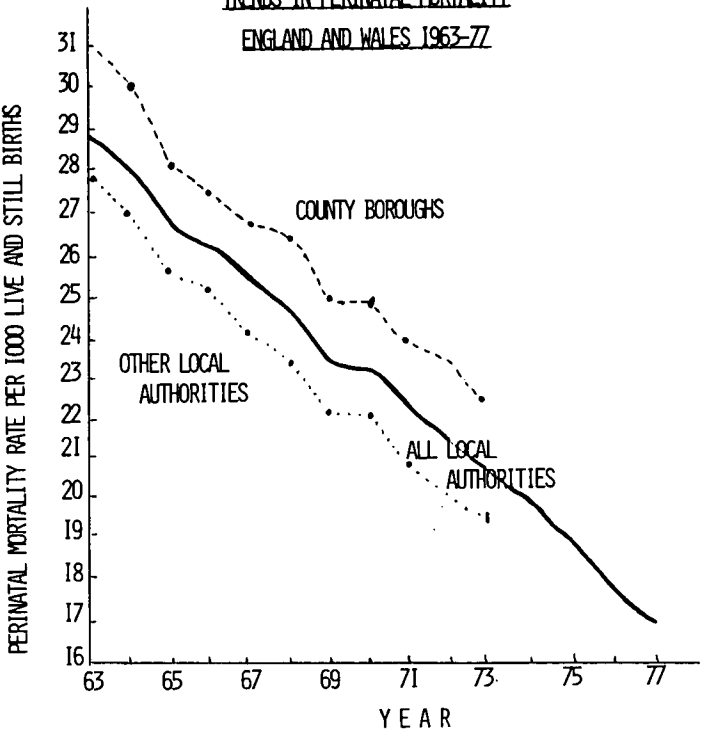


SOURCE: HUNTINGFORD (1978)

Northern district some three-quarters of the mothers delivered at the CU had made at least one visit to the CU prior to the eighteenth week of gestation and nine-tenths made at least one visit before delivery. In the South West the position was very different in that only one-third of the mothers delivered at the CU had made at least one visit for ante-natal care by the eighteenth week of gestation and more than a quarter of these eventually delivered at the CU had no previous antenatal care there. In general, the higher social classes appeared to obtain an above average level of care. The consumption of resources in the CU was measured in terms of intervention at delivery and length of post-natal stay. It was found that patients receiving antenatal care for the first

FIGURE 8

TRENDS IN PERINATAL MORTALITY
ENGLAND AND WALES 1963-77

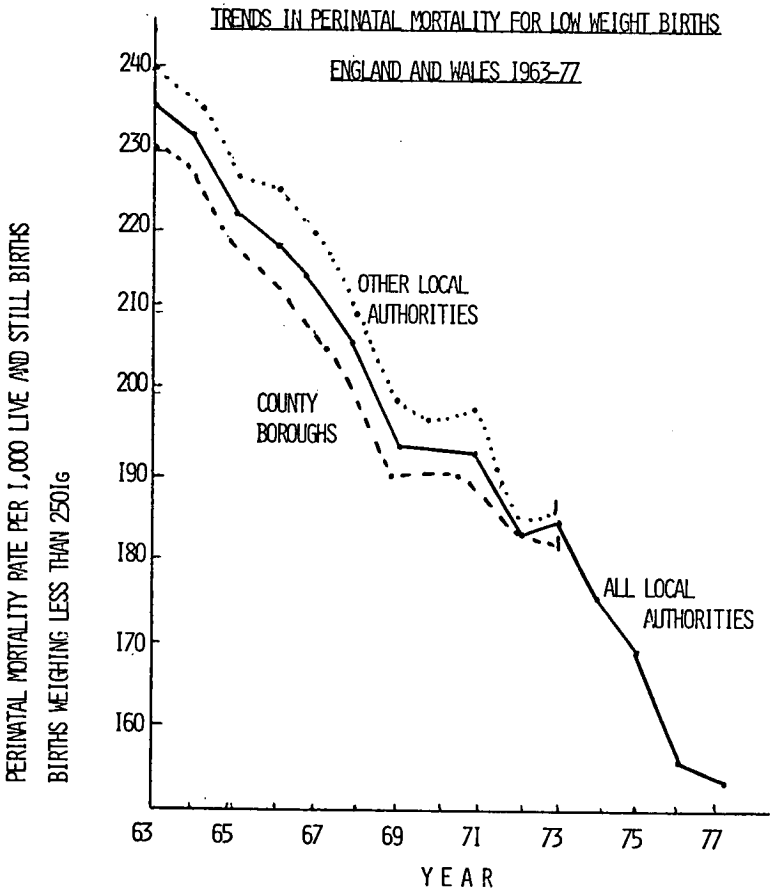


time late in the pregnancy or not at all tended to require more resources than those seen at the CU at an early stage in the pregnancy.

5. Outcome

Mortality rates relating to both mother and child provide the only reliable and generally available indicator of the outcome of maternity care. Maternal mortality rates have been published annually for England and Wales by the Registrar General since 1863. The rate remained almost constant at four to five per 1,000 total births until 1935, but since that time has fallen steadily, the greatest progress being achieved between 1935 and 1955, as indicated in Figure 7. From 1952, 'confidential enquiries' have been conducted into each maternal death and a

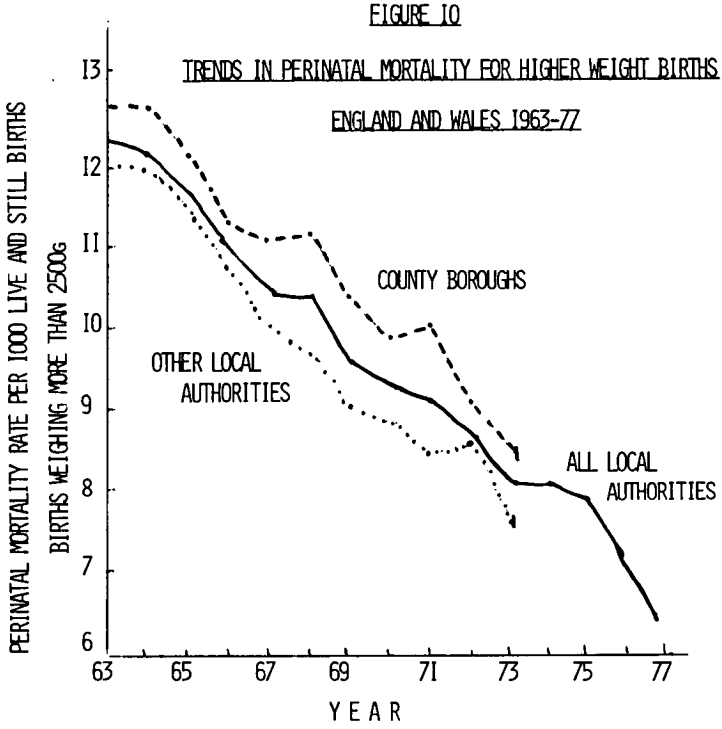
FIGURE 9



very low level of maternal mortality has been achieved. It has been suggested that the main reason for this improvement has been the increasing proportion of hospital confinements, but Huntingford (1978) has pointed out that the largest and most gratifying reductions in maternal mortality were achieved between 1942 and 1945, during a period when doctors, nurses and hospital beds were scarce and working under intense pressure.

Recent changes in perinatal mortality are summarised in Figures 8, 9 and 10 which refer respectively to all birthweights and to low and higher weight

FIGURE 10



births separately. Reference to Figure 8 shows that overall perinatal mortality has fallen steadily as time has passed, from about 29 per 1,000 in 1963 to 17 per 1,000 in 1977. Perinatal mortality in the county boroughs has remained consistently higher than in the other local authorities and the gap of about 3 per 1,000 has not decreased as the years have passed. The results for the low-weight births also show continuing decline, from about 235 per 1,000 in 1963 to below 160 per 1,000 in 1977. In contrast to the results for all birthweights and for the higher weight births (Figure 10), perinatal mortality in the county boroughs was lower than in the other local authorities. Reference to Figure 10 shows that perinatal mortality amongst the higher weight births has also fallen, the figure for 1977 being only about half of that for 1963, in comparison with a reduction of about one-quarter in the perinatal mortality rate for the low-weight births over the same period.

TABLE 3

SECULAR TRENDS IN THE MORTALITY-BIRTHWEIGHT RELATIONSHIP, ENGLAND AND WALES, 1963-65 - 1974-77.
PERINATAL MORTALITY RATE PER 1,000 LIVE AND STILL BIRTHS

MORTALITY GRADE		BIRTHWEIGHT (G)					
		BELOW 1,001	1,001-1,500	1,501-2,000	2,001-2,250	2,251-2,500	BELOW 2,501
1 STILL BIRTHS	63-65	405	366	183	75.2	41.6	129
	74-77	358	274	117	45.0	23.6	86.1
	% CHANGE	-11	-25	-36	-40	-43	-33
2 DEATH WITHIN 24 HRS	63-65	387	195	72.4	27.2	13.1	67.5
	74-77	359	149	47.9	17.3	8.1	48.5
	% CHANGE	-7	-24	-34	-36	-38	-28
3 DEATH BETWEEN 24 HRS & 7 DAYS	63-65	103	94.6	49.3	21.8	11.2	34.1
	74-77	108	82.4	33.6	13.6	6.6	25.4
	% CHANGE	+5	-13	-32	-38	-41	-26
4 DEATH BETWEEN 8 AND 28 DAYS (LATE NEONATAL)	63-65	13.3	16.5	7.7	6.1	4.3	7.0
	74-77	25.8	20.1	8.8	5.1	3.4	7.5
	% CHANGE	+94	+22	+14	-16	-21	+7
1 + 2	63-65	792	561	255	102	54.7	196
	74-77	717	423	165	62.3	31.7	135
	% CHANGE	-11	-25	-35	-39	-42	-31
1 + 2 + 3 (PERINATAL MORTALITY)	63-65	896	656	304	124	65.8	231
	74-77	825	505	199	75.9	38.3	160
	% CHANGE	-8	-23	-35	-39	-42	-31

Table 3 shows the changes in various mortality rates amongst the low-weight births between the two three-year periods 1963-5 and 1974-7. Taking all birthweights below 2,501 g together, the still-birth rate, the mortality rate between 0 and 24 hours of birth and the mortality rate between 24 hours and 7 days of birth have all fallen by between one-quarter and one-third, whereas the late neonatal mortality rates has actually risen by 7 per cent. The greatest progress has been made in the upper part of the low birthweight range, but even in the below 1,001 g group perinatal mortality has been reduced by 11 per cent. The increases in mortality between 8 and 28 days in the below 2,001 g birthweight groups indicate that there has been a tendency for death to be deferred. All these improvements in mortality in the low birthweight groups are substantially smaller than the reduction of about 50 per cent in perinatal mortality for birthweights of more than 2,501 g.

In addition to the overall mortality rates, the extent of the variation between different geographical areas is also of interest. A study has therefore been made of the variation in perinatal mortality between the 11 standard regions of England and Wales employed by the Registrar General prior to 1965. The results obtained are summarised in Figure 11, which shows the trends in the coefficient of variation for all birthweights and for low and higher weight births separately. The coefficient of variation for all birthweights has remained at about 10 per cent for the whole of the period between 1963 and 1977. In other words, as perinatal mortality has fallen, there has been no reduction in the proportionate variation between regions. Throughout the whole period, perinatal mortality has remained highest in the north and the west of the country and lowest in the south and east, the relative position in 1974-7 (Ashford, 1980) being characteristic of the earlier years. The results for the separate birthweight groups also show no evidence of a decline in variability as time has passed. It is interesting that the coefficient of variation of the mortality rates for the higher weight births is consistently higher than that for the low-weight

births. A similar pattern is revealed when the data are considered at a lower level of aggregation on the basis of local authority (rather than regional) populations.

Figure 12 shows the trends in perinatal mortality for the low-weight births in terms of place of confinement. Until 1970, mortality amongst the domiciliary births was substantially lower than that amongst the hospital births, a result which is consistent with the selection of 'high-risk' cases for hospital delivery. Since 1970, however, mortality amongst the domiciliary births has increased steadily and from 1974 onwards has exceeded that amongst the hospital births. This suggests that the selection procedure has broken down at the very low levels of domiciliary confinement which have prevailed in the recent past.

It is an unfortunate feature of the statistical data on mortality which is generally available that no distinction is made between CU's and central or remote GPU's. Information about the risk associated with the various places of confinement can only be obtained as a result of special studies. Table 4 summarises the results of one such study carried out in three geographical areas in 1970 (Ferster and Pethybridge, 1974), which shows a very consistent pattern. The highest perinatal mortality rates are found in the CU's, reflecting the adverse case-mix. The rates for the central GPU's and the home deliveries in each district are in close agreement. However, mortality in the rural GPU's is higher than in the corresponding central GPU, the difference in the south-west being statistically significant. In this particular study, each delivery was classified according to whether or not intervention took place, the term covering a wide variety of procedures from surgical or medical induction to emergency Caesarean operations. As might be expected on general grounds, the percentage of CU intervention is highest in the districts with the lowest proportion of CU deliveries and vice versa.

On the basis of the changes in the structure of the population of births summarised in Tables 1 and 2, estimates have been made of the corresponding

FIGURE 11

TRENDS IN THE SPREAD OF PERINATAL MORTALITY RATES BETWEEN STANDARD REGIONS OF ENGLAND AND WALES

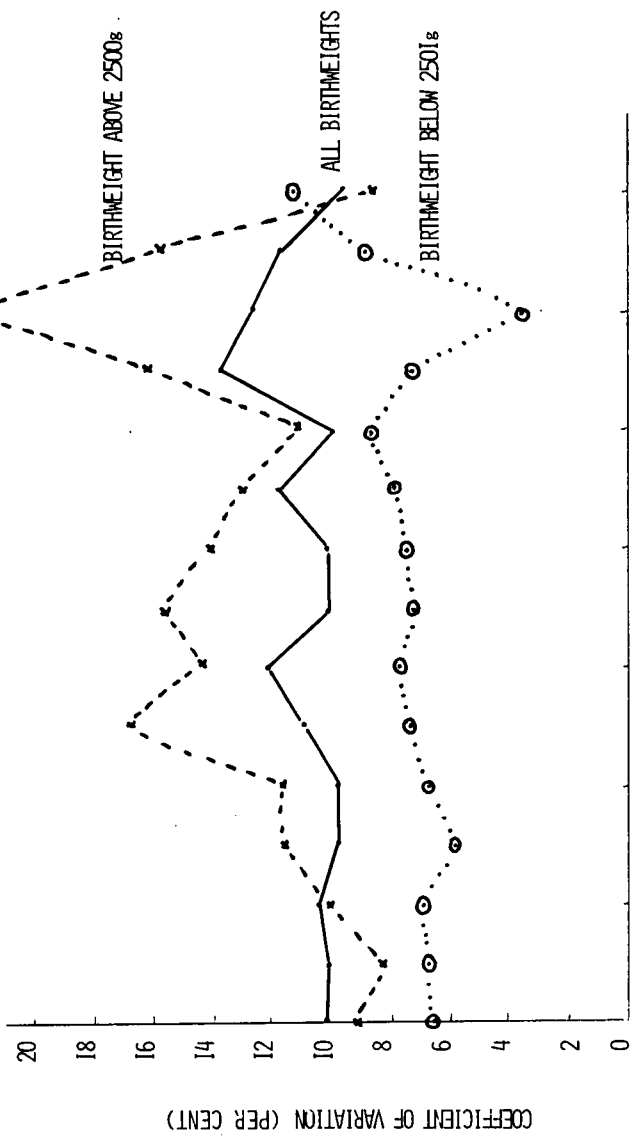


TABLE 4

THE OUTCOME OF MATERNITY CARE IN THREE AREAS OF ENGLAND, 1970

PLACE OF CONFINEMENT	SOUTH WEST			EAST MIDLANDS			NORTH WEST		
	DELIVERIES		P.M.*	DELIVERIES		P.M.*	DELIVERIES		P.M
	NO.	PER CENT		NO.	PER CENT		NO.	PER CENT	
CU CITY	1501	41	48.6	1655	51	36.7	2642	78	35.
GPU1 CITY	911		3.3	514		3.9	395	11	10.
GPU2 RURAL	98		10.2	193	22	5.2	-	-	-
GPU3 RURAL	356	46	11.2	-	-	-	-	-	-
GPU4 RURAL	270		14.7	-	-	-	-	-	-
GPU5 RURAL	90		11.1	-	-	-	-	-	-
DOMICILIARY CITY	211	13	4.7	279	27	3.6	345	10	8.
DOMICILIARY COUNTY	254		0	617		†	-	-	-

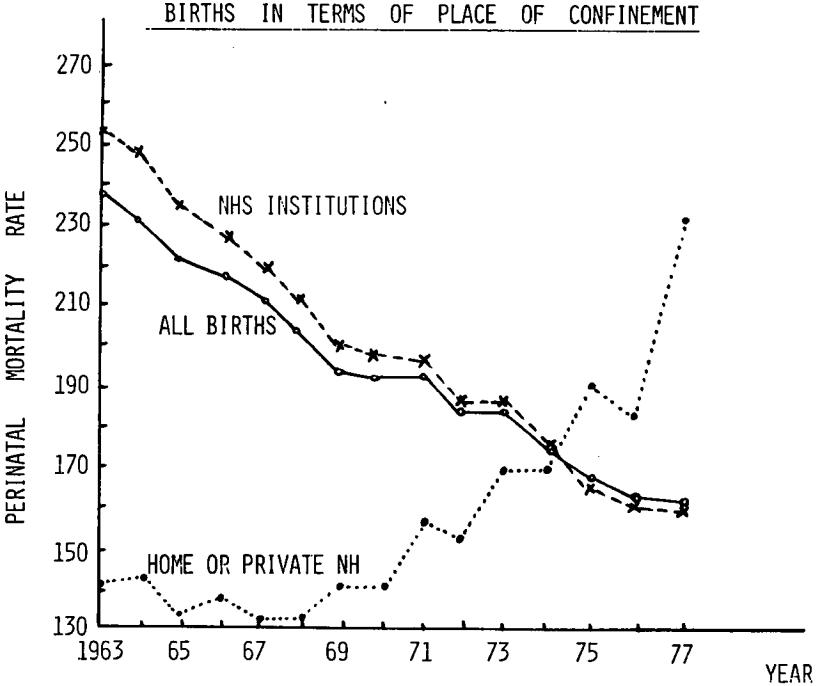
* PERINATAL MORTALITY: RATE PER 1,000 LIVE AND STILL BIRTHS.

† UNKNOWN

regimes during the ante-natal, delivery and post-natal periods is not generally available. However, estimates of the cost to the NHS of maternity care from the confirmation of pregnancy to six weeks after delivery have been made by Ferster and Pethybridge (1973) and the results for three districts in 1970 are summarised in Table 5. A consistent feature of these data is that domiciliary deliveries were comparable in expense to the cheapest of the hospitals in each area and cost very much less than the most expensive. In each case, there was considerable surplus capacity in the domiciliary service as a result of the fact that the numbers of such deliveries had been run down faster than the available staff. If the staffing levels had been in balance with the work-load, the overall

FIGURE 12

TRENDS IN PERINATAL MORTALITY FOR LOW WEIGHT BIRTHS IN TERMS OF PLACE OF CONFINEMENT



effect on perinatal mortality rates. Thus, Ashford (1978) has suggested that about one-third of the reduction in perinatal mortality in England and Wales between 1970 and 1975 may be attributed to this cause. In respect of legitimate singleton births, Hellier (1977) has suggested a figure of about one-quarter for the period between 1950 and 1973. Both estimates are based upon the assumption that relative differences in perinatal mortality in terms of social class, parity, maternal age and legitimacy have remained unchanged.

6. Costs

Within the NHS, quantitative information about the costs or resource implications of alternative

TABLE 5

THE COST OF MATERNITY CARE IN THREE AREAS OF ENGLAND, 1970.

PLACE OF CONFINEMENT	INTERVENTION	SOUTH WEST	EAST MIDLANDS	NORTH WEST
CU	NO	83	98	114
	YES	115	127	154
CITY GPU	NO	88	125	133
	YES	95	146	130
RURAL GPU's	NO	103-127	174	-
	YES	112-152	192	-
DOMICILIARY	NO	70-99	77	80

TOTAL COST* TO NHS (£)

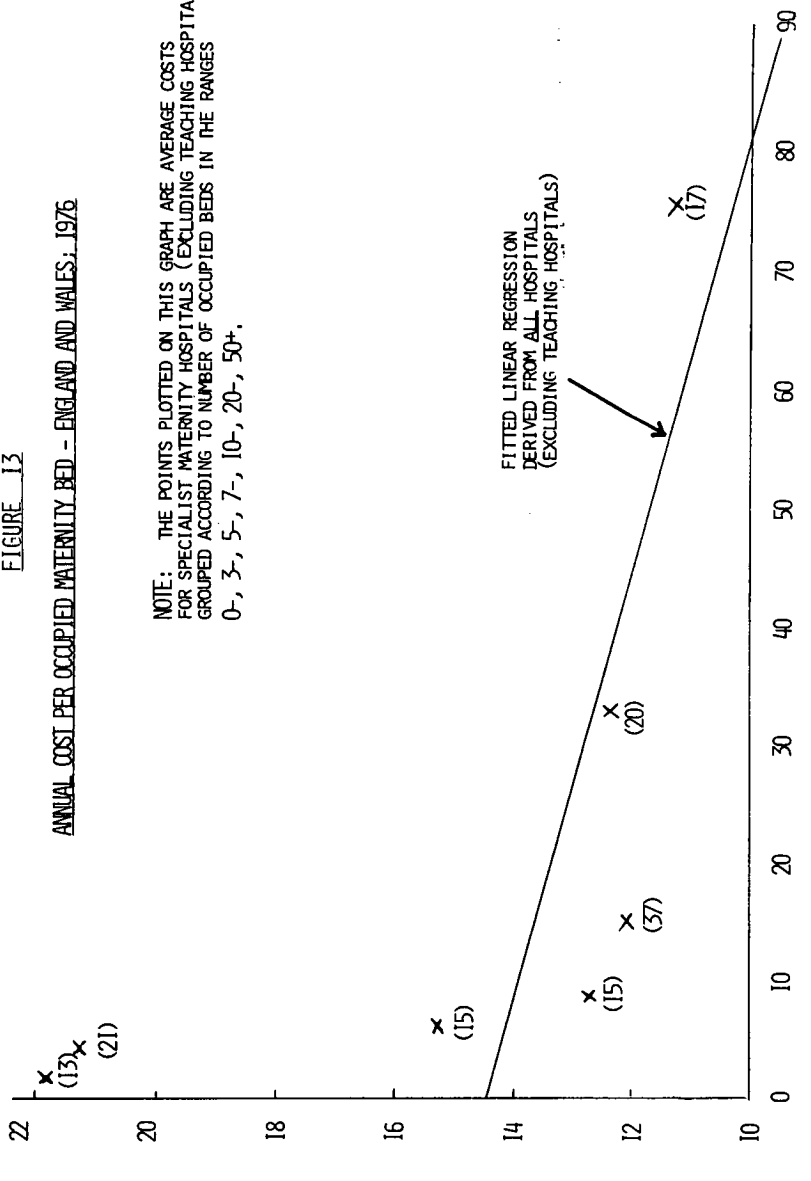
*THESE COSTS INCLUDE HOSPITAL, LOCAL AUTHORITY AND GP COSTS BETWEEN THE CONFIRMATION OF PREGNANCY AND THE END OF THE 6TH WEEK AFTER DELIVERY, BUT EXCLUDE MATERNITY BENEFITS AND GRANTS PAID DIRECT TO THE MOTHER.

costs of home delivery would have been considerably lower. A further and somewhat surprising observation is that cost per delivery in the GPU's, and particularly the rural GPU's, was up to twice as high as in the corresponding CU's. This underlines the paradox that the less intensive form of institutional care was substantially more expensive per delivery.

Various studies have been carried out of alternative policies for the provision of maternity care in particular local situations, using some of the techniques of operational research (Ashford, Ferster and Pethybridge, 1973; Ashford and Hunt, 1975). These

FIGURE 13

ANNUAL COST PER OCCUPIED MATERNITY BED - ENGLAND AND WALES: 1976



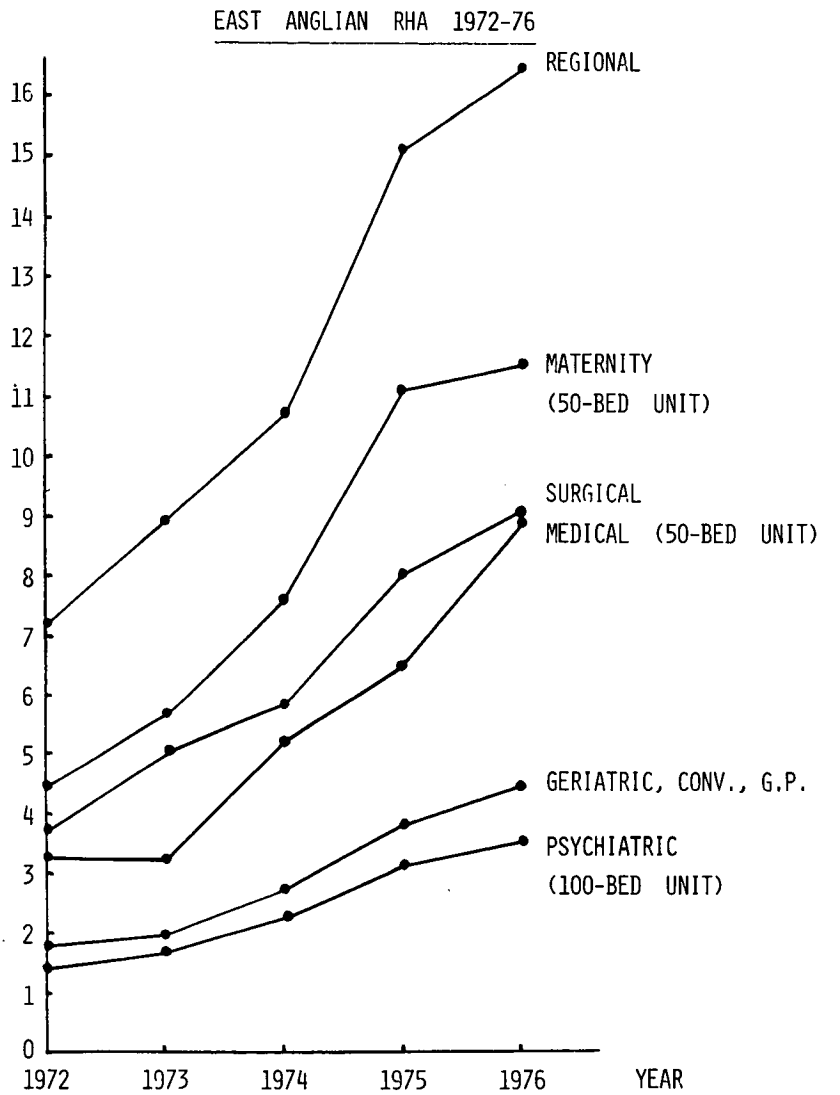
exercises point conclusively to the fact that given the birth rate prevailing in 1970, reductions in the cost of a local maternity service of up to 25 per cent can be achieved by closing the small GPU's and by either expanding the numbers of domiciliary deliveries or the number of CU deliveries, without increasing levels of mortality. With the reductions in birth rate which have taken place since that time, the excess capacity within the maternity services is now substantially greater and the range of feasible and more cost-effective policies even wider.

More recent information about the cost of hospital deliveries, derived from the Hospital Cost Returns for 1976, is summarised in Figure 13. On the basis of the costs and activities in some 2,300 non-teaching hospitals in England and Wales, statistical methods were used to determine from the total hospital inpatient cost and a record of activity in various specialties the costs associated with particular groups of specialties (including maternity) (Ashford and Butts, 1979). For maternity specialties, the analysis was carried out on the basis of costs per 'occupied' bed (by 1976 many of the 'available' maternity beds were out of commission (see Figure 3)). Reference to Figure 13 shows that the estimated cost per occupied bed increases as the number of maternity beds in the hospital decreases. In other words, the unit cost of the larger, more specialised units is less than that of the smaller units. Figure 13 also shows the average costs per 'occupied' bed in the group of some 138 hospitals which contain maternity specialties only, and which therefore permit the direct calculation of the cost per bed. These data reinforce and amplify the results of the analysis covering all hospitals. In particular, they indicate that the unit cost in the specialist maternity hospitals with less than five 'occupied' beds is more than twice as high as in the large maternity units. The former are all GPU's and the majority are remote from a CU.

No quantitative information is generally available about trends in the funding of particular sectors of the NHS, such as the maternity services. However, an

FIGURE 14

TRENDS IN COSTS PER BED IN MAIN SPECIALTY GROUPS



analysis of hospital costs in one region, the East Anglian Regional Health Authority, year by year between 1972 and 1976 gives an indication of the extent of the recent growth in unit costs in

different parts of the hospital service. Reference to Figure 14 shows how the unit costs of maternity care have increased in relation to other main groups of specialties. It is interesting that with the exception of the regional specialties (eg. neurosurgery), maternity has been the most expensive of the specialty groups, costing appreciably more than the surgical and medical specialty groups. Even when account is taken of the slight reduction in the numbers of maternity beds (see Figure 3), the proportion of hospital costs accounted for by maternity care has changed very little during recent years.

7. Comment

There can be no doubt that 1963-76 has been a period of major change in all aspects of maternity care in England and Wales. The dominant feature is the continuous decline in demand. Not only has the total number of births fallen by one-third, but also changes in patterns of fertility have led to a more viable population of births. Concurrent with this decrease in the load upon the system, there has been a slow but steady increase in the total resources assigned to maternity care. This growth in expenditure is very much in line with that in other sectors of the NHS, to which an increasing proportion of a slowly growing gross national product has been assigned. Indeed, whatever the intention, the allocation of resources within the NHS has been a process of 'disjointed incrementalism', by which next year's budget for a particular service is determined by current expenditure and by little else.

The second major change is the de facto elimination of home deliveries. Although this option has been preserved formally as a matter of public policy, the numbers of home deliveries have been reduced to insignificant levels in most parts of the country. The hospitals have accommodated all the deliveries transferred from the domiciliary service and since the late 1960's the numbers of hospital confinements have declined year by year. The present position is one of over-capacity of hospital resources, particularly bearing in mind the prevail-

ing relatively long period of post-natal stay. The over-provision of hospital beds is particularly marked in the GP hospitals, where occupancy rates of below 50 per cent have become commonplace. As far as expenditure is concerned, the somewhat bizarre position has been reached in which the unit cost of maternity care in what are inevitably ill-equipped small GP hospitals is more than twice as great as in the larger specialist units and this position has now persisted for several years.

As measured by the continuing fall in perinatal and neonatal mortality, the general performance of the maternity services may be said to have shown steady improvement. However, part of the reduction in mortality rates is undoubtedly associated with changes in the structure of the population of births and improvements in educational standards, nutrition and economic well-being will also have made some contribution. The real question to be answered is whether that part of the improvement which can be attributed to better maternity care justifies the additional resources per confinement that have been allocated to the maternity services. In the present state of knowledge, this question is probably unanswerable, but it is not without significance that notwithstanding the existence of a free and universal health care system, England and Wales have fallen steadily behind other similar countries in recent international 'league tables' of perinatal mortality.

Several aspects of the data concerning mortality give cause for concern. First, the relative variability of perinatal mortality rates between different population groups has not diminished as the years have passed. Populations with a poor record in the early 1960's for the most part still have a poor record in the late 1970's and vice versa. The gap between the more urban and more rural areas, between the north-west and the south-east of the country and between the social classes has not declined. The extent to which the health care system is capable of ameliorating educational, economic and environmental disadvantage is not clear, but on the evidence available it appears that the balance between the

two factors has remained unchanged despite the major developments which have taken place in the maternity services.

The existence of consistently lower perinatal mortality rates amongst the low-weight births in the county boroughs than in the other local authorities runs counter to the inherent socio-economic disadvantages associated with city life. The most plausible explanation is that the more accessible and better-equipped maternity services which are available in urban areas are effective in this part of the range of birthweights. It is likely that changes in the nature and organisation of maternity care in more rural areas are capable of extending the same advantages to the populations concerned which, all other factors being equal, would be expected to have a better mortality experience in all birthweight groups.

The country districts have the further disadvantage of being served, at least in part, by remote GP hospitals. On general grounds, and on the somewhat sparse empirical data currently available, such hospitals are more dangerous to mother and child than GP hospitals situated close to CU's or than the CU's themselves. There is also some evidence that, at the current low level of activity, domiciliary deliveries carry a level of risk which is unnecessarily high and certainly higher than that which has prevailed in the recent past. For both remote GPU's and home confinements, existing and past policies have led to a service which is less effective and less efficient than need be the case. Recent trends have tended to emphasise the role of the CU in the hospital and the extra resources which have become available in maternity care have been used to develop a high technology, interventionist approach to hospital medicine (Huntingford, 1978). Whilst in particular cases there is no doubt that great benefits have been gained by these changes, the advantages to the great majority of mothers who enjoy normal, uncomplicated deliveries are now being seriously questioned (Kitzinger, 1978). Given the current low levels of mortality, consumer interests are right to question the ritualism implicit in

modern hospital obstetrics (Lomas, 1978) and to demand that greater attention should be given to the happiness, well-being and satisfaction of mother and child in what is one of the major landmarks of human life.

With the benefit of hindsight, it is easy to underline the deficiencies and shortcomings of the NHS maternity system, but in fairness it must be pointed out that this is a British institution which occupies a position in public regard second only to that of the Royal Family. The fact that no positive response to changing circumstances was forthcoming for many years was due in part to misplaced faith in expert demographic advice which has consistently and confidently predicted a revival in the number of births, despite the weight of empirical evidence to the contrary. Given the excess capacity which now exists and the chronic financial difficulties of the NHS as a whole, a review of the maternity services is overdue. The shape of any new system must involve a compromise between two conflicting interests. In the first place, deliveries involving a significant element of risk to mother or child must take place in a well-staffed and well-equipped hospital, which implies in a consultant unit dealing with a reasonably large volume of traffic. Secondly, some choice should be offered to the great majority of mothers whose confinement is likely to be without complication. Given that absolute certainty about the course and outcome of a pregnancy can never be attained, the possibility of misallocation in a system which does not require all births to take place in a large hospital must be acknowledged but reduced to as low a level as can be obtained. On this basis, it would seem reasonable to expand the domiciliary system to cover a substantial proportion of births (say, one-third), the remainder of the confinements taking place in CU's of a sufficient size. Existing human resources are still adequate to meet the requirement and, bearing in mind the current length of post-natal stay in hospital, spare capacity exists within the system to accommodate any likely increase in the number of births. Change along these lines would release resources amounting

to about one-quarter of the total assigned to maternity care and these could be redeployed to fill obvious gaps, including the improvement of access to services by the poor, the ill-educated and those living in isolated communities.

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The Health Service and Local Government Services

Can they work together
to meet the needs of the elderly
and of other disadvantaged groups?
Why is collaboration a problem?

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The Health Service and Local Government Services

Can they work together to meet the needs of the elderly and of other disadvantaged groups? Why is collaboration a problem?

Under what conditions can public services work together successfully to assess the needs of disadvantaged groups and to supply the help they require from the community in the most effective way? As a step towards answering this question, the authors undertook a study of the state of collaboration in four local authority areas and, subsequently, examined the conditions under which certain collaborative projects involving innovation for the benefit of the elderly had arisen and been at least partly implemented in seven different localities. We were concerned not only with review of achievement until 1979 but also with the prospects for the future. By abolishing area health authorities (AHAs), and replacing them with new bodies which, in many areas, will not share boundaries with local authorities, the government is creating a new set of problems(1). If collaboration is necessary, new difficulties are being created. On what principles should future relationships be sought? Before painting the background of the problem, examining the evidence and stating our conclusions on what basis collaboration might successfully be achieved, we must seek to answer the question of why collaboration should be presented as a major problem.

The need for collaboration arises from the dependence of health on the physical and social environ-

ment. This is the case whether we are looking at the condition of the community as a whole or at the individual case. McKeown has summarised the evidence that 'health is determined essentially by behavioural and environmental influences and that the scope for effective medical intervention is limited'(2). There is a health infrastructure which has been developed and maintained by services which are independent of the medical professions. The boards of health, sanitary authorities and school boards, perhaps the main benefactors of health in the nineteenth century, were amalgamated with other public services in local authorities which, in the twentieth century, have been endowed with a fairly comprehensive responsibility for this health infrastructure, employing a wide range of professionals to provide the relevant basic services and controls. The medical profession, through their main local government officers, the medical officers of health, can take credit from the fact that they were intimately involved in the motivation and execution of this work.

The integration of the system for the maintenance of the health infrastructure was lost in 1974. Water services were transferred to ad hoc authorities with only a tenuous connection with local authorities and even less with the health authorities. The medical officer of health disappeared and the new arrangements deprived his successor, the district community physician in the health service, or the medical officer of environmental health, of effective influence in local authority matters. We know of no clear evidence to show that this has so far led to a fall in the effectiveness of preventive action. If, as McKeown argues elsewhere, it seems essential to have a medical contribution in matters of environmental provision and inevitable that there will be serious omission so long as there is no organisation local as well as central with a more comprehensive responibility for health 'surveillance'(3) then it seems necessary to ensure that the gap is filled as far as possible by collaboration that goes beyond the shady and often forgotten role of 'medical officer of environmental health' in the district local authorities.

When we look at the individual case, the issue is much more obvious. We are here concerned not so much with prevention as with caring and rehabilitation. People who become dependent on the community for care often do so through failures in health; or their failure in health can happen though lack of care. The influences can be cyclic, leading to a downward spiral in health and social condition. Health care implies social care: social care merges into health care. The proportion of such cases rises sharply in old age and the problem is therefore becoming quickly more formidable as the numbers of very elderly increase. We have taken the elderly as a salient example of groups of disadvantaged where collaboration is imperative. While the population as a whole is expected to drop by some 200,000, the number of over 75s is expected to increase by some 700,000 (from two and a half million), while the over 85s are expected to increase by 217,000 (from a half million)(4), (Population Projections 1977-2017, Census of Population Reports, OPCS). A change of a few percentage points in those needing services will involve an increase in provision in health and social services of perhaps double or even treble the present level. On average an over 75 year old costs the health and personal social services seven times as much as one of working age(5).

Health conditions or disabilities create social isolation. About nine per cent of 75-79 year olds, according to one recent survey, are housebound permanently or temporarily, while the figure rises to about 24 per cent for the over 85s(6). Social isolation compounds the problems of disability. Over a third of the over 75s in Hunt's survey were living alone, while over 47 per cent were found to be living alone in another study(7).

If individual cases could be neatly classified as primarily health or primarily social care and housing problems, many of the problems of collaboration would vanish. But in fact conditions are complex: categories overlap broadly and there are wide 'grey areas' where care may be either by nursing auxiliaries or by domestic workers in the home or in long-stay geriatric hospital wards,

social services residential accommodation or special housing for the handicapped.

Again, if there were an ample supply of accommodation and other resources there might be no competition for places and problems arising from scarcity of resources, although there would still be a high need for collaboration in determining the most appropriate form of care and in the betterment of existing modes of care. But there is an acute shortage of accommodation on both sides. In the geriatric field, in social services provided residential care and in special housing for the elderly, supply has never kept up with demand, and expenditure constraints since 1974, with acceleration in numbers requiring special care, have progressively increased the scarcity.

Cases, as we have said, do not fall into neat categories. There are wide overlaps between the three modes of residential care we have mentioned in the types of residents for which they care. In any event, conditions of residents are not stable; it is desirable to re-locate patients who need a lesser degree of care than that provided in their institution through rehabilitation and, of course, those whose disabilities go beyond the purposes of their institution. There is a need for co-ordinated movements between modes of care.

Above all, there is a generally accepted need to enable residents to return to life in the open community when they are fit, providing such domiciliary support as may be necessary. Possible combinations of forms of domiciliary care are numerous, involving support by home nurses and nursing auxiliaries, home helps, housing wardens and voluntary workers as well as general practitioners and social workers. Such facilities as day hospitals, day centres, luncheon clubs and meals-on-wheels become relevant. At many points there is an overlap of interest.

It is possible to identify a number of levels at which such overlaps of interest are challenging to the authorities concerned:

1. Forward planning and capital investment. Accommodation, social and health needs are intertwined.

All authorities involved should be deeply concerned with appreciation of the degree of need and in making optimal choices for their investments. Without joint appreciation of the expenditure that will give the best return in human welfare, choice will be badly informed.
2. Forward planning and manpower budgeting. Similar arguments apply to investments in the recruitment and training of staff.
3. Use of current resources. The optimal use of existing premises and staff requires a similar joint appreciation.
4. Referrals and placement in residential accommodation; decisions on the nature of the domiciliary support required. If needs are complex, joint assessment arrangements may be necessary.
5. Joint casework. The optimum means of collaboration to assist particular cases needs to be devised jointly.
6. Innovation. The traditional roles in care may not be adapted to the most effective and efficient fulfilment of the needs of clients and patients. Development of the roles of institutions and of workers is necessary to adapt optimally to current concepts of need. Services are ill-adapted to do this in isolation: inter-service studies are essential in the perception of new needs, in devising optimal means of provision and not least in implementation.

The identification of inter-service collaboration between services as a major problem area arose in a series of seminars of practitioners and academics from various professional and disciplinary backgrounds arranged by the Nuffield Provincial Hospitals Trust. Its problematic nature was confirmed in exploratory fieldwork which we undertook as the first stage of our research. The high level of co-operation we received from officers in the various services was motivated by the feeling of dissatisfaction about achievement in this field which most of them expressed. Before we give the findings from this work, it may be helpful to readers unfamiliar with some of the historical background if we briefly

describe how the present relationships arose. It may also be helpful to describe briefly the character of the organisation of the two main services, since we found from interviews with senior officials in 1977-8 that there was a mutual lack of understanding of each others' organisational structures and systems which itself appeared to be a constraint on forming effective relationships.

The origins of the current situation

The Local Government Act 1972 provided for two types of structure and distribution of functions. In the six areas designated as metropolitan most functions, including those with which we are most concerned in this context—social services, housing and environmental health—were grouped under metropolitan districts, which in most cases were based upon existing county boroughs, although there were four cases in the North-West where there was no previous experience below county level of running social services functions amongst the authorities that were amalgamated. The metropolitan districts were very similar in their range of functions to the outer London Boroughs. In the non-metropolitan areas on the other hand, social services and education went to the county level, while the districts were given housing and environmental health responsibilities. The National Health Service Reorganisation Act 1973 provided for the grouping of hospital, community health and family health services under area health authorities (AHAs) which except in most cases in London were to have the same boundaries as the social services authorities (the metropolitan districts and the non-metropolitan counties). Thus the principle of co-terminosity was established (outside London) between social services and health authorities, nearly all of which had populations within the range of around 200,000 to 1,400,000.

One third of the membership of each AHA was to be nominated by local authorities. Each health authority has practitioner participation in that it includes two doctors, a nurse and two members of other NHS staff groups in addition to suitably

experienced laymen. The local authority members were meant to 'provide a link with the people whom they have been elected to represent on a local authority' but were told that they were not responsible for representing local authority interests. Their role is an ambiguous one and there is no indication that it has fostered collaboration.

In most cases AHAs served populations considered too large for operational purposes, and were divided into health districts, each with a population of around 250,000. The policy of the Conservative Government of 1979 is to simplify the structure by eliminating the larger health areas and setting up authorities at or near to the district level. Thus the policy-making and operational roles are being brought together. Health districts however do not correspond to local authority areas, since they are defined mainly for administrative convenience by reference to hospital complexes and catchment areas. The principle of co-terminosity with social services authorities has been lost. Management is by a multi-disciplinary team of community physician, nursing officer, finance officer, administrator and a general practitioner and hospital consultant elected by the District Medical Committee, which represents all medical practitioners in the District. Regional plans and guidelines are made in England by fourteen regional health authorities which similarly do not correspond to any one local government unit.

Changes of management arrangements in local authorities in 1974 were not at all as drastic as in the health service. The new districts, like the old, remained quite independent of the counties, and no regional level was established. Local authority departments remained largely self-contained, administered hierarchically under their chief officer who depended for political support upon the committee responsible for his services. All but one authority, however, appointed chief executives, with an overall responsibility in most cases to central policy and resources committees for overall management and integration of policy-planning. While this and tightening constraints on resources have meant that

departmental plans have come under sharper scrutiny and control by the chief executive, the management team of chief officers which he heads and central committees, departments such as those for social services, housing and environmental health have maintained a high degree of autonomy in planning and administering their own services. In the case of the needs of the elderly, for example, it is exceptional to find strong attempts to achieve a client-based policy which transcends the interests of the education, social services and housing departments, even in the only authorities which comprehend all these services—the metropolitan districts and outer London boroughs.

In search of the means for collaboration

Interdependence and the need for the integration of services has been a principal theme of a series of national reports. In 1962 the Porritt Report (8) stated that 'the separation of the Social Services from other health services has proved in our view one of the main stumbling blocks to a properly co-ordinated service'. The Seebohm Report(9) advocated the integration under one authority of social service, housing, education and health departments, but in practice its recommendations led only to the unification and further professionalisation of the social services. The Royal Commission on Local Government(10) similarly argued for integration of services under one authority, but failed to persuade the Conservative Government of 1970, which decided to place the social services function at a different level from local planning, housing and environmental health functions in the non-metropolitan counties. It also decided to consolidate medical functions in the health service, removing medical staffs from local government, and complementarily to consolidate social service staff within local authorities, removing social workers from the health service. Thus grouping of staffs was carried out rigidly according to profession, leaving collaboration entirely to bridging arrangments between autonomous authorities. The co-terminosity principle for AHAs

and social services authorities, now abandoned, was an attempt to facilitate bridging.

The government further showed its earnestness to achieve collaboration by setting up an inter-governmental and inter-disciplinary Working Party on Collaboration(11). Certain specific recommendations by this Group were embodied in provisions of the National Health Services Reorganisation Act 1973:

(a) 'In exercising their respective functions Health Authorities and local authorities shall co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales' (Section 10[1]).

(b) There shall be committees, to be called joint consultative committees, who shall advise Area Health Authorities and 'the local authorities wholly or partly within their areas on the performance of their duties under the preceding sub-section and on the planning and operation of common concern to those authorities' (Section 10[2]).

(c) Each joint consultative committee (JCC) 'shall represent one or more Area Health Authorities together with one or more' associated local authorities (Section 10[3]).

(d) The Secretary of State is given powers to make special provisions to provide for the way in which these provisions are to be carried out and to vary the arrangements in different ways by order, after consultations (Section 10[4]).

(e) The Secretary of State may supply to local authorities and other public bodies any goods or materials of a kind used in the health service and make available to them any health service facilities, such as the use of premises, vehicles, plant or apparatus and the services of persons employed by him or a health authority, and carry out maintenance work in connection with local authority lands and buildings (Section 11[1]).

(f) He is given a duty to make available to local authorities goods etc. and services of health service personnel 'so far as is reasonably necessary and practicable to enable local authorities to discharge their functions relating to social services, education and public health' (Section 11 [31]. Goods and materials may be bought or their supply arranged through third parties for their supply under these provisions (Section 11[8]).

(g) Local authorities are given a duty in return to 'make available to Health Authorities acting in the area of the local authority for the purposes of the authority's functions under the Local Authorities Social Services Act 1970 so far as is reasonably necessary and practicable to enable Health Authorities to discharge their functions under the Health Service Acts'. A local authority may make charges for such services subject to agreement with the Secretary of State or, in default of agreement, according to the results of arbitration. (Section 12 [2] and [3]). The implications of this Section are fairly clear in relation to hospital social work but not at all clear as far as the community health services are concerned.

A recommendation of the Working Party that hospital social workers should be transferred to local authority employment was in due course carried out through the provisions of the act. In this case the importance of integration between social work staffs within and outside the hospitals was rated higher than integration of staffs of different disciplines within the hospitals. It was argued that both health and social work skills needed their own bases and that the new arrangements would lead to more continuity of care between hospital and community.

The Working Party saw the need for safeguards, both for the hospital service and the hospital social workers, when the control of the latter was moved to the social services departments (SSDs). They recommended that a senior medical and a senior nursing officer should be responsible for ensuring the provision of medical and nursing support to the

local authority, while a senior officer in the SSD should be responsible to the director of social services (DSS) for the provision of social work support for the health authority. These duties have been filled by the appointment of liaison officers, usually a Specialist in Community Medicine (SCM) (Social Services) and a senior nursing officer on the health side and officers of varying status in SSDs, usually with a general responsibility for hospital-based social work as health services liaison officers. Recommendations were made for parallel AHA appointments in respect of liaison with education departments for child health services.

Other recommendations to authorities in the first and the two succeeding reports of the Working Group of interest in connection with this study are listed in Table 1. It may be remarked that our work in ten different health authority areas showed that, apart from recommendation 2, the other recommendations in the Table had been implemented minimally or not at all.

A second working party was set up to examine the problem of social work support for the health service(12) (Social Work Support for the Health Service, DHSS, HMSO, 1974) was mainly concerned with operational problems.

The administrative framework for collaboration was

Table 1

Collaboration Working Party's Main Recommendations to Local Authorities

1. Local authorities should co-opt AHA members or officers to their committees.

2. Local authorities should appoint nominees of AHAs as part-time 'proper officers' for environmental health functions.

3. Health and local authorities should pay attention to the importance of collecting and publishing information about comparative performance in joint working.

4. Health and local authorities should set up area joint working parties to ensure the best joint use of supply, building and engineering, management and computer services, ambulances etc.

5. JCCs should set up joint intelligence teams to develop collaboration on statistics.

6. Collaboration between the NHS and local authorities (especially social service departments) in training activities was important; at Area level the JCCs should provide a focal point for co-ordination and provision.

further elaborated in the report, Management Arrangements for the Reorganised NHS (The 'Grey Book')(13) and a number of DHSS and Welsh Office Circulars (HRC (73) 3, 17, 22, 24; LASSL (73) 26, 47; HC (76) 18/LAC (76) 6 and HC (77) 17/LAC (77) 10). The health district, as the operational base for the health service, was to be the focus for the multi-disciplinary examination of local needs. Involvement of the health care professions in this process was to be obtained through multi-disciplinary health care planning teams (HCPTs), set up at district level to assess needs and plan changes in services, particularly for the elderly, mentally ill, handicapped, children and maternity services—priority groups in which there was much interaction between hospital and community care. Representatives of the key local authority services were to be invited to join the teams. This was therefore the fundamental level at which inter-authority collaboration on policy planning and service development should occur. Some stress was also laid on the need for joint working groups of senior officers at AHA level to support the JCCs.

Previous to 1974 the key medical role in preventing ill-health and providing health care in the community had been that of the local authority medical officer of health (MoH). In the decade before reorganisation the work roughly corresponding to that of the MoH had been authoritatively defined as a medical specialty so that it could stand on a level with the other many specialites within the medical profession for postgraduate training and other purposes. The Todd Report([14]) (1968) defined community medicine as 'the specialty concerned not with the treatment of individual patients but with the broad questions of health and disease in sections of the community and in the community at large'. In 1972 the Royal College of Physicians established the Faculty of Community Medicine and the Hunter Report([15]) (Working Party on Medical Administrators 1972) attempted to define the role as one concerning data collection and analysis concerning the aetiology of disease and environmental conditions and the promotion of health through

improvements in services, better coordination and monitoring of results. Thus the specialist in community medicine, as he was to be called, was to bridge the services – community health care, primary health care (including general practice), and clinical care. He would also secure constructive relationships with local government authorities to secure close working with the social, education, housing and environmental services.

Within an health authority, under the new structure, there were to be three types of post: the area medical officer (AMO), who was to be the Authority's senior community physician as well as a member of the area management team, specialists in community medicine (SCMs) who would have responsibilities in special areas such as services for children and other special groups and planning, and district community physicians (DCPs) who would be members of district management teams, give advice and perform certain statutory functions for district councils in environmental health matters and coordinate the HCPTs.

Critique of structure

The general structure within which the problems of collaboration are set is represented in figure 1. Health and local authorities were statutorily required to set up JCCs in the 98 AHA areas in England and Wales. Their duties, in the words of the White Paper (NHS Reorganisation: England, Cmnd 5055) are 'to examine jointly the plans of the authorities and to advise on the planning and operation of services in spheres of common concern'. The 98 AHAs were expected to relate to some 411 local authorities, ranging from some with populations of under forty thousand (fifteen cases) to some with over a million (twelve). A further complication was that the operational and basic planning levels of the AHAs, the 222 health districts, overlapped local authority boundaries.

The simplest solution was where one area was administered by a single-district AHA and by a local authority with combined responsibilities for local

planning, education, social services, housing and environmental health. This is the case in three London Boroughs and in 25 metropolitan districts outside London. In non-metropolitan county areas, the split of local government functions between county and district means that arrangements had to be made for one AHA to relate to two to fourteen district councils. In the 81 multi-health district AHAs, there was also the need to involve two administrative levels in the health service if detailed local knowledge was to be available. In the most complex cases of the large county authorities, therefore, the AHA, one county council and fourteen district councils have to be involved, while it would be desirable to have some six health districts also represented in the machinery. A further complicating factor has been overlaps where health area and district operational areas overlap social services authority boundaries as a 'temporary' arrangement.

The problem has a special character in London, where in thirteen cases the AHA comprehends more than one London Borough area, as well as being multi-district. In Inner London complexity was increased by the fact that education comes under a separate authority, the ILEA, a sub-authority of the GLC.

A further complexity arises from the fact that functions within local authorities are departmentalised. If the knowledge, expertise and interests of education, social services, housing, environmental health and planning (strategic and local) are to be available, then the relevant committees and/or departments have to be represented. Questions of overall priorities and resources may also require participation from policy and resources committees and the chief executives, treasurers and chief administrative officers.

The levels of complexity implied are clearly unmanageable and some means of simplification have to be adopted. In 1973 there was a clear choice between a single JCC for a health area or splitting into two or more JCCs. The problem of negotiating suitable arrangements is perhaps the main reason why

it took over three years from the election of the new local authorities in 1973 before there were JCC arrangements in every area. By 1976 there were 63 areas with a single JCC and 27 with more than one JCC. In some cases arrangements were made for district councils to be jointly represented. Housing committee and officer representation appears to have been generally weak. A frequent complaint was that leading members on policy and resources committees were not represented. While education committees and officers were normally included, the balance of business and interest tilted strongly towards the social services. In fact in a committee comprehending all the main services concerned, our observations showed that all except the social services tended to be peripheral to the discussion. This tendency has been accentuated by the joint financing arrangements, where expenditure may only be upon matters under the competence of the DHSS. Thus while joint finance has provided a much required focus of interest for JCC discussions—the JCC having been given a central role in making recommendations—it has demonstrated clearly that JCCs are dominated by health and social services interests and relationships.

A critique of collaboration

The first stage of our study involved interviews with some 114 officials in the health service and local authorities within the areas of four area health authorities, studies of relevant records and some attendance at meetings. Two of the health authority areas were of the multi-district non-metropolitan county type, one was a metropolitan single district authority and the fourth comprehended all or most of three London borough areas and accepted agency responsibility for part of a fourth. The officials who were interviewed carried managerial as well as professional responsibilities of different kinds. We went to only five non-metropolitan district councils because early interviews indicated that the relationships between them and health authorities were tenuous and that to extend the

sample was not likely to be a productive use of time. We did not attempt to explore in detail the network of relationships between officials and consultants and GPs or between authorities and the family pracitioners' and medical committees. These committees were hardly mentioned spontaneously in response to general questions about collaboration by health and local authority officials: their perceived role in inter-authority work was clearly very slight in this group of cases. Boundaries of the research were deliberately kept open and relevant leads followed as they arose. The extent of the interviewing enabled us to collect a number of converging perceptions of what were the key problems and relationships, coming from different authorities and points within each authority.

Because of the narrow scope of what can be included in an essay, we can present findings only tersely and without supporting data.

The community medicine specialists were remote from the decision-making in planning, housing and environmental health services and had little or no influence. Such specialists were nominally medical officers of environmental health to local authorities but appeared only to have a role in the event of a health emergency. There was nothing to compensate for the fragmentation of authorities for environmental services in 1974 or to contradict McKeown's statement that 'it seems inevitable that there will be serious omission so long as there is no organisation, local as well as central, with a more comprehensive responsibility for surveillance'(16).

Care for the handicapped, ill and highly vulnerable, on the other hand, has been the main focus of collaborative activity. The problems of placements and support bring officers together both at field level and at officer level. It was here that the main constraints on collaboration are felt, because of shortage of facilities and staff and day-to-day pressures, especially in fields where the pressure of numbers is growing, such as the care of the elderly. Both pressures from below and the priority status given to these issues in policies

from above caused them to be matters of central concern in joint policy-making and planning bodies.

Joint policy-making and planning

Little had been achieved towards inter-organisational planning and policy-making in the four areas we studied. Attempts to agree common goals and objectives and to develop common policies and strategies were rare. Where they had been made they had not had any impact on the practice or substance of the ongoing planning of services within the collaborating authorities. Exchanges of plans, policy statements and budgets were common but appeared to have had little effect and not to have resulted in dialogue. In both types of authority, planning activities tended to be fragmented between units. It was difficult for members of one authority to appreciate the points to which they could effectively relate for planning purposes in the other's hierarchies.

Proof of effective joint policy-making would be given by cases where one authority had re-ordered its priorities for joint benefits. We found no indication that this had happened, although the joint financing scheme had led to the revival of some previously planned projects that had dropped out of local authority programmes due to restrictions on expenditure. The new opportunities provided by the scheme had not changed priorities but had enabled projects to be undertaken outside the normal political process.

How is the vestigial nature of joint policy-making and planning to be explained? A general problem is the lack of arrangements by which key groups, such as members of local authority committees, local authority chief officers (excepting the Directors of Social Services), consultants and GPs, are brought together in a collaborative relationship for planning purposes. But such arrangements would have little purpose and indeed would be frustrating unless there was availability of uncommitted resources and an understanding and commitment to a purpose. Concepts of collaboration and the purposes

of collaboration were, as we have indicated above, undeveloped in some fields and it was sometimes significantly remarked that participants in joint meetings did not understand what joint planning was about. There were great uncertainties both about the nature of the field and about the availability of resources on both sides.

A short account of the government's provision for joint finance and the related concept of joint care planning will be appropriate here, since they did at least create an area of greater certainties and have provided the main focus of formal collaboration in the last four years. The concepts of a joint care planning system and joint finance were announced in 1976(17). Certain formal arrangements for planning were recommended, which we shall discuss below, and funds were made available to health authorities to allow them to support selected spending on the personal social services by local authorities which 'will be in the interests of the NHS as well as the local authority, and can be expected to make a better contribution in terms of joint care if applied directly to the health services'. In 1978 these allocations were planned to rise to £40 million a year in the period 1980-2 which, according to the current projections, would be equivalent to over 75 per cent of the total capital spending otherwise expected from the social services authorities, although only a little more than four percent of expected current expenditure. This money could be spent on either capital or current expenditure projects or on those involving both. Local authorities, it was suggested, should contribute 60 percent of costs of projects initially, decreasing to nil in the sixth year. 'The aim should be to develop at LA/AHA level a strategic approach for several years ahead in order to provide guidelines for officers in health districts and local authorities who are responsible for drawing up shorter-term operational plans'. Thus it was hoped that joint funding could form part of an area-based strategy.

Joint financing arose from a need to find a means to maintain expenditure on the social care of the priority groups in spite of strict spending

restraints within local authorities. It undoubtedly established a priority which was of first importance for health service objectives. But the pressure on local authorities to make expenditures requiring health authority approval led to negative reactions in all local authorities of which we have relevant knowledge, especially amongst elected members, chief executives and treasurers involved in the problems of restraining expenditure. Local authorities were in a position to impose their own conditions and in a large proportion of cases insisted that there must be one hundred per cent finance for such projects. It is clear that in many cases developments and staff that had been originally envisaged as part of authorities' own social services provision were 'fitted in' to joint financing programmes.

Many projects valuable for both health and social services have been financed through 'joint finance' but it did not create a basis for general joint planning and, in the majority of areas, it caused rather the 'concocting' or resurrecting of schemes to which both sides could give some measure of approval. Local authorities approached joint planning reluctantly because they saw it as a one-sided attempt to influence local government expenditure patterns, upset their corporately agreed priorities and win from them long-term commitments for short-term financial contributions.

The machinery of collaboration

The six JCCs we studied met at the most quarterly. Secretarial arrangements were ad hoc, usually undertaken reluctantly. Most business was generated by the AHA and most members therefore tended to regard the committee as a health service body. Nowhere had the JCC established a clear role and the many adverse criticisms directed at AHAs suggest they have been an unsuccessful and perhaps inappropriate means of collaboration, extraneous to the work of both authority. Evaluation of AHA District Council JCCs was particularly negative.

In three areas there were joint officer groups reporting to the JCC. They tended to be dominated by

a few officers who were described as 'lecturing' members. Re-design of the approach after the DHSS advice to set up joint care planning teams (JCPTs) led to fears that a top level officer team would pre-empt the possibility for decisions on joint finance at member level.

In all, the JCCs have illustrated their inability to act as planning bodies, as intended, and done little more than give support to ideas and developments which have arisen in various parts of the collaborating organisations. With infrequent meetings, large and complex membership and business that is complex and strange, their capacity for developing dialogue and appreciation is low. We think the small and more specialised joint working group is necessary to involve members in studies in depth.

Health Care Planning Teams had existed in all the health districts studied although the pattern of HCPTs and the extent that they were regarded as a success varied greatly from district to district. They had served as very useful forums in which people could become acquainted immediately after reorganisation and had in a few cases proved valuable for operational co-ordination, but rarely for planning co-ordination. Lack of usefulness may be attributed to (a) the failure of generically organised social services departments to match client group based HCPTs satisfactorily; (b) problems and uncertainties about their roles (whether executive or advisory); (c) leadership problems (the most successful leaders tended to be DCPs or SCMs or general administrators who prepared agendas and background material); (d) the often irreconcilable conflict between keeping the group sufficiently small and having representation of all the important interests relating to a client group; (e) uncertainty of role of members (whether contributing as individuals or representatives); (f) failure of members to communicate or follow through the conclusions of HCPTs satisfactorily within their own authorities.

Generally there was no corresponding group or team to the HCPTs on the local authority side, and the local authority representatives did not therefore

have an opportunity to discuss the business of the HCPTs widely within their own authorities.

The demands on officers of relating in a joint process the contrasted health areas' and districts' planning processes on the one hand and the local authorities' planning processes on the other become extreme in cases where there is little co-terminosity or matching between boundaries. The demands on the liaison roles (especially SCMs) become almost impossible to meet. In a single district area, on the other hand, collaborative planning may be achievable by cross-representation of authorities on each other's planning machinery.

We looked in particular at SCM, DCP/MoEH and local authority liaison officers roles. SCMs (Child Health) and SCMs (Social Services) have been appointed in almost all authorities. A third SCM role exists in most authorities, but it is highly variable. It may cover one or more of the three areas of responsibility of (1) information collection, anlaysis and monitoring, with an emphasis on epidemiology, (2) environmental health and (3) staffing and planning. The third role at area level is problematic, because the health monitoring and management information tends to fall most naturally at Health District level, where the detailed planning and operational responsibility demand it. It overlaps the DCP's responsibilities. The SCM (Child Health) role tends to be dominated by the demands of field problems and administration: routine demands tend to drive out the policy advisory and innovative functions. The SCM (Social Services) on the other hand is clearly under challenge to show leadership in the main areas of joint development: the mentally and physically handicapped, the mentally ill and the elderly. At Area level he has a difficult problem, especially in a multi-district authority, in covering the multiplicity of groups and functions and the differing demands in the several health districts and social services and housing areas. There are problems of communication with district and hospital levels and GPs, as well as with local authority departments, which require high levels of energy, initiative and

diplomacy if they are to be satisfactorily overcome. As a non-executive officer, dependent to a large extent on the degree of professional authority which his word carries, the SCM is at a disadvantage against consultants with high status in the medical profession who are also the main sorce of operational knowledge and whose co-operation is essential for the implementation of schemes.

In summary, the SCM in a multi-district authority lacks sufficient support to provide effective leadership for strategic change within his areas of responsibility. The responsibilities of the job tend to be vaguely formulated (excluding the SCM (Child Health)'s executive function). 'Advice', 'Co-ordination' and 'liaison' are not functions for which operational objectives have been satisfactorily defined. He is at a remove from the district level, at which change must usually be implemented, so that he has problems in relating to practical levels of implementation. Most of these problems are lessened in a single-district authority, where, as illustrated in the single district area we examined, his role both as an operational co-ordinator and initiator of developments is much easier to fulfil.

The DCP was not found to be playing the central role, as intended, between hospitals, GPs, community medicine staff and local authorities in developing a community health programme. The ideal role seemed too ambitious in terms of the relationships and the abilities in social medicine, administration, statistics and environmental health that it demands. Relationships with GPs appeared no better if not worse than for the pre-1974 MoH. As MoEH, the DCP was more distant from the District Councils and relationship with hospitals was difficult. HCPTs had in some cases been a valuable means of shared evaluation, but in others they had failed and left no alternative. In multi-tier AHAs the relationships with social services and education departments on policy matters were confused because they did not relate to the structural linkage at AHA/County Council level. At planning level concepts of clear joint tasks were lacking, but when particular joint tasks were perceived at operational level, the

relationship tended to be good. The major problems for the DCP, however, relate to communications within the health service. For example, unless ways can be found to build up a satisfactory system of communication with GPs, community based solutions to problems of joint care which depend upon GPs' collaboration cannot be effective.

Following the recommendations of Working Parties on Liaison in 1973-4, three of the six Social Services departments we studied had appointed Principal Social Workers (Hospitals) who had major liaison roles. They were at the third or fourth departmental level, and only one was a member of her departmental management team. Their main problems arose from the structural divisions in both health service and local government. In a large county department they were at some distance from both Health Districts or District Councils. Where a department decentralised its operation to areas which related approximately to Health District Areas, the main liaison was at this local level. In the London Borough situation, the liaison post was considered a most valuable means of help to creating a joint focus on community care problems and, of course, to achieving better relationships between hospital and community care.

Constraints on collaboration

We found no indication that any fundamental interrelationships in policy-making and planning had been achieved. The need for collaboration is accepted as conventional wisdom; but senior officers we interviewed stressed that concepts of forms of joint work were undeveloped and ill-defined. There was a haziness of purpose about most of the joint meetings that had taken place. Some of the reasons are as follows:

(a) Each authority has well-established functions and its primary interest is normally to maintain and develop those functions. They are rooted in history and have, to a varying degree, a well-developed corpus of theory and knowledge. Professions based on quite different and contrasting

theory and knowledge advise them. There are conceptual gulfs between professions. There is no development of concepts of collaboration unless these professions come together and work them out. The papers submitted to meetings aiming at collaboration present cases that appear to be either in the self-interest of one side or another or to lecture one profession on another profession's responsibilities. In both cases the reaction can be defensive because it is seen as an attack on an authority's priorities from a quarter that is not identified with those priorities.

(b) The means as well as the ends of collaboration are unclear. In the abstract the aim of integrating means of provision to achieve more effecient and effective results is unexceptionable, but the implications cannot be understood except in terms of models of how this can be achieved in practice.

(c) The formal machinery of collaboration is unmanageable. Health districts, district councils and usually SSD areas, lack matching boundaries and any common controls. The social services principle of relating to the family as a whole by generically trained non-specialised workers fails to give a concentration of interest within the local social services teams to which those on the health services side concerned with specific group of clients can relate.

(d) At staff levels the styles and objectives of professional groups clash and cause misunderstanding and resentment. Doctors and nurses tend to be authoritative in manner and to assume that their expertise entitles them to prescribe action according to their judgment. Much has been made in social work, on the other hand, of the 'non-judgmental' approach which depends upon assisting people in trouble to make their own decisions. It is at an opposite pole and perhaps only possible in the light of what often seem to medical staffs ludicrously low case-loads.

(e) Most doctors have to deal fairly rapidly every day with a large number of cases and have relatively little flexibility in the disposition of their time. Social workers necessarily work more slowly but are normally under a different form of pressure because they are dealing with behaviour problems that are complex, with uncertain roots and in a large proportion of cases intractable.

(f) In the health service, highest status is to be found amongst practitioners and teachers: in social work, status is acquired by an ascent of the hierarchy which takes the worker out of practice into administration. Thus in the field status and experience on one side meet inexperience on the other.

(g) Shortages of finance, manpower, time and accommodation give no margin for development. The rationale of collaboration is of course efficiency - that it enables better use to be made of existing resources - but scarcity of resources undoubtedly contributes to the defensiveness prompted by the fear that the other organisation is prompted by self-interest.

(h) Ill-definition of health objectives in local government. One problem is that local government's health objectives, except in the statutory area of responsibility for environmental health, are ill-defined. Its role in rehabilitation and continuing care is therefore uncertain. If it accepts a general responsibility for promoting community welfare of which personal health is an essential part, then it depends on the contribution of health service experts in goal-setting and in assessing the impact of its policies (albeit indirect) on personal health. We found hardly any indication of assessment of local authority policy-making made jointly with health service experts. Any suggestion of a transfer of costs from one authority to another when the services concerned may be thought to fall in this grey area is likely to be bitterly resisted, especially when political objectives – locally and

nationally - are to hold expenditures tight and keep down rates and public expenditure as a whole. If the aim of the health service is to empty its beds more quickly, local authority members must be on the defensive since this will raise demands on its services which mean that it cannot maintain them at existing levels. This will expose it to attack not only by the public and by the political opposition but also from within, by its own staff.

(i) Effects of demands for services in grey areas. Staff interests are of course not only explicable in terms of professional self-interest - the wish to safeguard the integrity of the profession and its development - but also in terms of the maintenance of norms of service. The growth of the number of elderly incapacitated is an illustration of how external pressures threaten those standards and enforce a change in the nature of jobs. The rise in the level of incapacity of residents in homes and in sheltered housing requires wardens to be increasingly concerned with critical conditions and raising the intensity of care. They and their staffs become increasingly involved in what would formerly have been regarded as nursing activity. Resource constraints would seem inevitably to press authorities and their staffs to admit ony minimal responsibility in the grey areas of responsibility - with appalling results for those who then fall within such grey areas.

How is innovation possible?

We became concerned during the course of this study about the problems of innovation in the grey but crucial areas that are the special province of collaboration. Bargaining between authorities for more or less of the standard entities which traditionally constitute the services was an unsatisfactory model in the light of changing needs and perceptions and scarce resources. Such innovations as we encountered derived from relationships established before 1974: had the new system destroyed the capacity to innovate? We were concerned about joint

project development level because of a conviction that qualitative development, given such scarcity of resources and compartmentalisation of existing systems, depended upon new types of collaborative provision.

An inquiry about new collaborative innovations in the summer of 1978 in five health regions to health and social service administrators and directors of social services, limited to services for the elderly, produced replies from 30 of the 36 health/social service authority areas concerned. Of 168 projects reported, only 77 appeared to involve a significant degree of collaboration and to be innovative in the sense of introducing new concepts or forms of collaborative working. Forty-nine of these came within joint financing projects. We found that twenty-eight aimed at support in people's own homes, seven related to sheltered housing schemes, thirteen to day-care, nine to residential care and fourteen to joint assessment, admission and discharge schemes. Thirteen involved inter-authority teams. Another thirteen introduced new roles or implied a modification of existing roles (eight for 'caring aides' in the grey area between nursing and home help involving duties that can be adequately performed by persons with suitable interests after a short course of training). There was no new approach to establishing joint residential or day-care institutions.

Using the five region survey as a basis for selection we investigated a limited number of innovations in some depth in order to identify the conditions under which innovation had taken place and progressed from conception to at least partial implementation. We hoped that the case studies would provide evidence to test the following hypotheses concerning innovations in an inter-organisational context which had been suggested to us by observations in the earlier four-area survey:

(a) Innovations in services requiring collaboration by different occupational groups tend to be conceived and initiated by professionals engaged in, or close to, practical work.

(b) Such professionals tend to have close relationships to key decision-making groups within their own authorities.

(c) Such professionals tend to have good informal inter-authority relationships at operational management levels and knowledge of the administrative system.

(d) The professionals concerned tend to have a peripheral relationship to the management systems to which they belong. Their role in effecting innovations which demand organisational change tends to be uncertain and ill-defined, as are the means by which they present and exert influence in such matters.

(e) Innovations, if they require collaboration across organisational boundaries, normally require multi-agency commitment and development through formal organisation.

(f) Inter-dependencies between area and district health authorities and between county and district councils are likely to precipitate clashes of interest over innovations.

(g) Where a new project has been defined and resources identified, operational implementation is relatively unproblematic.

(h) Matching areas facilitate effective relationships.

Relating the evidence of the case studies to our eight hypotheses we found that there was strong support for hypotheses (a), (b) and (c). In particular, of the twelve schemes which involved the implementation by statutory authorities of new services to clients, we identified eight in which a single individual could be identified as having a key role in the development. New developments can be initiated within an area at some remove from central management provided that the 'entrepreneur' can mobilise sufficient resources under his immediate

control or within the voluntary sector. Two cases showed a general practitioner and a social worker establishing community enterprises which could then draw upon various sources of help from statutory agencies as well as from the public. Such cases, included on returns by officials within the category 'collaborative innovations', are examples of how collaboration can be generated by activities with their base outside the management system. But thirteen cases involved development by HCPTs or other inter-authority groups. In these cases the 'entrepreneurs' were well 'keyed-in' to the management system, although in one case the ideas came primarily from a prominent member of a university medical faculty who was 'co-opted' into the work of a joint team.

Proposition (e) was concerned with how innovations gained commitment and were developed. In four cases HCPTs or similar groups played the main role in their early development. In four cases organisations for group support were quickly developed in the community to manage contributions from statutory as well as voluntary sources. In five instances early development was in an informal group or network, although in four of these there was an entrepreneur confident of support within his or her authority and of the support or consent, at pilot stage at least, of the other collaborating authority.

In several cases the means of project definition appeared slow, expensive and clumsy. The HCPTs were not fitted or intended for this work, which requires a small planning team including an officer skilled in costing. At the same time it must be recognised that there are several potential advantages to be gained from utilising and stressing the role of teams such as HCPTs, DPTs etc. They were sufficiently localised to be able to comprehend, and where appropriate analyse, community need. They were sufficiently small to make the total number of relationships manageable. Conversely, by concentrating on a limited set of problems (eg the needs of a particular client group) they were able to include a wide representation of all categories of personnel contributing to the problem area. Finally, being

comprised primarily of staff who had operational rather than purely planning or administrative functions, they were able to comprehend the problems of implementing existing services and any envisaged developments.

Administrative support for work to improve services for vulnerable groups should clearly have a high priority. There is a danger that, since this often appears to be the other authority's responsibility due to the 'greyness' of the area of operation, it is neglected and the planning teams lack the help of which they have need. Liaison officers such as SCMs and social services department health liaison officers may play a useful role in 'oiling the wheels' but they do not usually have either the experience of project evaluation or the intimate operational experience in the services concerned to substitute for such a team. Also, their ambivalent role between services is not helpful.

We found no evidence to support proposition (f) that innovations precipitated inter-authority clashes, but this was perhaps to be expected because our cases were those in which at least partial success had been achieved. Any ideas which might precipitate conflicts were perhaps stifled at birth due to the need to maintain harmony within the team and not attempt the impossible.

Proposition (g) was that where a new project had been defined and resources identified, operational implementation was relatively unproblematic. The problems of implementation we identified arose mainly from failures either to commit sufficient resources or lack of clarity in objectives. Failure to commit resources arose in some cases simply from scarcities – particularly with regard to occupational therapists, social workers and hospital beds. Where inputs were expected to be made by means of rearrangement of staff duties or by re-allocation within departmental budgets – as with the four day centre schemes – problems were experienced. Better assumptions about staff availability would have produced more realistic project planning.

Our cases were generally characterised by clear statements of objectives, intent or purpose, and

many key participants acknowledged that this was an important contribution to their implementation. We suggest that where people come together from different organisations and professions, the need to work out objectives that are clear and unambiguous is greater than in cases involving single organisations and professions. Mutual understanding about goals or tolerance of ambiguity cannot be assumed in multi-organisational or multi-professional ventures.

Finally, proposition (h) was about co-terminosity; matching areas facilitate effective relationships. Key informants emphasised the importance of at least an approximate match between health districts, social services districts and housing districts in three areas. Two cases illustrated the value in having closely associated housing authorities. In one case, overlap between district council areas resulted in a clumsy and unbalanced HCPT.

To summarise the indications we found in the innovation studies:

1. The cases we studied appeared to be significant partly because of their rarity. New use of existing resources is an important characteristic. These resources may be staff, where the 'grey areas' of care between health and social services may be more satisfactorily covered by changes and co-ordination of roles, providing better prevention against the occurrence of crises and rehabilitative resources. They may also be resources of accommodation. Hospital and other buildings are often vacated in connection with new development programmes and provide important opportunities for collaborative ventures of an innovative kind. Housing accommodation, integrated within the community, brings major possibilities for adaptation for the purposes of care, rehabilitation and assessment, in which health and social services objectives converge. Cases showed that the potential role of the housing authority is important in these matters.

2. The main initiators or entrepreneurs of collaborative innovations may come from any service or any

of the main professions involved in management in a related field and tend to be in positions with immediate operational responsibility. They possess good networks of relationship within their services and with other services.

3. Joint groups are important in the development of innovations because they give support and protection for ideas, correct errors, share responsibility and reduce the riskiness of promoting new ideas, round up support outside, provide diversity and richness of inputs and 'short-circuit' the complex machinery of bureaucracy.

4. The entrepreneur and group involved in promoting complex innovations require good administrative support.

5. Clarification of objectives and ensuring that there are no irreconcilable conflicts is important.

6. Co-terminosity of areas of administration is helpful but not an absolute condition of successful collaboration.

Conclusion

The approach to joint planning

The DHSS circulars on joint planning[18] suggest that the approach should be both strategic and orientated to needs in the field. They imply that plans would be fixed at a central point and then 'imposed' downwards. The assumption that concepts of comprehensive, rational strategic planning to fulfil needs can be applied directly in the area of collaboration appears inappropriate. The objective analysis of need is undeveloped and problematic, both in its definition and methodologically. It is not prominent in practice either in local government or in the NHS. Resource allocation is dominated by the need to maintain what has been previously provided. Changes are marginal and guided by subjective judgments of 'need' and opinions of politi-

cians and professionals within their own organisations. Those who attempted to apply a rational need based model found themselves trying to operate a process largely alien to practical experience and subject to the problem of the basic lack of information about the type and amount of need. The implication that existing patterns and priorities in resource allocation might require change in the light of a jointly-agreed assessment of need appeared threatening. Our case-studies provided much evidence of protective reactions by authorities. Members and senior officers of organisations normally work to protect and augment their organisations' resources. The implied role of 'strategic joint planners' runs counter to their habits. Moreover, increasing limitations on expenditure in this period have given representatives additional reasons to protect existing resources. They have followed the general tendency to make central to their concern those matters over which they had most control. Issues of joint concern fall into the category of those under least control and therefore peripheral to their interest. Consistent with this tendency, officers whose duties are primarily concerned with liaison tend to be in a relatively weak position in the process of allocating resources within their own organisations. Their defined jobs give them little organisational power. Influence depends on the individual, not the nature of the job. The problem is exacerbated where the status of the job is low in a professional hierarchy. Unfortunately this is true of the specialty of community medicine within the medical profession.

There are other reasons for the ineptness of the model. Professionals are powerful. They expect and are expected to exercise strong influence in goal-setting in their organisations because of their specialised expertise. But, as we have already indicated, their values and norms differ strongly according to their particular professional conditioning. The consensual model of decision-making is difficult to operate within the health service. It is much more difficult between services dominated by professions with contrasting approaches.

Moreover, local authority representatives are not accustomed to decision-making by consensus. In particular, British local authority members have a strongly engrained 'gladiatorial' approach, conditioned by long experience of party battles in committee and council where they expect to either win or lose on a divisive vote. The rewards of joint agreement were not clear. No useful political publicity was available from collaboration, nor were additional resources—at least not until joint finance appeared as an issue—and attitudes to this, as we have seen, were ambivalent. Thus, as can be predicted from many past studies of inter-organisational problems, chances of implementing the model were small.

Returning to our special concern with the conditions of innovation, it is clear that innovation is not something that arises from high-level joint machinery. Planning at such levels can generally deal only with stock types of unit—so many bed-spaces, nurses or home-helps. It cannot devise or easily absorb new concepts which do not fit into the traditional categories of resource allocation. Innovation derives from practical experience in the field: an individual's response to a particular problem, perhaps born of an experience on a visit, or to his reading of a report in a journal. The innovative idea then has to be canvassed for support and many people convinced before the force can be built up for success against established conceptions.

An alternative to the 'top-down' strategy-oriented model of planning is a 'bottom-up' model. This obviously coincides with the furtherance of innovation without the need to gain the support of a large committee with fundamental splits of interest and little relevant field experience. Our case-studies suggested that innovations tended to arise in a small-scale context. They were developed for a specific group of clientele, involved a small group of health and local authority personnel and avoided the need for large-scale organisational change in attitudes, jobs or structures. It was possible for the originator to work intensively with a small

group of people to develop and achieve their identification with an idea.

There are of course other justifications for the 'bottom-upward' approach. Most fundamental is that arising from the relationship between planning and implementation. Unless planning is grounded in implementors' perceptions of needs and has their commitment, they are unlikely to implement it, or will implement it imperfectly. A problematic relationship is likely to result between planners and implementors, as has happened between some health areas and health districts of which we have knowledge.

In the health service context there is a pattern of status relationships which runs contrary to the normal hierarchy of a local government department, where status and financial reward relate directly to level on the organisational tree. In medicine the highest prestige - and high financial rewards - go to the specialist practitioner. Large-scale administrative responsibilities carry less prestige, not more. To gain from the status of its originator, an innovation has to be an innovation in the field. The practitioners are the managers and controllers of main resources (and make what are the literally life and death decisions). They have strictly observed autonomy in their control of hospital beds and work with their 'firms'. Seen from a higher organisational level, they are the main constraint on planning, since they naturally defend and seek to enlarge their own resources and can always argue from perceived needs. They should be associated with and committed to planning, but are the main obstacles to transfers of resources.

If we turn to a particular field of need, such as the care of the elderly, it is clear that, given clear national priorities in response to a broadly based consensus on need for special investment in the area and the implications of demographic trends, there is a need for a 'top-downward' allocation of priorities which will counteract the influence of surgeons or others who are pursuing expensive specialities for tiny groups of patients. It is broadly a matter of the perceived benefits or interests of the

many patients against the few. These are matters which have been managed within the health service under the planning system of guidelines and agreement of plans. Removal of the 'area' level of authority implies greater competence at the district level, since the region will have much less local knowledge than the area has had for intervention with judgments of local need.

Thus a high level of delegation to the district level becomes almost a practical necessity, with controls to ensure as far as possible that its expenditure is in accord with broad national priorities subject to essential flexibility in the light of particular local priorities. In the case of services requiring joint provision, the protection of the resources intended for vulnerable social groups through a system which, like joint finance, guards them from consumption by authorities most powerful interests, is a necessity. How far control of allocation of resources amongst vulnerable groups should go is not an issue with which we are here concerned. Obviously local needs vary with local conditions in a way that can only appreciated by local people. Within an area of priority expenditure at least, the case is overwhelming for bestowing full local responsibility.

It is at present understood that the government intends that there should be JCCs at health district level. These must bring together the local authorities in the non-metropolitan areas where there is a split between education/social services authorities and environmental health/housing authorities. The problems of non-coterminosity will produce some unwieldy memberships if the JCCs are to be based on health district areas. The alternative of basing the JCCs on district council areas is attractive where the management of county social services is decentralised to district areas coinciding with those of the district councils, but would seem to have little merit otherwise.

The best local solution will vary according to local circumstances, but it cannot save the JCC from suffering from most of the problems which we have described above.

There are certain local conditions which will be more important to foster collaboration than the constitution of the JCC, and these follow directly from the argument we have developed above. We make no rigid prescriptions for overcoming local problems, since each situation is unique and what will work in some circumstances will not work in others.

1. Responsibilities for the planning of local social services should lie at a level within the related social service department at which there is an intimate knowledge of local conditions and where close relationships with health district and district council housing staff can be maintained.Most social services departments already decentralise operational tasks but there is a tendency even in some social services departments covering large areas towards a high degree of centralisation of detailed planning. This creates problems for relationships with health district staff for development of new joint projects and related planning. We observed close and fruitful relationships and an innovative approach dependent on inter-service collaboration in policy-making and project development in a health district where the local district social services headquarters took a major planning role within the preparation of county-wide policy plans and programmes.

2. The key services for a particular priority group, such as the elderly, need to have a meeting point where time is available to consider all aspects of desirable action which require collaboration. The concept of the multi-service and multi-professional team is a sound one and has been at the heart of most innovations which we studied. Examples showed, in the case of teams for services to the elderly, that the close association not only of an influential social services area officer concerned with local policy-making as well as with implementation is important, but also that a district council housing officer can make a leading contribution. Public housing is a major element in the

support of the elderly and available accommodation is capable of many different kinds of adaptation for the purpose of maintaining the handicapped elderly in their own homes.

3. The expertise and experience of consultants in appropriate specialties is of course of the highest importance to such a team. In the case of a team for the elderly, the association of specialists in geriatric and psycho-geriatric medicine is of obvious importance. The specialties concerned have become increasingly orientated towards securing better conditions for the maintenance of the health of the elderly in the community in recent years. Given the wide over-laps between domiciliary, social services and long-stay hospital accommodation in the extent to which they provide for groups with the same degree of handicap, the comprehensiveness of their concern in the care of the elderly suffering from health problems should be accepted by all the parties concerned. The contributions of specialists in community medicine, nurses, administrators and other officers may have equal importance. We would not suggest that leadership should lie in any particular quarter: it should vary according to subject and need. It should not be confused with chairmanship, where the appropriate skills and general acceptability are important.

4. The composition of a multi-service team which is not so large as to be unwieldy is not easy to achieve, especially when there are overlaps between health and local authority administrative districts, since the range of professional representation desirable is in itself so wide. Experience appears to indicate that fairly frequent meetings are necessary - say once a month, at least in the initial stage of achieving mutual understanding. But flexibility in delegation of tasks to sub-groups and individuals is essential.

5. The concern of such a team should embrace the full cycle of the process of management: research, policy-making, planning, programming, implementation

and evaluation, because all phases are interdependent. It requires fairly clear definition of the scope it is to be allowed and of available resources. The task area can be defined clearly in terms of clientele, and the overlaps with other client areas—such as that between geriatric and psycho-geriatric care—covered by defined arrangements for consultation and over-lapping membership. The work of a team would be greatly facilitated if it had defined resources placed at its disposal. The joint finance scheme to a limited extent makes this possible, although any recommendations for services do of course have wider implications which must be the concern of those responsible for controlling resource allocation as a whole within an area. Work is needed on defining the scope of resources that can be forecast as available for a particular client group so as to provide a basis for realistic planning and experimentation.

6. The linkages with general administration in the services concerned are of first importance—for accessibility to up-to-date information on contingent decision-making, resource availability, obtaining commitment and achieving influence. In the health dstrict a senior administrator should be involved directly. The problem is more difficult in the local authority. If a housing manager is a member of a joint team, he could brief his district council management team of chief officers at intervals on joint work for the elderly, or whatever client group is in question, and raise the implications for the authority as a whole. At least there should be a system of reporting to the district council chief executive and housing manager on proposals for action so that they can consider and where appropriate react to the report. The social services officer concerned would carry the responsibility of seeing that management in his own authority was informed of the implications of the team's work.

7. The question of the status of a care team is important. HCPTs have been 'owned' by the health

service and have had no formal channels to local authorities. The functions of these and similar groups are essentially consensus-forming and advisory and do not conflict with lines of management control. There is no reason why they should not report to and consult with local authority departments as well as health service management teams, or why, in matters of local importance, reports and consultations by such teams should not be referred to local authority members. Since responsibilities overlap, consultation should overlap. Local authority representatives on such a team should have their positions recognised as one of direct interest to the local authority and an important channel of communication on community welfare. The general implication is that joint teams for reporting on the health care arrangements, including interdependent social and housing care aspects, should be given recognition by local authorities as an important resource in fulfilling their general welfare responsibilities.

8. Local authorities lack a political focus on the needs of the elderly and handicapped. Great improvements have been made since the establishment of social services committees but there is a danger that, due to the increased fragmentation of the services concerned, the problems of these groups are not seen and appreciated as a whole. Some authorities have developed client-group based policy-analysis and programming with the intention of developing a rational approach to meeting their needs, at least as far as services within their own control are concerned. This is a major step towards inter-relation of provision with that of the health service, which already has elements of a client-group orientated planning system. Inter-service consultation in such work should be of high value in the complementary adjustment of programmes. Analysis of policy on a client-group basis also provides a means of enabling elected members to focus on these problems in a systematic way and to take well-formed decisions.

One perhaps surprising finding in our studies is

the relative lack of involvement of elected members, who, within local authorities, are often closely associated with innovation. The current joint planning machinery appears to give little opportunity to elected members for creative contributions although in areas such as services for the elderly one might expect to find a high degree of interest, both for political, personal and altruistic reasons.

The idea of a district 'ad hoc' group for the elderly, and perhaps for other priority groups, which would include members of local authorities, health authorities, local voluntary agencies and expert officers and which could put forward ideas to authorities and act as a sounding board deserves serious consideration. It could have a voluntary base and be given consultancy status by local and health authorities. There could be a recognised channel of dialogue between it and a corresponding care team at official level. Such bodies might be more satisfactory for some purposes than the present community health councils. (There is evidence that that joint groups, with a mix of councillor and officer membership, can be effective even at the level of a very large Scottish region(21)). Such a body may work well in some areas, but elsewhere other means to bring together community concern for the needs of the elderly might be more successful.

9. Administrative support by authorities could come from nominated officers in the health district and the local authorities concerned who would share responsibilities and report to their authorities on matters concerning the ad hoc groups and care teams. The time and costs involved seem to us to be probably reasonable and manageable within existing resources.

10. Specialised staff liaison roles, such as those of the SCM and social services department health services liaison officer, specialising in needs of priority groups, fulfil needs which it is difficult to envisage being met in other ways. They must however be closely associated with decision-making in management teams in matters concerning their

areas of concern if they are to be effective in policy liaison. A professional liaison officer also needs strong administrative support if he is to be closely involved in planning. Such posts are of doubtful value if they become at all remote from the central stream of decision-making in an authority.

11.The levels of health district, social services district and district council may be still somewhat remote from the local levels at which excellent schemes for community care can develop.Several of our case-studies indicated the feasibility of 'parish' or 'general practice' areas of self-management involving local GPs, community nurses, home help organisers (the importance of whose role as reflected in case studies has been somewhat neglected in this essay), social workers, sheltered housing wardens and voluntary workers. A comprehensive system of care and support must rely largely upon local voluntary resources working with professionals at the local level, and perhaps the most valuable work joint groups can do is to foster joint local initiatives close to the ground by providing them with key resources not otherwise available to them.

A major concern in developing collaboration is to ensure that there is a means of control to match the uniqueness and variety of the local situation, a matter which, as Stafford Beer and others have pointed out, is a central problem of modern society(21). What is needed, consonant with values which are widely held, is not organisational stereotypes which inhibit variety and entail growth of bureaucracy, but highly localised and various means of control, broad enough to bring together the knowledge and expertise required and given necessary support by the redistribution of key resources through a superior authority. Statutory higher-level authorities cannot of course abnegate their responsibility but neither should their role be seen as one simply of control. They need to activate and influence community organisation, facilitate relationships between voluntary groups and encourage local

development and the selective use of resources, all of which suggest a high degree of delegation.

It is to be expected however that there will be resistance to delegation of responsibilities. There is an innate tendency to feel threatened by autonomy at 'subordinate' levels and when higher level planning fails to be effective the reaction is commonly to tighten control, which in some cases may kill local initiatives and in other cases produce resistence and avoidance.

To concentrate therefore solely on concepts of delegation in order to achieve localised initiative is unlikely to prove entirely effective. The activities of revaluating service provision, seeking to ensure that minimum standards are achieved and advising on broad resource allocations remain of importance and must be provided for by more centralised collaborative machinery. We would not therefore propose to abolish JCCs and JCPTs, particularly in the light of the simplification of structure proposed in Patients' First, but would give much less stress to their importance in the development of joint working.

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18. Ibid.

19. Descriptions of the individual cases are available from the Publications Officer, Joint Centre for Regional, Urban and Local Government Studies, University of Birmingham, P.O. Box 363, Birmingham B15 2TT. Details of cost of particular case-studies will be supplied on request.

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