COMMENTARY

The strategy behind the Jenkin non-strategy

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Every Secretary of State responsible for the National Health Service faces the same fundamental dilemma: how to strike a balance between central direction and local autonomy. The aim of Mr Patrick Jenkin, as proclaimed in *Patients First*¹ and as expressed in the current reorganisation of the NHS, is to tilt the balance towards local autonomy: to encourage more freedom of decision making by the new district health authorities. But this still leaves unresolved the question of the extent to which a national service, set up precisely to achieve national standards of service provision and to promote geographical equity in access to care, can devolve decision making to the periphery without breaking up into a loose federation of 200 or so local district health services, each pursuing its own priorities and applying criteria in determining how to spend its budget.

So far, all attempts to square this circle have foundered. Now Mr Jenkin has published his own formula: the Department of Health and Social Security's latest strategy document, *Care in Action*.² Subtitled "A Handbook of Policies and Priorities for the health and personal social services in England," this is a direct descendant of the two earlier documents—sponsored, respectively, by Mrs Barbara Castle and Mr David Ennals—which sought to provide a framework of national planning within which local decisions could be taken. Both the similarities and the differences between *Care in Action* and its two predecessors—the 1976 consultative document, *Priorities for Health and Personal Social Services*,³ and its 1977 successor, *The Way Forward*⁴—are striking.

Consider, first, the following quotations from the introductions by two Secretaries of State:

"Ever since I became Secretary of State, health authorities and local authorities have been pressing for less central intervention in day to day management, and I have readily accepted that more devolution of detailed decision-making must take place. At the same time, as the Minister responsible for the National Health Service, I have a duty to set national policy guidelines within which local needs can be assessed."

"Local initiatives, local decisions and local responsibility are what we want to encourage. . . . But a National Health Service must also have regard to national policies and priorities, and I must ask you to take account of them in making your plans and decisions."

The first quotation comes from Mrs Barbara Castle's preface to the 1976 document; the second comes from Mr Patrick Jenkin's preface to the 1981 document addressed to the (as yet non-existent) chairmen and members of district health authorities. The rhetoric has hardly changed. Nor, for that matter, have the actual priorities being pursued. Indeed, *Care in Action* explicitly emphasises this continuity of policy. Overall, the strategy remains to give "high priority both to the prevention of ill-health and to the so-called 'Cinderella' services for people who are mentally ill or handicapped, and those who are elderly." The section that lists priority groups and priority services is

familiar enough. The priority groups are the elderly, the mentally ill, the mentally handicapped, and the physically and sensorily handicapped. The priority services are primary care, those related to the care of young children at risk, and maternity and neonatal care. Only the last marks any kind of policy reversal: the 1976 priorities document said that "the hospital maternity services have attracted too large a share of resources" and argued for a reduction in the level of provision. This change of policy no doubt reflects both the upturn in the number of births since 1976 and the growing concern about the quality of the maternity services, as reflected in the report of the Social Services Committee on perinatal and neonatal mortality.⁵

Subtle change of emphasis

Interestingly, too, all three documents expound the theme of efficiency: all emphasise that, given financial constraints, new priorities can be achieved only by making more efficient use of existing resources. But here a subtle change of emphasis is evident. In illustrating the scope for greater efficiency *The Way Forward* cited 40 examples of innovations in clinical practice: from moves towards day care to ways of reducing unnecessary x-ray examinations. In contrast, *Care in Action* puts more emphasis on housekeeping economies: energy saving, stock control, cost-effective storage arrangements. Apart from drawing attention to the need to review the use of drugs, it carefully avoids the area of clinical practice. Since it is the decisions of clinicians that largely determine the use of resources in the NHS—from beds to diagnostic equipment—this seems somewhat curious.

Though the general emphasis of *Care in Action* is on continuity—and the document bears the fingerprints of the same civil servant establishment that produced the earlier documents—there are also some marked differences. Predictably, there is strong emphasis on the functions of the voluntary and the private sectors. But, more important, the language of priorities has changed: in effect, the attempt to devise an explicit national resource-allocation and standard-setting strategy has been dropped.

The 1976 and 1977 documents marked a breakthrough in the administrative history of the NHS. They translated, for the first time, general policy objectives into specific resource-allocation policies. Thus the 1976 document set out explicit expenditure planning targets—that is, the spending implications of its priorities. Thus it was assumed that the average annual growth rate would be 3.2% for services used mainly by the elderly, 2.8% for services for the mentally handicapped, 2.2% for services mainly for children, but only 1.2% for acute services, while expenditure on the hospital maternity services was expected to fall by 1.8%. The 1977 document, *The Way Forward*, was less explicit, conceding, for example, that it was unrealistic to make a sharp distinction between services for the elderly and the acute services. But it still set out a "programme budget"—that is, a table setting out past and planned expenditure on specific services. This, for example, assumed that the share of total NHS spending devoted to the general and acute hospital services and the maternity services would fall from

42.7% in the mid-'seventies to 39% by the end of the decade.

Another characteristic of both the 1976 and 1977 documents was that financial targets were further buttressed by guidelines about desirable norms of provision. For example, *The Way Forward* set out guidelines for the provision of beds for various types of patients—2.8 per 1000 appropriate population in the case of acute inpatients and 0.68 for mental handicap inpatients—as well as for community services. These norms showed where there was a surplus of provision (acute beds) and where there was a shortfall (almost every other kind of provision). Thus they provided benchmarks against which to measure progress, or the lack of it, towards the achievement of the Government's priorities over time.

None of this is to be found in the 1981 document, *Care in Action*. There are no resource-planning targets linked to specific services or to the individual priority groups. Nor are there any norms, or guidelines, about desirable levels of provision. In this respect it would seem to be a non-strategy document. Its priorities would seem to be simply general aspirations—exhortations to the field authorities to move in a particular direction. If the test of a strategy is to be the same as that applied to scientific theories—that is, that it should be falsifiable by events and that there should be some criteria by which it is possible to judge whether or not it has succeeded—Mr Jenkin has failed the test.

On the face of it, therefore, *Care in Action* would seem to represent a retreat from rational planning, defined as the setting of explicit policy objectives, linked to specific financial targets, and the monitoring of progress towards their achievement. Indeed, the DHSS devised its programme budget precisely as a mechanism for relating decisions on policies and priorities to decisions on financial allocation.⁶ If the DHSS's priorities are not expressed in programme budget terms or norms—if there is indication of their implications for the future level of spending or provision for specific services or client groups—how will it be possible to tell whether or not they have been achieved?

Again, as Mr Patrick Jenkin warns in his preface to *Care in Action*, "It cannot be assumed that more money will always be available to be spent on health care." The warning is apt, for, though the Government is still committed to a growth in the NHS budget, the actual rate of growth achieved is vulnerable to the cash limits squeeze. Thus in 1979-80 a planned rate of growth actually turned into a fall in real spending levels as a result of such a squeeze.⁷ Consequently, it cannot be taken for granted that the Government's priorities can be painlessly financed out of the dividends of growth. The implicit assumption of *Care in Action* would seem to be that they can be financed out of the dividends of increasing efficiency. But how realistic is this assumption? And what happens if it turns out to be over-optimistic?

Meaning of priority

To ask these questions is to underline that a policy of priorities, if it is to be more than rhetorical window dressing, implies that some services will get less than others: that, indeed, some may have to be cut in order to create spare resources for the priority areas in a period of slow or nil growth in the total budget. This was recognised in the 1976 and 1977 DHSS documents on priorities. It is not recognised in *Care in Action*. Yet the very use of the word "priority" implies a hierarchy, or order of precedence, for the achievement of various policy aims: an orderly queue for scarce resources. So the real test of political commitment to a particular order of priorities would seem to be a willingness to state who comes at the bottom of the queue. If services for the elderly, the mentally ill and handicapped, mothers, and children are to be improved—at a time of severe budgetary constraints—who will have to put up with the status quo, at best? *Care in Action* provides few clues, though the logic of its approach would seem to suggest that it is the acute services that should come bottom of the queue (with perhaps the

private sector mopping up any consequent overspill of demand). Somewhat gnomically, it points out that "Authorities will need to reappraise priorities within the acute sector and in particular weigh the claims of developing services, such as renal services, against the continuation of established patterns of expenditure elsewhere."

But to make these criticisms is to risk missing what is perhaps the real message in *Care in Action*. This is that, implicit in its whole approach though never explicitly argued, there is a new and different definition of rational policy making in the NHS; a definition that defines rationality in terms of what is realistically feasible (as distinct from what is abstractly desirable), given the constraints imposed by economic recession and the complexity and heterogeneity of the NHS. So what may appear as a non-strategy, judged by the criteria of the 'seventies, may in fact be a rational strategy in the context of the state of affairs in the 'eighties.

Through the statistical marble of the priority documents of the 'seventies, there ran a flaw of ambiguity. The documents set out priorities expressed in what seemed to be hard statistical terms with precise implications for future resource allocation. At the same time, they emphasised that the target figures in the programme budgets were only illustrative, indicating merely the national direction of change but not attempting to prescribe the pace of change in any individual locality. As *The Way Forward* put it, "they are not specific targets to be reached by declared dates in any locality." So it was never entirely clear whether the priorities documents were to be taken as a commitment by the Government to a specific plan of action or as the agenda for a dialogue between the centre and periphery. The fact that individual health and local authorities might diverge from national figures was accepted. Unfortunately, the DHSS never made explicit its own criteria for deciding what degree of divergence was acceptable and on what grounds.⁸ The deceptively clear-cut commitments of the priority documents thus turned out to be on closer inspection something more akin to verbal massage: persuasive, not binding statements.

Thus it may be argued that *Care in Action* simply resolves this ambiguity by abandoning the pretence that central government has commitments to specific courses of action. In doing so it would seem to be accepting the view of planning as dialogue⁹—a continuing conversation between centre and periphery—as distinct from planning as command. In support of this view it can invoke both experience and theory. Several studies of local decision making in the NHS¹⁰⁻¹¹ have suggested that in practice central pronouncements about priorities have at best had only a marginal impact at the periphery. And, more generally, it has been argued that attempts at comprehensive problem solving in complex organisations are irrational in that they assume capacities of analysis and powers of implementation that may not exist,¹²⁻¹³ and that, consequently, a process based on incremental adjustment and dialogue is more rational than the abstract rationality of the designers of programme budgets and other ambitious tools of planning.

Language of economic growth

Again, the abandonment of norms—of guidelines setting targets of desirable levels of provision—may be defended. Norms are the language of economic growth.¹⁴ Their use assumes a belief in progress—the ability to go on increasing expenditure on services. If there can be no certainty that extra funds will become available is there much point in setting out norms that will serve only to underline the gap between what is possible and what is desirable? Equally, it may be argued that the use of norms reinforces the belief that the only way of improving services is by increasing the inputs: that more resources (beds, day-care places, manpower) automatically means better services. Yet possibly services can be equally well improved by a more imaginative and innovative use of existing resources. Furthermore, resources in the health and personal social services can be

used in many different combinations, while the use of norms assumes that a particular mix or pattern of resources will necessarily yield the best results. The result may therefore be to set certain assumptions about the mix of services that is required in the concrete of norms, rather than encouraging flexibility and substitution in the use of different kinds of inputs. If the logic of the non-growth society is a new approach to the welfare state¹⁵—no longer assuming that the future will be very much like the past, only more prosperous—then simply extrapolating past policies is a recipe for ensuring frustration and disillusionment.

Indeed, a positive political strategy seems to be implicit in *Care in Action*. During economic growth governments tend to pursue policies of credit centralisation—that is, they tend to emphasise the directive task of central government on the reasonable assumption that this will allow ministers to claim credit for improvements in services that will be brought about as a result of growth. In periods of pessimism about the economy governments tend to pursue policies of blame diffusion, tending to minimise their own task and to emphasise the importance of local decision making, on the rational calculation that there is little point in claiming responsibility for what will almost inevitably be bad news. Such an approach not only fits in snugly with Conservative ideology but might well tempt other governments too. If unpleasant decisions have to be taken as to who is *not* going to get what—if the problem of priorities is increasingly going to be to determine who should get less in order that others may get more—it is not surprising that governments may prefer that such decisions should be as invisible as possible and should be taken by individual clinicians or authorities but not by central government.

Given such considerations, *Care in Action* can be seen as part of a coherent strategy, in line with the emphasis on devolution of responsibility to the new district health authorities. Even so, the circle has not been squared. For the central dilemma remains: how can national policies and priorities be reconciled with local freedom? *Care in Action* may define these policies and priorities in less rigid and more general terms than its predecessors but it cannot be taken for granted that this will necessarily help the members of the new authorities. If the new authorities cannot steer by norms—if they are not working towards a national pattern of resource allocation as between different services and groups—what criteria are they to use in making their own decisions? If they cannot cite national policies and invoke central government pressure when they seek to restrain the momentum of existing commitments in order to free resources for the “Cinderella services” will they want to incur the hostility of the constituencies for the status quo, which are so strong in the NHS and which may well be all the stronger in the parish atmosphere of the new authorities?

Indeed, running through *Care in Action* there seems to be a minor-key realisation of the possible dangers of local autonomy leading to local drift. There is much emphasis on the need for self-audit and the assessment of services provided. There is, furthermore, the suggestion that the new authorities might issue an annual report that would review the standards of service provided. There are references to pilot studies of the best means of monitoring quality and efficiency. But this is to beg some crucial questions.

Crucial questions

Firstly, developing the capacity for self-audit is going to require resources of skill. Where are these going to come from?

And how compatible is this aim of policy with the Government's intention of cutting management costs? Over the past few years management staff has been cut by 6.6%—as against a rise of 12% in the numbers of administrative staff attached to consultants and patient services.¹⁶ It is not at all clear how 200 or so district health authorities are going to develop the new tools of management that 90 area health authorities have so far failed to do, particularly since the new structure will mean the dispersal of the all too few people in the NHS with the requisite skills.

Secondly, reviewing the standards of services implies the existence of benchmarks or criteria for assessing what is being provided. What are they? Statistical comparisons, *Care in Action* warns, need to be “undertaken with care.” So how are the members of the new authorities (many of whom may be unfamiliar with the NHS) to set about their tasks? Are services to be reviewed in terms of the quality of care given to individual patients or in terms of the provision of care to the population as a whole? Is the objective going to be to maximise the care to the individual or to maximise access for the community?¹⁷—objectives that may well conflict? If norms of provision are no longer going to dominate planning—reasonably enough—surely norms of output are required.

So if Mr Patrick Jenkin and the DHSS are going to succeed in their aim of devolving decision making from the centre, while yet maintaining the concept of a *national* service, the central government may actually have to be more active in developing indicators of performance. For the paradox would seem to be that only if there are explicit criteria of performance and if there is clarity about objectives can governments afford to allow the periphery freedom to decide on the means for achieving such national ends. The price of local autonomy, it is tempting to conclude, is more clarity about ends and better information about progress towards achieving them.

References

- 1 Department of Health and Social Security. *Patients first*. London: HMSO, 1979.
- 2 Department of Health and Social Security. *Care in action*. London: HMSO, 1981.
- 3 Department of Health and Social Security. *Priorities for health and personal social services in England*. London: HMSO, 1976.
- 4 Department of Health and Social Security. *The way forward*. London: HMSO, 1977.
- 5 Social Services Committee, session 1979-80. *Perinatal and neonatal mortality*. HC 6631. London: HMSO, 1980.
- 6 Banks GT. Programme budgeting in the DHSS. In: Booth A, ed. *Planning for welfare*. Oxford: Basil Blackwell/Martin Robertson, 1979.
- 7 Social Services Committee, session 1979-80. *The Government's white papers on public expenditure: the social services*. HC 702. London: HMSO, 1980.
- 8 Klein R. Priorities and the problems of planning. *Br Med J* 1977;iii: 1096-7.
- 9 Outer Circle Policy Unit. *A new perspective on the national health service*. London: OCPU, 1978.
- 10 Hunter DJ. *Coping with uncertainty*. Letchworth: Research Studies Press, 1980.
- 11 Hayward S, Alaszewski A. *Crisis in the health service*. London: Croom Helm, 1980.
- 12 Wildavsky A. *The art and craft of policy analysis*. London: Macmillan, 1980.
- 13 Lindblom CE, Cohen DK. *Usable knowledge*. New Haven: Yale University Press, 1979.
- 14 Stewart JD. From growth to standstill. In: Wright M, ed. *Public spending decisions*. London: Allen and Unwin, 1980.
- 15 Klein R. The welfare state: a self-inflicted crisis?. *Political Quarterly* 1980;51:24-34.
- 16 Comptroller and Auditor General. *Appropriation Accounts 1979-80. Report*. Vol 3. HC 98. London: HMSO, 1981.
- 17 Klein R. The conflict between professionals, consumers and bureaucrats. *Journal of the Irish Colleges of Physicians and Surgeons* 1977;6:88-91.