Transfer of finance between health and local authorities

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This paper tries to demonstrate that close consultation, co-operation, and joint planning between the Health Service and local authorities is insufficient to ensure the appropriate development of services for common client groups. A mechanism should be found which will enable capital and/or revenue to be transferred between authorities. The mentally handicapped services have been used as an example.

*Better services for the mentally handicapped*¹ established planning yardsticks for both health and social services provision. A comparison of existing services with the planning yardsticks (see table) shows that there will be a rundown of total hospital bed provision in association with the build up of the local authority services. At the same time the large hospital institutions would be run down with local hospital units for those that need hospital care.

A look at the distribution of mental handicap facilities in the South-east Thames Regional Health Authority at 31 December 1973 brings out the following points²:

(1) There are two large institutions of over 1000 beds in Kent. Kent has, in fact, 82% of the hospital provision for mentally handicapped within the South-east Thames RHA and only 39% of the population.

(2) One of these institutions provides adult hospital provision for three other area health authorities, none of which has any adult hospital inpatient facilities.

(3) The hospitals in Kent also compensate for a lack of 1501 residential places which should be provided by seven social services departments (East Sussex has been excluded from these figures).

The ability of Kent Area Health Authority to develop a progressive policy in mental handicap is, therefore, dependent on the speed with which three other area health authorities (Lambeth, Southwark, Lewisham, Greenwich and Bexley; and Bromley) together with their six social services departments meet their requirements, and a build up of social services provision in Kent itself.

There is one hospital in Kent which receives, in practice, virtually no consultant care but instead general medical care is given by a general practitioner to patients who are ambulant and nearly all able to go out to work. Though this is technically a hospital it should be handed over to the social services along with the necessary revenue. The same could be done with two of the smaller units. Mental handicap facilities for children are only slightly better.

Long-term programme

A resource allocation group established by the previous regional hospital board attempted to draw up a 15-year programme based on the proposals of the local authorities and hence the ability of the Health Service to run down its bed provision. It was assumed that social services residential places would be built at the rate suggested in the local authorities' 10-year plans, less one-third (in practice this may turn out to be overoptimistic). It was also assumed that the new social services places would be used to expand the provision and not as replacement accommodation.

By 1983 the percentage of the yardsticks which would be achieved in relation to adult residential provision by each social services department will be Lewisham—89%; Bexley—68%; Lambeth—68%; Bromley—66%; Southwark—56%; Kent—48%; and Greenwich—37%. This means a shortfall of 797 places, of which 500 will relate to Kent County Council social services department. (The deficiency would be 445, of which 357 would relate to Kent, if the local authorities actually achieved their targets). These figures are based on an assumption that local authorities' hostel places would be in their ownership and take no account of the places contracted for in private and voluntary homes. The latter would reduce the necessity to aim for the command paper planning figure.

On the hospital side the regional health authority planned to provide, by 1979, 257 beds in new fabric (at an estimated cost of £10 000 per bed) and 198 beds in existing converted fabric on two hospital sites to serve the three area health authorities with no facilities. There would still remain a shortfall of 357 beds. It is now not known whether any capital will be available for the schemes to proceed within the next few years but the target figures of 1979 cannot be met. There are no plans whatsoever for any day hospital places.

The irony of the whole problem is that unlike many medical problems the patients and therefore the "needs" are known and there is no vast clinical iceberg. The prevalence of mental handicap is fairly static with a decline in the number of mentally handicapped born each year being offset by a greater life expectancy. The need is primarily one of capital to rehouse hospital patients into appropriate accommodation. Revenue is already being spent and there is no reason to suppose that additional finance will be necessary if it could be transferred although their needs will become greater in time because of the change in the age distribution. Transferred revenue could also be used to develop fostering or services by voluntary organisations.

Medical manpower figures (see figure) show how unattractive the present work is to doctors born in the United Kingdom and Eire. If

Planning figures for services for the mentally handicapped compared with existing provision

Type of service	Places for children (age 0-15)			Places for adults (age 16 +)		
	Required		Provided	Required		Provided
	Per 100 000 total population	Total England and Wales 1969	Total England and Wales 1969	Per 100 000 total population	Total England and Wales 1969	Total England and Wales 1969
Day care or education for children under 5	8	3900	500*	—	—	—
Education for children of school age:						
In the community—						
(i) for children with severe mental handicap living in the community	56	27 400	23 400	—	—	—
(ii) for children coming by day from hospital	6	2900		—	—	—
In hospitals—						
(iii) for inpatients	7	3400	4600	—	—	—
(iv) for day patients	6	2900	200	—	—	—
Occupation and training for adults:						
In the community—						
(i) for adults living in the community	—	—	—	130	63 700	24 500
(ii) for adults coming by day from hospital	—	—	—	20	9800	100
In hospitals—						
(iii) for inpatients	—	—	—	35	17 200	30 000*
(iv) for day patients	—	—	—	10	4900	200*
Residential care in the community (including short-stay):						
(i) in local authority, voluntary, or privately-owned residential homes	10	4900	1800	60	29 400	4300
(ii) foster homes, lodgings, etc:	2	1000	100	15	7400	550
Hospital treatment:						
(i) for inpatients	13	6400	7400	55	27 000	52 100†
(ii) for day patients	6	2900	200*	10	4900	500*

*Estimated.

†NHS beds allocated to mental handicap.

Mental handicap medical staff.

the misplacement of the present services could be corrected the role of a consultant in mental handicap serving health, social services, and educational authorities would become clearer. Because of the present economic position³ services for the mentally handicapped will remain static until local authorities can provide the revenue for running costs as well as for the loan sanctions. This is unlikely to occur for many years.

Discussion

At present a health authority cannot supply capital facilities for local authority use (except as allowed under Section 11 1(b) of the NHS Reorganisation Act) and it has no power to meet the revenue costs of a service provided by the local authority (except under the powers of Section 11 of the Act). Also it does not seem possible for a health authority to provide contractual services to local authorities.

Several reasons are given against altering the present arrangements: the Layfield Committee has not yet reported; the Health Service should not provide facilities which are the responsibility of another service—two wrongs do not make a right; the autonomy, authority, and freedom, of local government would be undermined if the Health Service or any other agents of central Government could switch finance and resource in such

a manner; less "progressive" local authorities would further abrogate their responsibilities and "progressive" ones would be penalised.

Nobody would deny that different social services can be substituted for each other. The Secretary of State herself has stated that we should be frank and admit that the boundaries appear the least rational, the most arbitrary where the mentally handicapped are concerned.⁴ In fact, within the field of mental handicap the Wessex RHB provided, through the DHSS, the capital and revenue for hostels which were, and still are, technically the responsibility of the local authority. This is not, however, the most satisfactory solution since it is the Health Service which is running these hostels rather than the local authority.

Nobody would wish to interfere with the autonomy of local government or increase central control, but it should not be impossible to devise a method which does not interfere with these principles and yet achieves the appropriate priorities for the client groups. The alternatives would all be based on a joint desire by the Health Service and the local authority for a particular development. I am not competent to suggest a possible formula but Klein has suggested that one method might be to have a system of ear-marked grants to individual local authorities to finance projects agreed with health authorities.⁵ In the present economic climate the best formula would be one based on additional finance being made available for capital expenditure by the DHSS or Department of Environment but the revenue would have to be found from within either service. There is one safeguard which would have to be instituted, namely that the relatively well-off area health authorities should not be allowed to transfer revenue to local authorities without some system of ensuring that it is not depriving other area health authorities within the regional health authority of urgently-needed funds. This could be achieved within the framework of the revenue formula.

¹ *Better Services for the Mentally Handicapped*, Cmnd 4683. London, HMSO, 1971.

² *The need for hospital beds for mentally handicapped in the South-east Thames Region*, South-east Thames Regional Health Authority.

³ *Public Expenditure to 1978-9*, Cmnd 5879. London, HMSO, 1975.

⁴ *Mental Handicap Services*, DS 76/75. London, DHSS, 1975.

⁵ *Inflation and Priorities*, ed R Klein. London, Centre for Studies in Social Policy, 1975.

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Full-time Medical Teachers and Research Workers Committee

There was a full agenda for the second meeting in the session of the Full-time Medical Teachers and Research Workers Committee on 20 February, which was chaired by Professor J P Quilliam. Preclinical teachers and representation were among the subjects debated, and the meeting opened with a general discussion about recruitment to the hospital service.

Professor J P Payne reported the debate in the CCHMS Negotiating Subcommittee on the hospital practitioner grade. Applicants to the grade would, he said, earn more than some consultants. In Edinburgh five anaesthetists with the fellowship had become GPs and would probably return to the hospital service as hospital practitioners. The committee secretary, Dr D L Gullick, told the meeting that no hospital practitioners

had been appointed yet in England. He explained that pro rata the salary grades were higher than the lower rungs of the consultant scale. The salary was increased to take account of the 30% expenses element.

There were only 23 British graduates out of 750 surgical SHOs in approved training posts, Professor Payne said, and Mr T Hamilton added that 400 doctors had sat the ECFMG this year in Edinburgh. But Professor G P McNicol cautioned that sitting the examination did not mean that doctors would emigrate and a combination of TRAB and the increase in output from British medical schools would mean competition in the hospital service in a few years' time. General practice would be full and other countries might curtail medical immigration. It was now that action was needed to improve recruitment. Professor Payne insisted that hospital medicine should be made more attractive.