MONITORING HEALTH CARE PLANNING FOR THE ELDERLY IN THE UNITED KINGDOM NATIONAL HEALTH SERVICE: A REVIEW OF THE GENERAL RESEARCH PROBLEMS

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THE CONCEPT OF MONITORING

Monitoring has been defined as "the process of information-gathering by which an organization checks its performance relative to targets".[1] In the context of social service planning, monitoring implies checking whether the strategy chosen to reach a given goal is in fact achieving that goal. Here the process of monitoring provides an opportunity to test the correctness of assumptions underlying plans, and thus to validate or reject the implicit social theory upon which the plan is based.

Current attempts at formal planning of health care in the NHS provide fertile ground for the development of monitoring procedures. The researcher eager to take advantage of NHS planning to increase his knowledge of the working of the health care system has the task of providing planning teams with tools for information-gathering which are appropriate for testing the assumptions underlying the NHS plans.

THE APPLICATION OF MONITORING PROCEDURES TO HEALTH CARE PLANNING FOR THE ELDERLY IN THE NHS

The increase in the absolute and relative numbers of the elderly in the population has made the planning of health services for this group an urgent task. In the U.K. explicitly stated planning guidelines for the health care of the elderly have been worked out and incorporated into the formal strategic plans of Regional and Area Health Authorities. The tasks of the researcher wishing to develop procedures for monitoring these plans include making explicit the implicit hypotheses regarding the connection between a course of action and achievement of a goal and devising instruments for measuring the input components of the action plan,

the output components and possible intervening factors. These tasks may be illustrated with direct reference to the planning objectives and targets developed for health care services for the elderly in the U.K.

The document "Priorities for Health and Personal Social Services", issued by the Department of Health and Social Security in 1976, stated in clear terms the main objectives of services for elderly people: "to help them remain in the community for as long as possible" and to provide nearby "long-term hospital and residential services for old people who can no longer continue to live independently in the community even with the support of all available health and social services".[2] The general strategy outlined in this document for achieving the goal of prolonged community living for the elderly was the strengthening of primary health services, meaning family practitioner services, the health centre programme, health visitors, home nurses, and social services provided by local authorities. The strategy was operationalized in terms of suggested yearly growth rates in expenditures by service between 1975-76 and 1979-80, and/or target staff (service)/population ratios, as follows: Family practitioner services 3.7%/year, health centre programme 11%/year, health visitors 6%/year, home nursing 6%/year, chiropody 3%/year, home helps 2%/year (12/1000 people over 65), meals 200/week/1000 people over 65, day centres 3.4 places/1000 people over 65.

For the elderly too infirm to remain in their homes, the DHSS suggested improvements in residential and in-patient services - in patterns differing from traditional ones. It was aimed to reduce the number of long-term geriatric cases inappropriately cared for in acute hospitals or in large, dilapidated mental hospitals; instead, small "community" hospitals with GP access and small residential facilities run by local authorities or voluntary agencies were stressed. These strategies were operationalized in terms of target numbers of beds for the elderly in community hospitals, district general hospitals, and residential places.

Evidence of the determination of the DHSS to emphasize the development of community services and streamline acute services

may be found in its budget proposals. In the summary table provided at the back of the document, "Priorities for the Health and Personal Social Services", the 'illustrative average growth rate p.a. 1975-76 - 1979-80' was given as 3.8% for primary care and only 0.9% for general and acute hospital and maternity services.[3]

In the one regional strategic plan which it was possible to study, there was a large degree of agreement expressed for the national objectives on care for the elderly. Much of the plan consisted of a repetition of the DHSS objectives and targets and of statements of intention to work towards them. An effort was also made in the regional plan to present statistics permitting comparison of the regional situation with the DHSS targets.

On one level, monitoring of the planned health services for the elderly may be construed to mean just continuous comparison of regional rates of expenditure, staff/population ratios, or bed/population ratios with national targets. However, of more significance is the use of monitoring to examine the validity of assumptions underlying the planned course of action for meeting the increasing needs of the elderly population. Critical implicit assumptions include the following:

(1) Emphasis upon primary care rather than the acute sector is realistic in light of the constellation of interest groups on the various levels of the planning hierarchy.

(2) Increases in the volume of community health services to given target levels will help the elderly to maintain their health and social independence and postpone their need for institutionalization.

(3) The providers of community health services will be able to adjust to their new workload and will be able to function as teams, providing coordinated regimens of treatment and social services to the elderly.

The need to test the validity of such assumptions has been pointed out by planners and researchers worried about making major investments in new patterns of care without evidence of their effectiveness. The drafters of one regional plan pointed out that "there is no clear conception of what the job of primary care is, or what GP's should be doing...No real cost-benefit analyses have been done for hospital care vs community care. No-one has established the full effects of a significant reduction in hospital facilities and a corresponding need to develop community services".[4] Similarly, Donald Hicks cites Curwen and Brook's comment that "there is at present no machinery for collecting, assessing, and disseminating information about health centres and the impact they are making on the standards of community care".[5] Hicks himself concludes, "...because of what is at stake, it is urgent that comprehensive operational research studies incorporating the many facets of health centre operation and care should be mounted if we are to avoid making costly and irreparable mistakes".[6]

The testing of the 'implicit assumptions' regarding the planned health care for the elderly would entail the gathering of data within a carefully specified research design. Some issues and possible data requirements for examining the validity and implications of various assumptions are discussed below.

Assumption 1. Emphasis Upon Primary Care Rather than the Acute In-patient Sector is Realistic in Light of the Constellations of Interest Groups on the Various Levels of the Planning Hierarchy

The most straight-forward method of monitoring the feasibility of the planned resource deployment schemes is to obtain information on how money is actually being spent in the region under study. However, the form of the final budget is the end-result of a complicated process of drawing up proposals and approving plans, in which many groups take part. Those identified in the planning document, "The National Health Service Planning System"[7], include the Regional Health Authority, the Regional Team of Officers, the Area Health Authority, The Area Team of Officers, the District Management team, the District Planning Team, the Community

Health Council, Family Practitioner Committees, Joint Care Planning Groups, Joint Consultative Committees, and Local Authorities. The Regional Strategic and Operational Plans are supposed to have as input the proposals and plans of all the planning and management teams on the area and district levels, and thus must come to grips with the possibly conflicting interests and priorities of these groups. To understand the reasons for the compliance or lack of compliance of a given region to national budgetary priorities, it would be necessary to examine the interplay of these groups' interests. It is of great potential aid to the investigator that many of these groups are required to draw up in written form guidelines for planning, plan proposals, or actual plans. Thus evidence exists on the basis of which the researcher could analyze the grouping and weighting of interests, or compare the characteristics of planning groups in various localities which registered greater or lesser degrees of compliance to the budgetary guidelines.

Assumption 2. Increases in the Volume of Community Health Services to Given Target Levels Will Help the Elderly to Maintain Their Health and Social Independence and Postpone Their Need for Institutionalization.

Because this assumption is based upon the implied relationship between the input of resources and the impact upon the health status of the elderly, its correctness can best be monitored by means of experimental techniques. The role of the researcher is to alert planners to the prerequisites of the experimental method and to provide them with appropriate measurement tools for carrying out a prospective study. The setting for this type of study is ideally a 'laboratory' community, or in the context of the NHS planning system, a planning unit such as the district.

The task of the researcher is to study the assumptions upon which the health and social service 'targets' are based, i.e. to determine the level of treatment by type of disability and the amount of disability in the elderly population implied by the targets. To monitor the correctness of these assumptions, it is necessary to measure the impact of increasing the volume of services upon the disability and social independence of the elderly living

in the 'laboratory' community, and to compare the status of the elderly receiving services with a control group of those who are not.

The basic monitoring tools are an instrument for measuring the amount of disability in the elderly population and a method for accounting for the level of services being administered. The tool for measuring disability could be similar to the OARS Multidimensional Assessment Methodology developed by the Centre for the Study of Aging and Human Development at Duke University[8] or the physical, mental and social indices developed for a study of service provision to the elderly in Greenwich, England.[9] Problems of accessibility to professional records would have to be overcome in developing a tool for measuring levels of service. Planning statistics published for regions in England show a low level of knowledge about the number of community health professionals currently working, much less about the type and level of activity performed by them. In one set of statistics on community services, for instance, such data as the "elderly patient/GP ration", the "amount of domiciliary consultation by geriatricians", and the "per cent of GP's using a health centre as a main surgery" were missing. It seems necessary to try to develop a counterpart to the "Hospital Activity Analysis" for primary care.

The ultimate object of the monitoring process would be to collect data on the impact of the health and social services on the health 'careers' of the elderly being served.

Assumption 3. The Providers of Community Health Services Will Be Able to Adjust to their New Workload and Will Be Able to Function as Teams, Providing Coordinated Regimens of Treatment and Social Services to the Elderly.

Many of the changes involved in a shift from institutional to community care imply increased responsibilities for the GP: growth in the number of elderly people in the population increases the amount of traditional services to be performed for this patient group; rationalization of acute services with shortened lengths of stay implies more work with convalescent patients in the community; the policy of placing very infirm elderly patients

in small community hospitals with GP access increases the in-patient responsibilities of the GP; finally, the development of the 'primary health care team', with the GP as the "first-among-equals" implies supervising and planning coordinated regimes of health and social service care for elderly patients.

Testing the validity of the assumption that the GP will be able to adjust to his new responsibilities would ideally require the development of tools for measuring the GP's activities. It would be necessary to develop such tools initially within the context of the individual practices of GP's or their activities within health centres, although the ultimate criterion is success in maintaining elderly patients in the community. The difficulties of such measurement are evident. In the absence of direct measurement, the best available bases may be the systematic organization of subjective assessment, e.g., as reported through Family Practitioner Committees; and comparative observations or judgements of what practitioners see as "equivalent" workloads in different mixes of total patient numbers, demographic mix, and planned health care regimes.

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