HEALTH CARE NEEDS AND HEALTH POLICY:
THE CASE OF RENAL SERVICES

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Abstract

This thesis presents a critical ethnography of decision making with respect to the assessment of health care needs in the UK health system. Theories of need, justice and rights are reviewed in relation to structural changes to the National Health Service, together with the different theoretical approaches underpinning health policy based on human needs. The research on which this thesis is based focuses on a case study of an independent review of renal services in London, concentrating on the needs assessment work of the review group set up by the government and the decision making debates this review group engaged in. The methods used are based on a participatory, critical ethnography. The review process is evaluated critically by relating the technical knowledge produced by the group to a theoretical framework for assessing needs and by using a Habermasian perspective to investigate the ways in which the language of need is used to legitimise the agendas of various vested interests. This work is linked with an analysis of quasi-markets in the health service to explore the capacity that the technical discourses of markets and contracting have for reinforcing the ideological distortions identified in the analysis of the group's debates concerning need. Finally, by linking an analysis based on a case study of renal services to theoretical understandings of health care needs and health policy, a general critique of the UK health system is constructed.
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Er cof am fy nhad
INTRODUCTION

The problem of human need in relation to health care

This thesis presents a critical ethnography of decision making with respect to the assessment of health care needs in the UK health system. Theories of need, justice and rights are addressed in relation to structural changes in the National Health Service. The analysis focuses on a case study of an independent review of renal services in London, concentrating on the needs assessment work of the review and the decision making debates the review group engaged in. The methods used are based on a participatory, critical ethnography. The renal review process is evaluated critically, using a Habermasian perspective, to investigate the ways in which the language of need is used to legitimise the agendas of various vested interests. This work is linked with an analysis of quasi-markets in the health service to show the capacity that the technical discourses of markets and contracting have for reinforcing the ideological distortions identified in the analysis of the group’s debates concerning need. Finally, the implications of the findings for a general critique of the UK health system are discussed.

Health care needs in the NHS

The NHS was originally set up on the basis that it would provide universal health care to all, free at the point of need. Harrison et al (1990) and Klein (1983) have argued that from the very beginning the NHS was very much a compromise, and the description of a needs based service was more a product of rhetoric than reality. Over the years the concept of a ‘free’ service has been redefined and the ability of the system to respond to needs has been continually questioned. The image of the
NHS as a universal service is however strongly supported by the British public. This may be due in no small part to marked improvements in the health of the British public since the inception of the NHS. However, McKeown (1979) has argued that most of the improvements in life expectancy and in health status during the twentieth century can be attributed, in the main, to improvements in socio-economic conditions and not to the developments made in modern health care. McKeown’s thesis has been criticised for understating the impact of local politics and public health interventions (Szreter 1988) and for underplaying the role of health services (Mercer 1990), particularly in the period after the inception of the NHS. During this period, others have argued that inequalities in health have persisted despite improvements in health status (Townsend and Davidson 1982). During the decade of the eighties, these inequalities have been seen to increase and have been attributed to the relationship between poverty and health (Whitehead 1987, Marmot 1989, Phillimore et al 1994).

These arguments seem at times to have been a backdrop to changes that have been happening to the structure of the NHS system itself. These changes have been highlighted by Roberts (1992) when she draws a historical picture of the NHS progressing through three periods; the administrative period, the planning period and the management period. It was during the management period that questions began to be asked about, not only the structure of health service delivery, but also about the supply and demand for health care and the way that health care could be financed in the future (Culyer, Donaldson and Gerard 1988). In response to reviews that argued against a radical reform of the financing of the NHS, the Thatcher government turned towards radical initiatives on the structure of the NHS. The capacity of
quasi-markets\textsuperscript{1} to introduce competitive disciplines to the public sector was seen as an attractive solution to the problem (Enthoven 1991), and led to the NHS reforms of 1991.

**Structural reforms and their impact on needs**

Since 1st April 1991, District Health Authorities (DHAs) have had to set up contracts for health services with providers (Hospitals, Community services, NHS Trusts and Directly Managed Units (DMUs), private and voluntary sector providers) on the basis of an assessment of the health care needs of their residents. General Practitioner fundholders have also been allowed to contract for a limited set of health services, independently of DHAs. This arrangement is termed the 'purchaser provider split' where purchasers buy services on behalf of their residents or practice populations and providers sell their services in return for payments made from the purchasers' limited budgets. Negotiations for the buying and selling of services are undertaken through what is called the contracting process. In most cases departments of public health take on the role of 'needs assessors' for the purchasing authorities. Although *Working for Patients* [wfp] (DoH 1989a) did not consider public health needs assessment in detail, the relationship between public health and needs can be traced back to the Acheson report (Acheson 1988), which called for regular reviews of the population's health. The question of how needs assessment and purchasing health care are linked was addressed by the Department of Health (*Secretary of State* 1989; EL 1990), concentrating initially on an epidemiological approach to needs assessment. This was given a critical dimension by the work of

\textsuperscript{1} The term quasi-markets refers to the separation of supply and demand within an organisation. The terms internal markets and managed markets are also commonly used to describe such a system.
Stevens (1991) who related Need (defined as what people benefit from) to Demand (defined as what people ask for) and Supply (defined as what is provided). The Department built on this by developing a three pronged approach to needs assessment, based on epidemiological, comparative and corporate approaches to health needs, (DoH 1991) as a basis for contracts. This approach has not been without its critics however and some have argued that health care should not be purchased on the basis of total needs assessment but on economic evaluations of competing demands for resources (Donaldson and Mooney 1991). In this way it is argued that ‘rational’ decisions can be made about where resources should be allocated. It was never clear therefore, what needs assessment in the reformed NHS should amount to, and there was and is still confusion concerning how resources can be allocated to services by means of contracts according to estimates of need. It is the aim of this thesis to address the way debates about needs form a basis for decision making in the health service.

The NHS reforms provided an opportunity to develop processes for need assessment in the health care arena, but the Department of Health gave no guidance as to the theoretical basis for this work. As a result, much of the work to date has been based on a ‘synthetic’ epidemiological approach, applying estimates of disease incidence and prevalence to local populations. In this thesis I will argue that whilst such an approach is useful, its relevance to the experiences of individuals and groups receiving care is limited. In addition there seems to be no apparent attempt to link this work to a theory of needs and more significantly to operationalise a theory of needs in health terms, so that results of the work can be channelled into effective purchasing. These deficiencies have been highlighted by Frankel (1991) when he delineated the confusion surrounding the term ‘health needs assessment’. This confusion stems from a number of different imperatives that influence the
relationship between 'needs' and the provision of health care. The public health imperative is concerned with total population needs and developing strategies based on prevention and health promotion. The economic imperative is concerned with marginal met needs and the most efficient ways of meeting needs, whilst the political imperative has been one of reconciling a welfare system to the demands of free market ideology. In the midst of this an understanding of the relationship between the human subject and the system is in danger of being marginalised and the extent of this marginalisation seems to be related to the lack of recognition given by health policy to the relationship between health and rights. That is to say, policy is not grounded in any formal recognition of a relationship between needs and entitlements. On the contrary there seems to be a deliberate muddling of the issue so that an already fragmented system is unable to take responsibility for the needs of those it was designed to serve.

The problem of need and scarcity

The 1980s saw much debate concerning the relationship between needs and welfare provision (Doyal and Gough 1984, Geras 1983, Wiggins and Dermen 1987, Soper 1981). The debate focused on absolute, normative and relative definitions of need, and discussed them in terms of their implications for political economy. Others have used this debate to redefine the concept of need in economic terms (Culyer and Wagstaff 1991). Even those who have argued for substantive needs, recognise that there are instances (particularly in areas like the provision of health care) where the concept of needs breaks down (Braybrook 1987, Thomson 1987), but these instances can provide valuable insights into the dilemmas that surround the concept and the implications this has for health policy.
Doyal and Gough (1991) have developed a theory of human need centred on the individual’s capacity to participate in social life. They state that the two most basic needs are physical health and autonomy forming the preconditions for participation in moral life. Their argument focuses on a negative definition of health based on survival and avoidance of harm. Health care, in this theory, is a specific satisfier of the need for health and autonomy.

The fair and just allocation of scarce health care resources according to need, requires a theory of need that calls on appropriate principles of justice and equity and can be operationalised within the system, but such an idealised approach will fall on barren ground unless the problem of scarcity is addressed at the same time. How and whether suitable and appropriate principles of justice are embedded in the NHS is unclear. The NHS is funded from taxation and works in the main by means of allocating capped budgets by a central bureaucracy. Given budgets are limited it is axiomatic that rationing is necessary. Those who argue in favour of markets in the NHS state that rationing has always gone on but the criteria for rationing will now become more explicit and thus rationing itself will be fairer and more objective. If rationing is inevitable, it is not clear how the action of making it more explicit automatically leads to it becoming fair and objective. Doyal and Gough address this issue by adding a procedural element to their theory of need. They utilise Habermas' idea of the validity of human interests stemming only from agreement in free and open communication. For Doyal and Gough, agreement over needs and prioritisation between competing needs can only be legitimate if debates are grounded in this Habermasian approach.
Aims of the thesis

It is not my intention to test Doyal and Gough's theory of human need but to use it, and the Habermasian framework it draws on, to evaluate a policy making process. Nevertheless, in doing this I hope to gain insights into the relevance of Doyal and Gough's theory for health policy in the UK. I aim to develop a critique of health policy that highlights the limitations of the policy formation and implementation with respect to human needs.

I begin by reviewing the literature on theories of health and health care need (Chapter 1). This review is not presented as an original theoretical contribution to the needs debate but as a background to inform my interpretation of the ways in which different understandings of need were employed in a practical setting. Having set out the bases for the theoretical debate I outline Doyal and Gough's theoretical framework and consider its potential for evaluating needs assessment in the NHS. I reflect on the implications that a theory of need has for health policy, focusing in particular on the development of quasi-markets in the UK (Chapter 2). It is at this point that the importance of Habermas' theory of communicative action for my work is brought to the surface. Habermas' condition for universality is consensus arising from an ideal speech situation and Doyal and Gough base the procedural part of their theory on this idea. Habermas' theory of communicative action presents a means for evaluating the ways in which needs are discussed in the public domain. It is the potential that Habermas' approach has for evaluating debates concerning needs in the health care system that I explore in this thesis. I do this by adopting a critical ethnography (Chapter 3) in the context of a case study of renal services in London (Chapters 4, 5 and 6). I conclude by presenting a critique of health needs assessment in the NHS (Chapter 7). I consider the strengths and
weaknesses of Doyal and Gough's theory and the advantages and limitations of the Habermasian evaluation I have undertaken. Finally I outline the ways in which this work can be developed in the future.

Chapter summaries

Chapter 1  Health Care Needs, Justice and Rights to health care

This chapter reviews arguments concerning 'objective', universal needs in the context of health care. If universal needs exist, can they form a basis for health policy and if so how can they be measured to inform this policy? I will address alternative notions of need as a basis for health policy, ranging from the new right, health economics and relativist notions of need. Definitions of need as a function of an individual's capacity to benefit will be reviewed together with the values that underpin such an approach. The 'objectivity' of economics will be questioned in light of this. In contrast I will make a distinction between the need for health and the need for health care and relate Doyal and Gough's paradigm of need to the health care system and consider a framework for assessing health care needs based on Doyal and Gough's concepts of health and autonomy. I will outline my intention to use Doyal and Gough's framework in relation to a critical evaluation of the practicalities of health planning and decision making. Following on from this, principles of justice will be considered in relation to health care from the viewpoint of the new right, health economics, Marxist, communitarian, feminist and liberal thinkers. I will draw on the relationship between needs and rights to argue with Doyal and Gough that in striving for a just system, their framework for assessing needs must, in turn, be based on procedures that rely on communicative ethics.
follow a path illuminated by Doyal and Gough's work and turn to the work of Habermas (1984) as a potential source of a theoretical basis for the communicative justice the health care system requires.

Chapter 2   Health Policy: A critical perspective

This chapter looks at the history of policy explanations in the context of health care and relates four major theoretical perspectives; pluralist, public choice, elitist and Marxist, to the theory of human needs. I look at the theoretical background to the development of quasi-markets in health care and consider the implications of this development for the system. I focus on the importance of theories of power for any understanding of health policy and highlight the relevance of Habermas' communicative ethics to an analysis of decision making in the NHS. I outline my understanding of Habermas' rules for ideal speech and set out my intention to use this as a basis for my critical evaluation of the London renal review's work.

Chapter 3   Methodology

In this chapter I set out the justification for undertaking a critical ethnography based on participant observation. The setting for the research is a review of renal services in London, undertaken by an independent review group as part of the process of implementing the Tomlinson proposals for rationalising health care in the capital (Tomlinson 1992). My focus will be the process of policy making with respect to renal services and the extent to which discussions concerning health needs acted as a rational basis for decision making. The review was undertaken in the four months
between March and June 1993 as one of the six speciality reviews established by the London Implementation Group set up in the wake of the Tomlinson report. The renal review group reported in June 1993 and made recommendations on the future of renal services in the Thames Regions (Renal review group report 1993). The empirical part of this thesis will draw on the group's technical assessment of the need for renal services in the four Thames Regions, covering a population of some 14 million people. There will also be a qualitative analysis of the review group planning process based on the minutes of the group's meetings with renal units and transcripts of taped meetings of the review group where decisions about the future pattern of services were made. The findings of these two approaches will be related to the wider policy picture informed by a textual review of renal contracts produced by a sample of DHAs in England and Wales. The thrust of the work is not to test empirically a theory of need but rather to analyse British health care policy in terms of its appeal to needs as a justification for allocative decisions. I base my research methods on an understanding of depth hermeneutics using the three phases of social analysis, discourse analysis and interpretation (Pile 1990). I move from the technical assessment of need made by the review group (based on the group's epidemiological work) through an analysis of debates concerning needs (from tapes and field notes) to an analysis of markets (based on contracts for renal services).

Chapter 4 Assessing the need for renal replacement therapy in the Thames Health regions.

This chapter will summarise and evaluate critically the epidemiological evidence on RRT used by the Renal Review Group as a basis for its decision making. The definition of the need for RRT will be compared with data on the use and the supply of services. This reflects the Department of Health approach to need in relation to demand and supply. The limitations of this approach and its lack of attention to a fair and just policy will be highlighted. The group's technical data will be presented
showing how data on the age, sex, ethnicity and treatment options of patients by area of residence was related to 1991 OPCS census data to produce a socio-demographic analysis of renal provision within the Thames Regions. A picture will develop of existing service provision showing the extent of inequalities in access to services within the geographic area. This technical data on needs will then be analysed critically by relating it to the framework for assessing needs set out in Doyal and Gough's theory, to identify the gaps in the group's technical knowledge and the possible effects these had on the 'rationality' of decision making. The review group's work will be placed in its historical and geo-political context to identify the exogenous pressures on the group as a prelude to a deeper analysis of the dynamics of the review group's deliberations.

Chapter 5  Planning Renal Services - a critical evaluation

Having examined the available technical data used by the group to inform its decision making it is my intention to analyse the extent to which the review group engaged in democratic and rational debate. This will involve a review of the meetings held by the group both at the Department of Health and at the eleven renal units it visited across London. These meetings were formally minuted and tape recorded by me.

Doyal and Gough argue that in order for rational and democratic discussion of optimisation of needs to take place then there must be sufficient technical knowledge available to all involved and rules of practical understanding, truth telling and democratic communication must be adhered to. This view draws heavily on Habermas' rules of ideal speech, seeing them as prerequisites for rational resource
allocation decisions on the basis of need. The main aim of this chapter therefore will be to determine whether the lack of a firm theoretical basis for discussing needs together with the limitations of technical knowledge available to the group, combined to allow vested interests to undermine the 'rationality' of the review group's decisions. I will focus on the ways in which the language of need is used by various interest groups to legitimise their actions. I will highlight the dangers of new technical discourses developing that are linked to the ideology of markets in health care. The ability of these discourses to exclude some groups from debates on need will be considered.

Chapter 6 The contracting culture and health care needs

In this chapter the theoretical analysis of needs and the empirical work on the renal review group will be brought together within a textual analysis of contracting. The aim will be to demonstrate the failure of the contracting system to be grounded in an adequate theory of need and the dangers this entails with respect to parallel attempts to plan services. The chapter will begin with a discussion of the ideas behind the contracting culture, relating them to critiques of quasi-markets. The technical limitations of a sample of contracts will then be considered along with questions of the extent to which contracting conflicts with any attempt to plan services on the basis of 'need'. I will emphasise the contradictions between the renal review group report as a planning document and contracts as mechanisms for purchasing services in a quasi-market. Finally, I will consider the specialised language of contracting and how this has a potential for reinforcing the codified discourses discussed in the previous chapter.
In this my concluding chapter I argue that the present system cannot address justice and rights in health care because its approach to health care needs is muddled. The ability of interest groups to override needs based arguments and even to use needs based arguments to promote their interests, remains a dominant characteristic of the system. The drive towards competition and markets is presented as a challenge to these interest groups but I argue that there is a duality to this strategy because of the capacity of contracting processes to reinforce the power base of certain interest groups. An important aspect of this is the way in which the medicalisation of need is both a means by which the ‘systemworld’ colonises the ‘lifeworld’ and a means by which challenges to the existing order can be made. These challenges are however held fast by the medical framework within which they are formed. I argue that quasi-markets appear to play an important role in reinforcing this process. Finally, I draw conclusions about the practicalities of grounding health services in a theory of need and the implications of such an approach for evaluating the health system’s role as a specific satisfier of health care needs.
Chapter 1

Health Care Needs, Justice and Rights to health care

"to render available to every individual all necessary medical service, general and specialist, and both domiciliary and institutional" (Beveridge Report 1942 paragraph 427)

"The Patients needs will always be paramount" (Margaret Thatcher 1989 foreword to Working for Patients)

The focus for this thesis is population needs assessment and health policy determination. My intention is to examine the relationship between theoretical and practical understandings of health care needs on the one hand and the determination of policy on the other. I wish to explore the nature of our understandings and interpretation of health care needs and their capacity to both inform policy decisions and legitimate policy making. This chapter looks at the theoretical debates surrounding health care needs. I structure the chapter by contrasting concepts of need and justice that have been developed by the New Right\(^1\) and health economics\(^2\) with a wider debate concerning the philosophical basis for a needs based health care system. I do this because health policy in the UK has been influenced by key ideas from these two separate, sometimes

\(^1\)I view the term 'New Right' as encompassing libertarians and neo-conservatives. It is however important to distinguish between the two because the former are committed to free market policies on the basis of theories of personal freedom whilst the latter support free markets because of their presumed link with traditional values, the family and the disciplining force of respect for authority. These two approaches bring different perspectives to bear on needs: on the one hand from a commitment to personal freedom and on the other from a commitment to social policies based on 'moral standards'. The impact of New Right thinking on health policy in the UK has stemmed from the way in which these two separate streams of thought were mixed together to form the drive to expose the NHS to the disciplining effects of the market under Thatcherism.

\(^2\)Health economics is the application of the discipline of economics to the topic of health care (Mooney 1986 p5). It brings to health care the question of choosing between competing alternatives for action within the limits of scarce resources. The goal of health economics therefore is efficiency. Within these parameters however there is plenty of scope for health economists to develop different approaches to their discipline.

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conflicting, but influential strands of thought. I use my critique of these approaches as a basis for considering the possibilities Doyal and Gough’s theory of human need (Doyal and Gough 1991) holds for health care needs assessment. Doyal and Gough have constructed a theory of human needs based on the notion of basic needs being health and autonomy, an optimum level of which is fundamental to allow participation in social life. Soper (1993) is attracted to the theory at this general level but argues that as the theory becomes more exact and moves on to intermediate needs and the specific satisfiers for these needs then their ‘universality’ becomes more problematic. My aim will be to show that whilst there are strong theoretical arguments for accepting the existence of universal human needs at a general level, the project of maintaining such a universal position becomes more difficult as we begin to specify particular needs; health care being a prime example in this respect. If health care resources are to be allocated according to ‘need’ therefore, we require a procedural framework for discussing needs together with what constitutes a ‘just’ distribution of resources. After reviewing various approaches to justice, I emphasise the importance of Habermas’ communicative ethics, not only for Doyal and Gough’s theory but for my own project of evaluating needs assessment in the health system. This will be expanded upon in chapter 2.

1.1 Health Care Planning and the problem of human need.

It is important to distinguish between the need for health and the need for health care. This thesis is specifically concerned with the latter. Health care is a

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\(^3\)Doyal and Gough define the ‘optimum’ at two levels; the participatory optimum and critical optimum. The first refers to levels of health and autonomy such that individuals can choose the activities in which they will take part within their culture. The second refers to levels of health and autonomy such that individuals can question their form of life and participate in political processes that allow them to be critical and change cultures. In neither case does optimum imply maximum. (Doyal and Gough 1991 p160)
satisfier that is one way in which we can meet our need for health. The need for health has been perceived by Acheson (1978) as relief from the negative states of distress, discomfort, disability handicap and the risk of mortality and morbidity. These concepts form the basis of but do not wholly determine the need for health services. This amounts to a biomedical approach to health care needs and as such it excludes positive concepts of health and health promotion. The approach is popular because it lends itself to quantitative measurements of health status, and the resulting health care needs fit conveniently with the biomedical focus on the incidence and prevalence of disease. Bradshaw (1972) on the other hand has constructed a paradigm of need in terms of normative, felt, expressed and comparative need. This forms a sociological approach to needs that sets up a useful matrix of the ways in which needs can be defined. However, as Bradshaw points out in a later piece (Bradshaw 1994), this was never intended as a way of constructing a hierarchy of needs. Indeed, Bradshaw argues that the concept of need is too imprecise and fraught with difficulties as to be a useful basis for health policy.

Arguments surrounding needs and health care have tended in the past to concentrate on the relationship between needs and service use and how the burden of needs interacts with the demand for, and access to, services (Titmuss 1968, Hart 1971, Last 1963). In this sense need is not an absolute concept, but is relative and dependent on socio-economic and cultural factors as well as supply side factors. It is here that arguments have developed around the effect of supply and demand on need (Eddy 1984, Friss et al 1989) and a questioning of the appropriateness of subjective value judgements of third party needs assessors as an alternative to consumer sovereignty (Culyer 1976). The nebulous nature of ‘need’ and its formulation as an antithesis to consumer preference theory has also formed the basis of the New Right’s view of need, who see attempts to determine needs as the first steps towards authoritarianism.
1.1.1 Need and the New Right

The New Right are not a homogenous group of thinkers and there are a number of streams of thought which can be described as New Right in origin. However, there are common elements to the approach of the New Right to the concept of needs and health care needs. Firstly, the New Right sees the expression of individual preferences through the market mechanism not only as a more effective means of distributing resources, but also as having moral superiority over any attempt to plan on the basis of need. Secondly, the libertarian stream within the New Right equates personal health with individual responsibility as a means of promoting the ideal of 'self ownership'. This can be seen in Hayek's (1944) arguments concerning the link between markets and freedom, and Nozick's (1974) attacks on taxation, setting limits on its legitimacy as a means of supporting welfare provision.

Within health care, the New Right have approached needs with suspicion. Whilst arguments against objective, universal needs are not exclusively those of the New Right, their critique characteristically places an emphasis on the individual. Green (1986) argues that:

“medical ‘need’ cannot be objectively measured or predicted, and resources allocated to match. Any decision about whether or not to proceed with some recommended course of treatment entails judgements which touch upon intimate personal matters such as willingness to endure pain, face risks and, not least incur costs in the light of alternatives on which money might be spent.”

(p95)
The New Right therefore deny the existence of objective health care needs arguing instead that individual feelings about treatment decisions will vary considerably. There are tensions within the New Right however; Harris (1988) for one argues that:

"The trouble is that kindness corrupts, and in the end can even kill. Once policy departs from concentrating state help on the declining minority in quite specific forms of absolute need, the categories of prospective beneficiaries multiply and 'need' assumes an elastic dimension in the name of relative poverty" (p18)

Some of the New Right therefore argue that some form of decent minimum requirement exists in terms of absolute basic needs. Thus their argument often seems to contradict those who argue against needs in any sense.

Perhaps the most damaging attack on the concept of 'health needs' and the ability of the NHS to meet 'needs' came from Enoch Powell (1966). Powell focused on the demand for health care and emphasised the role of price in the process of translating needs into demand for services. He argued that demand for health care was infinite where there were no price barriers to care, as in the NHS. Buchanan (1965) laid the ground for this attack by setting out two principles in support of a theory of infinite demand. The first was the elasticity principle which states that when price elasticity of demand is greater than zero, then individuals will demand more goods provided by public services than they would if those services were provided at a price in the market. The second principle is that of external economies whereby if externalities exist, these can be internalised in a publicly provided service but result in under-investment in a
market system. He argued that these principles had a 'mutually reinforcing' effect and therefore would have expected that subsequent to the creation of the NHS there would have been a marked increase in public spending and provision relative to what would have been spent under a market system. He argued that this did not happen in the UK because the relationship between 'needs' and infinite demand was strictly controlled:

"The British experience strongly suggests that, rather than responding to 'needs' through increases in aggregate supply, governments have chosen to allow the quality of services to deteriorate rapidly, both in some appropriate physically measurable sense and in terms of congestion costs imposed on prospective customers." (p9)

The New Right therefore succeeded in the past in arguing against the concept of 'needs' whilst simultaneously chastising welfare state institutions (such as the NHS) for failing to respond to 'needs'. This reflects a fundamental problem with the New Right's approach in that by promoting the superiority of individual preferences and the moral force of the market they imply the existence of needs. Arguments that reject need are therefore contradictory in that they imply the existence of need. Arguments for basic needs on the other hand seem to be an attempt to reconcile the New Right's nebulous view of need with the need to specify some 'objective' basic minimum as an absolute standard. This again implies the existence of a universal objective notion of need, but fails because the 'decent minimum' is so clearly based on subjective notions of what a democratic free market system can tolerate. Perhaps in view of these difficulties, Gray (1992) develops an argument for a social market economy with
an enabling welfare state, based on a central premise of ‘satiable basic needs’\(^4\). To develop his argument Gray draws on the work of Raz (1986) and the value given to autonomy as a basic need. Gray’s arguments are particularly interesting when applied to health care:

> "Raz illuminates a fundamental property of basic needs, as distinct from wants or preferences, when he notes that, most of them, in principle, are capable of complete satiation. The needs of the disabled, or of the illiterate, though sometimes perhaps expensive to meet, can be met completely, that is to say, to the point at which they can lead reasonably autonomous lives." (p66)

Gray recognises that with respect to medical care there are difficulties:

> "Medical care generates peculiarly difficult problems...in that by no means all medical needs are fully satiable. Whereas those of the disabled are usually fully satiable, those connected with the process of ageing, or with illnesses that are terminal but which can (with an ever worsening quality of life) be indefinitely staved-off, sometimes are not.” (p66-67)

Gray points out that the policies put forward by the New Right, such as voucher schemes are guilty of the same indeterminancies that have been applied to ‘needs’. As he points out “What should be the size of a school voucher, and

\(^4\) It is important to clarify the meaning of terms like ‘satiable’ and ‘basic’ in relation to needs. The term basic needs implies a narrow range of needs that are essential for human functioning. A satiable need implies a need that can be fully satiated by the resources available to society. A satisfiable need may or may not be fully satiated and can be met either by the provision of a specific satisfier or by manipulating the need itself.

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how (and by whom) is this to be determined?” (p68). This returns us to the dilemma of how to reject an objective notion of needs whilst at the same time presenting a case for satiable basic needs. Gray seems to find a solution to this problem by arguing that the characteristics of satiable basic needs are such that the goods necessary for their satiation can be defined by the agent in need:

"The deeper objection concerns the commensurability of basic needs. Among medical needs, can the preservation of life be ranked against the alleviation of pain? And how are medical needs to be weighed against educational or intellectual needs? It would seem that such judgements could be made, if at all, only by invoking a thick and comprehensive conception of the good life about which there is, among us, no consensus. Distribution according to basic needs would then be arbitrary, in that it would impose on all a conception of the good life that was only one of several, possibly incommensurable conceptions harboured in our society. What can be said against this claim? An answer can be found I believe, in the fact that the content of a basic need is subject to partial self-definition by the agent. A person may have basic medical needs which require residence in a nursing home, but the detailed mixture of goods and services may again be determined by the person himself.” (p68)

Gray seems to take this line of thinking to be sufficient to justify vouchers in that vouchers are in this sense a species of welfare benefit that is akin to a positive right. In a sense the idea of the voucher is introduced as a way of avoiding the 'paternalistic' characteristics of basic needs that the New Right object to. The New Rights approach to need is therefore twofold; either need is rejected
completely, or some form of decent basic minimum is postulated, provided this is underpinned by concepts of individual choice and freedom.

Another flaw in the New Right approach can be found in their idealisation of the relationship between consumer sovereignty and human interests (Penz 1986). There are many diverse conceptions of human interests but the main thrust of consumer sovereignty sees what is produced, how it is produced and how it is distributed, as determined by consumer preferences expressed through individual choices in a free market. Even if we accept that consumer preferences revealed through the market are a plausible representation of the interests of individuals in production and distribution, this still leaves open the question of what these interests are. Seen in these terms consumer sovereignty has a normative centrality, it:

"is not a goal that competes with other primary goals of economic policy but rather a core value that underlies the most important economic policy goals in liberal or social democracies". (Penz 1986 p12)

However, in order that individuals are to reveal preferences a range of choices is required and this presents a problem in terms of how wide a range of choices is necessary. Penz argues that there is a trade-off between variety and quantity in that standardisation in production gives greater quantity of output for the same input but this is done at the expense of variety. Welfare economics tries to avoid the conflicts in this trade-off by focusing on efficiency. However, there are problems with the efficiency conception of consumer sovereignty because of an inability to distinguish between inefficient sovereignty and sovereignty constrained by other sovereign powers. Within health care where individual consumer sovereignty is at best compromised by a plethora of factors such as the
agency relationship (Arrow 1963), lack of information and inability to discount risks, these arguments weaken considerably the New Right’s approach to health care need.

1.1.2 The Economics of Need.

Traditionally economists have been suspicious of attempts to define needs. Culyer (1976) pronounced that the word 'need' ought to be banished from discussion of public policy. Williams (1978) also argued that 'need' confused matters. More recently however economists have argued in terms of 'marginal met needs' resulting in the somewhat contradictory position where health economists have been the most vociferous in advocating health services be allocated on the basis of need. Indeed in talking about the NHS reforms Culyer, Maynard and Posnett (1990) argue:

"This reform has been influenced considerably by the work of economists who have long advocated that care should be allocated on the basis of need and that the efficiency of resource use be improved by the explicit measurement of costs and outcomes." (p1)

Economists have therefore developed arguments that accept 'needs' provided they are placed within an economic context. Culyer (1991) is open about this tactic:

"...on the 'if you can't beat 'em join 'em' principle (but only on my terms), it becomes necessary - stick though it may in the gullets of many economists to do so - to provide the word [need] with suitable content" (p14)
The economic approach to needs in general and health care needs in particular is based on the concept of marginal met needs\(^5\) (Steel 1981) manifested in arguments put forward in support of economic evaluation or ‘marginal needs assessment’ as it is sometimes called. Donaldson and Mooney (1991) argue that there are fundamental flaws in the concept of total or epidemiological needs assessment on the following grounds:

- ‘need’ per se is a red herring, changes in ‘need’ met (or marginal met need) being the relevant outcome factor on which to focus;
- failure to account for the responsiveness of disease to health care interventions;
- failure to account for changes in costs and benefits resulting from interventions.” (p10)

The economic approach therefore uses the idea of the subjectivity of ‘needs’ to postulate an alternative paradigm of ‘need’. Because of the ‘subjectivity’ of needs, the process of needs assessment is inevitably value laden, given that opinion on a patient’s needs is usually made by a third party (usually a doctor). This argument about the subjectivity of needs and the superiority of individual preferences expressed through demand as measures of the appropriateness of health services underpins the economic approach and mirrors some of the arguments developed by the New Right. The argument is however, more complex than this. Economists see the ‘objectivity’ of need as patronising and dangerous but with respect to health care they concede that the agency relationship\(^6\) (Arrow 1963), undermines the reliability of preferences.

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\(^{5}\) Marginal analysis starts from the existing pattern of expenditure of resources and considers the effect of small changes to that pattern.

\(^{6}\) The ‘agency relationship’ refers to the way in which the doctor acts as the agent of the ill-informed patient.
Economists therefore work towards making preferences more reliable and making needs assessment less patronising by opening it up to ‘rational economic analysis’.

Culyer and Wagstaff (1991), consider the relationship between economic evaluation and need in detail. Their main concern is with the allocation of resources and the relationship between the two principles of “distribution according to need” and equality of resources. They argue that the two principles are not linked and that any allocation of resources according to the principle of “distribution according to need” does not automatically result in equality and may indeed result in greater inequality. What is significant to the present discussion is that to make their case Culyer and Wagstaff set up an economic definition of need which gives greater weight to the concept than previous economic approaches. Culyer and Wagstaff begin their analysis as sceptics of any attempt to construct a universal concept of need that embraces common meanings of the word. Instead they proffer a precise definition of need that relates specifically to health care:

“Instead of defining the need for medical care relative to some pre-specified end-state, we define it simply in terms of improving (or maintaining) health. A need for medical care is then said to exist so long as the marginal product of care is positive, i.e. so long as the individual’s capacity to benefit from medical care is positive. We define an individual’s level of need as the amount of medical care required to reduce the marginal product of care (or equivalently the individual’s capacity to benefit) to zero. Clearly, “need” so defined is not synonymous with capacity to benefit...but rather is a function of capacity to
benefit, depending too on the productivity of medical care at the margin.” (p6)

The result of this is that they set themselves in opposition to Thomson (1987) who has argued that there is an “element of practical necessity” in any normative use of ‘need’. They argue that Thomson’s approach is flawed because there are practical implications to his argument which he fails to address. Despite this it is important not to lose sight of Thomson’s attempt to relate the denial of a need to a consequence of ‘serious harm’. For Thomson, need is at the core of moral debate and should determine our moral judgements. The identification of a fundamental need forces us to pass from the is statement ‘there is a need’ to the ought statement ‘the need ought to be met’.

Seeing needs in instrumental terms requires that the ‘end states’ or ‘goals’, towards which needs are instrumental, be examined. Culyer and Wagstaff again see problems here citing the various end states that have been put forward such as freedom and autonomy (Wiggins and Dermen 1987), life and health (Braybrook 1987). They also argue that the attempt by Wiggins and Dermen to develop a categorical concept of need, fails because it appeals to the ethical force of the ends. In terms of health being a goal they argue that where health is seen as a binary variable i.e. sick or healthy then this gives rise to a binary interpretation of need. The binary interpretation of need, it is argued, puts needs in conflict with the construction of health and health care as continuous variables. If health is a continuous variable then the end point or goal towards which needs are instrumental, becomes elastic and nebulous. These arguments lead them to conclude that a necessary condition for a need is that if what is needed is provided it should result in a person moving towards the goal or end state required. From this they conclude that with respect to health care then if the satisfying of a ‘need’ has a very small or negative impact on the end state,
namely health, then the ‘need’ cannot be needed. For a need to exist, therefore, some positive productivity in response to the need is a necessary prerequisite. This is not all of the picture however, for they argue that there may be more than one way of achieving this positive productivity, and therefore cost-effectiveness has a role to play in this process. Allied to these points, they argue that to be sick is not a necessary precondition of being in need. This statement allows the possibility for being in need of preventive services, as well as the situation where an individual is so sick that no amount of health care will improve their condition.

The problem with the approach is that ultimately need is equated with the productivity of the good identified for satisfying that need. A person is only in need of health care if health care can produce positive benefit; need is a function of supply. What are the implications of this for improving health care and identifying needs? There is a danger that needs may go unrecognised whilst health care does not presently exist to produce benefits in response to those needs. More importantly, the raw materials that health care is interacting with to produce a benefit are not homogenous units that react in predictable ways. Seedhouse (1994) sees the benefit definition of health care need as bizarre in that the necessary condition of a person having a health care need is the existence of beneficial health care. If needs are defined by the services available to meet them, then increases in beneficial services lead to increases in need, thus making it impossible for needs to be reduced by meeting them with more services. It would also be possible to argue that in the past, when there was less health care and less beneficial services, then there were less needs. Similarly, where national and geographic boundaries place limits on access to health care, then in countries where the levels of health services are lower than others, under the benefit definition, it could be construed that there are relatively less needs. The
limits placed on needs when they are defined in relation to productive processes within the parameters of time and space, should not be overlooked.

The economic definition of need is popular however because it enables conventional marginal product theory to adjudicate among competing claims for health care. When prioritising between goods the yardstick by which they should be judged should be the relative social value attached to the ultimate outcomes relative to other components of social welfare, thus allowing the value to society over and above the value to an individual to be included in the priority making process. The popularity of the definition of need introduced above is dependent on how 'benefit' itself is defined. There seems to be an implication that benefit, unlike need, is real and quantifiable or at least is more easily quantifiable. Are we in danger of substituting one difficult word (need) with another (benefit) to which we are ascribing a false sense of exactitude? Economists view health benefits in terms of survival and quality of life:

“The most obvious effect of many health treatments is that the natural history of disease is changed for the better. That is life may be extended, or the quality of life may be improved”
(Drummond 1980 p12)

The key concept is that such improvements can be examined at the margin thus allowing comparisons of incremental changes in benefits. Economists don’t just see the consequences of these benefits in individual terms. They also argue that we all derive benefit from the health gain of others and that this should be accounted for as part of total social gain. Kilner (1990) examines four aspects of benefit; medical benefit, likelihood of benefit, length of benefit and quality of benefit and shows that there are considerable problems with this approach. The attraction of medical benefit as a criterion for the allocation of scarce resources is
The pragmatic argument is that any medical intervention that does not work (i.e. has no benefits) is a waste of resources. This is different, however, to saying that resources should be allocated on the basis of the comparative medical benefits of different interventions. Such calculations are often made not on certain knowledge about benefit but on assessments of likelihoods, risks and subjective value judgements about quality. The subjectivity involved should remind us of economists complaints about the nebulous nature of ‘needs’. The fundamental difficulty with the use of benefit as a criterion, therefore, is that it fails to supply a universally acceptable definition of what benefit means and how it can be measured. In this sense it suffers from the same criticism that economists have levelled at previous definitions of need in that, at best, benefit is dynamic and open ended.

Health economists have been successful in promoting the benefit approach because the discipline has argued persuasively that decision making in health care should not be made on the basis of implicit value judgements of professional groups. Health Economics, it is argued, can make decision making explicit and thus paves the way for a fairer system of resource allocation. But economics is not value free. There are various schools of thought that represent differences of opinion on key economic issues from the role of the market in determining the distribution of resources to the impact of consumer preferences on the demand for primary goods. Within health economics too there are differences of opinion about the analysis of health care as an ‘economic good’, and about the effect of price and supply on the demand for health care. Arguments abound on a host of key areas such as assessing the value of life, the elasticity of demand and the impact of vertical and horizontal inequity.

Can the claim that economics offers an objective and rational approach to health care decision making stand up to scrutiny? Penz (1986) argues economic
approaches to welfare are not objective because of 'evaluation circularity'. Evaluation circularity, as described by Penz, refers to the interactive loop between the institution and processes of production and the consumer preferences that form the basis for evaluating these institutions and processes. This is the process where instruments of economic measurement have an effect on that which is being measured and the thing being measured changes the economic instruments. As a result claims of economic objectivity and rationality are compromised.

“What is being evaluated determines, in part, the criteria by which it is being evaluated.” (Penz 1986 p87)

This is the fundamental weakness of any attempt to promote individual utility values as a means of identifying human interests. In the field of health care this weakness becomes a fatal flaw because of the nature of health and the extent of uncertainty. Avorn (1984), writing from the viewpoint of one concerned with discrimination and the elderly, argues that many of the methods employed by health economists:

“embody a set of hidden value assumptions that virtually guarantee an anti-geriatric bias to this purportedly objective data.” (Avorn 1984 p1295)

The problem is the base on which health economics works, namely utilitarianism which imports implicit valuations of productive worth. Assumptions are made about the validity of individual preferences and these assumptions are presented as an objective and rational basis for formulating policy decisions. Within these assumptions are a set of implicit value judgements, and in the rush to argue that economic methods make decision making more rational these implicit value
judgements are often overlooked. Redefining need as a function of capacity to benefit does not relieve economics from the above criticisms. Instead it imprisons us in what Seedhouse calls a 'looking glass' logic (Seedhouse 1994 p29). It is these criticisms that should remind us that measurement of clinical benefits, whilst offering a useful guide for physician decision making at the level of the individual, imports a host of ethical and technical problems when operated at group level or at the level of society.

1.2 Health Care as an intermediate need

Daniels (1985) attempts to characterise the relevant categories of needs in a way that explains two central properties that basic needs have:

1. that they are objectively ascribable i.e. they can be ascribed to a person even if she doesn’t know they exist and even if they are contrary to her preferences.
2. they are objectively important; importance is given to the claims based on them in a variety of moral contexts, independently of the importance given to them by individuals.

The task for Daniels therefore is to define the things we need which have the above two properties. Daniels associates needs with normal species functioning. Need is related to harm and its effect on the normal species functioning so that:

"impairments of normal species functioning reduce the range of opportunity open to the individual in which he may construct his 'plan of life' or 'conceptions of the good'." (p27)
The implication of this argument for disease and health is considerable. Daniels starts with a narrow definition of health as the absence of disease. Disease is formulated as deviations from natural functional organisation of a typical member of species. This is a biomedical model of health and there are clear problems with such an approach in that it tends to see diseases as deviations from social norms. There are problems with the definition of what is normal. Can we distinguish disease from genetic variations? What environments are 'natural'? An environment full of white racists, for example, could characterise being black as a disease. In order to avoid these criticisms, Daniels modifies the biomedical model to allow for some relativism by saying the line between disease and absence of disease is generally uncontroversial, and can be ascertained by means of publicly acceptable methods. The problem here is that this may be easier to achieve for some diseases than others. Getting agreement on a definition of mental illness is more problematic than this account suggests. A complete theory would have to establish what counts as health and what is disease and would have to determine the priorities among those principles covering health care needs and principles covering health care services and other social and individual goods.

Liss (1993) sees need in terms of a gap between an actual state and a goal. If X is needed to enable a person to move from an actual state to a goal, then there is a need for X. This of course is dependent on further clarification of the nature of the goal in question. Doyal and Gough follow a path that is similar to Daniels in their theory of human need. In their interpretation of the statement ‘A needs X in order to Y’, the end state Y is not ‘health’ with all its associated definitional problems but the avoidance of serious harm which they equate with minimally disabled social participation. ‘A needs X in order to Y’ therefore becomes ‘A needs basic need satisfaction in order to avoid disabled social participation’. Now the basic needs Doyal and Gough have in mind are health and autonomy.
and these give rise to a set of intermediate needs among which the provision of ‘appropriate’ health care is included. The link with Liss’ account is the goal of participation in society, and health care may or may not be an appropriate means of achieving this goal. In terms of health care, therefore, the statement becomes, ‘A needs appropriate health care in order to avoid disabled social participation’. ‘Appropriate’ health care, preventative, curative and palliative, is an intermediate need operationalised in terms of its effectiveness in optimising social participation, and minimising disabled social participation, relative to other intermediate needs. Health promotion is an important component of appropriate health care in that it aims to enhance levels of critical autonomy, that is; the ability of individuals to make healthy choices as well as criticise and challenge the range of choices available to them. Survival however, is the primary objective of health care for how can we participate if we are dead. This does not however exclude the possibility that a person may need to die, provided they are right in their belief that their capacity to flourish through social participation has ended (Doyal 1993).

Minimising disabled social participation is based on an interpretation of disability as standing between the medical construct of disease and the social construct of handicap in the sequence; Disease --> Impairment --> Disability --> Handicap. In order to assess the need for health care, therefore, we need measures of disability and agreement over definitions of disability. Doyal and Gough refer to the OPCS work on the prevalence of disability in Adults (OPCS 1988) which used a ten point disability scale to support their approach. OPCS sought agreement on the definition of disability from a judgement panel of professionals, researchers, people with disabilities, carers and voluntary workers. The panel was asked to arbitrate on the severity of various conditions. Although imperfect, this was an attempt to develop agreement on the definition and measurement of disability in a publicly acceptable and accountable manner. For
Doyal and Gough therefore, agreement on needs as defined in relation to
disability requires a framework for open discussion of disability. The provision
of health care as an intermediate need should be determined by reference to its
capacity to minimise effectively, death and disability in that order. Doyal and
Gough operationalise their theory using physical health, ill-health, autonomy and
opportunities for economic activity as the components of basic needs that are
measurable. A framework for these components is given in table 1.1.

Table 1.1 The components of basic needs

<table>
<thead>
<tr>
<th>PHYSICAL HEALTH:</th>
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<tbody>
<tr>
<td>Survival chances</td>
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<tr>
<td>Mortality Rates</td>
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<tr>
<td>Risk of death</td>
</tr>
<tr>
<td>Physical Ill-health</td>
</tr>
<tr>
<td>Prevalence and severity of disability</td>
</tr>
<tr>
<td>Morbidity rates by disease categories</td>
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<tr>
<td>Pain</td>
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<tr>
<th>AUTONOMY</th>
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<tbody>
<tr>
<td>Mental disorder</td>
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<tr>
<td>Prevalence and severity of mental illness</td>
</tr>
<tr>
<td>Cognitive deprivation, literacy, attainment</td>
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<tr>
<td>of basic skills, absence of skills</td>
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<table>
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<tr>
<th>Opportunities for economic activity</th>
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</thead>
<tbody>
<tr>
<td>Extent of employment</td>
</tr>
<tr>
<td>Free time</td>
</tr>
<tr>
<td>Extent of engagement in social interaction</td>
</tr>
</tbody>
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Source: Doyal and Gough 1991; adapted from table 9.2, p190

This constitutes an attempt to define and measure physical health in negative
terms as minimisation of death, disability and disease and to define and measure
autonomy in negative terms as minimisation of mental disorder, cognitive
deprivation and restricted opportunities. They consider the combination of these two negative definitions to approach a positive concept of well being. In later chapters I will use the components of basic needs framework to evaluate the work of the renal review group.

Doyal and Gough's conceptual framework has been applied in an audit of local needs in Leeds (Percy-Smith and Sanderson 1992). This audit demonstrated the relevance of Doyal and Gough's work to community based understandings of need combining a 'bottom up' (using the views of local residents) and 'top down' (using expert and professional knowledge) approach to needs assessment. With respect to health care Doyal has emphasised the importance of the framework for evaluating the quality of services (Doyal 1992). When they consider the measurement of the intermediate need for health care, Doyal and Gough can only offer indicators of need that chart people's access to appropriate health care. These include direct indicators of health care provision (e.g. doctors/beds per capita) and direct indicators of access to services (e.g. proportion of the population without access to community health services). This does not provide a sufficient basis for evaluating a health care system's capacity to address health care needs. In order to do this we must look at whether the components of basic needs are addressed and how they are defined and measured by the system. The problem of course, lies in the detail; in the extent to which we can define disability and come to agreement over the capacity of various health care interventions to be effective. The word 'appropriate' is important here in light of research showing variations in physician practice amidst different professional understandings of 'appropriate' health care interventions (Evans 1990). In addition, the normative definition of disabilities is not supported by some disabled groups; there are problems in defining the body in relation to social norms (Seymour 1989) and the cultural production of disability can understate the social determinants of handicap (Oliver 1990). Even survival
presents difficulties for reaching agreement as the cases of persistent vegetative state have highlighted (Lancet 1993 (editorial)). With respect to mental illness, these difficulties are amplified. It is important to note that renal disease is an area where the problems of definition and agreement outlined above are, on face value, easier to address.

Operationalising health care in relation to minimally disabled social participation demands an openness in decision making. If we are to come to agreement over survival and disability, and which health care treatments are appropriate in meeting our goals, then a framework has to be found for discussing these issues in an open and fair manner. The issue of determining a just distribution of health care becomes important here. In the next section I will examine principles of justice in relation to health care needs, and explore how we can build a framework for discussing the equitable distribution of health care resources.

1.3 Health Care Planning and the problem of equity

The principle of equity in health care has driven much of the work of social reformers during this century for example, but much of the analysis of health care systems in the past thirty years has concentrated on inequalities in health (Townsend 1993, Whitehead 1987). The focus has therefore been on the growing health divide and how differences in health status between social classes should be addressed. On a theoretical level, the principle of equity has received considerable attention from the New Right and from health economists. Economists have been particularly successful in highlighting the problems of the trade-off involved between goals of equity and efficiency (Le Grand 1990), and between distribution according to need and equality (Culyer and Wagstaff 1991).
In this section I will address, in turn, the arguments put forward by the New Right and by health economists regarding equity, presenting a critique of their approaches based on the view that inequity follows directly from these theoretical positions. I will then consider a minimal criterion for justice based on Habermas’ communicative ethics, showing how this links in with Doyal and Gough’s work as a necessary procedural element to their theory of need. The policy implications of this, in terms of rights to health care, will be emphasised. To begin with however, it would be useful to reflect on what is meant by justice.

1.3.1 Justice

In “The Lottery in Babylon” Jorge Luis Borges describes a society where all social benefits and costs are distributed according to a periodic lottery. This seems a bizarre social system, but there are clear parallels with contemporary arguments about rationing health care and welfare programmes where scarcity is a constraint. Many of the arguments surrounding rationing have been based on the view that present policies are unjust precisely because they amount to a lottery and there seems to be no basis in justice for such a system. Others have argued that what is required is some form of systematic lottery as a way of choosing between moral equals. Patients waiting for kidney transplants are in a queue for a scarce resource. The allocation of such scarce resources could be made on many differing bases (the highest bidder, individual preferences, merit, race, gender etc.). If we are to decide on which method is best then we need to refer to some standard of justice in order to make such a judgement. Merely stating that we need such a standard, however, does not free us from the relativist critique; there is no Archimedean position of absolute moral objectivity. But it

7 This linking of Borges’ story to a discussion of justice is taken from Beauchamp and Childress (1989).
does make it necessary for us to look around for the best basis for justifying our moral values and principles.

Marx criticised justice on the basis that standards of justice are internal to the economic and cultural characteristics of each society. Similarly he argued that rights embody the model of man as egoistic individual. The critique of justice as being embedded in existing productive relationships and determined by the ideology of the dominant class still has force (Wood 1981), but the ambiguities of Marx's approach to justice leaves questions over whether his critique focuses on a judicial paradigm of justice, thus leaving room for an appeal to an objective ideal of justice. It has been possible for justice to be dismissed by Marxists, particularly when it is argued that under communism, moderate scarcity (Hume's condition for justice), ceases to exist. This argument can be criticised on two counts. Firstly, conditions of scarcity exist as of now and, if we accept that time is a resource, then scarcity of opportunities for action will always exist (Buchanan 1982). Secondly, the approach does not tally with Marx's own critiques of capitalism, for if we are to judge whether a socialist society is better than a capitalist society, we need some standard of justice in order to make such an evaluation. Indeed, it has been argued that if Marx did not recognise the moral force of justice how was he then able to criticise capitalism (Peffer 1990).

Communitarians also have an ambivalence towards justice arguing that 'traditional universal' accounts of justice are inadequate, indeed can be harmful, and that a truly good community has no need for justice (Sandel 1984). A society is considered just by communitarians if it acts in line with the shared understandings of its members (Walzer 1990). Sandel (1982) sees family love and solidarity as institutions embodied in the community that make justice irrelevant. Indeed, the liberal preoccupation with justice is seen as harmful to those institutions. Walzer (1990) argues that the concept of 'objective justice'
having a perspective from outside society is misguided and the requirements of justice is identified by the way each community understands the value of social goods. Justice is therefore specific to each community. Such arguments have been opposed by Cohen (1986) who argues that the values embodied in the social institutions of communities, although idealised by Walzer, are often those of the powerful. In addition, if the institutions of communities are capable of reinforcing harmful practices and traditions, then communitarianism becomes essentially conservative. The communitarian framework could result in practices such as female circumcision, for example, being justified under circumstances where the power structures and prevailing ideologies within a community presented female circumcision as an acceptable and widely supported tradition.

Justice has been seen as a male notion, inadequate to meet women's needs (Gilligan 1987). For women, morality is equated with responsibility and the protection of relationships in contrast to male notions of rights and abstract rules. Gilligan argues that to address this problem what is required is an ethics of care. Some have argued that the notion of care developed by Gilligan is already contained within justice particularly Rawls' theory of justice (Okin 1989), but liberal theories of justice have been criticised by some feminists for being subject to a historical commitment to a public/private distinction where the private sphere of the family has not been subject to principles of justice (Kearns 1983). Kymlicka (1990) rejects this critique on the grounds that it conflates public/private, state/society and public/domestic, arguing that the problem of incorporating the role of the family is common to all theories of justice.

Despite the disagreements about justice outlined above, it would appear that they share a fundamental premise namely that the interests of the members of community matter and matter equally (Dworkin 1983). This premise is referred
to by Dworkin as the 'egalitarian plateau'. Similarly Sen (1992) sees a basic common premise to disagreements about equality. With respect of health care the problem of what is considered a 'just' distribution of scarce resources is subject to this same 'egalitarian plateau'.

1.3.2 The New Right and justice

The New Right draw on entitlement theory to argue that justice is embedded in free markets. The championing of free markets results in arguments for health care to be distributed by means of the price mechanism on the basis that this results in a just allocation of health care resources. This argument is buttressed by entitlement theory (Nozick 1974) which states that individuals are entitled to what they have acquired provided it is acquired justly. This includes the inheritance of resources acquired justly by those who give them to us. In this sense distribution is determined largely by luck. Nozick proposes a night-watchman state, minimalist in character with its functions limited to protecting the rights and entitlements of its citizens. He rejects all material principles of justice in favour of the principle of self ownership. This states that each individual has full rights to self ownership and can acquire exclusive property rights to any part of the unowned world provided this does not make anyone else worse off. In his mind, the proper framework for the application of these principles is the free market. The theory is based on a weak interpretation of the Lockean proviso that acquisition of property is just, provided it does not make anyone worse off, but self-ownership is compromised when the rights of property owners are determined at the expense of restricting the freedoms of the propertyless. With respect to health care it is unclear whether the theory can operate in terms of our entitlement to levels of health or levels of health care. Persons are born with different levels of health, some are able bodied and
become disabled, others are disabled from birth. They have acquired their health status through no fault of their own merely through the lottery of life. Entitlement theory at its crudest would seem to accept this state of affairs as just and would therefore oppose any attempt by a health care system to rectify the situation. Entitlement theorists would be entitled to object to this interpretation, and Nozick does argue that in cases of 'catastrophic moral horrors' entitlement rights could be modified, but this implies modification in extreme cases so the point with respect to health status still highlights a considerable weakness in entitlement theory. Individuals can choose some lifestyles that are less risky than others but the extent to which individual choices result in different health status is unclear and the impact of exogenous factors on individual health cannot be ignored. In light of this, the reductionist approach of entitlement theory seems inappropriate to any analysis of health care.

Nozick however is emphatic in his view that the right to health care is dependent on it being acquired through the market or voluntary charity. Attempts by the state to redistribute health care to the poor are therefore unjust. Nozick dismisses attempts to introduce the value of caring, compassion, externalities or uncertainties into the equation. It is with respect to the last two factors that the theory is most seriously flawed. It is doubtful whether a perfect market for health care which could act as a mechanism for an entitlement theory of health care, exists either in theory or reality. This can be seen with respect to persons who are in, or about to go into, end stage renal failure. Kidney patients could reasonably come under Nozick's definition of catastrophic moral horrors. However, kidney patients are continually faced with factors such as lifestyle choices, externalities and uncertainties which have an effect on their health status and their need for health care. Some of these factors will be wholly or partly within their control whilst others will be completely beyond their capacity to influence. The relationship between choice and control over factors that affect
the health status of such patients is complex. Entitlement theory does not pursue an understanding of these complexities, instead it relies on the market as the most just method of allocating resources. In doing so it cannot avoid ‘victim blaming’ in the cases of persons who do not fit into its model of ‘self ownership’.

The New Right have built on the foundations provided by Nozick and others to produce arguments that oppose attempts by the state to redistribute resources in a fairer manner. With respect to health care these arguments are employed to argue that the organisation of health care according to market principles is the best way of ensuring its fair distribution. This is based on the New Right equating the free market with liberty and is dependent on the notion that liberty is equated with the number of choices available to individuals (Gray 1988). However, it is unclear whether, and how, liberty could be measured by reference to the number of choices available. What is the value in choosing between a vast array of different dialysis machines for example? It seems unlikely that such a variety of choices extend our liberties in any way.

There are of course all kinds of problems associated with the extent to which health care is a good that can operate in a free market at a price, including consumer ignorance, the agency relationship and the value of social goods such as medical education. Light (1992) gives a detailed synopsis of how competitive markets are distorted in the field of health care. It is because of this that the approach of the New Right to justice in health care is flawed: entitlement theory cannot take account of the complex relationship between individual health status, access to health care and externalities.
1.3.3 Health Economics and justice

The two main strands of economic approaches to equity in health care have been the health maximisation account and the equity as choice approach. A more recent strand based on Sen's (1992) capabilities approach has much in common with the arguments presented in this thesis. Each of these arguments will be considered in turn but first it is necessary to grasp the problem that equity presents for economics.

The economists concern for consumer sovereignty can sometimes result in a somewhat cavalier attitude to moral questions. Maynard for example has argued that

"...equity like beauty, is in the mind of the beholder"

(quoted in Pereira, 1990a p4)

Mooney and McGuire (1987) have also highlighted the numerous, sometimes conflicting, definitions of equity that can be used in relation to the distribution of health care resources. When looking at economic definitions of equity it is therefore important to understand the extent to which different strands of health economics relate to concepts such as consumer sovereignty and utilitarianism. Sen (1987) highlights the contradictions between utilitarianism and justice, emphasising that utilitarianism's concern with welfare is balanced by a lack of concern for the distribution of the sum of utilities. Economists view this criticism with varying degrees of concern; the extent to which the decreasing marginal utility of money is recognised being a crucial determinant of how economists see maximising utility conflicting with equality (Smith 1994). Nevertheless, Sen has succeeded in demonstrating that the consequentialism of utilitarian theory presents considerable problems with respect to equity.
The goal of health maximisation has been a means of avoiding these problems. It is argued that equity exists in a health care system where distributions serve to maximise health in society. The argument is so closely linked to basic utilitarianism however, that its inherent inequity is a clear problematic. There have been two main attempts to employ the health maximisation account, the first tries to take account of externalities whilst the second is the quality adjusted life year (QALY) approach. Culyer (1980) presented an argument for welfare maximisation by arguing that in measuring social welfare it was necessary not only to aggregate individual personal utilities but also necessary to take account of the utility individuals gained from knowing that the welfare of others was protected. This Culyer called the 'caring externality' which seems to appeal to notions of compassion (measured in terms of utility) as opposed to justice. Culyer attempted to move away from 'crass utilitarianism' by defining utility in a broad sense. The 'caring externality' therefore appears to be an attempt to 'buy off' the basic critique of utilitarianism by presenting us with a more sophisticated version of it.

The objective of health maximisation has also been presented in terms of QALYs. This has been seen as a rejection of traditional Paretian welfare economics and a radical break from measuring utility. The QALY approach moves away from individual valuations of health and regards a QALY as having an equal value for everyone (Wagstaff 1991). This has led to the argument that whilst utilitarianism may not be concerned with the distribution of utilities merely the sum of utilities, QALYs are concerned with the distribution of QALYs. The problem with this is that QALYs of themselves are

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8 More recently the debate concerning QALYs has surrounded the equity of policies based on SAVEs and HYEs (Saved young lives and Healthy Years Equivalents), (Meherez and Gafni 1989, Buckingham 1993).
discriminatory (Harris 1985). One argument has been to attach weights to QALYs to take account of these distributional problems. But this seems to go against the original argument in favour of the QALY which presented them as having the property of being equally valued by all, thus avoiding the criticisms of utility theory (Culyer and Wagstaff 1993).

If we turn to the definition of equity as equality of health it would seem that under this definition any reduction in inequality is a good thing. Wagstaff (1991) argues that the pursuit of the goal of equality of health does provide a basis for equitable allocation of resources but the principle conflicts with efficiency, and with health maximisation goals. How can these conflicts be reconciled? One approach suggested is to employ a social welfare function constructed to take account of society’s objections to inequality allowing a trade-off between inequality and efficiency. It is clear that problems with defining equity will lead to problems in its pursuit in practice. If individuals value equity differently then different weights can be given to it as an objective of the health care system. In this sense equity is viewed only in terms of trading it off with other objectives, particularly efficiency. It is argued that equity and efficiency tend not to conflict in cases of horizontal equity and that the ‘trade-off’ becomes more acute in cases of vertical equity. With respect to vertical equity there is a fundamental problem of prioritising on the basis of which patients are worse off (De Jong and Rutten 1983). This idea of a trade-off is an important part of the utilitarian debate. Implicit in the argument is the tendency to view equity as having a utility that allows it to be measured against the utility gained from efficiency.

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9 At the level of society QALYs could result in weak and vulnerable groups being denied treatment precisely because they are weak and vulnerable and thus unable to achieve good QALY scores.

10 Horizontal equity refers to the equal treatment of people in equal states and vertical equity refers to the unequal treatment of people in unequal states.
Le Grand (1987) proposes a concept of equity in terms of equal constraints. Under this approach inequalities in levels of health are acceptable provided they are the result of choices made under the same constraints. Where variations in health status are the results of the 'lottery of life' or factors beyond individual control then we face an inequitable position, but where these variations are the result of life choices that are within the power of individuals to control then the variation is equitable. According to Le Grand, where rational individuals are facing equal choice sets then the outcome of their choices is equitable whatever the outcome in distributional terms. This has parallels with Nozick's entitlement theory. The argument is attractive because it recognises that individuals do face varying constraints and therefore some (e.g. people with low income) can have more limited choice sets. At an empirical level therefore the approach has great potential in measuring the different choice frontiers that individuals face and the factors that determine the limits to their choice sets. As has been stated previously however, health care is an area where uncertainty and limits to consumer knowledge are magnified. The rational individual with perfect knowledge making autonomous choices on the basis of her preferences represents an economist's ideal rather than reality. Neither is it clear that an individual's choices result in direct trade-offs between healthy and unhealthy options. The application of the approach to health policy also results in the introduction of value judgements about the different constraints that are problematic in themselves. Le Grand however argues that his approach should not affect how people are treated by the health care system but could have a bearing on whether they ought to contribute towards financing their care e.g. smokers being given an extra tax. In contrast to this, the envy-free approach to the distribution of resources attempts to define an equitable distribution as a situation where relative individual positions are judged by the extent to which individuals would prefer to be in the position of others. In a two person economy for example an equitable distribution exists where one individual's
utility for their own bundle of goods equals the utility value they place on the
others bundle of goods and vice-versa. The appeal of this approach to the
economists lies in its emphasis on individual preferences rather than by appeal to
a moral theory. The approach is flawed however because of its methodological
individualism. Relative utility values cannot be relied upon to distinguish
between demand for services by a person requiring hip replacement as opposed
to a sports person’s demand for sports equipment if both end up giving equal
value to each others potential utility.

Economics fails to give an adequate basis for evaluating the fairness of a
distribution. This stems from the ambivalence accorded to concepts such as
‘need’ and ‘health’. If moral philosophers are correct in their assertion that basic
health is a necessity for the goal of flourishing or a good life then need, capacity
to benefit and income are not as important as equality of health. This leads
Culyer and Wagstaff into a circular argument:

“...if it is the ethical status of health as necessary for the
leading of a “flourishing” life that conveys any moral
superiority to “need” over mere “demand”, then it is also the
same ethical force that makes need an insufficient
distributional principle: the resultant distribution of health
may not correspond to that required (whether equal or
unequal) to ensure that each has a fair chance of leading a life
that is as “flourishing” as resources permit.” (Culyer and
Wagstaff 1992 p16-17)

This argument relies on the ambiguity of the word ‘health’ for its support. It
skirts around the relationship between health as a basic need and justice.
Kennedy (1983) reminds us that equity is a fundamental moral principle which is
of critical importance with respect to health care. The problem with economic approaches is that they either exclude justice completely or fail to take it seriously enough.

1.3.4 The Basic Capabilities approach

An approach that has taken many of the above criticisms on board is the basic capabilities approach, based on the work of Sen (1985, 1992) and applied to health care by Pereira (1990b). Sen argues that it is the capabilities of individuals to transform commodities into human functionings that is important. In this sense his argument owes much to Rawls (1972) whilst criticising what Sen calls Rawls' goods fetishism. By this he means that Rawls' theory places too much emphasis on goods in themselves rather than on what people can do with them.

In placing the emphasis on 'functionings' (how people use the characteristics of goods to produce human activities) Sen highlights the problems he sees in the link between functionings and utility. Individuals with low levels of functioning may have higher utilities than those with high levels of functioning. Clearly an analysis based on functionings is less open to the distortions of a utility based analysis. In addition there is a clear link between Sen's functionings and Doyal and Gough's needs that enable participation. In relation to equity Sen argues that it is capacity to function that is important and the equity principle can be summarised by 'equality of basic capabilities'. Within these basic capabilities Sen includes the ability to meet needs for food, clothing, shelter and good health. With respect to health care an individual's capacity to function will be dependent on access to basic goods and her personal capacity to interact with those goods to optimise her functionings. Equity can then be said to exist when individual capacities to use the characteristics of goods to achieve a desired function are
equal. The approach is open to similar criticisms that have been laid at the door of Le Grand's equity as choice theory namely that some choices may be due to individual tastes whilst others are exogenous and due to societal/biological constraints. The problem is in the extent to which it is possible to differentiate between the two types of choices. Nevertheless, the basic capabilities approach represents a major step in the economic sense towards taking the concepts of justice and equity seriously. By examining philosophical approaches to equity I shall show that the relationship between functioning and impairment and notions of human rights has considerable consequences in terms of a theory that provides a basis for an equitable health care policy.

1.4 Philosophical approaches to equity

Liberal theories of justice have been re-examined in recent years from a variety of philosophical positions. A major focus for this has been Rawls theory of justice (Rawls 1972). Justice, for Rawls depends on how well it does by its least advantaged participants. Rawls' theory is a theory of rights and justice which implies a social policy whose goal is to maximise the position of the least well-off. Rational individuals acting under a 'veil of ignorance' about their relative positions in society would choose a policy that would maximise the position of the worst off. The theory is postulated in terms of a set of 'primary

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11 Rawls argues that rational contractors in a fair bargaining situation behind a 'veil of ignorance' would accept the following principles of justice:

(I) The principle of equal liberty
(IIa) The difference principle
(The difference principle permits inequalities in the distribution of social-economic goods only if they benefit everyone especially the least advantaged)
(IIb) The principle of fair equality of opportunity

The principle of equal liberty has absolute priority over other principles and must be satisfied before these are considered. Moreover the principle of fair equality of opportunity has priority over the difference principle.
social goods', health care not being one of them. It is important to note that Rawls excluded health care because he wished to avoid trade-offs with other primary goods such as income.

Rawls' theory has been criticised by Dworkin (1981) on the grounds that the difference principle is applied to groups not individuals. He proposes an alternative based on equality of resources whereby an equal share of resources be allocated to each individual on the basis of the opportunity cost of such an allocation to others. He argues that the liberal concept of equality is fundamental, and that rights to particular liberties are dependent and derivable from this concept (Dworkin 1977). However, Dworkin's arguments have been criticised as legal imperialism (Hunt 1992). Dworkin's theory is presented in terms of formal rights and not substantive rights and rights therefore become 'commodities' that need to be hoarded (Hutchinson 1992). There is a lack of attention to substantive inequalities and this, in part, legitimises the continuation of socio-economic inequalities. Thus structural forces, such as class and gender, through which other forces of power are exercised on individuals, together with their relationship with state power, are largely ignored (Munzer 1990, Edgeworth 1992).

The possibility of applying Rawls' theory to health care has been explored by Pogge (1989) and Daniels (1985). Pogge argues that by extending Rawls' theory to health care there should be formal equality of medical opportunity. For Pogge, fair equality of medical opportunity is concerned with the distribution of health: that is the distribution of medical care relative to medical needs (he assumes that medical needs occur naturally). His approach is that social systems are not unjust if medical needs are unmet. Injustices arise if people are denied access and find that their needs are not being met whilst those of people with
comparable needs are. Daniels (1985) clearly argues that health care should be governed by the principle of justice guaranteeing fair equality of opportunity.

"if an acceptable general theory of distributive justice requires us to guarantee fair equality of opportunity, then a principle for the distribution of health-care seems to follow" (Daniels 1985 p86)

He attempts to do this by stating that within the framework of Rawls’ theory, health care should be a background institution that ensures equality of opportunity. This should not be taken to mean that the health care system can be considered in isolation from the rest of society, for such an approach can give the illusion of equality within the system when it is in fact surrounded by a sea of inequality. As Seedhouse says:

"Equal access to health services makes sense only if 'equal access for equal need' has been first applied to other areas of life so as to truly make illness/disease/sickness a matter of misfortune rather than something which could have been avoided given more general egalitarian planning." (Seedhouse 1994 p80)

Daniels’ approach is important in that his definition of equity as equality of opportunity for equal need is a principle that operates independently of Rawls’ theory. Daniels’ approach has a clear and significant concern for needs and the extent to which individuals can derive rights from their needs. Daniels argues that the normal opportunity range (NOR) in any given society will be the range of life plans that reasonable persons will construct. Now this range will vary in distribution according to the society (i.e. it is relative) but normal species
functioning acts as a clear parameter to allow us to define the normal opportunity range. Some diseases will have more serious effects on the NOR than others but because NORs are relative (between societies) the impact of the same diseases will be different between societies. Therefore if we work on the principle of impairment of opportunity then the social effects of diseases will be important. Within a society the NOR is abstracted from effective opportunity, that is individual sub sets of NOR. Impairment of NOR is a crude measure of the relative importance of society’s health care needs. In this sense Daniels deals in aggregates at the macro level and clearly recognises that these may differ from individual perceptions of the good.

The question that needs to be addressed is how is it possible to measure impairment and its effects on the NOR. Should we use a full range satisfaction scale or a truncated scale of well being\textsuperscript{12}? Rawls argues for a truncated scale rather than a satisfaction scale on the basis that a satisfaction scale commits us to an unacceptable view of persons as “containers” for satisfaction. This is an important point, for a further danger is that individuals are treated as mere foci for measurement rather than moral agents. Just distributions of health care resources therefore have to be based on shared understandings of the relationship between needs, disability and normal opportunity. This presents problems in that (as we have already seen) these are disputed concepts and even where there is no dispute we must be wary of ways in which structural forces act to distort understandings.

\textsuperscript{12} A full range satisfaction scale considers the complete range of an individuals’ needs and preferences. A truncated scale is a selective scale which excludes some preferences and focuses on the things we claim to need (see Daniels 1985 p24-25)
It is clear from our discussion so far that the concept of justice is problematic and attempts to develop liberal theories of justice are open to charges of naiveté towards the operation of power in society. Habermas offers a universal but minimal criterion for justice as a way through this morass (White 1988). The justice of normative claims can be assessed by universal procedural criteria but this does not amount to specifying a set of universal principles on which justice is based. For Habermas, a universal account of justice is only possible through his conception of communicative action (Habermas 1990). Agreement over a proposed norm is only legitimate if it is based on a communicative discourse involving all those affected by the norm. Norms are the focus for legitimising the satisfaction of 'human interests' or 'needs'. This does not mean that Habermas accepts the notion of universal basic needs. Needs are culturally variable and specific to societies in that they are a function of what each society believes is necessary for the flourishing of human life. The concept of objective universal needs has been undermined by arguments about the fragmentation of modern society and the elevation of consumption as means of defining the 'self'. Marxists can also see needs as socially relative, arguing that within capitalist societies the structure of needs is specific to capitalism (Soper 1981, Geras 1983). Any attempt to apply needs, as defined by modern capitalist society, in some objective universal sense to other societies, is seen as cultural imperialism. The importance of this argument is seen in attempts by those in power to use definitions of needs to legitimise their own wants. In response to this it is argued that needs are legitimate and objective only when they are determined by specific oppressed groups (Walzer 1983). Ethnomethodological arguments link into this debate in that they question any attempt to impose explanations of social phenomena in one group by another group. The only way of coping with this is to describe the different subjective notions of need that are employed in social
contexts. This view firmly rejects a universal objective notion of need seeing it instead as a dynamic social construct. These arguments are particularly relevant to health care because attempts to define health care needs can be criticised in the sense that they can only reflect professional perspectives and professional ideology. Against such a backdrop any attempt to define health care needs is always open to criticisms of having a dual role of subjugating the individual or group being assessed to the needs of the system or professional interests within the system, whilst simultaneously constructing a picture of what that individual or group 'needs'.

However there are problems with the relativist position. How can we be sure that definitions of need within an oppressed group will not contain definitions that are oppressing people within the group. Arguments about fragmentation and cultural imperialism are contradictory in that they do accept that need exists but it is argued that only the group in question can assess them. If you are oppressed then there must be some standard by means of which your suffering is measured otherwise how could either you or anyone else know you are being oppressed. Sexism and racism can only be bad if we have a notion of what is good or bad as a reference point. Every group, even an oppressed group, has powerful vested interests leading it; the David Koresh\(^\text{13}\) cult being a case in point. If we accept that this happens then the search for standards external to any group to evaluate their moral standing is valid. But if we are to address the criticism that such standards involve cultural imperialism, we will need a coherent theory to inform them so that the distortions of need that are an inherent part of modern capitalist society can be avoided. Our search must be for a framework for discussing needs, particularly intermediate needs and their

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\(^{13}\) David Koresh was the leader of a religious sect in Waco Texas. Attempts by the American Federal Authorities to arrest members of the sect in April 1993, led to a siege which eventually ended in the destruction of the cult headquarters and the death of Koresh and many of his followers.
satisfiers, in an open and fair manner which allows these needs to change and
develop in response to this open and fair debate. However, the capacity of the
language of need to act as a means of social control should not be forgotten in the
rush to demonstrate agreement (Fraser 1989). Striving for a better
understanding of needs, through communicative practices, does not entail
specifying the basic needs everyone has in a 'good society', for such a project
ignores the requirement of reciprocity (since some potential voices will not be
given a fair hearing). It is the requirement of reciprocity that is at the heart of
Habermas' criticism of Rawls' theory of justice. Persons in the original position
are contracting on the basis of a pre-defined set of primary goods, (liberty,
opportunity, wealth and income). These create a bias towards a particular type
of society. To be fair, Rawls recognises this and accepts that his version of
justice is valid only for members of 'modern democratic societies' (Rawls 1980).
The communicative ethics proposed by Habermas illuminates the road towards
fair procedures for judging normative claims. Such an ethics requires that actors
engaged in discourse be flexible, critical and willing to change their view of
needs in response to the discourse. The importance of this for health care can be
found in the dilemmas arising from those attempts, discussed so far, to extend
Rawls' theory of justice to cover health care. Doyal and Gough argue that the
relationship between harm and impaired social participation is fundamental to
the identification of need. In order that social participation is optimised then
impairment has to be minimised. This is true whether impairment is acquired
genetically or otherwise. Health care is a social good that operates to minimise
levels of impairment and disability. If health care is to be allocated in a just and
equitable manner then policy must be grounded in shared understandings of what
is necessary for social participation, based on procedures that rely on
communicative discourses. It is here that they base the procedural part of their
theory on Habermas' communicative ethics. This in turn has implications for
any understanding of rights to health care.
1.6 Rights to health care

No one has the right to a specific treatment under the NHS. Health Authorities are only required to have regard to the health needs of the population. To say that an individual has a right to something implies that someone else has an obligation in respect of that right. In other words rights entail duties (Waldron 1984). If we accept that health is a fundamental prerequisite for individuals to participate fully in society then expecting people to be good citizens contains an implicit commitment to ensure that they achieve optimum levels of health (Montgomery 1992).

Public perceptions of the NHS are based on the concept of universal access at the point of need and the notion of a fundamental right to health care has very strong support. But the relationship between the public's concept of the right to health care, the historical background to such rights and their relationship with the concept of equity are extremely complex. Increasing societal pressures on individuals to take responsibility for their health are linked to the concept of an automatic right to receive care being questioned and proscribed (ten Have and Loughlin 1994). If there is support among the general population for the right to free health care then this has implications for any attempt to ration by means of restricting treatments. Equally, if health is a basic human need that entails rights and responsibilities, the health care system cannot be examined in isolation from other demands on society. In this sense it would be immoral to ration health care when resources are being expended on areas which do not provide for basic human needs in the same way. The problem is that of reconciling rights, needs and resources against a backdrop of scarce resources and misuse of resources. Under conditions of scarcity, needs cannot automatically entail rights (Plant 1992). The argument that someone has a right to demand health care from the state contains an implicit requirement that this demand is given a priority. This
is not to say that a right is absolute for there may be other more pressing policy considerations. In contrast to this, it could be argued that whilst resources are still being used inappropriately then the relationship between need and rights has enough moral force to make any rationing of satisfiers of basic needs untenable. The link between health needs (based on the minimisation of impairment and disability) and rights lies in the expectation that individuals meet the duties of citizenship. If these duties are to be met then individuals have a right to basic need satisfaction to enable them to fulfil their duties. If rationing is to be made explicit then the relationship between needs and rights also has to be made explicit. If debates about health needs are to be democratic then they have to be embedded in a process that strives for a shared understanding of needs and the rights that the needs, so identified, entail.

1.7 Conclusion

This chapter has looked at the theoretical debates concerning health care needs, justice and rights to health care. The extent to which health care needs can be considered objective and measurable has been discussed in the light of different theories and Doyal and Gough’s theory has been examined as a possible avenue for treating health care as an intermediate need. The problem of how the health care system can operate in a just manner has been considered and I have shown that the way we arrive at a view of a just health care system is dependent on the ways in which we define needs. This in turn has repercussions for our understanding of rights to health care. In order to address these issues Doyal and Gough have constructed a theory of human need that has a substantive part which sets out the arguments for basic needs and a procedural part setting out a framework for coming to agreement about how needs are to be met and how they are to be prioritised. This procedural framework uses Habermas’ communicative ethics as a basis. Any attempt to situate this theory within a
practical policy framework must however address the capacity of power and vested interests to distort debates concerning needs and rights. I will show in chapter 6 how the UK has engaged in an age based rationing policy for the treatment of End Stage Renal Failure. If we are to gain an understanding of how such rationing policies come about, how they are legitimised, perpetuated and challenged, then we need to consider the relationship between health policy, health needs and the operation of power. In the next chapter I consider the ways in which Habermas' communicative ethics can bring a critical perspective to this relationship.
Chapter 2

Health Policy: A critical perspective

"Every point of view, every kind of knowledge and every kind of experience is limited and ignorant" (Delmore Schwartz, 1959, Summer Knowledge: author's note)

2.1 Introduction

My discussion so far has drawn on Doyal and Gough’s theory of human need as a basis for my critique of various approaches to health care needs. At the same time I have drawn attention to certain tensions within Doyal and Gough’s own project that stem from an attempt to situate their theory in a practical policy framework. In order to better understand these tensions therefore it is necessary to consider the various paradigms of health policy that are available to us and how these can form the basis for a practical understanding of health care needs in relation to policy. If, as Doyal and Gough argue, it is possible to construct a basis for discussing human needs from Habermas’ communicative ethics, then we must be confident that such an ethics, placed in the context of the health care system, is capable of operating despite the tensions and conflicts that exist within that system. This in turn requires an understanding of the operation of power in the system.

I begin this chapter by looking at the history of policy explanations in the NHS, concentrating on four major theoretical perspectives: neo-pluralist, public choice, neo-elitist and neo-Marxist. I move on to examine the development of markets in health care; considering the structure of markets and the extent to which contracts for health services can be based on assessments of needs. I consider the implications of each theoretical perspective for an understanding of health
care needs. I then examine theories of power in relation to the NHS, highlighting the importance of an understanding of the operation of power for my analysis of health policy. Subsequently I outline the relevance of Habermas' communicative ethics to the debates concerning power. Finally I set out how I intend to use a Habermasian framework in my analysis of policy making with respect to renal services, using it to develop a critique of that policy making process. Through this process I hope to explore the problems that stem from the use of idealised states to criticise and at the same time create a practical state of affairs.

2.2 Paradigms of health policy: The history of policy explanations

During the 1960s and early 1970s a set of shared policy views on health and welfare was developed, reflecting the consensus politics of the time (Harrison et al 1990). At a public level this consensus was reflected in popular support for the NHS (Taylor-Gooby 1985a, Klein 1983) whose durability has been evidenced in recent debates on the resourcing and reorganisation of the NHS. Health policy was increasingly explained by incrementalist models as opposed to rational comprehensive models of the system (Lindblom 1959, 1979). The incremental analysis stood in direct opposition to any attempt at developing a grand theory. Its attractions were numerous. The policy process was described as one of 'partisan mutual adjustment' between various actors in the system. The actors in this adjustment process were the medical profession, consumers, lay representatives and managers all of whom played different roles and occupied different partitions of power. These actors were caricatured as being powerful (Doctors), weak (lay members and consumers) and reactive (managers).

This paradigm provided elegant descriptions of policy changes in the sixties and seventies and still has powerful explanatory powers today when applied to local
area levels of health management (DHAs and trusts) (Harrison et al 1990). The theory failed to describe adequately policy processes at the level of central government and, because of its relativist position, was open to the charge that it could not distinguish between small and large changes. In other words it could not provide a way of telling when an incremental shift becomes a radical shift. This critique became increasingly relevant during the 1980s as Conservative governments set out to reform the structure of the NHS. Incrementalism fails to provide a comprehensive explanation of policy changes because its treatment of power relationships is superficial. It ignores the importance of structure and environment as part of the policy picture.

Theories of distributive power have been applied increasingly to the health policy field in recent years. Allsop (1984) discusses theories of professional dominance, political economy, Marxism and the New Right as explanatory accounts of health policy. Similarly Ham (1985) discusses three theoretical approaches (Marxist, pluralist and structuralist) and suggests that of themselves they provide incomplete accounts but taken together have considerable potential for policy analysis. Harrison et al (1990) consider four theories in the light of the NHS reforms; neo-pluralism, public choice theory, neo-elitism and neo-Marxism. It is these theories that I turn to as a starting point for my own analysis of policy.

2.2.1 Neo-pluralism

Classic pluralism saw power as being widely distributed within society, with negotiation taking place between groups through a bargaining process that had the state as a focus. Neo-pluralism gives greater emphasis to the unequal nature of relations in this process. This refinement denies the state complete neutrality in the bargaining process. The advance made by neo-pluralists is seen in their
acceptance of the role of big business and capital in the power game. The theory does not however deal with structural constraints (e.g. demographic change) and their effect on decisions. With respect to the NHS reforms Harrison et al (1990) argue that neo-pluralism does not explain policy in recent years. Government is clearly not a referee between competing interests, and has taken an active and centralised approach to directing policy, whilst lobbying, although energetic and sometimes successful at local level, has not been decisive in influencing broad policy decisions. The neo-pluralist account of policy has strengths in explaining the inability of the system to address health care needs. If policy is based on negotiation, with the state playing a fulcrum role, then a neo-pluralist argument could suggest that the language of needs has developed to form the lynch pin of negotiation. In this sense an appeal to needs based policy is the ‘appeal in the last resort’ of a semi-codified language of negotiation. Unfortunately within the constraints of neo-pluralist theory this argument fails to explain the role of the Department of Health in trying to develop resource allocation policies that are based on an assessment of health care needs.

2.2.2 Public choice theory

At the heart of public choice theory is the classical economic belief in the utility maximising individual, the moral superiority of markets and the threat that welfarism represents to liberty. The quality of the arguments supporting this view tend to vary considerably however. Friedman for example seems to think it sufficient to argue that the market, through the price mechanism, involves voluntary exchanges of goods and services between individuals, (Friedman and Friedman 1980). But Friedman’s analysis is too simplistic and relies on a naive view of the price mechanism that fails to situate it within institutional conditions. According to Hindess (1987):
"Friedman's social analysis reduces to three interacting elements: human individuals making choices, governments interfering, and chance." (p126)

Hayek, on the other hand, offers a more challenging theory that has had considerable implications for debates on welfare provision and social policy, (Hayek 1944). Hayek sets up an argument against central planning and in favour of the market because the former cannot gather together sufficient knowledge about the required social order in the same way that the later does through market mechanisms. In addition to this Hayek argues that central planning is dangerous because it leads to coercion by the state and sets limits to freedom. This view of the welfare state as a coercive force has been extremely influential in the development of a public choice theory approach to welfare policy and to health policy. Niskanen (1971) is one who argued that public sector bureaucracies tend to over-supply services because managers try to maximise their own utility through maximising their own budgets. In this way the public choice theorists have been able to present themselves as arguing against a system that promotes professional interests at the expense of human needs. The contradictions in their arguments can be found in simultaneous attempts to deny basic needs and show that the welfare state fails to meet needs (Goodin 1988).

Public choice theory fails to adequately explain developments of health policy even within the context of a government whose ideology has been directed by such thinking. The 'inefficient' central planning of 1970s welfarism for example, failed to result in an oversupply of health care. Indeed, in comparison to other countries, the NHS has been singularly successful in controlling costs and restricting funding within capped budgets. In light of this it is worth questioning whether the NHS reforms are the result of policy making led by public choice theorists. Perhaps the public choice arguments are more an
attempt to rationalise in retrospect those actions already decided upon. In elevating the price mechanism and consumer sovereignty to an idealised status, public choice theorists are dismissive of human ‘needs’. Needs per se are only discussed in terms of a minimum set of basic necessities. Any attempt to plan welfare services on the basis of need is seen as inefficient and patronising at best and coercive at its worst. For a government whose ideology has been so clearly directed by public choice thinking therefore, a health care system that gives responsibility to its officers to assess health care needs would seem somewhat of a contradiction. It is difficult to marry loyalty to the notion of consumer sovereignty with the existence of a professional cadre of needs assessors. The quasi-market in health care has been dressed up in the rhetoric of consumer choice and patient participation. It is here that appeals to the ‘language of need’ have to be set in context, and questions have to be asked of the commitments being made to a health care system that in principle allocates resources according to an assessment of need. Specifically, it is important to ask whether this aspect of the reforms represents a three way compromise between free market theorising, the imperatives of state bureaucracy and the demands of professional dominant interests.

2.2.3 Neo-elitism

Neo-elitism argues that power is concentrated in the hands of elites. These elites may conflict with one another but in the main they co-operate to prevent mass participation. Liberal corporatism, is a recent development of neo-elitism which sees the state offering favours and status to a few select groups in return for their moderating influence (Schmitter 1974). The medical profession is a clear candidate for interpretation as one of these favoured groups. However, the role of the medical profession in opposing the recent reforms does not correspond with this view of health policy (Harrison et al 1992).
Structural interest theory, (Alford 1975), is a brand of neo-elite theory that allows for competition between elites. Alford defined interests by their relationship with the principles by which institutions operate. He identified three interest groups:

‘dominant interests’ --- Doctors
‘challenging interest’ --- Managers (corporate rationalisers)
‘repressed interests’ --- Community groups and population groups

The usefulness of this approach is that it deals with the policy processes that go on between and within organisations. Its weakness is that it cannot analyse economic and technological changes very well. Alford’s theories give insight and understanding into the ability of hospital consultants to maintain control over their working practices. The impact of national policies on their main areas of interest are minimised by means of strategies of avoidance. Seen in the light of neo-elite theory the 1984 general management reforms and *Working for Patients* therefore seem to be attempts to give management the power and momentum to challenge medical elites. The period of post-war consensus has been replaced by policies that emphasise the role of management (corporate rationalisers), who are being encouraged by means of incentives and the direction of policy to challenge medical interests.

The implications of Alford’s theories of structural interests for a theory of health care needs can be found in the extent to which these structural interests take needs seriously. The idea that the language of need is used as a negotiating instrument is important here. In addition to this, Alford’s theory sheds light on the extent to which different definitions of need are used by these structural interests as they compete. At a simple level the ‘dominant interest groups’ (physicians) appeal to clinical definitions of need, the corporate rationalisers (management) tend to adopt an economic approach to need, whilst the ‘repressed
interests' tend to present a 'community' based notion of need. Later in my analysis of the work of the renal review group I reveal these attitudes in the concerns of the physicians on the group for an epidemiological analysis of needs and the managers concerns for the relationship between needs and contracting, both of which can be contrasted with patient group concerns for the survival of their local hospital. The relationship between the different groups was more complex than this suggests and there was 'cross-fertilisation' between the beliefs of these different structural interests. Nevertheless the analysis is useful in providing an understanding of how confusion arises concerning needs based policies and the extent to which rights and duties can be ascribed to individual needs.

2.2.4 Neo-Marxism and the new left

Orthodox Marxism presented a mechanistic approach to social policy whereby in the struggle between capital and labour the state was portrayed as the instrument of the capitalist class. Neo-Marxism has developed this analysis so that the class structure is given a more complex structural analysis. Elites are not seen as the result of a deterministic economic/social process but are related to the underlying class structure. The consequence of neo-Marxist analysis for social policy is that the state is no longer seen as the tool of the capitalist state but instead the welfare state is given a duality that sees it at one level as part of the functional requirements of capitalism and at another level as an achievement resulting from working class struggle. In this sense the welfare state is seen as a battleground (Poulantzas 1978). This 'paradox' of welfare is best summed up by Gough(1979):

"[o]nce universal suffrage and the other major liberal rights are established, this provides a crucial channel through which
to obtain welfare improvements. Indeed, welfare becomes a means of integrating the enfranchised working class within the capitalist system and of obtaining certain concessions from the organised labour movement" (Gough, 1979, p60-61-quoted in Hindess 1987)

Neo-Marxists still see the liberal state as being unable to cope with the plurality of demands made of it (Offe 1985). Within this critique the welfare state, and the NHS as part of it, maintains inequalities. These arguments have echoes in the work of Barr (1987) who argues that the welfare state operates as an efficiency device.

The neo-Marxist approach sets out three categories of welfare expenditure; social expenses to maintain order (police), social investment (supporting the process of capital accumulation e.g. transport and energy) and social consumption (health and welfare to maintain the workforce and to 'legitimate' the system). Capital interests are divided between industrial capital and financial capital and between local capital and international capital. With respect to health care policy these arguments formulate an extremely powerful analysis providing explanatory insights on the formulation of the NHS, episodes such as CBI lobbying for reductions in NHS workforce and the so called 'crisis of welfare' in the 1980s and 1990s. The significant contribution of the Marxist analysis is to be found in the account of the crisis of legitimacy. The capitalist system, in theory, should only invest in the welfare state up to the point where it optimises legitimacy.

The relationship of neo-Marxist theory to health policy and health care needs seems to be focused on the interpretation of the pursuit by the state of a policy based on an assessment of needs. The significant factor in this relationship is that health policy puts the responsibility of identifying needs and allocating
resources in the hands of Purchasing Authorities in the role of 'champions of the people'. Purchasers act as a buffer between central government and the residents they serve. This allows the centralisation of state power and the devolution of responsibility to occur simultaneously leading to concerns about accountability within the system. Indeed, some commentators have argued that there is evidence to support the view that there has been a rise of Stalinism in the NHS (Craft 1994). The authoritarian roles of surveillance, monitoring, assessing needs and reporting to central government sit uneasily with any attempt to empower and involve local populations in decision making. The conflicts that arise from this are manifested in part through the language of need. As far as measuring health care needs are concerned, Marxists see attempts at introducing cost-efficiency, performance indicators, savings etc. as means to secure greater output (legitimacy) for less input.

My analysis of renal policy draws on a number of strands contained in the theories I have just outlined. But in particular my interpretation of policy will focus on elitist perspectives, concentrating on the use of the language of need as a legitimating device in the hands of different interest groups. In order to do this however, I require an understanding of the operation of power within the quasi-market system of the NHS.

2.3 Quasi-Markets in health care

Although the Thatcher government had made significant changes to the management of the health service following the Griffiths report (Griffiths 1983) the concept of a universal health system financed from taxation remained largely intact between 1979 and 1987. However, it was clear that the government was searching for more radical ways of reforming the NHS and the critique of the
British system by the American economist Alain Enthoven (1985) and the solutions he offered in terms of internal markets finally led a review of the financing and organisation of health care in Britain and ultimately to *Working for Patients* (DoH 1989a). *Working for Patients* created a separation between purchasers of health services (DHAs, FHSAs and GP fundholders) and providers of health services (NHS trusts and Directly Managed Units, private and voluntary sector providers). Purchasers are given an annual budget, in the case of Health Authorities this is calculated according to allocative formulas based on population size, age and proxies for morbidity. In the case of GP fundholders this is based on historical patterns of service use. In both cases they are required to spend this money according to the needs of their populations. In general the providers provide levels of service in return for an agreed sum and the focus for this agreement is the contract for health care. Enthoven’s critique of the NHS paid tribute to the success of the system in containing costs, to the strength of primary care and to the economies of scale arising from the concentration of specialties. He argued however that the system was too rigid, over centralised and contained perverse incentives. These weaknesses resulted in inefficiencies, lack of innovation, poor accountability and lack of responsiveness to the consumer of health services. Enthoven proposed the creation of a demand side (purchasers of health care) that was separate from the supply side (providers of health care) to create the necessary conditions for markets to operate (Enthoven 1991). The terms internal markets, quasi-markets and managed markets have been used to describe such a system. Although these terms can be used interchangeably, I have settled on the term quasi-markets to describe the new NHS system. It is tempting to view Enthoven’s critique as the manifestation of attacks on the NHS by the Right but we should not forget that quasi-markets had also been advocated by some writers on the political left (Young 1989). Quasi-markets have also played a significant role in post-Fordist developments of capitalist organisation where centralised bureaucracies have decentralised by
means of contracting out (Harvey 1989). Quasi-markets could never result in the introduction of ‘the market’ to the NHS either in its pure, abstract sense or in the sense of markets for goods and services in the high street. This is because quasi-markets are by definition different in nature to ideal markets as well as the imperfect markets of the private sector. On the demand side the power of the consumer is not expressed in terms of individual ability to pay but in terms of budgetary allocations or vouchers. The agent for the expression of this power is a central government bureaucracy or a third party such as a GP fundholder. On the supply side the motives of suppliers may not be profit maximisation and the ownership of assets is often blurred. These factors combine to make quasi-markets operate differently to ordinary markets and produce a complex set of problems and weaknesses many of which Enthoven failed to highlight. These weaknesses cast doubt on the ability of the new system to meet the promised objectives of increased efficiency and improved responsiveness.

2.3.1 Contracting and quasi-markets

Immediately following the publication of Working for Patients the NHS Management Executive set itself the task of producing a set of operational principles for contracting in the new system. These principles were set out in September 1989 and they outlined a framework for agreeing general principles, for negotiating contracts, monitoring contracts and settling disputes (DoH 1989b). Early guidance covered such matters as the type of contracts, their duration, quality, the setting of prices, management responsibilities and the establishment of patient residency for the purposes of billing. As time went on however, guidance became increasingly concerned with ways in which the assessment of population need could be used as a basis for contracts. This culminated in a three pronged approach to needs assessment as a basis for the contracting process (DoH 1990, DoH 1991). The cautious approach of the
Central Management Executive towards the introduction of free markets in the first year of contracting is significant in that it betrayed a sense of uncertainty and a need to maintain the status quo. The key phrase at this time was 'steady state' and it highlighted a tension between a policy that called for more devolved decision making and fear of what markets could do to the system if they were allowed to operate freely. These tensions were rationalised by analysts who saw that if markets are to be managed then this requires a deeper understanding of the nature of quasi-markets than had hitherto been the case (Roberts 1993).

2.3.2 Market structures

The idealised market structure is one where there are many providers on the supply side and many purchasers on the demand side resulting in a competitive environment. Price in such a market should be responsive to demand and supply. Although the New Right place their faith in the capacity of markets to deliver health care more efficiently, this faith is based on limited evidence (Glaser 1993). Indeed the evidence in the UK to date is largely contradictory (Light and May 1993). It is useful to distinguish between market imperfections in general which can be found at all levels of the system and imperfection of health care markets in particular. Health care markets are inherently imperfect because they offer a multiplicity of opportunities for doctors and managers to collude, to manipulate markets, to segment markets and shift costs (Light 1993). On top of this, health care markets are complicated by reason of the product involved (health care and ultimately health) being so difficult to define. The relationship between purchaser, provider and consumer is complex because their roles are often blurred with purchasers relying on providers to specify the goods and services being bought whilst consumers place both providers and purchasers in a position of trust in terms of the appropriateness, quality and price of the goods they receive. Information on products is difficult to interpret and time consuming to
collect and this makes ‘shopping around’ for the best service almost impossible for consumers who often do not want to do this because they are already ill. The location of providers, particularly in rural areas means that conditions necessary for choice do not exist, thus monopoly markets operate. Finally poor quality providers are protected from the possibility of exit from the market and can operate at low levels of capacity whilst the better providers are overburdened with excess activity.

This is a far cry from the notion of ‘contestability’ (Baumol et al 1982) where the threat of new entrants into the market is believed to instil competitive discipline. If we consider the possibility of market segmentation however, the concept of contestability does have some force. For highly specialised treatments such as transplantation and some forms of cancer therapy the economies of scale involved make monopoly supply attractive and diminish contestability. For treatments such as renal dialysis however, contestability is much more of a reality as increasingly the major service determinant is patient convenience. Distinguishing between fixed costs (costs that remain until activity ceases) and sunk costs (costs that continue beyond cessation of activity) is useful because they influence the risk associated with contestability. Providers with large sunk costs have more to lose if their contracts are terminated or diminished in any way. Asset specificity, the extent to which assets can be redeployed, has similar consequences. It is unclear at present whether the annual cycle of contracting in the health service is sufficiently flexible to accommodate the risks involved in such market structures (Roberts 1993). In trying to shift some of the risks involved on to the purchasers, franchise type arrangements may appear where providers lease capital assets from the purchasers. The potential of this for renal services is considerable as satellite dialysis units and their equipment could be quickly set up by purchasers in geographically accessible areas and then contracts agreed with providers to provide a service from those units. Where the risks of
entering into contracts are great however, close relationships between a purchaser and a provider may develop to such an extent that institutional loyalties become entrenched and contracting evolves according to an increasingly specialised language. These close relationships could have positive or negative repercussions for the ultimate consumer of services. A specialised language evolves where the explanations, terms and definitions used as a basis for contracts become more intelligible for those involved in the contracting process and less understandable for those outside this process.

The way quasi-markets function is dependent on the nature of transaction costs and the extent of uncertainty. Transaction costs can be divided into *ex ante* exchange (costs incurred in drafting and negotiating contracts) and *ex post* exchange (costs incurred in monitoring outcomes and ensuring compliance) (Williamson 1975). The tendency is that high *ex ante* costs lead to lower *ex post* costs and low *ex ante* costs lead to higher *ex post* costs. Arguments against the introduction of markets highlight low transaction costs in the system before the reforms. The global shift towards decentralisation, flatter organisations and other aspects of post-Fordist forms of production may, on the other hand, reflect the capacity of new information technologies to reduce transaction costs. Nevertheless, the setting up of quasi-markets in the health service has involved a considerable degree of investment in new technologies and management personnel reflecting a tendency toward higher transaction costs.

Uncertainty is a feature of markets that can make it difficult for purchasers and providers to engage in forward planning. This tendency is compounded by the difficulties involved in processing the complex pools of information that comprise market signals. This is the bounded rationality that Williamson (1975) refers to and in the face of the uncertainties involved, organisations construct bureaucracies and hierarchical structures to cope with such an environment. The
role of contracts as mechanisms that are designed to minimise uncertainty and risk is crucial. It is through the need to enforce and monitor contractual obligations that purchasers and providers; a) incur increasing transaction costs and b) concentrate their contracting energies.

The motivation of actors involved in the contracting process is rarely clear cut. Providers are not profit maximisers and their actions are often motivated by the desire for kudos and to protect budgets. The role of purchasers is also unclear in that the 'champions of the people' often find the interests of consumers, the need to preserve good relations with providers and their own long term interests, in conflict. The position and motives of purchasers are significant in relation to the assessment of the needs of consumers. Whereas in conventional markets the consumption of goods is determined by the ability to pay, quasi-markets place a third party between the consumer and the providers and access to goods and services is dependent on the need criteria of the third party purchaser (often using provider advice as a guide). It has been argued that quasi-markets establish:

"...a correspondence between need and consumption. Where this correspondence is achieved, the quasi-market will meet the criteria of equity in the use of services." (Bartlett and Harrison 1993 p32).

Now this is a considerable claim on behalf of quasi-markets and its validity is dependent to a large extent on the meaning of need in this context and the absence of 'cream skimming', that is the ability of providers to discriminate against high cost users. These factors cause confusion concerning the question of what contracts can deliver. Quasi-markets could create incentives for increased efficiency and for reducing costs. On the other hand where the risks
are high then this could lead to increasing costs and opportunism leading to
reductions in quality and productive efficiency.

Insufficient knowledge and information to monitor contracts leaves purchasers in
the position of having to trust providers as far as the levels and quality of
services are concerned. Opportunistic behaviour becomes more likely in such
circumstances. This can present itself as a form of moral hazard, where
providers provide a lower quality service than is specified in the contract, and
where information that places the provider in a bad light is concealed from the
purchaser. Cream skimming is also a danger in such circumstances. The
response to the possibility of such opportunistic behaviour has been to look to
accreditation and registration systems and to rely on the role of professional
ethics in maintaining a baseline of treatment according to clinical need. The
pressures that quasi-markets bring to bear on physician behaviour when budgets
are capped should not be underestimated however, and as budgets begin to
contract:

"Treatments according to medical need and no other criteria
appears less and less likely to guide the ethics of medical
practice." (Roberts 1993 p308)

Clearly the market in the form of the Purchaser/Provider split is not designed as
a means of injecting more money into the system from central funds, rather it is a
mechanism for improving efficiency. One of the ways the market addresses
efficiency considerations is by bringing scarcity of resources into sharp focus.
This is because the limited budgets of Purchasing Authorities are now applicable
to defined populations. The NHS has always been subject to scarcity but
purchasing, in theory at least, offers new ways of addressing the problem:
1. By challenging 'provider capture' - the way resources have in the past gravitated towards traditional areas of professional interest; purchasing could act as a lever for allocating resources towards priority areas thus breaking away from historical patterns.

2. It presents opportunities to reflect the views of local people. Purchasing Authorities are encouraged to develop the role of 'champion of the people'.

3. Purchasers are concerned to buy services that are cost-effective. The extent to which purchasing offers 'value for money' is therefore a crucial strand in arguments in its favour.

However, purchasing either creates or highlights a number of dilemmas (Heginbotham et al 1992). These include the balance between expert and lay opinion, the conflict between individual need and institutional response, the resourcing of acute versus community services, prevention versus intervention, weighing the quality of life against saving life itself and the priority given to maintaining a balance of services across all care groups against priorities within care groups. Most of these dilemmas existed before quasi-markets but purchasing seems to bring them into a sharper light.

Purchasing is seen by some as ethically good because it forces rationing decisions out into the open (Harrison 1991). However, there is a considerable gap between the rhetoric of democratic accountability and the extent to which communities are involved in reality. We need to ask ourselves what communities should be consulted, how can complex issues be presented to the public in a meaningful way (Bowling 1993)? Are Purchasers 'champions of the people', or are they engaging in social control (Jones 1992)? Purchasing seems therefore to
represent a change in the balance of power. The extent to which power relationships have shifted in reality is unclear (Harrison et al 1992). The policy implications of these shifts in spheres of influence can only be grasped if we consider theories of power in the NHS.

2.4 Theories of power in the NHS

The analysis of power in organisations can be traced to Weber's work on bureaucracies which focused on power operating on hierarchical levels (Giddens 1971). This approach was expanded by Lukes (1974) to include the operation of control over individuals. Attempts have also been made to account for the way structural factors affect policy discussions through individual policy actors (Harrison et al 1990).

Power operates at a number of levels. The 'first face' of power presents itself as open conflict whereupon an individual or group submits to the demands made by others through the open operation of power. The 'second face' of power operates through the manipulation of processes and institutions by the powerful to ensure that their preferred interests are addressed and issues that challenge those interests are suppressed (Ham and Hill 1984). This can be achieved either through direct action taken by the powerful or by subordinate groups deciding not to raise the issue because they feel that it's 'not worth it'. In this way the powerful are able to preserve and even advance their interests without engaging in open conflict (Bachrach and Baratz 1970). The third face of power operates invisibly by stimulating, shaping and swaying the desires and wants of others. In this way the powerful are not only able to maintain their authority but also gain legitimacy in the eyes of those they dominate (Lukes 1974). This third face of power presents problems for policy analysts because of its invisibility, for how
are we able to analyse something that by definition lies hidden from view? The invisibility of the third face of power does not however mean that it is undetectable nor is it immune from critical analysis and it is through the development of critical methods that the problem of invisibility can be overcome.

Within the NHS, power operates at all of the levels discussed above. Attempts by the conservative government to diminish trade union strength during the 1980s seem to have operated in tandem with a strategy to increase control over the NHS structure through the introduction of general management. The first and second faces of power were clearly at work in this process. However, doctors have been able to resist governments’ attempts to change the system in different ways. Harrison et al (1992) refer to the ‘macropower’ of doctors operating through national pressure groups such as the BMA and the Royal Colleges who bargain with the state, and the ‘micropower’ of doctors who operate at individual and local levels as the ‘gatekeepers’ to the health care system. The mythologising of medicine - the belief in doctors as Gods, the kudos given to medical elites and the reinforcement of medical power through socialisation (Zola 1972, Illich 1976) all mean that doctors are often able to avoid having to use the first face of power.

There is a danger however in overstating the extent to which the socialisation of medicine allows medical elites to exercise power in less visible ways. The role of uncertainty in the health care system and the way it interacts with the forces of power makes an important contribution to the understanding of policy and decision making. There is considerable uncertainty within the health care system concerning health needs, health status and the appropriateness of alternative therapies (Mooney and Loft 1989). Lipsky (1980) argues that where there are high levels of uncertainty then variations in responses are found to be more acceptable and the influence of centralised power is lessened. This has
important implications for interpretations of the NHS that see it moving from a Fordist to a post-Fordist culture where direct centralised control is replaced by a fragmented structure based on contracting (Harrison et al 1992). The relationship between uncertainty, power and shifts in culture within the NHS is reflected in the ‘macropower’ of doctors coming into open conflict with the government through the BMA whilst the micro-power of doctors is still able to operate to resist change. Gaining insights into the ways in which power, uncertainty and culture interact provides opportunities for interpreting policy processes. Because of the ‘hidden’ nature of some of these relationships the relevance of Habermas’ critical project to policy analysis becomes apparent.

2.4.1 Habermas and communicative ethics

The relevance of the Habermasian project to the analysis of health policy is found in the insights it can give into the distortions of communication by powerful groups, (the colonisation of the lifeworld by medicine being an example), and the opportunities for health care policy that would arise as a consequence of achieving undistorted communication (Scambler 1987). For Habermas, linguistic communication between individuals contains implicit ‘validity claims’ in that what is said is comprehensible, spoken with sincerity, its propositional content is true and it is justified. The first two of these can be defended by individual behaviour whilst the last two can be defended in dialogue; they are ‘discursively redeemable’. When all four of these validity claims are met then undistorted communication is being entered into, what Habermas calls the ‘ideal speech’ situation (Habermas 1979). Habermas places
reliance on truth being achieved through consensus in an ideal speech situation (White 1988) 1.

It should be clear that this is a procedural theory and that “practical discourse is a procedure for testing the validity of hypothetical norms, not for producing justified norms” (Habermas 1990 p122). For Habermas the validity of a statement can be justified by means of a three stage analysis through claims to truth (concerning the objective world), claims of rightness (concerning the shared world) and claims of truthfulness (concerning the subjective world). Critics of Habermas see this as idealistic in that it is unable to grasp the extent to which power discourses invade all speech situations, (Lukes 1982, Keat 1981). Habermas’ response to this is that his position reflects a goal and not an actual state of affairs and that his theory can form the basis of a critical analysis of communicative practices. The aim is the exposure of systematic distortions so that the exercise of power and dominance can be revealed as ‘ideology’ or ‘false consciousness’. However, the practical effect of setting up an idealised situation is to separate power relations from communicative relations. The danger is that power is then seen as being located in words and not in the institutional context in which they are used (Bourdieu 1991). This highlights the dangers of adopting

1 The ideal speech situation is formally operationalised as claims of truth telling by the following rules:

1. Each subject who is capable of speech and action is allowed to participate in discourses.

2. a) Each is allowed to call into question any proposal.  
   b) Each is allowed to introduce any proposal into the discourse  
   c) Each is allowed to express her attitudes, wishes and needs.

3. No speaker ought to be hindered by compulsion - whether arising from inside or outside of it - from making use of the rights secure under 1 and 2.

From these rules Habermas proceeds to assert that:

A. Whoever engages in argumentation presupposes the validity of the discourse act  
B. When argumentation concerns norms, actors must admit (or otherwise contradict themselves) that universalisation is the only rule under which norms will be taken by each to be legitimate.
an uncritical view of Habermas' idealisation. Later in this chapter I will discuss this in relation to Doyal and Gough's use of Habermas.

Habermas makes a distinction between two forms of rational action, 'purposive rational' action and 'communicative' action. The former represents a technical rationality analogous to Weber's *Zweckrationalität* and is embedded in social systems such as welfare systems, and markets. Communicative action is a form of linguistic interaction aimed at achieving understanding. The paradox of rationality for Habermas is that social systems colonise the 'life-world' (where social interaction and culture are sustained and reproduced) with rationality that has positive and negative characteristics and effects (Thompson 1984). This can be seen in the way medical expertise has colonised the life-world. This has occurred through the social respect attributed to medical expertise which itself is legitimised and founded upon a form of formal knowledge which presents itself as 'purposive rational' action (Friedson 1986). The positive aspects of this rationality are to be found in the contribution it makes to meeting generalisable interests whilst the negative aspects can be found in the inappropriate use of formal medical knowledge to justify or legitimate the vested interests of the powerful. In this sense 'formal knowledge' becomes 'ideology'.

Now the distinctions I have made here are not as clear and precise as I have so far implied. Certainly the work of Foucault should cause us to pause at this point to consider whether it is possible to distinguish between different types of rationality when the effects of power may be all pervasive (Rabinow 1984). In his analysis of power Foucault searched for those who resist established practices of power to gain the perspective of a counterpower. He was careful however to state that every counterpower moves with the horizon of the power it challenges and at the point of transformation into a new power complex it also stimulates a new counterpower. In this way Foucault resisted the temptation to take sides
and was dismissive of those who interpret power as evil or bad and those upon which power is exercised as good (Levy 1977). For Foucault, power was productive. It is not necessarily a repressive force but creative in the sense that it is the means whereby knowledge, forms of pleasure and discourse, happen. Foucault saw power as a force that:

"is exercised only over free subjects, and only in so far as they are free". (Foucault 1982, p220)

In this sense his interpretation of power seems to contain constraining aspects, but in its relationship to knowledge, power by virtue of "multiple forms of constraint" is an inherent part of the production of truth (Foucault 1980). This allows Foucault to argue that medical practitioners (to take one example) have been able to classify, observe and experiment on the bodies of subjects (be they patients or populations) by means of a set of power relations that provide the means to further knowledge and at the same time take that knowledge into judicial spheres to legitimise their claim to expand their areas of practice. It is here that we find an intermingling of claims to power and claims to knowledge (Philip 1985). Thus through a multiplicity of such power relations, operating through institutions and human sciences (asylums and medicine being prime examples) power saturates the social field.

Foucault emphasised the way disciplinary power defines bodies subjecting bodies to normalisation through what he termed ‘biopower’. This is an important point, for Foucault argued that biopower can function without having to resort to a false consciousness which could be tamed by critical discourse. If we accept this analysis then anyone working in Marxist and Freudian traditions using distinctions such as legitimate and illegitimate and conscious and unconscious motives, to fight the 'dark forces' of repression are themselves in
danger of reinforcing the violent effects of normalisation on the body. If this is so, then why and how should we engage in political opposition? Foucault started to develop criteria for addressing this problem based on anti disciplinarian rights that are free from the constraints of sovereignty (Foucault 1980). But Foucault’s critique of modern power could only be constructed by reference to normative notions and it is difficult to see how he could escape this (Fraser 1981). It is this that leads Habermas to argue that the development of normative structures in connection with the modern formation of power were ignored by Foucault (Habermas 1992). Giddens argues that in focusing on power, discipline and surveillance Foucault leaves little room for the concept of agency or the individual embodying it (Giddens 1982). He goes on to argue that institutions such as hospitals did not appear as if from nowhere “behind the backs” of those agents who built them. This is contested however, for Foucault was concerned with processes of self-formation in which persons were active (Foucault 1982, Rabinow 1984). In light of these points, the importance of turning towards a critical theory that can expose the exercise of power using the distinctions I have outlined earlier, but recognising that they are clouded by the operation of power within the system, becomes apparent. It is with the aid of such a theory that we can gain insights into how power operates in the NHS.

2.4.2 Communicative ethics and power

Habermas’ project sees critical theory working towards exposing the operation of the hidden faces of power. This is an ambitious project fraught with complexities but Habermas seems to suggest that the analysis of speech acts has potential to form a basis for the analysis of power. In his analysis Habermas makes a distinction between communicative action and strategic action (Habermas 1984). Communicative action is a form of linguistic interaction where all the communicants perform actions in speech with the aim of achieving
consensus and understanding. It is only in communicative action that all speech acts contain validity claims concerning comprehensibility, sincerity, truth and justification, which are openly criticizable and discursively redeemable. Strategic action on the other hand, occurs when at least one of the communicants aims to produce an effect on the others through speech acts. The aim of strategic action is therefore success. Open strategic action occurs where the speakers intention to influence and have an effect on the listener(s) is openly declared. Concealed strategic action occurs where there is no such open declaration and involves deception. This can be conscious deception whereupon the speaker manipulates the speech act to give the impression of communicative action whilst pursuing the goal of successfully influencing the listener(s). It can also take the form of unconscious deception where the speaker engages in self-deception concerning the aims of his speech act. How such forms of deception can be assessed in practice is, of course, a major problem. More important perhaps is the danger of assuming a privileged position for assessing speech acts (not only the speech acts of others but one’s own speech acts). Such an objective position is impossible in practice and untenable in theory. For the purposes of my research I address this problem by undertaking a critical ethnography (see chapter 3).

Habermas’ analysis presents us with a formal guide for interrogating discourses of power. Scambler (1987) explores the relevance of Habermas’ theory to the medicalization of the life-world in the experience of pregnancy and childbirth. He relates Habermas’ concern with new social movements to the success of women’s and users’ groups in challenging medical interests in the field of obstetrics and gynaecology. He counsels caution however, stating that the capacity of the medical establishment to absorb changes whilst retaining their power should not be underestimated. It is through the increasing power and influence of the medical industrial complex that the relationship between the
colonisation and rationalisation of the life world is cemented. The Habermasian project gives a strong emphasis on the need to empower social movements and has parallels with ‘bottom up’ approaches to health policy. My research has concentrated on a ‘top down’ method of planning services but such an analysis can also benefit from the rigorous gaze of a critical social theory. Before I begin to do this a restatement of the relevance of the Habermasian project to a theory of needs is necessary.

2.5 The basis for discussing health care needs

If there is agreement over giving priority to need satisfaction as a goal then policy makers must face the problem of how to agree on the best strategy for achieving this goal. A number of questions immediately arise from this. In the first instance there is a need to know how effective particular technologies are in achieving goals. More important perhaps the issue of who should control their development and use is pertinent to a policy framework that has participation at its roots. Policy makers need to know what are the appropriate social policies to satisfy needs e.g. prevention versus cure. As a back drop to this of course is the problem of whether it is possible to meet needs within a resource constraint. The problem that throws up these questions is confounded by lobbying, conflicts of interest and conflicts between individual, moral and professional interests.

Within Doyal and Gough’s theory of needs, communicative action is seen as a prerequisite to decision making that involves conflicts over needs (Doyal and Gough 1991). Decisions should emerge from debates that yield the most rational and efficient solution to the problem of needs satisfaction in any particular context. Such debates must occur in an open and critical
communicative process involving disagreement in a way that demonstrates objective acceptability of some forms of consensus.

The focus on autonomy and equality in a needs based policy framework demands a commitment to political democracy. There are clear conflicts here, the tyranny of the majority over the minority being one. Another is the threat of a strong centralised planning structure to individual autonomy. On the other hand a completely decentralised democracy could place limits on the kind of long-term planning efficiency which needs satisfaction demands. Decentralised decision making may also lead to variations in levels of provision resulting in inequity in the nation space. To tackle these problems as part of a theory of need, Habermas' ideal speech situations could be used in an attempt to focus on a means of enhancing the rationality of needs based policy debates. For Habermas the problem of reason is identifying the principles by which the most effective policies for meeting 'generalisable interests' can be determined. In light of this Doyal and Gough propose three rules for rational and democratic discussion of needs:

1. "All participants should possess the best available understanding concerning the technical issues raised by whatever problem they're trying to solve"

2. "If disputes about such knowledge threaten the optimisation of need satisfaction, their rational resolution will require specific methodological and communicational skills" [controlled trials (methodological) - hermeneutic understanding, practical understanding and pragmatic rules of truth telling (communicational)].
3. "Communication intended to lead to improved technical and practical understanding - and thus the possibility of optimising need satisfaction - must be as democratic as possible." (see page 122 A Theory of Human Need).

Doyal and Gough's rules are an attempt to operationalise Habermas' communicative ethics. In doing this they can be criticised for adopting a naive view of the struggles over needs in late capitalist societies. What form should the 'democratic communication' that Doyal and Gough envisage take? Can we rely on 'pragmatic rules of truth telling' to address the forces of institutional power, when those forces are producing the "rhetoric of expert needs discourses" (Fraser 1981 p174). These questions highlight the problems and pitfalls of attempts to base policy on ideal states. Schlosberg (1995) uses the example of the Community Board Program of San Francisco to argue that communicative practices can be seen as "an expression of and an ongoing guide for emancipatory struggle and practices" (p311). However, he also identifies a tension between the recognition of diversity and difference by such emancipatory groups and Habermas' emphasis on universalization and ultimate consensus. Despite this, Habermas' work can still provide us with a basis for evaluating communicative practices. In this respect Doyal and Gough's rules do represent a useful starting point for examining the ways in which needs are discussed in practice.

My analysis of renal policy in London will use this framework of rules as a basis for a critical evaluation of the renal review group's work to determine the extent to which they were engaging in democratic and rational debate. Given that barriers to this will be vested interests I will be sensitive to the operation of power throughout the group's activities. My main aim will be to identify the extent to which the lack of an explicit theory of need and the associated technical
knowledge and understanding it demands, led to discourses being invaded by the rhetoric of need. The extent to which vested interests were able to manipulate channels of communication and reinforce their prejudices through their control of the technical knowledge on ‘needs’ will be a crucial part of this analysis.
Chapter 3

Methodology

3.1 Introduction

This chapter sets out the methodological basis for this thesis, together with the methods I use in my research. I begin by outlining the limitations of traditional forms of policy analysis and ask how meaningful bodies of knowledge that relate to the practical understandings of the people concerned can be developed. The manner in which I gathered empirical evidence has meant that I have had to construct an interpretative methodology in retrospect as a way of interrogating the discourses I encountered as well as reflecting on my role as a participant observer. While adopting elements of ethnographic methodology I will present a critique of ethnography (Hammersley 1992) and follow a path signposted by arguments for a critical ethnography (Moon 1983). One of the main aims of the research is to examine the extent to which members of a group of professionals, reviewing renal services in London, adopted pragmatic rules of truth telling and had sufficient hermeneutic understanding to allow disputes about need to be resolved rationally in a way that optimised need satisfaction. Recognising this, my methodological starting point seems to lie naturally with the problem of linking theoretical explanation and understanding through a hermeneutic methodology (Pile 1990). Following an outline of the research process itself including a detailed analysis of my field relationships, role as participant observer and analytical methods, I use a framework, based on Habermas’ critical social theory and Doyal and Gough’s Theory of Human Need, to evaluate the London review of renal services both in relation to the assessment of needs made and the review group’s decision making processes. This evaluation is based on an analysis of three interrelated aspects of the renal review; a) the technical
information produced by the review group as an assessment of the needs of renal patients, b) the minutes and tapes of the renal review group's meetings, c) the renal contracts in place at the time of the review process.

3.2 Traditional policy analysis

Within the NHS the methods used to study policy making have tended to concentrate on reviews of official documents and interviews with policy actors. Ham (1981) for example, in a historical study, used oral evidence of health board members together with official documentation from Health Board Committees. Similarly, Haywood and Elcock (1980), in their study of the relationship between Area Health Authorities, the Regions and the centre, scrutinised AHA papers, logged attendances at meetings and interviewed Authority members and officers. McNaught (1988) built on these techniques to the extent that he attended specific meetings and interviewed policy makers as a basis for his study of race and health policy in West Lambeth. These studies follow a tradition in health policy research, of using official documents alongside interviews with key groups or individuals as a basis for analysis of decision making. Some of these studies have encountered the problem of tending to miss those issues that policy makers either deliberately or unconsciously avoid. The researcher can become too engaged in the role of observer and this observational gaze places limits on the researcher's horizons of understanding. This is not to say that researchers have failed to utilise interpretative methods that go beyond the observational approach. Some studies have explicitly recognised this and explored ways of overcoming the problems involved. The majority of such studies however have examined the perceptions and beliefs of individuals as members of communities or patients (Cornwell 1984, Eyles and Donovan 1986). These approaches promise a deeper understanding of perceptions and meanings. Whilst
recognising the usefulness of traditional methods therefore, it is clear that if an
assessment of decision making by elite groups is to avoid being subsumed by the
discourses of power it tries to describe, then it is essential that an active
participatory and reflexive methodology is employed.

3.3 Ethnography and social research

My concerns with the limitations of policy analysis have led me towards the
interpretative stance of qualitative methods which has been promoted as an
essential part of policy research (Walker 1989, Pollit et al 1990). It is
unfortunate that approaches to social research have been polarised between
positivism and naturalism. Positivism is portrayed as an attempt to apply laws
of natural science to social science. Researchers therefore categorise variables
and test relationships in the light of testable laws and theories. Critics of
positivism describe it as preoccupied with the measurable and quantifiable.
They argue that it artificially divorces theory from method so that theory is
validated by the application of the methods. Thus, the assumed neutrality and
objectivity of positivism is questioned and its implicit subjectivity exposed.
Naturalism on the other hand is said to distinguish between social phenomena
and natural phenomena. The emphasis here is on social meanings and intentions
which form the basis of the appearance of social phenomena. Naturalist
approaches vary from ethnomethodology (Garfinkel 1967), phenomenological
sociology (Schutz 1970), and transcendental phenomenology (Wolff 1964).
For naturalists the appearances of social phenomena are sacrosanct. Theories
can be made of them but not about how they came to appear that way.
Ethnography belongs firmly in the naturalist camp.

Although the origins of ethnography are to be found in cultural anthropology, its
relationship with interpretative sociology has been a source of much controversy
and debate and the extent to which it draws on symbolic interactionism, phenomenology, hermeneutics and ethnomethodology adds to the confusion that sometimes surrounds the term. Giddens (1976) formulates the ethnographic approach as a process of "mediating frames of meaning". The researcher's loyalties should be with the people/subjects or phenomena being studied, not to the methodology or particular principles of the methodology. The development of verstehen as a principle of reflexive explanation is important here but ethnography demands more than reflexivity because this on its own has the effect of isolating the researcher from the researched.

"...the adoption by the participant observer of a critical, interpretative stance, necessitates an evaluation of the relation of the researcher to the researched " (Evans 1988, p200)

Ethnography is therefore clearly based on a recognition of the power relations between researcher and the subject of study (Smith 1988). Policy research demands a sensitivity towards action and structure so that multiple versions of reality seen by different actors are recognised along with the historical evolution of ideas and actions (Pettigrew et al 1988). The attractions of ethnography for my role as researcher based within a group of powerful medical and management elites should be clear. In addition a method that does not follow a linear ordering of hypothesis, experiment, results related to hypothesis and then conclusion is also relevant in that I engaged in a process where all these occurred simultaneously during the research. Finally ethnography's focus on the researcher as participant observer promised a deeper understanding of my role in the research as one who was participating in the activities of the people I was researching:
"Participant observation by its very nature is a fluid process involving changes in the researcher and his or her relation to the subject community in the course of the research" p204 (Evans 1988)

3.4 A critique of ethnography

Ethnography’s focus is description but ethnographers argue that they offer a unique form of description, namely theoretical description. This seems odd in that of themselves descriptions cannot be theories but they are informed by theory and in turn inform the development of theory. Ethnography’s claim to offer theoretical description has its sources in a number of approaches. Insightful descriptions, description of social microcosms, applications of theories, and development of theory through case study, are all rationales that have been promoted as forming the basis for theoretical description (Hammersley 1992). The problem with insightful description is that its appeal seems to be grounded in the extent to which ethnography can reveal social phenomena in new and innovative ways. This is fine but seems insufficient as a basis for the development of descriptive theory. Are we to accept the description that provides the most innovative revelation as a theoretical basis? This seems to leave theory open to the vagaries of a market in descriptions. Arguments for the theoretical nature of ethnographic description are also found in the claim that by describing particular phenomena it is possible to find or extrapolate to the general. Ethnographers celebrate the diversity and complexity of human life but at the same time believe that general features of social life can be discussed through the description of social microcosms. One consequence of this is that ethnographers envisage ‘theory’ emerging from the descriptive data. How this mysterious process happens is more difficult to comprehend. Silverman (1993)
addresses this when he states that qualitative research should be driven by theory, not by technical considerations.

Grounded theorising moves beyond the comparison of single cases to evaluate theories on the basis of strategic selection of cases, (Strauss 1987). There is a duality to grounded theory in that it attempts to describe situations whilst simultaneously producing theory, this duality makes it unclear whether grounded theory is testing theory or developing it or both. The theory is evolutionary and pragmatic, growing out of the research context by being grounded in the experiences of the researcher (Glazer and Strauss 1967). It recognises that the research process does not operate on the basis of an objective preconceived reality. In response it seeks to use each specific situation contingently. Grounded theorising is highly relevant to policy research because it lends itself easily to the pluralistic nature of many policy processes. Through its commitment to map the social world in all its complexity whilst maintaining a direct approach to ‘naturally occurring phenomena’ it is possible to gain new theoretical insights that then interact with existing abstract theory. However, the commitment to theoretical description has sometimes meant that ethnographic research does not make the values on which it is based explicit. This failure can give an ethnographic description the appearance of being the only available explanation of the social phenomena when it is in fact as moulded by values as other sociological methods are.

3.5 Critical theory - Hermeneutics

In light of these criticisms there have been calls for a critical ethnography. Ethnographic researchers have been chastised for being too insular and unresponsive to a critical dimension. Critical ethnography in this sense is an attempt to link the methodology to a political understanding. These criticisms
come from concerns that ethnography by its commitment to descriptions has focused on cultural analyses at the expense of any theoretical construction of the conflicts and power relationships that affect and limit human understanding. Describing peoples understandings at face value allows ideological distortions and power relationships to be reinforced (Moon 1983).

Traditional ethnography is therefore criticised for taking ideological constructs for granted. Critical ethnography on the other hand is presented as a synthesis of empirical-analytical and hermeneutic methods involving an interpretative understanding of phenomena that run alongside the development of causal explanations. Fay (1987) outlines four levels for these theoretical explanations:

1. A theory of false consciousness
2. A theory of crisis
3. A theory of education

The theory of false consciousness considers how ideological understandings can be false, how these falsehoods are constructed and reproduced and finally attempts to construct alternatives. A theory of crisis is designed to identify social crisis\(^1\) and the ways it came about. A theory of education should identify methods to overcome these problems and finally a theory of transformative action must show what changes are necessary and how social transformations can occur. The danger of this is that the researcher is assumed to have a privileged standpoint from which the truth or falsity of understanding is assessed. Looked at from this perspective critical ethnography places intense demands on the researcher. Nevertheless, its criticisms of traditional ethnography are relevant

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\(^1\) Social crisis refers to a society marked by structural conflict that threatens to lead to the breakdown of the society
and have encouraged me to bring critical perspectives into my work. I have attempted to do this through the use of interpretative methods and depth hermeneutics.

3.6 Depth Hermeneutics

Habermas (1977) and Gadamer (1975) view communication as a practical activity where the interpretation of language cannot be divorced from the context of action in which it is produced. The consequence of this for the researcher is that the search for meanings in language, speech and text requires an engagement with actors as a participant. The role of participant observer is on an 'intersubjective dialogical' level where the participant strives with the actors for understanding, whilst maintaining a critical awareness of the process. The aim of the research becomes the 'fusion of the horizons of understanding' of the researcher as participant and the people involved. The goal that interpretative hermeneutics aims towards is more consensual understanding. Interpretation involves understanding how actors express subjective truths that simultaneously mean, either knowingly or unknowingly, something else. Critical understanding therefore aims to identify and eliminate prejudices and suppositions that are embedded in the linguistic process. However, by recognising that language is the medium through which the reproduction of society is carried out, hermeneutic understanding acts as a bridge between subjective individual actions and objective historical processes. Whilst Gadamer and Habermas agree up to this point they diverge over the balance between reason and tradition. For Gadamer, the universality of language means that no knowledge exists outside of it. Appeals to truth are therefore intersubjective processes that inevitably carry an element of rhetorical persuasion. For Habermas this means that Gadamer's analysis is susceptible to distortions of power and is unable to distinguish
between authority, reason and tradition. Habermas argues that such distortions can be overcome through the recognition of a 'shared lifeworld' which is historically constructed. My position as a researcher working on the renal review meant that I was engaged with actors as a participant. However, I cannot claim objectivity from this position (see section 3.7.3) and my analysis is dependent on my own subjective stance as researcher. Nevertheless, by taking the path of a critical ethnography that draws on Habermas' insights I hope to structure my analysis in ways that allow me to evaluate critically the renal review's needs assessment and decision making process.

3.7 The research setting

An element of chance played its part in my choosing a setting for my fieldwork. From the outset I wanted to examine theories of need in relation to health policy and to situate my research in the area of end stage renal failure. This was because I felt that this is a service area where theories of need and the imperatives of service delivery come into conflict spawning moral dilemmas that go to the heart of health policy. I began my research endeavours with a literature search on needs assessment and the epidemiology of renal failure. I also instigated a programme of acquainting myself with local renal units, visiting the sites and getting to know physicians, nurses and support staff. I obtained permission to shadow a renal unit social worker to get a 'feel' for the daily routine of a renal unit, the workload, the demands on staff and the different social circumstances of patients. At the time I had introduced myself as a potential researcher on patients needs. Staff welcomed me and were positive in their response, often volunteering the kind of issues that they thought would interest me. I had not as yet identified clearly what my fieldwork would entail. At this

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2 At the time I was a research fellow in health care needs in East London. My grant was funded by the local health authority and I worked closely with the local department of public health on a number of projects looking at the health and health care needs of the local population.
time the Tomlinson report on the future of London's health service had been published (Tomlinson 1992) and had recommended the setting up of a London Implementation Group to steer the changes outlined in the report. As part of this implementation group's work, six independent specialty reviews were set up for Cancer, Children, Plastic surgery and Burns, Neurosciences, Cardiac and Renal services. Their task was to review service provision and to make recommendations to the Minister for Health on the future provision of speciality services in the capital. The backdrop to the review process was therefore one of calls for a rationalisation of London services during a period of intense resource constraint, an economy in recession and political uncertainty. The chief executive of the health authority I was based in was appointed to the renal specialty review group. I expressed an interest in being involved and was invited to provide research and administrative support to the group. My work for the review group involved the task of collecting and analysing data from every renal unit in the four Thames Regions. I also assumed the role of recorder for the group in its visits to each renal unit in London and in its own meetings. In the event I was also called upon to assist the chairman of the review in the writing of the final report. This meant that I accompanied the group on their visits to renal units and participated in the working meetings of the group held at the Department of Health.

The collection of the quantitative data involved the administering of a questionnaire to renal units asking for information on the geographical, demographical and medical characteristics of renal unit patients. This was analysed in conjunction with 1991 census figures to provide the group with an epidemiological picture of patient 'needs'. This was a population based geographic analysis of rates of acceptance on to renal replacement therapy (RRT) in the four Thames Regional Health Authorities. My role in producing this analysis in conjunction with a public health doctor on the group was not neutral
and I was able to call for additional information and analysis that I believed would improve the group's technical knowledge on needs. Nevertheless I was constrained in this task by the group's perceptions and the group as a whole was constrained by the time scale demanded by government. My role as a researcher in the group producing this work meant that I was collaborating with the public health doctor in pushing all the time for the epidemiologically based analysis to be as rigorous as possible whilst recognising its limitations and the possible ways it could be ignored or distorted. This highlights an important and difficult aspect to my role as participant. Although I did discuss the limitations of the needs assessment process with group members (and many of them were equally aware of its limitations) I did not openly question the work in review group meetings. In helping to produce the epidemiological analysis therefore I was contributing to the work that I critically evaluate in this thesis. My complicity is important for it grew out of my investment in the epidemiological approach and manifested itself in my tendency to adopt the often dehumanising medicalised language of the group. For example I found myself using terms such as the 'stock' of patients and the 'harvesting' of kidneys.

My qualitative analysis was based on the meetings of the group. I minuted the group meetings (5 in all) and its site visits (12 in all). I also tape recorded these meetings and visits. Site visits usually lasted three hours, while group meetings lasted a working day. The review group's work was conducted between March 1993 and May 1993. A chronology of the review process is given in chapter 5 appendix 5.2. During this period I developed a relationship with review group members that both affected my interpretation of events and affected events themselves. I adopted a strategy of continually questioning my responses to situations and scrutinising my actions. The review group also had a 'weekend away', which was not minuted, to reflect on the information it had collected and mutual understandings grew during this period. Although my time on this
weekend away was largely spent in analysing epidemiological data and presenting it to the group, I kept a record of each day's events, in the form of fieldnotes and diary, keeping an account of my thoughts and impressions on the group's progress (see section 3.8.2). On site visits however, my role became more passive and observational. These visits were very much a stage for professionals to take up negotiating positions. Each meeting of three hours took about a day and a half to transcribe fully. Although the site visits contained an element of repetition as the chair explained the review groups aims and thinking, this was transcribed each time to ensure that there were no inconsistencies and to record the questions that renal unit representatives raised. Both following and during transcription I made notes of ideas and interpretations that arose from the process. I also referred to the notes I made during the meetings.

I wished to relate my analysis, of what was essentially a planning process, to the wider context of a developing market in health care. There were a number of ways in which I could have done this. I could have interviewed key informants who were working on managing the market in London, alternatively I could have examined the changes in the delivery of renal services as the market developed. I was however, interested in the way in which the language of need related to the market. In this respect the contracting system was the formal link between the identification of health care needs and the system's response to needs (Jones 1995). I therefore decided to focus on the contracts for renal services in place at the time of the review. I began by writing to every Director of contracting and purchasing in the English District Health Authorities and Regional Health Authorities. At the time many of the contracts were still being administered by the Regional Health Authorities and replies from the District Health Authorities often referred me on to either the regional purchasing department or to their local provider who had a contract with the region. I followed up my letter with phone calls to encourage responses and with additional letters to those
individuals who had been brought to my attention by DHAs who were unable or unwilling to provide contracts. After 8 weeks I had collected 21 contracts covering 98 DHAs (six of the contracts were Regionally based) covering 51% of the possible DHAs in England. The list of responders and non-responders is given in Chapter 6, Appendix 6.1. This shows that the responses came from a mixture of inner city, urban and rural DHAs. Non-responding Regions were broadly similar in this respect. Responders came from regions in the north, the midlands, south west England and the Thames area. There were no responses from Trent, East Anglia, Oxford, Mersey and South West Thames Regions.

3.7.1 Ethical considerations

My decision to undertake research into the behaviour of powerful actors in the context of assessing needs was motivated by a mixture of circumstance, judgement and ethical constraints. Ethical considerations arose out of the fieldwork process itself and out of the data collected (Jenkins 1987). I faced three major ethical constraints; the extent to which I should reveal myself to others as a researcher, what to do with ‘off the record’ statements and how and when to obtain consent.

In all the meetings, the chair of the group asked for permission for the meetings to be minuted and taped. The reason given for this was to ensure accuracy in recording. The chair informed everyone that I would be using the tapes to write up the minutes of the meetings. However, this necessitated my obtaining consent for using the tape transcripts in my research retrospectively. The tapes recorded events in official meetings only. No attempt was made to tape record private conversations or ‘conversations in corridors’ though these were clearly an important part of the review group’s work and influenced my interpretation of events considerably. I wrote up my notes of the meetings (including details of
the 'conversations in corridors') every evening in the form of a field diary after having completed the minutes of the meeting. This was a laborious task but my field notes contained details of my experiences throughout each day including my impressions of events during and outside the meetings. The chair of the review group directed both meetings and site visits.

The meetings with the renal units all followed a fairly set pattern. Four to five members of the renal review group would attend including myself and the chair, and each unit would be represented by renal clinicians, clinicians from connected specialties, nurse managers, hospital chief executives and financial managers and medical school representatives. Meetings began with the unit presenting its case, setting out its strengths in terms of geographic location, service provision and research and academic activity. The chair of the review group would then outline the proposed model for rationalising services down to five core units before asking for comments on the model and how the unit saw itself fitting in to future provision. There was general agreement with the model itself and so debates were mainly concerned with the issue of which units should form the core five. At the end of the meeting the review team would be invited to visit the unit's facilities and this was often an opportunity for further 'off the record' discussions to take place. All members of the review group visited at least one of the units. The only persons to visit all of the units were the chair and myself. The discussions were led by the chair who would ask the group members if they had any questions or points to make during the negotiations. This meant that while no individuals were excluded entirely there was a pecking order in terms of contributions to the debate that may have acted to allow Lukes' second and third faces of power to operate in the form of self censorship (see chapter 2 section 2.4).
I drafted the minutes of the meetings and sent a copy to the chair of the review group for comments. I sent a second amended draft to the heads of the renal units asking for any comments and made any necessary amendments with the chair's agreement. The final set of minutes were then signed by the chair and circulated to the review group members and the renal unit director. The minutes were therefore an official record of the debates held with each renal unit. They were important to the units as an opportunity to record their case accurately and to express the strength of their arguments and feelings. This was reflected in a number of responses from renal unit directors asking for changes to be made. In all of these cases these changes were complied with. The chair of the review group seemed to see the minutes as having two main functions; a) to clarify the contentious issues being debated and b) to give units an opportunity to have their say and to have it recorded formally. This he was able to do whilst having control over the writing of the minutes. In this sense the minutes were a mechanism for ensuring that debates were formalised and decisions and comments could not be 'gone back on' subsequent to meetings. The extent to which this placed constrictions on the debates is unclear but most units welcomed the opportunity to be frank (although it should be noted that there were times when individuals asked for their comments not to be recorded). This does not mean that I believe the recorded debates to be completely free and open, often there were hidden agendas and sub texts at work, but the official record was used by both sides as a way of getting their point of view across, though obviously in controlling the writing of the minutes the chair was in an unequal relationship with others in this respect. The character of the field notes I made of meetings changed over time and were inevitably open to the contingencies of the research settings. Knowing that the meetings were being recorded allowed me to make deeper notes of what was going on. This meant that whilst having one eye on recording events in a manner suitable for official minutes I was also recording other details of events, details of tensions, conflicts, support and
ambivalence. I was continuously aware that often the units were taking a negotiating stance and presenting us with a version of their views designed for public consumption. After all they were actors whose futures were under threat. It was therefore necessary to search beneath public pronouncements and the codified language. Examples of these informal comments can be found in appendix 5.3.

My position as participant in the group meant that my research agenda was concealed from the actors involved. I believe that this concealment was more profound in the case of renal unit representatives (who saw me only as a worker on the group) and less so in the case of group members (most of whom were aware that I was doing research). Nevertheless, I never revealed my research aims and methods fully to any of the actors concerned. This presented me with a second group of ethical problems in connection with ‘off the record’ statements. Often speakers would ask for certain matters not to be minuted though no one asked for the tape to be switched off. I decided that this was an essential part of the debates the group had and I therefore transcribed this material. Although I did not quote individuals, I used it to inform my analysis. I also wrote up any memories and impressions I had of ‘conversations in corridors’. In this sense I was eavesdropping on the debates.

In light of these problems, I decided to adopt a strategy of obtaining retrospective consent for my research. I believe this was acceptable because consent had been freely given for meetings to be minuted and tape recorded. Consent was also obtained for tapes to be transcribed. The minutes of meetings were official records and I had permission from the group’s chair to use them in my research. I did not however, have consent to quote individuals in my work. I spent some time negotiating permission from the chair of the group to approach individuals. The chair wanted to see all the quotations I intended to use before I wrote to
individuals asking for consent. This placed considerable pressures on me. Should I select as many quotes as possible before analysis? What if I based my work on quotations that I subsequently would not be able to use? My ethical constraints were therefore to be found in the moral problem of obtaining consent retrospective to an act of concealment and the practical problem of having to undertake analysis without being confident that consent would be given. In order to address both these issues I developed a strategy based on the distinction I made earlier between the renal units, from whom I concealed my research agenda and the review group members who were more aware of my research. I decided to quote from official minutes in the case of analysing renal unit meetings and to quote, anonymously but with permission, from the transcribed tapes in the case of group meetings. The implications of this distinction for my work are highlighted in chapter 5. All the individuals I approached gave their consent to be quoted.

3.7.2 Field relationships

Access is very important. My appearance, behaviour and use of language as well as my usefulness influenced my ability to be accepted by the group. I was aware that the definitions made by others of ‘self’, my age, race, gender, qualifications and a host of other personal characteristics, determined the extent of my access. One of the consequences of dealing with people more powerful than myself was the sense of exclusion from some of the debates. This was keenly felt at the outset of the review group’s work when I was clearly a stranger to the individuals involved, many of whom had strong and long standing professional relationships. This feeling subsided as I began to develop a relationship with group members, although it was clear that I might still be excluded from key discussions. This had potentially disastrous implications for my research in that by attempting to gain access to key decision making
discussions I might only succeed in describing and analysing those discussions that group members considered appropriate to place in a public domain. In attempting to resolve this problem I was careful to monitor continually my relationship with group members and develop a sense of when debates were so sensitive as to make my exclusion (and the exclusion of other group members) more likely. Identifying significant individuals and attaching oneself to them was an important part of this process. These individuals became ‘gatekeepers’ to the research setting. I developed a close association with the Chair of the review group as the ‘gatekeeper’ and with the public health doctor on the group. These associations inevitably placed constraints on my relationship with the hospital representatives. I therefore needed to be aware all the time of not over identifying with the gatekeepers and monitoring how my loyalty to the review group was influencing my reading of the presentations made to us. This highlights the practical and ethical difficulties with my approach as participant observer.

3.7.3 Reflecting on my role as participant

When reflecting on my role as a participant the words of Kornblum (1974) strike a chord:

“if one wishes to watch decisions being made in a competitive political system, it is often necessary to become part of the decision making process itself.” (p240)

Although I was not interviewing individuals for private views (I was observing and recording an official process) my role was not purely one of listening to debates either. As a working member of the review group I was expected to contribute to discussions. However, the structure of the meetings sometimes
prevented me from probing in more depth issues that were of interest to me but were not part of the group's immediate agenda. All the time I was recording the meetings, making notes for minutes and making personal notes on the participants, the surroundings, the situation and the environment. Reflexivity and the ability to re-examine my role in retrospect therefore formed an important part of my methodology:

“....the success of participant observation does not primarily depend upon the casual adoption of one set of rules as against another but upon a profound level of introspection on the part of the researcher with respect to his or her relationship to what is to be (and is being) researched.” (Evans 1988 p197).

An awareness of the extent to which I participated is very important but difficult to disentangle from the ambiguity of my position. Hammersley and Atkinson (1983), talk of a continuum between total observer and total participant. The roles of complete participant, participant as observer, observer as participant and complete observer are useful as points of reference. Junker (1960) notes the fluidity of these positions and the ability of the researcher to shift from one to another. Participant observers have to share the lives of those being observed and to take on the appropriate roles for the setting. The role of the stranger was formulated by Simmel (1971) who saw the researcher as a marginal individual so that they take on the role of a 'stranger' to the sociological phenomenon studied. This formulation raises questions as to how research can be validated or verified. This is relevant to my research in that I found myself operating at a number of levels depending on how individuals saw my role. I was seen as:
(i) A scribe
(ii) A vital documentor of events
(iii) A report writer and co-ordinator
(iv) An advisor
(v) A researcher for the group
(vi) A researcher of the policy process

Some individuals I encountered only saw me as having one of those qualities whilst others, particularly group members, recognised them all. It was known among group members that I was doing research on renal services and in this sense they saw me as a researcher both for and of the group. Outside the group in renal units I was less likely to be seen in this role and more likely to be seen as a documentor. I began on the periphery of the group itself, an outlier, but increasingly as the group realised I was useful to them as a researcher and co-ordinator, I was drawn into the decision making process. However, I was also excluded at many times from vital moments and the combination of decisions made in corridors, telephone calls to ‘smooth the waters’ before difficult meetings and a host of scattered events, fragmented the policy forming process. This meant that in attempting to thread these events together I was using incomplete material. I addressed this problem in two ways. Firstly, in the process of collecting data I was conscious of the need to confirm my understandings by relating different events to each other, monitoring my access to group discussions and reflecting on the completeness of the data I was collecting. Secondly through the process of analysis I was careful to validate the data and my understandings of the data.
3.8 Analysis

A three phase structure for a methodology of depth hermeneutics has been developed by Thompson (1981). These three stages are social analysis, discourse analysis and interpretation. They should be considered, not as discrete stages on a linear path of analysis but as thematic dimensions of an interpretative process (Pile 1990). Social analysis involves an identification and analysis of the circumstances in which people act. This incorporates historical, institutional and geographical aspects. Social analysis is undertaken at the levels of action, the institution, and structure. An analysis of action examines the context of human experience and the understandings individuals have of this context. With respect to the renal review this involved examining the review group discussions and decisions, considering the context in which these decisions were made and critically evaluating the recommendations made in the review group report. An institutional analysis recognises that institutions provide the conditions for action and the location for power relations. The source of material for this study and the field for social relations is the provision of renal services in London. The epidemiological evidence gathered by the review group to back up its recommendations was an important part of this material but in order to place this material in its historical, economic and geo-political context there was a need to supplement it with a review of national and international aspects of renal services and an understanding of how the health service market for renal services was starting to operate. This was achieved by an analysis of renal service provision in the UK and abroad. A structural analysis is introduced by looking at the parameters that defined the review group’s working limits and the constraints placed on the individuals involved. This meant the study of technical data used by the review group, their perceptions of it and an analysis of the groups communicative understanding of the needs assessment process. This was supported by an analysis of the contracts for renal services in place at the time of
the review group’s work. The intention was to situate the group’s planning function within the wider context of the development of markets for health services.

The task of discourse analysis is to examine meanings with the aim of getting deeper understandings of the way discourse sustains power relations. Discourse analysis is undertaken at levels of narrative, argumentative structure and syntactic structure. An analysis of narratives looks at the use of myths, stories and anecdotes in justifying existing power relations. Argumentative structures are forms of discourse made up of explanations and ‘chains of reasoning’. By reconstructing these ‘chains of reasoning’ it may be possible to expose contradictions and inconsistencies in arguments. Finally by the analysis of syntactic structure (the use of pronouns, structure of tenses etc.) we can see the way processes are represented as things outside of immediate time and space and can therefore be discussed at ‘arms length’. In this way it may be possible to gain insights into how ideology exists within linguistic forms.

Finally interpretation is a fusion of social analysis and discourse analysis into a comprehensive account of the ‘lifeworld’. Interpretation goes beyond analysis by projecting possible meanings on the discourse. I am not trying to confirm a single identifiable reality but exploring the different foundations for the actions of stakeholders. In this sense I follow Silverman (1985) and recognise that I could not cover every possible view but I could consider the ‘situated work’ of the stakeholders. By weaving together social and discourse analysis into an interpretation of actions I hope to make a claim to truth whilst acknowledging that it is still only an interpretation. By participating in the production and reproduction of the lifeworld (in this case the lifeworld of policy makers) I am striving to develop an interpretation that combines hermeneutic understanding and causal explanation. I do this by relating my experiences in the renal group
to my understanding of the theory of human need. It is in this way that I develop a critical evaluation of the needs assessment and decision making process.

I present my analysis in three stages. The first stage looks at the technical data produced by the review representing the epidemiological analysis, the second is an analysis of tapes, minutes and field notes and the third stage is an analysis of contracts for renal services. During each stage of my analysis I engaged in all three phases of depth hermeneutics but the epidemiological stage is an important source for my social analysis whilst the stages incorporating an analysis of tapes and of contracts were rich veins for my discourse analysis.

3.8.1 Epidemiological analysis

I examined the technical data on needs used in the needs assessment process, relating it to Doyal and Gough's theory of need. I considered the way in which an epidemiological definition of need was chosen and documented by the group together with the group's proposed plan for future services. The process of collecting and analysing data is presented along with the main results. This is then situated within a historical, geographical and economic analysis of renal services provision in the UK and abroad. This forms the basis for my social analysis and allows me to use a framework where a comparison is made between the review groups use and understanding of traditional needs assessment: epidemiology, survival data, outcome data, cost data and travel times with the framework for operationalising needs demanded by Doyal and Gough's theory of needs (see chapter 1, table 1.1).
3.8.2 Tapes, minutes and field notes

I contrasted the official record of the review with the discourses contained in the tapes and the impressions recorded in my field notes to develop a deeper understanding of the way needs were interpreted and used in the policy process. To facilitate this I structured my analysis by dividing the actors involved into groups; managers, academics and medics, using Alford’s (1975) interest groups and Mitroff’s (1983) stakeholders as models. I was not only aware of the theoretical constructs that I wanted to examine in the context of my research but I was involved in an attempt by group members to gain an understanding that was itself a hermeneutic process. I interrogated the minutes and tapes looking for ways in which needs are defined, how needs are used to legitimise various arguments, and the extent to which the operation of power and protection of vested interests leads to the ideological distortion of needs.

My analysis went through a number of stages. I began by carefully re-reading all the material I had gathered using the minutes of group meetings, my tape transcripts (including notes of ideas that arose during the transcription process) and my field notes and diary. At this stage I was looking for anything that was interesting or puzzling in the data. I was trying to relate what was arising from the data to what I was expecting to find there, to official accounts, to possible theoretical explanations and to common sense knowledge. I maintained a critical stance by searching for any inconsistencies or contradictions that arose. I did this by continually linking my reading of the transcribed tapes to my notes and diary of the meetings and to the official minutes of the meetings. I then progressed to constructing analytical categories. I began by constructing lists of key issues that arose at different stages in the group’s discussions. The most obvious of these was the use of the term need. I identified and marked out sections of the text where need was discussed for more detailed analysis. I also
used computerised search facilities to help identify instances where need was being discussed to ensure I was not missing any key debates. I then embarked on a more detailed analysis of the discussion of need, looking at how need was discussed in relation to other key issues for example identifying the links that individuals made between needs and markets. All the time I was contrasting what I found in the transcripts with the minutes and my own field notes. This process was repeated for a number of key issues some of which arose spontaneously from the text, others arose from this process itself. In this way I was doing more than documenting the use and meaning of the term ‘need’. I was constructing evidence of knowledge, beliefs and actions concerning need. At the beginning my analytical categories were not well defined but they could be seen as ‘sensitising concepts’ (Blumer 1954) representing a starting point from which theories could emerge and further data analysis could be undertaken. I began to sift the data systematically making comparisons between data, concepts and theory. Through this process I was able to identify new categories, strengthen my understanding of existing categories and gain confidence in the validity of my constructs. This process led to my focusing on a defined set of analytical categories (see table 3.1):

<table>
<thead>
<tr>
<th>Table 3.1 Analytical categories for tapes and field notes</th>
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<tbody>
<tr>
<td>The definition of need</td>
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<tr>
<td>Decision making criteria</td>
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<tr>
<td>The model for renal services</td>
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<tr>
<td>Economic arguments (costs)</td>
</tr>
<tr>
<td>Markets</td>
</tr>
<tr>
<td>The role of the review group</td>
</tr>
<tr>
<td>Power and vested interests</td>
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<tr>
<td>Outside pressures and interests</td>
</tr>
</tbody>
</table>
I interrogated each of these categories by searching for typologies within them. For example, under the 'markets' category I was able to identify different ways in which the market was perceived; as a managing mechanism, as a threat to established interest and as a solution to structural problems. I was examining my categories at the levels of narrative, argumentative structure and syntactic structure. I critically analysed each of these levels using Habermas' implicit 'validity claims' and the three stage validity analysis involving claims to truth, claims to rightness and claims to truthfulness, as a guide (see section 2.4.1). For example, where I identified a discussion about needs involving a claim about 'needs' in some way, I examined the narratives, argumentative structures and syntactic structure of that claim with a view to understanding and evaluating its position in relation to Habermas' ideal speech situation as expressed in Doyal and Gough’s rules for the rational discussion of needs. In this way I hoped to identify the way in which stakeholders engaged in communicative action, open strategic action and concealed strategic action.

3.8.3 Contracts for renal services

I examined renal contracts in operation in England at the time of the review to relate the review process to the development of markets in the NHS. I examined the texts of these contracts by going through a similar process to my analysis of the tapes and minutes. However, in doing this I brought in ideas that had germinated and flowered in my analysis of the transcripts. These inevitably influenced my search for key issues within the text of the contracts. I also used ideas and issues I identified here to go back to my analysis of the tapes and minutes to strengthen the development of typologies there. In addition the contracts themselves tended to follow a standardised format which influenced the way key issues were identified. I was able to develop a defined set of categories to structure my analysis (see table 3.2):
Table 3.2 Analytical categories for contracts

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>The format of contracts</td>
</tr>
<tr>
<td>The use of need as a basis for contracts</td>
</tr>
<tr>
<td>Contracts as a tool for change</td>
</tr>
<tr>
<td>Contracts as monitoring instruments</td>
</tr>
<tr>
<td>Types of contract and costs</td>
</tr>
<tr>
<td>Specialised language</td>
</tr>
</tbody>
</table>

My textual analysis of the contracts enabled me to focus on the use of the term need within these categories to consider the scope of contracts, their function and how their structure and content relate to the operation of markets in the NHS. In this way a picture of their relationship to the planning of renal services could be developed in parallel with a critique of this planning process.

3.9 Triangulation

My interpretation is constructed by linking analysis of language with social analysis of the environment in which discourses are produced. Part of this process involves assessing people's validity claims against my own criteria of judgement. To do this I used *data source triangulation* to compare data from different parts of my fieldwork (be it from different participants, from different meetings or different time periods) but relates to the same phenomenon. For example I was able to compare data on markets from statements made by different individuals or by the same individuals at different meetings. I also used *technique triangulation* so that data produced by different means was compared. I was also able to turn to other data sources to reinforce this approach. At meetings where the group's results were presented I took extensive notes of audience responses and the informal views of group members and was able to compare these statements with my own interpretation of events.
This was a useful form of feedback. The validity of my inferences was reinforced by processes that included the seeking permission from individuals to use quotes in my thesis. Their responses to my requests often contained comments on the text that supported the inferences I had already made and also provided additional insights. However, I was not simply looking for confirmation of my own interpretations. Differences in data were extremely illuminating and helped me to discard early ideas and reflect on how I had arrived at certain views. It was important that I explained differences in my data. In this way I engaged in *reflective triangulation* to buttress the validity of my inferences (Hammersley and Atkinson 1983). By building up my interpretation in this way I began to feel confident that my work was developing a coherence. Of course I can never prove that my interpretation is reliable. However, I did have privileged access to the internal discussion of the review group and through processes of cross-checking and validation I consolidated the internal consistency of the data and my interpretation of it.

3.10 Summary

The methodology used in this thesis combines qualitative and quantitative methods in an attempt to evaluate critically a policy process. The main thrust of the research is to contrast the demands of the theory of need with the political realities of decision making. In order to do this the technical data used by the renal review group is criticised in relation to a framework for assessing needs in chapter 4. In chapter 5 the discourses of the review process are interrogated to identify those areas where power relations operated to the detriment of responding to needs. Finally the texts of contracts for renal services are analysed in chapter 6 thus placing my critique of the renal review within the wider context of the developing market in health care.
Chapter 4

Assessing the need for renal replacement therapy
in the Thames Health Regions

4.1 Introduction

Following the publication of The Tomlinson Report (Tomlinson 1992) the London Implementation Group\(^1\) established six specialty review groups to examine the provision of key tertiary services in Greater London. As one of these six specialty reviews, renal services was clearly identified as an area where rationalisation of services needed careful planning. The renal specialty review was set up in March 1993 and reported in June 1993. The aim of the review group was to assess current and projected needs for the specialty, to develop criteria for the development of major tertiary centres and to advise on the future pattern of service provision including the location of major centres in order to achieve the most effective services for the local resident population (Renal Review Group, Report of the Review of the London Renal Services 1993)\(^2\). The review group perceived its main purpose to determine whether services to patients with kidney disease in London

\(^1\) The Tomlinson inquiry was set up in October 1991 to 'advise on the organisation of and inter-relationships between, the National Health Service and medical education and research in London'. The report recommended that 'a dedicated implementation group be set up to co-ordinate change and that it placed priority on setting up working groups to review the rationalisation of specialty provision in London' (p1 Tomlinson report).

\(^2\) The review group focused on renal services in the Greater London area but also considered the four Thames Regions as a whole since there was 'substantial overlap in the provision for patients throughout this area (page 1 renal review group report).
were appropriate\textsuperscript{3}. This chapter presents an evaluation of the work of the review group with respect to the technical assessment of needs and the planning of appropriate services. I will assess critically the way in which the group defined the health care needs of the existing and potential renal patient population and the criteria it used to inform its decision making. I will also situate the model for future service provision recommended by the group within a historical, economic and geopolitical context in order to discuss its main motivating factors. Finally I will examine the group’s technical knowledge of needs and critically evaluate it in relation to the framework for operationalising needs used by Doyal and Gough, as a guide to understanding the extent to which the renal review group was able to utilise the technical knowledge on needs available to it.

4.2 Membership of the group

The membership of the group is given in Appendix 4.1. The chairman of the group was a Professor of Renal medicine at the Manchester Royal Infirmary with an international reputation, highly respected by his peers, who had been involved in epidemiological studies of need for renal services and modelling renal services. The other clinicians on the group all had specialist knowledge of renal services as well as membership and influence within professional bodies that brought skills to the group and legitimacy in terms of ‘peer respect’. The managers on the group comprised a chief executive of a recently merged purchasing authority and a Department of Health civil servant recently seconded to that authority who had

\textsuperscript{3}Renal replacement therapy (RRT) is given to people who are suffering from End Stage Renal Failure (ESRF). Without therapy these patients will die. The main types of treatment offered under RRT are, dialysis, haemodialysis, continuous ambulatory peritoneal dialysis and transplantation. Further details of these treatment types are given in appendix 4.2. A glossary of the terms and abbreviations used in this chapter is given in Appendix 4.3.
played a considerable part in drafting the Tomlinson report. This invested a managerial legitimacy in the group as well as providing it with access to a ‘network’ of managerial and physician links across London, and beyond, that were clearly used by the group at different times to ‘smooth the waters’, promote co-operation and minimise conflict. The nurse manager on the group came from Manchester as part of the chairman’s team and was experienced in reviewing nursing services and again brought legitimacy to the review of nursing services. The group also had a ‘patient representative’ as a member: a Director of the National Kidney Research Fund. During its deliberations the group sought support from other clinicians, management consultants, epidemiologists and health service researchers. In drawing these people together the chairman was concerned to ensure ‘technical’ legitimacy for the group by the membership having the respect of peers and by the final decision being informed by the best knowledge base available, given the time constraints they were working under. There also appeared to be a concern to ensure that the group had individual members who were capable of challenging orthodoxy and more importantly to be seen by others as representing challenging interests. The dynamics of the group will be discussed further in the next chapter where the power discourses and ideologies arising during the group’s deliberations will be interrogated.

4.3 Definition of ‘need’

The main body of work used to inform the renal group’s decision making focused on the population need for renal replacement therapy (RRT). The epidemiological approach to needs assessment was therefore given a high priority in the groups deliberations. The review used a ‘gold standard’ of population need for RRT, based
on the Renal Association’s recommendations (Renal Association 1991), of 80 new cases per million population per year under age 80. The Renal Association’s recommended rate was itself derived from studies that had identified unmet need for services in Devon, Lancashire and Northern Ireland (Feest et al 1990, McGeown 1990). The group concluded that the overall population need in the Thames Regions was likely to be greater than the national estimate of 80 per million because of the ethnic composition of the population, and considered 90-100 million to be a more realistic figure (see section 4.5.2).

The Feest data (based on populations in Blackburn, Exeter and North Devon) and the McGeown data (based on the population of Northern Ireland) came from areas where the proportion of minority ethnic groups in the population was low or where the average age of people from minority ethnic groups was low. The group stressed that it was essential to consider the variation between districts in population need and their access to current treatment when deciding on the future location of renal services. Age and ethnicity were considered the important socio-demographic factors determining population need for RRT and these were reviewed in detail in the report. The effect of socio-economic factors was not considered by the group because no information was available on the socio-economic characteristics of renal patients in the Thames Regions and there was very little literature on this aspect of renal disease. Knowledge of the relationship between social class and renal failure is limited although a weak association was found between lower social class and chronic renal failure in one Scottish study (McCormick & Navarro 1973). In terms of evaluating equity of provision therefore this represented a gap in the review group’s knowledge base. Given the time scale for the review group’s work and the existing knowledge base this was probably an unavoidable gap. However, the group did not examine gender differences in use of RRT. The studies on which the
The incidence of End Stage Renal Failure (ESRF) is difficult to determine but varies according to a number of risk factors. The burden of ill-health and morbidity from untreated renal failure is even more difficult to assess. Co-morbidity and further morbidity occur and make estimations difficult. Both in primary care and in clinical practice, rationing is underpinned by value judgements on the extent to which individuals would benefit from treatment. A number of studies have derived estimates of the community prevalence and incidence of chronic renal failure, Branch et al (1971), McGeown (1972). In the survey by Feest et al (1990) the incidence of advanced chronic renal failure was estimated using a blood serum creatinine level of greater than 500mmol/l as an indicator. In people aged less than 80 it was estimated that 78 new patients per million would need dialysis annually. The study also demonstrated a marked increase in incidence of chronic renal failure with age. The survey by McGeown used a questionnaire to General Practitioners to identify the need for treatment. Table 4.1 gives the age related incidence of chronic renal failure in the population surveyed in the two studies.
Table 4.1  Age related incidence of advanced chronic renal failure

<table>
<thead>
<tr>
<th>Age range</th>
<th>Feest (Blackburn, Exeter, Devon) Rate/million (95% confidence interval)</th>
<th>McGeown (Northern Ireland) Rate/Million (95% CI)</th>
<th>Pooled data Rate/million For Feest and McGeown populations combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>6 (-2 to 14)</td>
<td>24 (11 to 38)</td>
<td>20</td>
</tr>
<tr>
<td>20-39</td>
<td>20-49</td>
<td>37 (19 to 55)</td>
<td>37</td>
</tr>
<tr>
<td>40-49</td>
<td>58 (38 to 78)</td>
<td>90 (45 to 135)</td>
<td>90</td>
</tr>
<tr>
<td>50-59</td>
<td>160 (96 to 224)</td>
<td>197 (124 to 271)</td>
<td>185</td>
</tr>
<tr>
<td>60-69</td>
<td>282 (197 to 367)</td>
<td>220 (138 to 302)</td>
<td>243</td>
</tr>
<tr>
<td>70-79</td>
<td>503 (307 to 636)</td>
<td>167 (81 to 253)</td>
<td>296</td>
</tr>
<tr>
<td>&gt;80</td>
<td>588 (422 to 754)</td>
<td>78 (0 to 167)</td>
<td>345</td>
</tr>
</tbody>
</table>

OPCS; total populations, 1988:
Blackburn, Exeter, North Devon (Feest) 708,997
Population of Northern Ireland (McGeown) 1.5 million

Both studies derived estimates of the population in need for renal replacement therapy based on those patients considered suitable for treatment whether they received it or not and this is shown in table 4.2.

Table 4.2 Population need for renal replacement therapy

<table>
<thead>
<tr>
<th>Age</th>
<th>Feest</th>
<th>McGeown</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-59</td>
<td>50 (44 to 90)</td>
<td>50 (44 to 90)</td>
</tr>
<tr>
<td>0-79</td>
<td>78 (63 to 93)</td>
<td>77 (63 to 91)</td>
</tr>
<tr>
<td>All Ages</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Feest figure of 78 new patients per million was arrived at once those considered not suitable for treatment were removed. The proportion of those not considered suitable increased with age (in patients aged 60-80 years 51% were not referred). These figures are similar to the estimates made by McGeown. In the Feest study the authors estimated that 29 (54%) out of 54 patients not referred under the age of 80 should have been referred for treatment. It is important to note that the elderly
are a group where thresholds for treatment change. The incidence of disease in the elderly (in excess of 200 per million population per year) is far in excess of the numbers of elderly accepted for Renal Replacement Therapy (RRT). In the UK in 1991, only 60.7 new patients per million were being treated (Renal Association 1991). This would imply that there is unmet need amounting to at least 20 new patients per million population per year. In addition, the work done by both Feest and McGeown would suggest that these are mostly high risk or elderly patients. It was in light of these figures that the Renal Association recommended a target rate of 80 patients per million under age 80 and this figure was used as a baseline for the renal review group's comparative work.

4.3.1 Critical analysis of the definition of need

The definition of population need used by the review group raises two major questions. Firstly the level of need used was defined by reference to the most recent and most relevant epidemiological studies which had received recognition and acceptance by the medical profession. The legitimacy of the figures produced by these studies was confirmed by the figure of 80 new patients per million being adopted by the Renal Association as a target. There was therefore an apparent medical consensus on what the level of population need should be and the legitimacy of this consensus was validated by reference to the epidemiological studies that supported it. Secondly, the studies considered whether patients were suitable or not for treatment. Decisions about suitability were made by the physicians involved in the research on the basis of their reviewing patient notes. The need for care was therefore determined by a medically defined cut-off based on whether treatment was considered beneficial or not. Clinical benefit as perceived by physicians was therefore an important determining factor in defining levels of need. There may
however be variation in the ‘thresholds’ for referring patients to renal services as
defined by general practitioners, general physicians and renal physicians. The
studies did not give clear details of how thresholds for treatment were agreed upon.
Given the capacity for disagreement among physicians about whom to treat and not
to treat (Parsons and Lock 1980), the medically defined ‘cut-off’ should not be
construed as definitive. Comparisons with other countries also show that higher
rates are achievable (Baker 1993). This was acknowledged by group members.
Nevertheless, in terms of medical consensus (containing some provisos) on ‘need’ at
a point in time, the figure of 80 per million had considerable weight. It is significant
that at no point during the group’s deliberations was this figure questioned by the
managers in the group. If we consider that the estimates of the number of people
who could benefit from RRT during the 1970s and early 1980s were 40 new patient
per million population per annum (Branch et al 1971, Halper 1989) then the
definition of need used by the review group may be more transient and susceptible to
revision than was originally thought. The group’s own epidemiological analysis
adds weight to this view.

4.4 Main recommendations of the renal review group’s report

One of the main concerns that informed the review group’s recommendations was
the current provision and future need for renal services. The group’s analysis of
epidemiology, geography and access to services led to the view that the present
siting of renal services in the capital created inequity of access. Services had to be
moved out of the teaching hospitals to areas that were closer to patient populations.
This had to be balanced however, with the group’s concern to preserve and develop
teaching and transplantation services both of which, it was felt, needed a critical
mass of service provision. The solution to preserving this balance was called the
'hub and spoke' model of service provision. This envisaged specialist University transplant centres at the core in inner London (hub) and satellite units doing basic dialysis located outwards closer to populations (the spokes) but with support from the specialist mother units. The London area was split into five crude geographic sectors, South-East, North-East, North-Central, West and South-West with a central core of five tertiary referral centres (one in each sector). The sectors followed the boundaries of the existing Thames Regions with the North Central sector dissecting the boundary between the two North Thames Regions. This fitted with the teaching hospital groupings recommended in the Tomlinson report. Each centre would provide a transplant service for approximately 3 million people, expert nephrology for some 1.5 million people and provide Renal Replacement Therapy (RRT) support for at least 80 new patients per annum. Five autonomous centres were also thought to be required, sited strategically and predominantly in the shire counties. These would provide the same services as the central core but without transplant or academic provision. It was thought that one such unit per 3 million population was required. The proposed network of 'satellite' units would link each to either a teaching centre or an autonomous centre. The group considered the staffing and facilities available at each unit in detail and recommended that in the five core units the staffing structure and bed complement be in place within a specific time scale ranging from one to three years according to each unit. The siting of the core units was specified in the report. Suggestions for the siting of autonomous centres were mentioned but it was accepted that the decision on these would ultimately rest with purchasers and providers.
4.4.1 Siting of Teaching/Transplant core units.

The decision on the siting of core units was based on a number of criteria. The consideration of a site's potential for future multi-disciplinary work and future academic excellence was given a high priority. The group was not able to make a decision on the basis of comparative costs of service provision in different units due to the generally poor quality of costing data provided by units. Sites were selected with the aim of sustaining and creating opportunities for clinical service and research. At a basic level therefore, equity of access considerations, tempered by the need to maintain critical mass, determined the development of a model for renal service provision in the capital. However, once the model was decided upon, the siting of units was largely justified by reference to standards of clinical service and research.

Figures 4.1 and 4.2 show the configuration of services in London before and after the recommendations of the review group. In the South-East sector Guy's/St Thomas' trust was recommended, in the North-East the Royal London Hospital (RLH) was preferred as a site for a merged St Bartholomew's and RLH unit. In the North-Central sector the preferred site was University College Hospital/Middlesex, whilst in the South-West the chosen site was St George's. Finally in the Western sector the Hammersmith Hospital, with a link to a nephrology service at Charing Cross, was favoured. Services at King's, Royal Free, St Bartholomew's, St Mary's and St Helier's either faced closure, a reduction in size or merger with other units. The rationalisation of services was presented not as a cut in services but as a re-provision eventually leading to an expansion in patient numbers.
Figure 4.1
Main Specialty Centres
Renal
Current service configuration

Source: Renal Review 1993
Figure 4.2
Main Specialty Centres
Renal
Future service configuration

Source: Renal Review 1993
4.4.2 General recommendations

The group also made general recommendations covering staffing, teaching, prevention and the quality of care. The review was critical of the quality of nursing in the capital’s renal units and made a number of specific recommendations for future staffing structures. The final group report suggested that in terms of monitoring quality, purchasing authorities should require prospective audit of quality of treatment using survival curve analysis as well as more detailed analysis of the efficiency of dialysis techniques. The group also recommended the setting up of a national registry of renal patients.

In terms of purchasing renal services the group recommended that because of the low volume and high cost nature of renal treatment, health authorities should consider forming consortia to purchase services. This, it was felt, would allow a more stable market to operate. The purchasing authorities would contract with tertiary or district nephrology centres who would then have the responsibility for making arrangements with satellite units. This reflected the ongoing debate that group members had about how the recommendations made in the report could come to fruition in a quasi-market system.

4.5 Demographic and epidemiological analysis

The main demographic factors associated with ESRF are age and ethnicity. Incidence is estimated to be high in areas with high proportions of the elderly and ethnic minorities. Afro-Caribbeans, Bangladeshis and Far East Asian groups all have risk factors such as hypertension, Systemic Lupus Erythematosis (SLE) and Non Insulin Dependent Diabetes (NIDDM) which make them particularly vulnerable to
renal disease (Melia et al. 1991). To examine the demographic profile of patients currently receiving RRT in the Thames Regions the group asked each renal unit in the Regions and those bordering the Regions to supply a profile of new patients accepted on to their programmes for the calendar years 1991 and 1992 and of all patients receiving renal replacement therapy on the unit’s programme at the end of 1992/early 1993. Acceptances are the number of patients taken on to RRT in any one year and can be presented as a rate for a population. The number of patients alive and on RRT at a point in time can also be presented as a rate. The demographic profile produced by the group was based on the patient’s District Health Authority of residence, age, ethnicity and diabetic status. This allowed a geographical and epidemiological analysis of renal disease to be drawn together looking at risk factors, associated disease, demography and access to services. The age groups used in the group’s analysis were 16-54, 55-64 and 65+. This followed a profile of low, medium and high risk patients adopted by the group (see section 4.5.4 on modelling). The age bands allowed the calculation of age-specific rates for ethnic groups but there was no attempt to produce age-standardised rates for the Thames Regions. This was a significant weakness in the review group’s analysis.

4.5.1 Risk factors

Risk factors associated with the incidence of renal failure can be split into social, demographic and medical. If information on the proportion of patients with specific medical conditions progressing to ESRF could be relied upon for accuracy a picture of the relative importance of different conditions in determining need for ESRF could be drawn. An analysis of the distribution of primary medical conditions of patients admitted on to renal programmes in the UK showed that the most frequent primary condition was aetiology uncertain (19%) followed by
glomerulonephritis (with histology) and renal vascular disease (EDTA 1988). Diabetics are at increased risk of developing renal disease but they are under represented as far as acceptance onto RRT is concerned (Joint Working Party on Diabetic Renal Failure, 1990). The Joint Working Party estimated that diabetic nephropathy affects 50% of long term insulin dependent diabetic (IDDM) patients diagnosed aged under 31, and two-thirds of these will progress to ESRF. It is difficult to estimate the proportion of IDDM patients developing ESRF, partly because some patients die before developing diabetic nephropathy (Gill 1989) or ESRF, (Selby et al 1990). The group was keen to gather information on the medical risk factors associated with renal failure. An attempt was made to do this with respect to the proportion of new patients who were diabetic but units had insufficient data on this at the time of the report to allow a robust analysis.

4.5.2 Ethnicity

The review group was concerned to examine the effect of the large ethnic minority populations in the Thames Regions on the need for RRT. The group used 1991 census figures for ethnic populations broken down by District Health Authority of residence. Unfortunately the ethnicity of patients was defined by the units who used, in the main, the categories of White, Black, Asian and Other. This meant that the patient data (numerator) and census data (denominator) were based on different definitions of ethnicity. Ethnicity in the census was self defined from a large selection of ethnic classifications. Ethnicity in the renal units was defined by clinicians and administrators from a limited choice of classifications. This forced the review to undertake a restricted analysis of ethnicity (see figure 4.3) which can be criticised for confusing race and ethnicity and for categorising ethnic groups inappropriately to the extent that 'labelling' occurs (Sheldon and Parker 1993).
Figure 4.3 Classification of ethnic origin used in the review

<table>
<thead>
<tr>
<th>Renal Units</th>
<th>1991 Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>White</td>
</tr>
<tr>
<td>Black</td>
<td>Black (Caribbean), black (African), black (other)</td>
</tr>
<tr>
<td>Asian</td>
<td>Indian, Pakistani, Bangladeshi and 50% of Asian other</td>
</tr>
<tr>
<td>Other</td>
<td>All other</td>
</tr>
</tbody>
</table>

According to the 1991 census the proportion of the population in each ethnic group for the four Thames RHAs was 88.6% White, 5.5% Asian, 4.2% Black and 1.7% Other. The Asian and Black populations were concentrated in parts of Greater and Inner London and had a significantly younger age distribution than whites. In terms of planning future provision the likely increase in the numbers of Asians and Blacks aged over 60 in future had a considerable influence over the group’s thinking. In the timescale available, the group was not however able to make projections of numbers of patients based on projected changes in ethnic populations.

The group engaged in a thorough literature review of renal disease and associated diseases (diabetes and hypertension) in Asians and Blacks. This was informed by knowledge among group members of evidence for higher rates of disease in Blacks and Asians and the numbers of Blacks and Asians on RRT had already been raised by clinicians in units visited by group members. The evidence for higher rates of renal disease in Blacks was mainly based on studies from the United States. The group drew on a substantial body of evidence that acceptance rates on to RRT are two to four times higher in Blacks (Eggers et al 1984, Beech et al 1994, Shulman and Dallas Hall 1991, Hiatt and Friedman 1982). Higher levels of prevalence and
severity of hypertension in Blacks in the United States compared to Whites have been highlighted (McClellan et al 1988). It was recognised that such evidence could not be directly applied to the UK experience but higher rates of mortality from hypertension and stroke in UK Blacks was considered important contributory evidence (Balarajan and Bulusu 1990). There was similar evidence for higher rates of disease in Asians showing the relative risk of end stage renal failure secondary to diabetes to be increased tenfold in Asians (Burden et al 1992) and diabetes was found to be the commonest underlying cause of end stage renal failure of Asians accepted on a London renal unit (Pazianas et al 1991). This evidence was drawn together to support the renal review group’s need for information on the relationship between ethnicity and renal disease. The main implications of the literature review was that the ethnic composition of a population can have a significant impact on the need for renal services.

From the data provided by renal units for the review it was found that crude acceptance (incidence) and stock rates were increased threefold in Blacks and Asians (Table 4.3) and the total acceptances and stock rates were 20% and 17% higher than the whites only rate.

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4 Throughout its working life the group used the term ‘stock’ to describe the number of patients alive and receiving any form of RRT at a point in time. This term was later amended to ‘prevalence’ when some of the group’s work was published, in response to comments from journal referees that the term ‘stock’ was inappropriate when referring to humans (Roderick et al 1994).

5 The figures presented here are based on the review group’s epidemiological analysis published in Roderick et al 1994. During the review group’s lifetime the group was presented with sets of figures that were slightly different to these because data were being revised continuously. Nevertheless the large differences in ethnic rates and geographic accessibility were apparent from the outset and any changes in the figures were minimal.
Table 4.3  Ethnic rates of renal replacement therapy acceptances and stock

<table>
<thead>
<tr>
<th></th>
<th>WHITE</th>
<th>BLACK</th>
<th>ASIAN</th>
<th>OTHER</th>
<th>WHOLE POP’N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acceptances 1991-92</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Number</td>
<td>743</td>
<td>101</td>
<td>123</td>
<td>35</td>
<td>1002</td>
</tr>
<tr>
<td>Annual Rate per million</td>
<td>60.9</td>
<td>175.0</td>
<td>178.3</td>
<td>119.3</td>
<td>72.8</td>
</tr>
<tr>
<td>Relative Rate (95% CI)</td>
<td>1.0</td>
<td>2.88</td>
<td>2.93</td>
<td>1.96</td>
<td>1.20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (%)</td>
</tr>
<tr>
<td>Rate per Million</td>
</tr>
<tr>
<td>Relative Rate (95% CI)</td>
</tr>
</tbody>
</table>

Source: renal review data (Roderick et al 1994)

Looking at the age structures of the patient population a higher proportion of both Blacks and Asians were aged under 55 than the white population (Table 4.4)

Table 4.4  Age and ethnic profile of patients accepted onto renal replacement therapy in 1991 and 1992

<table>
<thead>
<tr>
<th>PERCENTAGE (NUMBER)</th>
<th>WHITE</th>
<th>BLACK</th>
<th>ASIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-54</td>
<td>46.9 (402)</td>
<td>51.9 (55)</td>
<td>55.0 (71)</td>
</tr>
<tr>
<td>55-64</td>
<td>19.3 (166)</td>
<td>30.2 (32)</td>
<td>27.1 (35)</td>
</tr>
<tr>
<td>65+</td>
<td>33.7 (289)</td>
<td>17.9 (19)</td>
<td>17.8 (23)</td>
</tr>
<tr>
<td>Total</td>
<td>100 (857)</td>
<td>100 (106)</td>
<td>100 (129)</td>
</tr>
</tbody>
</table>

Source Roderick et al 1994

Differences in acceptance rates for the ethnic minority groups relative to the white population increased with age from three fold at age 15-64 to five/six fold at age 55-64 to seven fold in over 65’s (Table 4.5)
Table 4.5 Age specific ethnic acceptance rates onto renal replacement therapy

<table>
<thead>
<tr>
<th>AGE</th>
<th>WHITE</th>
<th>BLACK</th>
<th>ASIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-54</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate per million</td>
<td>52.5</td>
<td>160.0</td>
<td>158.1</td>
</tr>
<tr>
<td>Relative rate</td>
<td>1.0</td>
<td>3.05</td>
<td>3.01</td>
</tr>
<tr>
<td></td>
<td>(2.30 - 4.04)</td>
<td>(2.31 - 3.94)</td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate per million</td>
<td>114.4</td>
<td>623.3</td>
<td>830.7</td>
</tr>
<tr>
<td>Relative rate</td>
<td>1.0</td>
<td>5.46</td>
<td>5.99</td>
</tr>
<tr>
<td></td>
<td>(3.62 - 8.24)</td>
<td>(4.5 - 7.99)</td>
<td></td>
</tr>
<tr>
<td>65+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate per million</td>
<td>119.1</td>
<td>922.7</td>
<td>952.0</td>
</tr>
<tr>
<td>Relative rate</td>
<td>1.0</td>
<td>7.76</td>
<td>8.01</td>
</tr>
<tr>
<td></td>
<td>(4.81 - 12.5)</td>
<td>(5.18 - 12.4)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Roderick et al. 1994

The acceptance and prevalence rates for districts in the Thames Regions were mapped showing an overall acceptance rate of 74 per million (see figures 4.4 and 4.5). This showed marked geographic variation, from 51 per million in the Shires, 82 per million in Outer London and 110 per million in Inner London. Acceptance rates significantly higher than the target rate of 80 per million were found in the Districts of Harrow, Parkside, West Lambeth, Camberwell, Lewisham and North Southwark whilst rates significantly below 60 per million were found in the Shire Districts of North Bedfordshire, North East Essex, Mid Essex and Maidstone.

Inaccuracies in the data (both unit and census data), closer proximity of Blacks and Asians to units and increased rates of disease in Blacks and Asians were all considered as factors explaining the differences in rates. There was some discussion in the group as to the extent to which the proximity of Blacks and Asians to renal units affected referral rates. There was a significant correlation between acceptance rates of Greater London districts and their respective proportions of all ethnic
minorities (see figure 4.6) but the group's timescale and data limitations meant that it was not possible to estimate the proportion of geographic variation accounted for by age and ethnicity. This evidence, coupled with concern among group members about poor accessibility to health services among ethnic groups led to the view that higher rates of disease was the most likely explanatory factor.

4.5.3 Access

Distance of residence from renal services has a significant effect on rates of service use. Indeed a study of service use in NETRHA found a correlation between the average acceptance rates and travelling distance to the nearest unit (NETRHA 1990). This study was unable to control for the composition of populations. Other studies have confirmed that uptake is lower in districts without a renal centre compared with districts with renal centres (Feest et al 1990) and have found a correlation between acceptance rates for new patients and distance to unit (Dalziel & Garret 1987). The mapping of prevalence and acceptance rates by DHA allowed a limited analysis of equity of access to services to be made. The review group placed considerable emphasis on travel times to units, seeing this as a marker for evaluating access. The review found wide variations in patient travelling times and distances with some patients taking 1 hour to travel 4 miles and others travelling 85 miles in 2.5 hours. Using average distances and times of patients using hospital car services, a hidden cost of £613,043 was estimated. Patients on low income and family support are able to claim travelling expenses but there was no information available on this.
Figure 4.4
Adult acceptances onto renal replacement therapy in the Thames regions
Adults, annual rate per million 1991/92

Source: Renal Review 1993
Figure 4.5
All renal replacement therapy prevalence in the Thames regions
Adults, rate per million, December 1992

Source: Renal Review 1993
Scatterplot of dialysis rate against non-white as a proportion of the population.

Greater London Districts only

\[ \text{No} \text{-white\ as\ a\ proportion\ of\ the\ population} \]

\[ R_s = 0.6131 \]
After much debate amongst group members, travel costs to patients were not seen as NHS costs and were not included in service costings, but travel times were perceived as a cost on the quality of patient life. This was used to back up arguments for services to be sited closer to patients in satellite units. The group recommended however, that the choice of the most appropriate sites for sub-regional District General Hospitals and satellite units be made at a local level. This reflected its concerns to get consensus on a model for renal provision and on the selection of five teaching centres in London, rather than being prescriptive about which other sites in the Thames regions should be chosen for expansion.

4.5.4 Modelling

The prevalence of patients on RRT in the UK was 331 per million population at the end of 1990. A ‘steady state’ situation for RRT would exist when the number entering and leaving the process are equal. At present more are entering RRT than leave it. A recent study (Bolger and Davies, 1992) presented a model of demand and supply for renal services and estimated that under present conditions the prevalence of patients will increase by 40% before the turn of the century. It should be noted however, that thresholds vary between units and this model applied to one specific area. In addition the model and the information used within it has been criticised for being inaccurate, (Feest and Harrison 1992). A model for planning growth in the prevalence of patients was designed for the review group using techniques developed by Wood et al (1980 and 1987). This was used in preference to Bolger’s simulation models which were believed to provide less opportunity for understanding by non-specialist planners. The Wood model used a threefold definition of renal patients:
Low Risk  -  under 55 non-diabetic
Medium Risk  -  55-64 non diabetic or diabetic under 55
High Risk  -  65 and over or diabetic 55 and over

Low and medium risk patients were considered suitable for transplantation but high risk patients were not. Risks were defined in terms of patient survival and probability of transplant failure. The model was refined following discussion by renal group members and used to provide five-year estimates for growth from current prevalence levels. This was used to reinforce the perception of likely increases in demand on services in the future. The eventual steady state position with an acceptance rate of 80 per million was modelled at 11,638 patients with 7,417 on dialysis. With an acceptance rate of 100 per million however, the model predicted a steady state of 13,304 patients with 9,083 on dialysis. This contrasted with the existing Thames patient population of 5,778 with 2,700 on dialysis. The review therefore relied on a medical definition of need and applied a ‘risk’ analysis to this definition using techniques that had been tried and tested in the past. This risk analysis was then used to predict future demand for services, thus ensuring a strong link between medically defined need and predicted demand within a ‘rational’ framework. The argument presented by the group, on the basis of this, amounted to ‘unmet need’ existing at present and that an expansion in resources was required, but that the eventual steady state position would ensure that problems of ‘infinite demands’ would not arise.
4.5.5 Transplantation

Transplantation is considered to be the most cost-effective treatment option for ESRF (West 1991) offering the opportunity for a better quality of life for most renal patients. In terms of patient needs and equity of provision therefore the availability and quality of transplantation services was an important issue for the review group. Thirteen NHS units in the Thames Regions were transplanting kidneys into adults at the time of the renal review. The review group examined their workload, staffing and survival data. Transplant activity in the Thames Regions was considered to be relatively high totalling 485 transplants per annum. There were wide variations between units in the size of activity, the proportion of patients transplanted who were elderly and the proportion of transplant patients from ethnic groups. The issue of ethnic differences in transplantation was not considered in detail by the group although there are clear concerns about the fairness of transplantation policies (Purviance 1993). Outcome data also varied with patient survival ranging from 79% to 96% and graft survival from 73% to 94% after the first year. The group judged that, allowing for case-mix, these figures were not below average and some units had exceptionally good crude rates. The group was however, struck by the high levels of resources required to maintain this activity particularly with respect to nurse staffing.

Any expansion of transplants is dependent on the pool of available donors. The number of patients waiting in the UK for a kidney transplant at December 1992 was 4,364 (Poulter 1993, source UKTSSA). There was already a perceived national need to increase the availability of organs and a number of recommendations had been made at a national level to increase the harvest rate (Gore et al 1989). Since April 1992 the NHS management executive has reimbursed units maintaining
donors to cover the extra costs involved in obtaining donor kidneys but there are a number of factors which act against increasing donor numbers. The group thought it unlikely that cadaver organ availability would exceed 40 per million population in the foreseeable future, and at that rate the population of the Thames Regions would yield an expected 600 transplants per annum. The group took advice from the Royal Colleges of Surgeons and Physicians and the British Transplantation Society, and concluded that each transplant centre should conduct at least 100 donor grafts per year. This represents the sense of a 'critical mass' necessary to ensure high quality transplantation services. Some units raised the concern that the group's proposals would lead to very large units with large numbers of patients. The group's report stressed that this was not what was envisaged, and that the core units should only provide tertiary, specialist and transplant care. Under this scenario, the number of patients treated in central London would decrease as more geographically accessible units became available, and consultants developed outreach clinics closer to the patient populations.

4.6 Academic appraisal

The group considered the academic excellence of the London units in some detail. Details on the funding and research activities of each unit were scrutinised and advice was taken from funding bodies, and from national and international authorities in academic renal medicine. The HEFCE ratings of general medical departments were also noted. The academic appraisal had a considerable influence over the decision of where to site the five central core units. The group came to a consensus on the Royal Postgraduate Medical School and University College Hospital having the strongest academic base. The strength of the academic
reputation of St Thomas’ and Guy’s was given considerable weighting in the group’s decision and there was a strong academic argument for relocating the large unit at St Helier to St George’s. The reasoning behind this academic exercise was to protect and develop the academic and research base of London. The group was at pains to undertake the academic review in as objective way as possible and to ensure that the London units saw it as a fair and objective exercise. As we shall see in the review of the group’s meetings however, the weighting given to the academic exercise for some units came into conflict with the review’s opinion of those units in other areas of evaluation.

4.7 Costs

The review group requested business plans from each unit in the Thames Regions for 1992/93 and 1993/94 and details of service costings. The aim was to compare the cost-effectiveness of the different units and come to some conclusion on comparative costs. Unfortunately the group received a poor response from all but two of the units. Review group members had more accurate information from units outside the Thames Regions and it was decided that a pragmatic alternative would be to construct ‘built cost’ profiles from these other centres and apply those as a costing template for the services proposed in London.

4.8 Consultation with Patient Groups

The review invited views and comments from the National Federation of Kidney Patients Associations (NFKPA), British Kidney Patient Association (BKPA) and the
twelve London based Kidney Patients Associations (KPAs), of whom ten replied. The general response was summarised in the review group report showing support for dialysis in the patient's home and for satellite units. The level of services contained in tertiary centres, including staffing levels, was stipulated in detail. The responses stressed the need for accessibility, timeliness and communication placing emphasis on the need to 'continually improve patient information, knowledge and awareness regarding treatment'. Finally the role of social workers and the need to assess employment opportunities for renal patients was stressed. The review group's report only listed the 12 renal patient associations consulted. Their responses were not reproduced in detail. Whilst supporting the principle of getting services closer to patients the KPA responses often concentrated on supporting the case for their particular unit to be retained. This raised a number of questions concerning the consultation exercise. It clearly did not represent an adequate consultation and the KPA responses were not discussed in detail during the review group's deliberations although the Chairman was at pains to retain dialogue with patient representatives at all times. The limitations of the exercise will be discussed in the next chapter.

4.9 Critical analysis of the review

This section places the renal review group's work in a historical, economic and geopolitical context comparing UK health care policy with respect to renal services with those in other Western countries. In this way the main exogenous pressures on the group influencing their decisions will be highlighted. The 'rational' basis for constructing a future model for services that fitted with the imperatives of a quasi-market will be critically assessed.
The history of ESRF treatment in UK has been one of under referral and under supply compared with other countries (Wing et al 1982, Wing 1983, Halper 1989). This has led to the criticism that the British health care system uses age based rationing to deny care to those most likely to need RRT and that access to treatment is arbitrary and inequitable (Baker 1993). UK policies have changed considerably in recent years however, and since 1984 there has been an increase in the proportion of new patients being treated annually. In 1991 the UK treated 3,430 new patients which was the third highest number of the countries registered with EDTA. However, acceptance rates show that the UK had a rate of 59.7 patients per million which ranked fifteenth; many countries having rates in excess of 75 new patients per million (see table 4.6).

Table 4.6 - Summary of new patients accepted for renal replacement therapy (RRT) during 1991 in Europe

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of new patients in 1991</th>
<th>Per million population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Israel</td>
<td>493</td>
<td>106.3</td>
</tr>
<tr>
<td>Austria</td>
<td>805</td>
<td>105.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>852</td>
<td>99.6</td>
</tr>
<tr>
<td>Switzerland</td>
<td>639</td>
<td>95.5</td>
</tr>
<tr>
<td>Germany (West)</td>
<td>5771</td>
<td>94.1</td>
</tr>
<tr>
<td>Belgium</td>
<td>868</td>
<td>86.7</td>
</tr>
<tr>
<td>Portugal</td>
<td>887</td>
<td>85.5</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>30</td>
<td>79.4</td>
</tr>
<tr>
<td>France</td>
<td>4350</td>
<td>77.1</td>
</tr>
<tr>
<td>Greece</td>
<td>709</td>
<td>70.6</td>
</tr>
<tr>
<td>Cyprus</td>
<td>47</td>
<td>67.0</td>
</tr>
<tr>
<td>Norway</td>
<td>47</td>
<td>67.0</td>
</tr>
<tr>
<td>Germany (East)</td>
<td>1045</td>
<td>62.6</td>
</tr>
<tr>
<td>Netherlands</td>
<td>896</td>
<td>60.0</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>3430</td>
<td>59.7</td>
</tr>
<tr>
<td>Spain</td>
<td>2341</td>
<td>59.5</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>873</td>
<td>55.7</td>
</tr>
<tr>
<td>Finland</td>
<td>271</td>
<td>54.4</td>
</tr>
<tr>
<td>Italy</td>
<td>3105</td>
<td>53.9</td>
</tr>
<tr>
<td>Iceland</td>
<td>13</td>
<td>50.4</td>
</tr>
</tbody>
</table>

(source EDTA - quoted in Poulter 1993)
It is also important to note that within the UK acceptance rates varied considerably between regions and acceptance rates were higher for men than for women. Again, comparisons are difficult because of differences in ethnic composition and social class. The majority of under referrals were in high risk categories (elderly and diabetics) but between 1980 and 1985 the proportion of patients in these ‘high risk’ groups increased considerably, although the UK still had lower rates than several European countries. In 1986 the acceptance rate per million population in the UK for patients aged 65-74 was 112 for men and 57 for women. This did not compare favourably with other European countries (see table 4.7).

Table 4.7 Acceptance rates per million population in patients aged 65-74 in 1986

<table>
<thead>
<tr>
<th>Country</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Germany</td>
<td>225</td>
<td>153</td>
</tr>
<tr>
<td>Italy</td>
<td>208</td>
<td>117</td>
</tr>
<tr>
<td>Spain</td>
<td>160</td>
<td>98</td>
</tr>
<tr>
<td>France</td>
<td>132</td>
<td>90</td>
</tr>
<tr>
<td>UK</td>
<td>112</td>
<td>57</td>
</tr>
</tbody>
</table>

(Source Wing 1993)

There are a number of international differences in the mix of treatments offered by renal centres and this has changed over time. This alone is sufficient reason to justify examining the appropriateness of different forms of treatment. Appendix 4.2 summarises the definitions of the different treatment methods of haemodialysis, transplantation and Continuous Ambulatory Peritoneal Dialysis (CAPD). Data from EDTA (1988) indicates a growth in services throughout Europe between 1971 and 1985 particularly in transplantation and CAPD. It has been argued that levels and methods of funding services are a major determinant of treatment policies (Simmons & Mrine 1984). In the UK the system of fixed budgets and smaller
budgets per head of population has resulted in not only rationing of services in terms of number of patients treated but in a different mix of treatment options (Rennie et al 1985). The UK also has a lower number of renal centres per million population then other Western European Countries whilst the capacity for hospital haemodialysis within centres is lower in the UK.

As a result the UK dialysis programme differs considerably from those of other developed countries. As has been shown the situation during the 1970s was one of under provision. In the 1980s the UK expanded its dialysis programme considerably with the introduction of CAPD. This development was not reflected in the rest of Europe where expansion occurred through renal units as haemodialysis treatment centres. In the UK, the large number of patients on CAPD puts a different pressure on existing haemodialysis units where much work is directed towards preparing patients for CAPD and treating CAPD failures. This is what Greenwood et al (1992) termed the ‘imbalance in the UK dialysis programme’. In the UK, hospital haemodialysis is less common accounting for 17% of patients in 1986 whereas for 11/33 countries in EDTA the figure was 70%. Transplantation is the most common treatment in the UK (50% of patients in 1986, the comparable figure for EDTA was 27%). For patients aged over 65 years, haemodialysis and CAPD are more common treatments in UK and for diabetics CAPD is more common. Table 4.8 compares the number of transplants carried out in a selection of European countries and shows the waiting list in those countries at 31st December 1992.
Table 4.8 Kidney transplants in Europe 1991 and 1992

<table>
<thead>
<tr>
<th>Country</th>
<th>Transplanted</th>
<th>1991 Rate pmp</th>
<th>1992 Rate pmp</th>
<th>Waiting List @ 31 December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>389</td>
<td>51</td>
<td>306</td>
<td>40</td>
</tr>
<tr>
<td>Belgium</td>
<td>378</td>
<td>38</td>
<td>330</td>
<td>33</td>
</tr>
<tr>
<td>Germany</td>
<td>2195</td>
<td>28</td>
<td>2034</td>
<td>26</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>7</td>
<td>19</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>426</td>
<td>29</td>
<td>428</td>
<td>29</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1620</td>
<td>28</td>
<td>1622</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: adapted from Poulter 1993, pmp= per million population

To address the imbalance in UK services it would appear that there needs to be an expansion in haemodialysis facilities in decentralised units so that facilities are closer to patients. Such a policy would inevitably place great strains on existing facilities particularly those based in teaching hospitals with large capital costs and overheads. An expansion in home haemodialysis seems to be unlikely as the increase in demand will come from older and more vulnerable patients who need more support than home haemodialysis can provide. Contracting out of dialysis has been pioneered in Wales. Private ventures have been a commercial success and have been welcomed by the Renal association. Nevertheless there are dangers in commercialisation of renal services. The drawbacks associated with monopoly suppliers and the restraints on clinical advancement should not be forgotten. Because of its over reliance on CAPD and the potential for expansion of unit haemodialysis the UK is seen as a unique market for private service providers. As pressure mounts to reallocate resources from large inner city teaching hospitals to purpose built centres, then competition to provide such services will come not only from NHS providers but private hospitals and “large multinational companies like Baxter, Gambro and Fresenius” (Greenwood 1993) The NHS Management Executive on the other hand has suggested that the predicted expansion in patient numbers should be met through an expansion of CAPD. This view has been
criticised by Greenwood on the basis that their figures are based on the characteristics of patients presently receiving RRT and 'perpetuate the myth' that CAPD is cheaper and is the treatment for choice for the elderly.

Clearly the predicted increase in demand for RRT, particularly among elderly and high risk patients, will have considerable resource implications. To address the growth in patient numbers the review group had to balance demands for cost-containment from the management executive with the need to protect core services and the need to ensure that services appropriate to the needs of new patients were planned for. In Europe, survival rates for patients on all forms of RRT and all ages have increased since the 1970s. This is also true for the UK. It is difficult to compare survival rates between age groups, for those aged over 65 are likely to be selected differently and survival rates will vary according to risk category. There are however large differences in survival rates between different countries though comparison is on the basis of crude rates. Age standardisation would improve the quality of comparative data. There is a debate about the effect of different levels of dialysis. In the USA the mortality rate among dialysis patients increased from 20.1% in 1983 to 24.3% in 1988 whilst average treatment length decreased over the same period. Greenwood (1993) suggested that USA providers have operated an 'irresponsible' rationing policy as a result of a financial squeeze derived from the introduction of a prospective composite reimbursement system. He argued that failure to use urea kinetic modelling (UKM), as a method of monitoring a patient's dialysis needs, led to less dialysis being prescribed to malnourished patients. These patients needed more dialysis but their malnourishment was associated with low serum urea and creatinine thus on routine measurement they appeared to require less dialysis. Such practices may be creeping into the UK system; with the introduction of quasi-markets, the incentive at present is to accept as many patients as possible.
Units are only able to maintain a certain prevalence of patients however and as the pressure to accept more patients grows so does the pressure to 'compromise' dialysis policies:-

"Limiting access to haemodialysis, continuing patients on CAPD despite peritonitis, reduction of dialysis times and slippage from thrice into twice weekly dialysis schedules, without quality assurance by UKM, have all crept into UK practice over the last ten years...There are enough similarities with the USA to cause alarm. Clearly, forces are operating which can result in clinical compromise." (Greenwood et al 1992 p8).

UK policies may have an adverse effect on survival rates. One study referred to the UK as having a 'go home for treatment or else die policy' (Rennie et al 1985) but there have been marked improvements and changes in policy since. Outcome studies however, should go beyond just survival and take into account quality of life including psycho-social implications and the effect of treatment on an individual's capacity to participate in their chosen form of life (Hardy et al 1991). Inter-treatment comparisons are in their infancy and as yet there have been no randomised control trials. Differences in the quality of life of patients on different modes of treatment are difficult to interpret (Simmons et al 1988, Hart and Evans 1987) and subjective assessments of what is valued most by patients are likely to influence outcomes (Kutner et al 1986). Fifty percent of patients on RRT are alive after 10 years and 40% after 15 years. Transplantation has the best survival rate, 80% at one year (Lancet 1990 (editorial)). The effect of market pressures on the quality of services and patient outcomes was a matter of concern for the review group. Data on patient survival was available but was not considered sensitive enough to be used
in decision making. Similarly a policy decision was taken not to use outcome data, such as it was, to inform decision making. The main thrust of the groups thinking in this area seemed to be based on ensuring good outcomes through maintaining a 'high quality core service' in the central tertiary centres. Each renal unit was asked its view on this approach and there seemed to be a general acceptance that the difficulties of comparing outcomes for different case-mixes justified the exclusion of outcome data in the decision making process. The chair of the review group was meticulous in ensuring agreement on this. The apparent consensus however may have concealed some disputes for there was some variation in survival data and the performance of some units in relation to patient survival was considered sufficiently poor by some clinicians, based outside London, to be a basis for decision making.

4.9.1 Economic evaluation

Economic evaluations of renal treatment comparing survival data with cost per life year gained have been extensively reviewed, (West 1991, Ludbrook 1985, Mancini 1983). There was a feeling among some group members that economic evaluations were liable to become outdated very quickly. Ludbrook concluded that the method of financing services in the UK had resulted in more cost-effective patterns of care. Transplantation was considered to be the most cost-effective form of care, home dialysis and CAPD being the next most cost effective. However this was not taken as an argument to expand home dialysis and CAPD indiscriminately. Indeed the arguments about the under utilisation of hospital haemodialysis still remain and the inappropriate allocation of patients with social problems or multi-system disease to

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* I gleaned this impression from responses made by clinicians to the review group's presentation of its findings at the King's Fund; King's Fund conference 1993
home care is still an issue. Estimates of the annual cost to the NHS of maintaining a patient on RRT are given in table 4.9.

Table 4.9 Cost estimates of treatments

<table>
<thead>
<tr>
<th>Treatment modality</th>
<th>Annual Cost to NHS (1990 prices) £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Haemodialysis</td>
<td>18,000</td>
</tr>
<tr>
<td>Home Haemodialysis</td>
<td>11,000</td>
</tr>
<tr>
<td>CAPD</td>
<td>13,000</td>
</tr>
<tr>
<td>*Kidney transplant:</td>
<td></td>
</tr>
<tr>
<td>Operation</td>
<td>10,000</td>
</tr>
<tr>
<td>Maintenance</td>
<td>3,000</td>
</tr>
</tbody>
</table>

* Operation is the cost in the first year of transplant, maintenance is the cost in every subsequent year;


The use of lower cost treatments is more common in the UK than other Western European countries. However, it has been argued that CAPD will appear less expensive because a large proportion of associated costs are incurred under other budgets e.g. GPs, Pharmacists, Social Services (Catalano et al 1990). Rennie et al (1985) also argue that hospital haemodialysis is inefficiently used in the UK since although the capital equipment is in place it is under used because of lack of nurses.

Table 4.10 gives cost per Quality Adjusted Life Year (QALY) estimates for RRT methods showing that transplantation has the lowest cost per QALY compared with other RRT modalities.

Table 4.10 Cost per QALY estimates for RRT methods - UK studies

<table>
<thead>
<tr>
<th>Prices</th>
<th>Discount Rate</th>
<th>Transplant £</th>
<th>CAPD £</th>
<th>Home HD £</th>
<th>Hospital HD £</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988 *</td>
<td>5%</td>
<td>-</td>
<td>6,731</td>
<td>9,292</td>
<td>15594-17,549</td>
</tr>
<tr>
<td>1988 +</td>
<td>5%</td>
<td>1,724</td>
<td>-</td>
<td>-</td>
<td>11,071</td>
</tr>
<tr>
<td>1990 ^</td>
<td>5%</td>
<td>4,710</td>
<td>-</td>
<td>17,260</td>
<td>21,970</td>
</tr>
</tbody>
</table>

* Smith, Cohen & Asscher 1989
+Hutton, Leese and Maynard 1990
^West 1991

(Adapted from Beech et al 1994)
The differences in the cost per QALY estimates are determined by a number of technical factors including the discounting method used and the inclusion or exclusion of different types of costs (e.g. social costs). Table 4.11 shows cost per QALY estimates for other treatments compared with RRT. Mason et al (1993) have highlighted the pitfalls involved in making such comparisons but their influence over policy makers at times of acute resource constraint should not be underestimated.

Table 4.11 Quality adjusted life years (QALY) of competing treatments

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Cost/QALY (£ Aug 1990)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol testing and diet therapy only (all adults aged 40-49)</td>
<td>220</td>
</tr>
<tr>
<td>Advice to stop smoking from general practitioner</td>
<td>270</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>1180</td>
</tr>
<tr>
<td>Coronary artery bypass graft (left main vessel disease, severe angina)</td>
<td>2090</td>
</tr>
<tr>
<td>Kidney transplant</td>
<td>4710</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>5780</td>
</tr>
<tr>
<td>Heart Transplantation</td>
<td>7840</td>
</tr>
<tr>
<td>Home Haemodialysis</td>
<td>17260</td>
</tr>
<tr>
<td>Coronary Artery bypass graft(one vessel disease, moderate angina)</td>
<td>18830</td>
</tr>
<tr>
<td>CAPD</td>
<td>19870</td>
</tr>
<tr>
<td>Erythroprotein treatment for anaemia in dialysis patients (assuming no increase in survival)</td>
<td>126290</td>
</tr>
</tbody>
</table>

source Mason et al (1993)

What economic studies have failed to do, so far, is look at survival data for patients randomly allocated to different modes of treatment. There are clear ethical problems with such research. In reality patient selection is done rigorously. In addition patients often switch between different modes of treatment. This not only complicates but often invalidates cost comparisons. Hunt (1990) has argued that a new drug, Erythroprotein, can improve the quality of life of patients on dialysis dramatically. The costs of the drug are however, prohibitive (Hutton et al 1990). Another new development is the use of cyclosporin as an immunosuppresive for post-transplant patients. These advances were often referred to by the clinicians on
the group to highlight how technical advancements are often running ahead of health service planning mechanisms. This reflected doubts and unease among the group concerning the permanency of the proposed model for services.

The review group received poor and inconsistent cost data from the units and it was decided that a cost comparison could not be undertaken. Nevertheless, the review was able to show that there was considerable under use of dialysis machines in London and that some units operated at very inefficient levels (The Times 1994). The only cost data used by the review group came from units outside the Thames regions. This was used to create an 'ideal' costing template for future services. This meant that the existing cost-effectiveness of units was not analysed as part of the group's evaluation. Given that there is a considerable body of work on the economics of RRT (Beech et al 1994) this represents a large gap in the group's knowledge base. I will show in chapter 5 that there was some conflict between group members concerning the validity of past economic evaluations. In addition there was a feeling among some group members that the units were being deliberately obstructive in the limited financial data being made available to the review. After all the data was highly sensitive and, given the insecure position of many of the units in relation to the proposed rationalising of services in London, its publication had potentially disastrous consequences.

4.9.2 Implications of quasi-markets for renal services

The management of the finances of ESRF services have been reviewed prior to the implementation of the NHS reforms (Steele 1989, Mays 1990) but these reports could not deal with the likely effect of the new contracting systems on demand and
supply for services. The reforms could result in more competition with the private sector but private provision has not been found to be more effective or efficient although it has been found to be able to increase capacity more quickly in response to demand (Smith et al 1989). The opportunities for expansion that a market might bring have been highlighted by Wing (1990). The tensions that these ‘opportunities’ created for a review group that was essentially engaged in a traditional ‘Stalinist’ planning exercise were considerable and will be discussed in the next chapter. It is clear that renal services in the UK have developed differently to those of other countries. The bureaucracy and overcentralisation of the UK system has been identified as a core factor in determining the pattern of provision (Baker 1993). Marked inequity in provision and poor access to services have also been a strong part of the UK picture and has led to calls for provision of services to be closer to patients. The push to create a quasi-market has also created considerable uncertainty as responsibility for purchasing renal services was being devolved downwards from Regions to Districts. At one level it can be argued that this places decision making at a closer level to patients and sets up a market where decisions can be explicitly made. At another level it is possible to argue that for large specialties such as renal medicine, devolving of decision making creates greater bureaucracy and hinders the ability of decision makers to take a ‘wider view’.

4.9.3 Evaluating the assessment of needs

My analysis so far has shown that the renal review group was planning future services in London in the context of considerable historical, geographical, economic and social forces. In the face of this the group was able to pull together a considerable amount of technical information on ‘needs’ for services. Need was defined in terms of incidence of disease, epidemiological risk and geographic
access. Information on health status, disability and social participation was not available although much was made of estimates of travel times to units. Travel times were seen as proxies for measuring patient access and used to consider the consequences of changes in siting of units. In order to relate the achievement of the group in constructing a technical assessment of need to my earlier discussions of how health care needs can be understood I use Doyal and Gough’s framework for measuring needs. Figure 4.7 summarises the extent to which the analyses undertaken by the group meets the framework for measuring needs set out by Doyal and Gough. The key headings for measuring need in Doyal and Gough’s theory are linked with the work done by the review group in each area. This allows the gaps in the needs assessment work to be identified together with the possible effects this had on the rationality of decision making. The limits of time and resources available to the group should not be forgotten here but a number of gaps are apparent and these had a considerable consequence for the rationality of decision making for they allowed the exogenous pressures discussed in this chapter to affect the decision making process. Figure 4.7 shows that information on survival was either insufficient or not used because it was considered too sensitive. Information on service use, in the form of acceptance rates was by far the most accurate data available to the group and this was used extensively. Even here however, the limits of the data were apparent. The review group were only able to analyse activity occurring in the NHS. Private patients were therefore excluded from the analysis. Whilst this was not considered a major problem by group members, the relationship between private practice and health sector inequity has been graphically highlighted in other specialties (Yates 1995).
Figure 4.7 Framework for Needs Assessment

<table>
<thead>
<tr>
<th>Theory</th>
<th>Renal Review</th>
<th>Gap</th>
<th>Effect on rationality of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survival chances</td>
<td>Survival chances</td>
<td>Insufficient data on co-morbidity.</td>
<td>Criticism of decisions by some physicians who thought that mortality data for transplantation was sufficient to inform decisions and should have been used more</td>
</tr>
<tr>
<td>Mortality Rates</td>
<td>Mortality Rates</td>
<td>Survival and mortality data collected but not used</td>
<td></td>
</tr>
<tr>
<td>Risk of death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical Ill-health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence and severity of disability</td>
<td>Rates of acceptance on to RRT by District of residence age and ethnic group</td>
<td>No measure of disability or patients perceived health status</td>
<td>Influence of inequity of provision on decisions to site services</td>
</tr>
<tr>
<td>Morbidity by disease categories</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td>Not covered</td>
<td>No data on mental illness in renal patients despite strong evidence of the psycho-social impact of renal disease on family relationships, friends and support networks</td>
<td>Some subjective appeals to the psycho-social impact of renal disease made as a way of justifying a policy of getting services closer to patients.</td>
</tr>
<tr>
<td>Prevalence and severity of mental illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive deprivation literacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>attainment of basic skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>absence of skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Opportunities for economic activity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extent of employment free time</td>
<td>Some measure of travel times to renal units</td>
<td>Socio-economic impact of renal disease not covered.</td>
<td>Access and travel times used as appeals to patient 'needs' - used to criticise units</td>
</tr>
<tr>
<td>extent of engagement in social interaction</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There was no analysis by gender or social status and no information was available on levels of disability, patient functioning or patient’s health status. The group had no information on the mental health of the renal patient or on the impact their condition had on their social networks. There was no assessment of the socio-economic impact of renal disease. The group’s work therefore only covered autonomy in the sense of some comments by group members on the psycho-social impact of the condition and a general opinion that travelling long distances to treatment centres compromised the quality of life of patients. The inaccessibility of some units was highlighted and in this way improving ‘access’ was seen as an important component in the task of addressing ‘need’.

The framework reveals the extent to which inequity of access became a determining factor in the construction of a technical picture of patient needs. The phrase ‘equal access for equal need’ therefore describes the overall approach undertaken. Decisions were based on quantitative data showing variations in use of services (focusing on ethnicity and geography) together with the subjective opinions of group members on the impact that travelling long distances had on the lives of patients. Data on outcome and objective levels of disability were either ignored or not available. This framework does not allow for the construction of an economic critique of the review. However, it does highlight the way the group focused on a particular interpretation of need for its work. It is more difficult to untangle the way in which this was used to inform decision making. In deciding on which units should be retained as tertiary centres the group turned to its assessment of their academic status and to judgements about their viability in the wider context of a developing market for health care in London. The main factors affecting the group’s decisions therefore were:
1. Need: epidemiologically defined and related to access to services
2. Academic status
3. Market viability

To understand how these three factors interacted and affected the rationality of decision making I need to examine the group’s discussions in more depth. I do this in the next chapter, using depth hermeneutics to analyse the review group’s meetings with renal units and the group’s own meetings.
Appendix 4.1

COMMITTEE MEMBERS

Professor N P Mallick  Professor of Renal Medicine, Central Manchester Health care Trust, Manchester. Chairman

Mr P Coe  Chief Executive, East London and the City Health Authority

Dr N J B Evans  Chairman, United Kingdom Transplant Support Services Authority

Professor D Gray  Dean of Postgraduate Studies, Exeter University

Professor D N S Kerr  Lately Dean, Royal Postgraduate Medical School

Dr G Maidment  Consultant Physician, Windsor

Professor M G McGeown  Professorial Fellow, Queens University, Belfast

Dr P Roderick  Consultant in Public Health Medicine, North West Thames Regional Health Authority

Professor J Salaman  Professor of Transplant Surgery, University of Wales

Mr J R Stopes-Roe  Locality Director (Newham), East London and the City Health Authority

Mr J Wellbeloved  Lately Director, National Kidney Research Fund

Mrs L Whitworth  Nurse Manager, Renal Services, Central Manchester Health Care Trust, Manchester.

Dr A J Williams  Consultant Renal Physician, Morriston hospital Swansea
Appendix 4.2

DEFINITION OF MAIN TYPES OF TREATMENT

(source NETRHA discussion document for renal replacement services, March 1990)

<table>
<thead>
<tr>
<th>DIALYSIS</th>
<th>The clearing of waste products from the body’s circulating fluids carried out either in a hospital environment (HOSPITAL DIALYSIS) or a home environment (HOME DIALYSIS).</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAEMODIALYSIS</td>
<td>The filtration of the body’s blood supply through an artificial membrane during which waste products are removed. The patient is linked, via blood lines, to a static dialysis machine which controls the flow of blood through a synthetic kidney. A patient would typically require dialysis three times a week for four hours at a time.</td>
</tr>
<tr>
<td>CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)</td>
<td>The principle is the same as for haemodialysis, but the membrane is the patient’s own peritoneum. Unlike haemodialysis, the process is continuous, and uses portable appliances. No machine is involved, and so the patient has the freedom to walk about</td>
</tr>
<tr>
<td>TRANSPLANTATION</td>
<td>The replacement of a diseased kidney with a healthy one, either from a cadaver or live donor.</td>
</tr>
</tbody>
</table>

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### Appendix 4.3

**Glossary of terms and abbreviations**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRT</td>
<td>Renal Replacement Therapy</td>
</tr>
<tr>
<td>ESRF</td>
<td>End Stage Renal Failure</td>
</tr>
<tr>
<td>SLE</td>
<td>Systemic Lupus Erythematosis</td>
</tr>
<tr>
<td>NIDDM</td>
<td>Non Insulin Dependent Diabetes Mellitus</td>
</tr>
<tr>
<td>IDDM</td>
<td>Insulin Dependent Diabetes Mellitus</td>
</tr>
<tr>
<td>UKTSSA</td>
<td>United Kingdom Transplant Support Service Agency</td>
</tr>
<tr>
<td>NFKPA</td>
<td>National Federation of Kidney Patients Associations</td>
</tr>
<tr>
<td>BKPA</td>
<td>British Kidney Patient Association</td>
</tr>
<tr>
<td>KPA</td>
<td>Kidney Patients Association</td>
</tr>
<tr>
<td>pmp</td>
<td>Per million population</td>
</tr>
<tr>
<td>CAPD</td>
<td>Continuous Ambulatory Peritoneal Dialysis</td>
</tr>
<tr>
<td>UKM</td>
<td>Urea Kinetic Modelling</td>
</tr>
<tr>
<td>QALY</td>
<td>Quality Adjusted Life Year</td>
</tr>
</tbody>
</table>
Chapter 5

Planning renal services - a critical evaluation

5.1 Introduction

The aim of this chapter is to examine the extent to which discussions of the renal review group could be explained in terms of strategic action (aimed at achieving success) or communicative action (aimed at achieving consensus). Did the group have vigour, derived from a commitment to expose ideas and arguments to collective evaluation? What was the group's theoretical understanding of needs and how did this relate to the dynamics of the group's communicative understanding given the constraints it was acting under? The source materials for my analysis are the minutes of the review group's meetings, the field notes and diary I maintained at the time and the transcripts of the tape recordings I made at the meetings. A guide to the transcript symbols I use is given in Appendix 5.1 and a timetable of the review is given in appendix 5.2.

I have organised my analysis into two main sections. The reason for this is that it allows me to distinguish between the review group's internal debates and the debates the review group had with the units it visited. The first section deals with the meetings held at the 12 renal units in London together with the meeting to review the academic status of units. These meetings were tape recorded with the permission of the individuals present. Their consent was based on the need for accuracy of minute taking. The main products of these meetings were the official minutes which were used as a basis for formulating the review group's consultation with each unit. With this in mind I interrogate the official minutes using the transcribed tapes as a reference and aide memoir. The ethical considerations involved are discussed in chapter 3 section 3.7.1. The second
section of this analysis deals with the working meetings of the renal review group held at the Department of Health. Again these meetings were tape recorded with the permission of the individuals present. These meetings were primarily working meetings where individuals were expected to develop ideas and address key issues in relation to the planning of services. The free flow of ideas was encouraged; this section therefore uses quotes from the transcribed tapes with the consent of the participants. The group used these meetings to write and edit various sections of the final report. These meetings debated the evidence on need, the robustness of the proposed model for future services, the economics of renal services and the policy implications of the group’s decisions. In both sections I draw on the minutes, tapes and my notes of meetings to inform my work. In this way the contradictions between different data sources are brought to the surface. I outlined in chapter 3 how I used depth hermeneutics to distil a set of analytical categories and typologies from the data (tables 3.1 and 3.2). I present my analysis using these analytical categories as sub-headings for my work. Appendix 5.3 gives a worked example of my analytical approach.

5.2 Meetings with renal units

My analysis of the debates that occurred in the meetings with renal units is based on drawing a distinction between communicative action, open strategic action and concealed strategic action. The ostensible driving force behind the discussions was the need to get issues out in the open and to allow the actors involved to participate fully. However, the extent of this participation was limited in two crucial ways; firstly by the exclusion of actors who would be affected by the debates and secondly by the extent to which powerful interests set constraints on the willingness of individuals or groups to question proposals, express their views and introduce their own proposals. The extent to which
actors were excluded could be clearly seen in the limited involvement of patients and patient groups and the medical dominance of the debates. The constraining effect of powerful groups is more difficult to analyse as this may have resulted in some voices not being heard at all, whilst others may have modified or muted the tenor of their remarks.

5.2.1 Definition of need and decision making criteria

Units used the meeting to present a case for them to be a future core centre. The formal arguments and evidence they employed focused on geographical access, quality of services, cost-effectiveness of services, the unit's position in the market, the unit's ability to manage change and the academic and research record of the unit. The emphasis given to each of these areas varied from unit to unit. This depended on two main factors: a) the unit's perception of where its main strengths lay and b) the unit's perception of what factors the renal review group would base its decision on, the relative weight it would give to geographic access vis-à-vis academic excellence for example. The St Bartholomew's unit placed considerable emphasis on geographic access:

"All agreed that dialysis needed to be devolved closer to patient homes" (Barts p3)

but they tempered this with evidence on the needs of patients in their immediate area:

"Hackney is an extremely deprived area and it was felt that moving the dialysis unit away from Barts could add to their disadvantage." (Barts p5).
These statements reveal the strong link made between patient needs and geographic access and an acceptance that service provision in London would have to change to address these needs. However, in order to justify arguments for the Bart's unit's continued existence there is an equally strong emphasis on the need of local populations where needs are linked to levels of relative deprivation. The renal review group's emphasis on restructuring services in order to make them more appropriate to patient needs was not being disputed, but there was a strong appeal to the link between deprivation and increasing need for renal services to add force to arguments in favour of the unit being retained. These arguments can be contrasted with the renal review group's working definition of need which did not make such a link. Although the review group had made a clear definition of epidemiological need, it was clear that the ambivalence that still surrounded the term 'patient needs' still allowed it to be manipulated to legitimate particular arguments and interests. In this sense the need for renal services was still a contested concept.

Most units regarded the arguments linking patient needs to geographic access (based on evidence showing the remoteness of services and underprovision in certain areas) as indisputable. The review group's presentation of a model for future provision based on these arguments was generally accepted. The focus for disputes therefore was the selection of which units should form the core. The main decision making criteria for selecting units was considered to be the research and academic record of a unit. The damage that shifting units around could do to their respective research potential was often cited as an argument for staff to remain on their existing sites, and units spent considerable time outlining their research output and future research plans. As time went by it became increasingly apparent that a pecking order was forming in terms of each unit's relative research and academic status. Those units lower down this pecking order and in competition with the high status units, were more likely to
emphasise their strengths in meeting patient needs as well as the cost-effectiveness and quality of their services. It was possible to distinguish between units that were perceived by the group, and by the units themselves, to be of high academic and research standards, and units that were considered to be of a lesser standard but often with a good record in providing a renal service. Some units were strong in both areas of course and this gave them a considerable advantage in that they could play the 'patient need' and the 'academic record' with equal effect in their negotiations with the review group. Nevertheless, there often seemed to be confusion within units about which strengths to play to. At St Thomas' for example the emphasis was placed on the potential for future research:

“[W] added that the judgmental value should bear in mind the potential of units for research.” (St Thomas’ p4)

but this statement, although mainly concerned with how research should be judged is immediately followed by a statement emphasising another decision making criteria:

“[J] argued that service provision should be the major determining factor.” (St Thomas’ p4)

The St Thomas’ clinicians seemed to be able to jump from needs/service based arguments to arguments concerning future research with ease. Indeed, if they saw conflict between the two they were very careful not to show it. This perhaps reflected the unit’s ability to demonstrate strengths in both areas whilst recognising the need for improvement. These arguments were presented to the group by the St Thomas’ team in a friendly, non-confrontational, manner where there appeared to be a good deal of understanding between clinicians on the
review group and the hospital clinicians. Clearly it was important for the St Thomas’ team to set out a strong academic and service case. It would be wrong however to interpret this in Habermasian terms as a form of ‘action oriented towards understanding’, since some interests were excluded at the time of the debate; most notably the patients and their representatives. This highlights the importance of Habermas’ point that the validity of any claim is subject to the consensus of those affected by the claim. The structure of the review group’s meetings meant that interested parties were inevitably excluded from certain debates. These included the public, renal patients, NHS staff and consultants in other units. Given the practical difficulties of undertaking a review of this sort, it would be impossible to involve all interested parties in the debate. We must not forget that Habermas’ concept of communicative understanding is an ideal type of communication. Nevertheless, it is still possible to criticise the review process in relation to how much it endeavoured to ensure open and fair debate. There was no formal mechanism for the minutes of meetings with the group to be circulated among every unit in London for example. In light of this the statements made in the minutes must be seen primarily as elites taking up negotiating positions and as forms of strategic action. In the case of the St Thomas’ team, their negotiating position was very strong and they could therefore afford to be generous in their statements. This was reflected in the comparatively relaxed atmosphere of the St Thomas’ unit. At the Royal Free hospital, on the other hand, tension between academic criteria and patient needs could not be so easily reconciled and the unit questioned how:

“comparisons could be made between academic research and patient care as a basis for the review group’s decision making.” (Royal Free p8)
The Royal Free was a unit where the review group’s deliberations were seen much more as a threat to the unit’s future. The unit had emphasised the high quality of its service, its cost effectiveness relative to other London units and its accessibility to patients. The possibility of losing out to a judgement that gave too much weight to ‘academic’ status at the expense of the above qualities was therefore a considerable concern. This can be contrasted with the arguments presented in favour of the St Peter’s unit at University College Hospital where:

“The primary reason given was the academic and research base for nephrology at St Peter’s. These were believed to be real, tangible and important. Progress in clinical management was dependent on such a base.” (St Peter’s p6)

The emphasis here was on the research and academic excellence of the hospital as a whole and for the renal unit:

“it would not make sense to be separated from it, despite some problems of access for patients.” (St Peter’s p6)

Here we clearly see precedence being given to academic status over patient access, by a unit confident in the strengths of its research and academic position and the impact that would have on the renal review group’s judgement.

‘Need’ was most frequently spoken of in the context of access to services. This was formulated in terms of patients not receiving treatment because not enough services were available, and in terms of the distances patients had to travel to units. The first part of this formulation was used to buttress arguments that services had to be protected and even expanded in the face of calls for
rationalisation. The later part was used to highlight the remoteness of London units from patients populations and the consequent need for relocation of services. There was a general recognition that services were inappropriately located and had not developed in a manner that addressed patient needs. However, beyond this shared understanding there was plenty of scope for disagreement and debate concerning which services should be rationalised and which should be developed. Relating this to Doyal and Gough's rules for discussing needs (see chapter 2 section 2.5) it is clear that these debates were a threat to any attempt to address need satisfaction. The group was not only looking at the need for services in the population but also at how services could be reconfigured in a way that ensured the future of London units as 'centres of excellence'. This suggests that the group's discussion on needs corresponded with 'expert needs talk' (Fraser 1989). This refers to 'needs talk' that can perpetuate professional class formation, provide a platform for defusing political conflict in relation to needs and can be understood as forms of social problem solving. This in turn meant that the basis for discussing future service provision and the criteria on which decisions were to be based were clearly contestable concepts. By emphasising the importance of academic excellence above all other criteria as a means of securing their own survival, units were engaged in strategic action. This could be interpreted as open strategic action because the intention to influence the review process was openly declared. However, looking at the ways in which the arguments were presented it is also possible that processes of unconscious self-deception were also at work in that the justification for maintaining academic excellence stemmed from a highly medicalised perspective. From the viewpoint of the medical elites it is not surprising that patient needs appeared secondary to research interests.
5.2.2 Markets

The potential the market had for affecting radically the plans of the various interests involved, was a source of considerable concern. There was a realisation that not every unit stood in the same position relative to the market, and this generated levels of uncertainty. To understand how this uncertainty affected the negotiations taking place it is important to grasp the way in which the various factional interests interacted. The different renal units were clearly a set of interest groups, vying with one another to be chosen as a specialist centre. Managers, nurses and medics within each unit presented a united front in support of the unit. On the other hand, there were also divisions between professional groupings particularly medics and managers. These divisions could work across unit loyalties and were discernible in the way in which managers and medics reacted to the review group's suggestions; managers demonstrating a much greater willingness to accept the fundamental need for rationalising services and the perceived inevitability of the Tomlinson proposals, while medics were more likely to challenge the assumptions behind the review group's remit. The market therefore was seen to have the capacity to determine the 'winners' and 'losers' in this process as far as renal units were concerned. However, the levels of uncertainty produced by this, created opportunities for managers, as an interest group, to increase their influence over matters and remind medics of the rationalising imperative driving the whole process.

The relative strengths and position of units in the market was debated time and time again. This had particular relevance to the Hammersmith hospital which had Special Health Authority (SHA) status. Being an SHA meant that the unit could not yet compete in the market and its services were paid for directly from central funds thus making them an attractive zero price service for local purchasers. The Hammersmith physicians, when criticised for not developing
dialysis services in response to patient needs, countered with the argument that their SHA status had not given them the freedom to do this:

"The team also felt that they had been constrained by the market. Purchasers have treated the Hammersmith as a free good" (Hammersmith p6)

Implicit in this was the belief that if the Hammersmith team were allowed to enter the market then they could attract the necessary funds to allow them to expand services. While they were seen as a free good however there was no incentive to do this. The chair of the review group saw this as an opportunity to state that if the unit was to be allowed to enter the market, in order to survive in the market it would have to expand its renal programme to address patient needs. Here the market was being used as a threat. This argument was accepted but concerns were raised about the effect this would have on the academic workload of the unit which was seen as its greatest strength. These concerns, which in turn had a feeling of a veiled threat about them, were swiftly countered with the chair of the review group stating that he:

"...recognised these concerns but added that the reality of the market may force the unit to dilute the purity of its academic position." (Hammersmith p6)

This shows the duality of market based arguments. The market could be utilised by a unit to support its case but there was also a danger in such a strategy for the same market based arguments could be turned back against the unit by the chair of the review group. The perceived danger of the market for prestige academic units can be clearly seen here. The weakness of a pure academic unit such as
the Hammersmith could easily be exploited and its neighbouring unit, Charing Cross, leapt at the opportunity:

“The Hammersmith may not have fully grasped the consequences of becoming a DGH within the market...the interdependencies that Charing Cross had built up in the area made them a strong player in the market.” (Charing Cross p5)

Although the medics in the units were clearly aware of these arguments and frequently alluded to them, it was noticeable that the managers involved (the chief executives and financial managers) were more likely to vocalise such arguments. There was a general awareness of what the market meant for individual units in terms of threats and opportunities. When this was translated into the implications for London as a whole, the potential the market had for forcing the pace of change was not underestimated:

“DHAs had not attempted to play units against each other yet, though clearly their view is that there are too many units at present. It was generally accepted that purchasers will be able to push for rationalisation.” (Guys p6)

There was a strong belief in the ability of purchasers to use the market to rationalise services. There was a marked split in the attitude of managers and doctors towards the market. The former were more likely to perceive the market as something positive that was driven by patient needs. The latter were more prone to see the market as a potential source of chaos. No one produced any evidence of the market’s capacity to do these things. In this sense, when individuals spoke about the market they were referring to something abstract: an
idea of the market. If we take Habermas’ distinction between the objective world, the social world and the subjective world, the abstract nature of the market becomes problematic because it was used by the speakers to justify their notion of changes to the objective world. Their perception of the market however was drawn from their subjective world experiences and from the social world of interpersonal relationships. This highlights the ways in which the market is socially embedded but was portrayed as something of the objective world. The importance of this characteristic of the market is that it then becomes a powerful argumentative device because it is seen to represent something about the world that has a claim to truth.

It is interesting to contrast the perceived role of the market with the perceived role of the renal review group. One of the main reasons for setting up the specialty review groups was to manage the market; to minimise the potential chaos the market could create. The group’s task in writing an independent review of renal services was to draw up a set of recommendations for future provision of services. Such an objective might be seen in terms of an exercise in traditional ‘rational’ planning but the realisation that such a plan would ultimately be tested in the market place meant that it would be impossible for the group to indulge in ‘classical planning’ in the face of market imperatives. This created an ambivalence in the minds of renal review group members and representatives in the units:

"[E] asked how the centre could ensure that the periphery retained their original function and did not expand their services to include transplant for example. [M] added that this was a crucial question for the London Implementation Group (LIG) because of the interface
between LIG’s planning role and the role of the market.”

(King’s p7)

This question was never resolved either within the group or outside it. From the point of view of the meetings with the renal units, what is interesting is that some clinicians in the units did see the review group as having the potential to counter the threat from the market:

“[L] argued that the breakdown of Regions contributed to planning blight and saw this exercise as an opportunity to reintroduce some planning.” (Guy’s p7)

These sentiments were echoed by those units who emphasised their research status and can be contrasted with the views of those units who were happier to see their future being determined by the market. To reconcile the review group’s planning role with the introduction of the market requires a perception of the group as an attempt to manage markets. The meetings with the units were settings for debates between powerful vested interests and the minutes of these meetings document the manner in which these vested interests were confronted with, and responded to, the prospect of the market. Whilst managers remained fairly silent during the debates on patient needs and the research status of units, seeing this as the domain of the medics, they were quick to engage in debates concerning the market. This reflects the extent to which managers saw discussions about ‘the market’ as part of their domain, somewhere where their expertise and knowledge could influence debate. The importance of this for my analysis is that managers contributed to debates by using ‘the market’ as a platform for strategic action. There were important differences in the way the market was interpreted by managers and doctors. Despite the fact that there was no clear understanding of what ‘the market’ stood for, the existence of ‘the
market' was not questioned because, however it was defined, the term had a social currency that allowed it to be used to support the agendas of particular groups.

5.2.3 Power and vested interests

The operation of power and the protection of vested interests was most visible in the way the review group addressed the future of academic units in relation to the restructuring of medical schools in London. In the South Western sector, medical school support played a crucial role in determining the choice of St George’s hospital over St Helier; so much so that the Dean of the medical school:

“...stated that the medical school did not believe that the academic developments could be centred on the St Helier site.” (St George’s p3)

In the North and the North East, the possible future configuration of medical schools and hospitals made the situation particularly complex. In order to facilitate decision making, the chair of the review group pressed at every meeting for a clear statement from medical school representatives on the units they planned to be linked with in the future. In light of this, the relationship between medical school representatives and the renal unit representatives was difficult to untangle. A medical school representative attending a meeting between the review group and a unit linked to the medical school may have given verbal support to that unit, knowing that the medical school’s future lay elsewhere. This meant that the chair of the review group found it difficult to tie the representatives down to a confirmatory statement at the formal meetings but
instead would opt for an agreement from the medical school to give a statement in writing:

"[G] agreed to provide a formal statement on [the] college’s position." (St Mary’s p9)

This strategy released the representatives from the difficult task of making statements in the presence of colleagues most likely to be affected by them, thus saving face, whilst at the same time tied them down to making a commitment to giving a written statement to the renal review group. This shows how the discussions with the renal units, whilst giving the appearance of free and open debate, contained layers of concealed views and hidden agendas. The strategy of the chair was to try to reveal the ‘true’ agendas of the actors involved, without causing or threatening the kind of embarrassment in front of colleagues that would result in such views becoming more difficult to gather. This meant that some negotiations and meetings were inevitably conducted outside the formal consultation process of the review. Between the review group’s members there was a recognition that discussion outside of the review group’s formal process would be necessary and that these discussions were vital if potential conflicts were to be defused:

"Requests had been made by medical bodies for prior sights of [the group’s] draft report; these would be refused, but it might be helpful to hold confidential discussion later." (minutes of internal review group meeting 1/4/93 p2)

This did not mean that all the group members approved of this. I was not party to these discussions but it was impossible not to be aware of this aspect of the
review process, as the chair would regularly update group members on the outside discussions he and others had been having. In this sense there was no concealment of a strategy to influence matters outside of the group. Given the nature of some of the discussions and the medical elites involved, it would have been surprising if this had not been happening. Relating this to the tension between understandings of power and the formal rules for an ideal speech situation, the compulsion not to speak openly in the debates often manifested itself in the form of self censorship by the powerful, who saw opportunities to indulge in forms of strategic action outside of the formal review process. This corresponds to Lukes' second face of power and, by acknowledging its importance and participating in its production, the review group members were compromising the character of the debates.

5.2.4 Conclusion

The minutes can be interpreted on a number of levels. They were primarily a means of documenting the meetings between the review group and the renal units. They were also a means of formalising discussion and agreements, ensuring a future model of renal services was accepted and minimising the possibility of any post-review report conflict. Although the meetings of the review group with units were presented as an opportunity for a fair, open and democratic debate on the issues, the exclusion of some groups and the conduct of negotiations outside the meetings meant that the impression of fairness and clarity of debate given in the minutes was illusory (see appendix 5.3). The idea of having gone through the process of consulting the units and allowing them to have their say could be seen more as a cathartic exercise than an attempt to open debate. On the other hand, the entrenched institutional and professional loyalties of unit representatives also stifled any discussion of service need. The
combination of these forces meant that the desire to minimise conflict acted to dampen debate.

5.3 The renal review group working meetings

This section interrogates the tapes of the review group working meetings held at the Department of Health. All of the review group members attended the meetings and a number of finance managers, researchers and academics also attended to give specialist advice. Apart from the chair (T) individuals are only identified by a code representing their status (C=Clinician, M=Manager, A=Academic, N=Nurse), a full list of codes and transcript symbols is given in appendix 5.1. In some parts of the analysis I present quotations from the transcribed tapes in conjunction with the relevant extracts from the minutes of the meetings; the tapes are printed in ordinary font whilst minutes are printed in italic. This allows me to contrast the discussions of the group with the formal record and to throw light on how the discussions were used to manufacture a coherent plan of future services.

5.3.1 A model for renal services

As we have seen, the group's brief was to come up with a model of future renal service provision across London. This was being done against a backdrop of expectations of considerable rationalisation in the capital and considerable uncertainty as to the effect of health care markets in the future. The group's chairman was therefore concerned that the model the group came up with was acceptable to as many people as possible, particularly the clinicians, some of whom could possibly lose their power base because of it. It is therefore
significant that at only the second internal meeting of the review group, before the review process had been undertaken, the minutes concluded with the following statement:

"Preliminary conclusions on tertiary centres

The Steering Group noted that London fell naturally into five sectors. In the South East, the merger of Guy's and St Thomas' was already agreed, and the Group considered that this unit's strength left King's as a weak contender for renal services in this sector. In the North East the Royal London, perhaps merged with Bart's was the obvious site. In the South West, there was only one academic unit - St George's - despite the wish of St Helier for separation. St George's strength as a cardiac unit made it the obvious choice for renal services. In the North/centre, University College Middlesex had the best academic and scientific base in London. In the West, Hammersmith too was the outstanding performer. The Chairman reported that this overview was consistent with the emerging views of the Cardiac and Neurosciences group."

(internal review group meeting 1st April 1993)

This extract highlights a number of important points. Firstly, it shows how the planning process of the review was constrained from the outset by the concept of five geographical sectors for London's specialist health services. Secondly, it demonstrates the extent to which the possible recommendations of other review group's (Cardiac and Neurosciences) influenced the decision making processes of the renal review. Thirdly, and most importantly, it shows that not only was the model for future provision agreed by the review group from the outset, but the five specialist centres were also identified very clearly. The above statement

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is almost identical to the final recommendations of the review group report. This suggests that the review process itself was less a means of arriving at a set of health care decisions and more a means of legitimising decisions that had, more or less, already been taken.

Getting agreement on the proposed model as early as possible formed the foundation of the review Chair’s strategy. This meant ensuring all the group members were committed to the proposed model and there was no likelihood of dissent at any part of the process (particularly when group members were visiting units). From the transcribed tapes of the same meeting it is possible to see the importance given to this:

T  “Now I, I, I, don’t want to end up within the group with conflict on this issue that would mean chaos really and I, I, I think we need just to have it out so that people understand what we’re talking about and if anybody has questions or views let’s have them now.”

The chair made it clear that the group was free to, and indeed should, debate the relative merits of the different units, but there had to be a commitment to the model from the outset. The operation of power is clear here and the tone of the statement implies disapproval of any questioning, doubt or scepticism as far as the model is concerned. This does not mean that individuals could not voice doubts within the group, but it clearly meant that those doubts could no longer be openly and formally expressed as part of the review group’s dealing with the units. The fullness of the participation of review group members in the debate was thus immediately placed in jeopardy. Indeed, it was difficult for anyone to raise questions or proposals concerning the model subsequent to this event. The
freedom of members to question any proposal or introduce any proposal into the discourse was constrained by the chair’s statement.

The proposed model focused on five teaching units based in central units with autonomous non-teaching units on the periphery of the Thames Regions, and smaller units in between providing basic dialysis care. The group spent a good deal of time and energy discussing how these different types of units could be described in the model and a whole host of terms including secondary, tertiary, teaching, primary, satellite were used, discarded and returned to again and again.

T  "I think if we were just to say autonomous centres and centres which look to other centres, somewhere else for support, that might be sufficient."
C5  "The use of the word secondary and tertiary confuses it rather. We must use secondary, if we use it at all, for those centres which have two to three nephrologists able to do the work."
T  "Looking at this green book here M2 you’ve got a facility for words, what term should we use?"
M2  "I must admit I’m still a little unclear about what we’re griping at with autonomous and secondary so I’m not yet in a position to do the words."
T  "Well can I reiterate then. An autonomous centre is one which carries out all the foreseeable functions a nephrology centre should carry out with one exception and that is transplantation."
M2  "Got that."
C4  "I would call that a secondary centre."
C2  "Can I just say that we’d prefer not primary because of its connotations with primary care."
M2  “So we’ve got autonomous centres which,”
T   “We’ve got University centres.”
M2  “Oh sorry yes right, the University centres, then autonomous
    centres which have full scale nephrologist cover on site.”
T   “Why can’t we just call them nephrology centres?”
M2  “OK and they do all the things you’d expect a nephrological
    centre to do except transplants. I, I, I, can grasp that, Emmm
    ...(1.5) I’m not sure I like the lesser centres.”
C5  “Well I,”
C2  “We used to call them subsidiary centres but ehmm,”
M2  “Hence the word satellite or is satellite one yet again?”
T   “No, satellite might cover it. It has different connotations
    which is helpful...”

These debates were often quite frustrating for those involved, and sometimes
bordered on the farcical, but the semantics involved were a crucial part of the
group’s work. Using the three phases of depth hermeneutics it is important to
remind ourselves of the social context for these debates. Specialist services in
London were under pressure to rationalise because of oversupply, uncoordinated
supply and poorly planned supply. If these criticisms were to be addressed, then
inevitably some prestigious teaching centres would be under threat. The model
for future renal services proposed by the group had to make a distinction
between the teaching centres that would survive the shake up, and those centres
that could no longer be described as teaching centres. There was also a need to
identify the continuing function of these non-teaching centres (assuming the
hospitals themselves did not close). Finally, in line with the perceived need to
expand services into geographic areas where people were not receiving
treatment, the idea of smaller units had to be clearly defined. Against the
background of trying to reconcile competing claims of increasing provision to
meet unmet need, the need to preserve teaching centres and the need to rationalise services; the importance of agreeing clear definitions of services becomes apparent.

The definitional problems seem to centre on the need to distinguish between units in a hierarchical sense without introducing terms that could be construed as demeaning to a unit. Terms such as 'secondary', 'subsidiary' and 'lesser' were introduced but were clearly unacceptable. Here we see a sensitivity to the cultural consequences of changes in service levels. The importance of this nomenclature becomes apparent if we consider its possible effects on the responses by London's renal physicians to the review group's proposed changes.

In analysing the tape extract, it is significant that the discussion was mainly conducted between the chair of the group and one of the managers on the group. The contributions of other members were peripheral to the main thrust of this debate, which was to instil in all group members, but particularly managers, a commitment to a three tiered hierarchy of renal units. A look at how this debate was recorded in the minutes of the meeting shows how this commitment was formalised:

"It was agreed that there were three levels of renal unit:

University transplant centre - the five London centres already tentatively identified, providing all renal services

Autonomous renal unit - having resident nephrologist(s) and substantially all services except transplantation"
Satellite unit - linked to one of the higher units providing routine dialysis and outpatient clinics as needed.”

(Internal review group meeting 1st April 1993)

The apparent ambivalence of the manager in the taped extract towards the distinction between the words ‘autonomous, ‘secondary’ and ‘satellite’ reflects an overall ambivalence towards the construction of a ‘blueprint’ for London’s services. The minutes gave these concepts a clarity and legitimacy that was missing from the debates. The construction of an elegant model for future services does not therefore appear to have arisen from the review group’s work. Instead its genesis was external to the review and it was brought to the group for confirmation by the Chair.

In many respects, apart from the siting of the five teaching centres, the group shied away from specifying where other smaller units should be sited and although the group discussed possible sites for smaller units, the large units themselves were encouraged to come up with solutions to this problem. This issue was brought up when the group visited different units, but the issue was also discussed outside official group meetings between the clinicians on the group and the clinicians in the units.

T “now Canterbury, I have debated that with the Guy’s unit already and they feel that it is probably, despite its apparent geographical isolation, probably a place where further developments could take place, it’s already a fully established service of course.”

It is interesting to note that Canterbury is seen as ‘geographically isolated’, perhaps reflecting the London focus of the review rather than an understanding
of the geographical location of Canterbury. In addition, the passage gives an indication of the extent to which the units outside London came under (or at least was seen to be under) the sphere of influence of London’s clinicians. The statement hints at the kind of informal negotiations that were being carried on outside the group, but also highlights the Chair’s concern to keep group members informed of what was going on and to bring these issues back to the group for confirmation. There may have been instances where the Chair chose not to inform the group of certain discussions, but his strategy at all times was to ensure that the final report had the full agreement of group members. Making group members feel that they were engaged in all debates was an important part of this strategy. This could be interpreted as a search for consensus, but the need to placate those who were excluded from these behind the scenes negotiations was also a factor. Some of course were not placated, and my notes of these meetings indicate that there were instances where individuals voiced, in private, some concerns about the nature of informal discussion. There was a clear division between doctors and managers in this respect, with both set of stakeholders engaging in outside discussions among their own peers. Academics, nurses and patient representatives were, in the main, excluded from this and in informal discussions would frequently question the process, often taking the opportunity to make jokes about their ‘subordinate role’ or the deliberations of the ‘great and the good’. Many of the discussions held within the group therefore may have appeared to be open and democratic and of being oriented towards understanding, but exclusions (most notably of renal patients) and restrictions within the group itself, ensured that the debates were ‘closed’, undemocratic and oriented towards strategic action. The basic membership of the group should remind us that it is easier to maintain the illusion of openness where the possibility of challenge and conflict is minimised.
5.3.2 *Definition of need*

The group had built up a picture of need based on the figure of 80 new patients per million population per annum and found considerable geographic variations in access to services depending on age, ethnicity and proximity to services (see chapter 4). This prompted considerable debate among group members as to how the 'unmet need' and the inequity that they had identified could be addressed, and whether they could relate this to other debates they were having about the cost and cost effectiveness of renal services, the balance between population needs and the need to protect academic interests:

A1 "There's one other thing which is a long term issue which we perhaps come to, there's evidence that the more renal units you have the higher the referral rate becomes.

(Laughter)

I mean one of the things, although the London system is by no means planned, it is a highly effective safety valve or rationing device because centres are so relatively inaccessible and poorly sited and we have, ehm, people have to realise that one of the consequences of Tomlinson renal service distribution is going to be much greater pressure on GPs and General Physicians, now whether that 'you ain't seen nothing yet' could be one motto they have to warn people that they are, that from decentralising provision in other countries, it does lead to much greater problems of high extra demand, you've been able to keep a lid on expansion by reminding Guy's, Barts and the London to provide a service so ehm,"
"But it's so unequal you see South West Thames and North East Thames, North West Thames and South East it's very low."

"Well that's their problem isn't it."

"No, No, after all there are people there. I mean we know from our studies, eh, that somewhere between 70 and 80 new patients a year would be produced from the population that is there. So we have to plan for the population that's there, not what it has come to before, and eh, moving the sites is not going to reduce the patients, they're there, they're not imaginary."

"Yes that's a nice way of putting it."

This excerpt reveals a tension between the resource implications of defining 'need' at levels above those being met by present services and the moral implications of people not receiving care they 'need' because of geographic inequity. The statement referring to the levels of services provision under the existing London system as an 'effective safety valve' is important because it highlights the dilemmas arising from calls to make the system more responsive to need when by being unresponsive the system had functioned efficiently as a rationing device. Thus the conflicts between a government policy aimed at meeting needs and government policy aimed at controlling public expenditure are thrown into stark relief. Although the group never resolved the conflict between limited resources and unmet need (they would return to this issue on a number of occasions), the baseline need figure of 80 new patients per million served as an ultimate appeal to an absolute level of need in the case of disputes. The clinicians on the group focused on the inequity of provision and the unmet need that the epidemiological work had highlighted. There seemed to be two factors at work here: a genuine concern that people were not receiving treatment
and were therefore dying unnecessarily and an opportunity to focus on arguments for an expansion in service provision as a balance to the Tomlinson report's drive for rationalisation. There were concerns however that the idea of 'unmet need' could represent a moveable feast characterised by regular shifts in the threshold for need. Clearly these ideas were underpinned by the concept of infinite demand and there was some suspicion as to the absolute nature of the clinician's figure of 80 new patients per million per year. Nevertheless, the epidemiological arguments held sway.

Discourse analysis suggests that the academic here (A1) was trying to introduce a proposal into the group's discussion; that of rationing by means of controlling the quantity of supply, the location of supply and public expectations. The laughter from group members following the academic's first statement is a sign that they were aware of these issues. It is interesting that the managers present did not follow the academic's lead and challenge the implicit assumption that services needed to expand. The clinicians on the group on the other hand were quick to respond by claiming the moral high ground of 'unmet need'. Not only does this emphasise the importance given to the epidemiological definition of need, but more importantly we see that the ownership of the definition was clearly in the medical domain and was very difficult to challenge. This is apparent in the way the debate appears to abate after C5's somewhat crude summary of the epidemiological evidence. What seems to evolve from this analysis is the idea of a medical paradigm of need that acts as a major controlling mechanism for the group's debates. This paradigm of need can be related to Habermas' three stage validity analysis where the validity of a statement is justified by claims of truth (concerning the objective world), claims of rightness (concerning the shared world) or claims of truthfulness (concerning the subjective world). The definition of need seemed to be presented as a claim to truth (saying something about the objective world). However, the academic on
the group revealed the subjective elements to the definition of need. It is clearly a social construct and is concerned with the shared world. It is a normative claim that can be challenged and defended on a number of levels. The lack of debate concerning this paradigm of need, together with its apparent use as an objective claim to truth, suggests that it possessed a social currency that allowed the clinicians on the group to avoid having to justify its validity.

5.3.3 Economic arguments (costs)

The group spent a considerable amount of time discussing the costs of renal replacement therapy. Part of this discussion focused on patient transport costs. There was concern, particularly among the clinicians on the group that patient travel times were not only a cost to patients themselves but a drain on NHS resources:

T "That’s 90 minutes a day, three times a week and that’s just travelling time let alone the waiting time, so you are looking at very large costs. How can we get at that M2 have you any idea?"

M2 "I don’t think we should."

T "Eh, right OK."

M2 "I think our job, is certainly to take a view on the proper level of accessibility and it may well be that our view is that many places are unacceptably inaccessible, if you see what I mean, ehm but having done that the principle in the rules of the game is that patients find their way to reasonably accessible units and that’s their affair. There are costs of course for people who can’t, you know, there
are special you know low income provision and all that sort of thing.”

T  "So we don’t, I mean you could take, do have to point out the cost of not having satellite units. I mean there is a profound negative cost in having sixty percent of your maintenance patients travelling by hospital car or ambulance.”

C8  "It could be quite important. I would really say if we’re actually saying we’re going to have more elderly patients on dialysis, one model is to have more hospital based dialysis that’s accessible. It’s going to be such an NHS transport cost if the elderly are actually going to require an ambulance or a hospital car to get up two or three times a week.”

M2  “Ehm, where there is an inescapable cost on the NHS then we should be taking account of it but I don’t think, eh we should not be doing some macro department of transport style, you know we saved the van driver four minutes at the by-pass.”

T  "Right, yes fine.”

N  "Just to say though that over the years the transport costs have gone up of course. Because of the elderly patient because technology’s improved, we’re treating more sick people who can’t make it under their own steam. So if we’re saying that the population is going to increase, is going to double over the next seven years, so will transport costs.”
This interchange reveals some tension within the group as to the extent of its remit. Managers were conscious of their need to ensure that the group kept to a prescribed task and did not stray too far away from its main aims. The short time scale for the group's work was often cited to back this up. In discussing transport costs there was a danger that the group became too involved in the wider social implications of their investigations. The argument that the group should only concentrate on NHS costs was therefore strongly pushed by the managers on the group at this point. Relating this to the aims of the group, one of which was to assess patient needs, it is clear that managers may have been content to accept a medicalised definition of need but were opposed to any attempt to broaden the analysis of needs and quickly stifled any thoughts of looking at the impact of travel costs on individual patients.

The manager on this debate emphasised the role of taking a view on the 'proper level of accessibility'. This suggests that the role of the group as one of 'taking a view' on matters, recording the wisdom of the 'great and the good' or documenting the opinions of elites was acceptable to managers. They were however less comfortable with the notion of the group becoming enthusiastic about its remit and looking at the evidence for needs in greater detail, particularly when this seemed to involve straying into the territory beyond the immediate responsibility of the health service. The managers were therefore keen to set limits to the concept of 'accessibility' used by the group. Their success in doing this stems, in part, from the inadequate basis for discussing the relationship between 'need' and 'access'. Without a clear understanding of how these issues should be discussed they were subject to the problems of contrasting and conflicting definitions. In other words the framework for debate was sufficiently malleable to allow managers to renege on the concept of accessibility. In response to the manager's statement, the clinicians seemed to modify their approach to set out the impact of an increasingly elderly population,
that is remote from service centres, on direct health service costs such as hospital cars and ambulances. This was then re-interpreted by the manager in terms of looking at 'inescapable costs' to the NHS. This reveals the ways in which costs and needs can be captured by the perspective of the actors discussing them. Given their brief, the managers were right to remind the group that this was a review of health services. However the distinction between health service and non-health service costs becomes blurred when the kind of issues raised by the nurse in the debate are considered. It is this blurring that the managers on the group wished to avoid. Nevertheless the review did estimate that savings of about £550,000 would accrue from providing satellite units closer to patients and that these savings would "rise to between £1.6 million and £1.8 million for a full steady state haemodialysis population", (Renal Review Report, Appendix D page13).

The clinicians, managers and academics on the group found it more difficult to resolve the contentious issue of the cost-effectiveness of renal services. This was due to the clinicians on the group contesting the view that CAPD was more cost-effective than hospital haemodialysis.

A1 "Well, yeh I mean, unless we understated the full cost of CAPD and I understand some studies did then obviously ...we're talking about a very much less cost-effective service at the margin and that is something, I mean although you said that quality wasn't an issue for the group I mean cost-effectiveness is something some of the purchasers are going to be concerned about. I mean we may not have the perfect set of research studies unfortunately but the existing literature is very very clear that if people have the choice then of course CAPD is
being pursued at a national level but it happens for a wide spectrum of patients to be more cost-effective that’s not to say it’s ideal for any one individual patient but at a service level because of the differences in cost...

C7  “No, I think the costs are narrowing because people are aware that in fact it isn’t cheaper and in fact what wasn’t being costed before is now being costed.”

T  “The hidden costs are coming out.”

C7  “The hidden costs are coming out and I think the fact is as we mentioned earlier, you can’t have a CAPD programme without having a haemodialysis back up. It’s not possible.”

The clinicians were not disputing the theoretical basis to the use of cost-effectiveness analysis in health care, rather they were questioning the technical basis for the cost-effectiveness studies that had been undertaken in the past. They were in fact keen to get good cost-effectiveness data into the report but clearly this had to be done on their terms. Their terms included a severe criticism of previous cost comparisons of different treatment options and an insistence that the interdependence of different forms of treatment be given more recognition in cost calculations. The debate reveals some of the tensions and conflicts between a national policy of promoting CAPD as a treatment option, individual patient needs and a need to maintain ‘viable’ renal replacement therapy units. The clinician (C7) was making an important point about the weakness of previous economic evaluations, but the opportunity to widen the debate to consider the appropriate balance of treatment options to meet patient needs was lost by the urgency of the need to criticise cost calculations. It is here that the strength of the clinicians on the group is most apparent for they were able to direct the debates concerning the cost of renal services. Managers were
largely passive, leaving the discussions to the academics involved. Given that these discussions dealt with the factors that could determine the cost and structure of future services this is initially surprising, but it became increasingly apparent that the managers on the group were more concerned with controlling the working parameters and ensuring the group kept to the timetable for producing a report. They seemed to have a jaded attitude to the review and they often betrayed a sense of scepticism towards the planning process, seeing it as somewhat passé in the brave new world of purchasing and contracting. This is not to say that they failed to engage in the issues being considered by the group. Rather they seemed to see their role as one of keeping the groups discussions ‘on the right track’. This being to produce proposals that conformed with the agendas for rationalising services in London. One of the ways in which they tried to do this was by reminding group members that the NHS now had a market.

5.3.4 Decision making criteria

Although the baseline need figure acted as a gold standard it was not the sole criteria used for planning services. The review was dealing with a large number of specialist teaching hospitals, and the preservation of teaching and research excellence in the face of the Tomlinson recommendations was an important consideration, particularly for the clinicians on the group. A dual basis for decision making was quickly established based on geographic need and academic excellence. This decision was not questioned by group members to any great extent and the managers on the group did not challenge the physicians in any way on this.

"I should say this is unique to our specialty at the moment there’s an opportunity because renal disease is historically a
very academic specialty in medicine over many years much longer than renal replacement therapy has been around and of course it is now re-emerging with one of the major chairs in medicine going to a nephrologist, we are therefore going to be left with five centres picked on geographical and academic excellence, which we can look at fairly carefully, and I think that’s not too difficult in the end I think to justify.”

This statement reveals the chair’s strategy of appealing to the academic status of renal medicine to buttress the decision making criteria of the review group. The clear intention was to provide a cement for the legitimacy of the geographical and academic approach by reference to the elite status of a powerful medical specialty. There was however an additional facet to this strategy and that was the need to move away from need based arguments (concerning the formation of the model for renal services) to arguments about academic excellence (determining the choice of specialist units).

It is interesting to examine the above statement, made by the Chair of the group, in the context of what was agreed at the group’s meeting to discuss the research status of the units. The minutes of the meeting begin by stating:

“The main principle guiding the renal review is that of population need. However, the need to take account of the academic profile of London units was particularly important for renal units.”

(Research meeting p1)

Following this statement, the whole of the meeting was then dedicated to discussing the relative academic merits of each London unit on a sector by sector
basis. Once the issue became one of deciding the future of individual units, then ‘epidemiological need’ gave way to arguments about academic excellence. The criteria for assessing academic excellence relied on the value judgements of the individuals involved in the research meeting. These included research advisors from the Wellcome Trust, the Medical Research Council and the University of Cambridge. They were asked to discuss, in turn, the five geographic sectors of London. Their views on the academic status of units were to be based on publication records, grant records, scores in the UFC grading exercise and their own subjective estimate of a unit’s position relative to others. The need for sensitivity and secrecy was a notable feature of these discussions, as was the barely concealed loyalty of some group members to units with whom they had historical links.

The debates concerning the North Western sector are interesting because they focused on the choice between the Hammersmith (a centre of academic excellence) and the Charing Cross (a centre with an impressive record of service quality). The group considered a compromise of a split site option keeping the Hammersmith and the Charing Cross units open. This was questioned by the academic advisers:

"[A2] believed that a split site option with academic activity at RPMS [The Hammersmith] and clinical activity at Charing Cross would cause difficulties (‘separating the brain from the body’)." (research meeting p5)

This gives us an idea of how these issues were perceived by research advisors, particularly the distinction between a centre of academic excellence (the brain) and a unit with a high service workload and good quality (the body). It should not be surprising therefore to find the following view expressed:
"RPMS [Hammersmith] had several academics of international standing and a number of junior staff who had the potential to be so. The academic arguments were therefore 'cut and dried'"

(research meeting p4)

Given the force with which these arguments were made, and the emphasis given by the Chair of the group to the views of the academic advisors, it is easier to understand the confidence expressed by T, in the quoted extract, in the group's ability to justify its decisions. The process was clearly not driven by a desire to develop shared understandings of decision making criteria. Rather it can be firmly placed in the realm of strategic action. The transparency of this strategy meant that group members became aware that this was an opportunity to influence the decision making process, if they so wished.

At this point it is important to note that justifying decisions is not the same as ensuring their implementation. This may help to account for the lack of management involvement in this debate. They were aware that the likelihood of implementation of the review group's recommendations would be largely governed by the tension between the central government's response and the developing market in health care. The five centres were to be based in five geographic sectors that had been conceived in the Tomlinson report. What is interesting is that no one questioned the reasoning behind the geography of these sectors. They were accepted as a given. This highlights the way in which central government, was able to influence the direction the group took, by fixing its parameters from the outset. In a sense, the independence of the group meant that it was caught between the demands of central government and the demands of the medical elites in the units. Independent review bodies have, of course, been in similar situations in the past, but in trying to work within a traditional
rational planning framework the group found that it had to cope with the additional problem of the uncertainties that markets were now introducing.

5.3.5 Markets

The group focused on trying to reconcile a rational planning process with the introduction of markets. Markets were seen by some as having positive benefits, others focused on the fragmentary qualities of markets and the dangers this entailed for providing a consistent service. These concerns developed into attempts to identify ways of managing markets and controlling their negative consequences:

C3 “That's a very important part of all of this set up isn't it that if they suddenly fragment the purchasers you could easily end up with black holes round the place.”

M2 “Well I suspect that even if there were fragmentation, there isn't any but if there were to be, I think arrangements could be made.”

The clinicians were therefore prone to be more sceptical of the market, seeing it as having a destabilising potential whilst the managers were eager to dispel these fears. They were unhappy with any view of the market as having a disruptive effect and were eager to highlight that the market could be managed:

M1 “I think that relates to some of the issues around trying to understand what marketing means now which isn't necessarily the cut and thrust of the street market but more the John Lewis, Marks and Spencer examples where you have a preferred provider, supplier and you do develop
with that person a particular relationship. You look at venture revenue and venture capital together because that reduces your overall purchasing costs...I think that there will be a fragility in this market for a long time to come, but if we develop preferred provider models it actually allows both sides of the organisation to win something out of it."

The managers clearly saw themselves as having the role of legitimising the market. They were at pains to persuade the more sceptical clinicians on the group that a raw aggressive market was not going to be unleashed, and that they had the theoretical and practical capacity to manage the market. Such a strategy relied heavily on persuasion using rhetoric that was immersed in the technical language of quasi-markets. It is important to recognise the capacity of this technical language to form the foundations for a strategy of deception. The idea that certain models of the market can allow 'both sides to win' is clearly part of the rhetoric of markets. In addition the manager quoted above was referring to an imaginary market lying somewhere in the future, but in tones that imply that its arrival was imminent. This bore no relation to the existing conditions in London. The aim appeared to be to build a picture of a market that was controllable provided the knowledge base of the managers was adhered to. There is clearly a measure of deception at work here. Whilst open in support of the market, their approach contained elements of concealed strategic action which involved some conscious deception (in persuading the clinicians that they had the situation under control) and unconscious deception (in convincing themselves of the aims of their speech acts). Self deception comes about through the creation of a collage of terms and ideas such as 'preferred provider models', 'venture revenue' and 'market fragility' that gloss over the more immediate concerns of what the market is capable of in terms of hospital closure.
Through the build up of layer upon layer of jargon, eventually the self deception is complete and can be seen in the managers attempts to establish that they had frameworks for evaluating the impact of the market on service provision and patient care:

M1 “one establishes a corporate contract with Region...so there is an actual framework and then in fact one has to use various efficiency or other terminology to find a way which can demonstrate you’ve improved local health care year on year.”

This is an interesting choice of words, for it suggests that what matters here is not so much the real effect of changes on service provision, but the ability to construct a language that can demonstrate improvements in health care. This aspect of the renal review group’s debates began to create a confusion in my mind as to whether managers were concerned with the ability of the market to address health care needs, or more concerned with the creation of a new technical discourse that of itself would demonstrate the beneficial effects of the market. It is here that the dangers of combining the rhetoric of need with the ideology of the market should become apparent. ‘Improving health care’ is not the goal in the above statement. The goal is the construction of a set of codes that are then accepted by professional groupings to signify improvements in health care. Relating this to Habermas’ view that engaging in discourse assumes the validity of the discourse act, what is at stake is the extent to which the kind of discourse shown above is able to colonise the speech acts of decision makers to such an extent that it becomes impossible to distinguish between debates concerning ‘real’ needs and debates that are infused with an ideology that uses the discourse of needs for other purposes. For Habermas, “practical discourse is a procedure for testing the validity of hypothetical norms not for
producing justified norms" (p122 Habermas 1990). Clearly what the manager was aiming for in the above statement is a language which is believed to produce justified norms. The reliance of the group on an epidemiological framework for discussing needs made it easier for distortions like this to operate, but it is not clear whether the existence of a framework based on a comprehensive theory of need could have prevented them from operating. In light of this it is important to explore the ways in which managers could contribute to the legitimization of distortions through the creation of a parallel technical discourse based on markets. This is examined further in the analysis of contracts in chapter 6.

5.3.6 The role of the group

The issue of markets influenced the way the group members saw their role. The clinicians on the group were particularly concerned about this, and it is interesting to note that the managers on the group intervened in these discussions to try to reassure clinicians that what they were doing was worthwhile, and that the ambivalence between planning a service and the market was not a problem:

M2 "Can I offer, I think, something that might make you feel a little more comfortable about that. As one of the authors of working for patients, I don’t worry about that and I think the point is, or one of the points is, that we do not have a mature balanced market. Our job is first of all to put that in place instead of something unbalanced with literally twice as many centres as plainly there ought to be, so I don’t think you need feel embarrassed about planning the pre-market stage of all this."

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Once more the managers were engaged in giving the review group legitimacy in the face of market imperatives. The problem with renal services was not that there was too much provision, but that provision was in the wrong place and may even have been insufficient. The problem therefore was how to produce a massive restructuring of services. The contradiction was, if the market could not deliver such a structural change why was it being advocated as a solution? The chairman of the group saw such arguments as being crucial to how the group’s report would be implemented:

T “I have only one reservation about that and that is where one writes the report and then goes away and if you’re not careful the report goes to one side and everyone goes their own sweet way ...and I think that it’s going to need a little bit more than, you know, a bag of chocolates, to pin it down you’d need a gun.”

The clinicians on the group were therefore voicing concerns about the extent to which writing a rational plan could be reconciled with a market. There was no doubt in their minds that if the review group’s report was to be implemented, then control mechanisms would need to be set up to keep the purchasers and providers committed to the plan. There was uncertainty as to who would ensure that such mechanisms would be set up and whether central government would want such mechanisms to exist. It was this uncertainty that affected the dynamics of the group, particularly the tensions between the interests of the doctors on the group and those of the managers. The manager (M2) described the group’s role as ‘planning the pre-market stage’. This implies that, provided the group set up something planned and well ‘balanced’, the market could be allowed to function. This can be contrasted with the Chair (T’s) concern with the danger that the plan could be by-passed by the market once the group’s work
was completed. The concerns about the market seemed to instigate a search for mechanisms that would protect and enforce the recommendations of the group in the face of market imperatives. This highlights the way in which group debates were based around positive and negative interpretations of markets. One interpretation saw the power of markets as a locus for change and the other interpretation searched for an alternative source of power to counteract the destructive qualities of the market. The group members were therefore struggling with different understandings of markets. These differences remained unresolved throughout the group’s lifetime and yet the group was able to function despite these difficulties. This reflects the capacity within the group to raise these issues without threatening a complete breakdown in communication. Individuals understood that there was no possibility of consensus nor was it likely that they could persuade others to change their opinions. In this sense there were elements of posturing in the statements of the managers and the clinicians involved. The fluidity of strategic action was an important characteristic of these debates, as actors used different types of strategic action depending on the issue being debated and their view of their relative power vis-à-vis other group members.

5.3.7 Protection of interests

The clinicians formed the most powerful interest on the group, managers had a particular dynamic with respect to the clinicians whilst the nurses, research staff and patient representative had much weaker roles. It is interesting however to note that the issue of nursing, particularly the poor standards of care across London led to conflicts of interest because a prestigious academic unit was singled out for criticism:
"At _____ for instance, which when we visited presented a very good report about the academic quality of the hospital and in fact went on about it at some length, but their nursing service was quite the worst I’ve ever seen."

The clinicians attempted to place this criticism in the context of poor nursing standards across the capital, but the unit was singled out on more than one occasion for its poor nursing standards. It was also significant that some members of the group had specific loyalties to this unit:

"This situation is not just confined to renal medicine. I mean I have had the occasion in cardiac recently to experience it, as someone from the inside, and there is a similar picture there I’m sure."

"I agree with you I agree with you."

"It isn’t just _____ to be fair."

"Oh no it’s not just ______."

This represented a mini crisis within the group as those who wished to see the future of this unit secured were forced to develop strategies to deflect the criticisms of the quality of services. There were considerable discussions within and outside the group to try to address this. The criticisms however could not be dismissed; in response to this the most powerful clinicians on the group began to argue that problems of service quality could be addressed but once a unit’s research capacity was lost it would be ‘lost forever’. Nevertheless, the nurse had clearly exposed a prestigious unit’s weakness in terms of service quality. This led one clinician to resort to appealing, as ‘someone from the inside’, that other specialties have similar problems, suggesting that he had access to privileged information. Once the nurse conceded this, the argument that this
problem was not specific to that unit was raised and an appeal to ‘fairness’ was made before the nurse conceded this point as well. This was clearly a strategy to deflect an argument based on evidence with arguments based on the intuitive knowledge of powerful individuals. This illustrates the sophisticated nature of the arguments employed to persuade some members of the group to conform in support of vested interests. It also reveals the nature of the forces that any attempt to place debates about need on a rational footing would have to contend with. This is as true for Doyal and Gough’s rules for ‘rational and democratic discussion of needs’ as for any other. The capacity of such forces to remain hidden from view, forming Lukes’ third face of power, even if Doyal and Gough’s rules were to be followed in future debates, should not be underestimated.

5.3.8 Outside pressures and influences

There were considerable outside pressures on the group ranging from the Department of Health’s concern to ensure that deadlines and its agenda were being adhered to, to the more wide ranging pressures of trying to plan an expansion in provision in the context of a British economy in decline:

T “you’ve got a country which is 50 billion in the red externally, 20 million internal deficit and you try to increase financial provision for a particular group of patients who immediately hit the headlines every day and how do you deal with this... well you really have to look at the cost-effectiveness of your programme whether you could bring costs down even below your present minimum. So I think cost-effectiveness is crucial to the expansion which we foreshadow clearly.”
This articulated the attempt by members of the group to anticipate the repercussions of their identifying gaps in service provision. They had to build a strategy for reconciling their highlighting 'unmet need', with the inevitable arguments about budgetary constraints. Placing the emphasis on cost-effectiveness was identified as one way of doing this. A major part of the group's strategy therefore was to anticipate any critiques of its report either from central government, purchasers, renal units or renal patient groups. Group members were acutely aware that the independence of the group did not mean that it was immune from the wider structural influences affecting the NHS as a whole. Here we see the danger of focusing too narrowly on the inter-relationships of group members, and the rationality of internal group debates, at the expense of external factors. The ways in which group debates could be tailored by exogenous factors are revealed, together with the importance of situating debates within a wider social and political context. The relationship between the balance of power within the group and external forces was not lost on its members who linked it with the question of accountability of the whole review process. One clinician on the group neatly linked these issues to the question of the accountability of the market:

C9  “if you now strip down to 5 units, they’re going to be very powerful, all powerful providers and you will have to find some way of balancing the authority and monopoly of those five provider services, or they will turn around and say well you take it and what choice will you have. And the choice I offer you is that you have to find ways of getting a much stronger voice for patients. It’s been notably absent in these few days the patient association not being here.”
Although the review group consulted with patient groups and had a patient association representative as a member, this consultation was restrictive and limited in scope. Clearly the review failed to engage in open and democratic debate with those actors most affected by its decisions. There was of course a trade off between the degree of openness and accountability that was possible, and the practical necessity of producing a report in a given time scale. Members of the group were not only aware of the problems of accountability, but were also concerned that the market was capable of reinforcing this lack of accountability. They were not however, able to translate this awareness into attempts to make the review process more open. The point being made by C9 had uncomfortable implications for the group’s work. Its failure to engage with patient representatives was being contrasted with the proposed creation of five very powerful centralised suppliers. This is an indication of the extent to which the membership of the group placed constraints on its discussion of health care needs and health service provision. The exclusion of patient groups, the medical dominance on the group and the gender bias of the group, all contributed towards the creation of specific parameters to the group’s debates. Habermas’ communicative ethics has provided the theoretical basis for exposing and analysing these exclusions and parameters. These parameters could be breached by individuals like C9 criticising the process of the review, but these criticisms could not develop sufficient momentum to deflect the review group from its main objective (be it conscious or unconscious), which was to justify the proposed model for future service provision. It is here that the group’s function as an agent of legitimacy becomes most apparent.
5.4 Conclusion

In this chapter I have interrogated the minutes and taped meetings of the renal review group, searching for discourses of power and relating them to my understanding of Habermas’ communicative ethics and Doyal and Gough’s rules for debating needs. It is clear that the debates of the review group were not open and democratic, but were constrained firstly by the exclusion of actors affected by the group’s decision and secondly by the operation of power, both within and outside the group. This latter constraint was manifested in the strategic action of group members and individuals outside the group. I have also related the dynamics of the review process to the presence of markets within the NHS. The limits to the review process were not a result of the health care markets, clearly previous independent reviews had suffered from similar limitations before the introduction of the market reforms. However, the existence of the market gave the review process another dimension which affected the relationship between different stakeholders. In particular, markets allowed managers to construct their own area of specialisation that had the capacity to constrain the already limited epidemiological approach to need constructed by the doctors. Before I can develop this theme to construct a general critique of UK health policy in relation to Doyal and Gough’s theory of need, I need to consider the operation of a market for renal services at the time of the renal review in more detail. This I do in the next chapter.
Appendix 5.1

Transcription symbols

(       )  untranscribable passage
(conflict)  guess at unclear utterance
(0.5)     silence in seconds
(...)      passage not transcribed
...        passage not included in quote
          _______ or [W]  Name deleted to preserve anonymity

Transcript markers

These markers appear before each passage of transcript as a guide to its origin.

T            Chair of group
M1,2...     Manager
C1,2...     Clinician
A1,2...     Academic
N1,2...     Nurse
Appendix 5.2

Review group timetable

22nd February 1993  Renal review group - working meeting (DoH)

26th March
(morning)  St Peters renal unit - Middlesex hospital
(afternoon)  St Bartholomew's hospital

29th March
(morning)  Guy's hospital
(afternoon)  Hammersmith hospital

31st March  Renal review group - working meeting (DoH)
1st April  Renal review group - working meeting (DoH)

8th April  Economic sub group meeting (DoH)

13th April  Royal Free hospital

14th April  Royal London hospital

15th April
(morning)  St George's hospital
(afternoon)  St Thomas' hospital

16th April
(morning)  St Mary's hospital
(afternoon)  Charing Cross hospital

19th April
(morning)  King's hospital
(afternoon)  St Helier's hospital

23/24/25th April  Renal review group working weekend

28th April  Academic sub-group meeting (DoH)

4th May-1st June  Sub group on epidemiology - working meetings and report writing - not taped or minuted.
Appendix 5.3

Worked example of analysis

After reading through my notes, transcribed tapes and official minutes I began constructing lists of key issues that arose out of this data. I worked with all three data sources side by side, referring from one source to another, checking for internal consistencies and for any contradictions in the data, making constant comparisons. One of the first key issues I came across was the discussion of the 'model' for future renal services. This was discussed in depth at the group's preliminary meeting at the Department of Health before going out to meet the units. My notes of the meeting (written up on the evening of the meeting) were prefaced by a summary of my impressions:

"The chair began the meeting with a detailed summary of his thinking to date. He used this as an opportunity to give a strong direction to the thinking of the group towards the pattern of future provision that appeared reasonable. There was no open dispute about the basic idea of rationalisation of services into larger units but there were clearly some concerns among group members. The chair was anxious to ensure that any prospect of a dispute within the review group itself was eliminated as soon as possible and demanded that any reservations be brought out into the open at this point. Although there clearly were still some reservations among group members their commitment to the model (at least in public) had to be assured."

These notes (which included comments made outside the meeting in tea breaks, in corridors etc.) show that I felt there was some scepticism about the model, but
there were formal and informal expressions of this scepticism. At the informal level, some managers on the group expressed doubts about the group’s ability to ‘deliver the goods’. They were impatient with the concerns of the chair and other clinicians on the group. On the other hand, some clinicians were uncomfortable with the idea of centralising services on large specialist sites. Comments like ‘how will it possibly work?’, ‘how can we make people agree to this?’ and ‘what about patient choice’, were common. These comments are characteristic of the language used in tea and lunch breaks.

In formal settings these concerns were modified. Concerns were voiced about ‘units being sited in areas where consultants ‘did not live’. There were worries about ‘the commitment consultants had to local populations’. Questions were asked about how the model could fit with what was termed ‘the geography’ of London. ‘How could hospital catchment areas fit with areas of population need?’ The chair responded to these concerns by stating that he was ‘comfortable’ with the idea of five large units within the M25 and there was a need for nephrologists to adapt and to become more committed to patient populations. He stated that the first concern of the review group must be to patients, something he said that had been missing in London for years. Following this the chair asked if the group could take the model of five large units in the conurbation as agreed and move on. Rather than openly questioning the model, the doctors on the group raised technical problems (the managers on the group were conspicuously silent at this point). The chair was impatient with some of the questioning that was starting to build up. Some members asked how autonomous centres outside the capital would be set up and who would take responsibility for this. The chair tried to emphasise that it was important to get the concept right first. Nevertheless, concerns about how such a model could be brought about, and what incentives would be used to implement it, were forcefully raised. These concerns seemed to register with the chair who noted
that the last thing he wanted was for the group’s recommendations to be ignored. This stimulated a discussion about the market and how the supply of service could be controlled when a market for health care was being developed. Group members were worried that if purchasers became fragmented and unable to buy services on a planned basis then large gaps in service provision could appear. Some expressed a feeling of ‘ambivalence’ between planning services and helping to introduce markets. It was at this point that the managers on the group began to intercede to address these concerns. They had been silent so far in debates on epidemiological need and on the nature of the model, but they were stimulated by questions of the role of the market in the process. Their response was to emphasise that the market for health care was ‘not yet mature’, and was in any case different to the ‘cut and thrust of everyday markets’. They seemed to be at pains to allay any fears group members might have had about their role and the role of the market.

The narrative set out above describes the long and protracted discussions the group engaged in about what the chair regarded as the ‘concept of a model for future services’. The minutes of this meeting however did not reflect these debates but rather stated:

“It was agreed that there were three levels of renal unit:
University transplant centre - the five London centres already tentatively identified, providing all renal services
Autonomous renal unit - having resident nephrologist(s) and substantially all services except transplantation
Satellite unit - linked to one of the higher units, providing routine dialysis and outpatient clinics as needed.”
This highlights the chair's concern that minutes were short summaries of final decisions and not full records of the debates. The minutes imply broad agreement and consensus on a seemingly clear and unambiguous concept, but my notes of this meeting showed that this was far from the case. Indeed, I had noted dissent and discontent with the model both within the meeting and outside it. Members raised concerns in public, not by openly challenging the model but by raising questions about other external factors that might cause problems for the model such as the geography of London, travel times to units and the pressures on consultants covering large populations. Outside the meeting more explicit objections to the model were raised, such as the potential reduction in choice as a consequence of centralisation on five sites. There were therefore public and private accounts of member's views on the model. These concerns were more than matched by comments made in meetings with the units. Here, my notes show there was agreement with the idea that transplantation should be rationalised onto fewer sites, but there were strong objections to other characteristics of the model, some anticipating the creation of very large and impersonal units (comments from St Bartholomew's) others seeing it as a means of protecting medical school interests (comments from St Helier).

Using the above narrative (and others like it) as a guide, I was able to identify at least three key issues from this part of the group's debates, (i) the model for future service provision, (ii) markets in health care and (iii) decision making criteria. I was able to build on these by looking at other debates the group had and by comparing the responses to these issues when the group visited the units. I was able to compare and contrast what had been said and how the key stakeholders involved approached these different issues. In this way, these key issues developed into a set of categories.
Moving into depth hermeneutics

In this next section I utilise depth hermeneutics to analyse the narratives I have outlined above.

1. **Social analysis**

*The level of action*

Historically, health services in London had not developed in the interests of patients. Renal services had expanded in the UK through the use of the comparatively cheaper treatment of CAPD. Provision in London was unequal and inconsistent and was facing the challenge of a growing elderly population and a complex ethnic mix. With these facts, and my own understanding of the historical and geopolitical context of the review in mind (see chapter 4), I reviewed my notes of review group meetings. I searched for instances where individuals had expressed (either formally or informally) their understanding of the context in which the group was working. I also identified notes I had made outlining my interpretation of other peoples understandings. I was able to refer from these notes to the corresponding minutes and tapes to confirm my understandings of statements made by different actors, and construct a richer picture of events.

Early in the group's work, doctors expressed their belief that this was an opportunity to demonstrate underprovision in renal services. They clearly understood however, that their brief was to produce a report that addressed the need for rationalisation of services. They were also acutely aware of, and to some extent encouraged, forces calling for the protection of the interests of the nephrologists in London (particularly academic renal interests).
In trying to reconcile government pressures for rationalisation of services with pressure to protect service interests, the question of identifying and legitimating unmet need was highly significant. The understanding of health care need was based on the epidemiological approach to needs assessment and this was given prominence by the doctors on the group, and fitted in with the advice of the NHS management executive (through the London Implementation Group).

At the beginning of the group’s discussion, the managers did not appear fully aware of the strength of arguments based on epidemiological need. It was not clear whether this was due to a lack of knowledge or a lack of faith in ‘needs assessment’. Informally managers expressed doubts about the ‘needs assessment’ aspect of the group’s work, but appeared willing to treat this as the realm of the doctors and academics. Their understanding was very much focused on the functional aspects of delivering a coherent report that fitted in with the governments overall plans for London. In the renal units, both doctors and patient representatives were clearly threatened by the review, but the process was also perceived as an opportunity to get views across to the government. I noted that there was however, some cynicism about the group’s independence and about its ultimate objectives. Similar sentiments emanated from within the group itself. Individuals clearly had a sophisticated awareness of the contradictions involved and were able to reconcile their own scepticism about the review process with the need to engage in that process.

The level of institution

Renal services in London had developed in an unplanned manner. The group had to negotiate with hospital management teams, hospital medical teams, powerful medical school interests and the Department of Health. The perceived threat of closure meant that individual units were in competition with each other.
The review of specialty services provided a focus for conflicting power interests and a platform for arguments to be rehearsed. In addressing the questions of the location of power relations therefore, I drew a distinction between power relations within the group and outside the group.

a) Within the group:

I structured my examination of the location of power relations within the group by adapting Alford's structural interest theory and Mitroff's stakeholders (Alford 1975, Mitroff 1983 - see chapter 3, 3.8.2). I identified the doctors on the group as (dominant interests), managers (challenging interests) and patient representatives/nurses (repressed interests).

b) Outside the group:

Sources of power that impinged on the review process were located at the Department of Health and the London Implementation Group, at the Regional Health Authorities, at District Health Authorities, at the hospitals and medical schools, renal patient groups, health campaigners, the media and the population at large. The interrelationship between these sources of power were complex. In the units for example, the existence of stakeholders and interest groups was clearly apparent in the different attitudes that doctors and managers had to the NHS management executive and the medical schools. Loyalties were often divided between unit and medical school or unit and the general management community.
The level of structure

The group was working within a structure that placed limits on its activities. There were time constraints, geographic parameters that had been laid down in the Tomlinson report and inter-relationships with other specialty reviews. Although the group was engaged in an 'independent review' of renal services, it was working to a brief set down by the Department of Health. In addition the chair of the group and the managers on the group set limits to the group's horizons particularly when it came to discussing needs and the model for future provision.

2. Discourse analysis

This section illustrates my use of discourse analysis in the three key areas of the model for service provision, markets in health care, and criteria for decision making.

(i) The model for future service provision

Level of narrative

Renal physicians, in general, were presented to the group (by the renal physicians on the group) as 'hard working, conscientious doctors'. The comparatively small amount of private work done by renal physicians was cited as evidence of their commitment to the NHS and to patients (surgeons based at two units were identified as being heavily involved in private practice and the clinicians on the group made it clear that they disapproved of this). Renal physicians were also described as individuals who were at the 'forefront of scientific medicine' (one
of the elite’s elites). Much of this was based on stories and anecdotes that may or may not have had a basis in fact. The importance of such narratives lay in the way they were used to legitimise doctors in the face of evidence that renal services were not serving the capital’s populations. In other words this state of affairs had come about despite the best intentions of the community of renal physicians. With respect to the model for future service provision the characterisation of renal physicians as people who placed the needs of patients uppermost may have had a basis in fact but this was being utilised to support a strategy that had more ambiguous aims. In this sense anecdotal evidence, derived from the enclosed shared world of renal physicians, was being used to support a truth claim.

*Level of argumentative structure*

Looking at the chains of reasoning in the argument over the model the chair stated early on that:

"London fell naturally into five sectors"

There were no clear arguments to support this. The concept of five sectors seemed to have been taken from the Tomlinson report and from directives from the Department of Health. There was no real debate about the relevance of this five sector approach to renal services. In addition, if as the chair had argued, that ‘the main loyalties of renal physicians were to the centre’, and that this had been to the detriment of patients (particularly the geographically remote patients), then further centralisation seemed to be contradictory. The use of the term ‘naturally’ therefore represents a form of strategic action, for it acts as a barrier to any attempt to question or debate the validity of the five sectors.
Level of syntactic structure

The group spent a long time discussing the differences between tertiary, secondary and satellite units:

T  “I think if we were just to say autonomous centres and centres which look to other centres, somewhere else for support, that might be sufficient.”

C5  “The use of the word secondary and tertiary confuses it rather. We must use secondary, if we use it at all, for those centres which have two to three nephrologists able to do the work.”

This extract shows how the group was able to discuss these matters in the abstract. The chair was always at pains that the ‘model’ should be agreed, and in this sense the concept of a model becomes all important. The use of the personal pronoun ‘we’, by both speakers, indicates a desire to achieve agreement as a group on the issue, and the clear understanding that this was the aim of the discussions. The issue then became less about individual units (e.g. Hammersmith versus Charing Cross) but the concept of a University Teaching Centre. Agreement over a concept helped to depersonalise the arguments. The importance given to the identification of ‘names’ to describe the types of unit involved can be seen in C5’s opposition to the use of secondary and tertiary. The wish to avoid any suggestion of a hierarchy in the naming system indicates the sensitivity of group members to the power relations that the group was addressing. This is however, a form of strategic action for the aim was to present an agreed abstract model to the unit, thus depersonalising the debate and minimising conflict.
Typologies for the model:

1. A 'rational' solution to the problem of need
2. A 'rational' response to external pressures
3. A constraint on the internal dynamics of the group
4. A way of depersonalising the issue of choosing between units.
5. An imposed solution.
7. A means of defending vested interests.

(ii) Markets in health care

Level of narrative

There was no clear understanding within the group of what the developing market in health care meant. Much of this stemmed from a lack of knowledge and uncertainty. The managers on the group were keen to dispel any characteristic of the market as 'bad', disruptive' or divisive'. Terms such as 'pure market' or 'street market' were used to cover the idea of markets as dangerous or threatening. In response, the managers used the term 'managed market'. They cited 'John Lewis' and Marks and Spencer' as examples of companies who controlled the excesses of the market. The idea of maintaining 'stable markets' was therefore very important, as was the idea that purchasers and providers could both win in circumstances of managed markets. The managers were engaged in strategic action to persuade the group that the 'market' would be beneficial, provided it was well managed. They were therefore striving for legitimacy at two levels; legitimacy for the emerging market in health care as a change for the better, and legitimacy for themselves as
a professional group who could deliver a well ‘managed market’. The arguments they employed to achieve this can be seen as strategic action incorporating conscious and unconscious deception. At the level of narrative, this is clear from appeals to examples such as ‘Marks and Spencer’ and references to involvement in the production of NHS documents on ‘good practice and innovation in contracts’ as evidence of specialised knowledge in this area.

**Level of argumentative structure**

The market was promoted by managers as something that would improve services, bring about efficiency and enhance consumer choice. In contrast to these arguments, the group’s task was to by-pass the mechanisms of the market and produce a comprehensive rational plan for London’s services. Many of the group’s members were uncomfortable with the contradictions that seemed to rise from this. This prompted the managers on the group to argue:

“...we do not have a mature balanced market. Our job is first of all to put that in place instead of something unbalanced...”

The group was not however creating a market out of nothing. After all, the market had been operating for two years prior to this. Clearly ‘the market’ was taken to mean different things at different times. The managers did not appear uncomfortable with the ambiguities involved. Not all the participants in this debate had access to the ‘knowledge’ of the managers on the group. Instead of sharing their knowledge of markets the managers seemed more concerned with deploying a smoke screen of jargon and rhetoric. This involved both conscious and unconscious deception in that managers were giving the impression of trying to engage in debate, whilst concealing the contradictory nature of their
arguments. The fluidity of their position is apparent when we consider the extent to which managers were deceiving themselves with these arguments.

*Level of syntactic structure*

The creation of a technical language by the managers and its use in a form of strategic action can be clearly seen in debates concerning the setting up of contracts for renal services, how these could deliver change and how they could be monitored:

one has to use various efficiency or other terminology to find a way which can demonstrate you’ve improved local health care year on year.”

The shift from the reciprocal pronoun at the beginning of this sentence to the personal pronoun is important because it gives an indication of how the manager views efficiency terminology (reciprocal and abstract) in relation to improvements in local health care (personal). The implication is that efficiency is an objective concept, about which truth claims can be made, whilst ‘demonstrating improvements in local health care’ is closer to the manager’s personal objectives. Here we see how the language of the market lends itself to a discourse that is removed from reality. The concerns expressed here are not with the impact of change on the ‘needs’ of patients, but with a discourse that legitimises the market, and the manager’s own position. This is a form of concealed strategic action that involves conscious and unconscious deception.
Typologies of the market:

1. A solution to structural problems
2. A threat to established interests
3. A managing mechanism
4. Owned by the managers
5. Containing its own discourse
6. Part of a strategy of concealment
7. The conflict between balance/stability and chaos/fragmentation

(iii) Decision making criteria

*Level of narrative*

The criteria for decision making had to be divorced from any hint of supporting vested interests. The chair and group members would continually refer to the basic criteria of ‘population need for renal replacement therapy’. The appeal to ‘need’ was very powerful and the basis for defining ‘population need’ was presented as ‘clear cut’. However, measures of ‘population need’ were not as objective or as ‘clear cut’ as the clinicians on the group appeared to suggest (see chapter 4 for my critique of population need). Despite group members being aware of these problems, epidemiological need was often used to support claims to truth, and this can be interpreted as a form of open strategic action.

The argument in favour of academic excellence was also claimed to be based on ‘objective criteria’. Group members however would introduce their own opinions, loyalties and prejudices into the decision making process using sweeping statements about ‘world centres of excellence’ referring to some
hospitals as being ‘not so hot’ and ‘academically off the wall’. Personal remarks were also made about clinicians in some of the units such as ‘you’ll have problems getting him to work with anyone’. Again it is difficult to untangle fact from fiction in these narratives. They were personal views based either on a claim to knowledge about academic excellence or stories about the personalities in the units under discussion. However, the weight given to these narratives in the group’s discussions cannot be underplayed. In this respect they were claims to rightness (concerning the shared world of physicians) and were used to buttress forms of strategic action.

*Level of argumentative structure*

The arguments used to support the group’s decisions seemed to contain a fundamental contradiction. Population need was always referred to as the main criteria for decision making but when final decisions were made, precedence seemed to be given to the research status of units. This was clearly seen in arguments about one unit that had received a very poor report on the quality of its service and the manner in which it addressed patient needs but was considered to be excellent in terms of teaching and research. My notes of this part of the debate record that one group member had strong loyalties to a particular unit and:

> “group members were very wary of upsetting him about anything to do with ____. It is clear that his presence was inhibiting any opportunity to criticise the unit.”

In this case the evidence on quality and need gave way to evidence on teaching and research. Any semblance of debate on this issue had collapsed in the face of open strategic action on the part of a powerful member of the group.
Needs based arguments were being used at a number of levels, but in appealing to 'needs' group members were able to depersonalise the debate concerning the choice of future units, and give the impression of 'objectivity', when in reality the debate was coloured by the personal 'subjective' preferences of individuals on the group. For example, this can be seen in the chair's repeated insistence that the 'main principle guiding the review is patient need'. Clearly patient need was an important principle but this was a rigid medical definition of need that excluded other paradigms of health care need, thus placing constraints on the debate. In addition, this medical definition of need lent itself easily to being used and discarded at points in the argument that suited the interest groups involved. It could be utilised in forms of strategic action as a claim to truth giving an objective gloss to subjective views. For example, one member who expressed strong loyalties towards a particular unit utilised medical need to argue that 'services should be expanded not cut', but dropped needs based arguments when it came to comparing the relative performance of units in addressing needs.

Typologies for decision making criteria:

1. Genuine appeals to need
2. Trade off between immediate patient needs and the long-term benefits of research.
3. 'Need' as a cloak for the arguments of vested interests
4. Contradictory nature of criteria
5. 'Need' as a source of spurious objectivity
3. Interpretation

The data relating to the 'model for future service provision' highlights the way decisions were prejudged by the chair of the group and yet the group's work was presented as resulting from an open debate of the issues. In this sense, the illusion of communicative action was being presented whilst key stakeholders (including the chair, renal physicians, and managers) were engaging in strategic action. There were tensions and conflict between group members, but these were not explicitly acknowledged or addressed. Instead, the dynamics of the group and the capacity of vested interests to use linguistic practices to further their interests, meant that the processes by which these tensions and conflicts were worked out were often concealed. One of the main ways in which this occurred was through appeals to 'need' and appeals to 'the market'. The model did not arise from the technical data on needs discussed by the group, rather this technical data was grafted onto a model that had already been formulated before the group met. In this sense, the task of the group was to produce a report that legitimise decisions that had been taken outside the group. The data on markets reveal the extent of confusion surrounding the term 'market', and how managers were able to develop a model of 'the market' using an emerging technical discourse. In this sense the managers were engaged in strategic action with the aim of persuading group members of the legitimacy of quasi-markets, and their own role in managing them. Finally, the data in the criteria for decision making suggests the ways in which needs based arguments could be utilised to give the impression of 'rationality' in decision making. By emphasising the pre-eminence of population needs whilst acting on criteria unrelated to need, the review group was engaging in a form of concealed strategic action. In this way, professionalised needs talk was able to cover a subjective and personalise debate in a veneer of objectivity.
Chapter 6

The contracting culture and health care needs

6.1 Introduction

This chapter sets out an analysis of contracts for renal services existing in a sample of health authorities in England at the time of the renal review. The extent to which contracts were based on understandings of health care needs is considered and the importance of the language of contracting is emphasised. The possibility that this language contributes towards the creation of barriers to open and democratic debate about needs is analysed, and the capacity contracts have for distorting the relationship between health care needs and health services is highlighted.

6.2 Evaluating contracts

In evaluating the extent to which contracts are based on need it is useful to distinguish between quasi-markets as ends in themselves and quasi-markets as means to other ends. Quasi-markets have been evaluated, to some extent, on the basis of well defined criteria such as their ability to increase productive efficiency, to improve responsiveness to users, to enhance consumer choice and to promote equity (Bartlett and Le Grand 1993). There are however, other aspects of quasi-markets such as their scope, how they are specified and defined and who defines them, which have important repercussions for any analysis of their basis in a theory of need. The language of contracting is an important feature in this respect, so that by examining what is included and excluded from contracts it may be possible to gain insights into the way markets are defined.
This can also allow an exploration of whether contracts, as texts, help to facilitate open and fair consideration of needs; or alternatively act as a constraint on discussions surrounding needs in that their framework predetermines a rigid and one-sided definition of human interests. The scope of quasi-markets (what aspects of services they cover, the extent and depth of that coverage) can often be found in how contracts are specified, the main negotiating points and the agreed method of monitoring contracts. Who defines a contract is important, for often the writers of contracts may not necessarily be those with the power to define the contracts. Untangling the relative influence of politicians, civil servants, managers, clinicians and users over the scope and definition of a contract should allow a better understanding of how markets are managed and to what extent health care needs influence their management and are in turn affected by the operation of the market. Where quasi-markets create an asymmetry of knowledge between providers and purchasers then contracts may become a battleground where the imbalance of knowledge is fought over.


I examined the service specifications for renal contracts that were in operation in England at the time of the renal review. Service specifications are the background documents that set out the content of a contract. In 1991/1992 contracting was at an early stage and advice to purchasers on how to draw up renal contracts was not yet available (NHSME 1993, DoH 1993). This meant that my sample of contracts was taken at a period when contracting mechanisms and processes were still in their infancy. The individuals who were engaged in drawing up contracts were taking part in processes that were new to the NHS and, given the timescales involved and levels of knowledge in existence, the contracts were at an early and unsophisticated stage in their evolution. The
Timing of this work is therefore important for it situates my analysis in a particular historical moment. Since the sample of contracts were written, contracting processes have developed and advanced. There have, for example, been attempts to contract for and plan changes to services in ways that involve the public more (Smith I 1994). It would be wrong therefore to assume that my analysis reflects the scope and character of renal contracts in present circumstances. However, the importance of analysing this sample of contracts lies in the ways they can be related to the work of the renal review group which was undertaken at the same time these contracts were being written and agreed.

I analysed the text of each contract looking for any common thread(s) to the contracts and those areas where contracts differed. The thrust of my analysis concentrated on what the contracts included and what they seemed to exclude. I distilled a set of analytical categories from the data in the contracts (see chapter 3) and use these as sub-headings for my analysis:

(i) The format of contracts
(ii) The use of need as a basis for contracts.
(iii) Contracts as a tool for change
(iv) Contracts as monitoring instruments
(v) Type of contract and costs
(vi) Specialised language

In the analysis that follows I use quotes from a number of the contracts to illustrate my arguments. I name the contracts these quotes came from but similar examples could be found in all of the contracts I analysed.
6.3.1 The format of contracts

There was considerable variation in the scope of contracts with some being extremely detailed, containing lengthy assessments of need and key indicators for monitoring quality and outcome, whilst others amounted to little more than statements of intent to purchase the services from the local provider or clinical overviews of the kinds of treatment a renal service should provide. Despite this, most contracts conformed to a common format summarised in table 6.1.

These sections comprise the basic skeleton of the contracts. I hope to show that within these sections there was considerable variation in the detail of what contracts covered but that also some contracts went considerably beyond this basic skeleton to cover areas such as strategic intent and commitments to or recommendations for change in the pattern of service provision. The variation in the detail and content of contracts reflects the early stage of an emerging contracting culture. Nevertheless, it was still possible to find within the contracts, linguistic and textual forms that are part of the ideology of quasi-markets. Inevitably some health authorities were further down the road towards developing detailed service specifications than others. Even at this early stage however, the common format of contracts suggested that standardisation (at least of contract headings) was taking root. This is important because the way in which characteristics of the contracts became accepted as standard forms can provide insights into the development of contracts as texts and mechanisms of control. In addition, deviation from standard forms can enhance our understanding of the way quasi-markets operate at local levels.
Table 6.1 Format of contracts

<table>
<thead>
<tr>
<th>Section Heading</th>
<th>Description of common contents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition of purchaser and provider</strong></td>
<td>The purchaser and provider would be named and in two contracts this was extended to provide the names of individual contract managers on the purchasing and providing side who had responsibility for the contract.</td>
</tr>
<tr>
<td><strong>Aims and Objectives of the service</strong></td>
<td>This section had a standard wording of aiming to provide a comprehensive and integrated service before listing, in detail, objectives such as accurate diagnosis, expertise, informed patient choice, skilled treatment and care, optimum access, health promotion and prevention and value for money.</td>
</tr>
<tr>
<td><strong>Population to be served</strong></td>
<td>The resident population to be served would be defined in terms of total figures, and who could refer. In four cases City and Hackney, Tower Hamlets, South East London Commissioning Agency and North West Thames Health Authority the population was described in more detail giving the proportion of elderly, ethnic groups together with deprivation scores.</td>
</tr>
<tr>
<td><strong>Service levels</strong></td>
<td>This section could vary from a simple statement of where services were to be sited to a detailed outline of staffing levels, ward size and equipment standards.</td>
</tr>
<tr>
<td><strong>Admission and Discharge procedures</strong></td>
<td>This would specify the differences between Acute Renal Failure, End Stage Renal Failure, Transplant and Dialysis patients. Referral procedures would be specified as well as standards for discharge.</td>
</tr>
<tr>
<td><strong>Quality and key indicators</strong></td>
<td>Most contracts referred to a general quality specification before listing in varying degrees of detail key indicators for renal services.</td>
</tr>
<tr>
<td><strong>Monitoring arrangements</strong></td>
<td>This section would outline the frequency of monitoring reports (monthly, quarterly or annually) and the responsibilities of the provider for providing these reports; state the right of the purchaser to have access to information and to make spot checks and outline the procedures to be enforced where standards were not being met.</td>
</tr>
<tr>
<td><strong>Contract type and price</strong></td>
<td>The contracts were varied from block, cost and volume to cost per case. In some contracts Acute Renal Failure was dealt with on a block basis whilst End Stage Renal failure was covered under a cost per case contract.</td>
</tr>
</tbody>
</table>

6.3.2 *The use of need as a basis for contracts.*

Need was most often referred to under the section dealing with the population to be served. Out of the 21 contracts, only 4 made explicit reference to the epidemiological estimate of need of 80 new renal patients per million population.
per annum (p.m.p.a.) The Bristol contract quoted 78 p.m.p.a comparing this to the present rate in the District of 38 p.m.p.a. and gave a target rate of 55 p.m.p.a. The South West Regional contract quoted a population need of 70-80 p.m.p.a. stressing that such figures were already being achieved in the South West of the Region but that there was a shortfall in the North East of the Region. The contract then made a general statement calling on purchasers in the North East to instigate changes that would address this geographical inequity. Contracts usually gave a figure for the resident population to be served, sometimes giving deprivation levels and numbers of elderly. Some, City and Hackney being a good example, highlighted large proportions of ethnic groups in the population and the effect this had on the demand for renal services. There was therefore considerable variation in the extent to which the contract specifications used available epidemiological knowledge to inform the use of need as a basis for service levels. Although the figure of 80 p.m.p.a was available in the literature at this time, clearly not every health authority was relying on it. This may have reflected a lack of access to available data or an unwillingness on the part of health authorities to make a formal commitment to the figure in the contract. If this is related to Doyal and Gough's rules for rational and democratic discussion of needs, then clearly most of the contracts were not reflecting the best available technical knowledge on needs. This theme will be developed in the section on contracts as monitoring instruments.

Some contracts contained philosophical statements which tended to appear under the section outlining the aims and objectives of the service. The City and Hackney health authority contract for example had a 'philosophy of care' which was:

"to encourage patient independence within the physical limitation of their age and disease process."
The use of such statements within the ‘aims and objectives’ of contracts is an important part of contracting discourse. These aims and objectives could, potentially, conflict with one another; for example, an objective to be ‘sensitive to patient needs’ and an objective ‘to support clinical research, education and training’. These two objectives could exist in tandem but on occasions they could come into conflict. The use of an idealised philosophy of care sets the contract on the path of constructing a ‘narrative’ that may or may not be an accurate description of the services patients receive. This is the fate of any set of aims and objectives. These statements should therefore be evaluated in relation to their basis in understandings of the goal of meeting needs.

The importance of the Hackney statement can be found in its links to theories of need that draw on concepts of autonomy and functional capabilities. It can be contrasted with the more ambivalent aims of the Greenwich contract which were:

"to enable patients to have as normal a lifestyle as possible"

(my italics)

The use of the word normal here is interesting. The intention may have been to refer to patient normality based on their lifestyle before renal disease. Alternatively the use of normality may have been linked to an understanding of what is normal for that particular patient group. Indeed a whole host of different interpretations could be applied to the term normal in this context. The link between normality and needs can be found in the ways in which health care needs are related to ‘normal’ human functionings and the process of defining and agreeing upon normal functionings. Clearly these complex issues cannot be addressed within a contract for the provision of services. The use of the term normal here therefore leaves all these questions open, outside the scope of the
contracts and subject to other processes beyond the realm of the contract narrative. This brings us to the question of what can be inferred from the wording of the contracts. It is difficult to grasp what assumptions were being made about the term ‘normal’ by the individuals involved in writing the Greenwich contract. An understanding of this would only be gleaned from speaking with the individuals concerned and becoming immersed in the local culture that underpinned the writing of the contract.

In the main, need was not addressed in any great detail. Instead the contracts seemed to concentrate on general statements about the thresholds for acceptance for renal replacement therapy. It is interesting that in Greenwich the starting point for the assessment of need and the setting of service levels for the contract was an analysis of historical patterns of provision. The contract recognised the limits of such an approach and commented about the need for the Regional Health Authority to maintain its strategic planning role. Despite this the contract maintained a conservative attitude to patient needs with the emphasis on maintaining the status quo and keeping rationing implicit. This can be contrasted with the contract for South East London Commissioning Authority (SELCA) which called for agreement with providers on guidelines for acceptance and priority for transplantation and dialysis, criteria for changes in treatment modality and for specialist and satellite referrals as well as criteria for prescribing and GP referral. Although these only amounted to statements of intent to produce guidelines in the future, they suggest a commitment to using the contract as a force for developing services to meet patient needs as well as a forum for ‘rational’ debate concerning the levels of services required.

Contracts dealt with adults (separate provision being made for paediatric nephrology) with no restrictions made in terms of age. Some contracts such as that for Wessex region stated explicitly that there was no upper age limit for
admissions on to the renal programme. There were however, attempts in the contracts to provide a definition of criteria for admission to different forms of treatment. The Shropshire clinical overview for example stated that:

“The selection of dialysis mode depends on various factors; medical, social as well as individual patient choice.”

It is difficult to disagree with this statement. It suggests an understanding of the complex relationship between need, service use, individual preferences and social priorities. What it does not do is address how, or by whom, decisions should be made about the selection of appropriate forms of treatment. Neither is it clear whether the contract allows this choice to happen. By not addressing this issue clearly, the contract confirms the traditional role of the hospital clinician in taking responsibility for such decisions. There were however, various attempts to deal with the issue of who should decide which treatment modality a patient needed. In the North West Region the emphasis seemed to be on involving the patient and primary care givers:

“Agreement on the most appropriate form of care to be provided for each patient should take into account the views of the patient, the patient’s general practitioner and community support services.”

Despite the emphasis on the patient, the wording of this clause still implies the decision on the type of care being needed is ultimately that of the clinician in charge, although in seeking ‘agreement’ on appropriate care other views have to be taken into account. This can be contrasted with the Barnet contract which emphasised the importance of involving the patient in decision making:
“the changing social and medical needs of the patient, together with individual patients choice should determine the type of treatment method.”

Here both ‘need’ and ‘choice’ are considered to be ‘determining’ factors in deciding the form of treatment used. Although once again it is implicit that the decision still lies with the clinician in charge, this is a more decisive version of the earlier City and Hackney contract and it suggests a strong commitment to individual preferences. It is interesting to contrast this with the wording used in the Bristol contract:

“Clinicians are expected to select those who require dialysis and offer them the appropriate treatment modality. Within this overall requirement, priority for entry to the programme of R.R.T will be given normally to those for whom the greatest benefits are predicted.”

This contract clearly specifies that clinicians are to decide on thresholds for care and benefit should be the criterion for decision making. No attempt is made to define what is meant by benefit, whether it is medical, social, economic or a mixture of these. Neither is there an attempt to qualify benefit to capacity to benefit since the maximisation of benefits in a crude sense seems to be the order of the day in this example. It is interesting that such a statement is found in the contract of the Authority where the levels of acceptance on to renal programmes were low (38 per million) and the target for future service development was only set at 55 per million. Rationing was being made explicit in the contract through the setting of a modest target of 55 per million and the contract was then being used to place the burden of rationing decisions (the selection of patients) on the provider clinicians, making it clear that the maximisation of benefit was the
criteria that they should use. This suggests that contracts could be reinforcing traditional roles rather than challenging existing structures. The problem for clinicians seems to be one of accepting the traditional task of deciding who gets treated whilst being constrained by the limits set by the resources available in the contract. If we compare this to the statement made in the Somerset contract:

“No restrictions are placed on the range of patients to be cared for concerning their diagnoses or the procedures undertaken on their behalf.”

We see that contracts can and do vary in their attempt to specify decision making criteria. Where criteria are specified however the decision is still left up to the clinicians. The implied ‘open access’ in the above statement belies the restrictions placed on referral processes by the size of the contract. The wording of the contract is not in line with the reality of unmet need. In this sense the argumentative structures of the contract are inconsistent and contradictory. Similarities can be seen in the Bradford contract’s description of access to services:

“Access is available for ‘Adult’ patients resident in the user’s District who on referral from a consultant or a GP in the user’s district are 16 years and over and subject to the discretion of the provider’s consultant to accept patients on clinical grounds.”

Despite the curious choice of words, this contract explicitly states that there are no restrictions or pre-requisites to acceptance for treatment. Again the onus for decision making is placed on the clinicians. However, these contracts do not give clinicians carte-blanche to treat as many patients as they like for they will
ultimately be constrained by the resources made available to them. In this sense what appears to be happening is that a decision to ration is made at one level whilst the harder individualised patient decisions are being devolved formally to another level. In this sense the contract gives the impression of a clear, unambiguous referral process but this has no relation to the 'reality' of inequalities of access highlighted by the renal review group. This highlights the capacity quasi-market mechanisms have for acting as a form of control. The purchasers are able to set limits to treatment levels whilst avoiding taking responsibility for the immediate consequences of these limits.

If this is related to the debate the renal services group members had about the levels of need required for RRT it is possible to see how contracts employ statements, using available epidemiological evidence, about levels of need and appropriate forms of treatment. The market's capacity to control need in the face of epidemiological evidence is still apparent however. The contract could be used to place limits on service levels by restricting budget levels, restricting the number of patients to be treated or using a combination of these two approaches. This suggest that the social currency of the epidemiological definition of need may not have the same impact at a local health authority level (where resource constraints are felt more acutely) than at a more strategic planning level. Contract specifications can therefore function as a sort of valve, controlling the pressure that builds up between needs and resources. They are more likely however to only document, very crudely, the way these pressures are dealt with in the system.

In attempting to evaluate the contracts in terms of their ability to play a part in communication intended to lead to improved technical and practical understandings of needs, then a number of problems arise. Firstly, it is not clear whether the contracts give a full record of understandings. This could be
deliberate omission (to hide the real level of unmet need) or an accidental omission (due to lack of local knowledge - either from oversight or lack of information). Secondly, disputes about need are, in the main, excluded from the contract. Uncertainties about the levels of service required to meet population needs do not fit with the desire to specify financial constraints. Finally, their description of needs give a one sided (often medicalised) view of human interest that are heavily influenced by the descriptors of the service. In other words, the contract is mainly concerned with describing the service and the sections on 'need' are constrained and shaped by this. The tendency therefore is for needs to be defined in terms of what is being supplied.

6.3.3 Contracts as a tool for change

It is difficult to assess the extent to which contracts were being used to produce changes in service provision. This is because my methodology did not allow an assessment of service levels before the contracts were negotiated. A quality specification asking for patients suggestion boxes for example may be a means of instigating a development in the service or a means of guaranteeing the retention of existing service aspects. My analysis therefore concentrated on those contracts that made explicit references to new developments. I found references to changes of varying detail in nine contracts. In the case of Barnet, change was dealt with in a conservative manner where the contract recognised a likely increase in demand for services but specified a 'steady state' for 1991/92. 'Steady state' is an interesting use of jargon that has the capacity to put a 'gloss' on what may be an unacceptable reality. I discuss this in more detail in section 6.3.6. Similarly the Greenwich contract dealt with the possibility of future developments by stating the Regional Health Authority would retain its 'strategic planning role'. One of the main contexts for change was the resource consequences of recognising higher levels of need in the population. An
acceptance that service levels had to expand was tempered by the need to specify
the financial implications involved. In East and North Herts a shortfall in
patient numbers was costed and £200,000 of investment was specified to meet
future demand. Provision for satellite units and an expansion of the main
haemodialysis unit was included in the revised contract price. Here we see an
acknowledgement of unmet need in the contract together with an attempt to
quantify the resource consequences of this. In Bristol, where a target of 55 new
patient per million was set, the necessary developments were clearly placed in
their economic context:

“In order to achieve this new level of investment in RRT, the
Authority will have to accept the opportunity cost of not
developing other services and the need to reduce expenditure
on current services if uncommitted growth funds are not
available.”

This contract specified a target level of services that was considerably lower than
the epidemiological need of 80 new patients p.m.p.a whilst giving clear signals
that finite resources place constraints on even this moderate target. The
impression given is of a contract being used to control and limit change in the
face of external forces to the contrary.

Contracts also focused on the need for structural change. This varied from
arguments in favour of new transplant units but no real commitment to change
(Hull and East Yorkshire) to detailed recommendations on where central units,
dialysis units and satellite units should be sited (Exeter). The Bradford contract
specified the number of beds a unit required, the timing of clinics together with
the necessary community clinics and domiciliary services, before stating:
“There will be continued progress towards increasing dialysis facilities in the community”

Similarly the East and North Herts contract specified a profile for future services that envisaged:

“Outpatient services within easy access for all major population groups...[and]... An equitable transplant rate for shires patients with other patients in the Regions.”

The problem with such statements is that, of themselves, they have no force. These contracts seemed to be reflecting changes that were already in hand and the contract was a means of reinforcing the commitment to these developments. This places a question mark over the contracts as regards their role in facilitating change. In the case of strategic change they appeared less a means of enforcing change and more a textual device for confirming decisions that had been made elsewhere. What would happen to the contract if these decisions weren’t followed up is unclear. Some contracts had been drawn up by providers before negotiation while in others the groundwork had been done by purchasers. A detailed analysis of the circumstances surrounding each contract would be necessary to probe these issues in more depth. Nevertheless, the contracts themselves often contained hints of the nature of the negotiations that had preceded them. The SELCA contract for example made an emphatic commitment to structural change in its opening section. This contained a ‘wish’ to encourage the restructuring of transplant and dialysis services to concentrate specialist provision in two centres by 1994/95 at the latest and to develop community based provision. The contract states that providers are expected to include proposals for establishing satellite units in their 1993/94 contracts. Under this contract, the relationship between the contract negotiating process
and the negotiations for changes in services seemed closely tied together with the contract being used to drive the structural changes that were required. The contracts could therefore be seen as having a role in creating an environment where change was possible. Documenting the kind of changes required in the future gives an impression at least, of a system that is working towards achieving change. At the same time contracts also had a role in confirming changes that had been previously negotiated. There was little evidence of contracts being used to change clinical practice. The main concern, common to the contracts, was changing the numbers of patients being treated and the accessibility of services, rather than changing the ways in which they were being treated. This may have reflected the lack of any real desire to change clinical practice at such an early stage in the development of markets. The process therefore seemed to be one of bringing ideas about how services could be changed (to meet needs, to make services more accessible or more efficient) to the contract negotiations for confirmation, acceptance or rejection. The danger here of course is that there is no mechanism for evaluating this process or ensuring it is open and democratic. The origin of these ideas, the evidence they are based on, and whose interests they serve are all hidden by the impermeable nature of the contracting process itself.

6.3.4 Contracts as monitoring instruments

Most of the contracts referred to a general quality specification designed to cover all of the services purchased by the authority with general quality standards. There were however clear attempts to introduce key indicators to specifically monitor renal services. The SELCA contract specified a list of indicators that the purchaser wished to monitor:
Number of infections per month
incidence of complications
quality of dialysis
graft and patient survival (adjusted for age)
patient satisfaction surveys

The contract also expressed a wish to develop specific indicators, asking providers to suggest possible areas for the 1993/94 contract. The City and Hackney contract specified the need for quarterly meetings between the purchaser and provider, access to premises, spot audit (i.e. access at any time without warning) and a report on patient complaints. A minimum data set was also required with the proviso that the purchaser 'may require further information to facilitate its needs assessment work'. These contracts were attempts to list, in detail, a set of indicators that could be used to monitor the contract. Similar attempts could be found in the Portsmouth, South Tees, Somerset and Greenwich contracts which concentrated on waiting times, speedy communication with primary care, appointment cancellations, complaints, courtesy of staff, patient satisfaction and regular updates on research and audit activities. The monitoring in these contracts seemed to concentrate on a balance between indicators dealing with patient access, convenience and satisfaction and indicators dealing with treatment outcomes. However, no clear targets were attached to these indicators. This meant that the process of monitoring was not addressing the task of measuring movement towards desired service change.

These contracts suggest that monitoring occurred at different levels and was approached from different perspectives. Some contracts leant towards softer indicators such as patient satisfaction and waiting times, some preferred to look for outcome based indicators such as rate of infections and patient survival whilst others focused on the standards that could be applied to the mechanics of
What all the contracts seemed to lack was (i) a focus on measures of patient health and disability and (ii) mechanisms for compliance. The lack of a focus on measures of disability suggested no clear link between contract monitoring and a concern for assessing the ability of the service to address patient needs. Instead monitoring focused on the information that was readily available. It is useful to relate the monitoring indicators and descriptors of need used in the contracts to Doyal and Gough's framework for assessing needs (see table 6.2).

<table>
<thead>
<tr>
<th>Theory</th>
<th>Contracts</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survival chances</td>
<td>Graft and patient survival</td>
<td>Mainly reliant on providers doing an audit of patients. No targets for improvement.</td>
</tr>
<tr>
<td>Mortality Rates</td>
<td>Some estimates of likely number of patients per annum</td>
<td>No information on patients not referred.</td>
</tr>
<tr>
<td>Risk of death</td>
<td>Quality of dialysis</td>
<td>Reliant on provider audit (Assumption that good quality services produces desired outcomes)</td>
</tr>
<tr>
<td>Prevalence and severity of disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morbidity by disease category</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy:</td>
<td>Patient satisfaction indicators</td>
<td>Some targets for responding to complaints.</td>
</tr>
<tr>
<td>Prevalence of mental illness</td>
<td>Not addressed</td>
<td>No involvement of patients in assessment except through patient satisfaction surveys. Patient ownership over this process minimal.</td>
</tr>
<tr>
<td>Opportunities for economic activity</td>
<td>Not addressed</td>
<td></td>
</tr>
</tbody>
</table>

Table 6.2 highlights the manner in which contracts reinforced the medicalisation of needs and formalised the situating of the process of defining and measuring
needs in the realm of clinicians and contract managers. They therefore seemed to mitigate against the democratic involvement of patients in the assessment of their own needs.

The Exeter contract specified a need for minimal standards for acetate dialysis, bicarbonate buffers and ultra filtration control, focusing on standards for the mechanics of treatment as a means of controlling quality. Concerns about the appropriateness of different modalities were covered by the statement:

"Centre haemodialysis in a hospital or satellite should be available for all patients who cannot cope with CAPD or home haemodialysis." (Exeter)

Similar concerns with the mechanics of treatment could be found in the East and North Herts contract which had detailed quality guidelines focusing on water quality and bio-compatibility as well as outcome indicators such as the peritonitis rate. This section of the contract was drawn up by the provider reflecting an asymmetry of knowledge as well as an asymmetry of information. This asymmetry was at its most acute with respect to monitoring clinical outcomes. There was an element of practical necessity in purchasers relying on the clinical knowledge of providers, but this casts doubt on notions of contracts being driven by, and based on, an assessment of patient needs. Incentives for improving quality and penalties to enforce the maintenance of standards were absent from all the contracts analysed. The lack of mechanisms for compliance adds weight to the view that contracts, at this early stage at least, were relying on professional ethics to maintain standards of treatment. I have described in chapter 4, the way renal services developed in the UK in inappropriate and inequitable ways as a result of a policy that relied on CAPD and rationing of treatment. The complicity of professional groups in the development of this policy cannot be
dismissed and should be a reminder of the dangers of relying too heavily on professional ethics as a means of guaranteeing the appropriateness of health care. In the midst of this, the capacity of the contracting system to undermine ethical considerations by the heavy reliance on short term financial considerations should not be forgotten.

6.3.5 Type of contract and cost

Contracts can be split into three main types; block contracts, cost per case and cost and volume contracts. Under block contracts access to a broadly defined set of services is provided in return for an annual fee. In a cost per case contract each case is priced separately according to average cost or where there is excess capacity according to marginal costs. A cost and volume contract is a mixture of the two where a base line level or set volume of services is funded as a block but any excess activity is paid for on a cost per case basis. The differences in the contract types are significant because of the incentives associated with each. The main type of contract in place at the time of the renal review was a block contract. The block contract tends to shift the burden of risk on to the provider unit and this creates incentives for providers to engage in opportunism (Williamson 1975). Opportunism occurs when providers attempt to reduce quality levels in return for the same annual fee. It is also manifest in drives toward expansion of contracts for prestigious treatments. The asymmetry of information between the provider and the purchaser makes it easy for the provider to engage in opportunism. By placing the burden of risk on the provider the fixed fee of the block contract may result in the fixing of high costs in cases of high cost variability. Cost per case contracts on the other hand require a great deal of information to monitor.
Although most contracts were broad block contracts there seemed to be a desire to move away from this format. The Greenwich contract for example was split with a cost and volume format for End Stage Renal Failure (ESRF) patients and a block format for Acute Renal Failure (ARF) and Nephrology patients. The contract was set to operate for 3 years and would be paid in monthly instalments. This seemed to be a common method for ensuring stability, reducing uncertainty and guaranteeing a regular flow of funds. Similarly the Hull and East Yorkshire contract was split with ARF costed on the length of stay and ESRF on a cost per case per annum basis. The NWRHA contract specified a cost and volume format totalling £3 million in 1990/91. The contract stated that indicative activity volumes were subject to amendment for any additional activity funded in 1990/91. The SELCA contract was a broad block contract but contained a statement that the purchaser would consider departures from this format in the future in two areas:

(i) Floors and ceilings, giving a range for the volume of activity with mechanisms for dealing with any activity that fell outside the range (e.g. financial clawback and payment on a marginal cost basis).

(ii) The specification of different volumes for different modalities but with the flexibility to allow providers to shift between modalities.

These ideas were followed by a statement on the need to maintain stability with the contract lasting 3-5 years but containing escape clauses. Here we can see the tension between attempts to make contracts more sophisticated and able to cope with risk and the desire to maintain a strong stable relationship between the purchaser and provider. The main concern that flowed from these sections of
the contracts was the uncertainty that surrounds the planning of renal services. It is difficult to predict accurately how many patients per annum will eventually be treated, let alone the complexity of the patient case mix. This uncertainty operated at the same time as a period of expansion in demand and calls for changes in the provision of renal services. It was clear that both purchasers and providers were looking for contracts that would minimise uncertainty and perhaps involve some sharing of the risk involved. The fairly unsophisticated level of contracts meant that they were not yet designed to cope with uncertainty. It would seem fair to assume that purchasers and providers were relying more on existing bureaucratic structures of the NHS to cope with risk at this early stage of the market reforms. Uncertainty was a major issue for the renal review group in its discussion about the impact of the market. Managers perceived the market as something that could be managed in a positive way whereas clinicians were more likely to perceive the potential uncertainty as a threat. The emphasis in these contracts on the need for stability is therefore important and reflects a need to counter the fragmentation that comes with the introduction of markets with a coherent and stable environment for services to be developed in. However, the contracts also display a desire to move away from block contracts to more flexible forms of contracting with mechanisms for allowing for variations in patient numbers and types of treatment. It is here that the language of contracting as a form of control becomes important.

6.3.6 Specialised language

The contracts were peppered with phrases and terms such as, “high quality value for money services”, “broad block contracts”, “floors and ceilings”, “financial clawback”, “steady state”, “leverage”, “baseline equity” and “generic quality specifications” that “include contra indications as well as qualifying criteria”.

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These few examples suggest a growing specialised contracting language. This reflects the close relationships between purchasers and providers which in turn suggests the existence of institutional loyalties and raises a number of questions about the motives of the actors involved. The dangers of developing a specialised way of speaking have been discussed in relation to health service managers by Loughlin (1994) who states:

"The alien nature of management-speak, expressed in its verbosity, its grammatical oddities, its constant ability to invent new and undefined technical words, and to use old ones in incomprehensible ways, seems to be a way to establish this 'distinctiveness'. The main virtue of these features of language - at least for the practitioners of the 'new science' - is that they make it hard for others to be sure what managers are saying." (p138)

Fraser (1989) points out the importance of talk about needs in late capitalist welfare state societies. She suggests that 'needs talk' functions as a medium for contesting political claims. She portrays it as an 'idiom' "through which inequalities are symbolically elaborated and challenged" (p162). The specialised language of contracting is subject to this critique because it is a technical discourse that provides the platform for removing political conflict from the issue of health care needs. It is a form of discourse through which inequalities are 'subjectified', become less real and therefore difficult to challenge. Fraser identifies three forms of 'needs talk'; 'oppositional needs talk' (a politicised needs talk, challenging existing structures from below), 'reprivatisation needs talk' (emerging in response to oppositional needs talk and resisting state provision for meeting needs) and 'expert needs talk' (a social problem solving and institution building form of needs talk that perpetuates
Contracting discourses belong firmly in the expert needs talk camp. Health care needs are translated through the contracts into bureaucratically administrable satisfiers. The needs talk is restricted to specialised management and medical groups and through this process, needs become divorced from any oppositional and politicised roots they may have. Their limits are defined in technocratic terms. In addition, the people whose needs are being considered in the contracts are rendered passive. They are:

"...positioned as potential recipients of predefined services rather than as agents involved in interpreting their needs and shaping their life conditions" (Fraser 1989 p 174)

The way specialised language provides the cement for the limiting nature of expert needs talk can be seen in the emphasis given in the contracts on the capacity of a service to meet needs:

"Increasing throughput at individual centres will provide the critical mass required for optimum results" (SELCA)

Terms such as 'throughput', 'critical mass' and 'optimum results' have exclusive properties whose meanings are only understood within the cultural context of professional classes. The conjoining of 'need' with 'supply of services' is also implicit in the above statement. This can be seen more clearly in the Eastbourne contract:

"As contracts are refined from 'block' to 'cost and volume' it should become possible to determine in advance the expected case-mix, age/sex mix and
geographical distribution of patients to be treated, on a
more equitable epidemiological basis” (Eastbourne)

Here we clearly see an assumption that better understandings of patient needs can be achieved through the refinement of contracting characteristics. The transformation of needs into bureaucratically administrable satisfiers is reinforced.

The use of specialised language does not by itself condemn the contracting process but does question any claims contracting has to make decision making more explicit through the working of quasi-markets. The existence of a specialised language leaves the door open for vested interests to manipulate, intentionally or unintentionally, markets for their own ends by allowing the operation of power to hide behind a veil of jargon and meaningless rhetoric. It is possible to link the specialised language of contracting to the post-modern idea that codes and signs are the organising principle of life in late capitalist societies. If these codes and signs do not refer to anything ‘real’ other than themselves then:

“...from now on signs will exchange among themselves exclusively, without interacting with the real.” (Baudrillard 1988a p125)

The importance of Baudrillard’s bold statement in relation to contracting depends on the extent to which we are willing to substitute the word contracts for signs. The contracts for renal services that were in place at the time of the renal review did, to some extent, contain concepts that could be linked to the ideas discussed by the renal review group. The need for more accessible services and more appropriate and efficient specialised centres had clearly been an issue for some
time before the review group met and before these contracts were written. The capacity contracts may have for driving change is difficult to assess. Contracts may merely reflect changes that occurred despite the contracting process. What is clear is that through the development of a specialised language, the contracts threatened to develop their own social currency. In this way they may interact with the real but at the same time they are removed from it.

6.4 Conclusion

This analysis of a sample of renal contracts has suggested that contracts have very little basis in an assessment of patient needs. Where needs are mentioned they are derived from epidemiological definitions of population need, and statements covering criteria for thresholds for access to care and types of care. Again these, in the main, rely on medical knowledge although tempered by the tensions that fixed budgets introduce. The relationship between need and demand, therefore, seems to undergo a process of scientization based on medical knowledge which is formally codified in the contracts. In this way contracts form a barrier between society’s needs and the needs of the system. Contracts acted as a basis for changes in the structure and provision of services, but some seemed to be used to drive changes whilst others were used as devices to simply document change. The importance given to contracts as instruments of surveillance was clear from the detailed lists of key indicators. However, there seemed to be no clear attempt to measure patient needs, no mechanisms for ensuring compliance of processes in pursuit of quality, and no mechanisms for compliance in the event of failures in quality. The production of monitoring lists implied a reliance on professional ethics to maintain standards.
The format of the contracts reflected the early stage of the market, but there were hints at mechanisms for sharing risk, reflecting the uncertainty associated with the provision of renal services. Finally, the specialised language used in the contracts suggested some degree of complicity (be it intentional or unintentional) between providers and purchasers, and cast doubt on the competitive nature of contracting. These points suggest that contracts are not informed by a clear understanding of patient needs, nor are they stimulating or stimulated by competitive forces. Instead, contracts form part of a bureaucratic structure, infused with a specialised language, keeping the operation of power and decision making remote from the ultimate consumer.
Appendix 6.1

List of DHAs and RHAs providing contract service specifications.

Regions:

Wessex, West Midlands, North West Region, South West Region, Yorkshire Region, South East Thames.

District Health Authorities (some overlap with the Regional responders):

Southampton, Dorset, Shropshire, Hull & East Yorkshire, City & Hackney, Tower Hamlets, SELCA, Cornwall & Isle of Scilly, Bristol & District, Solihull, South Tees, Oldham, Exeter, Greenwich, Somerset, Bradford, Southampton & West Hampshire, Eastbourne, East & North Herts, Barnet, North Staffordshire.

The Regions of non-responders:

Northern Region - (but containing South Tees)

Trent*

East Anglia

North West Thames (but containing East and North Hertfordshire and Barnet)

North East Thames (but containing City & Hackney and Tower Hamlets)

South West Thames*

Oxford*

Mersey*

* Regions where there was no response from the Region or any District within that Region.

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Chapter 7

Needs and the Political Economy of the Health Service

7.1 Introduction

This thesis has examined theories of need and justice with respect to health policy. The focus for the work has been an analysis of the planning of future provision of renal services in the four Thames Regions. The analysis has focused on the definitions of needs used, the rationale for decision making and the repercussions for purchasing services in the reformed NHS. The dilemmas in health policy that arise in this area of health care, where needs are acute and resources are rationed, bring questions of justice to the surface. It is clear from the previous chapters that there are vulnerable groups within populations whose need for, and use of, services varies and their relationship with the system is uncertain. This is occurring against the backdrop of a system that is undergoing both structural change and financial stringency. Within these parameters managers and clinicians alike are having to make hard decisions concerning prioritisation of resources. Many of the arguments to date have looked at how these decisions are made implicitly, to what extent they should become more explicit and how this can best be achieved. This thesis has considered a theoretical basis for such decision making and looked at how decisions are arrived at in practice. The gaps between decision making in theory and in practice have been highlighted and the extent to which these gaps are filled with the ideology of powerful interest groups explored. This implies that health policy should contain a commitment to a normative domain of procedural guidelines for discussing needs. In this final chapter I consider the contradictions involved in a welfare system whose aim is to ensure that there is
universal access to basic human needs whilst at the same time operating as part of the modern capitalist state. I argue that the drive towards markets and greater competition within the health care sector fails to take account of the need for a framework for discussing needs. On the contrary they make the possibility of such a framework more remote.

7.2 A return to theory

In chapter 1, I considered the relevance of alternative notions of need to health policy and emphasised the importance of the principle of justice in the search for a defensible health policy. I discussed how Doyal and Gough (1991) refer to the harm that occurs when needs are not met as disabled social participation. Intermediate needs such as health care should therefore be organised on the basis of the goal of minimising disabled social participation. If health policy is to be based on such a theory of need then the objective of minimising disabled social participation will require a framework for reaching consensus and agreement on definitions of disability and autonomy, measures of disability and autonomy and the processes by which measurement is undertaken. Their theory can therefore be split into a substantive part which identifies basic needs, and a procedural part which provides a framework for resolving disputes concerning policies for achieving a goal of need satisfaction (Gough and Thomas 1994). In chapter 2, I explored the potential a communicative ethics holds for producing a framework for discussing these issues. I related theories of power in the NHS to the development of quasi-markets in health care and considered the role of health care needs in this development. I then outlined the possibilities that Habermas' work held for evaluating assessments of health care needs, both in terms of the way needs are identified and the way needs are debated and agreed upon.
7.3 The case of renal services

The focus for this thesis was a case study of an independent review of renal services in London. I evaluated the work of this review in relation to Doyal and Gough's theory of human need. In chapter 3, I outlined my intention to base my methods on depth hermeneutics using the three phases of social analysis, discourse analysis and interpretation. The reference points for my evaluation were Doyal and Gough's rules for discussing needs and Habermas' communicative ethics. In chapter 4, I showed the technical limitations of the review process, the constrained definitions of need used, and placed the review group's decisions in the social, economic and geo-political context of a service that has been historically underfunded. I identified the gaps in the review group's technical knowledge of needs and considered the possible effects this had on the 'rationality' of decision making. In chapter 5, I considered the review process from a participatory viewpoint and analysed the minutes of review group meetings, and the transcribed tapes of meetings, using discourse analysis with an interpretative framework. Using Habermas' communicative ethics as a basis for my analysis, I was able to highlight the ways in which vested interests were able to operate to distort the understandings of need, and how different definitions of need were used as part of the strategic actions of powerful groups. Not only were these ideological distortions able to operate in the gaps left by a lack of technical knowledge of need, but also they contributed to maintaining a particular and restricted view of needs that set constraints on the search for technical knowledge. In chapter 6, I examined a sample of contracts that were in place in England at the time of the renal review. Using a content analysis, combined with an analysis of contract narratives, I explored the ways in which contracts, and the quasi-markets they formalised, reinforced the distortions of need I found in the review process. I highlighted the ways in which contracts contained descriptors of need that betrayed a narrow understanding of human
interests. The emphasis given to supply of services was distorting the way needs were described in the contracts. I was also able to examine the specialised language of contracting and the way in which this acted as a cement for 'expert needs talk'. I emphasised the role this played in alienating the contracts from the needs of those they were intended to serve.

In bringing together my analysis of the epidemiological work of the review, the review group's decision making processes and the contracts for renal services, I hope to have shown that the renal review was part of a process of managing the rationalisation of service in London and the simultaneous managing of the newly developing quasi-market in health care. Within this process appeals to need had a positive aspect in that they were used to challenge existing inequity and to challenge the potential inequities arising from the changes to the system. Appeals to need also had a negative aspect in their capacity to reinforce the claims of vested interests. Needs therefore could challenge markets or legitimise them depending on the way needs were defined.

7.4 A critical reflection on the research

This thesis grew out of an interest in the question of whether a 'universalist' approach to human needs could be defended at the level of a 'specific satisfier' of needs, namely health care. This was combined with an interest in the way 'need' was used in different ways by different groups within the health care system. The methods I used were based on participant observation in the context of a case study. Whilst giving me the opportunity to develop an in depth analysis of a decision making process, this approach inevitably had repercussions in terms of limitations on my research. These included limitations of time in that my field research was restricted to the short time-scale of the renal review process itself. In addition there were limitations of access in that I was not privy
to all of the informal negotiations by review group members. This problem of access to debates was compounded by the ethical problem of obtaining permission to use quoted transcriptions. These are common problems for policy research and I attempted to address these limitations through the process of analysis (see chapter 3).

My decision to examine contracts for renal services was based on the need to relate the case of the renal review to the wider issue of developing markets in health care. Although the contracts contained a rich vein of data for analysis, my analysis was limited by my not having access to the process by which contracts were drawn up. In addition these contracts were in operation at the time of the renal review and like the review process itself are historically specific. All of these factors inevitably place limits on the conclusions I can draw from my data.

Although I hope to have shown the value of Doyal and Gough’s theory of needs for evaluating health care decision processes, this study cannot show the practical uses of the theory as a basis for decision making because the framework for assessing needs was never used by the review group in this respect. In the same way, there was no attempt to set out ground rules for debate in the review group so Habermas’ communicative ethics could only inform my evaluation, it could not be evaluated itself. The extent to which a theory of need containing substantive and procedural parts could be used to inform decision making is therefore an area for future research.

In concentrating on the debates about need by a group of health service elites, the research focused on the processes of ‘expert’ needs talk. The way in which patients, communities and other health service workers were excluded from this professional discourse was an important finding of the research. The research
was not however able to examine the perceptions of these excluded groups. Their interpretations of needs and their relationship with the system are important areas for developing deeper understandings of the impact of policy making processes on human interests.

Despite the limits I have outlined above, this research has highlighted a number of important difficulties with health care decision making that purports to be based on an understanding of health care needs. It is the possible implications of these difficulties for wider UK health policy that I now wish to turn.

7.5 Implications for interpreting UK health policy.

Since the work of the Resource Allocation Working Party (RAWP 1976), the UK has been moving towards addressing the issue of equity in health care, but it is questionable whether this movement has been based on a clear theory of need. The move towards quasi-markets within a system where resources are allocated firstly on the basis of capitation and then on the basis of contracts adds a further dimension to the problem. This case study of renal services has shown that inequalities in health care provision exist and that these are diverse in origin and are based on the dimensions of geography, race, culture, gender, class and socio-economic status. Whether a model based on the centralised allocation of funds, within which competitive markets are encouraged to operate, can provide the necessary conditions to address such inequality is uncertain. What is more clear is that different understandings of need exist at various levels in the system. This is particularly true of understandings of the levels of need to be met by the provision of welfare and the levels of need ascribed to individuals. This presents problems for any attempt to assess the gap between the objectives of the system and the extent to which the system is meeting needs. My analysis of the renal review group’s work showed how the rhetoric of need could be employed...
by vested interests. This suggests that the fundamental ideal of a service based on the principles of justice and need can be compromised by the injection of procedures that allow prejudice to operate, albeit covertly or unintentionally. This has important consequences for the problems raised by the reformed health system. Its structures and processes cannot escape the questions of how, and by whom, individuals are to be valued in the new system. This phenomenon, and the way actors at a level removed from central government are adapting the reforms to their own view of the system, is an important area for the study of policy and its effects on needs. On a policy level, what is interesting is the extent to which the problems I have identified operate despite policy objectives, or because of the faultlines of policy itself.

It is useful to consider the relationship between framework (the extent to which the health care system is fixed or open to change) and compliance (the extent to which the framework complies with the fundamental principles of social justice and need satisfaction), (Curtis 1989). This facilitates a policy analysis based on whether the structure of the health care system contains inequalities and injustices and the relationship of these structural problems to sub-structures within the institution. The analysis can also be enriched by the understanding that the dynamics of health policy is based on power relationships, but that the key to these relationships is the inter-dependencies within structural constraints (Harrison et al 1990). In this sense structures have a different and wider meaning, so that structural constraints are the increasing elderly population, decreasing economic growth, past legacies such as ageing hospitals and labour market constraints such as nursing shortages. The arguments presented in this thesis have drawn on the idea that policy making, within these constraints, is not governed by 'rational planning' but is the product of a bargaining process between interdependent power relationships; 'a network or bargaining community' (Harrison et al 1990). This implies that health care decision making
is not underpinned by a theory of need and justice but is determined by a bargaining process. The impact of quasi-markets on this bargaining process cannot be underestimated. This process is strongly situated in the language of need making it difficult to distinguish between ‘genuine’ appeals to need and the use of ‘needs’ to support vested interests. Often patient needs and vested interests overlap making the process more complex and difficult to interpret. This can be seen in the way in which the medics on the review group were able to use evidence of ‘unmet need’ to justify decisions that protected vested interests.

It is possible to consider contracting between purchasers and providers as the bargaining process formalised at a micro level. If the contracting system is to deliver a service that is sensitive to patient and population needs it should act as a mechanism for clarifying the tensions between needs and vested interests. Indeed, supporters of the market argue that it has the potential to do exactly this because contracts make decision making more explicit and decision makers more accountable. This ‘explicit’ characteristic of quasi-markets has, it is argued, given the rationing debate a new importance (Heginbotham et al 1992). In the past the process of priority setting has been a political one. The policies are set at a national level and moulded at a local level by professional interests. Heginbotham et al argue that the purchaser-provider split has the potential to challenge ‘provider capture’; that is, the ability of powerful provider interests to direct where resources are to be allocated. By creating separate purchasing organisations the reforms have given purchasers responsibility to look at local needs, local morbidity patterns and consumers’ views and allocate resources accordingly. Purchasers also have a responsibility to examine the cost-effectiveness of services. Although it is important to recognise that there are strong elements of technocratic decision making in this process it is clear that there is potential here for altering the balance of power between professional
groups. Whereas rationing in the NHS can be an implicit process that sometimes explodes into the public domain by means of headline cases such as children not receiving high technology care or 'tramps' being refused renal treatment, the potential here is for the reforms to put rationing on a different level. This is an important point, but it should be tempered by the possibility that quasi-markets can also operate as a mechanism for reducing accountability, concealing decision making and stifling debate. If we recognise that quasi-markets possess this duality then it becomes ever more necessary to ground the policy process in a theory of need that is in turn based on a communicative ethics. My analysis of contracts showed that a specialised language was embedded in the contracts with the potential to provide a 'linguistic smoke screen' for undemocratic processes. In addition my analysis of the renal review debates showed how managers used the existence of markets, and their presumed knowledge of health care markets, to discourage open decision making and to limit debates on need and justice. The 'fairness' of market solutions were not in doubt, provided the managers were allowed the role of 'managing markets'.

It is important to situate any discussion of health care needs within the limits of present health care policies where policy makers are not able to escape the consequences of scarce resources. There is some 'rationing frontier' beyond which resources cannot be allocated without denying care to moral equals. The inevitability of rationing has been linked to arguments concerning the increasing elderly population and the widening gap between what is technically possible and what resources allow. Some have based these arguments on a model of exponential growth of public/professional expectations and resources, with expectations outstripping the capacity of resources to meet them (Thwaites 1987). Indeed Thwaites argues that his simple model:
"...explains, on the one hand, governmental exasperation that the ever increasing funding of the NHS goes unappreciated; and on the other, the readiness of the medical profession and the public to believe that the NHS is being increasingly severely cut." (p17)

Arguments that draw on concepts such as infinite demands and the growing elderly population have the potential to create a moral panic that justifies attacks on the welfare system. It is important therefore to situate arguments within this context if policy responses to the gap between resources, technology and expectations are to be understood. In this sense Thwaites' analysis is incomplete. The essential question with respect to the market is: what is being managed? Is it need or is it expectations that the market is dealing with? This question went to the heart of the renal review group's debates. The medical professionals on the group interpreted need at two levels: the numbers of potential patients in a population and access to services. The managers on the group did not challenge the medical definition of need but they directed the group's debates towards a limited and restricted understanding of access to services, arguing that the proper place for determining access was the market. In this way they seemed to be attempting to assert their domain of influence over accounts of the gap between need, resources and expectations. The focus of rationing seemed to be directed through the policy process towards dealing with expectations rather than needs. The implication of this for interpreting UK health policy is that the market may be presented as an attempt to allocate resources in a rational manner, but can manifest itself by impinging on the system as an exercise in legitimacy.
The relationship between need and legitimation has formed a pivotal part of this thesis. Salter (1993) points out that the popular perception of a universal NHS, free at the point of use, places no ideological barriers on individual demands for health. In these circumstances, where resources are limited by capitation, there will always be a mismatch between consumer demand and demand defined by purchasing authorities. The reconciliation of these two forces requires, in part, a selling of purchasing decisions to the public. In other words, purchasers have to ensure legitimacy in the eyes of their local populations. The process of legitimisation can focus on purchasing itself, or on addressing expectations, but as Salter argues:

“Once it is recognised that explicit rationing and the expectations created by the NHS myth are mutually incompatible, and that the gap between the two cannot be bridged simply by characterising the purchasing process as democratic and rational, other political forms have to be found to resolve the conundrum. The choice is between changing the expectations and changing the purchasing process. To date, the focus has been upon the latter.” (Salter 1993, p179).

This argument has important consequences for any Marxist analysis that sees the NHS (and the welfare state in general) existing in part to legitimate welfare capitalism (Gough 1979). The duality of the welfare state for Marxism is that it can be heralded as a prize for the working class (Navarro 1978), but at the same time it fulfils important functions for the capitalist state (O'Connor 1973). However, the state does not act as a single entity, with the knowledge and

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1 Taylor-Gooby (1985b) shows how the NHS ranks highly among welfare state institutions in terms of popular support.
awareness to be able to plan for the needs of capitalism. Rather it is made up of a plurality of institutions whose goals are diverse (Offe 1984). The main factors governing social policy therefore are the internal concerns of the state apparatus rather than the needs of class interests. Within this Marxist paradigm, as expectations increase, as technology changes, resources remain static and other structural considerations impinge on the state of welfare, then clearly arguments about a crisis of legitimacy come to the fore. The gap between expectations and resources is met by a plurality of policies from rational planning, decentralisation of responsibility, privatisation, contracting out and the scientisation of demands (Fitzpatrick 1987). These strategies can be clearly seen in the constraints placed on health policy by changes in the system. The scientization of demands is particularly important because it encapsulates the capacity of medical ideology to act in ways that translate health care needs into scientific issues, thus erecting a barrier between the health needs of society and the needs of the state. In this way the profession of medicine can be perceived as having an oppressive influence. Medicine becomes a medium by which the ‘systemworld’ colonises the ‘lifeworld’. Such a view must be tempered by the insight that the medicalisation of needs still has the potential to present the state apparatus with challenges to the existing order. Recognising the fluidity of the relationship between the lifeworld and systemworld helps to explain the medical profession’s role as a vehicle in a two way street. This is occurring in the context of a state that is experiencing major changes in welfare provision. These changes are influenced by our understandings of ‘needs’, how they are defined and by whom they are defined. The state’s role in allowing dominant interests the power to control areas like ‘needs assessment’ sets the parameters for this process. This places limits on the capacity of needs to challenge existing structures and indeed contributes to the moulding of needs into forms that support vested interests. This is reinforced by the push to situate this process within a framework of quasi-markets. ‘Needs’ are dressed in the language of ‘choice’ and ‘consumer rights’,

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they are seen as ‘liberating’ the individual from a bureaucratic system. These are the emperors new clothes however, for 'needs' are captured by the demands of the systemworld. Their enabling potential is dwarfed by the part they play in the system’s means of surveillance and social control. This case study of renal services has shown how a medicalised definition of need can challenge inequalities and force an institutionalised response within the system. However, the limits of this medicalised definition have also been exposed in that ultimately it is tied to the interests of medical elites. This suggests that challenges to inequalities of health, based on the medicalisation of needs, are constrained by the medical framework within which they are formed. It is through this kind of analysis that it becomes possible to argue that while the capitalist system exists through the commodification of needs, the welfare system has an ambiguous role acting, in part to support commodification, and in part to de-commodify needs (Higgs 1993). The problem for health care is that this de-commodification is held fast by the limits set on it by the medicalisation of needs and by the distortion of needs through the discourses of the bargaining process. Quasi-markets play an important part here in that they are a powerful vector for the commodification of needs.

The concept of ideology is a crucial part of this argument. Ideology, not in the sense of ideas that promote the interests of a particular class or group, but as a critical concept where needs and interests are hidden by the real appearance of distorted forms of thought (Larrain 1994). This interpretation can be contrasted with post-modern critiques of the relationship between ideology and need where it is argued that ideology may explain the fetishism of exchange values but needs and interests are not autonomous realities, but are themselves an effect of exchange value (Baudrillard 1988b)2. If we accept that 'needs talk' is the

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2 For an interesting discussion of these issues in the context of rationing in the NHS see Freemantle and Harrison (1993).
medium through which political claims are contested in modern society (Fraser 1989), then this post-modern critique gives an elegant account of how reason is crowded out by movements towards discontinuity, fragmentation and the recognition of unlimited particular interests. In this schema, universalist accounts are no longer tenable (Lyotard 1984). Such a position is dependent on the view that it is impossible to judge one discourse from the assumed privileged position of another discourse. This presents us with a contradiction in that by dismissing the validity of a universalist discourse the post-modern critique assumes its own validity (Larrain 1994). Whilst post-modern accounts of change in society are correct in their description of some political and economic trends the danger is that the consequences of change are missed (Taylor-Gooby 1994). In particular the decline of 'reason' runs in parallel with an increase in the social power of the industrial capitalist state (Giddens 1990). This manifests itself in increases in inequality, and in the surveillance and social control of vulnerable groups. Rejecting parts of the post-modernist argument however, does not free us from the problem of how real needs and interests can be distinguished from distorted needs and interests. This thesis has considered health care needs from the position that a morality is universalist if it recognises as valid only those norms that can be approved in open communicative action (Habermas 1989). The implications of this for health policy is that there has to be a normative domain of procedural guidelines to provide a forum for discussing needs. This is the only way to approach just and fair decision making:

"For how can one judge the validity of norms, when frequently parties present their own specific interests in a universal guise, under cover of the ideologies of, for example, national interests, civilised behaviour, the new world order, the imperatives of the market, and so on..." (Hewitt 1993 p68)
It is on the basis of this understanding that the capacity of the system to discuss health care needs and provide appropriate services to meet needs should be evaluated. The question of how such a normative domain can be approximated in practice can not be answered within the confines of this thesis. However, more innovative ways of commissioning health services that strive for shared understandings are being addressed (Hunter and O'Toole 1995). There should be scope for exploring the capacity of advances in information technology to 'democratise' debates around needs. More important perhaps is the need to recognise and counteract the ways in which lay accounts of health are discounted by scientific knowledge (Phillimore and Moffatt 1994).

7.6 Conclusion

This thesis has demonstrated the value of Doyal and Gough's framework for assessing needs and Habermas' communicative ethics for developing a critical analysis of health care decision making. The case of renal services has revealed that where vested interests are allowed to manipulate discussions, then appeals to need can be used as forms of strategic action. The Habermasian framework I have built on has, to some extent, allowed me to expose instances of strategic action and the ways in which an NHS based on quasi-markets reinforces the potential for strategic action. The problem at the heart of this work however, is that despite being a valuable framework for evaluating processes it is still questionable whether such communicative procedures of themselves can prevent the operation of power with the same success. Indeed the role of the state, in allowing dominant interests the power to control areas like the planning of services and thresholds to care, undermines the ability of an operationalised theory of need to function by means of ethical understandings. The political realities of policy promotes the rhetoric of need whilst implicitly impeding a needs based policy.
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