PLANNING FOR BETTER HEALTH — THE WELSH WAY

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This article discusses the approach to health planning in Wales, which aims to define priorities and targets for health improvement, strengthen accountability for health outcomes and increase community involvement in service planning. The main influences that have shaped the NHS Wales approach are considered, as are possible implications for the NSW health system.

Like most health systems, the Welsh National Health Service (NHS) faces an ongoing challenge to improve its responsiveness to local health needs and community preferences, and to strengthen its accountability for improving health.

In the Welsh NHS a model of strategic planning has been developed in response to this challenge which combines clear national direction and leadership with participative local decision-making.

Strategic planning opens a window on the future. It helps to clarify priorities — distinguishing the essential from the merely important — and focuses attention on what the health system should be aiming to achieve for a defined population using a given level of resources.

The strategic planning model described here has taken root in Wales over the past three years. The processes involved are helping to:

- clarify priorities for health improvement;
- link investment decisions with priorities;
- promote collaborative working within the NHS, and with other agencies that can help deliver health gain; and
- build community involvement in strategic health decision-making.

BEST IN EUROPE

In 1990 the NHS committed itself to working to ensure that health status in Wales compares favourably with other European countries. This ambition was set out in a vision statement, called the *Strategic Intent*¹, which stated: "Working with others, the NHS aims to take the people of Wales into the 21st century with a level of health on course to compare with the best in Europe."

At the same time, a complementary statement of *Strategic Direction* was adopted, clarifying corporate values, and describing how the *Strategic Intent* would be pursued and won. This calls on the NHS in Wales to be:

- health-gain focused, requiring decision-making and organisational effectiveness to be assessed in terms of their impact on prolonging life and improving its quality;
- people-centred, committed to providing high-quality health services, and valuing people as individuals, including patients, their families, staff and others coming into contact with the NHS; and
- resource-effective, striving to ensure the most cost-effective balance in the use of available resources.

Achieving balance in resource use reflects a concern with allocative efficiency. Essentially, this involves working to ensure that the distribution of resources is appropriate at two levels:

- between services directed at different health conditions (e.g. between cancer and trauma services); and
- between preventive, diagnostic, curative and rehabilitative services directed at the same health condition.

Strengthening the Service's focus on health gain is held to be the most important of these core values, calling for a critical examination of the health benefits obtained from existing and proposed new services.

Responding to the challenge of the *Strategic Intent* and *Direction* has required a re-definition of the health service's role. From a public health perspective, this has a number of important implications, including:

- recognition that the primary goal of the health system in Wales is to improve health, not simply to provide health services effectively and efficiently. One consequence is that the system's accountability for public funds, and its effectiveness in responding to major health challenges, needs to be assessed in terms of health benefits gained for resources invested, in preference to traditional measures of performance, such as hospital through-put.
- recognition that major opportunities for achieving health gain lie in addressing wider determinants of health through collaborative working with other public and private agencies, the community, and individuals, e.g. through programs aimed at reducing the incidence or impact of injuries. Where responsibility for preventive action lies outside the health sector (e.g. road safety), the NHS can have an important role in advocating changes that are beneficial to the health of local communities.

NATIONAL DIRECTION

The *Strategic Intent* and *Direction* are a national health strategy for the NHS in Wales, but to succeed local commitment must be harnessed. To provide a framework for local decision-makers, 10 priority areas for achieving health gain were adopted in 1990, selected on the basis of the contribution they make to premature mortality or morbidity in Wales. They are:

- cardiovascular diseases
- cancers
- maternal and early child health
- injuries
- respiratory diseases
- mental health
- emotional health and relationships
- learning disabilities
- physical discomfort and disability
- healthy environments

Expert review panels have been convened to produce planning guidance, called protocols for investment in health gain, for each of the 10 priority areas. Copies of the protocols can be bought from the Welsh Health Planning Forum, 22 Newport Road, Cardiff, Wales, CF2 1DB (telephone: (0222) 460015; facsimile: (0222) 492046).

The protocols highlight opportunities for achieving health gain, blending expert research, clinical and managerial input with a concern to increase community and consumer participation in strategic service planning.

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To sharpen further the focus on health outcomes, each protocol identifies a series of key issues for priority attention and sets health gain and service delivery targets for achievement. The table below illustrates this approach, using an example from the injuries protocol².

TABLE 1

TARGETING HEALTH IMPROVEMENTS:
AN EXAMPLE FROM INJURY PREVENTION

■	Key issue: A stronger emphasis on the primary prevention of injuries among vulnerable groups is required.
■	Health gain target: Achieve a 50 per cent reduction in the variation in injury rates among children from different socio-economic backgrounds by 2002.
■	Service delivery target: NHS to identify local injury blackspots, and to work with local authorities, the police and other partners to implement strategies to improve prevention in those areas.

Target-setting is a familiar tool in public health. The report³ on goals and targets for Australia's health in the year 2000 employs a similar approach.

In NHS Wales, the use of targets is not confined to preventive activities alone. Rather, they are used to promote improvements in performance across the full range of services provided, including in the diagnosis and treatment of disease and in rehabilitation and palliative care services.

For example, in relation to ischaemic heart disease, a key issue is to improve the response to an individual's need for rehabilitation after heart surgery. A target is to achieve a 95 per cent rate of return to work within six months of heart surgery for those patients who wish to do so and for whom this is a realistic option. Service agreements for cardiac services between purchasers and providers are required to specify how this is to be achieved and monitored locally.

A raft of such targets has been established across all health gain areas, aiding the definition of service development priorities directed at strategic health needs, as a counterweight to provider-driven agendas.

LOCAL ACTION

District health authorities lead the response of the NHS at local levels to the *Strategic Intent* and *Direction* and to the protocols for investment. There are nine such authorities in Wales covering a total population of nearly three million people. This management tier is broadly equivalent to Area Health Services in NSW, though with notable differences in role definition as a result of the separation of purchaser and provider functions within the NHS.

The challenge for health authorities is substantial. Their task is to define a response to the priority health gain areas, key issues and targets, reflecting local epidemiological knowledge and consulting with community interests, local health care providers and other relevant agencies.

The aim is for each authority to lead the development of partnership-based local strategies. Covering all 10 priority health gain areas, local strategies establish a single

planning framework within which the process of orienting available resources towards interventions and programs offering the best potential for maximising health gain can take place. Specifically, health authorities have been encouraged to examine the allocative efficiency of their investment decisions with a view to achieving an appropriate balance of resources between different health conditions and levels of intervention.

The nine local strategies have been in preparation since 1990, and in most cases are nearing completion. Once finalised, they will form locally based, long-term response strategies to the challenge of improving health in Wales. Their implementation will be phased over a 10-year period through a series of shorter-term rolling health plans and annual contracts for health care services.

In recognition of the substantial management challenge that a process of reorientation on this scale poses, considerable attention has gone into building consensus in the community and with key players in the health sector.

Furthermore, the 10-year implementation phase recognises that reorienting investment in a system dominated by a fixed structure of resources is best tackled through a program of marginal adjustments to budgets, achieved over a relatively long period.

INFLUENCES

Two major influences stand out among a myriad of others that have helped shape the NHS Wales approach:

- the role of leadership; and
- the separation of purchasers and providers within the health system.

Leadership

The new approach to health planning in Wales has been developed, and its implementation led, by a high-level multi-disciplinary group called the Welsh Health Planning Forum, which includes senior NHS managers and clinicians, consumer and academic interests and health promotion, primary, secondary and community care representation.

The breadth of interests represented at senior level on the Planning Forum has contributed to the ease with which the new direction has been accepted by clinicians and managers working in the Service, as well as among other agencies working to raise health status in Wales.

This leadership role has been seen at its clearest in the protocols for investment, developed under the Forum's direction, which have been a valuable and valued resource in local decision-making.

Purchaser-provider

The separation of purchasers and providers within the NHS has had significant implications. The move has facilitated the emergence of a management tier within the health system whose role has changed dramatically. Whereas previously health authorities were primarily concerned with managing the provision of services, their role now is to assess local health needs and plan the investment of resources to meet those needs.

This refocusing has been assisted by the introduction of self-government as an option for NHS hospitals and other health care providers. This effectively removes health authorities from any residual involvement in direct health

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Craniosynostosis in NSW

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of a single suture has not been convincingly shown⁷. However, children with single suture involvement will frequently be referred for surgery for cosmetic reasons and to prevent psychological problems in later life.

Craniosynostosis accounts for about 4.5 per cent of reported major birth defects in NSW². In this study, craniosynostosis was found to occur about twice as frequently among males as females. This has been noted previously by Alderman et al, who found males were affected about one and a half times more frequently than females⁹. Craniosynostosis cases did not differ from the population of births in NSW in 1990 for type of delivery, maternal age, gestational age at birth or birthweight.

The incidence of craniosynostosis was found to be 8.1/10,000 livebirths over the period 1988-1991. This is consistent with rates reported elsewhere, which vary from 3 to 26/10,000 births^{9,10}. As only about one-quarter of craniosynostosis cases are detected in the first month of life, the increase in the reported rate of craniosynostosis in NSW is almost certainly due to the change in the upper age limit for reporting of birth defects in NSW in 1989, from 28 days to one year.

The most common suture involvement was synostosis of a single lambdoid suture. This differs from the two published case series where a single sagittal suture synostosis was most common^{9,11}.

The rate of craniosynostosis was found to be higher in the South Eastern Region and Western Sydney Area. This is due to the referral of relatively large numbers of children with single lambdoid synostosis for assessment and/or surgery. The management of a single lambdoid synostosis is based on cosmetic concern as there is no evidence that a single lambdoid synostosis causes developmental delay. As the rates of multiple suture involvement, and involvement of single coronal, sagittal, and metopic sutures are fairly uniform across NSW Health Areas and Regions, the higher rate of craniosynostosis in these two areas is likely to be due to differences in clinical management practice, with a higher rate of surgical correction for milder degrees of lambdoid synostosis, rather than a real difference in the incidence of craniosynostosis.

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care management, leaving them to concentrate on their planning role. Arguably, it has also opened the way to greater objectivity in resource allocation by ending the accountability that health authorities previously had for the financial performance of providers.

Health authorities in Wales are thus able to define their accountability in terms of the health status of their resident populations, in a way that Area Health Services in NSW probably cannot to the same extent, given their more direct involvement in operational health care management.

RELEVANCE FOR NSW

The planning model outlined here has been developed in response to challenges that are generic to most health systems. These issues are equally relevant for NSW, as is clearly shown by the recent report⁴ on health funding by the NSW Parliament's Public Accounts Committee, which calls for greater emphasis on strategic planning, outcomes and community involvement in health decision-making.

The recent NHS Wales experience shows that adopting a stronger focus on outcomes across the health system in its entirety can be an achievable goal. Moreover, this can be progressed as part of a policy that requires the system to measure its performance in terms of the contribution it makes to improving health within a defined population.

The main messages are these:

- It is important to have strong, credible leadership when reorienting the health system towards better accountability for health improvement;
- The leadership must embrace direction-setting and the identification of very clear priorities for attention;
- A commitment to building partnerships is also essential, both in setting the direction for the system as a whole and in local decision-making;
- Within a clear framework of direction and priorities, local flexibility in implementation is important to encourage responsiveness and innovation, and to build accountability for health at the community level.

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