

# The rationing of care: Valuing public services is not, and should never be, an exercise in accountancy

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*A recent BMJ study showed that reducing cost through shedding or not replacing frontline nursing staff impacts negatively on the quality and safety of care which, in turn, is detrimental to not only on patient outcomes but also on the financial costs of the health and social care system. **Chih Hoong Sin** argues that the NHS needs to adopt a whole-system and outcomes-focused approach that illuminates the true costs of various services and staff, as well as the range of direct and indirect benefits.*



A recent paper published in the [BMJ Quality & Safety](#) reported on compelling evidence to show that lower nurse staffing levels in hospitals are associated with worse patient outcomes. The researchers hypothesised that this may be due to the omission of necessary nursing care – or ‘missed care’ as they put it – caused by time pressure. 86% of nurses in the study reported that one or more care activity had been left incomplete due to lack of time on their last shift.

There are a number of observations this research invites, which have important implications about how we think about care quality and efficiency in a time of public spending cuts.

## A ‘cut’ or a ‘saving’?

Firstly, with the NHS undergoing one of the most significant financial challenges in its history, numerous examples have emerged pointing to the conflation of ‘cuts’ with ‘savings’. As the BMJ study indicated, reducing cost through shedding or not replacing frontline nursing staff impacts negatively on the quality and safety of care which, in turn, is detrimental to not only patient outcomes but also on the financial costs of the health and social care system. Poor care quality often translates into unnecessary and avoidable usage of a wide range of health and other services. We already know, for example, that [cuts to specialist nursing](#) aimed at helping patients stay at home can lead to greater demands on hospitals. Hospital-based services account for around half of the total NHS spend. The [Nuffield Trust’s review](#) of NHS spending found that spending on hospital care in 2011/12 increased at a much faster rate than spending on either primary care or mental health services, raising questions about whether the NHS has the right balance of services for the future.

Moving forward, the NHS needs to adopt a whole-system and outcomes-focused approach that illuminates the true costs of various services and staff, as well as the range of direct and indirect benefits. This allows us to see how adjustments to one part of the system may impact on another. After all, the [Mid Staffordshire NHS Foundation Trust Public Inquiry](#) has shown how the Trust Board’s focus on short term cost control contributed to a range of adverse impact on the quality and safety of care, that have longer term financial (and other) implications.

## The ‘value’ of the ‘mundane’

Secondly, it is of concern that the BMJ study noted that the activity most frequently left undone was ‘comforting or talking with patients’. For many patients this is most tangible and visible part of a nurse’s role, and should it suffer in the face of other competing demands, there is a feeling that the public’s positive perception of the nursing profession will also diminish. We know that maintaining health and wellbeing is not simply about treating a disease or condition. Much has been made of the alleged ‘compassion deficit’, with nurses being blamed for being, amongst other things, “too posh to wash”. The BMJ study, however, provides compelling evidence that we cannot simply attribute the poor quality care to ‘rogue’ nurses who are uncaring. Adopting a whole-system and outcomes-focussed approach enables us to look at nursing practice in the context of the wider structure and system. The BMJ study demonstrated that the

number of patients per registered nurse was associated, at a statistically significantly level, with the incidence of 'missed care'.

A [systematic review](#) published earlier this year suggested that caring and compassion are inherent nursing values. The evidence suggests that while the development of these values is influenced by training and role modelling, the main influence is the organisation and culture in which nurses work.

While we value compassion and 'talking with patients', this value does not conventionally come with pound signs attached. In the blinkered drive to manage cost, are we in danger of valuing the wrong things? Are we only valuing the things that come with ready monetary values? While we may acknowledge that poor care incurs financial cost 'further down the line', our immediate concern is to make our books balance now. This raises the fundamental question of 'value for whom?' and therefore who should have a role in making decisions on appropriate resourcing to generate the types of values we want. Valuing public services is not, and should never be, an exercise in accountancy.

*Note: This article gives the views of the author, and not the position of the British Politics and Policy blog, nor of the London School of Economics. Please read our [comments policy](#) before posting.*

### **About the Author**

**Dr Chih Hoong Sin** is Director at [OPM](#) and heads up its Evaluation, Research and Engagement division. He recently edited [Valuing Public Services](#), which is a collection of articles published by OPM looking at practical ways of helping public services measure and demonstrate social and economic value. He designed OPM's programme of training and support, endorsed by the Institute of Leadership and Management, aimed at empowering frontline public service workforce to demonstrate the social and economic impact and value of services.