International Hospital Federation
in collaboration with
King Edward's Hospital Fund for London

The Hospital Services of Europe

Report of the Fifth European Conference 6—10 April 1970 held at the King's Fund College of Hospital Management

The Hospital Services of Europe

Fifth European Conference

Contents

Introduction

The conference, like its predecessors, was convened by the International Hospital Federation and King Edward's Hospital Fund for London. It was held 6–10 April 1970, at the King's Fund College of Hospital Management.

Participants were invited in their personal capacities and not as delegates. Each participant was asked to prepare a paper on one of the themes of the conference, setting out the relevant facts in respect of his own country and making such comments as he thought appropriate.

Copies of these papers may be borrowed from:

King's Fund College of Hospital Management
2 Palace Court
London W2 4HS

or

International Hospital Federation
24 Nutford Place
London WIH 6AN

Conference Themes

1 **Methods of Appraising Hospital and Health Services**

2 **Costing Hospital and Health Care**

3 **Manning Hospital and Health Services**

4 **Integrating Components of Hospital and Health Services**

Participants

Chairman of conference	**P H Constable OBE,** former secretary, Teaching Hospitals Association, London
Opening speakers	**Lord Hayter,** chairman of the Management Committee, King Edward's Hospital Fund for London
	F W Mottershead CB, deputy under-secretary of state, Department of Health and Social Security, London

Conference members

Austria	**Dr Elly E König,** senior adviser to the Government of Lower Austria, Vienna
Belgium	**Professor Dr J Blanpain,** director, Department of Hospital Administration and Medical Care Organisation, School of Public Health, Leuven
	Professor Dr A V Prims, Department of Hospital Administration and Medical Care Organisation, School of Public Health, Leuven
Denmark	**Dr C Toftemark,** deputy director-general, National Health Service, Copenhagen
Finland	**Mr A Asteljoki,** administrative director, Helsinki University Central Hospital
France	**M. P Aurousseau,** chairman, Association of Advanced Hospital Studies, Paris
Germany	**Dr S Eichhorn,** director, German Hospital Institute, Düsseldorf
Hungary	**Dr G Manyi,** Postgraduate Medical Institute, Department of Health Organisation, Budapest, Hungary

Ireland	**Dr M ffrench O'Carroll,** chairman, Hospitals Commission, Dublin
Italy	**Mr G Ciucchi,** Arcispedale S Maria Nuova, Florence
	Professor C Vetere, general medical inspector, director, Division of Hospitals, Teaching and Educational Activities, General Directorate for Hospitals, Ministry of Health, Rome
Netherlands	**Professor Dr J B Stolte,** professor of hospital administration, Tilburg
Norway	**Mr J Aker,** director, Akershus Central Hospital, Nordbyhagen
	Dr H A J Palmer, president, Norwegian Hospital Association, Drammen
Poland	**Professor S E Porebowicz,** professor of hospital architecture, Warsaw Polytechnic
	Dr B Saldak, Ministry of Health and Social Welfare, Warsaw
Portugal	**Dr J M S Caldeira da Silva,** director, Study and Information Centre, General Directorate of Hospitals, Ministry of Health and Social Welfare, Lisbon
Romania	**Dr M Mihailescu,** director-general of hospitals, Ministry of Health, Bucharest
Spain	**Dr A Serigó,** General Directorate of Health, Madrid
Sweden	**Mr G Albinsson,** secretary-general, Halland County Council, Halmstad

	Mr G Högberg, head of department, Institute for Planning and Rationalisation of Health and Social Welfare Services (SPRI) Stockholm
Switzerland	**Dr jur F Kohler,** director, Inselspital, Berne
United Kingdom	**Mr F R Reeves,** director of education, King's Fund College of Hospital Management, London
	Dr J J A Reid, county medical officer of health, Buckinghamshire
Yugoslavia	**Dr I Margan,** president, Federation of Associations of Health Institutions of Yugoslavia, Zagreb

Observers

Mr E U E Elliott-Binns, under-secretary, Scottish Home and Health Department, Edinburgh

Dr R Glyn Thomas, regional medical officer, Organisation of Medical Care, World Health Organisation Regional Office for Europe, Copenhagen

Dr A B Harrington, principal medical officer, Department of Health and Social Security, London

Mr F D Riddett, principal, Hospitals Division, Health Department, Welsh Office, Cardiff

Mr S E Taylor MBE, assistant secretary, Ministry of Health and Social Services, Northern Ireland, Belfast

International Hospital Federation	**Dr J C J Burkens,** president **Mr D G Harington Hawes,** director-general **Miss D Maitland,** assistant director **Mr B Watkin,** editor, *World Hospitals*
Reporter	**Mr L H W Paine,** house governor and secretary, The Bethlem Royal Hospital and The Maudsley Hospital, London

Report on Conference

by Leslie H W Paine

This was a meeting far removed from the hectic, oversized, diffuse, impersonal and often complacent affairs that some international conferences have now become. Its membership was small, knowledgeable, friendly, frank and spoke a common tongue.

Nineteen countries were represented by 25 conference members and nine observers, many of them friends from previous conferences. All, under the genial and experienced chairmanship of Philip Constable, and in the ordered quiet of the King's Fund College of Hospital Management, were relaxed and ready to talk freely about the problems and faults, as well as the achievements, of the health services of their various countries.

The result was a lively, participative gathering, interesting, informative and, in spite of the variety of topics discussed, notably cohesive. It could easily have been otherwise. For unlike its predecessors, this fifth conference had not one theme but four, and each concerned with a fundamental problem of health service provision.

The questions asked of the meeting were how to appraise, cost, man, and integrate national health services. They are the sorts of questions that are easier to pose than solve. No one doubted their importance – only perhaps the ability of those present to answer them.

Professor Stolte (Netherlands) succinctly voiced this underlying apprehension in a quotation from H A Simon: 'The capacity of the human mind for formulating and solving complex problems is very small compared with the size of the problems whose solution is required for objectively rational behaviour'.[1]

But the professor, like the Duke of Wellington, is not a man to accept difficulty as a good reason for failing to attempt any task, and he had a further quotation, this time from Chester Barnard, to explain why: 'To try and fail is at least to learn; to fail to try is to suffer the inestimable loss of what might have been.'[2]

It was a philosophy to which everyone present undoubtedly subscribed; and should this conference ever wish to adopt a motto, it would be hard pressed to find anything more suitable.

Theme 1 Methods of Appraising Hospital and Health Services

France, confessed M. Aurousseau, had tried unsuccessfully for many years to appraise the effectiveness of its hospital and health services. He, like Professor Stolte, saw the heart of the problem as our inability to define precisely our objectives or measure accurately the results of our efforts to achieve them. When health itself was indefinable and basic aims could be stated only in the broadest terms – reducing disease, removing suffering, prolonging life – how (except in certain restricted fields of health care) could we hope to calculate our achievements exactly? And if we couldn't evaluate work done, was it possible, when conflicting needs and demands were both so great, to make wise decisions for the future?

'How do we plan a service', he asked, quoting from a recent leader in the *British Hospital Journal*, 'which offers a theoretically unlimited entitlement in an area of theoretically unlimited demand, with strictly limited resources?'[3] It was the sort of question that once again set us wondering whether we were not attempting to ponder the imponderable. But ponder it we must for a health service was like ambition – its appetite increased with feeding.

France did not have a comprehensive health service of the sort seen in the United Kingdom and some Eastern European countries but, nevertheless, with nine-tenths of the population covered by the country's social security system, the national demand for medical care was disturbingly high. The French appetite for x-rays was almost as great as for motor cars, and the growth of social expenditure *in toto* (10 per cent per annum) was twice as fast as the annual increase in the national income. This meant, as M. Pompidou, President of the French Republic, had pointed out recently, that France had about twenty years to go before her social budget absorbed the whole of her national resources.

The point was reiterated by Mr Albinsson; Sweden had done the same sort of sum as M. Pompidou. Its estimate was that, at the current

rate of increase, health care would swallow up the whole of the gross national product by the year 2007.

Paying for health

Members understood, of course, that these arguments, while based on logical extensions of current trends, were still theoretical. No country either intended, or could afford, to devote the whole of its annual increase in national income to health care services. There were so many other things to be paid for. Social benefits, education, housing, defence, roads and transportation were but a few of the essentials which made heavy demands on any national purse. Some of them – education, housing, social benefits – like proper food, good working conditions and opportunities for leisure, were just as vital to a nation's health as a national health service. How far we could meet the public's requirements in every one of these areas was primarily dependent on the state of the nation's economic wealth, but as Dr Serigó (Spain) pointed out, the pattern of provision would also be affected by each country's history, traditions and culture.

Nevertheless, health care played a particular role in the creation of wealth by maintaining the national labour force. Hospitals in this respect, argued Dr Palmer were manpower-producing agencies. A Norwegian study had shown that if all the country's hospitals were to be closed, the amount accruing to the exchequer would be more than twice offset by the consequent loss of national production due to illness.

A good health service, members appeared to be suggesting, was not only a prime example of man's humanity to man, but an economic necessity as well. If, therefore, it had to be rationed, as inevitably it must, then on both grounds it was imperative that it be apportioned correctly. Value for money in this field of human endeavour was not just a question of producing an efficient service, but of providing the right service efficiently – an activity which involved careful selection and ordering of priorities.

To do this properly demanded the regular provision of reliable basic information, particularly on the extent and productivity of existing services and the size and range of future health needs. The trouble was that no one knew exactly how to produce such information. Dr Saldak, for example, described a national system of simple medical audit which had been introduced in Poland to assess the efficacy

of the treatment patients received from hospitals and general practitioners, but agreed that what was really wanted were criteria against which to judge the quality of care given.

Budgeting

Poor methodology and a lack of clear purpose, said Professor Blanpain (Belgium), limited the usefulness of any present attempts to evaluate medical care. He agreed that the benefits offered by different forms of health services were difficult to compare, but we must try to do so. Incorrect decisions on priorities, for example, resulting from, say, the influence of pressure groups, could well harm more people than they helped. We should, therefore, attempt to make a more conscious allocation of resources and have clearer ideas of the goals we hoped to achieve by so doing.

He recommended to the conference a method of output budgeting called the Planning, Programming and Budgeting System (PPBS) which was being tried out by the Belgian Ministry of Health. PPBS, explained Professor Blanpain, had been introduced in the American Department of Defence in 1961 and had proved most successful. Reduced to its essentials, it involved defining the objectives of expenditure; evaluating programmes designed to achieve these objectives; undertaking cost-effectiveness studies of alternative programmes; reviewing regularly the original objectives set; and implementing any necessary changes.

We must, however, *adapt* not just *adopt* PPBS. The two-year pilot scheme being undertaken in Belgium revealed the sorts of problems we would have to overcome in using the system to help us plan health care services. To start with, the US Department of Defence fully controlled its own affairs whereas the Ministry of Health in Belgium was directly responsible for only about one-third of the country's health care. The American Department was also concerned mainly with equipment, while health services everywhere were labour intensive and spent most of their money on staff. The difficulty of defining objectives and measuring results in the field of medical care also made accurate cost-benefit analysis difficult. It was neither easy to monitor what went on in the services with which we were concerned, nor to overcome their in-built resistance to change.

Nevertheless, he believed that a system like PPBS could be adapted with benefit to the planning of health care programmes so as to

give those concerned with their management a much clearer picture of what they were doing and what had to be done.

Professor Stolte, on the other hand, felt it would be wrong to pin too much hope on this sort of system. It was easy to measure the resources put into any aspect of medical care, but we still couldn't measure with any accuracy the results achieved. Also, while PPBS provided a useful method of rational planning, it offered no direct solution to the vital problem of deciding priorities. As a form of management by objectives it was to be welcomed, but who was to choose the objectives? The setting of priorities in health care was still a political decision in most countries and the conference agreed that in our present state of knowledge it must remain so. But politics was a power game in which conflicting interests exerted conflicting pressures not necessarily for the greatest good of the greatest number of people.

Wants and Needs of the People

'There is mounting evidence', Professor Stolte quoted from Peter Drucker, 'that government is big rather than strong . . . that it costs a great deal but does not achieve much.'[4] The views of politicians, said Mr Högberg, were not always those of the people, and the sort of health service that politicians wanted was not necessarily that which the public would like to have. This might not be the politicians' fault, implied Dr ffrench O'Carroll (Ireland) because it was no easy task to get facts and opinions from the people to the central administrators and so to the government. Communication was bad enough between staff at different levels of the service, and in his view the gap between officers at central government level (the men and women of files) and staff in the field (the men and women of patients) grew wider every year.

As planners and administrators of health care services, however, we must be aware of this communication gap and do our best to bridge it. Both Mr Högberg and Dr Serigó suggested that market research techniques should be used to discover the health *wants* as well as the needs of the population, and most participants agreed that as profferers of health care we had been over-paternalistic in the past. In England, explained Dr Harrington, consumer research was already being carried out in the areas of the British 'Best-Buy' hospitals. But detailed market research was bound to involve us in some difficult decisions. The desires of a variety of consumers were most unlikely to

be identical. The pressure groups which some speakers had criticised were only people emphatically making their wishes known. It was equally unlikely, argued Mr Reeves (United Kingdom), that the findings of market research and the interests of medical research would coincide. They were more likely to make conflicting claims on the same resources and we couldn't hope to meet either demand in full.

Priorities of Provision

This brought the conference face to face once again with the fact that the prime reason for trying to appraise the effectiveness of various forms of health care was to decide on the priorities of provision. Opinions differed on the likelihood of the cost-benefit methods of commerce helping us to do this. The general feeling of participants seemed to be that it was at least worthwhile experimenting with some method of output budgeting such as PPBS which Professor Blanpain had suggested. Even though the sort of objectives which could be defined for a national health service were only such generalities as reduction in mortality or morbidity, it would be valuable to have more exact information on whether or not they were being achieved and at what cost.*

While we continued to search for more sophisticated methods of evaluating our health services, however, we should not, said both Professor Blanpain and Dr Caldeira da Silva (Portugal) cease from trying to improve these services by practical schemes of integration and rationalisation wherever we could. The best must not become the enemy of the good, and much could be done on a common-sense basis to increase efficiency without decreasing humanity. We should, for example, look carefully at the possibility of a wider use of incentives to improve productivity; and we must certainly be prepared to spend money on research into the ways resources were used.

* Some weeks after the conference ended a leader writer in *The Times*, remarking on waste in government spending and the size of the Civil Service, produced a comment which could well represent the collective conclusion of members on this first theme of the conference: 'There is also a limit to the extent to which the techniques of business management and control are applicable to the public sector. Whitehall must develop and apply new techniques, such as output budgeting, to ensure that resources are used in an efficient way. But these techniques are not always the same as those used in progressive industry, for the simple reason that the output of much of the public sector cannot be judged in simple terms of prices and profits.'[5]

But in this logical pursuit of increased efficiency, pleaded Professor Stolte, let us concentrate our attention not merely on reducing health costs but also on improving health services. Let us try to discover the reasons why some services cost more in one country than in another, not to prove or disprove extravagance but to see whether the extra costs brought worthwhile extra benefits to the people.

Theme 2 Costing Hospital and Health Care

As the conference moved into the second theme, it became clear that the importance of reliable costing data might only be equalled by the difficulty of obtaining them. The basic problem, as Dr Eichhorn (Germany) saw it, was how to make costing generally acceptable. In West Germany there was considerable resistance to it, due perhaps to the fact that only about 50 per cent of hospitals there were in public ownership.

British representatives, had they wished, might well have interposed at this juncture that although virtually all hospitals in Britain were state-owned the situation here was little different. Costing, in fact, seemed to frighten hospitals – maybe because they relished neither the possible inefficiencies it could disclose nor the effort which would be involved in eradicating them. And since fear sprang from a lack of understanding it seemed that few administrators really understood or appreciated costing at all.

Cost Consciousness

Hospitals today, Dr Eichhorn went on, could no longer be passively administered, they had to be actively managed and costing was a useful weapon in the manager's armoury. Unless we had good 'on the spot' hospital management we would never achieve efficiency. When resources were limited, managers must be prepared to question the way they were used. Since nurses formed, and doctors committed, a large part of our resources, both must be actively and cooperatively involved in the pursuit of efficiency. They must become genuinely 'cost conscious' and this would involve adequate training, preferably given early before they had become set in their ways and careers. Professor Stolte agreed, but added that it was difficult to

see what in their present training programme could be jettisoned to make way for the management instruction that was required.

Also, participants accepted, if you taught staff to appreciate the value of costing it was incumbent upon you to see that the costing information provided for them was reliable and comprehensible. Those who were to use it must not only understand but believe in it. We must not produce costing data which were liable to inspire the sort of criticism that had been levelled in the past at the annual costing statistics published in Britain – 'some of the unhappiest returns of the day . . . they contain figures which in some cases are ratios of averages of estimations.'[6]

Dr Eichhorn, Dr Toftemark (Denmark) and M. Aurousseau, all felt that costing information was at present collected in many countries merely because it seemed the right thing to do, without sufficient thought being given to what was compiled and why. As a result, said M. Aurousseau, ministries, having obtained costing figures, felt obliged to ask local administrators questions based upon them. Local administrators in their turn felt obliged to reply, and spent time either justifying or repudiating the so-called costing facts. Neither activity in his view served much useful purpose. It was not only doctors and nurses in hospitals but administrators, both centrally and locally, who needed advice on how to interpret costing information and use it properly.

Departmental Budgeting

While not disagreeing with this, the Swedish representatives, Mr Högberg and Mr Albinsson, made the point that hospitals could take a leaf from their ministry's book by making individual departments produce their own annual budgets. The basis of good budgeting, wise spending and sound costing, said their colleagues from Norway, Mr Aker and Dr Palmer, was to inculcate a lively sense of costing consciousness at department level. Departments spent a hospital's financial allocation: they must help to produce the budget upon which it was based. In addition, argued Dr Eichhorn, hospitals should be put into the position where they reaped both the advantages and disadvantages of their local economic policies. They should meet their own over-spendings and retain legitimate savings. Only by such means were they likely to achieve financial maturity and come of age as far as costing was concerned.

This was the basis, Mr Elliott-Binns explained, of an experiment being tried in Scotland. Norms for hospital drug use had been agreed and departments were given annual drug budgets based upon them. Any savings made were retained by the hospital and split – half being used for general hospital purposes and half for the specific requirements of the particular department.

Standards of Service

His practical comment, like that of Mr Asteljoki (Finland) who described a pilot scheme to make better use of nursing staff* served to remind the conference that costing was of little use unless related to standards of service. Most countries have certain broad yardsticks upon which to base the planning of services. Ratios of specialist beds or doctors per thousand of the population were commonly in use. Sweden, said Mr Högberg, had agreed national norms to decide how many doctors should be employed in a hospital. In addition, they were concerned with studies to produce other health standards ranging from how long patients suffering from different illnesses should stay in hospital, to staffing ratios for nurses and medical secretaries.

Standards of service, however, as the Swedish and Danish representatives agreed, were hard to define and awkward to apply. How far, for example, the results of the Scottish or Finnish experiments would prove to be applicable to other countries was a matter of opinion. Generally, in their view, it would be unwise to consider any particular country's standards as necessarily valid beyond its own frontiers. Variations in the conditions of different hospitals even in the same country made comparisons so difficult that national standards could never be rigidly imposed. Costing, which ideally should be used to provide managers with financial foresight as well as hindsight, was likely to bear most fruit if it were kept on a standard basis and studied year by year in the same institution.

International Comparisons of Health Care

In the opinion of Dr Glyn Thomas (WHO), however, the comparison of hospitals and hospital costs in different countries was an interesting and a useful exercise. It spread knowledge and pointed the way to possible improvement. But to look at hospitals alone was

* See also page 18

to see only part of the story. We should consider health services as a whole if we were interested in efficiency. Hospitals might swallow the lion's share of the money spent on health care, but they dealt with only about 10 per cent of national morbidity. Surely, the way that the remaining 90 per cent was dealt with was just as, if not more, important. We ought to compare costs internationally but it must be the costs of health services *in toto*, not just of hospitals, and all such costs, if they were to be of any value, must be strictly comparable. Most of those at present available were not, and could provide only the slimmest guide lines for further investigations.

Dr Toftemark wondered whether the task of comparing the cost-effectiveness of different national health services was worth the time and expense involved; and Dr Burkens (IHF president) thought that the job might be more manageable and just as instructive if one studied the ways in which national health services differed and the variations in costs these differences produced.

Improving Methods of Costing

The conference agreed that there was room for many different approaches to the problem of providing accurate and useful costing figures. They also agreed that costing information of the right sort provided management with a valuable tool with which to reap the reward of greater efficiency that could come from better planning of services.

At present in the health care field, however, this tool was at the sickle rather than the combine harvester stage of development. Perhaps it might improve now that computers were more generally available and information could be processed in such a variety of ways and at such great speed. With their aid we should particularly concentrate on personnel costs. We all knew that most of the money spent on health services went to pay staff wages. The way to improve health services, therefore, was to make better use of the staff available. In health care, the proper study of mankind, in fact, was manpower – the third theme of the conference.

Theme 3 Manning Hospital and Health Services

It was essential, said Dr Kohler (Switzerland) that we learn to use our staff properly and in accordance with their varying skills.

Nurses, for example, must be allowed to concentrate their time on nursing the patients. The needs of patients alone, both in the hospital and outside it, suggested Dr Glyn Thomas (WHO), should decide the pattern of nursing provided in the health service.

It was in an attempt to match nursing provision to patient need, said Mr Asteljoki, that the University Central Hospital in Helsinki had introduced its pilot scheme in the use of nurses. All patients were divided daily into one of six treatment classes, depending on the amount and complexity of the treatment they required. Using this information, the head nurse allocated each morning the number and type of staff needed in every ward. Naturally, most nurses continued to work in the same ward most of the time to cover necessary nursing duties. The changing pattern of those duties, however, meant that staffing patterns had to be flexible also, and that marginal variations in the number and type of nurse employed were necessary.

It was this flexibility and marginal variation that the new system should supply; giving at the same time quantity, quality, and economic control of the largest single establishment of staff in any hospital.

In order to achieve these aims, however, a reservoir of readily available temporary staff was obviously necessary. Helsinki, Mr Asteljoki agreed, was unusually fortunate in this respect. Married nurses unable to work full time were still prepared to come into the hospital at short notice on an hourly employment basis.

Training Nurses

What affected the pattern of nursing care generally, however, was not merely the number of staff employed but the type and the sort of training they received. The present trend, whereby nurses were becoming fairly sharply divided into two groups, the more highly trained theorists and the lesser trained practical workers, was not necessarily the best way to continue in the future. All nurses, agreed Professor Vetere (Italy) must be both theorists and practical workers, for, as Mr Högberg also pointed out, the pressures of nursing work and the sometimes urgent needs of patients did not allow a permanent or exact division of duties between the two. To have it otherwise would be to risk the danger of status getting in the way of good patient care.

Dr ffrench O'Carroll raised the old question as to whether there

were not too many varieties of nurse training. Thought should be given, he suggested, to one basic comprehensive training followed by more postgraduate specialisation. Professor Vetere felt we might go even further and provide the same basic training for all para-medical staff.

Austria, said Dr König, had managed to produce a system to overcome the division between the two broad categories of nurse by providing a well established ladder of promotion. After three years work, nursing auxiliaries could do in-service training for two and a half years, leading to the nursing diploma. There was, as a result, no shortage of applicants for the lower grade posts, and Austria had a better record than most in the length of time that nurses continued to work in the profession – ten to fifteen years compared with three to five years elsewhere. It was not easy to say why, but certainly good working conditions and high standards of accommodation had something to do with it.

Attracting Recruits

This latter point, said Mr Aker, was important. The new teaching hospital at Akershus, near Oslo, which opened in 1960, had included housing for 80 per cent of its staff. This, most members felt, was unusual but all agreed that hospitals in general provided too little accommodation for their staff, and particularly for their married staff. In order to get a reasonable number of doctors to practise in rural areas in Poland, said Dr Saldak, they had to build good health centres and equally good houses for the doctors close at hand. Lack of married accommodation for nurses in Austria, suggested Dr König, was also the reason why they were unable to attract men into the profession, an unfortunate situation because they tended to have a considerably longer working life than many of their female colleagues. If population trends were anything to go by, said Dr Glyn Thomas, men were also the nurses of the future. In the United Kingdom, for example, the number of men and women would be roughly equal by the mid-1980s and, in theory anyway, there would by that time be few unmarried women prepared to devote their whole lives to nursing. This was a trend, added Mr Högberg, that Sweden took very seriously. In order to encourage married women to continue working, families in which the wife did not work were taxed more highly than those in which she did.

The ratio of men to women in nursing, and the number of part-time

staff employed, varied widely in different countries. Portugal, said Dr Caldeira da Silva, still had more men that women in nursing but the proportions were becoming more equal (51 per cent, men and 49 per cent, women). By contrast less than one-tenth of French nurses were men, said M. Aurousseau, and France, like Italy, Switzerland and the Netherlands, employed considerably fewer part-time nurses than Sweden and the UK.

This gave added point to Dr Serigó's argument that patterns of health care in different countries depended on things other than economic wealth. He stressed that no country could expect to solve all its health problems simultaneously, and that the decision as to which should be tackled first was affected as much by the form of a nation's society as by its economic situation.

Medical Services in the Community

The more developed a country and the higher the standard of living of its people, the greater would be the demand for specialists. This, in turn, created a need for more centres for the specialists to work in, larger teams of para-medical staff to work with them, and a sad decline in the status of general practitioners. The devaluation of the family doctor and his work was one of the most disturbing facts of more recent health care history. Large modern hospitals, suggested Dr ffrench O'Carroll, were tending to become impersonal supermarkets, and it was time carefully to reconsider their role. Many of the services they offered at present could and should return to the community to be provided from comprehensive health centres.

There was no reason why such centres, serving populations of about 60,000, should not give a full out-patient service and an old style family doctor service at the same time. Existing child welfare, school medical, and other public health services could operate from them; and they should include geriatric assessment centres, day care wards, social service departments and x-ray, routine laboratory, physiotherapy and chiropody services. General practitioners, restyled 'community consultants' on a level with their hospital specialist colleagues, would run them, supported by junior medical staff; and there would need to be close working relationships and linked appointments with local hospitals. An essential feature of the proposal was the introduction of a new form of community nurse who would be the first line of medical defence for an agreed number of families and provide them with basic family health care.

The conference was in full agreement on the importance of preserving a good general practitioner service. Dr Kohler described the new category of trained medical auxiliary which had been introduced in Switzerland specifically to assist the doctor working outside the hospital. Designated 'doctors' aides' they were part nurse, part laboratory technician, part physiotherapist. They could fit very well into Dr ffrench O'Carroll's concept of the comprehensive health centre. Like his community nurses, they would conserve the time of hard-pressed doctors and help them to see more of those patients who really needed their care.

Productivity and Incentives

Conserving time was most necessary if doctors were to improve their productivity although, as Professor Stolte reminded the conference, merely to do more work was not necessarily to be more productive in the true sense. The quality as well as the quantity of work done had to be borne in mind. Delegates agreed that we must be extremely careful to see that demands for greater output from all health care staff, but especially from doctors, did not merely result in more treatment being given of an unacceptable, lower standard. Productivity and standards were obviously important aspects of manpower planning, but so, of course, were incentives.

In Moscow, Professor Blanpain reported, he understood that some hospitals had been given approved budgets and predetermined work targets on the understanding that if the targets were achieved at less than the budgeted cost, 70 per cent of the savings made would be returned to the staff in the form of bonuses. The difficulty, however, was how to set work targets and how to measure the quality of the work done. We were back once more to the old, fundamental problems of trying to produce acceptable norms of service and cost them accurately so as to be able to assess the efficiency of health programmes.

The offer of financial rewards for suggestions which saved money or staff or made better use of resources was, of course, a simple, practical form of incentive scheme which had often been tried in the past. Experience in the UK, however, had shown that staff suggestion schemes of this kind were not notably successful in hospitals.

Personnel Policies

Dr Caldeira da Silva suggested that except in the more arduous manual jobs, bonuses and other financial incentives were less important in relation to productivity in the health care field than intelligent personnel policies. Adequate salaries, fair promotion, proper training, security of tenure, the provision of social amenities and an occupational health service, good communication systems and the opportunity for all staff to participate in decision-making, were more likely to increase efficiency than any general introduction of incentive bonus schemes. Scientific management techniques such as work study or job analysis had a part to play in improving the use and output of staff. And increased automation offered obvious labour-saving benefits. But, above all else, people needed to feel part of the organisation in which they worked and to be involved somehow in its management.

The staff *were* the organisation. Health services were only as good as the people providing them. Or, as Dr Serigó suggested, though the pattern of health care chosen by any country decided the amount and type of manpower required to run it, the sort and amount of manpower available decided the pattern of health care the country actually got. In support of this, Mr Constable (chairman) mentioned the example of Saudi Arabia. It was not lack of money that hindered development of health services there, but lack of people of the necessary calibre. This was why it was so important to keep good staff once you had managed to get them, why housing and expenses for moving house were necessary for all those whose jobs involved regular movement from one area to another, and why, as Dr Harrington suggested, 'bounties' had been considered in the UK to encourage married women doctors to return to work, particularly in the less popular medical specialties.

Theme 4 Integrating Components of Hospital and Health Services

Manpower would be most effectively used if the various parts of a health service worked closely together. Prevention, treatment, rehabilitation and after care, said Dr Reid (United Kingdom), were all complementary and must not be thought of as otherwise. It intrigued him to think that the title of the fourth and final theme of the conference might imply there was some distinction between the hospital and health services.

Admittedly, in the UK up to now the three areas of the National Health Service – hospitals, general practitioners and public health services – had been administered by legally separate authorities, but that did not alter the fact that functionally they were closely interrelated parts of one whole. Examples of integration which had already traversed the legal boundaries were legion: public health staff seconded to general practitioners; maternity and surgical patients discharged early from hospitals into the care of general practitioners, district and public health nurses. The success of each scheme, in fact, depended more on personalities and outlooks than on legislation and physical facilities, but the drawing together of the tripartite British health services under a number of area health boards, as proposed in the UK government's latest Green Paper[7], would provide management integration from which greater functional integration should grow. The conference was reminded at this point of Lord Hayter's opening speech and the following address by Mr Mottershead, both of whom had described the main proposals for integrating the British health service. To speed further advances it was now necessary to remove administrative and legal boundaries between the hospitals, general practitioners and public health services, that stood in the way of progress and effectiveness.

Patterns of Integration

Integration from the British point of view meant placing the separate parts of the health service under the direct control of multi-purpose area health authorities.

Norway, Denmark and the Netherlands were moving in the same direction. Romania, Hungary and Poland already had fully state-controlled and highly centralised health services. In these countries, however, the emphasis of integration was more hospital-centred than in Britain.

Dr Mihailescu (Romania) spoke of the 'unified hospital' principle which was now the basis of Romanian health care. The aim of this system was to bring dispensaries staffed by general practitioners, polyclinics and hospitals, together in one institution, varying in size and sophistication according to the area and population served.

In Hungary, explained Dr Manyi, the system was very similar. Not every area of the country had all three of the essential elements of health care – basic health centres, polyclinics and hospitals – and

in those that did, the three elements usually occupied their own separate buildings. The goal, however, was eventually to combine all three in the same institution, just as it was in Poland.

Structural integration, said Dr Saldak, was the Polish government's plan whereby all the main health services would coalesce into health centres for every county.

Arrangements in Yugoslavia were not dissimilar. Dr Margan described the integration of hospital and out-patient services into a new type of health institution which they called 'medical centres'. In a health service organised on a regional basis, these centres would serve populations of about 100,000 people.

Whether, in fact, the intention of the planners in Romania, Hungary, Poland and Yugoslavia, was to concentrate as much health care into hospitals as their representatives seemed to suggest at the conference, was difficult to say. There is, as Professor Stolte pointed out, a need for a multi-lingual dictionary of health care terms, and in it the various meanings and interpretations of the word 'hospital' would make interesting reading. Certainly in Britain, where polyclinics have never flourished, hospitals with out-patient departments have, in this sense, always been more integrated institutions than in some other European countries.

This was apparent from the interesting description by Professor Porebowicz (Poland) of the new type of integrated hospital being built at Brodno, an area of recent housing development in Warsaw. The basic principle of design was unity with flexibility, as adopted 40 years ago in the hospital complex at Lille (France), and more recently in the new district hospital at Greenwich (England). It involved centralisation of diagnostic and therapeutic functions, integration of in-patient and out-patient treatment and use of progressive patient care methods, in a building based on a standard module which allowed ready alteration and extension both internally and externally.

The size of the Brodno development (800–1,000 beds) and the 'unified hospital' concept of Poland and other Eastern European countries, demonstrated the trend, apparent in England and Wales with their proposed network of 200 district general hospitals, of fewer and bigger hospitals so as to gain economic advantages. Such hospitals, Dr Reid indicated, would be bound to play a major part in determining the pattern of medical care provided in their areas.

Planning for People

They also illustrated, as Dr Serigó pointed out, that comprehensive health care of the individual patient – the true aim of health service integration – was not possible at local level. Health care consisted of a series of defence lines of gradually increasing complexity, starting with the efforts made by people to remain healthy, and advancing through the work of the general practitioners, clinics and out-patient departments to hospitals and after-care arrangements. Obviously, all of these defence lines could not be provided for every community, urban or rural, no matter how small. With the limited means at our disposal, some could be offered locally and some only at district, area or regional level. The large district general hospital, as its name implied, served a district of probably 100,000–200,000 people, which, because of its size, would inevitably be made up of many local communities. Its main purpose was not only to bring medical specialties together but to centralise scarce resources.

This gave force to the argument of those participants like Mr Elliott-Binns who felt that the basic health care services must be within reasonable walking distance for most people. Comprehensive health centres on the lines suggested by Dr ffrench O'Carroll, he said, should be available for every 30,000 of the population.

Just as the district general hospital integrated specialist medicine, health centres could provide a practical means of bringing integrated health care to the majority of the people, and of helping to ensure that too great an emphasis was not placed on complex treatment at the expense of prevention.

Preventive Medicine

Dr Reid outlined the aims of primary, secondary, and tertiary prevention. Adequate health education and propaganda in such matters as, for example, smoking, could pay handsome dividends in relieving suffering and saving resources. By the same means, Professor Stolte asked, should we not also tackle other current menaces such as pollution, drug dependence and road accidents?

We must be careful, however, remarked Professor Blanpain, that, in our desire to produce a better and more integrated service, we do not allow ourselves to be carried away on a wave of 'preventive euphoria'. He agreed with Dr Reid and Dr Serigó that screening for

detection of such conditions as congenital dislocation of the hip or diabetes was worthwhile, but general multiple screening for early signs of illness might not be so.

Screening for warning symptoms of a genuinely incurable disease, for example, could be both unkind and foolish. And even successful screening for curable conditions, while it reduced the need for treatment in the long run, increased the demand for it in the short term. To press on blindly with preventive measures, without first considering what shifts of the total resources available they would involve, could easily reduce rather than increase efficiency.

Efficiency in Health Care

Like some of the early discussions, this one on prevention and integration, with its cross references to assessment of priorities and use of resources, demonstrated what had become clear early in the conference. The four themes prescribed for discussion were really aspects of one larger theme – efficiency in health care. Efficiency, however, is hard to define, which is why members may have felt at times that they were grappling with clouds. It is even harder to achieve, and that is why it is briefly worth reviewing the main conclusions that this conference reached.

Conclusions

National health depended on factors other than a health service. Health generally was indefinable with any exactitude; so, therefore, were the aims of a health service and the means required to meet them. The pattern of service provided was affected by each country's economic wealth and social structure. Nevertheless, as far as possible the services provided should match the requirements of the people. Such services were limited by the amount of money and the number and type of staff that could be devoted to them. The greater the unification of services the better they were likely to serve the public interest.

Since demands and costs tended continually to rise, all health services were rationing systems of medical care. In such circumstances, the ordering of priorities was vitally important. These, at present, were often political decisions and sometimes arbitrary. They should be based on greater knowledge. This involved knowing the health needs of the people, measuring the extent to which services met these

needs, and being able to compare the relative merits of different forms of service. To discover the former, more consumer research was required. To tackle the latter and much more difficult tasks, some form of output budgeting might be helpful. Communication between the centre and the circumference of the health service circle was badly in need of improvement.

Accurate and well-designed costing figures were likely to be particularly informative but at present were conspicuous mainly by their absence. Costing information must be provided, accepted and understood by all those who used health resources. Staff should be trained to be more 'cost conscious' and departmental budgeting and cost control should be introduced. National and international cost comparisons in the health field were as yet of limited value because of the difficulty of setting accurate and comparable standards of treatment and service. Annual cost variations in particular institutions still offered the sort of comparison most likely to be of benefit.

Since the cost of staff absorbed most of the money spent on health services, manpower must be carefully husbanded. Management techniques – work study and task analysis – together with automation were useful labour-saving devices. Incentive bonus schemes could increase productivity but were more appropriate to manual than to other kinds of work. For all staff, good and humane personnel policies were more important, and ways must be found of giving more people a genuine share in management decision-making. Such benefits as accommodation (especially for married staff), removal expenses, occupational health schemes and social amenities were valuable aids to recruitment and retention of staff. So was the proper use of their skills, particularly in the deployment of doctors and nurses. Their productivity could be increased by wise organisation, but the quality as well as the quantity of the work they did must be borne in mind. The provision of more treatment of an unacceptable, lower standard was certainly not productive in the true sense of the term.

Integration of services could have a vital effect on costs and manpower. Prevention, treatment, rehabilitation and after-care, were all complementary parts of a single service. Prevention in the form of screening for early detection of illness, health education and propaganda must be given its proper place in priority planning.

The development of health centres was essential to balance the

concentration of specialised medical services in large district general hospitals, and to save the general practitioner from denigration and ultimate extinction.

During the long search for better theoretical methods and measures of efficiency, existing practical schemes of collaboration between the providers of various forms of health care must be continued and extended. Legal niceties of who should provide what must not obstruct the advance towards comprehensive care of the individual patient. All health service agencies should work together in concert to improve efficiency in the service to the patient, and not only to save money or to streamline management.

'The patient does not come to the hospital to be administered' said a member of one of our earlier conferences*, so providing the reporter with a fine phrase with which to end his report.

The Fifth Conference produced no such ringing aphorism to conclude this account and linger in the minds of participants. They may in fact have been left with the inalienable feeling that the search for efficiency in health care was likely to be as long as that for the rainbow's end, and at times just as frustrating. None, however, will have doubted the importance of his efforts at a gathering such as this. Efficiency may be an elusive quarry, but its pursuit must be unrelenting in an area where any step forward, no matter how small, means a reduction in avoidable human suffering.

* R M Tornar, administrative director, General Hospital, St Polten, Austria, in a paper presented to the Second Conference on The Hospital Services of Europe, April, 1964.

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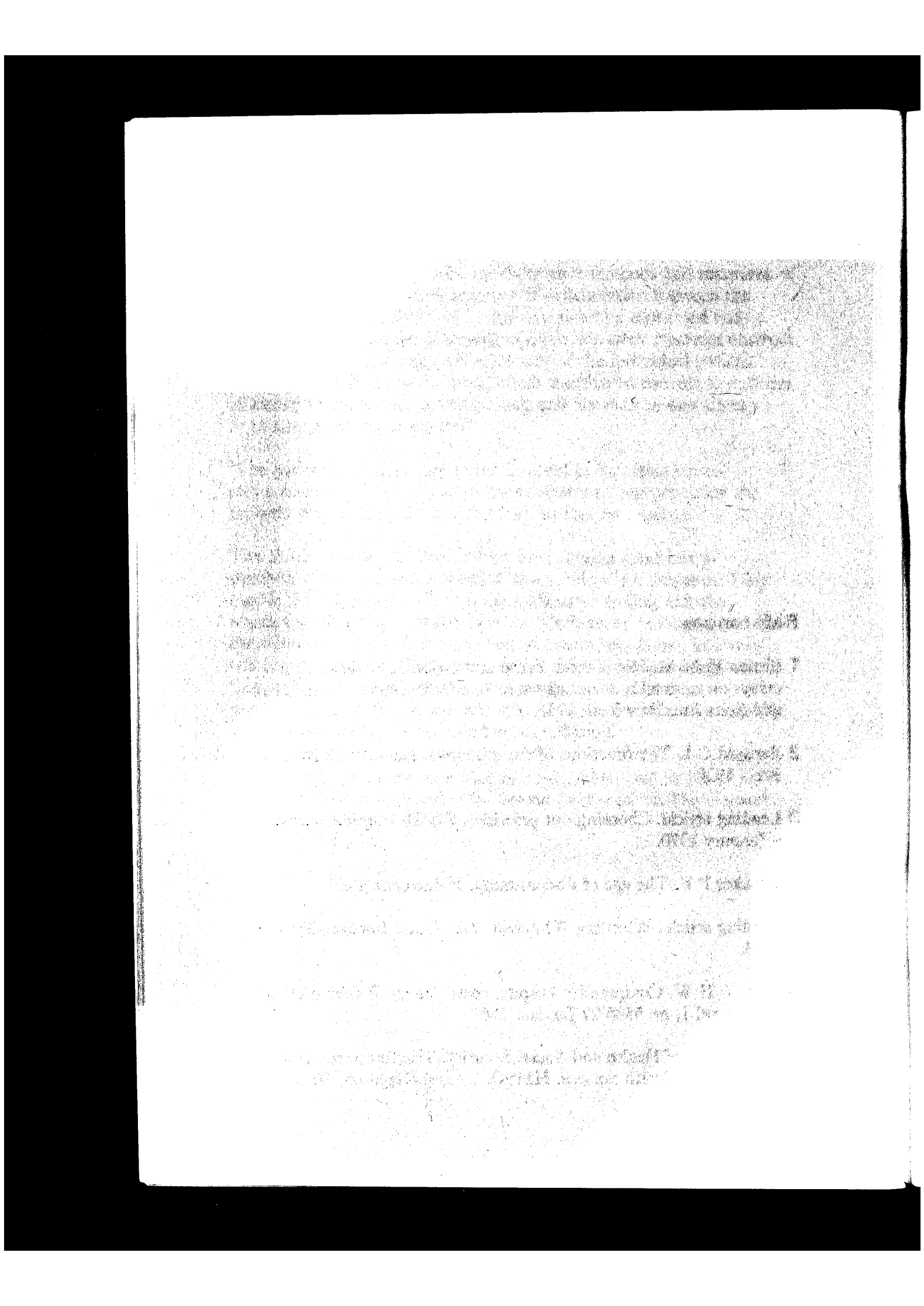

International Hospital Federation

President Dr J C J Burkens
Secretariat 24 Nutford Place London W1H 6AN

The International Hospital Federation, founded in 1929 when it was known as the International Hospital Association, is a non-profit making, non-political federation of all who work in or for hospitals. The official languages of the federation are English and French.

In pursuance of its objectives, the federation, which has its headquarters in London at the King's Fund Hospital Centre, 24 Nutford Place, London W1H 6AN, maintains a library and information bureau on hospital matters; offers advice and assistance to members on their special problems and in particular arranges hospital visits in any member country to meet individual needs and furnishes personal letters of introduction.

The federation holds an International Hospital Congress every other year, at which representatives of all branches of the hospital service can meet their colleagues from other countries and discuss common problems. Since 1949 these congresses have been held in the Netherlands, Belgium, England, Switzerland, Portugal, Scotland, Italy, France, Sweden, the United States of America and the German Federal Republic.

In the intervening years the federation organises study tours of hospitals in order to give members first-hand knowledge of hospital work in different countries. Countries visited so far include: Sweden, Italy, France, Ireland, Germany, USA, Belgium, Israel, Finland, Switzerland and the Netherlands. Both congresses and study tours are open to non-members, but members receive priority in the allocation of places and pay reduced registration fees.

The federation supports international study committees on current hospital problems and runs courses in hospital administration. It also publishes a quarterly international hospital journal, *World Hospitals*, in English, with summaries in French. This journal is issued free

to members to keep them informed of the latest developments in the hospital world.

Membership of the federation is divided into four categories.

1 National hospital organisations, governmental or non-governmental, including national associations of public or private hospitals, ministries of health, and any other organisations concerned with hospitals at national levels.

2 Any other organisations, associations and institutions whose aims or activities are directly concerned with the hospital service including professional organisations, regional or local health authorities, groups of hospitals and individual hospitals.

3 Members of all categories of hospital staff, or professions concerned with hospital work, of hospital management committees or boards and any other persons actively interested in hospitals and their work.

4 Professional, commercial and industrial firms concerned with the hospital field and publishers of hospital journals.

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