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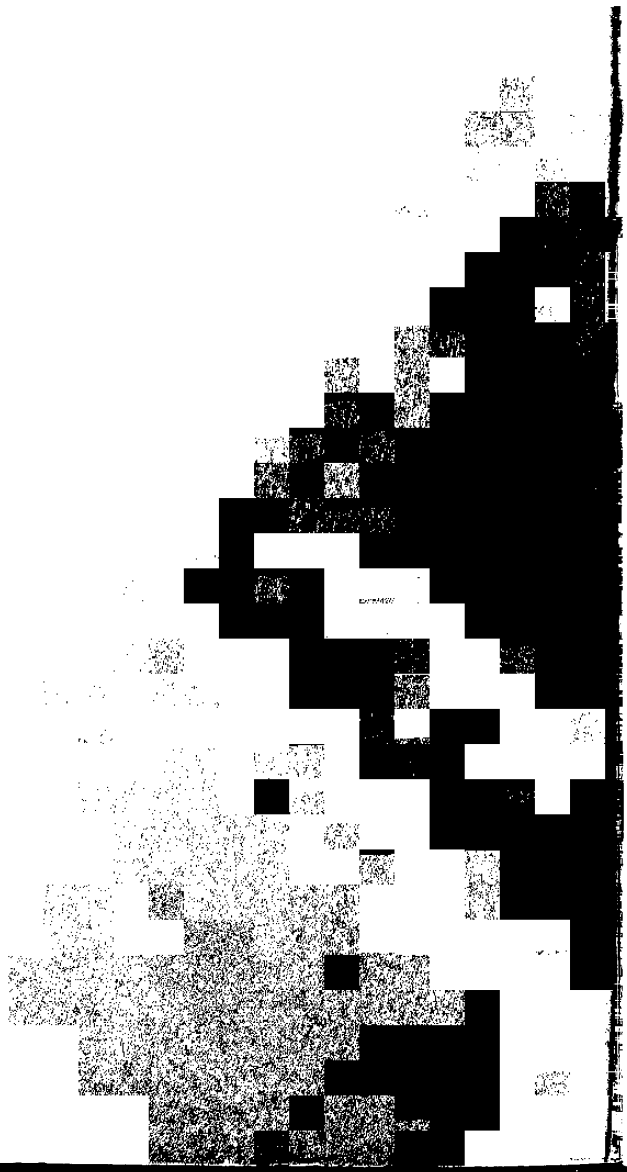
The future of NHS general management: where next?

GORDON BEST



THE FUTURE OF NHS GENERAL MANAGEMENT: WHERE NEXT?

GORDON BEST

KING'S FUND COLLEGE

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INTRODUCTION

Earlier this year, I had the good fortune to spend a number of weeks in Australia and New Zealand. Part of the reason for my trip was to talk to health service audiences about the impact of general management on the National Health Service. During this time, I had a number of experiences which, in retrospect, seem to me to be significant.

After each of my talks in the Antipodes, a small number of people invariably approached me either to follow up something I had said, or to make additional points they had not to raised in open discussion. And while this often happens at public lectures, what I was not prepared for was the fact that in almost all cases, the majority of these people were U.K.-born health service workers who had left the U.K. - and the NHS - within the last decade. Indeed, many of them had worked in the NHS until as recently as the early 1980s.

What was perhaps even more surprising is that in nearly every case, these people made the same point: namely, that they found it difficult to believe a number of the things I had been saying. In particular, they expressed a good deal of scepticism about some of my claims as to how the NHS had been changed by the introduction of general management. For example, they found it difficult to believe that since 1982, no two district health authorities had the same management structure nor were organised in exactly the same way. Nor could they quite believe that DHAs were relatively free to decide how to define a unit of management and, in many cases, then to decide how many units of management

they would have. Equally, they doubted my claims that each district had management 'boards' whose membership varied - some omitting key professional interests; that about two-thirds of such boards included a senior manager whose primary responsibility was to promote and improve service quality and patient relations; that nearly 1,000 senior managers in the service were subject to individual performance review and performance-related pay; and that, in general, the service was far more performance-aware and less internally-focussed than it had been even five years ago.

Shortly after returning from Australia, I had occasion to meet with two district health authority chairmen. In addition to being health authority chairmen, the two individuals in question were also successful businessmen with wide experience of private sector management. What was significant for me was that during this meeting, both chairmen revealed that, on a number of occasions, they had considered trying to interest their NHS general manager in a career in private sector management. And although both had resisted this temptation, they were very clear about why they had considered it at all: namely, that they had a high regard for their NHS general managers' abilities and felt that they would make successful private sector managers.

Taken together, these two experiences speak volumes about the impact of general management on the NHS. First, the managers and professionals whom I met in the Antipodes remembered a service which seemed extraordinarily different from the one I was describing in my lectures. What they remembered was a classic, public sector, administrative bureaucracy characterised by:

bureaucracys'

* uniform structures and procedures;

* an internal focus with a consequent insensitivity to the consumer;

* an administrative rather than a managerial approach to change; and,

* a reactive rather than a proactive stance in relation to the external environment.

By contrast, what they heard me describing was an organisation that, while still firmly in the public sector, now possessed a number of characteristics not previously associated with 'unmanaged', public sector bureaucracies. For example, I had described an organisation characterised by variety and local differences in the way services were being delivered; one in which nearly a thousand managers had accepted explicit responsibility for the performance of their sub-division; and one in which the consumer was far more visible. What I think these people found hard to imagine is just how an organisation as large, complex and politically sensitive as the NHS could have changed so much in so short a time. Hence their scepticism about my claims in relation to general management.

Second, my experience with the two chairmen simply brought the same point home in a more direct way. It seems to me highly unlikely that even as recently as five years ago there would have been many chairmen wishing to attract NHS administrators or other professionals into managerial roles in the private sector. But in 1987, this is arguably no longer true. Today, the best NHS managers are demonstrating that they can negotiate clear and realistic objectives, take responsibility for performance, and then deliver change on a scale and in a fashion that - given the

complexity of the NHS - compares favourably with many of their private sector counterparts (Ref. 1).

What I have concluded from these two experiences (and others) is that whatever else may be true about the introduction of general management, its impact on the service has been immense. In just five years, an organisation which employs more people than any other (non-military) public sector organisation in the world, and which spends £20,000 million a year, has been transformed from a classic example of an administered public sector bureaucracy into one that increasingly, is exhibiting the qualities that reflect positive, purposeful management. Moreover, it is becoming increasingly clear that many NHS managers are equal to the challenge of exploiting these changes in ways that in the long term - if not also in the shorter term - will strengthen the service and provide a better deal for patients (Ref. 2).

It would be difficult to overestimate the importance of this transformation both in terms of what has already been achieved and in terms of the potential which still exists. What might one of the largest public sector bureaucracies in the world already looks good value in international terms (Ref. 3), what might it eventually achieve as a managed service? Can the NHS continue to evolve into a more dynamic, responsive and actively managed service representing even better value for money? Or will the transition to general management be arrested? In short, what will we make of the opportunity which now stands before us?

GENERAL MANAGEMENT: WHAT NEXT?

It has become clear over the past year or so that the initial phases of introducing general management are slowly drawing to a close. Almost every general manager has been in post for well over a year; almost all have been working to explicitly agreed performance objectives for most of that time; considerable progress has been made in strengthening the performance review process; and so on. What the next phase of general management is likely to look like however, is less clear. Two trends are however, increasingly evident.

The first of these is the trend towards greater centralisation within the service. In particular, a number of developments suggest that the DHSS - consciously or otherwise - is engaged in a process of 'repossessing' general management. Moreover, in so doing, they are giving less emphasis to its decentralised, locally-responsive features, while simultaneously strengthening its top-down, line management aspects. Perhaps the clearest evidence for this trend appeared during the latter half of 1985 and the first half of 1986 when the DHSS issued a series of supplementary 'instructions' setting out details of how health authorities should implement the 1983 Circular (Ref. 4) on the contracting out of laundry, domestic and other support services. What was significant about these instructions, was their concern not only with what local health authorities should do, but also with the detail of how this should be done. As such, they represent a return to the classic, public sector bureaucratic means of delivering change: i.e., in accordance with uniform, pre-prescribed procedures which make little or no allowance for

local constraints and opportunities. Such an approach also assumes implicitly that general managers are little more than public functionaries whose performance is in important part judged by how efficient they are in implementing policies and procedures conceived by and driven from, the Centre.

The second trend is towards what for lack of a better term, I shall call 'unmanaged marketisation'. This trend has also been in evidence over the past 18 months or so, but has been particularly evident since the June election. Indeed, over the past six months there has been a spate of ministerial statements (Ref. 5), a number of publications (Ref. 6) and the setting up of at least two independent inquiries (Ref. 7), all focussed on how market forces - and in particular, competition and pre-paid insurance schemes - might be utilised to improve NHS performance.

Should this trend continue and begin to have an impact on government policy, the future of general management would seem to be intimately tied up with the introduction of market forces largely as a means of improving NHS efficiency. And while it would be indefensible to argue that the NHS should not be more efficient, it would seem equally mistaken to argue that general management in the public sector should - without adequate safeguards - become overly concerned with greater efficiency at the expense of say, geographical or social equity. There is after all, little evidence that market place incentives promote greater equity, better access or indeed, greater relevance to need (as distinct from expressed demand) (Ref. 8).

The next stages of NHS general management will without doubt, be determined in part by ministers, their civil servants, and therefore, the DHSS and the NHS Management Board. And this is as it should be for management in the public sector must in important part, be concerned with ensuring that ministerial - or central - intent is realised locally. No doubt too, there is a role for private sector market forces to play in ensuring that general management is responsive to incentives that promote greater efficiency. Given the nature of the opportunity which the general management reforms have created however, what is striking about both the centralisation and marketisation trends, is the lack of imagination they seem to reflect. On the one hand, general management is seen as little more than a means for giving effect to top-down line management. On the other, public sector general management is to be exposed to the same forces and therefore encouraged to pursue the same ends, as are pursued in the private sector.

If we are to make the most of the present opportunity, both of these trends need to be examined very carefully.

More Centralisation? (Ref. 9)

All large enterprises face recurring dilemmas about the desirable extent of central direction compared with local autonomy.

For example, risk averse individuals tend to encourage central controls, while the entrepreneurially inclined, and particularly those with a market (or consumer) orientation, will often sponsor

the opposite. Thus the British civil service, and the wider public sector, have historically supported Whitley pay scales but discouraged both local innovations and any personal identification with particular policies or achievements. In a classic example of Weberian bureaucracy, public employees have been expected to be anonymous, virtually interchangeable and to carry out standard procedures whenever possible. The worst risks associated with the exercise of individual autonomy in the public sector have been seen as potential embarrassments for Government ministers.

By contrast, Griffiths urged the appointment of individual general managers, personally accountable, and not part of a consensus. "There is a danger of over-organisation" he wrote, and consequently advocated greater freedom for chairmen, more devolution and a review of the pay system "so as to overcome the lack of incentive". From a similar perspective we find Peters and Waterman (Ref. 10) writing about the most successful companies and recording: "when we look at ... virtually any of the excellent companies, we find that autonomy is a product of discipline. The discipline (a few shared values) provides the framework. It gives people confidence (to experiment, for instance) stemming from stable expectations about what really counts".

'Shared values' can sound like the worst sort of sociological jargon, yet Peters and Waterman emphasise their pragmatic importance after studying excellent companies. In the final chapter of In Search of Excellence they wrote:

> "Carlson doesn't blush when he talks about values. Neither did Watson - he said that values are really all there is. They lived by their values, these men - Marriott, Ray Kroc, Bill Hewlett and David Packard, Levi Strauss, James Cash Penny, Robert Wood Johnson. And they meticulously applied them within their organizations. They believed in the customer. They believed in open doors, in quality. But they were stern disciplinarians, every one." (Ref. 10, op cit)

The lesson here is that corporate discipline can be achieved either through tighter central control or through the dissemination of corporate values. After the welcome spate of autonomy, enabling NHS innovations in 1984 and 1985, the pendulum now seems to be swinging back. It is not uncommon for large corporate enterprises to go through such swings and the tension between central direction and local autonomy is not necessarily a harmful force. The balance needs to be appropriate at any particular time, however, and the optimum point is likely to be perpetually shifting.

There is, of course, a case that can be advanced for more central direction. There have been several managerial 'successes' due to central initiatives - for instance, the introduction of Individual Performance Review for general managers (Ref. 11). Although the Griffiths Inquiry Team criticised NHS management for giving inadequate attention to questions of staff development and human resource management more generally, there was very little response to this criticism prior to the introduction of IPR. Since the introduction of IPR however, the majority of health authorities have begun to take staff development issues more seriously with, for example, a number of health authorities emphasising the importance of personal development within the IPR framework and expanding IPR to more junior tiers of management.

This example illustrates that not all central initiatives need be seen as 'interference' in local affairs. Rather, some might be seen as 'levers' which local management can make use of to come to grips with problems which might otherwise prove less tractable. But such advances should not be allowed to obscure the fact that a 'top down', line management model is only one possible model of general management and not necessarily the best one for the NHS. Unfortunately, this over simple idea of general management seems to be the implicit benchmark against which developments in the service are currently being assessed.

An alternative benchmark can be found by looking at the way in which many of the larger and more complex private sector organisations are managed. Many of these and in particular, many of the Japanese multinationals (Ref. 12), practise a form of general management that goes well beyond the simple line management model and which could have many lessons for the NHS. Here, the role of the centre is clear: it is

* to be precise about what is important and therefore what is to be achieved

* to provide only general guidelines about how this is to be achieved

* to ensure that there are strong incentives in place that will motivate local management to find innovative and creative ways to realise central intent in the light of local constraints and opportunities, and

* to be prepared to intervene in local management in situations where central intent is clearly not being realised.

The parent-company boards in many such multinationals will often set out specific performance targets for their national and regional subsidiaries. Such targets might include minimum acceptable returns on investment; market share targets; minimum safety standards and so on. In addition, they might specify guidelines within which these targets are to be pursued - for example, restrictions on employment or advertising practices. In addition, local management often reaps considerable benefits if such targets are met. Indeed, in many cases, these benefits will extend well down into the organisation sometimes incorporating the workforce as well as management (Ref. 13).

In these circumstances, it is not uncommon to find two national or regional sub-divisions of the same multinational managed in quite different ways yet delivering quite similar performance. The differences in management of course, reflect local differences in opportunity, constraints and requirements. Within this framework, general management at a 'local' level is intimately concerned with managers finding imaginative and effective ways of making use of the considerable freedom they are given, to realise central intent in ways suited to their local circumstances. Top down, line management is one important element in this approach to general management, but local initiative and experiment as well as 'bottom up' pressures and constraints, are also important.

Compared with the over-simple line management view of general management, this 'integrative' model not only seems more imaginative, it seems far more likely to produce results in an organisation as complex and diverse as the NHS.

Unmanaged Marketisation?

In a recent pamphlet published by the Centre for Policy Studies, John Peet makes the point that, alone amongst health care systems in the Western world, the NHS has an '... almost total lack of any incentives to greater efficiency'. (Ref. 14). And while there is a good deal of truth in this statement, it obscures an even more fundamental point: namely, that there is an almost total lack of any performance incentives in the NHS. There are for example, no incentives to encourage greater equity or better access to given services.

My colleague, Robert Maxwell, has suggested that the overall performance of any public service organisation needs to be considered in relation to a number of fairly discrete performance dimensions (Ref. 15). For health services, he has suggested six such dimensions as summarised in Table 1. It might well be argued that there is some overlap or double counting implicit in Maxwell's dimensions. There is however, unlikely to be much argument about two points: first, that one important reason why some service organisations are located in the public sector is that they cannot be solely concerned with efficiency but must also attempt to guarantee certain minimum levels of equity, access, and so on; and secondly, while market forces provide very effective incentives to greater efficiency, without

carefully designed countervailing measures, they can encourage public sector managers to buy increased efficiency at the cost of other aspects of performance such as equity or access (Ref. 16).

Clearly, if market incentives such as competition or 'internal-trading' are to be used to strengthen rather than to undermine the NHS, then it is critically important to think through what it is these incentives are intended to achieve and how managers can be encouraged to seek out appropriate trade-offs between different aspects of performance. To illustrate what is at stake, it is possible to look across the Atlantic at some recent U.S. experience:

> In 1985, Robert Maxwell and I paid a visit to the U.S.A. to (a) try to learn more about the recent spate of growth in the pre-paid health plans in that country, and (b) to talk with some of the managers of what were thought to be some of the better Health Maintenance Organisations (HMOs). During that time, we had the opportunity to spend two days in Cambridge, Massachussetts, talking with managers and others at the Harvard Community Health Plan (HCHP).
>
> HCHP is a large HMO (more than 300,000 members) catering for the population of greater Boston, but drawing a disproportionate part of its membership from academic communities in Boston and Cambridge. One reason that HCHP is able to attract this membership is that its medical and other clinical staff are drawn from some of the very best medical schools and teaching hospitals in the U.S. A second and related reason is that HCHP has a reputation for providing a very high quality service to its members. And indeed, our impressions throughout the visit were that this reputation was richly deserved.
>
> HCHP is, however, at least equally well known for its commitment to serving the less well off segments of greater Boston's population. Because many of its members are made up of academics and their families, HCHP benefits from having a relatively 'healthy' membership. On average, therefore, HCHP provides this segment of its membership with relatively little health care. The annual premiums these members pay thus exceed the costs of the services they require. Hence, HCHP makes a substantial 'profit' on this part of its membership.

DIMENSIONS OF PERFORMANCE	POSSIBLE MEASURES
Access to Services	* Waiting times for specific services * Ambulance response times * Travel times for specific services
Relevance to need (for the whole community)	* % of the budget being spent on (say) specific community services * Achievement of given care group service targets (e.g. immunisation rates) * The existence and use of follow up assessment procedures
Effectivness (for individual patients)	* Re-admission rates for the same diagnosis * Infection and complication rates * Existence and use of care 'protocols' for given diagnoses
Equity (fairness)	* Take up and admission rates for different sub-groups of the population * Waiting times by population sub-group * Availability of services for 'minority' diagnoses
Social acceptability	* Annual report (statutory) prepared by community representatives * Complaints * Number of residents travelling elsewhere for services available locally
Efficiency and economy	* Unit costs * Achievement of cost improvement targets * Achievement of activity level targets

TABLE 1 - DIMENSIONS OF HEALTH SERVICES PERFORMANCE (AFTER MAXWELL 1984)

Because, however, HCHP is a not-for-profit HMO, it diverts this surplus into providing services from clinics located in some of Boston's poorest communities. It thus provides family planning, abortion counselling, drug rehabilitation and other sorely needed services in some of Boston's least well off areas. Moreover, the premiums paid by these poorer members do not cover the costs of these services and so HCHP operates these at a loss. In effect, HCHP is in the business of promoting equity (relevance to need?) by diverting resources away from some of greater Boston's healthiest residents to some of its least healthy - a principle by the way, which underpins the concept of an NHS.

During our visit to Cambridge, senior management within HCHP were preoccupied with an external threat posed by competing HMOs. In particular, a number of for-profit HMOs were making significant in-roads into HCHP's academic membership base by offering this population a benefits package almost identical to that offered by HCHP, but at a substantially lower price. They were able to do this, of course, because they were offering their services only to the relatively healthy segment of HCHP's membership. In other words, without the obligation to promote equity, the for-profit HMOs were able to be more 'efficient' in providing health care to the academic population of Greater Boston. Left solely to the competitive market this situation could only be resolved by either HCHP abandoning its commitment to its poorer members (thus allowing it to lower its premium) or by risking bankruptcy.

This experience is not untypical. Indeed, Alain Enthoven in a recent article clearly states the more general case:

"Many proponents and critics of the competition idea share the misconception that 'competition' means a market made up of health care financing and delivery plans on the supply side and individual consumers on the demand side, without a carefully drawn set of rules designed to mitigate the effects of market failures endemic to health care financing and delivery, and without some form of collection action on the demand side. Such a market does not work. It cannot produce efficiency and equity. Health insurance and health care markets are not naturally competitive. Health

insurance markets are vulnerable to many failures that result from attempts by insurers to select risks, segment markets, and protect themselves from "free riders"." (Ref. 16, page 106, emphasis added.)

If market forces and incentives are to be channelled in such a way that they strengthen the NHS and improve general management, a number of points must be borne in mind:

* Managers in public sector service organisations are engaged in a continuous process of seeking out acceptable trade-offs between different aspects of their organisation's performance (Ref. 17). Market forces can be useful in providing incentives which promote certain kinds of trade-offs. It is critical however, that these forces are regulated so that they reinforce the mission of the organisation rather than simply certain aspects of its performance.

* As the Harvard Community Health Plan example illustrates, any organisation committed to promoting such ends as minimal standards of equity or access, can always become 'more efficient' by sacrificing these ends. If marketisation is intended solely or largely to result in greater efficiency, then this could be achieved more effectively by abandoning the NHS in favour of the private health sector. If the NHS is to remain in the public sector, then there is an urgent need to decide just what general managers are to be held accountable for: in short, there is a need to redefine the managerial 'bottom line'.

* The market is not the only source of incentives which can be useful to public sector managers. If public sector service organisations are in the business of promoting aspects of performance such as those suggested by Maxwell, then there is surely scope for the design of public sector incentives systems - including the use of regulated market forces - which encourage public sector managers to seek out those performance trade-offs that best reflect the mission of the organisation.

THE FUTURE OF NHS GENERAL MANAGEMENT

The two trends towards further centralisation and greater marketisation are, of course, not alternatives. One possible development over the next year or two would be for the DHSS to attempt to 'orchestrate' the further marketisation of the NHS. For example, we might find on the demand side some experimental schemes whereby large employers, insurance companies or indeed, health authorities, are encouraged to become major health insurers for defined populations while, on the supply side, more services become privatised so that the insurers have competing suppliers to choose between. In this case, the future of NHS general management will be determined largely by (a) what is to be privatised in what order (and therefore the degree to which NHS managers would need to act in a functionary capacity in causing this to happen) and, (b) market forces (and market failures) which could well mean that many NHS general managers would eventually become - or operate in a way indistinguishable from - private sector managers.

For the reasons set out above, this kind of future seems to me to represent an extraordinarily unimaginative use of the opportunity which now stands before us. Surely, the further development of general management holds out the prospect of strengthening the NHS not only in relation to its traditional mission, but also in ways that promote greater efficiency, responsiveness, patient choice and the other characteristics which, it is often held, greater marketisation will achieve (Ref. 18). The challenge now is to open up this debate.

Strengthening NHS General Management

The earlier discussions of different approaches to general management and the potential pitfalls of unmanaged marketisation, suggest some design principles which may be useful in thinking about how to strengthen NHS general management. These are:

* A strong role for the centre (the NHS Management Board?) in clarifying the core mission of the NHS (i.e. what matters) and in setting short term targets which reflect this mission.

* Sufficient freedom about how these targets are to be achieved so that RHAs and DHAs are able to explore inventive ways of responding to them locally.

* Strong organisational and managerial incentives that will have the effect of motivating DHAs and RHAs to be proactive, forceful and innovative in their search for locally suitable

ways of realising central intent.

* A commitment to setting targets and introducing incentives in such a way that general managers and their authorities will be obliged to seek out performance trade-offs that improve one or more aspects of performance while not making unacceptable sacrifices on others.

There would obviously be a number of difficulties in translating these principles into workable proposals that would find broad acceptance amongst ministers, health authorities, the professions, the broader community, and so on. Nevertheless, these principles are arguably no more radical than those informing the original Griffiths reforms and so it may be worth speculating further. Consider the following illustrative example:

> 'The NHS Management Board negotiates with each RHA a small number of targets intended to improve and/or sustain one or more aspects of NHS performance. (For simplicity, I will hereafter refer to Maxwell's dimensions of performance). Some of these will be non-negotiable - for example, a cost-improvement programme target or a specific service target - reflecting say, ministerial priorities. Others might be negotiable in order to provide RHAs and DHAs with more 'space' to devise local tactics for achieving the 'non-negotiables'. On the whole, targets will refer to minimum achievement levels, leaving it to RHAs and DHAs to work out how these are to be achieved.
>
> Each RHA and DHA is then given a prospective range within which their budgetary allocation for the coming year will fall. Where each authority will fall within that range (i.e. how much revenue they will actually receive) will then depend on how well they perform in relation to their targets. The revenue ranges would need to be adjusted to reflect RAWP-like considerations and the proportion of districts which could fall in different bands of the ranges would need to be fixed so that the total NHS budget could be fixed. But a key feature would be that every district (and unit?) would be in a position where - given good enough performance - it could increase its allocation

significantly. Conversely, given bad enough performance, a district could carry forward a significant overspend. Where each DHA and RHA fell in their range would be determined retrospectively at or near the end of the year in relation to the targets agreed at the beginning of the year.

Finally, both the Management Board and RHAs would need to be prepared where necessary to step in and modify management arrangements if for example, DHAs (or RHAs) continually fell in the lower end of their range.'

Imaginatively handled, relatively simple changes such as these could have a major impact on management in the NHS: for example,

* Health authorities would be likely to take on much more of a corporate identity and sense of purpose around strategies designed to secure greater - or at least no less - revenue.

* General managers' negotiating positions within their authorities would be considerably strengthened. For instance, it could well be easier to gain the co-operation of clinicians or other professional groups by holding out the prospect of more - or at least no less - resources if a particular course of action were to be adopted.

* Joint working with other authorities (DHAs and otherwise) might well become more common in the pursuit of greater resources. Small numbers of DHAs might for example, choose to negotiate some collective targets in order to improve their individual chances of achieving greater resources. These could lead to a considerable rationalisation of particular services provided that this did not entail unacceptable sacrifices in say, access to these services.

* Provided that negotiated targets were carefully derived,

reflected the important dimensions of NHS performance, and that some were minimums that had already been exceeded, local management would be likely to experiment to devise inventive ways of 'trading off' between performance dimensions in the interest of improving overall performance. In this case, a DHA might for example, choose to meet (say) its orthopaedic activity target by sub-contracting this to the private sector in order to divert savings into the community thereby improving its performance on the 'relevance to need' dimension (Table 1). In other circumstances, a DHA might choose to compete aggressively for private acute work (e.g. orthopaedics) in order to earn a surplus which, just as in the case of the Harvard HMO, it could then divert to say, long-term care, in the interests of promoting greater equity.

It is obviously difficult to speculate about the kinds of performance trade-offs NHS general management might devise. Given strong enough incentives however, and an explicit understanding of how achievement in each of the performance dimensions contributes to a DHA's overall performance, it is likely that the search for different kinds of trade-offs would prompt both partnerships and competition with the private sector as well as between different authorities.

* Finally, provided some dimension such as social acceptability were to figure in the overall assessment of performance (and therefore the likelihood of attracting more or less resources), it is quite likely that this would give rise to greater consumer responsiveness. For example, DHAs

might take on the role of community 'sponsors' with the task of persuading community representatives that the choices made say, between access and efficiency, and between private and public provision of services, are those which on balance, best reflect community need while maximising the resources available to invest in health.

CONCLUSION

Further speculation on what might happen in such circumstances is unlikely to be fruitful. What is intended however, should be clear. It is to strengthen and develop NHS general management by (a) taking more realistic and explicit account of the subtle and complex nature of the trade-offs public service managers must engage in to further the missions of their organisations; (b) devising incentive systems that encourage management to seek out new and inventive ways of making such trade-offs; (c) attracting private sector resources into health care in a way that strengthens rather than undermines the NHS; (d) providing strong central leadership and ample local 'space' so that NHS general managers can demonstrate what can be achieved through general management; and (e) as a consequence, making the best use of those resources which can be invested in health.

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18) Peet J., op cit.

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