NHS MANAGEMENT PERSPECTIVES FOR DOCTORS

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Foreword

Since it was launched in 1948 the National Health Service has developed into a mammoth industrial, scientific, caring, and curing organisation on thousands of sites. Such an enterprise needs effective management. For many years our hospitals were indeed run by 'management' committees, but it was rather a hollow title, for there was little management in the modern sense. Despite this, and the considerable expansion of the NHS, the dedicated staff somehow managed to fulfil its objective of providing patients with an accessible service of good quality.

In an organisation the size of the NHS, dedication and skill are not enough: good management is essential and in the 1960s the administrative cracks were showing. In 1974 and 1982 reorganisations were introduced to improve the NHS's administration. Criticism, however, has grown that those administering the NHS too often lacked management abilities and that those in authority had insufficient power to discharge their responsibilities effectively. The Griffiths inquiry was set up in 1983 to remedy these perceived deficiencies. Its answer was to propose that a clear line of decision making should be identified by the appointment at all levels of general managers with powers to make decisions. This line management structure was to be topped by a new NHS board of management.

What the introduction of the Griffiths arrangements has meant, however, is the appointment of many managers whose previous role was mainly to keep the NHS machine running smoothly. Will they be able to make the necessary metamorphosis and to innovate, to initiate, and to follow through new ideas that are so essential if the service to patients is to be improved? I hope so, for the public wants to see shorter waiting times for attending outpatients or entering hospital, as well as, for example, renal dialysis and hip replacement facilities that match patients' needs.

However good the new managers turn out to be, such improvements will take time. In any case, general managers at all levels will face a difficult trial period of three to four years. They are assuming new and daunting tasks with thousands of NHS staff taking a critical, worm's eye view of their progress, and with performance indicators giving a clear indication of their effectiveness. With resources under severe constraint, managers will be in an unenviable

position. During the next few years many of them risk being marked as scapegoats for inadequacies that are really a consequence of a service trying to operate with resources that do not match the community's needs.

The Griffiths management process has produced the inevitable 'reorganisation blight'—the third bout of morale-sapping disruption in a decade. This has diverted the attention of chairmen and management team members—and indeed all senior members of the health service—from their main task of facilitating the contacts between doctor and patient, whether in surgery, clinic, or ward. The reorganisations have given some clinicians a taste of management, but they have also engendered cynicism among some doctors about the whole management process. Speculation about and competition for the new management posts, and the high-risk exercise of dismantling management teams and management groups, has meant that many health professionals have been distracted from their main aim of investigating, treating, and caring for patients. The effect of this diversion of interest may not be quantifiable, but it is real. Certainly, after the NHS has set its Griffiths course it will stand no more than occasional touches on the tiller: any more recharting the course or redrawing of maps will probably cause a shipwreck.

If the Griffiths reform is to be effective the new management structure and those in it will have to attract the confidenece of clinicians, many of them instinctively suspicious of management and administrators. This attitude may not always be fair or constructive, for managers and administrators, too, have their point of view. This volume reprints the informed comments on management of participants or observers closely concerned with the NHS who come from different disciplines. Their contributions, published originally as a series in the *British Medical Journal*, carry the weight of their collective experience. Though they wrote before the introduction of Griffiths, the authors provide a practical perspective on management for doctors – be they clinicians, manager/clinicians, or managers— that should help the profession to understand its workings in the Griffiths era. A welcome aspect of the reform is the emphasis that Griffiths placed on clinicians taking an active part in management.

One final point: the latest management process prescription is broad enough for varied interpretations by managers and chairmen, and this should prompt some positive initiatives for carrying out multiple pilot trials (controlled or not). Health authorities may well

differ on how they interpret Griffiths, but on one thing they should be united: to institute as soon as possible a running evaluation of the cost effectiveness and efficiency of contrasting management arrangements within the Griffiths context at district and unit level over the next three to four years. This book should stimulate discussion and so help in this essential assessment process.

Maurice M Burrows

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[redacted]

Contents

Introduction

In a complex institution like the National Health Service, which is providing a wide range of sensitive personal services, the administrative structure and the quality of management are bound to influence the standards of service provided. However skilled and dedicated individual doctors, nurses and other health professionals may be, unless the environment is appropriate, the equipment satisfactory, and the financial and administrative responsibilities clearly defined, the service will suffer. Doctors have not been slow to criticise the administrative structure or the quality of management as interfering with their prime task of treating patients. Not all the criticism has been fair and some has been based on ignorance or misunderstanding of administration and management. If the system is to function effectively, all doctors need to understand how it should work and some need to take part to help make it work.

In 1984 the *British Medical Journal* published a 14-part series, *Perspectives in NHS Management*, which dealt primarily with the hospital service and was written by individuals experienced in or with knowledge of NHS administration. These articles have been collated together in this book and published with the generous support of King Edward's Hospital Fund for London. The series, which was compiled with the help of Dr David Allen, senior lecturer in health services management, Department of Social Administration, University of Manchester, was aimed at helping doctors towards a better understanding of and greater participation in NHS management. Dr Allen and Dr David Grimes, a consultant physician, have written an additional chapter on the Griffiths reorganisation to bring the book up to date. The articles themselves are reproduced as they were published in the *BMJ*, though in a different order.

Introduction

1 Who makes the decisions in the NHS?

RUDOLF KLEIN

There is one simple answer to the question in the title of this article. It is that the National Health Service is an organisation remarkable for the fact that almost everyone working in it—whether as a doctor or as a nurse, as an administrator or as a ward orderly—is a decision maker. For what makes the NHS unique is precisely the fact that health care is the product of countless individual decisions made every day by men and women with a wide range of professional and occupational skills, each of whom tends to enjoy a large degree of autonomy or discretion in his or her own particular domain of activity.

The degree of autonomy or discretion may vary; so may the scope offered by the domain. Clearly the doctor has more autonomy and discretion in a more important domain than the ward orderly. But what they both have in common is that, unlike workers on an assembly line, it is they who determine by their individual decisions what is being produced, rather than having their decisions determined by the routine processes of production. There are, of course, routines and established patterns of work, but they do not eliminate scope for individual decision making. Everyone in the NHS has the power to make decisions, even if they are only decisions about the speed and energy with which work is carried out.

It is precisely this proliferation and pervasiveness of decision making that makes any attempt to anatomise the process—to identify with precision who is responsible for what—so frustrating and baffling. For when everyone is a decision maker then, paradoxically, no one is: decisions evolve or emerge over time as a result of a process of bargaining rather than being taken by specific individuals or groups. And if decision making is taken to mean the ability to impose or pursue a course of action, to make a particular solution to a problem stick, then in a real sense little decision making goes on in the NHS. Everyone's decision making domain and scope is constrained, in turn, by all the others working in the NHS.

The theory and the reality

It is therefore not surprising that the reality of decision making in

the NHS is different from the constitutional theory on which its organisational charts are based. In theory, the position is simple. Decision making authority flows downwards from the Secretary of State, just as accountability for actions taken or not taken flows in the reverse direction. There is a hierarchy of authorities—at regional and district levels—who, in Nye Bevan's phrase, are the 'agents' of the Secretary of State.[1] In turn, this would imply a hierarchy of decision making, with the Secretary of State taking the major or strategic decisions and each succeeding level filling out the broad framework of policies in a series of tactical or minor decisions: while the centre takes decisions about objectives, in other words, those on the periphery take decisions about the means of achieving those objectives.

In practice, as several studies have shown, the picture is a great deal more fuzzy and confused.[2,3,4] The relation between the central government's strategic decisions about policy objectives or priorities and local day to day decisions is often tenuous. The former often seem to be little more than hortatory noises that may or may not encourage those at the periphery to move in the desired direction. Indeed, the view of district health authorities as the agents of the Secretary of State, though often implicit in the circulars sent out from the Department of Health and Social Security, seems to rest on bluff. It is not clear that the members of a district health authority are under any legal obligations to follow the instructions of the Secretary of State, apart from keeping within their budgetary limits. Nor is it self evident that the Secretary of State has any effective sanctions if district health authorities defy him, besides not re-appointing the chairman or sending in the auditors if there is any suspicion that local policies may be wasting money.

In turn, of course, the decision making scope of district health authorities is severely constrained. It is, above all, constrained by history. The most important decisions in the NHS, it is tempting to argue, are invariably yesterday's decisions. Once it has been decided, for example, to build a new district general hospital, then this inevitably mortgages future options and limits what else can be done. Given a blank slate, a district health authority might well prefer to put its money into community services. But given the need to finance the revenue consequences of the new building, this option may simply not be available. There will still be some important decisions that must be taken, such as which hospitals to close down

in order to find the money. Even so, the scope will have been severely restricted.

The decision making scope of health authorities—that is, those bodies that, constitutionally, carry the responsibility for taking decisions—is further limited. It is constrained by the decision making autonomy of clinicians. As clinicians are free to determine whom they select for treatment and how they treat them, district health authorities cannot actually take any decisions about the delivery (as distinct from the financing or organisation) of services. So, for instance, district health authorities may well think it desirable to introduce more day surgery or to have shorter lengths of stay, but they cannot *decide* that this should be done. Once more, as in the case of the DHSS, they can only make hortatory noises. Finally, at the coal face of health service delivery, consultants are constrained in their decisions by the availability of resources. Their freedom to make decisions is real but also limited. It is sufficiently real to frustrate the decisions of the policy makers at the top of the hierarchy but also sufficiently limited to frustrate their own aspirations in turn.

The hierarchical model of decision making in the NHS is thus inadequate as an account of what actually happens. For in the NHS, to return to the point made at the start of this article, there is a mismatch between the distributions of nominal authority and effective power. The hierarchical distribution of authority implies a top down view of decision taking, while the diffused distribution of power implies a bottom up interpretation.[5] Given the degree of autonomy and discretion enjoyed by those working in the NHS, it is those engaged in the delivery of health care who have the power to determine what actually happens. To the extent that the medical model—of accountability to one's peers rather than to one's hierarchical superior—applies to the NHS as a whole, if in various degrees, so it is inevitable that decision making power is diffused, and that the search for specific individuals or groups who take *the* decisions becomes a baffling hunt for the snark. Decisions shaping the implementation of policy are made at all levels of the NHS in the day to day business of actually running it.

This diffusion of decision making power is reinforced by another factor. Decision makers require information, though, of course, decisions may be based as much on gut instinct or log rolling among powerful interest groups as on the rational analysis of data. And one

of the characteristics of information in the NHS is that its interpretation often (though perhaps not quite as often as those who do not like its message are apt to pretend) requires local knowledge. The DHSS's current performance indicators exercise illustrates the point well. The statistics collected at the centre require local know how to interpret them: as the DHSS points out, 'local data and knowledge' must be used in any analysis.[6] The same point applies all the way down the hierarchy: if members of the district health authority ask awkward questions about performance they also are likely to be told that the available information cannot be taken at face value and that special factors must be taken into account.

In summary, the NHS seems to be an example of what may be called the law of inverse decision making. Those at the top with the greatest authority to take large-scale decisions often have the least power to make them effective in practice, while those at the bottom have the most effective power but the least scope. If Mr Norman Fowler at the Elephant and Castle often feels frustrated (as I suspect he does), so does the consultant at the periphery.

An alternative analysis

The discussion so far has addressed the question of 'who takes decisions in the NHS?' as though all decisions were of the same kind, differing only in their scale and scope. But this, of course, is to ignore the fact that there are different 'policy streams' in the NHS, as well as different levels of hierarchy.[7] Firstly, there are policies about the NHS as an institutional structure—that is, decisions about *how* the NHS should be organised. Secondly, there are policies about resources—that is, decisions about the distribution of funds. Thirdly, there are policies about how those resources should be used—that is, decisions about the way in which any given bundle of resources is used to provide services for patients. Fourthly, there are policies about processes—that is, decisions about what are desirable (or undesirable) practices.

Putting together the organisational hierarchy and the various 'policy streams' suggests that an appropriate model for the NHS would look like 'Babel House'—a model developed by Dunsire to describe complex organisations in general and represented in Figure 1 (see page 18).[8] In this the vertical lines represent different policy streams (and professional interests), while the horizontal tiers

represent the different organisational levels. As Dunsire points out:

'The building is a Tower of Babel because a different tongue (concepts, vocabulary) is talked on each floor—amounting to a considerable linguistic disparity between top floor speech and ground floor speech—and different jargons and dialects are spoken on any one floor, in each of the corners and other areas. As between one floor and the next, or as between one office and its neighbour on the same floor, differences in language and habitual style of doing business can be noted, though it is quite easy for adjacent ranks and denizens of adjacent offices, to understand one another. Messages from distant locations in any direction—from a far away corner, or from a much higher or lower floor—do not, by contrast, make much sense on first hearing or reading: the most distant, the less intelligible.'

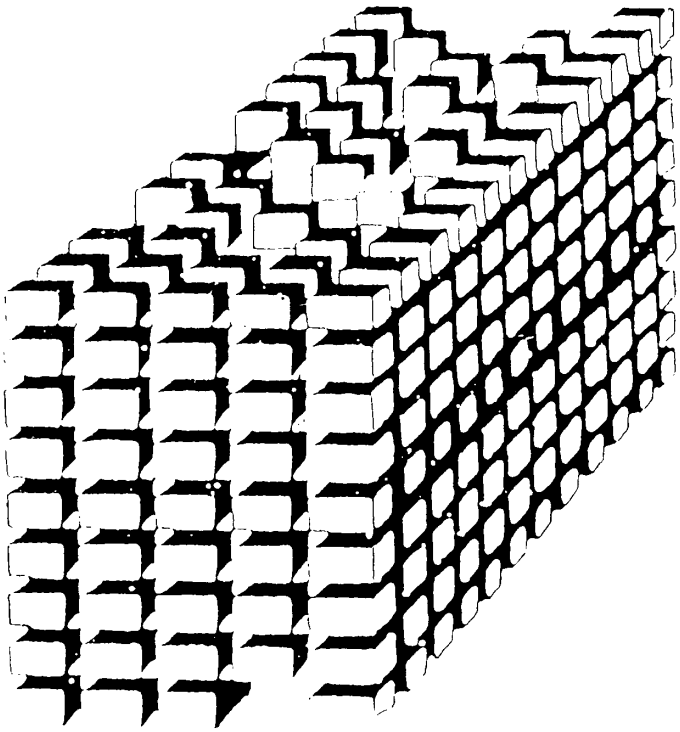
I have quoted the passage at length as it is so evocative of real life in the NHS—and could, indeed, be taken as a paradigm of the DHSS itself. But the Tower of Babel model is also helpful in analysing the decision making process in the NHS, particularly if we concentrate on the vertical lines of 'policy streams'—that is, the different *kinds* of decisions that are taken.

Firstly, in the case of decisions about the organisational structure of the NHS, it is clear that these are taken by the Secretary of State deploying the political authority of the government of the day. The decisions may emerge after prolonged bargaining with professional and other interest groups, but there can be no doubt about who has final responsibility. Moreover, once taken, such decisions are automatically implemented and translated into action at the periphery.

Secondly, in the case of decisions about resources, it is once again clear that the government collectively determines the total and the Secretary of State then decides its distribution to the regions. It is only at the subregional level that there may be some seepage in the decision making process. For although the Secretary of State may lay down the principles of distribution—such as the RAWP formula—its application in specific local circumstances, where there may be uncertainty or scope for special pleading about the meaning of demographic and other data, will once again lead to the diffusion of decision making.

Thirdly, in the case of decisions about the way in which any given bundle of resources is used, the Secretary of State's decision making power tends to be largely hortatory, as noted earlier. Not only is

Figure 1 The 'Tower of Babel'



Source: Dunsire A. *Implementation in a bureaucracy*. Oxford, Martin Robertson, 1978.

there little scope for decision making: history has already made most of the important decisions, and only marginal adjustments are generally feasible in attempts to change the mix or balance of services. But decisions of principle about priorities tend to fragment into individual decisions of practice by clinicians.

Fourthly, in the case of decisions about desirable (or undesirable) processes, it is clear that even the Tower of Babel understates the complexity of the decision making system and the plurality of decision making actors and points involved. For this is the area of professional practice, where each profession has (as it were) its own Tower of Babel and where individuals in the professions may seek the shelter of autonomy when coming to their own decisions.

The complexity of the analysis mirrors the complexity of the decision making process in the NHS. This complexity not only helps to explain the sense of mutual frustration that tends to afflict both those working in the NHS and those responsible for its overall

direction. But it also reflects the balance of power between clinicians and politicians, as well as between the various groups working in the NHS. To simplify the decision making process—to make the decision makers more clearly identifiable and responsible, as proposed by the Griffiths report—would therefore require a shift in this balance of power.[9]

References

1 Klein R. The politics of the NHS. London, Longmans, 1983.
2 Ham C. Policy-making in the National Health Service. London, Macmillan, 1981.
3 Haywood S and Alaszewski A. Crisis in the health service. London, Croom Helm, 1980.
4 Hunter D J. Coping with uncertainty. Letchworth, Research Studies Press, 1980.
5 Barrett S and Fudge C. Policy and action. London, Methuen, 1981.
6 Great Britain, Department of Health and Social Security. Performance indicators national summary for 1981. London, DHSS, 1983.
7 Webb A and Wistow G. Whither state welfare? London, Royal Institute of Public Administration, 1982.
8 Dunsire A. Implementation in a bureaucracy. Oxford, Martin Robertson, 1978.
9 Great Britain, Department of Health and Social Security. NHS management inquiry. Report. (Leader of inquiry: Roy Griffiths.) London, DHSS, 1983.

2 Current issues in administration: a more centralised bureaucracy?

D K NICHOL

Since 1948 the National Health Service has witnessed a frequently shifting management pattern in the balance between centralist forces and devolutionary pressures, partly attributable to the inherent paradox in the way that the NHS is organised. On the one hand, the funding for the NHS is centrally collected (95 per cent through direct taxation) and centrally allocated, with the Secretary of State and the permanent secretary held accountable for the proper use of the funds. On the other hand, the delivery of service is very much a local affair and essentially about contacts between professionals and patients. The 'bureaucracy' lies between the Secretary of State and the front line professionals and acts to achieve effective links between the two.

Power of centre consolidated

The 1950s reflected doubts about overcentralisation with the Guillebaud committee advising more relaxation of central control.[1] The then Ministry of Health did not contest this advice and was content to devolve executive powers; the notion of enforcing national policy was secondary. The 1960s saw a change in this position in the direction of more positive leadership from the centre, and the 1962 hospital building plan is the principle example of central initiative.[2] The NHS reorganisation of 1974[3] consolidated the power of the centre, and centrally promulgated policy documents such as *Priorities for Health and Social Services*[4] and *The Way Forward*[5] were issued, together with guidelines, norms of provision, and minimum standards.

The Royal Commission on the National Health Service returned to the theme that the centre gave too much guidance and that the concept of the accountability of the Secretary of State and of the permanent secretary distorted the relationship between the centre and field authorities, blurring the line at which the participation of the Department of Health and Social Security should end.[6] *Patients First* unambiguously advocated minimum interference from the centre.[7] In his foreword to *Patients First* the then Secretary of State,

Patrick Jenkin, strongly advocated devolution (see box, page 23).

Yet the NHS remains confused and sceptical about whether these explicit intentions are to be translated into practice. The annual review process, the development of performance indicators, and last year's imposition of a manpower target seem to indicate a top down approach and to emphasise accountability upwards rather than devolution downwards. The political objective of more local power could become a casualty of political expediency.

In this setting, how should we interpret the Griffiths report?[8] Certainly Griffiths emphasises the importance of delegating decision taking to the lowest possible level, not only from the DHSS to regions and then to districts but also within districts to units. Griffiths also emphasises the critical importance of bringing clinicians more closely into the management of the NHS—particularly through the development of management budgets.

Within this historical context current management developments in the areas of annual reviews, performance indicators and information, and general management should be examined in more depth. There are two prior self evident observations that are worth restating. There is no single objective interpretation of these developments. The threats and opportunities posed are in the eyes of the beholder.

Annual reviews

The problems of achieving accountability between the government and NHS operating authorities have increased in complexity in recent years for four reasons:

The demand for more public participation (consumerism).

The growth of trade union activity (unionism).

The pressure to devolve authority to the lowest effective operating level (decentralisation).

The professional's proper accountability to his patient (professionalism), which is perhaps heightened at times of limited growth in resources.

Government attitudes towards the NHS have been characterised by moves away from fiscal accountability towards accountability for

policy and programme achievement and process audit. Key parliamentary committees—particularly the public accounts committee—have intensified their concern with central performance on two fronts. Firstly, there is the achievement of national strategic policy objectives—in practice, the inability of the DHSS to change local clinical practices at a satisfactory pace—for example, towards community based care and the priority services of mental illness and mental handicap. Secondly, there is value for money in terms of efficiency and effectiveness.

There is a disconcerting public and media image of the NHS, left to its own devices, as a system of management that is not self motivated in the pursuit of efficiency. The public accounts committee expressed particular concern about the difficulty of reconciling central accountability for the whole of NHS expenditure with the greater delegation of day to day management decisions.[9]

To these issues the centre has responded by introducing a system of annual reviews to monitor each region's and in turn each district's achievement of selected planning objectives through the optimum use of resources. The process represents a pinning down of responsibility that falls particularly on chairmen of regional and district health authorities and also a focusing of the issues under review. The result is a quite specific contract for prospective improvement that will be evaluated at the subsequent review. The notion of holding individuals to account has much to commend it but of course in the last analysis does not ensure the delivery of goods in an environment as complex as the NHS. Furthermore, the contracts negotiated between ministers and regional health authorities will be of limited value unless they are also negotiated through districts in the light of local circumstances at the unit level of management and ultimately with local clinicians.

The annual review system is a logical continuum of the planning system in that it poses the question, 'did we achieve what we intended and did we maximise the use of our resources and if we did not why not?' What it also highlights, however, is the paucity of tools available to measure progress in achieving health care policies and in measuring relative efficiency. Unless the questions and the performance yardsticks are credible to the professionals at the front line, the process will fall into disrepute and will atrophy.

Performance indicators and information

The aim of examining variations in performance has brought with it a new industry in the use of statistical performance indicators covering clinical, manpower, and estate management functions. It is recognised that no single indicator or combination of indicators will lead to a firm conclusion about whether the use of existing resources is efficient or inefficient. Their function is to point to outlying values of data that merit further investigation, and judgments can be reached only after detailed study of local circumstances. The national comparative set of performance indicators developed to date has been geared to questions of economy—that is, carrying out a task at minimum cost—and the efficiency measures promulgated have attempted to look at technical efficiency—for example, throughput, turnover, interval, and length of stay—while some are concerned with cost efficiency—for example, cost per case.[10] Acceptable measures of effectiveness—that is, the degree of achievement of an intended outcome—and efficacy—that is, about whether the outcome was the desired one—are in scarce supply. The essential difference between economy and efficiency as opposed to effectiveness and efficacy indicators is that the latter require statements of desired achievements, and judgments may be made only with stated objectives in mind.

'Patients First'

'We are determined to see that as many decisions as possible are taken at the local level—in this hospital and in the community. We are determined to have more local authorities, whose members will be encouraged to manage the service with the minimum of interference by any central authority, whether at region or in central government departments.' (Patrick Jenkin, Secretary of State for Social Services, writing in the consultative document *Patients First*, 1979.)

The annual review process, therefore, is about clarifying objectives and measuring and reviewing progress towards them, and performance indicators may contribute to this measurement but only if the armoury of indicators includes indicators of effectiveness and efficacy. Their development will be one of the key problems for the recently established national DHSS/NHS joint performance indicator group.

The performance indicators described above rely on critical information about inputs and outputs. If information is to inform adequately the debate between managers and the prescribers of resources about the efficient organisation of clinical care, its credibility to the field user is all important. In this respect the NHS is indebted to the Körner steering group on health services information for emphasising the need to improve the timeliness and accuracy of information at the district and unit levels, where the pressures of negotiating the allocation of constrained resources are most acute.[11] Information for policy development and monitoring by higher levels then becomes an aggregated byproduct of information essential for operational management and not an end in itself.

General management: the Griffiths concept

The area of key importance in the Griffiths proposals is the unit level—the level at which the nature of the 'contract' between general management and the clinician needs to be explored and extended. Devolution to units and the participation of doctors in management budgeting represent the areas of maximum return from the Griffiths approach to management but paradoxically are likely to present the greatest problems in implementation.

Measures to reform the centre should be welcomed and seen in their own right as a necessary move to improve the coherence of policy making at national level that should result in fewer uncoordinated central initiatives and a clear national focus for NHS management. Reform at the centre, however, should not be confused with revitalising the top down approach that has been relatively unsuccessful as an approach in securing national policy objectives. The NHS as a whole has shown a remarkable ability to live within cash limits, but a relative failure to switch resources between patient care groups to the benefit of the undeveloped non-acute services and community care in general. If the issues of the day revolve round confronting the harsh choices to be made across programmes of patient care in the context of increasing demand for high technology expenditure and the implications of an increasingly ageing population, the negotiation on these issues of balancing and choosing across the options for patient care will be focused ultimately at the unit level. Despite national and regional intentions made explicit in the annual review process, the actions that need to be taken are at

ground level and require clinicians to agree collectively to abide by the consensus on priorities and to accommodate their clinical practices accordingly.

Consensus on priorities by clinicians

'... the actions that need to be taken are at ground level and require clinicians to agree collectively to abide by the consensus on priorities and to accommodate their clinical practices accordingly.'

For doctors this will result increasingly in their participation in some form of clinical budgeting as a method of ordering and negotiating clinical priorities. Doctors are unlikely to settle for specialty costing alone, and patient costing—given that the relevant data in the NHS do not come as a natural byproduct of an insurance based billing system as happens in the United States of America—is an unrealistic expectation for the near future. They will expect to be concerned in management budgets that encompass not only costs directly attributable to their clinical decisions—for example, drugs—but costs that are incurred by nursing, paramedical, and other supporting disciplines, presented in a way that will allow them to influence the level of indirect or overhead costs attributable to *their* management budget. It remains to be seen whether budgets based on specialty groupings—for example, surgery—clinical groupings across specialties—for example, neurosciences to include neurology, neurosurgery, neuroradiology, neuropathology, and so on—or smaller clinical groupings of one or more clinicians prove to be the more acceptable base for clinical participation in management budgeting.

The implications for the unit manager are equally radical. The picture of a unit manager planning and budgeting within the extensive limits of discretion implicit in the Griffiths scenario is a daunting one. The unit manager lies at the intersection between policy making at district level and its implementation within the unit. This calls for far more than a mechanistic approach to translating prescribed policies. It requires an interpretative ability that ensures that the unit remains faithful to policy objectives and directions in general but that allows for personal initiative and experimentation. It should also allow for the genuine exposure of a

mismatch between policy and the needs of an individual unit that may emerge from a process of evaluating policy. The NHS is looking for a considerable shift in the predominant culture of management at the unit level towards an approach that can address the implications of strategic change and is purposeful, innovative, and risk taking if the resource dilemmas confronting the delivery of care are to be radically addressed.

Conclusion

Given the nature of historical fluctuations in management patterns between the centre and health authorities, it is superficially attractive to characterise current developments as a response in favour of the centralist forces. This view regards the annual review process and the thinking behind the Griffiths recommendations as primarily reinforcing accountability upwards and developing the connecting links between the centre and health authorities as a strong executive chain of command down which the policies and decisions of the centre can be promulgated. In this context performance indicators are regarded as part of the central armoury producing bullets to be fired (some would argue indiscriminately) at the field troops.

Yet the past lessons point to the limitations of the top down approach and the effectiveness of health authorities in deflecting central objectives. The alternative interpretation of current developments squares the circle by showing that explicit accountability is not incompatible with devolving decisions and that a model of control without interference can be developed. This alternative scenario regards the annual review process as producing a negotiated policy framework (including a feedback loop to the centre of the affordability and consistency of policies as perceived by health authorities), which allows authorities the space to interpret solutions in the light of local circumstances. In other words, the discipline of working through the terms of the subcontract removes the need for the main contractor to undertake the work direct. In this setting the Griffiths proposals are seen primarily as measures to reduce the need for uncoordinated initiatives by the centre and to emphasise the fundamental importance of devolution to units and the development of management budgeting for clinicians. Performance indicators and information are tools to be refined for operational management control purposes and only secondarily for monitoring purposes by a

higher authority. I am still optimistic that the alternative interpretation will prevail.

References

1 Great Britain, Ministry of Health and Scottish Home and Health Department. Report of the committee of inquiry into the cost of the National Health Service. (Chairman: C W Guillebaud.) London, HMSO, 1956. (Cmnd 9663.)

2 Great Britain, Ministry of Health, National Health Service. A hospital plan for England and Wales. London, HMSO, 1962. (Cmnd 1604.)

3 Great Britain, Department of Health and Social Security. Management arrangements for the reorganised NHS. London, DHSS, 1972.

4 Great Britain, Department of Health and Social Security. Priorities for health and personal social services in England. London, DHSS, 1976.

5 Great Britain, Department of Health and Social Security. The way forward. London, DHSS, 1977.

6 Royal Commission on the National Health Service. Report. (Chairman: Sir Alec Merrison.) London, HMSO, 1979. (Cmnd 7615.)

7 Great Britain, Department of Health and Social Security and Welsh Office. Patients first. London, HMSO, 1979.

8 Great Britain, Department of Health and Social Security. NHS management inquiry. Report. (Leader of inquiry: Roy Griffiths.) London, DHSS, 1983.

9 Great Britain, Parliament, House of Commons. Seventeenth report of the Committee of Public Accounts. Financial control and accountability in the National Health Service. London, HMSO, 1981.

10 Great Britain, Department of Health and Social Security. Health services management: performance indicators. London, DHSS, 1983. (HN(83)25.)

11 Great Britain, Department of Health and Social Security. Steering Group on Health Services Information. A report on the collection and use of information about hospital clinical activity in the NHS. London, DHSS, 1982. (Körner report.)

3 Role of health authorities: deceptively simple?

BRUCE WOOD

District and regional health authorities have the deceptively simple task of 'managing the health services on behalf of the Secretary of State'.[1] Deceptively simple because the massive National Health Service is among the most complex of organisations, perennially subject to budgetary and resource constraints and to professional and public pressures.

Advice from the Department of Health and Social Security acknowledges some of these constraints. District health authority members should 'determine policies and priorities' and 'devise a sensible formulation and application of policy to local conditions', but only within 'national and regional guidelines'.[2] Such advice retains the concept of a national service with equitable access and treatment facilities even though considerable geographical variations remain the reality.

Even the smallest authority is large scale, with a budget of £10 million and more than 1000 staff. Its plant includes hospitals, health centres, offices, stores, and nursing homes. Its services may be dominated by acute hospital expenditure, but it will be under pressure to develop geriatric and psychiatric facilities, community care, and preventive services. There are an awful lot of 'priorities' in today's NHS.

The no longer deceptively simple but now rather daunting task of managing this monster falls constitutionally on part-timers—the normally 16 district and 18 to 24 regional authority members. Only the (ministerially appointed) chairman is paid—over £7000, to reflect a commitment of about two days a week, though most put more time into the job than this. The rest, expected to devote 'some 2–4 days a month, during and outside normal working hours', receive only their expenses, thus retaining the long standing British tradition of voluntary public service.[2] Members include a consultant, a general practitioner, a nurse, a trades unionist, and a university nominee, as well as four councillors and six generalists from a range of backgrounds.

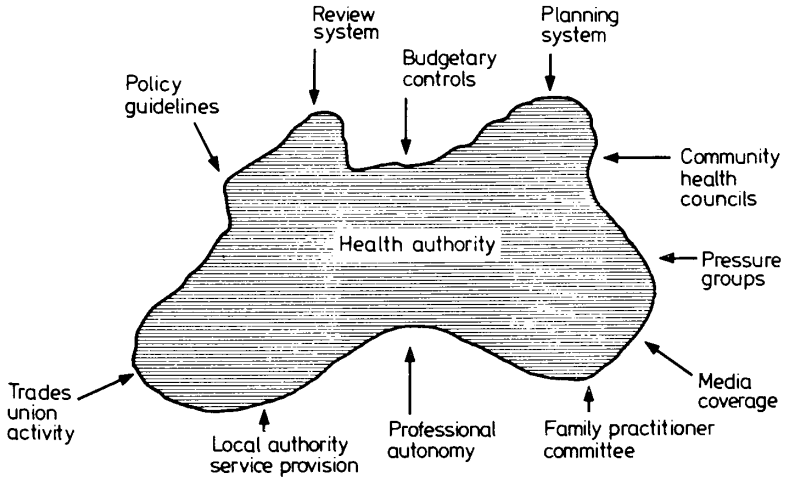
Local councillors, in particular, often find health authority work difficult because they already have a busy schedule of committee and

party meetings and they face an unfamiliar style of government in health authorities, which tend to operate as corporate entities rather than in the politicised adversarial style of local authorities.

The hierarchy of control downwards, from Secretary of State through region to district, is also one of accountability upwards. Subordinate authorities have to respect guidelines from above and work within the resources allocated to them (traditionally seen as money, but in practice including buildings and plant and—since 1983—manpower limits). They are accountable upwards through the planning system, under which quite detailed plans have regularly to be submitted, through budgetary control, and through the new system of regular reviews, initiated by Mr Norman Fowler in 1982–3. These reviews focus on an analysis of performance indicators of each region and district, and targets are set at meetings of chairmen. The review system is still in its early stages, but its importance is already apparent. Never before have health authorities come under such regular and detailed scrutiny, and the potential for substantially increased central control over regions and for regional control over districts is apparent.

Plans, budgets, and reviews are by no means the only constraints on the freedom of action of health authorities. Pressures vary over time, between issues, and according to personalities. The authority is an amoeba-like body, absorbing pressures from different angles at different times (see Figure 2).

Figure 2 Constraints on health authorities



Some of the constraints

Community health councils, the media, and pressure groups all seek to represent the views of consumers of the NHS, and they cannot easily be ignored. The rights of trades unionists and of professionals to be consulted are enshrined with the NHS administrative system through networks of advisory and consultative committees (such as the medical executive committee), which will be discussed in a later article in this series. In addition, the individual actions of doctors and other professionals—their diagnosis and treatment of a patient—clearly have spending and resource use implications. The largely open ended expenditure of, for example, general practitioners comes out of the total national budget for the NHS and so affects the amounts available for health authority services. Finally, the extent of local authority provision of social services may be a critical factor in determining whether or not community care is feasible: low levels of council provision may help to block beds and thwart community nursing staff.

Government pressure for reduced council spending has made cooperation between health and local authorities hard to achieve. Even 'joint finance', under which NHS funds can be used to boost council services, has not proved entirely successful because jointly financed projects can be undertaken only when the local authority is prepared to agree to take over the financing after several years, and councillors are reluctant to mortgage their future.

Perhaps the greatest constraint on the freedom of action of the part-time authority members is its team of senior officers (the regional team of officers; the district management teams). Constitutionally, this team is not the health authority, but it is appointed to manage the day to day activities of the authority and to advise and make proposals for policy changes and service developments. This gives the authority two roles: policy making and monitoring. A good team will normally give strategic advice that is acceptable to the authority, partly because it will inevitably anticipate the likely reactions to its proposals. But it is clearly 'the responsibility of members to review and, where necessary, challenge' recommendations of the team.[2] Monitoring the officers means assessing the quality of services being provided. The authority will receive information in reports made to it by the officers, through visits, and by setting up working parties, review bodies, and so on. In addition, receipt of complaints may also be seen as an aid to monitoring service

quality—though admittedly crude in that complainants are clearly not a random sample of users.

Formidable looking agenda

The 'model' is now complete and ready to be made operational through a case study. Like most health authorities, Bury has a monthly meeting that lasts about two and a half to three hours. The business to be transacted looks formidable in that the formal agenda characteristically contains 25 to 30 separate items, though a detailed study of one typical agenda shows that these vary in importance. Such a study also highlights the way in which the authority exercises its strategic and monitoring roles and responds to pressures placed on it.

The March 1983 agenda of Bury Health Authority was, as normal, in three parts—public items, at which the press and public were present (in practice few, if any, members of the public attend unless an issue such as abortion law reform is to be discussed); private items that will be in the formal minutes of the meeting; and an epitome of information, also private. The epitome consists of the minutes of various meetings of officers and staff, and is an important aspect of the monitoring role of the authority. In a premeeting session questions may be asked on any aspect of the activities of the district management team, nursing and midwifery committee, management staff committee, major medical committees, and the several health care planning teams responsible for policy advice in areas such as psychiatry, acute service, primary care, and geriatric services. Such questions invariably relate to day to day issues in that any major policy initiatives from this network of bodies would be on the main agenda of the authority.

The 28 items on the formal agenda spanned 116 pages of typescript: the effective member clearly needs to devote an hour or two to preparation for the meeting. Not all 28 items get discussed, for the agenda may be conveniently broken down into four categories, of which the first consists of procedural matters. These covered no fewer than 10 items including the receipt of apologies for absence, approval of minutes of the previous meeting, lists of gifts and donations, date of next meeting, and a statutory resolution to exclude the press and public when the confidential items were reached.

Monitoring, reacting, and making policy

It is the remaining 18 substantive items that were interesting. They

may be classified under three heads: monitoring service provision (six), reacting to higher authorities (seven), and making policy (five). In its monitoring role the authority received routine statistics on bed occupancy and throughput, outpatient attendances and waiting times, day care attendances, and the waiting list for inpatient admission. As a result of an earlier decision the latter gave brief (anonymous) details of cases where the waiting time had exceeded two years. Other monitoring reports included monthly updates on spending levels and the state of the budget, and on any delays to, or changes in, estimated costs of capital schemes. Another report gave changes among senior staff (in medical cases down to registrar level). Finally, written and verbal reports on members' visits were received, and one paragraph summaries of complaints and the action taken were tabled. On visits, the authority breaks into five three-member panels and this leads to 30 visits being made each year. In addition, each long-stay ward has a member assigned to it who is asked to visit at least monthly. Complaints number around 100 a year, so the typical agenda includes details of about 10, ranging from alleged medical mistreatment to loss of personal items, delays in being attended to, and so on. Justifiable complaints do lead to changes of procedure and improvements in services.

The seven 'reacting' items varied in the attention that they received at the meeting. Guidelines from the DHSS on the prevention of harm to patients due to staff disabilities and on developing services for mental illness in old age were, for example, quickly referred to the relevant officers. DHSS press releases were merely noted. Two substantial items did take time, however. Firstly, the authority received a recently completed report from the Health Advisory Service. A preliminary discussion on some of its several dozen recommendations took place, and officers were asked to provide detailed responses at a future meeting. Secondly, the regional review was received and considered.

The 22-page review documents from the regional health authority outlined an action plan of matters on which the Bury Health Authority was expected to respond over the coming months. Several of those matters were important—reducing the number of beds in some specialties, examining unit costs to find so-called 'efficiency savings', targets for improvements in throughput of hospital beds, for preventive services, and for more intensive use of outpatient clinics and day care facilities, manpower targets, and proposals to

develop priority services, such as local facilities for the mentally handicapped. Such pressure has never before been placed on health authorities, and the consequences for medical staff are apparent. Their activities are being placed under increasing scrutiny and, when criticism is implied, this may cause resentment. Presumably, doctors will understand that these new pressures are not of the authority's own making, and that the way forward is to work positively with the district rather than to take a negative stance. After all, authorities have no option but to respond to the review, and it is clear already that penalties could be incurred if the response is not positive: higher authorities have sanctions at their disposal and seem increasingly likely to use them.

Our final category—making policy—embraced five items. Two—a plan for computerisation and a decision about a surplus building—were non-controversial. How best to organise the cervical cytology recall scheme when the central service was discontinued also took little time. The block allocation—how best to spend the £$\frac{1}{3}$ million given to the authority for small capital items (medical equipment, vehicle replacement, upgrading of wards and dayrooms, and so forth)—took longer. A rolling programme reduced the problem of deciding, and only new items were at issue. The last item of policy was whether to transfer laundry services to a private contractor, not at the DHSS's request (at that time national policy on privatisation was only just getting off the ground) but because of dissatisfaction with the laundry service being provided by neighbouring health authorities (Bury had no laundry of its own).

Our study of a typical month's activities has shown the complexity of the NHS and the great range of issues facing health authorities. Though each authority behaves differently in detail, all found the pace hectic in 1983. All experienced increased pressure, through the regional reviews, the specific manpower targets of late summer, and the winter instruction to privatise support services. The pace seems unlikely to slacken in 1984—or beyond. Deceptively simple?

References

1 National Association of Health Authorities. NHS handbook. Birmingham, National Association of Health Authorities, 1983.
2 Great Britain, Department of Health and Social Security. Health services management: the membership of district health authorities. London, DHSS, 1981. (HC(81)6.)

4 Professional advice to the NHS—the medium or the message?

ALAN BUSSEY

The 1982 reorganisation triggered a reconsideration of ways in which professional advice could best be given to the NHS.[1,2] The inheritance was a complex, layered set of committees for each profession, which was widely regarded—especially by doctors—as time consuming and ineffective. The intention was, in the words of the then Secretary of State, 'that an authority should be able to obtain adequate advice when it needs it and in a suitable form. And, second, the profession concerned should have the absolute right to give advice when necessary, to be consulted on professional matters involving them, and to be satisfied that their advice is appropriately considered.'[3] The outcome some two years after reorganisation looks something of a curate's egg, only partly achieving these aims.

While acknowledging that professional advice from disciplines other than medicine is both required by and provided to authorities, doctors are understandably preoccupied by ways in which *they* may be consulted and may tender advice. They are, if anything, even more concerned over whether their advice is taken. In this connection, the profession has possibly seemed too arrogant in its approach in the past—assuming that medical advice is always more important than advice from others; that all medical advice by its very nature and source is both right and always in the interests of patients; and that for these reasons alone it should never be disregarded.

Many doctors do not see the picture that is presented to authorities and to the public more frequently than is good for the credibility of the profession. Intelligent, dispassionate members of authorities or of the general public are looking for balanced, considered medical views. On many occasions, of course, that is precisely what they get, but on others they are given a confused and confusing mixture. The ingredients are, in varying proportions, good solid technical or professional material; anecdotal evidence and unsubstantiated impressions—'in my clinical experience'; and medicopolitics ranging from national or specialty attitudes through intraregional infighting to local opposition to change. Add to all this a laudable but occasionally ill advised tendency to support doctors in other specialties, not because of the soundness of their case but simply because

they are colleagues, and it is perhaps remarkable that medical advice is taken as often as it is.

Part of the problem is the need for the profession to distinguish more clearly than it has done between the content of its advice and the machinery for collation and delivery—between the message and the medium, if you like. With hindsight it may be that, through the 1974 and 1982 reorganisations, too much attention was concentrated on the mechanics and too little on the content.

The machinery

While it is often difficult to disentangle professional advice on medical issues from medicopolitical and negotiating activity, each does have separate machinery. The latter activities are effected through craft committees with representatives negotiating by craft or collectively with the Department of Health and Social Security and the review body. These channels will not be considered further here.

So far as advice on medical issues is concerned, in England this is tendered to the National Health Service at three main levels—national, regional, and district. At national level the Secretary of State has the Chief Medical Officer and his staff of medical officers recruited from a variety of specialties to provide a continuing source of in house advice. Secondly, the DHSS relies on a large number of committees providing expert advice on a wide range of subjects. Some are standing committees while others have a limited life—called together to tackle a particular problem and disbanded after submitting a report. Both kinds of committees contain practising members of relevant specialties selected for their special knowledge, skill, and experience. The distillate of their deliberations frequently forms the basis of government policy or of DHSS guidance to the NHS on a particular medical issue. Still at national level, a further source is, of course, advice that is volunteered rather than commissioned. Examples of this are the series of reports on smoking from the Royal College of Physicians, and the report of the board of science and education of the BMA on nuclear war.[4]

Regional level

Those aspects of regional health authority work that require medical advice were clearly identified by the joint working group on regional management arrangements.[2]

These are:

a. long-term planning of health care services, including the preparation of planning guidelines with particular concern for the ways in which changes in clinical practice affect the distribution of resources;

b. the arrangements for supraregional clinical services;

c. the need and arrangements for regional and subregional services;

d. the allocation of revenue and capital moneys between health authorities;

e. setting of priorities for major capital investment in buildings and equipment;

f. the deployment of hospital medical and dental manpower, including changes in clinical practice, the development of clinical services, the provision of training, and the maintenance of a career structure;

g. the provision of appropriate resources for undergraduate teaching and research;

h. the encouragement of clinical and health services research;

i. the development of policy for the provision of postgraduate medical and dental education; and

j. the provision of a careers advisory service for doctors throughout the service.

In the arrangements for providing this advice the same three threads—in house, commissioned, and volunteered advice—are discernible. Each of the 14 regional health authorities has access to in house advice from the regional medical officer and his community physician colleagues on the staff of the authority. In addition, medically qualified members of regional health authorities provide another source that is partly within and partly outside the organisation. The main avenue of external advice is or should be, the regional medical advisory committee supported by the regional manpower committee and the regional postgraduate medical education committee.

The joint working group acknowledged that the structure of these committees was complex and costly. They found that the membership of regional medical advisory committees varied from 25 in one region to 50 in another. Infrastructures also varied greatly, with specialty subcommittees ranging in number from nine to 25; widely different arrangements for including general practitioners; and some

differences in representation of districts as opposed to specialties. Recommendations for simplification were made by the joint working group, but information on membership provided by 11 of the 14 English regional medical advisory committees, who replied to an inquiry in late 1983, showed that total membership still ranged from 25 to 45, with the infrastructures remaining complex and variable (J M Forsythe, personal communication).

District level

In formulating proposals for advisory machinery to district health authorities, the joint working group identified a requirement for the following two main types of advice:[1]

a. specialised advice on the current and future needs of patients and on methods available for treating them from the various individual specialties; and

b. general advice based on the broad medical view of priorities and the way in which resources should be allocated.

Experience has shown that this list could usefully be revised and clarified as follows (D A Perkins, personal communication).

i. Advice regarding the balance and operation of services within the district.

ii. Advice regarding the main medical priorities for service development (including medical manpower planning) within the district in the long and short term, and the way in which resources should be allocated.

iii. Advice regarding the coordination of services to patients provided by different sections of the health services, and by other services.

iv. Specialist advice relating to the development of particular services within the district in the long and short term.

There was also uncertainty in the joint working group report about the precise machinery required to provide this advice at either district or unit level. This was no doubt partly because of wide variations in existing customs and practices between one district and another. Also, while it is again possible to see channels for in house, commissioned, and volunteered advice, the basic framework shared by all districts differs in some important respects from that at regional and national level.

For example, while the district health authority has available in

house advice from the district medical officer and other qualified members sitting on the authority, an additional dimension is introduced through the consultant and general practitioner members of the district management team. Further complication is introduced by the presence of a consultant, general practitioner or, occasionally, community physician on each of the authority's unit management teams. And to complete the mosaic, a district medical committee embracing all specialties exists and attracts formal recognition in many district health authorities, while in others separate committees for hospital doctors and general practitioners channel advice through their district management team counterpart.

Does it work?

Curiously, for a science based profession, this question does not seem to have been addressed other than in very general terms, relying on the impressions of doctors and, to a lesser degree, those they advise rather than on objective assessment. The structural changes recommended by the joint working group do not seem to have been influenced by any systematic examination of function—for example, the topics and issues that the machinery has processed; the information supplied as well as that needed by both the donors and the recipients of advice; and the kind and quality of decisions taken as a result of it. Fortunately, a study of this kind is now under way supported jointly by the King's Fund and the South East Thames Regional Health Authority (D A Perkins, personal communication).

Some positive aspects as well as some problems are already evident, however. At national level much of the advice given by expert committees is highly valued internationally, let alone nationally. A great deal of the advice volunteered by the medical learned bodies is of equal repute. Moreover, it may well be that advice at this level will be translated into action more effectively now that it is presumably to be given to the Griffiths style health services supervisory board and to its subordinate management board.[5]

At regional level problems still seem to predominate. Conflict frequently exists between in house and external advice and occasionally between the respective advisers. Moreover, while the joint working group made proposals for simplification of regional medical advisory committees largely at the request of the profession, the

evidence suggests that many of these committees have changed little in response. No doubt this is partly because specialty and district representatives are unable or unwilling to agree to be represented by others. The danger remains that the purpose, quality, and content of the advice may be lost in the scramble for a place at the microphone.

Nor are the uneasy relationships at regional level solely the fault of the profession. How many regional health authorities have actively sought advice on each relevant topic in the *early or formative stages of policy* as opposed to asking for comments on documents that are virtually a *fait accompli*? How often are specialty subcommittees invited to prepare a strategy themselves rather than provide a token member for a working party? And how often have regional treasurers or regional teams of officers, which contain no clinicians, discussed with clinical representatives the detail of the Resource Allocation Working Party allocations[6] and their effect on the planning and operation of clinical services before submitting proposals to their regional health authority?

At district level authorities generally have three main sources of advice: medical members of the district health authority—general practitioner, consultant, and university representative; medical members of the district management team—general practitioner, consultant, and district medical officer; and a district medical committee or, where none exists, a constituency of general practitioners and another of consultants. Clearly, when these sources agree on a course of action the district health authority can proceed with confidence. The multiplicity of these sources, however, and the potential for honest disagreement between them is considerable. Here there is a lack of clarity in relation to the different roles of the medical members of district health authorities and district management teams in terms of who should finally guide authority thinking.

In contrast with regional and national levels, the presence at district level of clinicians on management teams does ensure that a clinical voice is heard early. But the dilemma of clinicians on these teams may be acute in terms of whether their role and consequently their advice is in house—that is, as part of management—or stems from outside the organisation—that is, from their constituency. Steering between the Scylla of management and financial imperatives and the Charybdis of the views of your consultant or general practitioner colleagues is a perilous, difficult, and time consuming business. Insufficient credit has been given by authorities or col-

leagues to the 400 or so clinicians who man the consultant and general practitioner posts on district management teams and the much greater number who now serve on unit teams.

When Griffiths comes to pass and general managers are established in units and at district level, further changes will inevitably occur. The essence of the general management function is its generality, and it follows that general managers will require more not less expert advice. This in turn points to a need, not so much for further strengthening of medical advisory machinery but for simplification and clarification of the channels and, crucially, greater clarity of content.

Experience so far suggests that one thing is certain—neither the medium nor the message is right yet. If medical advice is to be effective for both sides we should perhaps reflect that, while 'being there' is important, the quality and content of what we say when we are there is no less so.

References

1 Department of Health and Social Security. Medical advisory machinery in the reorganised NHS. Report by joint working group on district management arrangements. British Medical Journal, 1981, vol 282, pp 239–42.

2 Department of Health and Social Security. Medical advisory machinery in the reorganised NHS. Report by joint working party on regional management arrangements. British Medical Journal, 1982, vol 284, pp 64–7.

3 Great Britain, Department of Health and Social Security. Professional advisory machinery. London, DHSS, 1982. (HC(82)1.)

4 British Medical Association. The medical effects of nuclear war. London, Wiley, 1983.

5 Great Britain, Department of Health and Social Security. Health Services management. Implementation of the NHS management inquiry report. London, DHSS, 1984. (HC(84)13.)

6 Great Britain, Department of Health and Social Security. Sharing resources for health in England: report of the resource allocation working party. London, HMSO, 1976.

5 Are there lessons from abroad for the NHS?

DAVID ALLEN

The National Health Service is constantly under attack for alleged wastefulness and poor efficiency. At the same time the service is being changed and reorganised. Whether the NHS is as bad as sometimes portrayed and whether it is better or worse than the ways in which other countries provide medical care is hard to judge because reliable measures of health care are notoriously hard to establish. Certainly, much of the cricitism is ill founded because people do not understand the service and how it differs from other systems. All advanced industrialised countries share similar and serious problems in providing medical care: what is interesting is how different countries have attempted to cope with these. Are there lessons for the NHS in how other countries provide their medical services?

One of the distinctive characteristics of the NHS is the separation between primary and secondary care. This originated in the 19th century, was institutionalised by Lloyd George in 1911, was reinforced when the NHS was launched in 1948, and has had a lasting effect on medical care in Britain. The administrative and financial arrangements for general practice established by the 1911 National Health Insurance Act have preserved general practice in Britain while in most other countries it has declined. Now some countries such as Sweden and the United States are trying to re-establish their primary care and are looking to Britain with its well developed primary care system.

Most illnesses (as measured by patient contacts) are dealt with by general practitioners, and relatively few patients pass through this 'filter' and become inpatients in Britain, resulting in a low inpatient rate compared with other similar countries. The admission rate to general hospitals in England and Wales in 1974 was just over half that in the United States and Sweden and three-quarters that in West Germany.[1] This has kept costs down and helped to make medical care in Britain relatively cheap. In 1977—the latest year for which international figures are available—Britain spent about 5·2 per cent of its gross national product on medical care compared with 8·8 per cent in the United States, 9·2 per cent in West Germany, and 9·8 per cent in Sweden.[1]

Equity in the provision of health care, free access to the service, and improved effectiveness in providing care were and have remained the guiding principles of the NHS. Unfortunately, these objectives often prove mutually conflicting, which helps to explain many of the difficulties of and complaints about the NHS. In Britain state medical care covers primary and secondary care as well as community services, with local authorities providing personal social services. In the United States health insurance cover concentrates on hospital care and physician services, and the development of other services has been largely neglected. Care in the United Kingdom is (almost) free at the time of consumption. The principle of the 1946 NHS Act was to 'divorce the health care need from personal means'. Need is measured not by capacity to pay as in many other systems but by health care professionals such as general practitioners. This open ended system meant that governments soon found that the NHS cost much more than was expected, and in 1951 the then Labour government sought to reduce costs by introducing charges to cover items such as prescriptions, dental care, glasses, and so on. Even today, after they have been sharply increased in the past four years, charges cover only about 4 per cent of total NHS costs.

Medical care is also 'free' at the time of consumption in other countries—for instance, to those in America who are covered by Medicare or who are 'veterans'. For most Germans who are covered by social insurance funds medical care is almost free, though there are small charges for inpatient care. Medical care is nearly free to most of the French, who pay for it when they receive it but can then reclaim most of the charge (75 per cent for doctors' and dentists' fees) from the government's social insurance scheme. Most French people insure to cover the cost not covered by social insurance. The difference is that medical care in Britain is not only comprehensive but is also available free to all residents; there is no question about qualifying. Indeed, the NHS was the first health service in Western society to offer free comprehensive care to the entire population, though visitors are now expected to pay.

Who pays?

Free it may be to the individual patient, but the NHS still has to be paid for and overwhelmingly the money comes from public expenditure. Part of the cost (about 10 per cent) comes from National

Insurance (really a form of taxation). General taxation covers about 87 per cent of the cost, whereas in France and Germany health care is financed by social insurance and so is paid for as a proportion of income only by those in employment, and income from private individuals' investments is not tapped. Payment out of general taxation has the advantage of being progressive so that the biggest burden is borne by the rich.

The French and German systems are expensive to administer. It is estimated that 4 per cent of the premiums collected by German social insurance funds are used to pay the costs of collecting the premiums and paying the bills. In the United States administrative costs are much higher, in some instances up to 45 per cent for individual medical insurance policies. The provident associations in Britain also pay substantial administrative costs. As the funds for the NHS are mainly collected as part of general taxation there is no need for separate machinery and the costs are estimated at about 2 per cent. That means a big saving over other methods of financing on a total budget of £17 000 million.

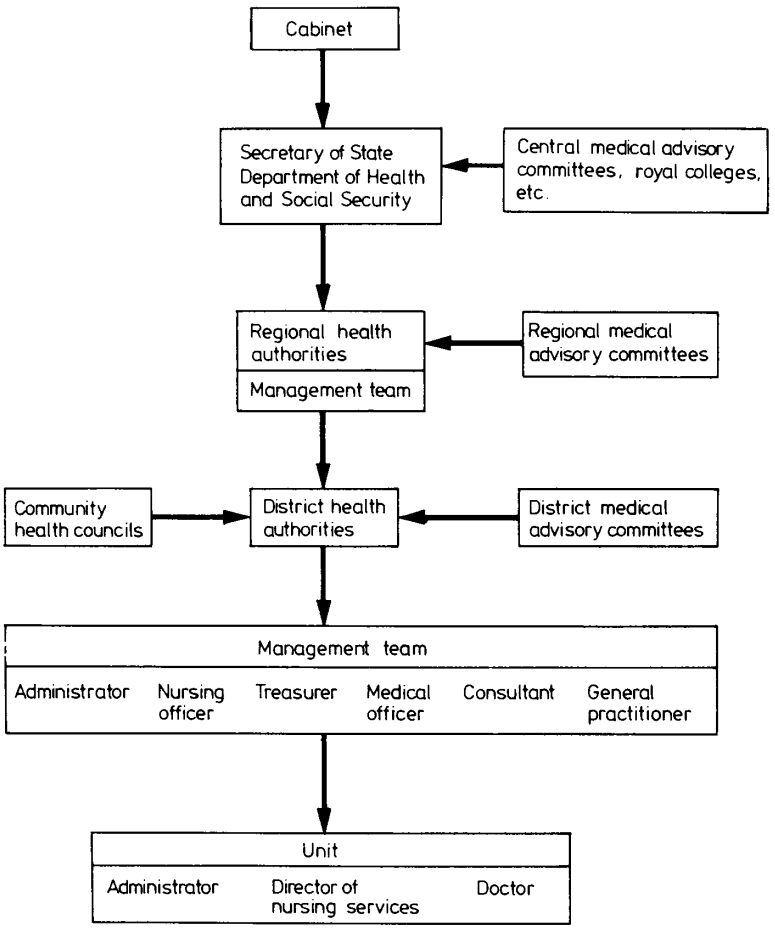
Payment out of government funds does, however, suffer the disadvantage that every year expenditure on health care has to be dragged through the budget process and so becomes a political issue. Governments in other countries do not have this stark annual decision to make of how much to spend on medical care. Even so, most medical care systems have to be subsidised by the state in one way or another and so other governments do have to decide how much to spend on subsidies, and this becomes a political issue. As the Royal Commission on the National Health Service said, health care costs are too large to be left alone by any government.[2]

Development of the NHS structure

If a service receives government finance in Britain government accountability is a constitutional requirement, and a hierarchy of control has been developed from the Secretary of State for Social Services and the Department of Health and Social Security to those working on the shop floor. The nature of control changes from time to time and some people believe that the present system is too centralised—it may become even more so when the Griffiths proposals for management reform are introduced.[3] In practice, however, the system of control of medical care provision is much

more highly developed in Britain than in other countries. The Secretary of State and the DHSS cannot maintain detailed control of all the people working in the NHS, so various public bodies have been created to act as the Secretary of State's agents.

Figure 3 Structure of the NHS



The major structural change produced by the 1946 Act was that most voluntary hospitals and all local authority hospitals were nationalised. This was done because the main alternative, local authority control, was unacceptable to many NHS staff, particularly doctors. The Minister of Health, Aneurin Bevan, had to set up new bodies to administer the hospitals and created regional hospital

boards and below them hospital management committees to act as his agents. In 1948 the local insurance committees, which had been established by the 1911 Act to administer the Act locally, were renamed local executive councils, and these supervised most of what we now call the family practitioner services. The local authorities were responsible for the provision of community services (maternity and child welfare services, health visitors, home nursing, and so on, which they had developed over the previous 50 years or so. This tripartite structure was much criticised later because of poor coordination, criticism that eventually prompted the 1974 reorganisation.

Until 1974 the emphasis in NHS planning was on hospital care. Since then an attempt has been made to plan medical care comprehensively by drawing in the primary care and local authority services. One of the aims of the 1974 reorganisation was to create a system that could provide continuity of care for patients—particularly of maternity, psychiatric, and geriatric patients—once they had left hospital. To this end the 1974 reorganisation created area health authorities, which covered the same areas (conterminous) as local authorities, so services could be more easily coordinated. In some places these areas were so large that they needed to be further subdivided into districts. This created an additional administrative tier, which soon led to complaints about excessive bureaucracy, and the tier was subsequently removed in the 1982 reorganisation.

The 1982 reorganisation aimed to improve decision making by cutting bureaucracy and bringing effective decision making closer to the patient. As well as doing away with multi-district areas and creating districts, each district was divided into several units, each unit being a patient group, such as psychiatric patients, or a geographical unit, such as a hospital. Each unit was to be administered by a troika—an administrator, a nurse, and a medical representative (see Figure 3, page 44). This arrangement will be superceded by the recommendations in the Griffiths report to create a general manager who will have overall responsibility for management performance at each level—DHSS, region, district, and unit.[3]

Who provides medical care?

Medical care everywhere is provided by a mixture of public and private institutions. Little health care provision is private in the

sense of profit making, and little is public in the sense of being government managed. Britain is the exception in the Western world in that the institutions are owned and managed by the government. Most medical organisations elsewhere are voluntary and non-profit making. The country with the biggest profit making sector is, of course, the United States, but even there that sector accounts for only 30 per cent of hospital care expenditure. In Germany the profit making sector accounts for about 5 per cent. In the United Kingdom it accounts for less.[4] How much of this private medical care in the United Kingdom is extra resources as opposed to resources transferred from the NHS and how much is overprovision and would not have been provided by the NHS has never been determined, though a recent report, *Health Care UK 1984*, has taken a welcome initiative in trying to estimate the total costs of health in Britain.[5]

The important difference between the NHS and other systems of medical care is that not only is most of the cost of medical care paid from government taxation but the government also owns the facilities and employs (directly or indirectly) the health professionals. It is this combination of public finance and public ownership and management of medical care that distinguishes the NHS from medical care systems in other Western countries. State expenditure on health in Britain is determined by the government's public expenditure survey exercise, where competing demands for public money are, in the end, resolved by the Cabinet. This allows the British government precise control over total expenditure on medical care, while other countries are desperately trying to develop measures to regulate medical care costs.

Health costs in France, for example, increased by seven times between 1950 and 1977 while Britain's increased about 2·6 times. Even the French admit that there is no evidence that the health of the British is inferior to that of the French. In 1979 the French government put a tithe on doctors and dentists, and it has tried other ways of controlling costs.[6] The German government has tried to contain costs by removing cover for some illnesses and cures, and German hospitals can now receive public grants for building only if the development complies with the state hospital plan.

The NHS has a structure that makes it easier for the government to tackle the uneven distribution of resources and inefficiency. As Rudolf Klein has noted, 'The NHS seems a remarkably successful instrument for making the rationing of scarce resources socially and

politically acceptable.'[7] Other advanced countries have similar financial and organisational problems, but they have to rely on medical care planning by prohibition of development, subsidised loans, and similar schemes to try and regulate the development of medical care systems. Furthermore, Britain does not have the expense of monitoring the quality of medical care, which other countries such as the Americans with their professional standards review organisations have to incur to protect their citizens. Even if it is still true that the NHS responds more rapidly to innovations in medical care than to changes in size and structure of populations—and, as Klein notes, 'state provision tends to institutionalise rigidities through organised lobbies for maintaining the status quo'—the structure of the NHS is a more direct, though far from precise, means of control of the provision of medical care.

Cost of doctors

It is generally accepted that British doctors are paid less than their colleagues in Western Europe or North America, but to make any sort of comparison allowances would have to be made for pension rights and their cost, the cost to doctors of their training, and the length of time before a doctor's maximum income was reached—British hospital doctors spend about twice as long in the training grades as those on the continent. Allowance must also be made for any income from private practice. NHS general practitioners earn relatively little from private practice, but about half of NHS consultants work part-time. Up to date information on consultants' earnings from private practice is not available, but figures for 1971–2 showed that part-time consultants on average derived about one-third of their income from private practice.[2] Since then there has been a considerable expansion of private practice with the three non-profit making provident associations paying out £70 million in 1982 in surgeons' and anaesthetists' fees.[8] Furthermore, about a half of all consultants receive distinction awards during their life, with about a third of consultants holding awards at any time.

Allowance also has to be made for differences in costs of protection against legal suits for medical negligence. The cost of protection in the United Kingdom, though rising, is still much less than that in the United States because lawyers are not paid by results and British courts have adopted general principles that set fair

criteria to be applied to judging medical negligence suits but that discourage volume litigation against doctors.[9] Finally, living standards generally are higher abroad, with Americans about 50 per cent richer than the British, the Germans about 25 per cent, and the French 20 per cent. Nevertheless, though it is difficult to make valid international comparisons on doctors' incomes, doctors in Britain are among the best paid and have one of the highest living standards of any group in the country.

Despite the fact that most of their income comes from the state financed NHS doctors have a surprising degree of clinical freedom. Much of the literature on the health service, including the Griffiths report,[3] emphasises the importance of delegating decision making to the lowest level: to doctors and nurses who make the decisions about the consumption of resources as opposed to the commitment of resources, which is done by health authorities and NHS officers. Health authorities and management teams decide on the level of provision of resources but it is up to doctors and nurses how these resources are used. As Professor Cummings says, 'the prescribing authority in the health service lies solely in the hands of the clinician—not only of drugs but to all expenditure'.[10] In the United States it has been estimated that doctors determine 60–70 per cent of health costs.[11] But because of the different system of paying physicians in the United States—and other market sensitive health care systems—there is a tendency to admit more patients for operation than is the case in the United Kingdom, where doctors do not benefit financially from admitting more patients to NHS beds. Furthermore, in the NHS general practitioners act as a gateway to the specialist services, thus exerting some control over the flow of patients to hospitals.

As Professor Klein said in Chapter 1 (and in the series in the *BMJ*[12]), 'Clinicians are free to determine whom they select for treatment and how they treat them. District health authorities cannot actually take any decisions about the delivery of services.' Consultants generally have to take patients who are referred to them from general practitioners. They can, however, influence the number and types of patients who are referred to them by giving some types of patients preference. This allows them greater freedom. It is these decisions that determine how resources are consumed, and, to quote Klein again, doctors' freedom to make decisions is constrained by the availability of resources but is very

real and 'sufficient to frustrate the decisions of policy makers at the top of the administrative hierarchy'.

The commitment of resources is not independent of consumption, for if resources are not consumed they are likely to be withdrawn by the health authority—or at least not allocated again. Similarly, if resources are all consumed early in the financial year further demands are likely to be made. So here is further opportunity for doctors to distort the strategic plans of the DHSS and district health authorities.[13] A recent development—the annual reviews, which monitor how NHS funds are being used—will, however, reduce doctors' freedom to some extent. But British hospitals are some way from adopting the strict peer review procedures that operate in many North American institutions, where accredited specialists who stray too far from the norm may lose their hospital access privileges.

Doctors in the NHS are not trained to think in terms of money and of how treating one patient will affect the treatment of others, and some people believe that they need such training.[14] Unfortunately, little information is available to doctors (or anybody else) to help them make decisions about the costs of alternative treatments or selecting particular patients for treatment, though this is the area of clinical budgeting that is now being developed.[15]

The amount of control that most NHS consultants have of their expenditure depends largely on the type of expenditure. For instance, there is little control on expenditure of drugs: providing the drug is in stock the doctor can use what and as much as he thinks necessary for a patient.* On the other hand, his expenditure on x-ray examinations and pathology laboratory tests or his use of operating theatres is limited by the availability of the service. Such rationing imposes some control on consultants' expenditure though it is of an arbitrary kind. The objectives of developing clinical budgets is both to limit expenditure and to increase efficiency by allowing the budget holder to use the money available as he believes most suitable. Although it may sometimes be difficult to identify precisely any direct financial savings from the use of clinical budgeting, its greatest benefit is probably that it changes the management style, drawing more doctors directly into the management of the health service.[16] This responsibility for budgets is something that is familiar to

* Since this was written the government has introduced some restrictions on NHS prescribing to reduce costs.

doctors practising in health care systems that are more sensitive to market forces: it should also help to improve management efficiency in the NHS.

Conclusion

It is difficult in a short article to provide comprehensive comparisons with other countries, but while Britain has something to learn from abroad its health care system has lessons for other countries. Britain seems to be the only country that has a firm grip on health care expenditure, and the government has helped Britain to spend relatively little on health care, yet the health of the population, as measured by life expectancy, perinatal mortality, and so on, compares well with that of other countries that spend more—and some much more—than Britain does.

Other countries have similar problems of containing total costs, while consumers complain that not enough is provided. The problem for the NHS is how to provide a government financed personal service: people as patients want a good service while as tax payers they want to keep costs down. It may be that Britain's present system of financing medical care means that the NHS will never match the community's expectations. People have to wait for care, hospital and surgery environments are sometimes unsatisfactory, and doctors' salaries are lower than in other countries. It may be that people would be willing to pay more for medical care. But if medical care were to be wholly or even partly financed through either private insurance or social insurance it would cost much more, some medical care provided would be wasted, and the detailed control of how money is spent would be sacrificed. Furthermore, we would face the practical and moral difficulties of restricting access as some patients would not be able to afford medical care and the gain in health of the population as a result of the increased expenditure would be questionable. The outcome would probably be medical care that was both less efficient and less equitable. Even a Conservative government committed to 'market force' policies decided after studying alternative methods of financing the NHS that it was not worth changing the present system.

All institutions reflect the society from which they come, and the NHS is no exception. It is a social institution that reflects the compassion of the British, but, internationally speaking, Britain is not a wealthy country and there are limits to what it can afford. So

the development of the NHS will continue to be permeated by the twin concerns of caring for all but on a limited budget.

References

1 Maxwell R J. Health and wealth. Lexington, Massachusetts, Lexington Books, 1981.
2 Royal Commission on the National Health Service. Report. (Chairman: Sir Alec Merrison.) London, HMSO, 1979. (Cmnd 7615.)
3 Great Britain, Department of Health and Social Security. Health services management. Implementation of the NHS management inquiry report. London, DHSS, 1984. (HC(84)13.)
4 Chester T E and Goldstein S G. Containing the health care cost explosion. Update, 1983, 1 November, pp 1287–96.
5 Chartered Institute of Public Finance and Accountancy. Health care UK 1984. London, Chartered Institute of Public Finance and Accountancy, 1984.
6 Corbett A. A French lesson for the NHS. New Society, 1981, 5 February, pp 236–7.
7 Klein R. Privatisation and the welfare state. Lloyds Bank Review, pp 12–29.
8 Maynard A. Private practice: answer or irrelevance? British Medical Journal, 1984, vol 288, pp 849–51.
9 Kloss D. The duty of care: medical negligence. British Medical Journal, 1984, vol 288, pp 66–8. (*See also* Chapter 14 of this book.)
10 Cummings G. The clinician as a manager. In: Allen D and Grimes D, eds. Management for clinicians. London, Pitmans, 1979, pp 36–7.
11 Spivey R E. The relation between hospital management and medical staff under a prospective-payments system. New England Journal of Medicine, 1984, vol 310, pp 984–7.
12 Klein R. Who makes the decisions in the NHS? British Medical Journal, 1984, vol 288, pp 1706–8. (*See also* Chapter 1 of this book.)
13 Wood B. Role of health authorities: deceptively simple? British Medical Journal, 1984, vol 288, pp 1771–5. (*See also* Chapter 3 of this book.)
14 Maynard A. The inefficiency and inequality of the health care systems of Western Europe. Social Policy and Administration 1981, vol 15, pp 145–63.
15 Steele R. Clinical budgeting and costing: friend or foe. British Medical Journal, 1984, vol 288, pp 1549–51. (*See also* Chapter 9 of this book.)
16 Allen D. The search for greater efficiency: budgeting in the NHS. Nursing Mirror, 1983, 9 February, pp 44–6.

6 Private practice: answer or irrelevance?

ALAN MAYNARD

Since the creation of the National Health Serivce in 1948 private practice has been a source of controversy. Depending on the ideological stance of the protagonists, private practice is seen to be either the answer to health care problems or an irrelevance. Such simplistic conclusions cannot be sustained after careful analysis of the available evidence. Private practice is neither an answer nor an irrelevance. Certainly, the compromise agreed between the Labour government and the medical profession, which allowed private practice within the National Health Service, has meant that private medicine could not be ignored by NHS management.[1] The industrial unrest and the medico-political disputes in the NHS in the late 1970s owed something to the political differences about the place of private medicine in the health service.[2,3]

About 96 per cent of the private health care insurance market is in the hands of three non-profit making provident associations: British United Provident Association, Private Patients Plan, and the Western Provident Association. The largest of these, British United Provident Association, controls 70 per cent of the market. The remaining 4 per cent of the total market is in the hands of the non-profit making hospital contributory funds and the fast growing (for profit) commercial companies such as Mutual of Omaha and Crusader.[4]

The subscription income of the big three provident associations was £274 million in 1982, and benefit outlays amounted to £233 million—that is, equal to about four or five NHS districts. These companies had 1·9 million subscribers covering nearly 4¼ million members.[5,6] A substantial minority of subscribers are in company schemes—that is nearly 49 per cent of subscribers have their contributions paid for them by their employers. It is this type of scheme, together with employee schemes that cover employed groups with subscriptions paid by the members, that has grown most rapidly recently. Only 28 per cent of subscribers purchased insurance cover individually.

The coverage given by subscriptions generates benefits that reimburse full costs in most cases. Generally, copayments or part payments by patients are absent if the depth of insurance coverage is

adequate. The main element financed by these outlays are room charges (about 45 per cent of payments), with £70 million or just over 26 per cent of benefit payments financing surgeons' and anaesthetists' fees, and just under 5 per cent of expenditure financing inpatient physicians' and specialists' fees.

In addition to these insurance incomes, which finance private care, some patients pay for care out of their own pocket. About 30 per cent of inpatient episodes are financed in this fashion. So, in 1982, an estimate of the total flow of finance into private health care would be of the order of £347 million—£233 million from BUPA, PPP and WPA, £10 million from other insurance institutions, and about £104 million of self finance.

Who provides what private care?

The range of activity in the private sector is narrow. The non-profit making insurance associations finance largely cold, elective surgery: perhaps more than 60 per cent of their outlays go on about 30 routine procedures, such as abortions, hernias, haemorrhoids, varicose veins, dilatations and curettages, and so on. Very little general practice, dentistry, and accident and emergency care is covered by these insurers.

In 1983 the number of acute beds in registered nursing homes in Great Britain was more than 6700, with most (93·8 per cent) being in England.[7,8] Considerable expansions in this stock seem to be in the pipeline (perhaps an additional 1500 beds) with non-profit making organisations (charitable and religious) being the least active in this growth. The distribution of these beds in England is unequal with 54 per cent in the four Thames regions. Just under a half of the private sector acute beds are owned by commercial for profit organisations (American and non-American), and it is these bodies that are adding and planning to add to private acute bed stock at the most vigorous rate.

There were more than 3250 NHS pay beds in 1983. Most (over 90 per cent) of these beds are in England and these are concentrated in the four Thames regions. The NHS pay bed stock was 2677 in 1981—that is, between 1981 and 1983 it grew by 17 per cent as entrepreneurial district health authorities sought to increase their revenue in difficult times. Thus, in total, there are just under 10 000 private acute beds (including NHS pay beds) in Great Britain.

Although this stock continues to grow, it remains small in relation to the NHS bed stock.

Problems in finance and provision

The rate of growth of the market served by the big three insurers has fluctuated greatly in the past five years, averaging nearly 13 per cent a year. The rapid growth of the late 1970s and early 1980s, however, has evaporated, with the market growing by only 3 per cent in 1982. What is the explanation of the growth rate declining to this level in 1982 from 25·9 per cent in 1980?

The reasons are many and complex. Firstly, premiums tend to reflect costs with the tax offset rules being modest (only those earning less than £8500 a year may set off their premiums against tax) and offer little public subsidisation (the tax offset rule reduced income tax revenue by £4 million in 1982–3). Costs have risen rapidly in the 1980s because of increased patient utilisation, perhaps associated with the coverage of blue collar workers, encouraged by the new NHS consultant contract, which encourages private work, and higher private sector fee scales.

These factors caused large increases in expenditure by the provident associations, and to balance their books they were obliged to raise their premiums. Thus one company raised all its rates for its main insurance package by 25 per cent in 1981, by 22 per cent in 1982, and by 14–18 per cent in 1983. These sharp increases in premiums had two effects. Firstly, the rate of lapses of existing subscribers grew substantially to over a quarter of a million in 1982 and, secondly, the higher premiums made it less easy to expand the coverage of private health insurance. These cost pressures seem to have moderated, and the industry believes that it is now in a period of relatively modest growth in premiums (perhaps 5–8 per cent in the next year) and slow but steady growth in coverage (perhaps 3–5 per cent).

The main problem facing the industry is cost containment. Costs can be contained by two methods: controlling demand or controlling supply. The industry favours the latter approach and adopts a gentle approach using moral suasion to curb the excesses of the medical profession. If this genteel approach fails the industry can either evaluate, monitor, and control the behaviour of private practitioners more rigorously or it can control patient demand by introducing

copayments—that is, part payment of the cost by patients may control costs by reducing demand for fear of its financial consequences.

The problems facing the insurers are making these pay masters more cost conscious. While the attempts to curb cost inflation eases the problems of the insurers, it worsens the problems of the providers, doctors, and hospital owners. If hospital use is curtailed beds may lie empty and consultants may become anxious about business. The paradox is that the insurers' problem is the providers' income, and effective control of providers' income enables the insurers to control costs, moderate premium increases, and generate market growth. The lesson of the 1980s is that the market works: the period of rapid growth in the 1979–81 period has been strangled by cost and premium escalation. Only if the insurers can moderate private sector costs—that is, the incomes of private practice doctors and the owners of private hospital beds—can they achieve substantial growth in their markets.

The only way in which the insurers can break this circle that limits their market growth is increased public subsidisation of their activities. To get this they lobby the Chancellor of the Exchequer each year in the hope that he may increase the limit below which subscribers can reduce their tax bills by offsetting their premium payments against their income, in the same manner that mortgage interest is offset against tax.

Any government that yielded to this pressure would be subject to several criticisms. Firstly, such subsidies would benefit income tax payers—that is, they would represent redistribution of income to the relatively affluent. Another criticism of such subsidies is that no right thinking, market-oriented libertarian, such as Milton Friedman, would support the provision of public subsidies to the private sector.[9] The libertarian believes that if private enterprise cannot generate a demand for its services, it should go out of business. As is well known, the Prime Minister, Mrs Thatcher, is no enthusiast for supporting lame ducks. If the private sector is to grow it must set its house in order by efficient management of its activities, and this means that it must control the costs, quantity, and quality of the private health care that it finances, or, to put it another way, the managers in the private health insurance industry must regulate the costs, quantities, and quality of care—that is, control the incomes of doctors and hospital owners.

Evolving responses to the problems of the private sector

The problems of cost containment and the debate about its resolution in the United States is relevant for the development of the United Kingdom's private health care sector—and of more than passing interest to NHS managers. In the United States the evolving trend has been the growth of the for profit movement and the relative decline of the non-profit sector (Blue Cross and Blue Shield on the insurance side and local non-profit hospitals on the provision side).

The for profit insurers have managed to carve out increased markets for themselves by creaming the market: they have identified groups who are good risks and offered them highly competitive premiums. The non-profit making companies have lost their good risks to their cheaper competitors, being left with high cost relatively bad risks. The non-profit companies have had to respond to this by changing their premiums setting policies, but creaming continues, with market forces tending to generate market segmentation of risks between the profit and non-profit making insurance companies.

The for profit hospitals generally operate in groups and have good collateral (their premises) for loans to develop and modernise their facilities. The non-profit hospitals in the United States tend to be local, individual institutions with poor collateral and substantial financial obstacles to modernisation. These factors have led to the relative decline of the non-profit hospitals or the 'corporatisation' of American health care.

Thus the United States market is producing a response to the private sector's problems that means the slow relative decline of the non-profit making movement in insurance and provision. The incentive structure of the for profits movement is powerful; managers and shareholders get a share of any increased profits that they can create by greater revenue generation. In non-profit making firms, as in the NHS, managers and shareholders do not get the fruits of increased efficiency generally and as a result may strive less vigorously to cut costs and increase revenue.

While the profit motive induces for profit managers to generate increased revenue, however, it may not increase efficiency. The successful firm may have high costs: some American evidence indicates that (for profit) investor owned hospitals had higher costs and charges than not for profit hospitals.[10] Thus the profit incentive

may generate higher costs and more severe cost containment problems.

The market trends in the United States, the rise of the for profit insurers and providers, can be seen in the United Kingdom. Nearly half of private acute beds are owned by for profit hospitals, and the three giant non-profit insurers are being challenged by as yet small but rapidly growing for profit insurers—for example, Mutual of Omaha. These trends will generate higher costs, higher premiums, increased pressure for subsidisation by the state, and increased questioning, as is happening in the United States, of whether higher costs give better quality health care or merely more luxury and profit for investor owned institutions.

The response of the optimistic pro-market libertarians is that profits will generate competition for new producers and that the profit motive will, via competition, control costs and maximise efficiency. The history of health care throughout the Western world, however, has been that competition has never and probably will never exist. President Reagan's initial love of competition in the health care market in 1980 was killed off by the opposition of insurers, professionals, and hospital owners who feared for their incomes and employment. As Adam Smith wrote in 1776: 'People of the same trade seldom meet together, even for merriment and diversion, but the conversations end in a conspiracy against the public or in some contrivance to raise prices.'[11]

As Smith recognised, capitalists are the enemies of capitalism. The health care market is highly monopolised, and these sellers—hospital owners and doctors—are interested in maximising their incomes. The challenge to insurers is to control these propensities to maximise revenues and incomes and achieve efficiency in the use of scarce economic resources.

Private practice: answer or irrelevance?

If she was a sincere libertarian Mrs Thatcher might regard private practice as an answer but would advocate, following Milton Friedman, the deregulation of the health care market and the abolition of the monopoly power (or the capacity of professionals to arrange their patients' lives) of doctors, pharmaceutical companies, and other powerful groups who would otherwise rig the market to their own advantage.[9]

If he was a sincere socialist Mr Kinnock might regard the private sector as a burdensome irrelevance that diverted scarce resources into activities inimical to the achievement of the objectives of the NHS. He would, therefore, advocate the abolition of private practice so that all available health care resources were mobilised to achieve the objectives of the NHS.

Politically, Mrs Thatcher does not have the strength to challenge the health monopolists and make the market work. Politically, Mr Kinnock does not have the strength to challenge the health monopolists by abolishing private practice and cutting their income and the choice of voters. Private practice can never be an answer or an irrelevance. It will continue to frustrate socialists and liberals alike. The former would like its abolition and the latter its triumph, but such ideals are unattainable and the reality is that the problems facing the managers of the private sector are remarkably like those facing the managers of the NHS—cost containment, value for money—that is, efficiency in the use of society's scarce resources.[12]

References

1 Anonymous. Mr Bevan's gesture. British Medical Journal, 1948, vol 1, pp 737–8.

2 Anonymous. No case for change. British Medical Journal, 1975, vol 3, p 452.

3 Anonymous. Independent practice and NHS. British Medical Journal, 1976, vol 1, pp 477–8.

4 Maynard A. The private health care sector in Britain. In: McLachlan G and Maynard A, eds. The public–private mix for health: the relevance and effects of change. London, Nuffield Provincial Hospitals Trust, 1982.

5 British United Provident Association, Private Patients Plan, Western Provident Association. Provident scheme statistics 1981: an overview. London, BUPA, PPP, and WPA, 1983.

6 British United Provident Association, Private Patients Plan, Western Provident Association. Provident scheme statistics 1982: an overview. London, BUPA, PPP, and WPA, 1984.

7 Clarke, K. Private hospitals. Written answer. House of Commons official report (Hansard). 1983, 8 November, 48, cols 55–61. (No 44.)

8 Clarke K. Pay beds. Written answer. House of Commons official report (Hansard). 1983, 28 November, 49, cols 419–20. (No 59.)

9 Friedman M. Capitalism and freedom. Chicago, Chicago University Press, 1962.

10 Pattison R V, Katz H M. The investor-owned and not-for-profit hospitals: a comparison based on California data. New England Journal of Medicine, 1983, vol 309, pp 347–53.
11 Smith A. In: Campbell R H, Skinner A S and Todd W B, eds. An inquiry into the nature and causes of the wealth of nations. Oxford, Oxford University Press, 1976.
12 Maynard A. Privatising the National Health Service. Lloyds Bank Review, 1983, vol 148, pp 28–41.

7 Issues in nursing management

YVONNE MOORES

What does nursing management mean to the average hospital doctor? The chances are that it means 'Salmon', and my experiences of addressing doctors prompts me to say with confidence that the word tends to provoke a brisk reaction, especially among elder members of the medical profession, who remember with nostalgia the days of matrons and all powerful ward sisters. I propose to put the nursing management structure in perspective by providing some background to and facts about the Salmon reforms. In 1963 Brian Salmon was commissioned to lead a study into the organisation of the nursing services.[1] At that time these services were headed by a matron, who reported to the hospital management committee through the group secretary. Mr Salmon's team concluded that someone who shouldered the responsibility for such a large share of the group's expenditure—nurses cost about 40 per cent of a hospital's budget—should report directly to the hospital management committee.

In retrospect it was, perhaps, a mistake to have assigned numbers to the new post holders, but the idea of appointing a nursing officer (No 7) to be responsible for the nursing service provided in, say, four wards of a hospital was cogently argued. There was logic in introducing a nurse manager at this level, as it facilitated the monitoring of ward nursing activities and standards. Two unforeseen consequences of this arrangement affected the medical staff. Firstly, many had become accustomed to thinking of 'their' ward sisters, and the interjection of a nursing officer was inevitably seen as disrupting this feeling of ownership. Secondly, Salmon schemes were introduced in an era when early retirement was an option seldom taken by nurses and, consequently, some assistant matrons were suddenly returned to active service despite their lack of up-to-date clinical knowledge and skill. This prevented the service reaping the full benefits of the structural change immediately and, worse still, it sowed the seeds of scepticism among medical colleagues. Unfortunately, it also deluded people into believing that the number of chiefs had outpaced the number of Indians. Published statistics and the report of the Royal Commission on the National Health Service subsequently showed, however, that the proportion of

nurses above ward sister level was lower than that before the implementation of the Salmon recommendations.[2]

The Salmon reorganisation produced some remarkably rapid promotions. Even so, I am convinced that the National Health Service now boasts an excellent body of clinically competent nursing officers. In many settings they have been instrumental in improving the quality of nursing care provided in the wards, and today's nursing officers possess a combination of management and clinical skill that encourages ward sisters to work with their colleagues in the manner originally intended by the Salmon report.

Can a nurse be a manager and what does a nurse manager do?

Behind the seemingly simple question, 'Can a nurse be a manager?' lies a suspicion that the attributes that attract a person into nursing must inevitably conflict with those required to be an effective manager. The question may also imply a belief that a non-nurse with a talent for managing could and, perhaps, should direct the nursing service. What we should recognise, however, is that not all management has to be modelled on the pattern necessary to save the British car or steel industry.

The style of management needed to 'control', for example, medical staff is clearly different from that needed to run an army or a supermarket. There would seem to be no *a priori* reason why some nurses should not be adept at managing the nursing service. It is, however, of vital importance that nurses see themselves as facilitators rather than 'bosses'. Nurse managers' single most important goal should be to ensure that the nurses who are caring for patients are able to provide the patients with the best quality of service. Monitoring performance is an integral part of achieving this goal. But in common with other professions, including medicine, nurses have made too little progress in doing this.

The management of any professional group requires appraisal of people's performance, and so members of that profession must be concerned in the management process. If the nursing management requires only such mechanical activities as producing off duty rotas, a manager without a nursing qualification might be appropriate; but it does not so it should not. Senior nursing staff must, however, be able to identify those staff who possess the attributes needed to generate confidence among junior staff and colleagues in other

disciplines. Too often in the past we have fallen into the trap of promoting people simply on the basis of their clinical competence, only to discover that they lack management skill or ability. Nurses assume basic management responsibilities from an early age—and I am not referring to those regrettable occasions when student nurses were left in sole charge of a ward at night. I am thinking instead of the multitude of activities that engage a typical ward sister intent on organising her ward effectively. She may no longer physically ladle out the soup or be responsible for the cleanliness of the ward but she still has to organise the provision of care and treatment for patients, to train and supervise the nursing staff, and to marshall the army of 'visitors' to the ward—be they consultants, physiotherapists, laboratory technicians, or relatives—who are quite oblivious to what goes on behind the scenes and sometimes impatient at not receiving instant attention to their requirements.

The 1974 reorganisation saw the team approach to managing the service formalised. Many senior nurse administrators felt threatened in this new environment, and this was nowhere better shown than in their desire to follow crash courses in such topics as understanding accounting concepts, and so on. Many of them now recognise the futility of much of that desperate search for defensive knowledge and are content to let the finance officer do what he does best. If nurses or doctors are not able to comprehend what is being said to them by administrators or finance officers it is for those officers to make themselves better understood. The nurse's major contribution to the deliberations of the team should be to bring a perspective born of her experience, as, presumably, do the doctors. Ironically, just as the different parties have developed a clearer understanding of each other's roles the game seems about to change and be played under the Griffiths rules.[3]

The Crimean contribution of Florence Nightingale was as much to do with management as with nursing techniques. All ward sisters are managers in the true sense of the word, and some of the best of them can and do go on to manage larger units.

Where have all the nurses gone and how many should there be?

The number of nurses employed throughout the NHS has been steadily growing. In 1980 the NHS in England and Wales employed 125 881 state registered nurses—equivalent to 105 416 whole-time

staff. The corresponding figures in 1950 were 50 701 and 48 577 respectively. An analysis of the figures shows that even allowing for the reducing hours of work there has also been a steady growth in the number of nursing hours. During this period there has been a quite dramatic reduction in the length of time that patients stay in hospital and a concomitant increase in the number of patients treated—patient throughput. This has had a substantial impact on the workload of nurses both in hospitals and in the community—in addition to the consequence of increasingly technical procedures. Nevertheless, doctors who ask where all the nurses have gone usually seem less concerned with the number of nurses and its relation to workload than with the loss of qualified staff. Their concern is to an extent justified, though I would take issue with the use of the word 'all'. Between 1940 and 1980 we produced over half a million state registered nurses, which puts the current staffing complement into perspective.

Training a state registered nurse costs several thousand pounds. For many years trainees were undoubtedly used to provide much of the care of patients in the mistaken belief that they represented a cheap form of labour. As a consequence the service felt under a little pressure to accommodate to the needs of an ever increasing proportion of qualified staff who wished to raise a family while continuing to work. A 'shortage' of nurses in the 1960s and 1970s, however, forced hospitals to explore how married nurses could be encouraged back to work. We have now gone full circle and there is growing evidence that we are producing far too many state registered nurses and state enrolled nurses. Nationally, this imbalance will have to be put right and soon. We now know that those who were attracted back made a valuable contribution, and we surely have a responsibility to ensure that those we train are able to practise the professional skills that they have so expensively acquired. The opening question is, therefore, somewhat out of date and perhaps should be reworded to read, 'What can be done for those wanting to work?'

This brings us to manpower planning and the pattern of training. Doctors are all too familiar with the medical manpower problem. The fact is that until recently nurses were not under pressure to produce sound methods for determining staffing levels. It has been left to outside observers to highlight the inefficiencies of the *laissez faire* policy. Without some sort of national manpower guidelines, matching output of trained nurses to nursing requirements and

availabilities must be a hit or miss affair. Even so, the cold wind of cash limits has forced us, along with other health professions, to investigate seriously methods for determining what constitutes a reasonable nursing establishment. 'Shroud waving' will no longer suffice. The work undertaken by the Griffiths inquiry has provided some useful insights in this area, though at least one North American system could readily and profitably be translocated across the Atlantic.

What is absolutely certain is that we must quickly harness the best of the methods be they American or British. Planning for staffing levels must go hand in glove with maintaining quality.

Can doctors go back to having their own ward sisters?

The answer to this question must be 'no'. Firstly, it would be putting the clock back in part of a well established management system. Secondly, tending to the needs of sick people whether it be in hospital or domiciliary based, is increasingly seen as a team effort. In advocating the team approach I am not reflexly reciting the latest 'accepted truth'. Visit a typical burns unit and you will observe doctors, nurses, dietitians and other paramedical staff all working together in a genuinely multidisciplinary manner to meet what are inevitably the multidisciplinary needs of patients. You will see the same constructive relations in most other environments, ranging from high technology units—such as those accommodating patients with end stage renal failure—to the home care of elderly patients.

The old cliché that doctors are in the curing business and nurses in the caring business is an out-of-date, simplistic dichotomy. Patients have medical needs but they also have nursing, dietary and physiotherapy needs—to name but three. Almost by definition this range demands a team approach, and while some sympathetic and intelligent direction is called for this cannot be interpreted as 'ownership'. This is no new realisation stemming from experience of either the Salmon reforms or the 1974 reorganisation. As a one-time sister on a men's medical word I would like to believe that the consultants on the ward viewed the relationship between the nursing and medical staff as a mutually supportive one. I would not have stayed there for six years had this not been the prevailing ethos, and the ward would not have been the agreeable environment it was for patients and staff

alike had this not been so.

What is the extended role of the nurse?

The demarcation lines in medicine about just who does what have never been immutable. Responsibilities are constantly changing and, indeed, in one hospital tasks may be performed by nurses that elsewhere are more usually done by doctors. Americans used to look askance at how many British births were supervised by midwives, and who would deny that the so-called barefoot doctors operating in several Third World countries are not a solution to medical care ideally suited to those environments. Lately, however, concern has emerged about what might be loosely termed 'legal cover' for tasks performed. In part, this probably reflects a wider concern with the insidious increase in litigation by patients about which we seem intent on mimicking the American experience. We now find professional bodies demanding formal authorisation for a specified grade of staff to undertake a particular task. For better or worse it is a development that is here to stay but, inevitably, it has focused attention on the whole question of who does what. Nurses have demonstrably never been averse to taking on board new responsibilities if these help to make more effective use of a team's combined talents. Of late, these changes might seem to have featured more burueacratic overtones, but medical colleagues will readily appreciate the need for the attendant safeguards.

Does the nursing process help the patient or does it just add to the paperwork?

In 1984 the *BMJ* published an article on the nursing process by Professor J R A Mitchell of the department of medicine, University of Nottingham Medical School.[4] Although his contribution was intended, presumably, as something of a 'put down' of this development in nursing, I found myself agreeing with some, but not all, of his contentions.

The nursing process reinforces the concept of the team approach to the provision of patient care, but many would agree that there has on occasion been an unfortunate over-emphasis on paperwork that has camouflaged the straightforward nature of a system intended to improve the nursing care of patients. The nursing process is intended to help identify the patients' nursing needs more effectively

and to help in meeting them in the most appropriate manner. Some of these will be inseparable from medical needs, and the concept of working together is not only appropriate but essential. Enlightened medical practitioners will, however, acknowledge that many of a patient's requirements relate to his nursing care and these have always been left to nursing staff to organise. What is so wrong with nurses exploring how best they should respond to these needs?

Professor Mitchell was quite right in arguing that the approach demands the development of effective evaluation procedures, but let us give the nursing process some credit for having provoked a discussion that has helped to foster this recognition. Nursing interventions do exist. Medical staff are, for example, little concerned with scheduling or monitoring the hygiene and care of the skin. The more enlightened nurse would freely admit that she has limited information as to the consequences of alternative regimens on this front. Assessment procedures are needed, and fortunately more and more are slowly forthcoming as a consequence of a growing body of nursing research.

Nurses are not alone in not knowing the consequences of all our actions; indeed, White recently concluded that only 15 per cent of all medical procedures have a proved effectiveness.[5] Professor Mitchell's statement, 'as doctors know only too well from our attempts to evaluate the best way to manage heart attacks, cancer, stroke, and high blood pressure you get good answers only if you have well designed studies and suitable mathematical techniques', comes across as a trifle patronising. More important than the well designed study and the complex mathematics is an initial inquisitiveness. The nursing profession now has a gradually expanding academic base for those intent on studying nursing in that environment. This, in turn, fosters the spirit of inquiry that has helped to spawn the present interest in the nursing process. The more we, as nurses, know about the patient's nursing needs, how to assess them, and how to set about ascertaining the consequences of responding to them in alternative ways the sooner will we be able to make a greater impact on responding to the patient's total needs. That response is best made as the member of a team.

References

1 Great Britain, Ministry of Health and Scottish Home and Health

Department. Report of the committee on senior nursing staff structure. (Chairman: Brian Salmon.) London, HMSO, 1966.
2 Royal Commission on the National Health Service. Report. (Chairman: Sir Alec Merrison.) London, HMSO, 1979. (Cmnd 7615.)
3 Great Britain, Department of Health and Social Security. NHS management inquiry. Report. (Leader of inquiry: Roy Griffiths.) London, DHSS, 1983.
4 Mitchell J R A. Is nursing any business of doctors? A simple guide to the 'nursing process'. British Medical Journal, 1984, vol 288, pp 216–19.
5 Tilquin C. PFN 80—An information system for nursing care management. Quebec, EROS, 1981.

with clinicians on value for money in investigation and treatment to ensure that available resources are being used to the maximum advantage of all patients. Financial pressures mean that great emphasis is now placed on performance and in the development of performance indicators. The DHSS has published volumes of these figures, but at local level it has been found relatively easy for clinicians to discredit many of them, often leading to genuine discrepancies in clinical practices being ignored due to the general criticism. These performance indicators must be seen for what they are—comparative, broad brush statistics that at best suggest areas where more intensive investigation is required to see whether a problem really exists. They provide a trigger mechanism that requires the help of clinicians not only to improve their applicability and robustness, but also to look behind the figures at the problem areas highlighted.

My personal preference would be to develop information systems that compare actual resources committed against those expected to be deployed, based on the case mix of patients being treated. This should provide the basis for the most relevant information being available to all levels of management, starting at the potentially most important one—the clinicians.

Clinical budgeting and costing

I support the growing demands for clinicians to be more concerned in the management of the NHS and the introduction of clinical budgeting. Increasingly, doctors want to know how much they spend, what resources they have committed, what cost improvements they could make, and so on. Treasurers must ensure that these demands are acted on and that clinicians receive a proper financial management service. Finance staff must not be sycophants but respected financial advisers to clinicians, and I believe that most treasurers are willing and able to introduce this concept in a reasonable time scale—but some pressure from the 'users' would do no harm.

There is little doubt in most people's minds that the present method of costing in the NHS leaves much to be desired as it is based on costing categorised hospitals over various headings. While it may give some useful information on the non-clinical aspects of hospital costs, it does little to provide adequate clinical related

information. The Körner committee, which has been examining the information needs of the NHS, has recommended that in relation to financial information in future the costs of specialties should be calculated as this will provide better management information on which to base decisions. Also, if clinical budgeting is to be introduced this is a useful base to develop from. If this approach is to be useful, however, there must be a proper breakdown of specialties with significant subspecialties to ensure that in any comparisons we are comparing like with like. I hope that the minimum data set of specialties recommended is not too small, although authorities can provide more detail locally if they consider it appropriate. Clinicians have a positive role to play in ensuring that the specialty breakdown provided within their district meets their needs as managers and budget holders.

While I accept that specialty costing is the best direction for the short term, I believe that there should be development of patient related financial systems integrated with the patient information systems. This would provide the greatest flexibility in applying the basic information—that is, an ideal data building brick from which you would be able to provide relevant information to all levels of management in the NHS structure. From this basic level specialty costs could be developed that allow for case mix, disease costing, case mix clinical budgets, better information for planning, patient costing, and so on. I do not believe that the costs of development would be large as most of the information will, in all probability, be available as the byproduct of other systems now being developed, and, looking at the potential benefits to managers, I believe this approach to be cost effective.

Redistribution of resources: geographical and care groups

The redistribution of resources has provoked arguments for several years and needs to be viewed from both a geographical and a care group aspect. Geographical redistribution between regions is really the battle of the Thames regions versus the rest, as London is comparatively overprovided in terms of health care. It would be easy to criticise the pace of change but I shall resist the temptation and look to the future. Current government policy is that by the end of 1993 all regions should be on or about the Resource Allocation Working Party revenue targets—that is, all regions would be

receiving their fair share of the revenue resources available, calculated on a population based formula.[2] This is, however, a comparative exercise that in no way assesses the funds needed to meet the health care needs of the population either locally or nationally.

Given the size of the regional allocations, we can accept a target being set without too much future debate on the detailed methodology of the present formula, though in parts it is applied with a broad brush. When this formula is applied subregionally, however, it may lead to all sorts of anomalies and problems due to the smaller amounts entailed and their consequent impact in terms of end result. Indeed, most regions have a continuing demand from districts to adopt, adapt and improve various aspects of their regional Resource Allocation Working Party formula. Perhaps the main problem to be overcome if this is used as an allocation methodology is how to integrate it with the planning system. Many regions now seem to be developing revenue allocation approaches based on funding the agreed district plans rather than using a Resource Allocation Working Party basis in an attempt to overcome this problem. This has the benefit of putting agreed health care aims first and the fair allocation of the available funds to support them as a follow on, which seems to be the correct sequence. This approach also provides a fairer basis for distribution of resources by allowing for the levels of health care to be provided and the levels of efficiency to be achieved by districts in that provision.

Almost every region suffers from a geographical imbalance of resources between districts, a distortion often complicated by a further imbalance between care groups. This is especially true of inner city authorities, who may be above or on their revenue allocation target but deficient in mental illness and mental handicap services, and so on. It is imperative, therefore, that we at least give careful attention to the means of achieving the desired end result of equal access to health care for all. It is vital that planning is on a realistic basis to ensure that health care plans are achievable. If they are not this not only discredits planning and management but leads to expectations from clinicians and patients that cannot be met. This would be in no one's interests.

In reality the process of achieving equality is difficult and fraught with problems. In some instances where health care imbalances have to be corrected it is often necessary in the interests of achieving an overall benefit for above or on target districts to lose money and

overprovided health care facilities to fund new developments in other districts in the short term, with their own imbalances being corrected in the medium or long term. This seemingly illogical—to the losing districts—approach is necessary to correct the worst imbalances in health care provision within regions as quickly as possible. This often leads to arguments about present locations of capital stock and whether districts should be self sufficient. In the present financial climate we must be sure that all resources are being used to achieve the greatest value for money. Part of that exercise must be to maximise the return from present investment in building stock, a policy that may lead to some district services being provided on behalf of other districts in many instances. This may be unfortunate but is a short- to medium-term necessity. When present capital stock requires replacing, however, it is imperative to replace it in the appropriate location for the population to be served.

It is the government's policy to redistribute resources from acute services to mentally ill, mentally handicapped, and geriatric services, and so on, as well as to run down the long-stay institutions. This shift is beginning to happen, but perhaps the greatest problems lie in the fundamental change from long-stay institutional care to community based care. There are some basic financial problems associated with this approach, in particular, the need to move funds to local authorities to enable them to undertake their responsibilities, especially for the mentally handicapped. Some may argue that funds should not be transferred, but if they are not most local authorities would not participate in this change in the method of providing care. At the end of the day what matters most is what is best for the patient.

Another problem is the high level of bridging finance required to fund new community services in districts while authorities continue to fund the long-stay institutions until they are able to rationalise their facilities and so reduce expenditure on a sensible and planned basis. Regions have a positive function here and must be prepared to commit funds accordingly if the end result is to be achieved on a planned basis and in a reasonable time scale. The final financial point is that it is probably more expensive in the short term to look after these patients in the community, but it is likely that as experience is gained on the alternative methods of care available future costs will fall to some extent.

There are some major problems that are not purely financial in

8 Learning to live with cash limits—and other financial matters

GORDON GREENSHIELDS

Many of the most contentious issues in health care finance stem from cash limits—the maximum amount of cash that a health authority is allowed to spend in any financial year. This limit on the amount of money available to spend on health care in a district, region or nationally is not new. Cash limits were introduced in 1976 but have been applied with increasing vigour in recent years. This restriction means that choices and decisions over competing needs and demands have to be made by clinicians, managers (a better word than administrators), and members of health authorities.

Whether cash limits should be applied to health care with their consequent rationing effect is and probably will remain a political decision. Nevertheless, so long as health care is a political football patients are potential losers in the game of cash limits. We must, however, live in the real world, where the costs of medical care dictate that there will be limitations on resources, limitations that will probably continue for the foreseeable future. Thus pragmatism dictates that we should spend more time and effort as managers trying to maximise the service to patients from present resources and less on complaining to all and sundry how difficult it all is. At the end of the day actions speak louder than words.

An important distinction in the allocation of NHS resources lies in the way that money is allocated by parliament between the hospital and community and the family practitioner services. Different rules pertain: for the former, strict cash limits are applied; but family practitioner services have an open ended budget—that is, there are no cash limits. This point came home rather forcibly in July 1983 when the hospital and community funds were reduced by 1 per cent as part of the public expenditure cuts and originally we were led to believe that this was due to the likely level of overspending on the family practitioner services.[1] Paradoxically, however, despite cash limits the hospital service has maintained its proportion of the total NHS budget at around 62 per cent of total expenditure. Nevertheless, these different funding rules cause problems and fuel accusations on lack of efficiency and effectiveness between the two factions, a position I believe could deteriorate if family practitioner

committees become more independent. Indeed, this division may increase overall NHS expenditure if health authorities introduce policies to transfer responsibility for prescribing drugs, and so on, from hospitals to family practitioners as part of their continual quest to reduce costs to enable them to live within their cash limits. It seems unproductive for this type of activity to continue as the patient does not necessarily benefit.

The Department of Health and Social Security commissioned management consultants to investigate the possibility of applying cash limits to family practitioner services, and if press reports are to be believed the investigators doubted the practicability of their applying limits in this particular case. Looking into my crystal ball, however, I would be surprised if some form of spending restraint on family practitioner services is not introduced in the next five years or so; indeed, the Secretary of State has promised a government green paper on these services.

Value for money

Resource constraints have intensified the quest for more efficiency in both clinical and non-clinical areas: they will continue to do so as government pressure mounts for cost improvement programmes and reductions in staff numbers. The in phrase in the public sector is 'value for money'—probably best defined as being the three Es—economy, efficiency, and effectiveness (see box).

- *Economy*—The practice by management of the virtues of thrift and good housekeeping; an economical entity acquires resources in appropriate quantity and quality at the lowest cost possible.
- *Efficiency*—Ensuring that the maximum useful output is achieved from the resources applied to each activity or, alternatively, that only the minimum level of energy and work is used to achieve a given level of output.
- *Effectiveness*—Ensuring that the output from any given activity is achieving the desired result.

Value for money is not necessarily about the cheapest in cost terms; it is about costs, but also very much about benefits and quality. It is vital, therefore, that there should be a practical dialogue

relation to the movement of patients out of the institutions. The fundamental one is whether the local communities are prepared to support this change of policy. I believe that people in general are against the concept, but mainly owing to total ignorance of the problem and a complete misunderstanding of what is wrong with the patients. Time and effort has to be spent in educating the population about this new policy and its consequences for the community. If this is not done it will be difficult to run down the long-stay institutions even in the long term.

High technology medicine

There is, and always has been, tremendous competition for available resources not only between districts and institutions but also between specialties. This problem is aggravated in times of financial constraint when a squeeze is exerted on available resources. This is further complicated by the growing interest in, and awareness of, health matters by the general public, who are rightly demanding the best possible local health care being made available to them.

The identification of national priorities that have to be followed may increase the problems locally relating to consideration of the alternative developments that may have to be foregone to meet the various demands. High technology medicine is and will continue to be a competing demand. There is little doubt that with advances in drugs, diagnostic and treatment techniques, surgical skills, and so on, more and more patients can be cured or death appreciably delayed. The cost of these advances, however, tends to be high, and careful consideration needs to be given to the options available, especially the opportunities that would be forsaken by expending resources on one patient, as against many patients in another specialty. There is no magic formula that can be used to ease this problem, but decisions, though difficult, have to be made. These decisions must be made specifically rather than passively to allow proper debate and consultation on the issues.

This whole problem is admirably expressed by Robert Maxwell in *Health Care—The Growing Dilemma* (see box, page 76).

This sums up the problem, but how do we decide how much should be spent on renal or bone marrow transplantation, cardio-thoracic surgery, oncology, and so on. The choices are easily defined; the decisions are harder to come by.

Asset consumption

Capital is a 'free good' to the NHS. Each year an amount of money labelled capital—£775m in 1984–5—is allocated to regions, and so on, and this is spent mainly on buildings and equipment. Unlike in the private sector, once this money is spent no further notice is taken of it when producing costs, and so on. This hidden cost nullifies most cost comparisons that are now undertaken. Treasurers are aware of this problem, and the Association of Health Service Treasurers will shortly be producing a report suggesting major changes on this matter. It is vital that proper recognition of the consumption of capital and assets is given in plans, budgets and costs to ensure that a complete data set of financial information is available to achieve the best value for money in health care provision to maximise the return on the investment of capital in the NHS.

Intraspecialty specialisation

Finally, I come to a financial problem that has worried me for some time—the consequences of the specialisation of clinicians within their own specialty. This trend is most apparent in teaching districts, where it is complicated by clinicians appointed by the university, over whose appointment the district has little or no control. Districts may appoint a clinician to a particular specialty only to discover afterwards that he is, or wants to be, an expert in a particular aspect of that specialty. His special skill means that he attracts patients from outside his normal catchment area for both first and second referrals. From the district point of view this may have various consequences ranging from a pattern of service being provided which is not that intended by the health authority, to a rise in resources committed if the treatment requires the use of expensive drugs, tests, and so on—expenditure that again may not be in the health authority's priorities. As a potential patient I want to be treated by the best doctor available, no matter where he works, but we need more local dialogue about intraspecialty specialisation before commitments are entered into to ensure that the most equitable use is being made of the scarce resources available to health authorities. If the numbers of consultants increase as intended, such specialisation may increase and the problems it presents may become more severe in future.

Treasurers used to be considered the great 'no men' of the NHS,

> 'Today, there is a new challenge: how to use wisely the armoury of treatment skills available. Thanks to advances in knowledge and techniques, the skills at our disposal are greater than ever before. To use them indiscriminately is, however, to use them irresponsibly. We have advanced far beyond the point where the main health problems are uncomplicated, the steps to be taken obvious, and the results guaranteed. Rather we must recognise that benefit from intervention may be small, despite a large effort and high cost. Since resources are inevitably limited we should constantly ask whether we are using them to best effect. If resources are used on any case without considering the priorities, others will suffer.' (Robert Maxwell in *Health Care—the Growing Dilemma.*[3])

but this image is changing. They would like to be 'yes men' in the best possible way—but this may only be done with clinicians' help. Together they can ensure that the most effective health care is being obtained from the resources committed. But, remember, it is the clinician who commits those resources.

References

1 Anonymous. Spending on health. British Medical Journal, 1983, vol 287, p 235.
2 Great Britain, Department of Health and Social Security. Sharing resources for health in England: report of the resource allocation working party. London, HMSO, 1976.
3 Maxwell R. Health care—the growing dilemma. New York, McKinsey & Co, 1974.

9 Clinical budgeting and costing—friend or foe?

R STEELE

Orwellian analogies were being rather overdone last year. Even so, the arrival of 1984 after Information Technology Year and the revolution in microcomputers coupled with a government wedded to cash limits provided an environment with more than a hint of Orwell's nightmare in which the medical profession needs to judge the role of budgeting and costing. Of all the changes facing the National Health Service, however, it is perhaps the present government's psychology that is the most crucial variable. How far is it prepared to apply its industrial and commercial analogy to the running of the NHS? The answer to that question will determine the role of the clinician in management and his attitude to budgeting and costing in the coming years.

A pattern seems to be emerging. Firstly, there was the 1982 reorganisation of the NHS, which removed an administrative tier—area health authorities—and increased the emphasis on management responsibility at unit level. Then came the introduction of accountability exercises, regional and district reviews, and performance indicators, and finally the Griffiths inquiry into management, which led to the appointment of general managers.[1] All three set or alter psychological boundaries in the NHS—that accountability for the use of resources is acceptable and should be widely practised, that performance can be measured and compared, and that better managerial decisions are required.

All three concepts reflect an ideology based on the line management theory of commerce and industry, with general managers providing the impetus to managing the system. Managerial methods in commerce and industry generally rely on line management, with specific and reducing accountability from top to bottom for deciding on the allocation of resources. The board of directors has overall control of the business, looking at overall strategy including hiring and firing general or divisional managers. The general or divisional manager in turn controls the unit managers subordinate to him and sets each unit's objectives and targets. The unit manager is then responsible for the day to day running of the business and short-term production decisions. Within the unit the supervisor supervises the

foreman, who oversees the workers at the end of the assembly line where the final product emerges. A hierarchy of control is practised.

To see the present political philosophy on how NHS management should be organised, simply insert Department of Health and Social Security, region, district, and unit, with general managers where appropriate. The health service, however, fits uneasily into a simple line management system when we look at the structure from the perspective of allocating resources. The NHS might follow the pattern from parliament and the DHSS through regions and districts to unit level in that they make decisions on setting overall priorities and major capital investment schemes. Once 'production' levels—the hospital—are reached, however, the line management analogue becomes confused. Admittedly, at hospital level the NHS will soon have the unit team or the hospital general manager who will be responsible for the day to day running of the hospital. Moreover, there are already supervisors and foremen in the service departments to ensure the efficient running of departments like catering, laundries, portering, and so on. But these are merely support activities to the hospital's main activity—the care of patients.

This is where any NHS line management system (and therefore the theory) runs into trouble, because those on the shop floor who commit resources and make decisions on their use are the *major* determinants in the system and not the minor ones envisaged in a traditional line management structure. They are the clinicians, who determine the levels of production (the number of patients), what is produced (the types of patients given care and treatment), and how it is produced (the methods of treatment and care given). These are not decisions normally taken by those at the 'end of the line'. Not only do clinicians not fit into the mould of line management but their non-conformity is buttressed by arguments about clinical freedom, which turn the concept of line management on its head.

Will clinicians fit into line management

Can line management, which underpins Griffiths and the government's cost efficiency approach, be made to work in practice by 'fitting' clinicians into the system? The Griffiths inquiry makes a play for budgets for clinicians 'to involve [them] more closely in the management process, consistent with clinical freedom. Clinicians must participate fully in decisions about priorities in the use of

resources.' The idea of budgets for clinicians and of bringing them more closely into the management process is not new. Even so, bringing both concepts together under a 'general manager' umbrella might well make clinicians worry as to their use and question whether they are the 'Trojan horse' to their autonomy. Certainly, this may be a danger if the system is misused. It would be unfortunate, however, if clinical budgets and, indeed, costing procedures were regarded purely as an administrative or a general manager's tool. There are other more laudable purposes.

There is little point in debating yet what should be included in budgets or how costs are calculated, though both will be seen to be complex and difficult questions once implementation begins. The general principle rather than the mechanics is at stake. Indeed, even the principle might not be worth arguing about if we had more than enough resources to meet the health needs of the country, but this is patently not true and any reader who believes otherwise will gain little from reading further. But if it is accepted that there are insufficient resources in the health service to meet all health care needs—and that there are unlikely to be in the near or foreseeable future—then the definition of clinical freedom must be a qualified one. It might still be regarded as the right to treat patients as the clinician wishes, but treatment is surely constrained by the availability of resources? There are already severe constraints on the clinician's clinical freedom, as Professor J R Hampton eloquently warned in a *BMJ* leading article in 1983.[2] There is a limit to the number of patients the clinician can admit, to the diagnostic tests he can give, and to theatre time available. The question is whether clinical costing and budgeting would provide further constraints or simply clarify the existing position and enable the clinician to provide a better service.

Let me make an analogy with nuclear power. Nuclear power as a source of energy and as an alternative to using up rapidly disappearing natural resources might be of great benefit to society, but its misuse to create nuclear weapons arguably not. Budgets too can be good or bad depending on their use and the users. The definition of a budget varies: Collins's *Concise English Dictionary* defines it simply as 'a collection of items', whereas Kohler's *A Dictionary for Accountants* sees it as 'any financial plan serving as an estimate and a control over future operations'. A 'collection of items' budget might simply be information on the activities of a clinical unit. If the information

is relevant it should allow the head of the unit to identify readily where and how his resources are being used and should help him make better decisions to the benefit of patients and society in terms of improved care, as well as reducing the risk of a wasteful use of scarce resources. Moving more towards the accountants' definition is carrying out this procedure within an environment offering positive incentives and disincentives for better use of resources, but it also carries dangers of performance monitoring and control by people not best qualified to do so.

Information: neither friend nor foe

Information is neither friend nor foe, nor does it solve any problem; rather it should give the user the ability to assess, analyse, and make an informed decision. The information is not master, nor can it monitor, control, or alter anything, it is merely an aid. So far clinicians have, by and large, reacted against ideas of costing and budgets. Perhaps this is simply because these have been proposed by administrators and treasurers and the information produced or planned, reflecting this source, is biased towards the accountants' definition of budgets for use by administrators. Clinicians fear the potential misuse of this information. Two quotations epitomise the present position and the different psychologies: the first comes from an economist in the NHS concerned with constructing clinical budgets, the second from a consultant physician (see box).

'Budgets imply accountability, direction, and planning. Costing implies a statement about a given situation although the resulting information may be subsequently used for planning' (personal communication).

'. . . direction is not a feasible method; doctors practise as individuals and their actions cannot be dictated by any management structure. . . . Efficient use of resources and good patient care are the same thing. Wasteful medical care is not only expensive but potentially harmful to the patient' (D W Young[3]).

The two quotations speak for themselves: the one approaches the problem of efficiency from the viewpoint that costing information and budgets are required for directing, planning and managing the service and the other from the viewpoint that good patient care gets there in the end. Each has merit but tends either to ignore the other's

view or to emphasise different parts of the same equation. Dr Young is correct, in that doctors' actions cannot at present be dictated by the management structure. That is the message from the line management analysis in the first part of this paper, and of course Dr Young is correct in saying that wasteful medical care is expensive and potentially dangerous. Nevertheless, and perhaps unfortunately, there are wider choices facing the clinician and the health service than simply the choice of treatment. Because of the scarcity of resources at our disposal there is an inevitable balance to be struck between the amount of resources we commit to one set of needs as opposed to another—for instance, more for general surgery implies less for mental illness. The amounts of time, effort and money invested in programmes of transplantation and high technology medicine are set against how much is needed to reduce waiting lists. In this last case the former gives great benefit to a small number of people and the latter a relatively small benefit to a large number of people.

There is the conflict between us as patients, when we want the best care possible, and as taxpayers, when we are reluctant to pay the bill for the care and demand that our health service resources be used efficiently and effectively.

The government's philosophy is that a system of general managers coupled with management budgets will achieve greater efficiency. To assess this belief we need to examine the roles of the players as well as the issues. Most importantly, will clinical budgeting necessarily compromise clinical freedom to any greater extent than the existing system? The answer must be no if it simply replaces the existing implied system of allocating resources with an explicit one. As to the role of the players, though I agree with Dr Young that the doctor should not be dictated to by management there is a difference between direction and dictation. The authority already directs the resources and their amounts to the clinician and the clinician dictates their use. Neither of these functions should change.

At present, however, clinicians make decisions in an implicit manner with little or no explicit consideration of how the resources have been used or might otherwise have been used. The resource consequences of decisions are largely unknown and little considered, and this is wrong when the resources in question are publicly funded through taxation. Even so, the explicit consideration of resource use needs to be put into context. The object of the exercise must not be

to face the doctor with the query 'can I afford to do this test, given my budget?' The resource consequences of treatment for a patient should not be made once the patient is admitted. Provided that there is medical justification for its use it should be done. But by giving the head of the unit the ability readily and routinely to assess past care this might lead to a reduction of what Dr Young calls wasteful medical care and also to a more efficient use of resources. At one level the head of the unit should have the ability to check the care and treatment given to patients within his unit and at another to 'manage' and plan the use of the resources available to him to derive maximum benefit not only for the patients he admits but also for those waiting to be admitted. A budget of this sort—the stock of items idea—should lead to improvement of the authority's function of direction and the clinician's of patient management (if only by stopping uninformed criticism) through the existence of an information system (or systems) showing patient activity and relative costs (resource inputs).

The work of both would be greatly enhanced if administrators and clinicians could indulge in informed argument instead of, as now tends to happen, uninformed 'slanging' matches. Setting up systems of information centred around a consultant's activity therefore should be beneficial to the health service. But a move towards the accountant's 'budget' with all that that entails is less likely to be the case, and in truth is even less likely to be successfully implemented. A precondition for any system is that clinicians and especially heads of units have a substantial influence on decisions at an early stage—that they help to decide exactly what information is required *for them* to assess their present levels of activity and the possible implication of any changes that they might want in their unit rather than having a system chosen for them by general management for general management.

Doctors must demand information

The managerial structure and psychology are changing. The medical profession must not be left behind in a defensive position but should be positively attacking management to provide them—the real patient managers—with information to allow *them* to run their own units efficiently and effectively in terms of *both* their use of resources and their clinical outcomes. The accountants' definition of a budget

is insufficient. Data of use to clinicians need to be patient based since this is their focus of management. To my knowledge the information systems being set up for management budgets are of particular interest and use to managers of the 'general manager' ilk for monitoring and control but of limited value to the clinician in his search for better patient care and management of his unit. The revolution in microcomputers is already making the collection of patient related resource information a reality. This should be encouraged. In a research project at Hope Hospital, Salford Health Authority is already producing patient related cost data for a surgical gastroenterology unit. So it is a practical proposition. Moreover, it was instigated and guided by the consultant, not by the administration. Clinicians should be pressing for greater responsibility and say on how their units and patients are managed, not abdicating the search for efficiency to administrators, treasurers and politicians. They will search for the efficient use of inputs into the health service, but who will balance the equation by assessing the quality of outcomes? Both need to be performed together, and at present clinicians, who are best qualified to do so, are allowing themselves to be led rather than leading.

Friend	**Foe**
● More informed decision making	● Misuse of information and system by administration and finance
● Less wasted resources; inefficient use denies other patients care	● Possible lack of flexibility; of give and take when necessary
● Greater control over own resources	● Highlighting problems, which are at present conveniently ignored
● Better patient management	● Overemphasis on input side to detriment of quality of outputs

As to the question of friend or foe posed in the title of this article, it is not easily answered and indeed might be unanswerable. Knowledge of the pros and cons, however, might help future development and the forewarning of problems, and allay them. But

the essential difference between the two is their early anticipation and the active participation of the clinicians (see box, page 83).

References

1 Great Britain, Department of Health and Social Security. NHS management inquiry. Report. (Leader of inquiry: Roy Griffiths.) London, HMSO, 1983.
2 Hampton J R. The end of clinical freedom. British Medical Journal, 1983, vol 287, p 1237.
3 Young D W. Costs and clinical decisions. Journal of the Royal College of Physicians, 1983, vol 17, pp 86–7.

10 Doctors have management responsibilities too

DAVID S GRIMES

Management is entering into the work of clinicians and is threatening to take up an increasing amount of their time. The cause is obvious. In an era of government cash limits overspending of district funds is illegal. Doctors control most clinical activity, which consumes virtually all the cash allocation of a district, so the pressure is on them to work 'economically' and 'responsibly'. But what does this mean?

The doctor's first responsibility is to his patients. He or she is trained to do the best for each individual patient, an ethos that applies whether he is in a clinical specialty with direct patient contact or in a service specialty such as histopathology. Excellence is the ground rule for the medical profession, and the royal colleges oversee this aim by insisting on exacting standards so that consultants are of high calibre at the time of appointment.

The doctor's second responsibility is to organise a service, thereby extending his activity from the individual patient to a group of patients. The service may be of a technological nature—for instance a laboratory or a fibreoptic endoscopy service—or it may be more clinically oriented—for example, a general practice, a diabetic clinic, or a geriatric day hospital. In providing the service a doctor soon realises that a queue of people await his expertise, and he will usually strive to meet this demand. A trade off will, however, be reached when in order to preserve a certain quality of care to individual patients he must restrict the number that he sees. As doctors are generally unable to control demand any restriction will soon produce a waiting list.

The third major responsibility of a doctor is to educate the staff around him. Finally, the medical profession as a whole has a responsibility to ensure the overall function of the health care industry—however organised—and to fulfil this some doctors will need to sit on committees. These may be local committees at unit and district level or perhaps regional and national committees. Support for the royal colleges is also part of this responsibility.

Avoiding waste

It is as important in the National Health Service as in any other organisation that waste is avoided, and a doctor has a responsibility in the way that he uses the resources that are allocated to him. Professor Hampton suggested that 'if we do not have the resources to do all that is technically possible then medical care must be limited to what is of proven value'.[1] This sounds right, and British medicine has a good tradition of controlled clinical trials to try to identify those potential treatments that are effective and those that are not. Unfortunately, treatments of proved effectiveness are not being provided to a significant number of potential patients yet we continue to use hospital beds to provide treatments that are not of proved value. One of the most expensive treatments provided by the NHS is inpatient care for patients suffering from stroke and many of these patients will spend between two and six months in an acute medical ward. The cost then becomes similar to that of a heart transplant. Most districts now have psychogeriatric units, but has the value of these been proved? The development of these units has been quite correct in that it leads to elderly disturbed patients being treated in a humane way, but does this count as treatment of proved value? It is a response to a demand from society as a whole expressed through the press and ultimately through parliament, but the debates did not discuss effectiveness or value for money. The decision to build psychogeriatric units was ethical or political rather than managerial, and management groups are increasingly expected to make such ethical judgments in allocating restricted resources.

A treatment will frequently be given to a patient when it is only with hindsight that its effectiveness is known. It has been proved statistically that certain beta blocking drugs prevent death after myocardial infarction. In a Norwegian trial the mortality in a group treated with timolol was 8 per cent at two years against 15 per cent in the control group.[2] This means that out of every 100 patients treated only seven will benefit, but there is no way of recognising them in advance. It also means that the treatment will be ineffective for the 93 other patients treated and this represents wasted resources. It might be questioned whether the adoption of this treatment is managerially correct or whether it is a misuse of resources. But a study of this type is unlikely to come to the attention of a formal management group, and the decision to prescribe the treatment will

be made by each doctor. This is a perfect example of what Rudolf Klein called the 'law of inverse decision making', when not only the ability to make decisions but also the expert knowledge lies with the 'workers' rather than with the management.[3] But in this particular example if we look beyond waste it can be calculated that the cost per life saved (drug cost for 100 patients for two years divided by seven) is approximately £1500, which is extremely good value for money if a patient survives for, say, 10 years.

This form of waste is similar to that of fire alarms. Over the next few decades only a small proportion of recently installed fire alarms will be used, but there is no way of predicting in advance which these will be. We therefore install far more fire alarms than will be needed and the vast majority will turn out to be unused and therefore ineffective. Taking the parallel further, it has been calculated that to save one life from fire in the NHS costs £63m. If a health authority decides that fire prevention is not cost effective and declines to install the recommended systems then any future death from fire would clearly result in legal action against that authority by the relatives of the deceased. The legal responsibility of a health authority to the safety of patients is in this respect not dissimilar from a doctor's responsibility to his patients in terms of their treatment.

It is relatively easy to calculate the cost of successful treatment but assessing the 'value' of diagnostic procedures is less straightforward. Some interesting observations may, however, still be made. A study published in 1983 looked at the value of computed tomography in investigating dementia.[4] The most important diagnosis being looked for was a subdural haematoma and four were diagnosed in 500 consecutive patients. Three of these patients were successfully treated. If we accept that a computed tomography scan costs £100 and that therefore the total cost of investigation was £50 000 it can be seen that the cost of one successful treatment was £17 000. Whether or not this was good value for money depends on how long a successfully treated patient survives with cerebral function close enough to normal for him to enjoy his remaining life. Even if this investigation were thought by a health authority to be good value for money the problem would clearly lie in finding the money to pay for computed tomography for all demented patients with reasonably good physical health.

One of the most valuable resources in the NHS is consultant time,

and it must be used carefully so as to obtain maximum benefit for the NHS. A consultant usually has all his sessional commitments devoted to patient care, and if he is diverted from this patients are not treated. Committee attendance is an example, and a consultant might be forgiven for asking himself if the time spent there has a more useful output than seeing patients. Experience tells him that this is rarely the case and many committees, especially when concerned with planning, seem to be a waste of time, with no obvious outcome. If the government wishes to increase the number of patients treated with existing staffing levels the time that clinicians spend in committees and on administrative work must be reduced to the minimum. If it wishes to bring doctors further into management their number must be increased; otherwise patients will be neglected. Management has its cost.

Efficiency

The efficiency of the NHS has increased remarkably over the past two decades and more patients have been treated in fewer beds.[5] Patients who have had a myocardial infarction are now kept in hospital for one week, whereas 20 years ago they would have been inpatients for four to six weeks. This change in treatment has been studied closely and shown to carry no cost of mortality or morbidity, and changes in treatment should be evaluated in this way.[6,7] More operations are being performed on a short-stay basis and new technology has greatly helped this trend. For example, common bile duct stones can now be removed endoscopically in outpatients using many fewer resources than an open operation necessitating around 10 days in hospital. Long-stay psychiatric hospitals had their bed allocations reduced drastically and many of their patients have been discharged into the community. There are doubts, however, about the clinical and social effectiveness of this particular change in policy, and studies of the long-term effects on patients have yet to be performed.

Efficiency may also be evaluated in the outpatient clinic, when again the consultant has the responsibility to avoid wasting resources, in this case outpatient time. If I increase the number of patients I see in a medical clinic from, say, 15 to 30 I am doubling the efficiency of my work. (Efficiency is a mechanical concept: it is work done divided by resources used. The efficiency of a car engine

is assessed by miles per gallon; efficiency of the NHS is assessed by patients per bed, per nurse, per doctor, per session, and so on.) Unfortunately, increasing the number of patients seen in this way as part of improving efficiency will reduce by half the time the doctor can allocate to each patient. This may not be detrimental to mortality or even morbidity but it is likely to reduce the patient's satisfaction. In a private session a consultant is likely to see no more than six patients, indicating an extremely low level of efficiency but arguably a higher level of effectiveness. Health service statistics tell us something about mortality, a little about morbidity, but nothing whatsoever about satisfaction. A patient who visits his doctor does not usually expect to have his life saved. He hopes that his symptoms will be alleviated, would like an explanation of the nature of his illness, and expects a prognosis. The success of this process is not measured.

While a doctor has a responsibility to work efficiently, treating as many patients as possible with the allocated resources, this must not be at the expense of a lowered quality of care. Furthermore, it is unrealistic for a doctor to work to a norm of patients seen, for doctors differ in their communication skills. Finally, it is hazardous to portray the most efficient doctor as the 'regional objective'. A doctor might see 80 patients in an outpatient session, but it is hard to imagine him providing good quality care, even though an administrator might judge him to be extremely 'efficient'.

Conflict between doctors and management

The doctor must ask himself if he is providing effective, efficient treatment. But what does he do if he fulfils these criteria and finds that the resources he is allocated are inadequate to provide such a service to all his patients? The doctor will clearly feel a responsibility to those patients who are left on the waiting list and who either go without treatment or wait a long time for it. He has, however, only a moral responsibility to them: a doctor is not liable in law for patients on his waiting list. The legal responsibility of a doctor is to the quality of his work, whereas the health authorities are more concerned with quantity. It is particularly in this area that conflict will arise between doctors and management. The doctor is likely to continue to treat patients, even though the allocated resources have been exhausted, and even though the budget of the district or unit is

likely to be overspent. Most doctors will think that their responsibilities are to the care of patients rather than to a budget, which is seen to be a thinly disguised government policy. Britain has a long tradition of doctors whose clinical work is independent of government and this is a great strength. The treatment of individual patients has never been interfered with by the government, but what should a doctor do if government policy attempts to prevent him from treating patients either directly or indirectly?[8] Professor Cameron and his colleagues put the dilemma forcibly: 'Should a doctor ever allow a patient to die because he is ordered to do so by a representative of the state?'[9]

Our arrangement of health service funding is ideally suited to an organisation that does not change. It is unsuited to present-day medicine with constant change and new advances occurring each year. New treatments are becoming available and so in 1986 we can expect to identify a group of patients for whom there will be an effective treatment that was not available in 1984. Similarly, timolol has been shown recently to be effective in preventing death from myocardial infarction. The acceptance of this as a treatment policy would add about £10 000 a year to the district budget, and though most of this would be paid for out of family practitioner committee funds, it will be taken out of the budget for the hospital service.[10] The doctor's responsibility is clearly to provide this treatment, which is of proved effectiveness and seems to be good value for money.

If the health service is to treat more patients each year then it is a growing industry but unfortunately one without a growing workforce and with little prospect of automation. There are limits to how far the redistribution of existing NHS resources will enable the health care needs of the population to be met, and the only way in which the funding of the NHS can be increased is by direct pressure on the government. This seems in practice to be the responsibility of the medical profession alone, and the BMA[11] and the royal colleges[12] have recently spoken out in this way. The press also has an important role in identifying and publicising the NHS's shortcomings and there are many examples of its success, especially with long-stay hospitals and more recently with bone marrow transplantation. This is in marked contrast to health authorities and their chairmen, who seem (at least in public) to be representatives of government policy rather than representatives of patients. Nevertheless, change

is in the air. In May 1984 the National Association of Health Authorities published a report highly critical of the government's level of funding of the NHS. I believe that full-time managers of the NHS hold similar views to those of doctors, but to protest against government policy might result in disciplinary action, an example of the value of doctors' independence.

Conflict will inevitably increase over the next few years. Greater efficiency will almost certainly become more widespread, but it will result in more work being undertaken and more patients treated. Increasing throughput will reduce the cost per patient, but unless there is strict rationing of treatment then the fact that more patients are being treated will mean a greater total cost and a greater threat on the district or unit budget. Gastroenterology is an example. In my hospital the number of endoscopy procedures has increased from 160 in 1971 to 1850 in 1983 to about 2000 in 1984. At 1983 prices the cost of a gastroscopy (staff plus equipment) has fallen from £220 to £18 during the same period, but the total cost of the service has risen to about £40 000 a year and it is this that affects the district budget. The expensive clinical departments are usually the efficient ones, and whereas in the past certain low spending departments or districts could be relied on to balance the budget, this will not be possible in the future if their workload increases.

The levels of productivity and efficiency of the NHS compare favourably with the health care industries of other countries. An example of this is the drugs used per head of population (see table,

Table Pharmaceutical consumption per head of population

Country	*$*	*Country*	*$*
Switzerland	160	Austria	70
West Germany	158	Norway	62
France	122	Italy	59
Japan	120	Netherlands	43
Belgium	115	Finland	42
United States of America	90	United Kingdom	40
Denmark	88	Ireland	22
Sweden	86	Portugal	18

Source: Office of Health Economics, 1982.

page 91). Only Ireland and Portugal are more efficient than the United Kingdom, whereas Germany and Switzerland are four times less efficient (whether their large pharmaceutical industries are a cause or a consequence of this is hard to judge). When the government acknowledges our present level of efficiency and when health authorities show active concern about quality and the plight of untreated patients then they might expect more cooperation from doctors. Management in medicine must not be seen merely as bringing doctors to heel: doctors who participate in management expect it to improve the care of their patients.

References

1 Hampton J R. The end of clinical freedom. British Medical Journal, 1983, vol 287, pp 1237–8.
2 Norwegian Multicentre Study Group. Timolol-induced reduction in mortality and reinfarction in patients surviving acute myocardial infarction. New England Journal of Medicine, 1981, vol 304, pp 801–7.
3 Klein R. Who makes the decisions in the NHS? British Medical Journal, 1984, vol 288, pp 1706–8. (*See also* Chapter 1 of this book.)
4 Bradshaw J R, Thompson J L G and Campbell M J. Computed tomography in the investigation of dementia. British Medical Journal, 1983, vol 286, pp 277–80.
5 Great Britain, Department of Health and Social Security. Health care and its costs. London, DHSS, 1983.
6 Gelson A D N, Carson P H M, Tucker H H, Phillips R, Clarke M and Oakley G D G. Course of patients discharged early after myocardial infarction. British Medical Journal, 1976, vol 1, pp 1555–8.
7 McNeer J F, Wagner G S, Ginsburg P B and others. Hospital discharge one week after acute myocardial infarction. New England Journal of Medicine, 1978, vol 298, pp 229–32.
8 Michael J and Adu D. Dialysis, cuts, and district policy. Lancet, 1982, vol II, p 990.
9 Cameron J S, Ogg C S and Williams D G. Treatment for renal failure in the West Midlands. Lancet, 1982, vol II, p 1163.
10 Greenshields G. Learning to live with cash limits—and other financial matters. British Medical Journal, 1984, vol 288, pp 1393–5. (*See also* Chapter 8 of this book.)
11 Anonymous. Increasing concern on NHS deficiencies. British Medical Journal, 1984, vol 289, p 142.
12 Feroze R, Campbell D, Duckworth R and others. Economies in the NHS. *The Times*, 1984, 21 March, p 15.

11 Can you measure performance?

J M YATES and M G DAVIDGE

The National Health Service collects a vast amount of information on a routine basis, but much of it is unused. For years any attempts to use such information to evaluate performance has been criticised by the medical profession. The fact that annual hospital returns fail to distinguish between discharge and death, or that a hospital activity analysis print out sometimes presents the number of women patients suffering from diseases of the male genital organ, are two of many examples that serve to undermine confidence in the statistical information produced by the NHS.

Reservations about using routinely collected data can be divided broadly into three areas: technical, conceptual, and emotional. Firstly, although we might hope that data would display certain technical characteristics like accuracy, completeness, relevance, and timeliness, they rarely do. Information collection can be a chore that is frequently delegated to the most junior staff, with adverse effects on its accuracy and completeness. A vicious circle develops in which information is not used because it is inaccurate and inaccurate because it is not used. The information that is presented invariably comes in an unattractive manner, with rows of figures rather like a railway timetable. Furthermore, the NHS tends to gather together information on a national basis in an aggregated form thus making district by district comparisons virtually impossible.

Secondly, the concept of examining the performance of any health service is traditionally based on using indicators of input, process, outcome, need, demand, and environmental influences.[1] Our understanding of relationships between these six dimensions is limited. To what extent is case fatality (outcome) influenced by the level of staffing (input), length of stay (process), incidence and prevalence of the condition (need), the patients' expectation and knowledge (demand), and their socioeconomic circumstances (environmental influences)? Our attempts to answer this type of question tend to polarise around two sorts of study. There are those that are detailed but include small numbers of patients—for example, randomised controlled trials—and those that generalise about morbidity using national census data. We can say with confidence that Charnley hip prostheses may be successfully implanted in patients suffering from

arthritis and that for certain conditions older patients will stay in hospital longer than younger patients. What we do not know is the extent to which the traumatic and orthopaedic services in a district are acceptable and whether, given differences in case mix, socioeconomic conditions and resource input, they produce the expected result. Indeed, we do not know what results to expect and would be hard pressed to explain variations in performance.

Thirdly, there are also severe doubts about being able to measure quality. Tender loving care and bedside manner are easier to recognise than specify and measure, and this difficulty sometimes raises an emotional barrier that results in clinicians distrusting any attempts to evaluate a service. Evaluation is then left to subjective value judgments and expert opinion.

It is not surprising, therefore, that attempts to use such information to assess performance—for example, the current Department of Health and Social Security performance indicator work—have been roundly criticised due to the inadequacy of the database. The shortcomings of NHS data led to the setting up of a wholesale review of data systems in the NHS chaired by Mrs Edith Körner.[2] The timescale to undertake and implement such a review is of necessity going to be at least five years. Despite the obvious limitations within existing information, we thought that greater use could be made of its worthwhile elements and also that using data improved its accuracy and completeness. Moreover, if we are seen to be making progress in tackling these technical failings we are in a stronger position to address the more important conceptual and emotional reservations.

Collecting and processing data

We started our study of routine data by looking at separate mental illness and mental handicap hospitals of over 100 beds in England. Later we extended the study to examine 34 selected specialties on a district basis. From the outset we accepted that a statistical picture would never precisely portray how a service or hospital performs, but, acknowledging that deficiency, we took the following approach.

We examined existing data sources to identify items that might make some contribution to assessing input, process, outcome, environment, need, or demand. Indicators of performance were derived from the data, which were not expected to be precise

measures, but merely displayed the variety that existed in the country. Given the volume of information available, it proved easy to produce a large number of indicators, although there was the usual preponderance of input measures (doctors, nurses, beds, and so on) and a virtual absence of outcome measures. For most specialties we selected some 32 indicators, such as beds per catchment population, length of stay, waiting list per bed, patient/staff ratios, and so on.

Then for each of the indicators chosen we identified the technical and conceptual reservations that might help to explain the amount of variation observed. In particular, we tried to establish what might indicate good or poor performance. For example, when examining a patient/nurse ratio in mental handicap it was thought unlikely that a high number of nurses per patient would be any indication of good care, but that low levels might make high standards of care difficult to maintain. We gathered data for the whole of England with the help of staff in each regional health authority and transferred it to an expanded BBC microcomputer. Programmes were written in order to allow colour graphic display of the data.

Presenting information

Information was then made available to clinicians and managers in the form of colour diagrams and text commentaries. Printed diagrams were always accompanied by text that sought to guide the users in the interpretation of the diagram produced. The different diagrams used are described below.

Histograms

These show the position of an individual district or hospital in relation to all other districts or hospitals in England (top of Figure 4, page 96). It is also possible to show all hospitals or districts in one region, or a group of districts and hospitals with similar characteristics—for example, teaching districts, hospitals of a certain size, and so on. For each histogram an explanatory text is produced, which explains the method of calculation and the reservations about interpreting it.

Profiles

In order to display several indicators each histogram may be converted to a percentile bar (bottom of Figure 4, page 96), which

enables three forms of profile to be produced:

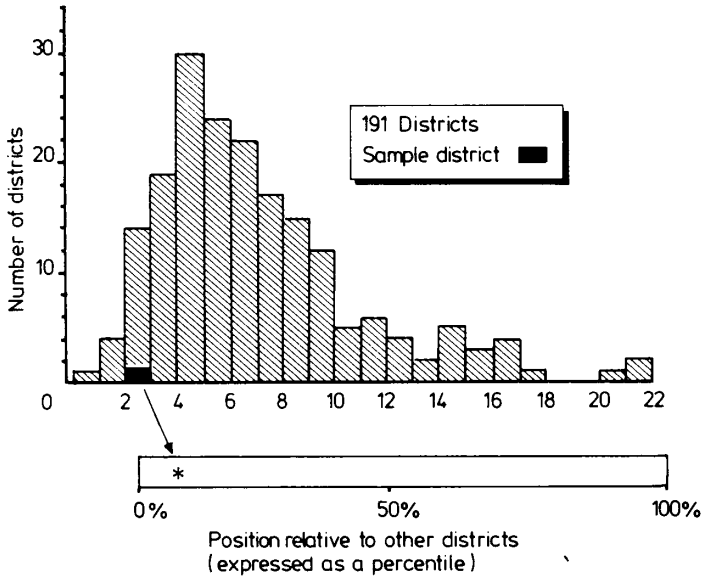
a. Multi-indicator Figure 5 (page 96) is an example of gathering together six indicators on one subject—in this case a mental handicap hospital.

b. Multispecialty It is also possible to have a similar presentation that displays one indicator for several specialties—for example, beds per catchment population for eight different specialties.

c. Multiyear (mental hospitals only) An alternative presentation takes one indicator for a 10-year period and examines relative performance over time.

On all the standard profiles any values that are unusual by English standards and might suggest performance problems automatically generate a comment that draws attention to that issue.

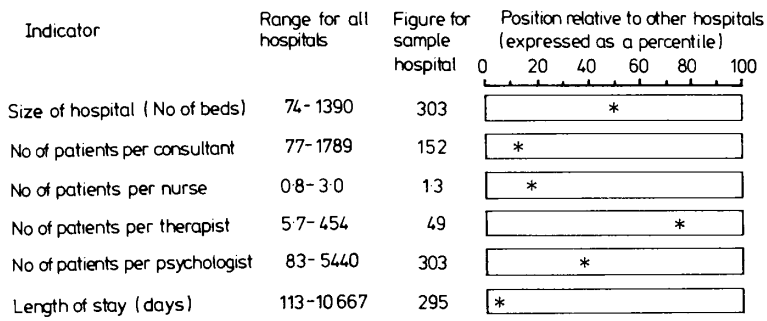
Figure 4 Waiting list per bed for general surgery, 1982



Scattergrams

These display any two indicators to see if any simple relation occurs between them. Each scattergram may be supplemented by various statistical measures.

Figure 5 Mental handicap hospitals' profile, 1980



Requests for information

Information was sent to clinicians and managers only when requested by them. The availability of the service was publicised merely through presentation at lectures, publication of papers,[3,4] and by word of mouth. The analysis of mental illness and mental handicap institutions has been available for three years, and services at a district level for two years. We have been asked for information about all 221 mental hospitals in the study and most of those requests have come from hospitals and districts. Information about district services has been requested by over 150 districts in England, with one-third of those requests coming directly from consultants. Within three months of the service being made available on BBC microcomputer, over 60 health authorities have purchased equipment to enable them to take information on floppy disc. We have also undertaken work for organisations such as royal colleges and the Health Advisory Service.

The speed of data turnround has been dramatically reduced. The Department of Health and Social Security's published statistics for mental illness and mental handicap hospitals are still some five or six years behind. The data for this study are received from regional health authorities nine months after the event and processed in our unit in less than two weeks. With regard to acute services, once data are received, which last year took 11 months, they can be processed in about four weeks. The problems of aggregation, lack of timeliness, and difficulty of access have been greatly changed and there is evidence that accuracy and completeness are beginning to improve.

Measuring performance?

Given the technical limitations of the information sources at our disposal it is hardly surprising that the NHS has been reluctant to develop indicators of performance from such information. What our project demonstrates, however, is that we can no longer refer to deficiencies such as inaccuracy, incompleteness, and lack of timeliness as bland excuses for failing to attempt serious evaluation. While we do not suggest that measuring performance is a problem that has been solved by the arrival of the microcomputer, there is evidence that the huge variations in performance cannot all be explained away by the inadequacies of error prone data. Early results indicate that current NHS data are capable of identifying performance failure.

Our analysis of mental hospitals over the past 16 years has already shown that certain groups of hospitals have a much greater risk of performance failure.[4] It is the large, badly staffed institutions with a slow turnover of patients that are more likely to be the subject of scandal and inquiry. In our study of district services we find that data are available that if treated with caution may highlight those areas that need further examination and possible help.

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References

1 Donabedian A. The definition of quality and approaches to its assessment. Michigan, Health Administration Press, 1980.
2 Great Britain, Department of Health and Social Security. Steering Group on Health Services Information. A report of the working groups A. London, DHSS, 1981. (Körner report.)
3 Yates J M. Staff patient ratios and hospital enquiries. Nursing Times, 1981, 9 December, pp 2143–5.
4 Yates J M and Vickerstaff L. Inter hospital comparisons in mental handicap. Mental Handicap, 1982, vol 10, pp 15–17.

12 Quality assessment in health

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Concern about the quality of care must be as old as medicine itself. But an honest concern about quality, however genuine, is not the same as methodical assessment based on reliable evidence. Still less is it quality control, which implies compliance with predetermined standards, as in an industrial process.

Among the pioneers of methodical assessment was Florence Nightingale, that scourge of those ultimately responsible for low standards of medical care in the army. Her devastating exposure of Crimean hospitals as death traps was based on showing that a key determinant of regimental mortality was distance from hospital. The least fortunate regiments were those with good access to hospital beds, because deaths depended less on casualties in battle than on acquiring an infection in hospital. She later developed her uniform system of hospital statistics, designed among other things to compare death rates and bed use by diagnostic category.

Another impressive figure in the annals of quality assessment is Dr E A Codman of Boston, who, in the early part of this century, instituted a one-year follow-up of all his surgical patients. Each patient was recalled a year after discharge and his health state assessed in terms of the original objectives of the operation. Codman sought to determine whether his diagnosis had been correct, whether the operation had been a technical success, whether the patient had benefited, and whether there had been harmful side effects. Perhaps not surprisingly, his colleagues at the Massachusetts General Hospital gave him little encouragement, so that eventually he left to found his own End Results Hospital.

Arguably, no major conceptual advance has been made since Codman. Brook and Avery pointed out that when—in about 1950 in the United States—attention again turned to quality assessment, the emphasis had shifted from end results to process, and from therapeutic outcome to utilisation and expenditure control.[1] Thus grew up the cumbrous American edifice of professional standards review organisations, now replaced in most hospitals by a unified quality assurance programme monitored by the Joint Commission on Accreditation of Hospitals.[2]

Paradoxically, American doctors are far more subject to system-

atic examination of their clinical work than are their British equivalents in our supposedly more bureaucratic health care system. Some of the reasons for this difference are to our credit, others less so. For example, since there are few incentives to overprovision of medical services in the National Health Service we do not need a compensating regulatory system designed to discourage abuse by providers. Similarly, there used to be greater problems in the United States than here with specialist procedures being carried out by doctors who had no advanced qualification in that specialty. Less creditably, the medical profession in Britain has seemed (at least until recently) collectively allergic to rational examination of the case for medical audit in any form.

Arrangements in the United Kingdom

That does not mean that no mechanisms exist in the United Kingdom for independent assessment of the quality of medical care. On the contrary, there is a wide range of such mechanisms including:

Educational accreditation for training purposes The royal colleges, the nursing regulatory bodies, and their equivalents in other professions, all inspect the relevant departments, institutions, and services to satisfy themselves that training arrangements in them meet the (generally rather shadowy) standards that they require.

The confidential inquiry into maternal deaths Stemming back to the 1930s, the inquiry consists of a confidential report from the local obstetrician, through a regional assessor, to national assessors. The assessors comment on the causes of death, identifying those that were in their view avoidable. They do so to those concerned with the specific case and (preserving anonymity) they also make a public report. It. seems probable that by calling attention to avoidable causes, such as toxaemia, and by suggesting remedial measures, the inquiry has contributed to the progressive reduction in maternal deaths and to the United Kingdom's relatively good international performance on this criterion. But that hypothesis cannot be proved. The confidential inquiry has been applauded as a method and has influenced the approach to (among other problems) perinatal deaths and anaesthetic deaths, though no other British audit is as thorough as this.

Clinical chemistry: United Kingdom national quality control scheme

The scheme began in 1969. Every two weeks a portion of material is sent to all participating laboratories for analysis. They return their results of several commonly performed tests, and the data from all the laboratories are compared. For each of the principal laboratory methods in use the mean value, the standard deviation, and a variance index are calculated. Thus each laboratory can compare its results with others, while confidentiality is respected. Those who administer the scheme have been able to show progressive reduction in the variance index, thus showing improvement in the consistency of results obtained by different laboratories. Similar schemes operate in haematology and bacteriology.

The Health Advisory Service and the National Development Team Set up by Richard Crossman in 1969, the Hospital Advisory Service (as it then was) was intended to be his eyes and ears in the long-stay sector. This was in the wake of a series of incidents and inquiries, such as that at Ely.[3] Multidisciplinary teams visit the major long-stay institutions to examine standards of care, and recommend improvements when appropriate. The teams discuss their findings on the spot, and make a written report to the district health authority and to the Secretary of State. Opinions are mixed as to the success of the service and the team. What is unusual, in international terms, is the concentration on quality assessment in the long-stay sector.

Peer review in general practice Until recently almost nothing was known about the quality of care in general practice. In 1980 the Royal College of General Practitioners set out to develop a framework for defining and auditing standards of care.[4] Four main facets of performance were identified—namely, professional values, accessibility, clinical competence, and ability to communicate. Within each of these facets several criteria have been chosen for differentiating good and bad performance. Pilot practice visits have shown that practices can be audited against these criteria, using a variety of methods, including the sampling of records, videotaped consultations, and interviews with the general practitioner and with ancillary staff. The process is voluntary.

Cluster analysis of performance indicators Yates has developed the idea of cluster analysis, using statistical data from standard sources, such as the SH3 and Hospital Activity Analysis.[5] His hypothesis is that people make too little use of the information that they already have. In particular, analysis of a few key indicators—for example, the ratio of nurses to patients, the size of hospital, and the length of

stay—can identify a relatively small number of mental handicap and mental illness hospitals that are seriously at risk, where the chances of a breakdown of patient care occurring are high. The argument is persuasive, at least in the long-stay sector. Whether it can be transferred to the acute sector is less clear. He and his colleagues at Birmingham University's Health Services Management Centre have now developed the technique to the point where the standard data sets are available on request on disc for every health district for most specialties.[6]

The medical services study group of the Royal College of Physicians The study group was set up in 1977 under the leadership of Sir Cyril Clarke to examine the efficiency and outcome of selected aspects of medical practice. It has undertaken over 20 investigations and has published a substantial number of articles.[7,8] The idea is to identify avoidable factors, as in the confidential inquiry into maternal deaths, and indicate measures that should improve performance.

These examples are not exhaustive. They do, however, illustrate attempts to assess quality through external review. In addition, many medical departments have their own internal reviews as an integral part of their commitment to education and to the quality of care.

Where next?

No doubt the majority view among British doctors is that assessing and safeguarding the quality of medical care are matters best left to voluntary initiatives among consenting adults in private. Self audit is good: external audit is a threat.

This is a perfectly understandable point of view—correct at least in emphasising that individual aspiration to raise standards is a *sine qua non* of professional responsibility. Nevertheless, important as self assessment is, it is unlikely to be sufficient. There are several reasons for this. For example, as Donabedian has recognised in his recent work, the judgment of quality is not simply a technical, professional matter.[9] It also includes interpersonal aspects where consumer opinion is at least as important. Interestingly, this links up with the recent emphasis in the Griffiths report on lack of sensitivity to consumer views in the National Health Service.[10] Moreover, one of the worst aspects of recent initiatives by the Department of Health

and Social Security is the persistently dreary emphasis on managerial efficiency, to the neglect of any discussion about what the NHS is actually trying to achieve. It is essential that discussion about the quality and effectiveness of care be reintroduced into the centre of the debate as they are, in the end, the more important dimensions of NHS performance. In the harsh world in which we live the Treasury is simply not going to be impressed by anecdotal evidence about health care quality based on self assessment. There has to be objective evidence.

The next necessary step in the argument is to recognise that the quality of care cannot be measured in a single dimension, comparable to the business analogy of return on investment. Donabedian's reference to the technical and interpersonal aspects of care has already been mentioned.[9] Beyond that, I suggest, are six dimensions of quality (see box) that need to be recognised separately, each requiring different measures and different assessment skills.

Dimensions of health care quality

- Access to services
- Relevance to need (for the whole community)
- Effectiveness (for individual patients)
- Equity (fairness)
- Social acceptability
- Efficiency and economy

To take accident and emergency services as an example, it should be possible to assess access in terms of ambulance response times and waiting time in the casualty department. Relevance to need would require some review and analysis of the different roles played by the accident and emergency department—including major accidents, minor trauma, and (in some cases) primary care. These measures would be different from those about technical effectiveness, which might include the adequacy of equipment and staffing in the casualty department, the incidence of complications, and some form of follow-up assessment. The social acceptability dimension could include conditions in the casualty department, privacy, and standards of communication—with the patient and the general practitioner. Efficiency and economy would require (among other things)

workload and unit cost comparisons with other accident and emergency units. These are not necessarily the right indicators but they do suggest how recognition of different dimensions of quality may lead on to a more illuminating choice of indicators than the standard accident and emergency statistics.

There are undoubtedly some outstanding examples of quality assessment activities in health services in Britain, such as the confidential inquiry into maternal deaths or the national quality control scheme in clinical chemistry. Increasingly, however, these fragmented activities will not be enough, because their coverage is incomplete and somewhat arbitrary and they lack any common core of concepts or of data. In the end, quality must be seen whole, not in fragmented parts.

Nevertheless, the last thing that we need is the creation of some new Frankenstein's monster in the shape of a quality assurance or quality control scheme that is insensitive to the variation, autonomy and trust implicit in health care. But it should not be beyond human wit to keep it simple, while providing a framework within which the quality of care may be studied, discussed, protected and improved. That will require encouragement, experiment and the sharing of ideas. It will call for a mixture of assessment methods—standard data analysis, sampling and follow-up, professional peer review, consumer opinion—tailored to an understanding of the multidimensional nature of quality itself.

References

1 Nuffield Provincial Hospitals Trust. A question of quality. London, Nuffield Provincial Hospitals Trust, 1976.

2 Sanazaro P. Quality assurance in medicine in world symposium for quality in health care. Report on the proceedings of an international symposium held at World Health Organization, Geneva, 22–4 June 1983. Geneva, WHO, 1983.

3 Great Britain, Department of Health and Social Security. Report of the Committee of Inquiry into allegations of ill-treatment of patients and other irregularities at the Ely Hospital, Cardiff. London, HMSO, 1969. (Cmnd 3975.)

4 Board of Censors, Royal College of General Practitioners. What sort of doctor? Journal of the Royal College of General Practitioners, 1981, vol 31, pp 698–702.

5 Yates J. Hospital beds. London, William Heinemann Medical Books, 1982.

6 Yates J M and Davidge M G. Can you measure performance? British Medical Journal, 1984, vol 288, pp 1935–6. (*See also* Chapter 11 of this book.)
7 Clarke C A and Whitfield G. Deaths under 50. British Medical Journal, 1981, vol 2, pp 1061–2.
8 Clarke C A and Whitfield G. Deaths from chronic renal failure under the age of 50. British Medical Journal, 1981, vol 283, pp 283–6.
9 Donabedian A. The definition of quality and approaches to its assessment. Ann Arbor, Michigan, Health Administration Press, 1980.
10 Great Britain, Department of Health and Social Security. NHS management inquiry. Report. (Leader of inquiry: Roy Griffiths.) London, DHSS, 1983.

13 Inequalities in health: can they be corrected?

R W DEARDEN

A major objective of the National Health Service at its inception was to provide readily accessible medical care to everyone, thus reducing inequalities in health. That objective remains. Given the substantial evidence on inequalities, however, it would be perverse to avoid the conclusion that the lowest social groups have relatively bigger health needs yet even now receive fewer and worse health services, particularly preventive and health promotion services.[1–7] Sadly, the NHS in its 36-year history seems to have made little impact on these figures, though no doubt they would have been even worse without it. Nevertheless, it is unacceptable to say to our poorest people that you will die sooner and while you live you will experience worse health and will have fewer health services, and that the health services you receive will be worse. What can the NHS do about it?

The idea of social class has some meaning for most people but it is limited at the level of social policy and inadequate for planning health programmes. A more important reason for not using class as a planning tool is that its use would hinder progress. The vocabulary of class and inequality is not a usual part of the conversations of professional people and is more likely to arouse hostility than support. Even worse, inventing yet another special case for more funds—Black style[3]—would add a weak bidder to the many competing interests for cash.

Instead of class, there is a need for accessible social information that health authorities could use in their planning. The case for an epidemiologically sound national morbidity survey, particularly at district level, is unanswerable and must surely come one day. The need for further information, however, is an inadequate alibi for continued inaction. Two proposals are made here that could be tried by any health professional interested in making progress in improving equity in health.

Geographical targeting

With the spread of information technology every health authority and family practitioner committee has at its disposal a wide range of

detailed census data about its population. This includes a wide range of social indicators often accepted as good proxies for morbidity. The small area statistics provide information down to enumeration district and postcode level. Following Brotherston's suggestion, each health authority or family practitioner committee could take selected social indicators and identify the worst 5 per cent of its enumeration districts.[8] This could identify those small areas within the catchment area with a relatively high incidence of, for example, unemployment, unmarried parents living alone, and overcrowding. This could be overlaid with such National Health Service indicators as perinatal deaths or failure to attend a clinic. This would enable each authority or practice to satisfy itself that care provided in those areas was of the right order within available resources. It seems likely that in any catchment area with substantial numbers of the lowest social groups then some redeployment of existing community services would be called for and possibly make a good case for additional resources.

Making a start

There are severe inequalities in health, and the NHS has so far done little or nothing to combat this. While many of the causes lie outside health institutions, leaders in the NHS have a responsibility to ensure that sufficient effort is applied towards achieving that founding objective of the NHS—equity. The type of programme outlined here is substantially untried, but it is easier to think of methodological objections and practical difficulties than to make a start. There is a genuine problem here, so let us make that start.

At risk registers

Something more accurate is still needed to identify specific patients or families. The household rather than the individual on the one hand or the parish on the other might be the most appropriate level. Registers of at risk households should be compiled. Putting resources where they will do most good is a familiar idea, as is an at risk register. Therefore there need not be any objections to compiling at risk registers to log those households actually or potentially experiencing health deprivation. The considerations to be taken into account are the variables to be used in compiling this register;

management of the register; and the response once action is triggered.

Compiling an at risk register

Each group of professionals could determine which variables to use and how to weight them in their own circumstances. A housing waiting list approach is suggested—partly because this is a widely accepted mechanism for rationing public service and partly because it can tackle a range of complexities flexibly. The variables included could be tailored to suit local preference. Given controlled trials, it would be possible over time to identify those variables and weightings that were good predictors of successful interventions. Initially, there would have to be a mixture of professional judgment and trial and error. The box (page 109) gives an example as an illustration.

This example includes both census social indicators and locally available data often thought to show an accumulation of deprivation. Practitioners will have their own preferences as to which variables could be excluded or added. The same is true of the weightings. Experience would suggest changes. Perhaps some variables will be so critical as to trigger action in themselves, and they would therefore need weighting at the appropriate level.

Management of an at risk register

Management of a register needs to be done from a convenient point such as the office of a director of community nursing services or a general practitioner's surgery. A split level register could be maintained with the first level regarded as provisional and the second level substantive. The provisional level could include entries scoring, say, five points or more and the second level would be where a response had been triggered in accordance with local policies, say at 15 points.

While it would be better to keep such a register based only on health service information than not at all, there would be obvious advantages in including information from other sources—for example, voluntary organisations, social services, education and housing authorities. Reports could be fed in as spin offs from normal visits by staff from all those participating agencies. To this could be added reports from attendance at accident and emergency departments and child development or school health clinics. Though these sources of

Illustrative social factors for an at risk register

Variable	*Points awarded*
● Head of household unskilled manual and unemployed for over two months	10
● Single parent family living alone, head of household not working	10
● Household lacking running water and inside water closet	5
● More than one person per room	5
● Entry in at risk register for non-accidental injury to children	15
● Late attendance at antenatal clinic	5
● Living in furnished rented accommodation	1
● No fixed abode	5
● No private transport	1
● Person over 75 living alone	5
● Registered disabled	1
● Failure to attend antenatal clinic	2
● Incomplete vaccinal state	1
● Illiterate adult	1
● School defaulter	1
● Head of household unskilled manual with six or more children	5

information will not be rigorously comprehensive, they will be able to provide a wide coverage. It is unlikely that many households at risk will not be visited by one of the agencies suggested or pay a visit to a participating clinic or department or both. Ideally, these data sources should be supplemented by specific programmes for households with no fixed above—for example, gypsies.

An option would be to add social indicator dimensions to general practice age and sex registers to carry out the functions of household at risk registers. This would have the advantage of building on existing practice systems and avoid relying on a wide range of disparate agencies. Naturally, the feasibility of this alternative

depends of the enthusiasm and stamina of the participating general practitioners. Another possibility might be to combine both approaches.

Such registers would be obvious candidates for computerisation. The number of entries would not be massive and once established not subject to rapid change. This avoids the huge back filing problems associated with some other patient administration systems. It will be commonplace for community health departments to have access to microcomputers and this at risk register could be an additional system at little marginal cost.

Triggering action

The objective is to use the register to change the way in which services are provided in order to improve the health of individuals. There are two key operational questions in implementation. The first is at what cut-off point will some kind of response be triggered? The variables and weightings can be changed easily to control the number of responses deemed feasible. It would be easy to define present and planned levels of response. In the illustration (see box, page 109) the following standards could be set:

minimum response—15 points;
planned level of response—11 points;
preferred long-term policy aim for response—5 points.

The response could also be triggered at the direct request of the appropriate doctor or nurse. Quite what the response should be would be determined locally by those providing the service and changed according to experience. The first response could be a home visit by an appropriate professional from the community health service who had local induction training into this specific programme. This might well be a health visitor—either an attached health visitor or one recruited specifically for this programme.

The initial visit would be for assessment and require extensive informal contact with at least one member of the household. Selection of the staff undertaking these visits would be crucial: they should be skilled in winning confidence and establishing communication in an unofficial, unauthoritarian way. The more sensitive these visits are to the lifestyles of the household being visited the better in order to avoid rejection. In the event of any such rejection, then the programme must withdraw contact. Some skill at generic

assessment visiting in circumstances where they are not always welcome has been built up by community psychiatric nurses, particularly those working with the elderly who are severely mentally infirm. Experience can also be drawn from other intervention strategies that are slowly spreading into the NHS—for example, coronary disease primary prevention projects. These do not so much require additional resources as a closer working relationship between staff than is common in the health and social services.

The second operational question relates to determining the aspects of health under consideration and the choice of a health programme appropriate to the individual concerned. This is likely to take the form of referral to the general pracititioner or other appropriate point for medical treatment of an active condition or to draw on appropriate health promotion activities or both. Programmes would be based on prearranged packages of medically agreed specific regimens for such activities as family planning, immunisation and vaccination, hygiene, nutrition, smoking, alcohol and drug abuse, baby and child care, school and play groups, money management, and social security. The potential list is endless, and the literature abounds with suggestions for both subject matter and programmes.

Can we afford it?

This programme is affordable if the motivation is there. There is a relatively small number of people at risk—perhaps 4000 in the average health district. No other similar high risk group would be so ignored. Most health authorities can afford to redeploy resources if they stop spraying them about and start using them selectively. This means at risk strategies in other services too. The onus of proof should be on those who argue that redeployment is impossible.

Quite modest numbers of staff are needed to deal with the minimal level of response suggested here. The employment of additional community health staff for these purposes would be an excellent use of joint funding that is still increasing. The experience of other programmes—for example, in relation to the elderly severely mentally infirm—suggests that around six to 12 people could provide the minimum service. This cost is substantial but manageable, especially when compared with the running costs of new hospitals, additional consultant posts, and the other more conventional growth areas still attracting money.

References

1 Townsend P. Inequality and the health service. Lancet, 1974, vol I, pp 1179–89.
2 Morris J N. Social inequalities undiminished. Lancet, 1979, vol I, pp 87–90.
3 Great Britain, Department of Health and Social Security. Inequalities in health: report of a research working group. (Chairman: Sir Douglas Black.) London, DHSS, 1980.
4 Forster D P. Social class differences in sickness and general practice and consultants. Health Trends, 1976, vol 8, pp 29–32.
5 Cartwright A and O'Brien M. Social class variations in health care and in the nature of general practitioner consultations. In: Stacy M, ed. Sociology of the NHS. Keele, Staffs, University of Keele, 1976.
6 Buchan I C and Richardson I M. Time study of consultations in general practice. Edinburgh, HMSO, 1973. (Scottish Health Services Studies No 27.)
7 Hart J T. Inverse care law. In: Cox C and Mead A, eds. A sociology of medical practice. New York, Collier and Macmillan, 1975.
8 Brotherston J. Inequality: is it inevitable. In: Carter C O and Peel J, eds. Equalities and inequalities in health. London, Academic Press, 1976.

14 The duty of care: medical negligence

DIANA KLOSS

Doctors may take out 'insurance' to cover themselves against claims from patients who allege malpractice. Indeed, health authorities in the National Health Service and (usually) general practice partnerships require doctors to belong to one of the medical defence organisations. Health authorities, however, as public bodies are not insured, so that the funds to meet any successful claims against them—and these with costs may sometimes run into several hundred thousand pounds—have to be found from within already tight budgets. Furthermore, a complaint, whether it reaches the courts or not, may consume considerable resources in terms of doctors', nurses', and administrators' time and emotions. So NHS managers have perforce to take a close interest in medical (and nursing) negligence, and the circumstances are unusual in that the 'shop floor' staff—doctors and to a lesser extent other health professionals—are the biggest risks and are usually joined with their employer in any legal action taken by a patient or relative.

As an organisation the NHS is probably unique in that it shares the responsibility for people's lives and, sometimes, their deaths. Civil actions against doctors and health authorities are now on the increase. The Manchester office of the Medical Defence Union reports an estimated 30 per cent increase in new cases in the past 12 months in that office alone. Most claimants are legally aided, which means that, even if a case is successfully defended, the authority and the doctor's medical defence society will find difficulty in recovering costs from the losing plaintiff. It seems unlikely that this increase is a temporary phenomenon, though fears that it may rise to the proportions of medical malpractice suits in the United States are probably not justified.[1] There, the contingent fee system whereby the lawyer is paid only if he wins the case, the far higher level of damages, including damages to punish the defendant as well as to compensate the plaintiff, and the presence of a jury in civil actions combine to make a successful claim a worthwhile financial proposition.

Doctors are not concerned only with injury to their pockets: the damage to reputation is probably a greater threat. Ordinary negligence is not criminal, nor does it amount to 'serious professional

misconduct'. Furthermore, most doctors have indemnity against liability as members of medical defence societies. It is the health authorities who are most concerned with the financial burdens of civil claims, as damages have to be paid out of funds already in short supply, and they are not covered by insurance. This may lead to friction between the doctor, who wants his case defended whatever it costs, and the employer, who may think that it is better to settle out of court for a reasonable sum.

Conflict may also occur when the health authority wishes to hold its own private investigation into an incident but finds that doctors are unwilling to say anything lest it be given in evidence in a subsequent court case. A decision of the Court of Appeal in 1983 is instructive.[2] A manager employed by a commercial organisation was in charge of a department and was concerned in fraudulent dealings in association with some of his subordinates. The court held that the manager had a duty under his contract of employment to disclose to his employers the misconduct of his subordinates, even though that necessarily meant revealing his own fraud, because he was in a supervisory position and therefore responsible for telling his employers what was going on.

At one time it was possible to keep the report of an internal inquiry out of the hands of the court by addressing it to the legal department and claiming that it was a privileged communication, but since the decision of the House of Lords in Waugh *v* British Rail in 1979 the courts have had the power to order production of such documents where the inquiry was partly to ascertain the facts and only partly to assess legal liability.

Doctors have frequently complained that the vagaries of the common law have made it difficult for them to assess before making a decision on treatment for a patient whether it would be approved by the courts at a later date. The ill wind of the increase in malpractice suits has at least begun to establish, in a growing number of test cases, the attitudes of English judges towards medical negligence.

Who decides what is reasonable?

Negligence is a failure to do what a reasonable man would have done in the circumstances. Where the defendant is a professional person he must conform to the average standards of his profession. In a case

reported in 1983 a professor of gynaecology was treating a woman suffering from stress incontinence after the birth of a child.[3] He agreed with his senior registrar that the latter should perform an anterior colporrhaphy only a month after the birth. It was proved to the satisfaction of the judge that the general practice was that this operation should not ordinarily be done until at least three months after the birth. In this case the operation wound broke down; two further operations were later performed, but the woman was left with permanent incontinence. The judge decided that where a doctor has departed from normal practice it is for him to show that there was some special reason justifying this and that in this case such a reason had not been produced. The action had been brought against only the senior registrar and the health authority, not against the consultant: the judge decided that the senior registrar was not negligent but that the health authority should pay compensation as employers of all the medical staff concerned.

In that case there was a well established practice, but in another 1983 decision medical opinion was clearly divided. In Maynard *v* West Midlands Regional Health Authority, the plaintiff was a nurse who had shown signs of tuberculosis. She complained that she had suffered paralysis of the left vocal chord as a result of a diagnostic mediastinoscopy, a procedure that, she claimed, should never have been done. The consultant had done the investigation because he wanted to be certain that she did not have Hodgkin's disease and called expert witnesses who said that some doctors would support him, though other (expert) witnesses disagreed. Lord Scarman, in the House of Lords, holding that negligence had not been established, said: 'In the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another.'

This does not, however, mean that doctors are safe in clinging to procedures that were formerly acceptable if they have now been rejected by the profession as a whole. There has to be a current debate about the right form of treatment for the courts to uphold both alternatives. There is no doubt that this emphasis on established practice may hinder new development. Where a new treatment is not yet widely accepted it is vitally important for it to be backed by as much scientific evidence as possible and, of course, for the patient to be aware of the treatment's novelty before he gives his consent.

How much should the patient be told?

Health service administrators still sometimes assume that all that is necessary to protect the authority against legal liability is that the patient signs a consent form agreeing to anything the doctor considers necessary. The law is that a consent form will not be effective to exclude liability for negligence; all that it can do is to protect against an action in battery—the touching of another without his consent. Even then, a 'blanket' form is worthless—it is only effective if the patient knew in general terms to what he was consenting at the time that he signed it.

Negligence in medical treatment may arise in several ways:

i. The treatment may be negligently performed—for example, the wrong drug administered.

In such circumstances consent is irrelevant for obvious reasons.

ii. The decision as to which treatment should be given may be negligent—for example, anterior colporrhaphy only a month after the mother has given birth.

In this case the consent of the patient is no protection against liability for negligence unless the doctor has clearly said to his patient: 'I want to do something that is not established practice, which most of my colleagues would consider negligent. Will you take the risk if things go wrong?' There would, of course, be ethical problems in such an event.

iii. The third type of case is one in which the operation or procedure is a proper one—that is, within the bounds of reasonableness—but the patient has been given insufficient information on which to base his decision to have the treatment, remembering that the patient has a right unreasonably to refuse reasonable treatment.

Here, the consent procedure is relevant because it is usually the means by which the patient is given the information that a reasonable doctor would give. Hills *v* Potter, another 1983 decision, was of this kind. The plaintiff had suffered for some time from spasmodic torticollis. The defendant, a consultant neurosurgeon, carefully performed an operation, but the patient came out of it paralysed from the neck down, due probably to a malfunction of a vertebral artery. This accident was unforeseeable at the time and so did not constitute negligence, but the operation did carry a known but slight risk of paralysis. The patient claimed that if she had been told of the risk she would never have had the operation and argued that the

surgeon had been negligent in not informing her. The main argument was about whether the standard by which the doctor should be judged in an 'advice' case was that of a responsible body of medical men or whether the court should impose the standard that the average citizen reasonably expected from the medical profession. Should we be told what doctors think we ought to know or what *we* think we ought to know? It was argued that to take the medical standard alone would be to allow doctors to maintain their conspiracy of silence. The judge decided that advice was no different from treatment and that the standard expected of Mr Potter was that of a reasonable neurosurgeon; he had discharged that responsibility because he had mentioned that there was a slight risk. The Court of Appeal adopted the same approach in Sidaway *v* Bethlem Royal Hospital.[4]

This does not mean, however, that surgeons will now be safe if they agree together to conceal risks from patients. The degree of risk, the intelligence and psychological state of the patient, the need for treatment, and the likelihood of failure must all be weighed before a reasonable man can decide to give or withhold information.

This case was also interesting because the judge repeated what had been said on previous occasions—namely, that battery was an inappropriate action in this type of case, where the patient had agreed to the operation that had been performed and was complaining only that she had not been told of the risk. Such cases should be dealt with as problems of negligence, said the judge: charges of battery should be reserved only for involuntary treatment. The Court of Appeal recently confirmed this in Freeman *v* Home Office.[5]

On whom does responsibility lie?

In law the primary liability is on the tortfeasor—the man who performs the wrongful act. The surgeon who performs the operation negligently or the nurse who gives an overdose of a drug is personally liable to compensate the patient injured. If the act is performed under the directions of another, however, the other will be liable. The consultant who instructs his senior registrar to perform an inappropriate operation is personally liable in negligence. Sometimes the negligence of the director will totally exonerate the actor, but skilled staff ought to be aware when instructions are careless and have a duty at least to check on their accuracy. If a doctor relies on

notes made by another he is not negligent simply because the notes are incorrect, unless he should have spotted the mistake or double checked the information because that was good medical practice.

The man in charge also has a duty to see that those working under him have reasonable supervision and are not asked to undertake tasks for which they are not qualified. In one case a hospital was held liable for putting a newly qualified anaesthetist into an unsupervised position where her inexperience led to a man's death. She was also held to be negligent, but only as to 20 per cent of the damages.[6]

If the tortfeasor is an employee his employer is vicariously liable for him when he is acting in the course of his employment, even if he is disobeying his employer's strict instructions. In many cases both the health authority and the employee will be liable and will come to an agreement with the doctor's medical defence society about sharing the damages. General practitioners are not employees, but partners are vicariously liable for the torts of other partners while acting in the ordinary course of business. It seems to be assumed that general practitioners are not liable vicariously for the negligence of doctors supplied by a deputising service (though they are responsible for them to the family practitioner committee under their terms and conditions of service.)

In some cases where patients have taken action over their treatment in hospital the courts have stated that the authority was liable for *all* those to whom it delegated the task of providing care: 'The reason is because, even if they are not servants, they are the agents of the hospital to give treatment.'[7] Where a patient is being treated privately he can sue those with whom he has a contract, but the National Health Service authorities are not liable for the negligence of doctors in relation to private patients.

Lack of resources: who is liable?

Lately, staff in the health service have been asking how far an individual may be held liable for lack of resources. Is a doctor negligent if he fails to use the latest equipment because it is not available? Is shortage of staff a defence to a doctor who has been unable to give the fullest attention to all his patients? The answer is that negligence consists of a failure to do what is reasonable in the circumstances. In a 1946 case it was held that it was reasonable in wartime to provide ambulances with left-hand drives because no

others were available, and that drivers were not negligent in failing to give signals that the structure of the vehicle rendered impossible.[8]

The potential liability of the Secretary of State and the health authorities is more complex. Although the courts have decided that on the whole they will not interfere with the essentially political decision to spend money on, for example, a maternity rather than an orthopaedic unit, they have shown themselves willing to impose liability for 'operational' negligence by public authorities.[9] In practice, this means that the health authorities could be liable if provision for existing patients falls below a level considered reasonable by the courts. The patient who is injured because of insufficient staff, the patient discharged too soon because of shortage of beds, might be able to recover damages from the health authority, but probably not the patient who dies of kidney disease because renal dialysis or a kidney transplant is not available. Yet what is 'reasonable' is always changing: it may be that in 10 or 20 years' time such provision will be regarded as essential and a failure to provide it grossly unreasonable.

No fault compensation

Is 'going to court' the best way of managing civil actions for compensation? Would it not be preferable to pay all those who suffered from medical accidents, whether negligent or not, out of an insurance based fund? One plaintiff spends years suing the health authority and loses on the evidence, another is successful and receives several hundred thousand pounds, even though she is so severely disabled that she has little on which to spend the money.

But even in a 'no fault' system it is necessary to distinguish between those who have suffered an injury through natural causes and those who have been victims of an accident. The families of children who have been born 'naturally' handicapped apparently find it difficult to accept that those who can prove that their similar handicap was caused by administration of a vaccine have the right to a substantial payment; it is argued that the money would be better spent providing facilities for all handicapped people. These are questions that concern us all—lawyers, doctors, and the community—and were the subject of a British Medical Association working party on no fault compensation established in 1983.

Finally, there is the issue of protecting the community against

negligent doctors. Civil actions are, as has been seen, an expensive and inefficient method of complaint and are based on the standards of doctors. The Health Service Commissioner has no jurisdiction over errors of clinical judgment, and the medical profession has no independent procedure for scrutinising allegations of carelessness. General practitioners are subject to some control by family practitioner committees, which have a nationally agreed service committee procedure for dealing with alleged breaches of a doctor's terms and conditions of service—though not alleged shortcomings in his clinical standards. An informal system for consultants to hear patients' complaints against their colleagues has been set up in the NHS[10], and a patient may complain to the General Medical Council about a doctor's behaviour or performance, though the council is reluctant to judge clinical competence. Has the time now come, however, for an independent body to hear complaints against doctors in the same way as is proposed for the police?

References

1 Whitehouse *v* Jordan [1981] 1 All ER 267.
2 Sybron Corporation *v* Rochem Limited [1983] 2 All ER 707.
3 Clark *v* Maclennan [1983] 1 All ER 416.
4 Sidaway *v* Bethlem Royal Hospital [1984] 1 All ER 1018.
5 Freeman *v* Home Office [1984] 1 All ER 1036.
6 Jones *v* Manchester Corporation [1952] 2 QB 852.
7 Roe *v* Minister of Health [1954] 2 QB 66.
8 Daborn *v* Bath Tramways [1946] 2 All ER 333.
9 Anns *v* Merton London Borough Council [1978] AC 728.
10 Great Britain, Department of Health and Social Security. Health Services management. Health Service complaints procedure. London, DHSS, 1981. (HC(81)5.)

15 Griffiths postscript

DAVID ALLEN and DAVID S GRIMES

Nineteen eighty-four was a memorable year for National Health Service management. Although ministers were at pains to deny it, the NHS began its second reorganisation within two years as the recommendations of the Griffiths inquiry were implemented.

Mr Roy Griffiths, managing director and deputy chairman of Sainsbury, headed a small team that submitted its report on NHS management to the Secretary of State on 6 October 1983. The report criticised the state of NHS management—particularly consensus decision making, which it condemned as 'too slow, and bad with the need to get a consensus agreement overshadowing substance'. The report recommended that a general manager, personally responsible for the performance of an authority, should be appointed at each level of the NHS, on a short-term appointment with the possibility of renewal after evaluation. The consequences of this inquiry, which was broadly accepted by the the government, will almost certainly prove to be the most significant change in the NHS management structure since 1948.

The pre-Griffiths management structure was implemented in the 1974 reorganisation and was based on professional hierarchies, with all health authority employees responsible to one of the professional officers and the officers in turn responsible to the health authority. With Griffiths this will change. Although officers will retain professional responsibility for their professional subordinates, and although they will have direct access to the authority on professional matters, all authority employees will be managerially accountable to the district general managers—assuming that it is possible to separate managerial and professional responsibilities. Once the managerial relationships are removed, however, justification for the current professional management structure disappears, and health authorities are now taking the opportunity to develop a management structure based on the functions to be fulfilled and the problems they face.

This means that there will be directors (or whatever) of planning, personnel, finance, and so on, as district staff, and unit general managers as operational heads of each unit. In districts which previously had a strong management team, some chief officers who

have not been appointed general manager in their district have gained general manager posts elsewhere, thus spreading managerial talent around, a distribution that may well benefit the NHS as a whole. Unless there are wholesale retirements and redundancies, the new district general manager will have to use the existing chief officers either in staff positions at district or appoint them to the new unit general manager posts. Inevitably, there will be some compromise between fitting individuals to the jobs and fitting the jobs to the individuals. Even so, staff cannot be expected to do things that they are unable or unwilling to do. On the other hand, general managers cannot be expected merely to tinker with the existing structure.

Many administrators have long believed that a management structure based on professional hierarchies has been a major handicap to the NHS, inhibiting effective line management. This may be so if the NHS is viewed as being a centralised organisation in which instructions from the Department of Health and Social Security must be passed to the operational levels. If, however, the NHS is viewed as a confederation of about 200 independent health authorities, and if the administration's *raison d'être* is seen as supporting the treatment of patients by highly skilled professionals who decide on appropriate treatment and care, then a management system based on professional hierarchies is rational.

Ceertain of the professional hierarchies' managerial functions are being transferred into the line management structure—in particular, planning and personnel. Nursing, however, presents problems: should it have its own personnel department or should it be part of a larger district personnel department? As nurses form about half the staff of an authority, such a department would require a strong nursing presence—assuming that those with nurse training must have a responsibility for nurse personnel. The point of the Griffiths proposals is that a nurse manager in the personnel department would be responsible to the district personnel director (who indeed might be a nurse by training) rather than to the chief nurse as at present. Similarly, should a nurse manager in the planning department be responsible to the planning director or to the chief nurse? Or does it really matter?

Although district general managers have been characterised as being autocratic chief executives whose writ will end consensus decision making, any manager would be unwise to ignore the views of his colleagues. Consensus management by a group of equals is one

thing, whereas consensus management by a group with a leader is another—as any Cabinet will testify. So district management teams seem doomed or if not doomed then docked of their previous power. The precise arrangements will depend largely on the district general manager concerned but the encouraging trend points to the appointment of advisory groups of senior staff and unit general managers to provide managers with information and advice, to receive and disseminate information and to turn the managers' decisions into action.

Many chief officers who have not been appointed general managers are feeling threatened, for many will lose their chief officer status. The uncertainty and concern is lowering morale, particularly as some district general managers are arguing that since they have short-term contracts and will have their performance evaluated, second in line officers should also have short-term contracts because their performances will affect the performance of the manager and the authority.

Despite the Griffiths report's suggestion that the district general manager should be from 'within the existing team or elsewhere according to local requirements', ministers have emphasised the importance of getting new blood into regional and district general manager posts by appointing businessmen to bring in a more 'virile business attitude'. There has been unprecedented ministerial interference in regional and district appointments. Indeed, so much so that district health authority chairmen in two regions have protested to ministers about the pressure they have applied to try and ensure that businessmen are appointed. Ministers have vetoed appointments when health service candidates have won the post in open competition and when the approved appointment procedure has been followed, including the presence of businessmen on the appointments committee. Every step of the appointments procedure has been subject to approval from higher authority, a procedure that in itself represents a new level of ministerial involvement.

Ministers seem particularly sensitive to any possible criticism that these general manager appointments are just 'jobs for the boys'. Even where outside management consultants have been retained by chairmen and where the management consultants have had a financial incentive to find an outside appointee, the NHS candidates have generally been judged to be best for the job. The outcome has been that few general managers from outside the health service have

been appointed. Where they have been appointed they have been given higher salaries than their NHS colleagues, a move hardly guaranteed to promote harmony among senior staff. Such higher salaries are presumably awarded as an incentive to move into the NHS and also to compensate for the short-term contracts they have been given. Their NHS counterparts, however, also have short-term contracts, though most have protected salaries from their previous appointments.

Given these problems it has been unfortunate, to say the least, that health authorities had to grapple with the introduction of the Griffiths plan without the benefit of the NHS Management Board, the topmost tier of the new structure. The long delay in appointing the top manager, Mr Victor Paige, and his board colleagues, left the service rudderless at a critical time. Whether this delay was because of infighting in Whitehall about the status and membership of the new board or whether it just reflected the difficulty in attracting people to serve on it are matters for speculation. Certainly, the delay did not smooth the launch of Griffiths.

The problems of NHS management have not necessarily been caused by the shortcomings of individuals. The NHS contains some very able managers, as management consultants have confirmed. The problems often arise in the nature of the system in which the manager has to work—the internal processes, the resource restrictions, and organisational constraints, particularly from professional groups. The appointment of one person responsible for performance will not remove these problems at a stroke. Nevertheless, the person appointed will have a greater incentive to solve them, not least because he has a short-term contract of between two and five years and his reappointment will depend on his performance.

Efforts are being made to bring doctors more into management, in particular by allowing clinicians who become general managers to do the work 'part time'. This is a constructive policy in principle because it will help to fulfil the Griffiths view that 'the nearer the management process gets to the patient, the more important it becomes for doctors to be looked upon as the natural managers'. There are, however, practical difficulties which can only be resolved locally in the light of local needs and personalities. Certain things are clear: there must be no 'no go areas', and particularly sensitive issues like the use of resources and beds by doctors—which should not be confused with their exercise of clinical freedom—should be tackled.

The independence of doctors has undoubtedly been seen by many administrators as a major stumbling block in their efforts to arrange priorities in the use of resources. Practising clinicians may see their independence in a different light—as a necessary protection for patients against the bureaucracy of a large institution. When doctors participate more regularly in management they will have to take a more objective view of priorities if they are to be successful in persuading their clinical colleagues to accept decisions that may be unpalatable.

Tackling the sensitive issues of management may be important, but changing the culture of NHS management and improving the morale and commitment, particularly of a 'critical mass' of intermediate level of administration will be a more important and a much more difficult job for the new general managers. Staff will quickly realise that the creation of general managers means a more precise and perhaps authoritarian management process with a single individual carrying the responsibility for many decisions. This will, for good or bad, increase the centralisation of management and reduce the freedom of health authorities, because information monitoring and advice will follow the natural line of management communication—from ministers to the management board to regional managers to district managers and unit managers and back.

So far the Griffiths proposals have largely failed to stimulate individual clinicians to participate. Medical organisations, such as the British Medical Association, despite initial doubts about the benefit of the Griffiths proposals, are now trying to encourage doctors to participate. But the number of doctors appointed as district general managers has been disappointingly small and this pattern may well continue in the larger units when the unit general managers are ultimately appointed.

One reason for this is that clinicians do not share Mr Griffiths's view of the major problem within the NHS, but he and his team were not invited to look at the problems of delivering care to patients. Their remit was to investigate the problems of health service management. For those working close to patients this is not the most serious problem, especially at a time when some doctors believe that they are being prevented from treating patients so that their health authorities can 'balance the books'. Paradoxically, clinical departments that overspend are often run by doctors who are effective managers working at high levels of efficiency, an example

being the cardiac surgery unit that managed to achieve its 12 months' workload target within eight months—assuming that this impressive performance was due to efficiency, hard work, and good management rather than to high staffing levels, plenty of theatre time, an ample number of beds, and so on. Understandably such doctors diagnose the ills of the NHS as being due not so much to poor managers or a faulty management structure but to a more fundamental defect: lack of resources.

Accompanying the Griffiths proposals and, most would agree, a necessary part of them are management and clinical budgets. Many doctors will view these as the means by which management will pass to doctors and others directly responsible for patient care the difficult decisions of meeting cash limits. But how, for example, will managers control an industrious and efficient consultant who overruns his budget but maintains a lower than average cost for treating patients. This will present them with a major dilemma and Griffiths offers no way out because while his plan provides a line of management running from the centre to individual units it stops short of those who deliver care to patients—the individual doctors. What authority will general managers have over clinical activity and over the quality and quantity of work that consultants do? This big unanswered question leads some people to suggest that in the absence of such authority the present reorganisation will not work. Equally, if managers had this unprecedented authority over clinicians the health service might suffer because of a crisis of confidence, with clinicians suspicious of and perhaps even uncooperative with management.

Mr Fowler also accepted other Griffiths proposals: the setting up at the DHSS of NHS supervisory and management boards to oversee and be responsible for day to day management of the NHS; he also supported the implementation of management and clinical budgets. As we have already pointed out, these are in an early stage of development and it will be some time before their effects are felt. The preponderance of civil servants on the management board has already raised fears that it will prove to be just an extension of the DHSS. If that happens the thrust of Griffiths will almost certainly be blunted. Only time will tell whether other recommendations in the Griffiths report will be translated into action—for example, the need to reward staff for innovation, to redeploy or dismiss non-efficient performers. Interestingly, Victor Paige has already floated the idea

of productivity agreements and differential pay among regional health authorities.

The implementation of the new management plan is at a time when the NHS will be fortunate to receive a 1 per cent annual increase in resources—which is barely sufficient to mark time. Change is always easier to introduce on a generous budget. On the other hand, if the management reform is effective, then the NHS should be able to make more efficient use of its resources. Even so, there are many other changes in train including the Körner recommendations on information collection, cuts in manpower, and so on. Inevitably, the pressures on NHS management are such that urgent matters take priority over important matters, the demand for urgent action usually coming from the top and the pleas to deal with the important matters coming from those coping with the patients.

Whether the Griffiths changes will modify these priorities and whether they will benefit the NHS is hard to say. Possibly they may even go unnoticed by those who work close to patients. It is to be hoped that they do not since the declared intention is to improve services to patients. In any case, changes in the structure and process of management are difficult to evaluate. To predict the outcome of the proposals is an uncertain exercise. What is certain is that this government has converted the Griffiths proposals into the current rules and it is determined that everyone will play by them.

NHS MANAGEMENT PERSPECTIVES FOR DOCTORS

Since 1948 doctors have had a powerful influence on national and local health policies. They have not, however, always had a happy relationship with the administration that had to implement the policies. But as health care costs rise faster than inflation, as demographic pressures on health resources build up, and as governments have more rigorously sought value for the taxpayer's money the argument for cost effective management – rather than just efficient administrators – in the NHS has been greatly strengthened. The changes, culminating in the Griffiths reforms, are affecting the medical profession's influence in the NHS. This book, based on a series in the *British Medical Journal*, is aimed at helping doctors to adjust to the management revolution and to guide them to a constructive and participative partnership with the new managers.

£5.50