BRIEFING PAPER

MANAGING CLINICAL ACTIVITY IN THE NHS

CHRIS HAM and DAVID J HUNTER

KING'S FUND INSTITUTE

No 8 in a series of briefing papers on current health policy issues.

ISBN 1 870607 11 2

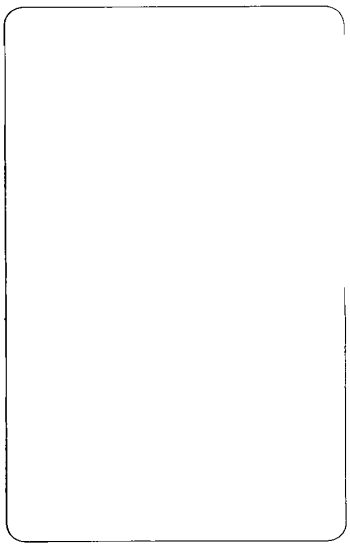
Published by the King's Fund Institute
126 Albert Street, London NW1 7NF

Copies are available at £5.95

J7959 / DESIGN & PRINT / REDESIGN / 01-533 2631

MANAGING CLINICAL ACTIVITY IN THE NHS

CHRIS HAM and DAVID J HUNTER



CONTENTS

ACKNOWLEDGEMENTS

The authors wish to thank the following colleagues and individuals for their assistance with the preparation of this briefing paper. From the King's Fund: Paul Beveridge, Tessa Brooks, Jim Coles, David Costain, Tony Dawson, Linda Marks, Robert Maxwell, John Mitchell, Peter Mumford, Charles Shaw, Jackie Spiby, Barbara Stocking, and Iden Wickings. From outside the Fund: David Bowden, Martin Buxton, Ken Grant, Willie Farquhar, Stephen Harrison, Professor Sir Raymond Hoffenberg, Russell Hopkins, Bryan Jennett, Howard Nattrass, Duncan Nichol, Christopher Pollitt and Graham Winyard. We would like to emphasise that the views expressed in the paper are our own. Those individuals we have consulted are not responsible for what follows.

We are grateful to *Public Finance and Accountancy* for permission to use Figure 1.

SUMMARY

This briefing paper analyses the management of clinical activity in the NHS. It does so against a background of increasing concern that clinical practices are not always as effective or efficient as is sometimes claimed. The paper considers critically the various policy options that have been put forward for tackling this problem, some of which are already operating. These range from proposals to **raise professional standards** (medical audit, standards and guidelines, accreditation) through **involving doctors in management** (budgets for doctors, resource management initiative, doctor-managers) to the **external management control of doctors** (managing medical work, changing doctors' contracts and extending provider competition). The main conclusions of the paper are set out below

● *Despite considerable interest and investment in medical audit, good intentions need to be translated into more widespread practical achievements.*

Much depends on the interest and enthusiasm of individual clinicians. A view commonly expressed is that audit should be based on the voluntary participation of clinicians and should not be imposed from above. At the same time, it is recognised that the leaders of the profession should support audit and managers should ensure that the necessary resources are made available. The interest shown recently in audit by the royal colleges indicates that a positive commitment exists among senior members of the profession. If used in association with the power of the colleges to give approval to training posts, this could be a powerful lever for change.

● *Audit is likely to be more effective if it takes place within the context of agreed guidelines and standards of care against which performance is reviewed.*

Guidelines and standards have been formulated in a number of fields in the United Kingdom but their development has been uneven. There is no organisation which has responsibility for standard-setting across the board and the existence of standards in any particular field therefore depends on the interests and inclinations of the bodies active in that field.

● *In the UK, there is increasing interest in accreditation and proposals have been put forward for the establishment of a national health accreditation agency or inspectorate to carry out this role.*

In the United States, Canada and Australia, the existence of accreditation agencies has provided a focus for the setting of service standards. These agencies make use of standards agreed by relevant professional groups in surveys of hospitals and other facilities carried out by visiting teams comprising experienced and respected professionals. If a similar agency is established in the NHS, careful consideration will need to be given to its role and powers.

● *Experience with management budgeting and resource management has demonstrated the need to obtain and retain the support of clinicians.*

Resource management has so far been mainly confined to a handful of carefully selected demonstration sites where clinicians were in principle supportive. This support may need to be won elsewhere. Moreover, a problem emerging from the sites has been retaining the support of clinicians in the absence of reliable and intelligible data about clinical work. Difficulties have arisen in providing accurate and clinically-relevant information and in funding the development of information systems. Resource management has not yet changed significantly relationships between managers and doctors, and the timetable of change is proving to be much longer than envisaged. It is likely to be a number of years before a resource management system can be fully implemented throughout the NHS.

● *There has been slow progress in involving doctors more directly in management.*

Few doctors have been appointed as general managers, and the development of effective arrangements for involving doctors in management within hospitals has been patchy. The most promising experience to date appears to have been at those hospitals where clinical directors assume management responsibility at the sub-unit level. Further analysis of the management arrangements under development at Guy's, Winchester and Brighton may be valuable in offering lessons to other health authorities.

● *In the future, changes to doctors' contracts will receive more attention as a mechanism of management control.*

In the case of hospital consultants, various changes could be introduced, including moving contracts to DHAs, involving managers in consultant appointments, specifying contracts in more detail, introducing short-term contracts, and enabling managers to reward good medical performance with discretionary salary payments. A policy of this kind is likely to meet with resistance among doctors and if the government wishes to achieve changes to consultants' contracts they may have to increase their basic salaries and provide generous levels of performance-related pay. In the case of general practitioners, Family Practitioner Committees are taking a closer interest in standards of general practice and proposed changes to GPs' contracts include providing financial incentives to encourage them to meet service targets. A danger inherent in enhancing external management control of doctors and changing doctors' contracts in that it may dissipate the goodwill that has been built up slowly through local experiments. On the other hand, it may ultimately be only through changing contractual relationships that significant advances can be made.

● *Extending provider competition will result in significant changes in the relationship between managers and doctors.*

Managers who negotiate to provide services for external purchasers will have to negotiate with the consultants who work in their hospitals to deliver these services to an acceptable standard and price. The

stimulus of competition may be a potent source of innovation in the NHS, although experience in the United States suggests that strengthening the micromanagement of clinical activity in response to competitive pressures is of limited effectiveness as a means of controlling costs.

Whatever changes are introduced, there is a need to evaluate their impact and to disseminate good practices. At present, good evaluative evidence on the experiments in progress is lacking, and efforts should be made to overcome this.

1 INTRODUCTION

Over a period of years, a more critical attitude has developed towards the role of doctors and their relationship with patients. In large part, this attitude is a response to mounting evidence that medical practices are not always as effective or efficient as is sometimes claimed. There are wide differences between hospital doctors in the number of patients treated, the length of time patients stay in hospital, and the resources used in treatment. More fundamentally, many medical interventions are unproven in their effectiveness, and in some cases may do more harm than good. In the light of this evidence, it has been argued that what doctors do should be scrutinised more rigorously to ensure that medical care is appropriate and effective and that patients benefit from the treatment they receive.

The interest shown in this issue has increased as advances in medical technology have opened up new opportunities for diagnosis and treatment and as resource constraints within the NHS have become tighter. Reflecting on these developments, Hampton (1983) has argued that:

> *In the days when investigation was non-existent and treatment as harmless as it was ineffective the doctor's opinion was all that there was, but now opinion is not good enough. If we do not have the resources to do all that is technically possible then medical care must be limited to what is of good value, and the medical profession will have to set opinion aside* (p.1237).

As Hampton notes, one of the implications is that there should be a greater emphasis on the evaluation of medical technology. It is also necessary for doctors themselves to examine clinical practices more systematically through medical audit and other means. At the same time, it has been suggested that doctors should assume greater management responsibility to ensure that resources are used effectively. As Sir Raymond Hoffenberg (1987), President of the Royal College of Physicians, has argued

> *Medical participation in management is imperative. By ensuring that resources are devoted optimally to serve the interests of patients, doctors will find that their own clinical freedom is maximised* (p.35).

Despite these and similar statements from the leaders of the profession, many doctors have questioned whether they have anything to gain from taking a more active role in management. Indeed, it is important to recognise that doctors face a real ethical dilemma in deciding whether to accept responsibility for budgets and to participate in management. The concern of doctors to do what is best for the individual patient may conflict with the need to set priorities between services, to maintain expenditure within agreed limits, and to maximise the benefit of services to the population served. Any attempt to integrate doctors into management has to recognise this legitimate conflict and to acknowledge the significant personal commitment of most doctors to provide a high quality service, often beyond their contractual obligations. Retaining this commitment while achieving a better fit between professional and managerial values is a major challenge.

The difficulty facing doctors is that if they do not take action themselves to raise standards and to participate in management then they are likely to find external management controls over clinical activity strengthened. The only other alternative is for doctors to practise medicine as if nothing had changed and to ignore the need to use resources more effectively. However, while it may be possible for some doctors to avoid resource constraints in the short-term, this strategy is unlikely to be feasible on a continuing basis. Untramelled clinical freedom is not a serious option, and this is increasingly acknowledged within the medical profession.

In practice, there are three broad strategies available to doctors, managers and politicians seeking to promote efficiency and effectiveness in health services (see Box 1). First, it is possible to encourage self-help among doctors to raise professional standards by medical audit, the use of standards and guidelines, and the accreditation of hospitals and other services. A second strategy is to seek to involve doctors in management by delegating budgetary responsibility to doctors, extending the resource management initiative throughout the NHS, and appointing doctors as managers. A third strategy is to strengthen external management control of doctors by changing doctors' contracts and encouraging managers to supervise medical work more directly. This could be associated with an extension of provider competition within the NHS as a means of influencing clinical practices.

The principal aim of this paper is to examine these strategies and to explore their implications for the medical profession. One of the purposes of the paper is to offer a counterweight to some of the analyses of these issues that have been published during the NHS Review. A number of these analyses make heroic and quite unrealistic assumptions about the potential for achieving change in this complex and sensitive area (see, for example, Goldsmith and Willetts, 1988). Far from encouraging doctors to become more closely involved in management, these proposals may make this objective harder to achieve.

BOX 1 · THE MANAGEMENT OF CLINICAL ACTIVITY

Raising Professional Standards	Medical Audit Standards and Guidelines Accreditation
Involving Doctors in Management	Budgets for Doctors Resource Management Initiative Doctor-Managers
External Management Control of Doctors	Managing Medical Work Changing Doctors' Contracts Extending Provider Competition

The paper avoids the naive assumption that all that is required is greater external management control of doctors. While this is clearly one possibility, and may be an important element of future government policy towards the NHS, a wider range of options is available to policy makers. By tracing the probable consequences of different options, the paper seeks to provide an informed basis for policy makers to choose the instruments most likely to achieve their aims.

Hospital doctors are the main focus of the paper. In concentrating on this group we have not sought to overlook the important role of nurses in the management of clinical work (they are, after all, responsible for around 40 per cent of the total hospital service budget). But the nursing profession raises management issues of a quite different order from those which affect the medical profession. At the end of the day, it is doctors who decide who to admit to hospital, when to treat and how, and when to discharge. While nurses will influence such decisions, the primary responsibility for them lies with doctors.

Because recent discussion of the management of clinical work has focused on hospital doctors, we have not sought to deal at equal length with general practitioners. Developments in general practice are at a less advanced stage in respect of most of the issues considered in the paper. Consequently we refer to general practice only where there is experience relevant to our main theme.

Defining the Problem

Within the NHS, doctors enjoy considerable freedom in deciding how to treat patients. The overall resources to be devoted to the NHS and broad priorities between services are determined by central government and health authorities, but the use of resources is the responsibility of doctors. In deciding how to use resources, doctors rely on their professional judgement and their interpretation of acceptable medical practice. Within constraints imposed by the overall budget for health services established by politicians, doctors have a good deal of autonomy to practise medicine in the way they consider most appropriate.

Medicine is one of the clearest examples of an occupation which has achieved the status of a profession. A key feature of professions is the power they are given by society to set standards of performance and hold their members accountable for achieving these standards. These are deemed to be matters of self-regulation rather than external audit.

Analysing the role of the medical profession in the NHS, Klein (1983) has noted that:

> *Implicit in the structure of the NHS was a bargain between the State and the medical profession. While central government controls the budget, doctors controlled what happened within that budget. Financial power was concentrated at the centre; clinical power was concentrated at the periphery. Politicians in Cabinet made the decisions about how much to spend; doctors made the decisions about which patient should get that kind of treatment. But this implicit bargain represented not so much a final settlement as a truce: an accommodation to what was, for both parties, a necessary rather than a desirable compromise* (pp.82-3).

The autonomy of doctors is most evident in the case of general practitioners (GPs) who are independent contractors rather than salaried employees. Family Practitioner Committees (FPCs) in England and Wales and their counterparts in Scotland and Northern Ireland have traditionally exercised only general oversight of the work of GPs and have not sought to regulate standards of primary health care in any direct way. In the hospital service, medical staff manage their own work and at consultant level have not been accountable to other doctors or to managers for their performance. This has enabled clinical freedom to survive even though resource constraints have become much tighter.

At various points during the last 40 years, attempts have been made to achieve closer integration between medical decisions on the one hand and political and management decisions on the other. For the most part, these attempts have been concentrated on the hospital service where the bulk of the NHS budget is spent. Thus, in the late 1960s the 'Cogwheel' system for organising hospital doctors was introduced. This involved doctors in associated specialties coming together in divisions, and the representatives of these divisions forming a medical executive committee for the hospital as a whole. The intention behind the 'Cogwheel' system was to encourage doctors to manage their work systematically and to become more aware of the interconnection between different services.

In 1974, the reorganisation of the NHS gave doctors a central role in the management of services. Not only was the profession represented on health authorities but also consensus management teams were to include medical participation. At district level, this involved a GP and hospital consultant sitting alongside an administrator, treasurer, nurse and medical officer. The reorganisation which took place in 1982 extended this process down to the unit level of management. A typical unit management team or group comprised an administrator, nurse and one or more medical representatives, supported by other managers.

Despite these initiatives, it was clear that the process of involving doctors in management had achieved only partial success. This was certainly the verdict of the Griffiths NHS management inquiry report, published in 1983 (DHSS, 1983), which argued that

> *Closer involvement of doctors is . . . critical to effective management at local level . . . Their decisions largely dictate the use of all resources . . . They must accept the management responsibility which goes with clinical freedom. This implies active involvement in securing the most effective use and management of all resources. The nearer the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers* (pp.6, 18-19).

To achieve this objective, the report recommended that the 'Cogwheel' system should be developed further, training should be provided to prepare doctors for management, and a system of management budgets

should be developed to relate workload and service objectives to resource availability.

As we discuss below, implementation of the Griffiths report has led to limited progress on these issues. A small number of general managers come from medical backgrounds; several health authorities have established management structures within hospitals in which doctors appear to be centrally involved; and experiments are underway to delegate budgetary responsibility to doctors. However, experience within the NHS is still very variable, and the available evidence suggests that many doctors are reluctant to give their support to these developments. As a consequence, hospital doctors continue to exercise considerable autonomy and managers lack real control over medical work and resist questioning professional practices.

Much the same applies to GPs who have also found themselves coming under increasing challenge during the 1980s. This challenge was evident in the introduction of a limited list for drugs and in the controls imposed over deputising services. Also, FPCs have been encouraged to adopt a more vigorous planning and monitoring role. Despite these moves, GPs retain a significant degree of freedom to practise as they consider appropriate.

Against this background, the medical profession as a whole continues to claim that self-regulation rather than external control is the most appropriate way of managing what doctors do. However, a number of commentators have questioned whether self-regulation is effective (Klein, 1983). Certainly, the accountability of doctors through complaints and disciplinary procedures is limited in the extreme (Ham *et al.*, 1988). Furthermore, doctors have not on the whole embraced medical audit and peer review with enthusiasm, nor have they systematically promoted the development of standards of performance against which practice can be evaluated.

This has begun to change in recent years, in part in response to the perception that if the profession does not put its own house in order then tighter external controls will result. Nevertheless, much depends on the willingness of doctors to participate in audit and to open their practices to scrutiny by peers. Involvement in these activities is not compulsory, and the effectiveness of self-regulation is therefore limited by the commitment of the individuals concerned. It is in this context that the involvement of doctors in management has again emerged as an issue of debate. Speeches made by Ministers during the NHS Review have indicated the high political priority attached to these issues. As the Secretary of State for Health, Kenneth Clarke, said in his speech to the Conservative Party Conference in October 1988

> *I believe that doctors and nurses are now more willing than ever before to be involved in the decisions about how . . . money can be used best for patients. Doctors and nurses need to face up to the cost of their decisions and to be given the information they need to take their share of responsibility for the best use of the money we give them.*

There is thus no doubt that the management of clinical activity in the NHS is an issue of enduring importance. The key question is how best to tackle the issue in a way which produces improvements in medical care without alienating doctors.

Plan of Report

The remainder of this paper is organised in four parts. In the next part – *raising professional standards* – experience of medical audit, the use of standards and guidelines, and accreditation is discussed. In part three – *doctors in management* – the recent history of clinical budgeting, management budgeting and resource management is analysed, as is experience of appointing doctors as managers. In the fourth part – *external management control of doctors* – the paper reviews the options available for changing doctors' contracts and introducing greater management control of doctors. The final part of the paper offers an agenda for the future.

The paper is based on a literature review, findings from completed and ongoing research, and discussions with a small number of experts, including doctors and managers. No attempt has been made to offer a comprehensive assessment of the issues discussed. Rather, major points of concern and key lessons from experience are identified. The main focus is experience in the United Kingdom but international evidence is drawn upon where appropriate.

2 RAISING PROFESSIONAL STANDARDS

In this part of the paper we review experience of medical audit, the use of standards and guidelines, and accreditation. Key lessons from experience are identified, and a commentary is offered on how these issues might be taken forward.

Medical Audit

Behind most definitions of medical audit is the idea that doctors should regularly review their work. This may take the form of an individual clinician reviewing his or her own work, or it may involve a group of doctors comparing and assessing one another's experience. Alternatively, an outside agency may be charged with responsibility for audit. Where audit involves more than the individual clinician reviewing his or her own work, it is largely synonymous with peer review.

While at one level audit involves simply describing and comparing clinical practices, at another it entails action to change these practices where shortcomings are identified. This can be achieved by isolating aspects of care which are deficient and encouraging the doctors concerned to change their methods of working. Quality can also be improved through the dissemination of good practices and by concentrating particular treatments in the hands of doctors who achieve better than average outcomes. A further aim of audit is to reduce unnecessary or inappropriate practices, thereby saving scarce NHS resources. This may involve reductions in lengths of stay, changes in prescribing patterns, and limiting the use of diagnostic tests. Efficiency as well as quality is thus a key aim of audit.

Within the UK there have been three main strands in the development of audit. First, a number of national initiatives have been taken. Examples include the Confidential Enquiry into Maternal Deaths and the Health Advisory Service (HAS). Each of these initiatives examines a particular aspect of health services and uses outside assessors to review standards of care. The assessors are experts in the relevant field and through their reports they are able to give advice to doctors and other health service staff on how to avoid mistakes and maintain high standards.

The HAS (see Box 2) is mainly concerned with non-clinical aspects of care for mentally ill and elderly people. Visiting teams from the HAS evaluate the quality of local services and prepare reports setting out proposals for action. These reports cover a range of issues including staffing, accommodation, and the effectiveness of planning procedures. A similar role is performed by the National Development Team for People with Mental Handicap. In contrast, the maternal deaths enquiry focuses directly on clinical standards. By reviewing individual cases and highlighting avoidable causes of mortality, the enquiry has drawn the attention of doctors and other staff to areas in which improvements can be made.

Second, the medical colleges and specialist associations have encouraged their members to undertake audit. In addition, specific studies are undertaken by the colleges to review individual aspects of medical care. Examples include studies of mortality associated with anaesthesia (Lunn and Mushin, 1982), deaths under 50 (Medical Service Study Group of the Royal College of Physicians of London, 1978) the use of x-rays (Royal College of Radiologists, 1979) and perioperative deaths (Buck *et al.*, 1987) (See Box 3). These studies identify areas in which changes and improvements in practice might be recommended in order to reduce adverse events.

BOX 2 · THE HEALTH ADVISORY SERVICE

The Health Advisory Service (HAS) was initially established as the Hospital Advisory Service in 1969. One of its original purposes was to act as the 'eyes and the ears' of the Secretary of State in order to avoid a repetition of scandals such as that which occurred at Ely Hospital. HAS teams visit local health and related services for mentally ill and elderly people. Visiting teams comprise experienced professionals who offer an independent view of the quality of services provided. Visits extend over two to four weeks and culminate in a report to all the authorities concerned. Reports are also sent to Ministers and since 1985 they have been published. Through its work, the HAS helps to disseminate good practices and to promote high standards of care. The advice offered at the end of visits is based on the expertise of team members and on ideas put forward by local staff. The HAS has no power to compel authorities to implement its recommendations. Its influence depends mainly on the credibility of its staff and the reputation it has been able to develop over the years. As well as issuing reports on local visits, HAS publishes an annual report highlighting general issues of interest and concern, and it prepares reports on specific issues, for example those for elderly people with mental illness.

BOX 3 · THE CONFIDENTIAL ENQUIRY INTO PERIOPERATIVE DEATHS

This Enquiry was a joint venture between the Royal College of Surgeons and the Association of Anaesthetists. The Enquiry investigated all deaths within 30 days of surgery in three English regions in 1986. Reports on deaths were prepared by the doctors involved and these reports were independently assessed by relevant experts. An overall death rate of 0.7 per cent in over 500,000 operations was found. Death was attributed to avoidable surgical and anaesthetic factors in around 20 per cent of patients. A number of causes of concern were identified in the Enquiry report. These included: inadequate supervision of junior doctors by consultants; surgeons performing operations outside their main area of expertise; and surgeons and anaesthetists not holding regular audits of their operation results. On the basis of these findings, a series of recommendations were formulated with the aim of improving the quality of care. CEPOD was extended to England as a whole in 1988 with financial support from the DHSS.

Third, there are several examples of clinicians taking local initiatives to develop audit (see Box 4). One of the best examples is the Lothian Surgical Audit involving all 31 consultant general surgeons and urologists in one area (Gruer *et al.*, 1986). Improvements in the outcome of surgery in this area have been attributed in part to the interest shown in audit. An example of audit by physicians is the clinical review process in Stoke-on-Trent. This involves monthly meetings to discuss the management of cases.

Other published examples include surgical audit in Oxford (Gough *et al.*, 1980), audit of oesophageal cancer treatment in the North East Thames Region (Earlam, 1984), surgical audit in a London district (Lee *et al.*, 1957), orthopaedic audit in Bristol (Bunker *et al.*, 1984) and audit by physicians in hospitals in Birmingham (Heath *et al.*, 1980) Stoke-on-Trent (van't Hoff, 1981) and Swansea (Swansea Physicians Audit Group, 1983). The last of these studies identified significant variations between consultants in the use of resources and drew attention to the potential for savings in expenditure on drugs and outpatient services.

BOX 4 · EXAMPLES OF MEDICAL AUDIT AT THE LOCAL LEVEL

The *Lothian Surgical Audit* involves voluntary participation by general surgeons and urologists in monitoring and improving the quality of care. The data collected enable each surgical unit to compare its performance with that of the group as a whole. Weekly meetings are devoted to discussion of specific problems. Changes in clinical practice have resulted from the audit including the decision to concentrate arterial surgery in the hands of surgeons who specialise in vascular surgery because they obtained better results. The Lothian system has been developed by the surgeons themselves with limited financial and staff support from the health authority.

The *Stoke-on-Trent Medical Audit* goes under the name of Clinical Review. Participation includes both consultant medical staff and juniors. The audit centres on monthly meetings at which cases selected by an independent chairman are presented by the doctors best acquainted with the case concerned. The cases are chosen from patients who have died in the hospital during the previous month. Discussion then follows on the management of the cases and on how care might be improved.

Despite the considerable investment in audit both locally and nationally, Sir Raymond Hoffenberg (1987) has argued that the medical profession has shown resistance to the concept. Hoffenberg contends that the profession should welcome greater scrutiny of clinical competence, for only in this way will public confidence be maintained and the threat of external regulation avoided. This view found support in the report of the Confidential Enquiry into Perioperative Deaths which noted that many surgeons and anaesthetists in the Enquiry did not hold regular audits of their performance. The authors argued that clinicians should assess themselves regularly, a conclusion strongly endorsed in a foreword to the report by Sir Andrew Kay and Sir Gordon Robson. The royal colleges, argued Kay and Robson, have a particular responsibility to promote the development of audit, and their main power rests in their ability to request that appropriate arrangements are in place for audit before training posts are approved.

This view has met with a positive response from both the Royal College of Surgeons and the Royal College of Physicians in London. The latter has set up a working party to examine the role of audit and to suggest how it might be undertaken more systematically. The Royal College of Surgeons has also emphasised the importance of audit and has argued that all surgeons should conduct a weekly review of their work (Royal College of Surgeons, 1988).

The development of audit in general practice has been stimulated by the Royal College of General Practitioners which seeks to encourage both self-audit and peer review. Four areas provide the focus of action: quality assessment, professional development, practice management and team work, and accountability, incentives and resources (Royal College of General Practitioners, 1985). Related to this initiative, the College has developed the 'What Sort Of Doctor?' project. This seeks to examine professional values, accessibility, clinical competence, and the ability to communicate. Standards or performance criteria have been established in each area. The assessment of performance is the responsibility of a visiting team of peers who analyse a doctor's practice making use of these standards. Participation in the project is voluntary.

Comment

While there is no doubt about the importance and topicality of audit, a key issue remains how to translate good intentions into more widespread practical achievements. Much depends on the interest and enthusiasm of individual clinicians. This is demonstrated by Heath (1986) who recounts the experience of establishing a system of audit in the medical and clinical pharmacology units at Birmingham. Heath notes that audit resulted in a number of improvements in the service provided, including better record keeping. However, he was unable to persuade fellow clinicians to follow his example, and he observes that many doctors still appear to feel threatened by other colleagues examining their work.

Echoing these views, van't Hoff (1981) emphasises that the work taking place in Stoke-on-Trent in which physicians routinely review deaths in hospitals (see Box 4) does not involve audit by other doctors as this would have been unacceptable. Rather, it involves the doctors in charge of the case making a presentation to colleagues and then participating in a discussion of how the case was handled. As van't Hoff notes, this process has an important educational value.

The general message from these and other commentators is that making audit mandatory and imposing sanctions on doctors found wanting would be counter-productive (Shaw, 1980; Reynell, 1986). The

challenge is to bring about change with the support of doctors rather than to enforce it from above. A voluntary approach to audit is favoured rather than a compulsory one. Motivating doctors to participate may not be easy but the consensus is that it would be inappropriate to impose a uniform and comprehensive system of audit within the NHS. Rather, the aim should be to build on experiments already taking place, and to encourage the exchange of ideas and experience.

On the assumption that audit should develop on a voluntary basis, the following guidelines have been proposed (Shaw, 1980):

- The purpose of audit should be educational and shown to be relevant to patient care
- Participation should be voluntary and control should be in the hands of clinicians
- Standards of care should be set locally by clinicians
- The method should be non-threatening, objective and repeatable
- The approach used should be cheap and simple
- Patient records should contain adequate clinical content and effective retrieval systems should be available.

In a later paper, Shaw (1987a) added that audit should be supported by the leaders of the profession, nationally and locally; there should be an appropriate structure in place for audit to occur; and managers should ensure that the necessary clerical, statistical and organisational resources were provided to support audit.

The last of these points is especially important for unless clinically- relevant information is made available then doctors are unlikely to participate enthusiastically in audit. This in turn requires an investment in information systems to ensure that accurate data are available. Such an investment is likely to be expensive and will require a commitment of resources by health authorities on a significant scale.

Standards and Guidelines

Audit can occur in the absence of explicit standards of care against which performance is reviewed, but it is likely to be more effective where such standards exist. Jennett (1988) argues that guidelines do not limit or constrain medical practice. Rather, used flexibly, they provide a framework and a series of benchmarks against which performance can be assessed.

For practical purposes Shaw (1987b) notes that standards can be divided into three categories. First, there are *service standards* for the organisation and management of services. Second, there are *standards for the delivery of specific services* by doctors to patients. And third, there are *standards for the individual competence of practitioners.*

The second category identified by Shaw is often referred to as *clinical guidelines*. These guidelines offer advice on the provision of services to individual patients. In contrast, standards for the organisation and management of services are typically concerned with the quality of the environment in which care is provided and the process of care. Guidelines tend to be advisory in nature while standards more often carry normative implications. In practice, attempts to develop guidance on good practices in health services may contain both service standards and clinical guidelines.

Clinical Guidelines

In support of the use of guidelines, Harvey and Roberts (1987) argue that:

> *clinical guidelines, based on the results of formal utilisation studies . . . aim to provide clinicians with information on the usefulness and costs of current clinical practices – for example routine skull x-ray in head injury – together with a set of patient-selection guidelines derived therefrom. Such guidelines aim to help clinicians in their investigation of individual patients* (p.145).

However, it is unlikely that guidelines will be implemented unquestioningly. This is because of the strength of clinical freedom, the desire of doctors to avoid risks to their patients, and the fear of litigation. Also relevant is the uncertainty involved in many areas of medical practice and the dilemma this creates for doctors in deciding whether to follow guidelines. Against this, guidelines that are developed following full discussion among doctors and which are supported by research evidence may offer some protection for doctors against litigation (Ham *et al.*, 1988).

The importance of clinical guidelines is illustrated in the audit undertaken in the Swansea district general medical unit (Swansea Physicians Audit Group, 1983). Variations in the number of outpatient attendances per consultant stimulated much debate on appropriate practice, but in the absence of agreed guidelines it was difficult to determine which rate of attendances was right. The significance of this conclusion is reinforced in another study which focused on the part played by guidelines in reducing the use of pre-operative chest x-rays (Fowkes, 1985). In this case, guidelines were effective in changing clinical practices when combined with feedback of information to clinicians and the existence of a utilisation review committee. Such a committee provided authoritative support for change and a clear focus for action.

This example illustrates the value of developing audit and guidelines in tandem. A review of research into the effects of information on clinical practice has shown that passive feedback is rarely effective in changing doctors' behaviour (Mugford, 1987). However, if information feedback is linked to the development of guidelines and medical audit then it is more likely to have an impact.

Drummond (1988) suggests that there are a number of features which are critical to the success of clinical guidelines. These include:

> *thorough discussion of the clinical evidence before devising the guideline; detailed attention to the method of disseminating the guideline; encouragement of local ownership and monitoring of adherence to the guideline; frequent revision of the guideline in response to changes in clinical procedures, new research results or local health care organisation.*

These factors, which exploit the profession's interest in providing good quality care, may be more effective than financial incentives in changing clinical practice.

Increasing reliance on guidelines is likely to be controversial (Ellwood, 1988). Clinicians, concerned to defend their freedom and to resist 'cookbook medicine', may prove to be resistant to the idea that practice should become more uniform. This is one of the reasons why the development of guidelines has been so uneven, although increasing evidence about wide variations in clinical practice may accelerate the process of guideline development.

If this is to happen, a clear lead will need to be given by the medical colleges and specialist associations. The initiative taken recently by the Royal College of Physicians on audit includes a commitment to producing guidelines for the treatment of common conditions. More generally, Shaw (1986) has identified a number of examples of clinical guidelines, including those on the use of x-rays and on infant care during the perinatal period. In the primary care field, the Royal College of General Practitioners has encouraged the development of clinical guidelines in the form of protocols for the management of common disorders. Working parties have produced information packs on diabetes, asthma, Parkinson's disease, cervical cytology, and epilepsy. There is thus considerable interest in clinical guidelines and it should be possible to build on the initiatives that have already been taken.

Service Standards

Professional bodies have also shown an interest in the development of service standards. A recent example is the report on anaesthetic services for obstetrics (Association of Anaesthetists, 1987). This drew on the results of audit, in particular the confidential enquiries into maternal deaths, to highlight deficiencies in services. The report emphasised the increased risks involved in providing services in small maternity units with infrequent requests for anaesthesia. It recommended that consideration should be given to the withdrawal of anaesthetic cover in these units. The report went on to set out standards for obstetric anaesthetic services in relation to staffing, organisation, training, equipment and other facilities, and a checklist of questions was suggested for auditing purposes.

Standards have been developed in a number of other fields in the UK. In relation to people who are mentally ill or who have a mental handicap, the Welsh Office, DHSS, and the National Development Group (now disbanded) have promulgated service standards for health authorities and professional staff to follow. Similarly, the Maternity Services Advisory Committee has published a series of reports setting out guidance on good practice. More recently, the National Association of Health Authorities (NAHA, 1988) has offered advice to health authorities on good practices in small hospitals.

In relation to primary care, FPCs are increasingly taking an interest in the development of service standards. This involves not only standards of premises, hours of availability and out-of-hours cover, but also targets for selective preventive measures. This interest reflects the concern at a national level to negotiate a new contract for GPs and to provide financial incentives to encourage them to meet agreed targets.

Interest in standards has not been confined to professional bodies and statutory agencies. Increasingly, organisations representing the public and service users have sought to promote the development of high quality services in this way. Two recent examples are a quality checklist prepared by the National Association for the Welfare of Children in Hospitals, designed for managers and consumers to assess the quality of hospital services for children, and a guide to good practice in accident and emergency departments published by the Association of Community Health Councils for England and Wales in collaboration with the Institute of Health Services Management. These reports indicate the growing concern among service users with standards of care and it can be anticipated that the development of a more articulate consumer movement in the NHS will lead to further publications of this kind.

In the UK, there is no organisation which has responsibility for developing guidelines and standards across the board. The existence of standards in any particular field therefore depends on the interests and inclinations of the organisations which have been active in that field. In recognition of this, the King's Fund, through its quality assurance project, has taken the initiative to stimulate the development of guidance on service standards for acute hospital services. Support is being provided to staff in a number of health authorities to enable them to develop guidance in relation to medical records and information systems, therapeutic services, environmental services, medical staffing, social care and public relations, and management arrangements.

The King's Fund has also contributed to standard setting through its programme of consensus conferences. The consensus statements published at the end of these conferences offer guidelines to health authorities, the professions and the public on the organisation and delivery of services and on appropriate forms of treatment.

Comment

A wide range of organisations have taken an interest in producing guidelines and standards for health services. The focus of these guidelines and standards varies from treatment options for individual patients, through standards for the organisation and management of services to checklists for use by patients and consumer organisations. Although professional associations have played a major part in the development of guidelines and standards, their work is increasingly being supplemented by other bodies and interests. Most of the standards produced to date are advisory in nature and leave scope for local interpretation. This applies particularly to clinical guidelines in recognition of the need for doctors to take account of each patient's needs.

Accreditation

The uneven development of standards and guidelines in the NHS is in contrast to the US, Canada and Australia where the existence of accreditation agencies has provided a focus for standard setting. Accreditation can take a number of forms ranging from inspection for licensing or regulation purposes to reviews which seek to raise standards through self-help. In the US, Canada and Australia, accreditation is normally used to promote higher standards through professional reviews. Thus, while the approach taken in each country is slightly different, a common strand has been the concern of health service professionals themselves to define and promote good practices in the provision and use of health care. This has led to the setting up of independent agencies charged with responsibility for developing standards and ensuring that they are applied in practice. In the main, this is done through visiting teams of professionals who survey hospitals and other health care services using standards agreed after discussion within the relevant professions. The approach is usually voluntary and accreditation serves to enhance a hospital's reputation.

There is no equivalent process in the UK, although the medical colleges do undertake some of these functions in giving approval to training posts. However, the focus of the colleges is narrower than that of overseas accreditation agencies. The main concern of the colleges is to ensure that adequate arrangements are in place for training purposes. They do not take it upon themselves to review standards in hospitals as a whole.

In Australia, accreditation is the responsibility of the Australian Council on Hospital Standards which was set up in 1973. Its membership is drawn from the health professions, government, hospitals and health care consumers (Sketris, 1988). The Council is now mainly self-financing and most of its funds come from fees charged for carrying out accreditation surveys. The standards used by the Council are published annually, and are applied by the surveyors on their visits. An evaluation of the work of the Council found that its activities were viewed positively by the staff whose hospitals had been surveyed (Sketris, 1988). An important element in the success of the Council has been its ability to recruit experienced and respected professionals to serve on its visiting teams.

In the US, the Joint Commission on Accreditation of Healthcare Organisations (JCACHO) was set up by the American College of Surgeons in 1917 with the aim of raising standards in hospitals. For most of its history, the Joint Commission has focused primarily on the quality of the environment in which care is provided. More recently, greater emphasis has been given to aspects of clinical performance and the Joint Commission is seeking to develop measures of clinical performance for use during visits. At the same time, higher priority is being attached to the existence of effective arrangements for peer review within hospitals (O'Leary, 1987).

Maxwell and colleagues (1983) have suggested that the approach of the Joint Commission has relevance for the UK. Among their recommendations for the introduction of a similar system in the NHS are that participation should be voluntary, multi-disciplinary teams should undertake assessments through peer review, and the emphasis of the teams should be as much on the outcome of care as on issues to do with structure and process.

Support for an accreditation agency has recently been provided by a number of organisations, including NAHA, IHSM and the Royal College of Nursing in evidence to the Government's Review of the NHS. Thus, NAHA argues that a national health accreditation agency should be established along the lines of the Joint Commission. In NAHA's view, the agency would develop and apply standards of service to be achieved by health authorities with the aim of ensuring that all NHS hospitals met required standards. A similar argument has been advanced by the House of Commons Social Services Committee which has proposed that a national quality assurance inspectorate for all health services should be set up.

As a number of commentators have noted, a possible model for such an agency is the Health Advisory Service (see above). Reviewing the experience of HAS in evaluating services for elderly people, Day, Klein and Tipping (1988) argue against extending its remit to other areas of the NHS. The limited resources of the HAS coupled with its purely advisory role and the failure to develop explicit standards for use during visits are fundamental weaknesses which in the view of these authors amount to a fatal case against the HAS model. As an alternative, they suggest more effective coordination of the work of existing agencies concerned with the setting of standards.

If a national health accreditation agency is established, then experience of inspecting residential care and nursing homes may contain some lessons. Responsibility for registration and inspection rests with individual health authorities and local authorities. There has been a strong emphasis to date on physical standards of homes and staffing levels. There is concern about the powerlessness of local authorities and health authorities to improve the unsatisfactory standard of care known to exist not only in the rapidly growing independent sector of residential care and nursing home provision but also in the public sector where often lower standards are tolerated. In particular, it has been questioned whether the authorities responsible for registration are genuinely independent when increasingly they provide support to the independent sector for the care of their patients and clients (Vellenoweth, 1988). Wide discrepancies in the quality of provision are a feature of the current position.

The Wagner Report (National Institute for Social Work, 1988) on residential care concluded that:

- local authority residential establishments should be registered and inspected regularly in the same way as those in the private and voluntary sectors
- to ensure independence and impartiality, no service-providing agency should undertake the inspection of its own establishment
- national guidelines should be drawn up for the inspection of residential establishments which should pay equal attention to matters relating to the

standards of accommodation, quality of life and the qualifications of management and staff.

The Report recommended serious consideration of a proposal for a unified independent agency to police standards and to register and inspect both residential and nursing homes.

Comment

None of the existing approaches to accreditation and inspection offers a model which can be readily transferred to other areas of the NHS. The key lessons from experience both at home and overseas are that accreditation needs to take place within the context of clear standards and guidelines developed by the health professions; these standards should focus on the outcome of care and service quality as well as structure and process; and the agency charged with the responsibility should be independent of those responsible for service provision. There is also a need to coordinate accreditation activities in order to avoid a fragmented approach and to be clear about the powers of those undertaking accreditation.

Overseas Experience

As a final comment on ways of raising professional standards, it is relevant to highlight overseas experience, particularly in the development of medical audit, standards and guidelines. This experience has often been cited in the debate surrounding the NHS Review and commentators have argued that the NHS may be able to learn from developments in both Europe and North America. Clearly, this is a major area of analysis in its own right, and in this section of the paper we can only describe briefly some of the key examples from overseas and comment on emerging points of debate in the UK.

Within Europe, various countries have taken initiatives to encourage medical audit and develop guidelines for good practice. One of the most systematic approaches is in Holland where a national organisation known as the CBO (translated as National Organisation for Quality Assurance in Hospitals) was set up in 1979 to promote activity on these issues. The CBO, which is independent and is supported financially by hospitals, grew out of the interest of doctors and managers. The CBO has worked both to develop standards and guidelines and to support medical audit in hospitals and general practice. As part of its interest in standards, CBO has organised a programme of consensus conferences. The approach to audit in Holland is essentially voluntary but operates within a legal framework which places an obligation on all health professions to organise quality assurance activities.

In Sweden, standards have been established in the form of medical care programmes. These are written local agreements providing guidance on the content and organisation of care to be offered to individuals with a particular disease. A medical care programme encompasses both clinical aspects of care and the organisation of services (see Box 5). It has been emphasised that the clinical guidelines

> *are advisory by nature. The programme is not intended to standardise medical intervention in individual cases* (SPRI, 1985, p.10).

Each programme is developed locally by the staff concerned and is intended to provide a practical guide for staff and patients. Also, the programme forms the basis for reviews of established practices. Assistance to staff is provided by the National Board of Health and Welfare and SPRI, a research and evaluation agency funded by national and local government. Early indications suggest that medical care programmes are valued both by staff and patients and that they lead to improvements in care without increasing costs (Eckerlund et al., 1985). However, it has been noted that interest in the programmes among doctors has been variable and that the active involvement of doctors and other staff is essential if the programmes are to be effective (Eckerlund, 1986). Medical care programmes have been taken forward in Sweden in association with a series of consensus conferences. A similar project has been undertaken in Finland. Medical care programmes for conditions such as stroke, varicose veins and asthma were developed under the aegis of the Finnish National Fund for Research and Development.

Reviewing experience in Scandinavia, Farquhar (1988) has drawn attention to the commitment of

BOX 5 · SWEDISH MEDICAL CARE PROGRAMMES

A medical care programme should, if possible, contain descriptions of:

- The causes and nature of the disease in question, its medical and social consequences, incidence and prevalence etc.
- The means available for preventing this particular disease (primary prevention)
- The possibilities for early detection and treatment (secondary prevention)

Goals for the specific medical care programme

Guidelines for various types of measures

- Preventive measures
- Diagnostic and therapeutic measures
- Convalescence and rehabilitation
- Complications and evaluation/follow-up measures

Care organisation

- Type of care, level of care and division of duties
- Referral patterns

Educational and information activities

Updating routines

Evaluation methods

Source: SPRI (1985)

doctors to engage in medical audit and to develop guidelines for clinical practice. Experience suggests that the availability of clinically-relevant information together with a strong medical interest in the use of standardised clinical protocols has resulted in a more systematic approach to the management of medical work in Scandinavia than in the UK. As Farquhar notes, the clinical culture in the Swedish health service with its emphasis on consensus and rational decision-making is more favourable to the acceptance of protocols than that which exists in many other countries.

Summary

Our review of the evidence suggests that the development of audit depends first and foremost on the interest of clinicians. Central leadership from within the profession may accelerate the more widespread adoption of audit, but too strong a lead from above may be counter-productive. On the other hand, support from managers and politicians in the form of clerical, statistical and organisational resources is needed to provide the information required for audit to take place. As we discuss below, audit may also be stimulated at the local level through peer pressure, for example from doctors who take on management responsibility.

Further progress in the development of standards and guidelines will also depend to a considerable extent on the leadership provided by the medical colleges and specialist associations. These bodies have traditionally assumed responsibility for promoting high standards of medicine, using the argument that the profession itself should carry forward this task. However, the emergence of a more critical attitude towards doctors coupled with high expectations among service users have put the colleges on the defensive. The nature of their response will determine whether the profession will retain responsibility for maintaining high standards or whether greater external controls will be introduced.

If external controls are strengthened, then it is possible that a national health accreditation agency may be established to encourage the development of high standards of care. While the profession will play a key role in such an agency, this approach will involve more outside involvement in reviewing professional practices than has traditionally been the case. A new accreditation agency needs to avoid the weaknesses of existing methods of inspection and review.

3 DOCTORS IN MANAGEMENT

Involving doctors in management can take various forms. Two possible options, both of which are being tested in the NHS, are examined in this part of the paper: first, attempts to encourage doctors to become more cost-conscious by involving them more directly in the management of resources; and, second, moves to appoint doctors to managerial positions.

Budgets for Doctors

In this section we review the extensive experience there has been with clinical budgets, management budgeting and resource management in the hospital and, to a lesser extent, community health services in the NHS. No moves have yet been taken to give responsibility for budgets to GPs although the possibility of experimenting with some such arrangement has been suggested by a number of commentators. We discuss this possibility in the next part of the paper in our analysis of provider competition.

The experience from other European countries mirrors that of the NHS (Bally, 1982; Farquhar, 1988). Perhaps most important, reviews of overseas developments have found that doctors participating in clinical budgeting do not regret it. Participation in budgeting gives doctors a firmer base from which to negotiate resources and encourages discussion of standards and quality of care.

Clinical Budgeting and Management Budgeting

The Griffiths NHS management inquiry emphasised the need to involve doctors more effectively in the management of resources (DHSS, 1983). As the inquiry pointed out, it is doctors' decisions that to a large extent determine how resources are used. Traditionally, doctors have not taken or been given responsibility for budgets, nor have they been provided with information about the resource consequences of their decisions. There is thus a gap between clinicians whose decisions on whom to treat and how exert a major influence on resource use, and managers who have overall responsibility for controlling budgets and keeping within cash limits.

For much of the history of the NHS, most managers have not seen it as central to their role to be involved in negotiating with clinicians about how resources should be used. Equally, most clinicians have not sought to become managers. Griffiths argued that this could not be allowed to continue and that clinicians should accept the management responsibility that goes with clinical freedom. More specifically, the inquiry recommended that health authorities should

> *involve the* clinicians *more closely in the management process, consistent with clinical freedom for clinical practice. Clinicians must participate fully in decisions about priorities in the use of resources . . . Clinicians need administrative support, together with strictly relevant management information, and a fully developed management budget approach* (DHSS, 1983, p.6).

This recommendation was regarded as fundamental to the success of general management by those who believed the whole reform strategy would fail if it did not tackle the freedom enjoyed by individual consultants to incur expenditure without reference to agreed priorities. The aim was to ensure that the activities of consultants form part of a coherent strategy for the health authority as a whole.

The proposal carried with it profound implications for the key participants, principally general managers, clinicians and treasurers, but also other professional groups, notably nurses. For the first time, clinicians were to be involved formally and explicitly (they have always been involved informally and implicitly) in financial management and decision-making and in being held responsible for the decisions taken. Moreover, the discipline of management budgeting demanded that doctors be accountable for their actions to someone who was not necessarily a doctor. Such a move holds little appeal for doctors.

The nomenclature employed to describe the various initiatives can be confusing. In recent years a number of different ways of involving doctors more directly in the explicit management and use of resources have been attempted (see Box 6).

The Griffiths proposals on management budgeting drew on experience in the 1970s and early 1980s to

BOX 6 · BUDGETING TECHNIQUES

Clinical Budget	A plan of objectives for clinical activity that incorporates detailed resources required to complete the specified level of activity and puts the associated costs into a financial statement. The plan should be agreed by clinicians in conjunction with service providers and finance officers
Management Budgeting (MB)	The name of an initiative derived from recommendations in the Griffiths inquiry (DHSS, 1983) which proposed improvements in managerial style. MB is an essentially similar approach to that of clinical budgeting and focuses on the devolution of financial responsibility to smaller administrative units supported by better information.
Resource Management (RM)	In 1986 the DHSS (Health Notice (86)34) gave fresh impetus to the MB initiative and renamed it resource management. The new approach aims for greater medical and nursing involvement and its focus is on achieving measurable improvements in patient care through better use of resources.

develop approaches to clinical budgeting. Reviewing this experience, Wickings *et al* (1983) argued that the picture was encouraging and there had been significant changes in the use of resources. The improvements in efficiency included reductions in unnecessary x-ray and pathology tests, in length of stay, in ward stocks used by nurses and less food wastage.

Management budgets as envisaged by Griffiths were broadly similar in conception to clinical budgets and demonstration projects were initiated in four health authorities to establish the viability of the approach. A firm of management consultants, Arthur Young, employed to assist in the development of management budgeting, identified a number of limited successes that had been achieved and a report published by the DHSS in January 1985 noted that there had been good progress in the projects. At the same time, both the DHSS and the management consultants acknowledged that various problems had arisen and that it would be some years before management budgeting resulted in significant resource shifts. In particular, medical staff were not always committed to the projects and this had delayed implementation; nurses felt left out; managers were inexperienced; planning was underdeveloped; and there was an absence of requisite information. These problems continued in the second generation of demonstration projects and it became clear that it would take longer than anticipated to develop a management budgeting system that could be applied throughout the NHS.

A review of management budgeting undertaken by the DHSS in 1986 concluded that management budgeting had failed to achieve its principal objectives. Among the reasons for this was a concentration on the technical aspects of budgeting to a neglect of the need to win support and commitment from key personnel. Also important was the absence of clear management structures to support the experiments, and the rapid pace at which developments were introduced. As Coles (1988) has noted:

> *It would seem that four years plus is the time required to make a start in changing the culture of a district's organisation and to develop clinical interest to a reasonable level* (p.136).

Resource Management Initiative

It was clear that a new approach was required if momentum was to be maintained. Accordingly, in November 1986, management budgeting was superseded by the resource management initiative. The change in terminology from management budgeting to resource management signalled recognition that involving clinicians, nurses and other managers more effectively in determining the use of resources could not be achieved by introducing a budgeting system in isolation. As the architect of the initiative, Ian Mills, Director of Financial Management on the NHS Management Board, has pointed out

> *The resource management programme is principally about changing attitudes and encouraging closer team work in managing resources among patient care professionals and between such professionals and other managers* (Resource Management Feedback, 1987).

Resource management is intended to provide more accurate and useful information to clinicians about their practice and its costs compared with colleagues in the same hospital, district or region. In this sense, resource management is a close cousin of medical audit in that it seeks to encourage doctors to review their performance and to improve standards of care.

As the DHSS has noted, it was crucial to the success of resource management to begin from the active involvement of doctors and nurses and to provide information perceived by medical and nursing managers as relevant to their work. To achieve this, a new series of experiments was initiated with the sites being chosen on the basis that doctors and nurses were already closely involved in management (see Box 7).

BOX 7 · THE RESOURCE MANAGEMENT PILOT SITES

Acute Units

Arrowe Park Hospital, Wirral*
Clatterbridge Hospital, Wirral* (subsequently dropped)
Freeman Hospital, Newcastle*
Guy's Hospital, Lewisham and North Southwark
The Royal Hampshire County Hospital, Winchester
The Royal Infirmary, Huddersfield*
South Lincolnshire (announced in April 1988)

Community Units**

Blackpool
Bradford
Brighton
Coventry
Halton
Leeds Eastern
Newcastle
Newham
North Lincolnshire
Norwich
Plymouth
Portsmouth
West Suffolk

* These sites are in designated second generation management budgeting districts

** All the sites are in designated second generation districts.

Furthermore, at a national level the NHS Management Board secured the support of the representatives of hospital doctors on the Joint Consultants Committee for the initiative. Experience in the experimental sites is being evaluated and the results will help to determine how the initiative is taken forward.

Comment

It is premature to reach firm conclusions about the progress and impact of the resource management initiative. Somewhat exaggerated claims have been made for it, but there is, as yet, little hard evidence to support them. What is not in doubt is that in the NHS at large it is taking time to win over many clinicians to the principles of resource management and to allay their fears.

Given what is already known about the earlier management budgeting exercises and the progress to date of the resource management initiative, it is

possible to provide a tentative interim assessment of the state of play and the prospects for further development. The first point to stress, though self-evident, is that budgets are not neutral or value-free but are the hard currency of political exchange and priority setting (Wildavsky, 1975). The early management budgeting exercises were pronounced a failure chiefly because they did not succeed in convincing clinicians and others that they had something positive to offer. Indeed, clinicians were, in the DHSS's (1986) words, so 'seriously antagonised' that 'there may be a case for suspending management budgeting development for the time being'.

Under management budgeting, even if clinicians had accepted their role as budget holders, they were still some way from agreeing that they should be accountable to another person for managing resources, especially if that other person was a non-clinician. Devlin (1985) asserts that management budgeting was:

> *unrewarding for the clinician, a fact that management consultants agreed in private conversations. In a cutback situation the health authority is having to grab every penny it can and will only squeeze further consultants who improve their output. I think management budgets by incentive is fraudulent unless the clinician is prepared to go home and rest when he has reached his target output — doing more, more efficiently, negates the savings the health authority is really out to achieve. Savings, not efficiency, is the real bottom line* (p.165).

In recognition of the failure of management budgeting, resource management has sought to emphasise 'the human relations dimension' (Mills, 1987). Whereas management budgeting was finance-led, resource management is principally concerned with making doctors more management conscious and accountable for the resources they use. Though it certainly seeks to do so, it is not clear whether the current resource management initiative has adequately addressed the problems outlined above.

An Economic and Social Research Council (ESRC) project is examining the extent to which general managers favour management budgeting and its successor, resource management, as means of influencing clinicians. The two initiatives, while having different emphases, are considered together because they are often perceived as indistinguishable in the field.

On the basis of an analysis of about half the total study material from 300 interviews with managers and others conducted between 1987 and 1988 in eight DHAs (including two resource management pilot sites) and the three parent RHAs, only one DGM perceived management budgeting or resource management as central to his/her mission (Pollitt, Harrison, Hunter and Marnoch, 1988). A widespread attitude was that while resource management should be important it had not been set up in ways calculated to produce useful results. The two most frequently mentioned ingredients for success were to present it to clinicians as a non-threatening information system, and to offer clinicians incentives to act on the information. In none of the sites in the general management study had significant clinical resource reallocations resulted from management budgeting or, more recently, resource management. Nor was there any direct evidence of consultant enthusiasm for such priority-setting. While some clinicians found the statistics produced valuable information within their own department or clinical team, they became anxious if comparisons with other units were suggested.

A few clinicians believed that the information could be used to argue for more resources for themselves which provided them with a very direct incentive to become involved. Indeed, the UGMs interviewed during the research believed that resource management-type information systems could be manipulated by consultants to intensify their 'shroud waving' skills. As one put it, consultants would become 'even more supreme technocrats' but not necessarily better team players.

Generally, consultants regarded management interference with medical workloads as undesirable. There was a good deal of distrust of the accuracy of the data. 'Lukewarm' is an adjective which frequently cropped up in discussions of management budgeting and resource management. For many general managers, these initiatives did not offer any prospects of instant returns. Even if one could be sure of the outcome, which was by no means self-evident, it would be a long haul. As one RGM commented,

> *I don't think that management budgeting or resource management is the problem – the issue is simply one of clinical freedom . . . so we have to proceed with some caution.*

He found 'naive' the view held by some at the centre that resource management was taking too long to implement.

For most of the general managers in the study sample avoiding overspending was their first priority. Introducing management budgeting or resource management was seldom mentioned. When it was, the general consensus was the need to go gently coupled with scepticism over the statement of John Moore, former Secretary of State for Social Services, that resource management would be working throughout the NHS as the Service entered the 1990s.

Another recent study, carried out for the National Health Service Training Authority (NHSTA), involved an analysis of relationships between managers and clinicians (NHSTA, 1987). Apart from reaffirming the familiar hostilities and perceptions which are all too evident on both sides to any observer of the NHS, the researchers reported that a primary task for the 20 DGMs sampled was to involve doctors more effectively in management. However, more ominously, few DGMs expressed very clearly what that actually meant, and even fewer shared their vision with others. DGMs differed in their approach to the problem. At one extreme was the DGM who believed that general management must curtail the excessive power of the doctors (a confrontational style) while at the other was the DGM who saw clinicians as constituting a powerful group which should not be neutralised by management but subtly handled and nurtured (a team-building

approach). The researchers found that most DGMs displayed elements of both the hard-nosed confrontational approach and the more enabling, facilitative style of management.

Significantly, the resource management schemes underway in many of the districts were seen as a key to getting doctors to think and behave more managerially. Indeed, 'a great deal of faith is being pinned on their success'. The importance of accurate and sound information for management was stressed. Inaccurate data can be damaging to managers' credibility with doctors. Careful attention has also to be given to the interpretation of information by doctors – it cannot be assumed that they are able to do this unaided. Moreover, information, however accurate and well-presented, is only a means to an end and can in fact intensify problems unless there already exists a basis for dialogue between managers and clinicians.

A further problem identified by the researchers has been forcing the pace of change. One DGM is reported as having learnt by bitter experience not to push change too fast.

> *I'm going to have to take management budgeting very slowly indeed, because a false move could blow it for 10 years.*

While identifying the difficulties at the doctor/manager interface as being in part at least a problem of managing change, few of the DGMs in the sample saw it in this light. However, the problem goes deeper and raises fundamental issues concerning differences of ethos between bureaucratic and professional modes of organisation.

Whereas managers in the NHS operate in hierarchical structures and focus their attention on whole communities receiving services, the medical profession has adopted a collegiate form of organisation and focuses its attention on the individual patient. The research shows that there is a long way to go in both understanding the attitudes and aspirations of doctors and managers respectively and in their working successfully together.

Doctor-Managers

The Griffiths NHS management inquiry emphasised that where possible doctors should themselves assume management responsibility. In part, this involves doctors becoming general managers, and in part it entails establishing appropriate systems for involving doctors in management within hospitals. Experience with the first round of general manager appointments indicated that few doctors were willing to apply for general manager posts. The majority of general managers at all levels were former administrators or managers, with doctors forming a small minority of those appointed, often on a part-time basis at unit level (see Box 8).

Reasons for a poor response included lack of management training and management ability among doctors, the limited interest among doctors in becoming managers, the absence of incentives to attract doctors into management, and the possible adverse effects on the career progress of doctors who took time out to work in management (Scrivens, 1988a).

BOX 8 · DOCTORS AND GENERAL MANAGEMENT

In 1987 the number of doctors appointed as general managers was

1 out of 14 Regional General Managers
15 out of 191 District General Managers
110 out of 599 Unit General Managers

Source: Stewart and Dopson (1988)

There has also been limited progress in establishing systems for involving doctors in management within hospitals. Traditionally, hospital medical staff have managed their own work and at consultant level have not been held accountable to other doctors or to managers for their performance. The experiments in clinical budgeting, management budgeting and resource management described above are aimed at changing this, most obviously by delegating responsibility for budgets to clinicians in individual specialties. Yet, as we have noted, the experiments have run into a variety of difficulties, including the absence of clear management structures to support the development of decentralised budgets. It has proved difficult to establish effective financial control procedures when those taking budgetary responsibility have neither management authority nor explicit reporting relationships with colleagues.

It is in this context that experience at Guy's Hospital in the last four years is relevant. In 1984, Guy's ran into significant financial problems, necessitating urgent action to close beds and cut back services. Clinicians at Guy's felt they had lost confidence in their managers and proposed the establishment of new management arrangements in which doctors were to play the key role. Drawing particularly on experience at Johns Hopkins Hospital in Baltimore, these arrangements involve a Management Board and 14 clinical directorates each headed by a senior clinician. The Management Board is chaired by a doctor and apart from the clinical directors it includes in its membership the chief executive, the director of nursing services, the personnel officer and the finance director.

It should be emphasised that the management system developed at Guy's stemmed directly from a need to control the worsening financial situation at the hospital. This provided the stimulus for action and motivated the clinicians concerned to become directly involved in management. As two of the key staff at the hospital have noted, in the financial situation in which they found themselves

> *a major debate ensued among the clinicians, which sought to reconcile clinical freedom with management authority and accountability. In the end, the consultants agreed to accept a system that sought to equate power with responsibility. In return for the freedom to manage their own affairs, they had*

to accept responsibility for the financial consequences (Smith and Chantler, 1987, p.14).

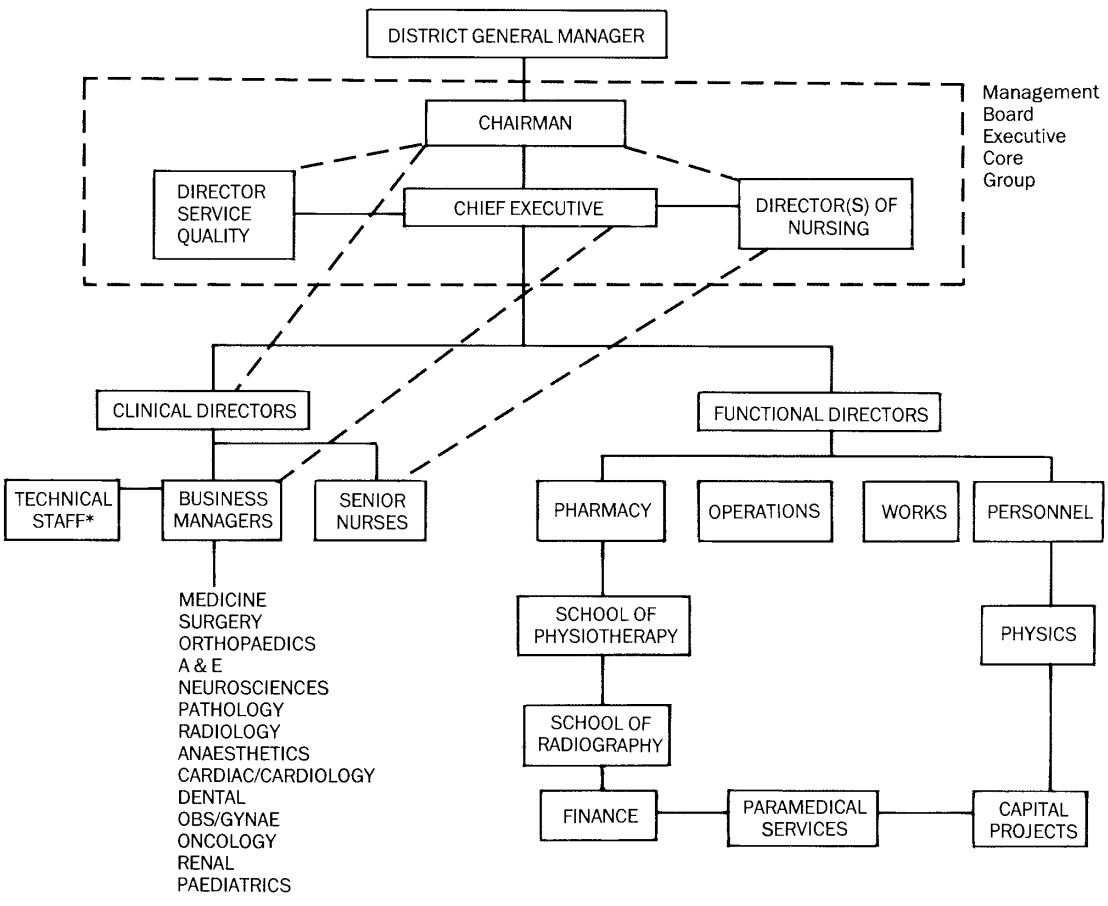
Each clinical director is responsible and accountable for consultants and other medical staff in his directorate. The directors are supported by a business manager and a nurse manager (see Figure 1). The directorates have considerable responsibility covering such issues as outpatient scheduling, in-patient admissions, quality assurance and customer relations, and medical and nursing resources. Comprehensive budgets for the directorates have not yet been established, although approximately 70 per cent of resources are under their control. The priority given to creating a medical management structure in advance of clinical budgets reflected the fact that

the size of the problem facing Guy's required a more radical approach than clinical budgeting (Smith and Chantler, p.13).

After three years' experience, those closely involved in the Guy's experiment have claimed a number of successes. These include bringing the financial situation of the hospital under control, improving the quality of care to patients, and achieving increased funding for regional specialties. More intangibly, it has been argued that clinicians have taken ownership of the finances of the hospital and have used this power to bring about significant changes in services.

On the debit side, there are indications that some directorates are working more effectively than others. A great deal appears to depend on the skills, interests and personality of the individuals appointed as directors. Experience has highlighted the importance of providing training and development for the staff involved and this is now being done through the involvement of an independent management consultant. A further point to emphasise is that clinical directors are intended to have a management role in

FIGURE 1 · GUY'S HOSPITAL – MANAGEMENT STRUCTURE



* reporting arrangements for technical staff vary within Directorates but this is a typical arrangement.

Source: Smith and Chantler (1982)

relation to their consultant colleagues and this has not proved easy to realise in practice. The likely response at Guy's is the establishment of clinical groups to take on management responsibility within the existing directorates. In this way, a larger number of clinicians will become involved in management.

Management arrangements similar to those at Guy's have been initiated at a number of other hospitals, including The Royal Hampshire County Hospital, Winchester. Like Guy's, the Winchester project is part of the resource management initiative and involves the delegation of management responsibility to eight directors. These cover medicine, surgery, obstetrics and gynaecology, orthopaedics, special surgery, pathology, radiology and anaesthetics/ intensive care. Clinical directors are chosen by the UGM and their clinical colleagues and report to the UGM (initially a doctor, now a nurse).

As at Guy's, one of the benefits claimed for the new management system has been improved financial control and a higher quality debate between managers and clinicians. A further similarity has been the need to provide training and support for the clinical directors and to invest in 'people development' (Nattrass, 1988). One of the emerging difficulties at Winchester is the existence of a division between those clinicians closely involved in the new arrangements and those outside. This has given rise to a 'them and us' attitude and again there are parallels with experience at Guy's.

Experience at Brighton Health Authority is in many ways similar to that at Guy's and Winchester. Brighton has had a longstanding involvement in quality assurance and initially one element of this entailed consultants participating in medical audit. Two of those closely involved have noted that

> *Enthusiasm has varied, but there is a common realisation that medical audit activity is desirable and should be engendered from within and not imposed from without. It should be voluntary but expected. The least surprising conclusion is that effective quality assurance requires more resources, particularly time* (Bowden and Gumpert, 1988, p.339).

Subsequently, steps have been taken to appoint clinical directors (known as consultant managers) and to give budgetary responsibility to these managers who are accountable to the unit general manager.

The Brighton initiative drew on experience from the US and it demonstrates the kind of progress made in health authorities not involved in the resource management initiative. It is also worth emphasising that the support of consultants was gained through an early focus on audit and efforts to improve the quality of care. This laid the foundations for the later development of management and budgeting systems. A major priority at Brighton, as elsewhere, has been the establishment of information systems to support these initiatives.

Comment

No independent evaluation of the impact of arrangements such as those that exist at Guy's, Winchester and Brighton has yet been published. Nevertheless, the accounts of those involved testify to the enthusiasm of the key participants and to the progress made in a number of fields. Difficulties have also arisen but these are perhaps not surprising in view of the significant departure from previous management arrangements that these initiatives represent.

If the initiatives are so far the exception rather than the rule, there is evidence to suggest that an increasing number of managers are seriously considering following these examples. A survey of DGMs conducted by Scrivens (1988a and b) found substantial support both for the appointment of doctors as clinical directors and the development of management budgets. At the same time, the survey reported that in many districts, general managers continue to rely on modifications to established methods of involving doctors in management, such as refining the medical advisory committee and strengthening the role of medical representatives on management teams. Moreover, managers interviewed for the ESRC study on general management mentioned in the last section claimed that what was possible in a large teaching hospital like Guy's could not be replicated across the country in the average DGH. Various problems were cited in some districts including an absence of suitably qualified and senior clinicians, a lack of training, and poor information systems.

Given the hostilities and differences between clinicians and managers uncovered by the NHSTA research into general management (NHSTA, 1987), it is likely to take some time before real progress is made in effectively involving doctors in management throughout the NHS. Just as important, the limited interest among doctors in management and in taking responsibility for budgets reported by Scrivens suggests that a major effort is needed to persuade doctors of the importance of medical involvement in management. A key element of future policy in this area will be a commitment to provide management training for doctors and to develop systems for identifying doctors with management potential. It may also be necessary to consider ways of offering financial incentives to attract doctors into management. Above all, as our analysis of the experience of clinical budgeting, management budgeting and resource management indicated, it will take time to make progress on these issues.

One of the points to emphasise about management arrangements which give a major role to doctors is that they are closely linked with the development of medical audit, guidelines and budgets. This is shown by experience at Brighton where, through audit, the interest of doctors in management and budgets was stimulated. A different pattern of development occurred at Guy's where an imminent financial crisis precipitated action to involve doctors in management and through this to promote audit and the delegation of budgetary responsibility. These examples illustrate that there is more than one way of making progress on the agenda of issues under discussion in this paper. More detailed analysis and evaluation of the approach taken in different districts may be valuable in offering some lessons and pointers to other health authorities. However, it is already clear that the changes underway

in these districts require an investment in training and management development if they are to succeed in the longer-term.

Summary

Four major lessons have been learnt from experience in the UK (specifically England) with management budgeting which have important implications for developments in resource management. First, as evidence from the various management budgeting sites showed, it is clear that the support and commitment of clinicians is needed if resource management is to succeed. This was pointed out by Wickings at the beginning of the management budgeting experiments and the force of his warnings was borne out in practice (Wickings, 1983). Second, investment in appropriate systems for collecting and processing accurate and clinically-relevant information must be an integral part of resource management, and indeed this has figured prominently in the work undertaken so far. Of course, this carries the risk (if, indeed, it is one) that 'better' information might lead to more effective lobbying of managers by clinicians for additional resources. Such a tactic would be quite legitimate especially if it triggered a more searching discussion of standards and quality of care.

Third, it would seem that only where real incentives exist are clinicians and nurses likely to be willing to put in the time and effort required to get resource management off the ground. Financial incentives may be involved but equally important is providing incentives through resource management for doctors and nurses to improve the quality of care. Such an approach includes establishing rules of the game to govern, for example, how savings will be deployed and how increases in activity above agreed levels will be handled. Fourth, and crucially, the timetable of change is longer than envisaged. This suggests that it will be a number of years before a resource management system will be fully implemented throughout the NHS.

While there is some anecdotal evidence to suggest that resource management may be more successful than its predecessors in achieving its aims there is no independent evaluation of such claims. It will be some time before the results of the national evaluation of the resource management initiative are available. Certainly, there is still a long way to go before it is possible to conclude unequivocally that resource management as currently being pursued has helped to raise standards and increase efficiency.

Finally, as far as the involvement of doctors in management is concerned, our review has shown that few doctors have been appointed as general managers, and the development of effective arrangements for involving doctors in management within hospitals has been patchy. The most promising experience to date appears to have been at those hospitals where clinical directors have been appointed to take on management responsibility at the sub-unit level. However, these initiatives have not been evaluated, and it is too early to say whether they provide a model for the NHS as a whole.

4 EXTERNAL MANAGEMENT CONTROL OF DOCTORS

The final issue that deserves highlighting concerns external management control of doctors. Two broad approaches to this issue are possible. First, the Government could seek to give managers more power to reward or penalise the performance of consultants. In particular, changes could be made to consultants' contracts to enable managers and health authorities to tackle inefficiencies in clinical practices. Second, it is possible to bring about changes in medical work by introducing greater competition among health care providers. The stimulus of competition may serve as a significant force for change, especially if used alongside adjustments to internal management systems of the kind discussed in earlier parts of the paper. We now consider these two approaches in more detail.

Changes to Consultants' Contracts

A package of possible reforms can be identified (see Box 9).

BOX 9 · POSSIBLE CHANGES TO CONSULTANTS' CONTRACTS

Moving contracts from RHAs to DHAs
Involving managers in consultant appointments
Specifying consultants' contracts
Short-term contracts
Performance-related pay

Moving consultants' contracts from RHAs to DHAs
Although not put forward as a recommendation in the Griffiths NHS management inquiry report, this has long been favoured by many managers and health authority chairmen and members. It is argued that the current position places considerable limits on the ability of DHAs to influence the behaviour of the consultants who work in their districts. If contracts were moved from regions, then DHAs would have greater control over what consultants do and would be better placed to negotiate changes in contracts. This would apply particularly if linked to the introduction of short-term contracts (see below). Against this, it should be noted that teaching districts have always held consultants contracts and there is no evidence that this itself alters the relationship between consultants and health authorities.

Involving managers in consultant appointments
If contracts were moved to DHAs, then a further possible change would be to give managers a direct role in consultant appointments. The profession has traditionally resisted this idea. Yet if managers are increasingly expected to meet performance targets which involve changes in clinical areas, it is logical to involve them in the appointment of the clinicians whose work they are ultimately responsible for managing. This would not entail managers determining consultant appointments. Rather, it would mean including the relevant general manager (unit or district) as one member of the appointments panel, thus enabling managers to influence the choice of new consultants.

Specifying consultants' contracts
Another change would involve health authorities specifying in more detail the nature of the work to be performed by consultants. At one level, this might cover the kind of clinical activity expected and at another it might require consultants to accept responsibility for budgets and for managing their services. Contracts might spell out the areas of work in which the consultant is expected to specialise and the volume of work associated with the appointment. In the long term, contracts might also require adherence to agreed protocols for the treatment of specified conditions. These protocols would establish indications for treatment, the nature of the tests to be performed, expected lengths of stay, and appropriate follow-up procedures. Contracts could also specify expectations concerning consultant involvement in medical audit.

Short-term contracts
In the same way as general managers are now appointed on contracts which vary from 3-5 years, so too new consultant staff would be appointed on short-term contracts. The performance of consultants would be regularly reviewed. The review might encompass both clinical competence and effectiveness in managing resources. Clinical competence could be assessed by medical peers and management effectiveness could be reviewed by the relevant general manager and his management team (including medical advisers). The more detailed contract under which consultants would be employed would provide the basis for performance review.

Performance-related pay
In parallel with short-term contracts and performance review, the distinction award system could be refashioned to enable general managers to reward good performance with discretionary salary payments. At present, distinction awards are determined by doctors alone and are supposedly made in recognition of clinical and academic excellence. One possibility for the future is to transfer control over distinction awards to general managers who with medical advice would be able to recognise good medical performance with financial rewards. This could be linked to greater openness to enable those doctors receiving awards to be identified publicly.

Comment
A package of the kind set out above would meet with strong resistance from many doctors. If the Government is therefore serious about achieving changes to consultants' contracts, it may need to sweeten the pill. The most obvious way of doing this would be to increase basic salaries for new consultants as a *quid pro quo* for the loss of job security, and to provide generous levels of performance-related pay for consultants. It may also be possible to extend opportunities for private practice.

It is difficult to predict the likely impact that these initiatives would have if implemented. In view of the rewards already available through private practice, it may be that the attractions of enhancing NHS pay would be limited. There is also the danger that specifying consultants' contracts in more detail may cause consultants to work only to contract and to reduce their commitment to the NHS.

If this is the case, a more promising route may be to seek changes in clinical practices through non-financial incentives. As we noted earlier, exploiting the interest of doctors in providing a high quality service and appealing to their professional values may offer the best means of promoting greater efficiency and effectiveness in the use of resources. Such a strategy is likely to have most impact when there is a clear lead from senior members of the profession and when there are local enthusiasts willing to follow this lead.

On the other hand, in situations in which consultants are not willing to respond to evidence about inefficiency or low standards, invoking professional self-respect is unlikely to be sufficient. Although such situations are rare, they do cause difficulty both for managers and for doctors. Changes in the contractual position of consultants may offer significant advantages to managers confronted by this difficulty. While the termination of contracts would occur only rarely, the threat of termination would be a powerful lever in negotiations about clinical activity.

Contractual changes may also help accelerate the process of implementing medical audit, developing standards and guidelines, and introducing resource management. Instead of relying solely on local enthusiasts and support from the royal colleges, managers would be able to insist on action on these issues as part of the conditions of employment of consultants.

As these comments suggest, changes in contracts are best seen as a means to an end. While the ultimate objective is higher quality health care, staging posts along the way include new contracts, the use of financial and non-financial incentives, the involvement of doctors in management, and a more systematic approach to medical audit, standards and guidelines.

In this context, it is worth referring to recent developments in the family practitioner services as these may hold some pointers for hospital doctors. FPCs have responsibility for monitoring standards in general practice in non-clinical areas. This includes inspecting the standards of practice premises and assessing the hours of availability of those providing family practitioner services, out-of-hours cover, and telephone answering arrangements. Since becoming independent authorities in 1985, many FPCs have developed and expanded this monitoring role, a trend which is encouraged by the White Paper, *Promoting Better Health*. In particular, the White Paper envisages that FPCs will develop policies for improving standards of practice premises, monitor more closely the level and quality of service provision and review referral patterns and prescribing rates with the assistance of independent advisers.

Alongside these developments, the Government has proposed changing the contracts of GPs to create incentives for the provision of certain services. *Primary Health Care: An Agenda for Discussion* (Secretaries of State for Social Services, Wales, Northern Ireland and Scotland, 1986) suggested that GPs should be paid a good practice allowance to reflect a high quality of care with performance being assessed through a combination of peer review for some procedures and objective criteria for others. As Gray et al. (1986) noted, this proposal reflected a more general concern to increase the accountability of doctors to the public through changes in the contract between the medical profession and society.

If accepted, a good practice allowance would have required the development of standards of practice and a system for auditing standards. In fact, the White Paper dropped this proposal in favour of providing incentives in the remuneration system to achieve specified target levels of provision for vaccination and immunisation and for screening, to provide comprehensive regular care for elderly people, and to provide payments for doctors carrying out minor surgery. The aim of these proposed changes is to reward those doctors who reach agreed standards. It remains an open question how effective these financial incentives (which are still under negotiation) will be in practice.

Extending provider competition

One of the issues that has received most attention during the NHS Review is the development of competition between health care providers. Competition has been seen as a way of increasing choice for consumers and promoting efficiency in the use of resources. Speeches made by Ministers during the Review have indicated the priority attached by the Government to extending provider competition in health services as part of the mixed economy of health. This is likely to involve competition both between health authorities and between the NHS and the private sector.

An increase in competition will have important consequences for the relationship between managers and clinicians. Not least, it will require managers who negotiate to provide services for external purchasers, for example other health authorities, to negotiate in turn with the consultants who work at their hospitals to deliver these services to an acceptable standard and price. To be able to do this, managers will require contractual control over clinicians, financial incentives in the form of discretionary salary payments or increases in departmental budgets, or some combination of these tools. Managers and doctors will also require accurate information about the costs and quality of the work that is done. This will stimulate the development of information systems to support competition. Some idea of the impact that competition has on the management of clinical activity can be gained from experience in the US, where provider competition has been extensively developed. In response to mounting concern over the spiralling costs of medical care, those responsible for financing health services have taken various cost containment initiatives. These initiatives include prospective payment for hospitals making use of diagnosis related

groups (DRGs), utilisation review programmes, and the development of health maintenance organisations (HMOs).

HMOs seek to contain costs by providing care for subscribers for a fixed annual sum This reduces the incentives to over treat patients and encourages HMOs and doctors to be more efficient. The same applies to DRG-based prospective payment systems. Reimbursing Medicare hospitals on the basis of a price established in advance of treatment creates incentives to contain costs. However, it may also encourage under utilisation and the quality of care may suffer as costs come under pressure. In an attempt to avoid this, peer review organisations (PROs) have been established to act as guardians of quality.

Utilisation review has developed alongside HMOs and prospective payment as a way of bringing clinical decisions under closer control. Utilisation review involves a variety of approaches including pre-admission certification of patients in which doctors have to obtain the permission of insurers to provide treatment, concurrent review of patients during treatment, and retrospective review after discharge. Another aspect of utilisation review has been the development of protocols for the treatment of particular conditions as a way of limiting the use of tests and procedures. Instead of seeking to impose global financial and management controls, the approach adopted has concentrated on limiting expenditure by changing doctors' behaviour.

How effective have these initiatives been? The evidence is decidedly mixed. Findings from studies on the impact of prospective payment indicate that hospital admissions have fallen, lengths of stay have been reduced, outpatient treatment has been substituted for inpatient care and there have been reductions in diagnostic tests and other procedures (Altman and Rodwin, 1988; Davis and Rhodes, 1987). Reports also suggest that quality of care for patients has not been adversely affected by the use of DRGs. However, the impact on overall expenditure has been limited because prospective payment applies only to inpatient care. Research indicates that the savings made on inpatient services have been used to finance an expansion of outpatient and home care (Altman and Rodwin, 1988). Moreover, as Caper (1988) has noted,

> *As fast as regulations and review protocols are written, physicians learn to circumvent them, resenting the intrusion into their clinical autonomy* (p.1535).

A recent study of the impact of prospective payment in New Jersey demonstrated that changes in services were brought about without significantly limiting clinical freedom (Weiner *et al.*, 1987). Although the originators of DRGs assumed that managers would use them as a tool to control resource use within hospitals, this did not happen. Instead, hospital managers succeeded in limiting the effectiveness of DRG reimbursement by negotiating concessions through the political system; they exploited the opportunities offered by DRGs through documenting complications in treatment and classifying cases with imprecise diagnoses to obtain higher levels of payment; and they generally avoided challenging clinical practices.

The main exception to this concerned lengths of stay where greater efforts were put into discharge planning to reduce hospital stays and where managers monitored and compared length of stay profiles. This apart, managers were reluctant to intervene in doctors' decisions. The findings of this study support the view that doctors and managers can find ways around efforts to control their behaviour and suggest that the micromanagement of doctors in the US has met with limited success.

The experience of HMOs is also mixed. Early evidence indicated that they were able to reduce costs and this was not achieved at the expense of service quality. More recently, as competition has increased, there has been bankruptcy among some HMOs. The reasons for this include the failure to achieve continuing cost reductions in a situation in which income is limited by fixed pre-payments.

Comment

In the current debate on the future of the NHS, the experience of the US is often commended as an example to the UK. Thus, Green (1988), Goldsmith and Pirie (1988) and Goldsmith and Willets (1988) have all pointed to the lessons that can be learnt from the US and have argued that there is an urgent need to manage clinical work more effectively in the NHS. This includes developing clinical protocols; making greater use of medical audit and peer review; and scrutinising decisions to admit and discharge patients to ensure that resources are not used inappropriately.

Implementation of these proposals would involve much closer supervision of clinical work than in the past. Indeed, this is an essential purpose of the managed health care organisations favoured by these writers. However, the medical profession is unlikely to acquiesce willingly to changes of this magnitude. If real progress is to be made on these issues, it will almost certainly require the offering of incentives (financial and other) to encourage doctors to relinquish some of the autonomy they have traditionally enjoyed.

But more fundamentally, it is doubtful whether strengthening the micromanagement of clinical work on the American model is an effective way of controlling costs and raising standards. Despite the controls that exist in the US, expenditure continues to increase rapidly. If one reason for this is the multiplicity of funding sources, another is the ability of doctors to find ways around externally imposed controls.

On the other hand, it may be possible to incorporate some elements of HMOs in order to strengthen incentives for efficiency. One possibility is that GPs could become budget holders, attracting a capitation payment for each patient on their list, and taking responsibility for the provision of primary care and hospital services within this budget (Maynard *et al.*, 1986). GPs would retain the difference between their income and expenditure, and hospitals would compete for business from GPs. In this situation, hospitals would depend for their income on the number of patients treated, and they would be rewarded for increases in productivity. A move in this direction was hinted at by the Secretary of State for Health in his speech to the Conservative Party Conference in October 1988.

Again, such a move would require the development of quite different relationships between managers and consultants. One option would be for consultants to become in effect private practitioners who would sell their services to managers. Consultants could organise themselves as producer cooperatives (or limited companies) based on particular specialties, and would contract with hospitals to supply negotiated packages of work. These are radical possibilities which assume that both GPs and consultants have the management skills required to operate in an entrepreneurial manner. They also assume that some hospitals or hospital departments would fail to compete successfully and would therefore go out of business, and GPs who did not manage their budgets effectively would incur a loss. None of these assumptions may be realistic. Changes of this magnitude may also produce unintended consequences, for example an increase in medical salaries without any commensurate increase in workload. If the principal objective is to promote greater effectiveness and efficiency in clinical activity, extending provider competition may not be the answer. At a minimum it would seem important to undertake a number of small-scale experiments and evaluate their impact before changing the entire basis of health service financing and management.

Summary

Any attempt to regulate clinical activity from the outside is likely to be resented and resisted. In view of this, introducing an overtly aggressive management style into the clinical field may be counter-productive and ultimately self-defeating. On the other hand, it may be that only through changing contractual relationships will significant advances be made. The key area of judgement is the pace at which changes in contracts can be achieved.

At first sight, extending provider competition is a more attractive approach to changing clinical activity than strengthening external controls. However, as our review has shown, US experience illustrates how doctors are able to circumvent controls over their work. While managed health care does make inroads into clinical freedom, in the US context it has had only limited success in containing costs. A more effective strategy, to return to an earlier theme, may be to appeal to the interest of doctors themselves in providing good quality care.

5 AN AGENDA FOR THE FUTURE

A major challenge in future is to improve the efficiency and effectiveness of health services. Central to this challenge is the management of clinical activity. Through better management of clinical work, it should be possible to ensure that resources are used efficiently and that patients benefit from the treatments they receive.

The analysis offered in this paper highlights both the uneven development of different approaches to the management of clinical work and the difficulties involved in persuading doctors to take a more active role in health services management. In this final section we outline the options available to policy makers in deciding how to take these issues forward.

It is apparent from our review that there is more than one way of making progress on the issues discussed. One strategy would focus on what we have referred to as *raising professional standards*. This would rely first and foremost on action by the leaders of the profession, professional associations and doctors at the local level. In the background there might be the hint or even threat of external controls being strengthened if action by the profession itself failed to materialise, but initially at least policy makers would appeal to professional values and self-respect in the hope of accelerating change.

A second strategy would seek to build on existing initiatives to *encourage doctors to participate in management*. This would concentrate on the appointment of doctors as managers and the extension of the resource management initiative. Priority would be given to management training for doctors, persuading doctors of the importance of medical involvement in management, developing systems for identifying doctors with management potential, and considering ways of offering financial incentives to attract doctors into management. Resources would also be made available for the investment in information systems needed to underpin resource management. This second strategy would take as its model the work currently underway at Guy's and other hospitals where doctors have been appointed as clinical directors and where budgets are in the process of being delegated to these directors. One of the merits of this approach is that it may be more acceptable to the medical profession than strengthening external controls. The reason for this is that doctors find it more acceptable in most cases to be managed by peers than by non-medical managers.

If our analysis is accurate, and support is given to the involvement of doctors in management, then three related initiatives may also be pursued. The first would involve doctors and managers collaborating in the establishment of a national accreditation agency. This is a model that has been tried in other countries and its establishment would demonstrate the commitment of two key professional groups to work together to achieve higher standards of care. An accreditation agency might eventually be self-financing, but its start-up costs could be met by Government.

A second initiative would be to involve doctors at a national level in identifying and disseminating examples of effective resource use in the clinical field. This is already done in Scotland through the Clinical Resource Use Group (CRUG). Although it is too early to assess the impact of CRUG, this example could be extended to the rest of the UK.

A third initiative would seek to build on experience in the Wessex region where the general managers have worked with senior clinicians to develop a strategy for involving doctors in management in the region. This involves supporting management training for senior doctors, spreading information about progress on resource management to clinicians who are seen as opinion-formers, and funding research into clinical outcomes. This is another example of how managers and doctors are jointly tackling the agenda of issues discussed in this paper.

As progress is made on these initiatives, it is probable that policy makers will also seek to enhance *external management control of doctors and change doctors' contracts*. In this, the third strategy, health authorities and FPCs would be expected to monitor standards of practice more systematically and contracts would be renegotiated to give managers more leverage over medical work. It would become easier to terminate the contracts of those doctors whose performance is unsatisfactory and equally it would be possible to reward good performance.

The danger with this strategy is that it might dissipate the goodwill that has been built up slowly through local experiments. On the other hand, it may ultimately be only through changing contractual relationships that significant advances can be made. If an attractive deal can be offered to the profession, then it may be possible to buy off opposition. Yet even if this is done, it is not certain that specifying contracts in more detail and laying down standardised protocols for treatment will be successful in producing greater efficiency and effectiveness in health care delivery. As our discussion of US experience has shown, doctors are well able to find ways around controls over their work. Working with doctors to produce change may be a more successful strategy than confrontation.

Linked to stronger external management controls, changes in clinical activity could be brought about by introducing greater competition among health care providers. Whatever its other effects and limitations on the provision of health care, competition is likely to be an important force for change in the relationship between managers and clinicians. The Government has made clear its support for competition and this will be a key element in future policy towards the NHS.

A final point to emphasise is that whatever changes are introduced there is a need to evaluate their impact and to disseminate good practice wherever it is encountered. In seeking to draw out lessons from experience, we have become aware of the lack of systematic, independent research into the issues we have examined. There are some exceptions to this, as in the evaluation now underway of the resource management initiative, but in general good evaluative evidence is not available.

In conclusion, within the NHS there remain formidable structural, managerial and clinical problems to be overcome before health services can be provided more effectively and efficiently. To succeed, the initiatives we have reviewed must not merely

change the management culture in the NHS but also, and arguably a much more difficult task, the clinical culture. Moreover, they must do so in a way which seeks to root out inefficiencies and restrictive practices without obscuring the importance of health outcome and patient satisfaction. The stark choice facing the medical profession is to accept the management challenge or to surrender the task to others with unknown consequences.

REFERENCES

S.H. Altman and M.A. Rodwin (1988), 'Halfway Competitive Markets and Ineffective Regulation: The American Health System', *Journal of Health Politics, Policy and Law*, 13:2, 323-339.

Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthetists' Association (1987), *Anaesthetic Services for Obstetrics – A Plan for the Future*, London.

Y.W. Bally (1982), *Clinical Budgeting in the NHS or Going Dutch (Swedish, French)*, Discussion Paper No. 05/82, Health Economics Research Unit, University of Aberdeen, Aberdeen.

D. Bowden and R.Gumpert (1988), 'Quality versus Quantity in Medicine', *Royal Society of Arts Journal*, April, 333-46.

N. Buck, H.B.Devlin and J.Lunn (1987), *The Report of a Confidential Enquiry into Perioperative Deaths*, The Nuffield Provincial Hospitals Trust and the King's Fund, London.

T.D. Bunker, C.E.Ackroyd and H.E.D.Griffiths (1984), 'Orthopaedic Audit: One Year's Experience in a District General Hospital', *Annals of The Royal College of Surgeons of England*, 66:6, 428-431.

P. Caper (1988), 'Solving the Medical Care Dilemma', *The New England Journal of Medicine*, 318:23, 1535-6.

J. Coles (1988), 'Clinical Budgeting as a Management Tool' in R.Maxwell (ed.), *Reshaping the NHS*, Transaction Books, Oxford, 126-137.

C.K. Davis and D.J.Rhodes (1988), 'The impact of DRGs on the cost and quality of health care in the United States', *Health Policy*, 9, 117-131.

P. Day, R.Klein and G.Tipping (1988), *Inspecting for Quality*, University of Bath, Bath.

DHSS (1983), *NHS Management Inquiry*, London.

DHSS (1986) *Health Services Management: Resource Management (Management Budgeting) in Health Authorities*, Circular HN (86)34.

B. Devlin (1985), 'Second Opinion', *Health and Social Service Journal*, February 7.

M. Drummond (1988), 'Incentives for Health Care Professionals'. Paper prepared for King's Fund meeting on the 40th Anniversary of the NHS.

R. Earlam (1984), 'Oesophageal cancer treatment in the North East Thames region, 1981: medical audit using Hospital Activity Analysis data', *British Medical Journal*, 288, 1892-1894.

I. Eckerlund, E.Jonsson, L.Ryden, L.Rastam, G.Berglund, and S.O. Isacsson (1985), 'Economic evaluation of a Swedish medical care program for hypertension', *Health Policy*, 5, 299-306.

I. Eckerlund (1986), 'Model health-care programmes', *European Newsletter on Quality Assurance*, 3:3, 4.

P. Ellwood (1988), 'Shattuck Lecture-Outcomes Management. A Technology of Patient Experience', *The New England Journal of Medicine*, 318:23, 1549-56.

W. Farquhar (1988), *Standard Clinical Protocols*. Report for Council of Europe, unpublished paper, Edinburgh.

F.G.R. Fowkes (1985), *Strategies for changing the Use of Diagnostic Radiology*, King's Fund Centre, London.

M. Goldsmith and M.Pirie (1988), *Managing Better Health*, Adam Smith Institute, London.

M. Goldsmith and D. Willetts (1988), *Managed Health Care: a new system for a better health service*, Centre for Policy Studies, London.

M.H. Gough, M.G.W. Kettlewell, C.G. Marks, S.J.K. Holmes, and J. Holderness (1980), 'Audit: an annual assessment of the work and performance of a surgical firm in a regional teaching hospital', *British Medical Journal*, 281, 913-918.

D.P. Gray, M. Marinker and A. Maynard (1986), 'The doctor, the patient and their contract. The general practioner's contract: why change it?' *British Medical Journal*, 292, 1313-1315.

D. Green (1988), *Everyone a Private Patient*, Institute of Economic Affairs, London.

R. Gruer, A.A. Gunn, D.S. Gordon, and C.V. Ruckley (1988), 'Audit of Surgical Audit', *The Lancet*, i, 23-26.

C. Ham, R. Dingwall, P.Fenn and D. Harris (1988), *Medical Negligence: Compensation and Accountability*, King's Fund Institute, London.

J.R. Hampton (1983), 'The end of clinical freedom', *British Medical Journal*, 287, 1237-8.

I.M. Harvey and L.J. Roberts (1987), 'Clinical Guidelines, Medical Litigation, and the Current Medical Defence System', *The Lancet*, i, 3525, 145-147.

D.A. Heath, R. Hoffenberg, J.M. Bishop, M.J. Kendell, and O.L. Wade (1980), 'Medical Audits', *Journal of the Royal College of Physicians of London*, 14:3, 200-201.

D. Heath (1986), 'The appropriate use of diagnostic services: (xiii) Medical audit in clinical practice and medical education', *Health Trends*, 18, 74-6.

R. Hoffenberg (1987), *Clinical Freedom*, The Nuffield Provincial Hospitals Trust, London.

B. Jennett (1988), 'Variations Data From Surgeons, For Surgeons', in C. Ham (ed.), *Health Care Variations: Assessing the Evidence*, King's Fund Institute, London.

R Klein (1983), *The Politics of the NHS*, Longman, London.

J.A.H. Lee et al., (1957), 'Fatality from three common surgical conditions in teaching and non-teaching hospitals', *The Lancet*, 785-90.

J. Lunn and W. Mushin (1982), *Mortality Associated with Anaesthesia*, The Nuffield Provincial Hospitals Trust, London.

A. Maynard, M. Marinker and D.P Gray (1986), 'The doctor, the patient, and their contract. III Alternative contracts: are they viable?' *British Medical Journal*, 292, 1438-1440.

R. Maxwell, M. Day, R. Hardie, H. Lawrence, M. Rendall and N. Walton (1983), 'Seeking Quality', *The Lancet*, i, 45-48.

Medical Services Study Report of the Royal College of Physicians of London (1978), 'Deaths under 50', *British Medical Journal*, 1061-2.

I. Mills (1987)'Resource Management Initiative', *Journal of Management in Medicine*, 2, 38-43.

M. Mugford (1987), 'The effects of feedback of information on clinical practice. A review'. Unpublished paper prepared for King's Fund meeting on changing clinical practice.

NAHA (1988), *Towards Good Practices in Small Hospitals*, Birmingham.

National Institute for Social Work (1988) *Residential Care: A Positive Choice*, HMSO, London.

H. Nattrass (1988), 'Resouce Management in Winchester', talk given at the NAHA AGM, Harrogate.

NHSTA (1987), *Managing with Doctors: Working Together?* Templeton Series on District General Manager, Issue Study No.5.

D.S. O'Leary (1987), 'The Joint Commission Look to the Future', *Journal of the American Medical Association*, 258:7, 951-952.

C. Pollitt, S. Harrison, D. Hunter and G. Marnoch (1988) 'The Reluctant Managers: Decisions and Budgets in the NHS', *Financial Accountability and Management*, 4:3, 213-233.

Resource Management Feedback (1987) 'The Resource Management Initiative', Issue No.1, August.

P. Reynell (1986), 'Medical Audit in Hospitals' in A. Harrison and J. Gretton (eds.), *Health Care UK 1986*, Policy Journals, Hermitage, 79-84.

Royal College of General Practitioners (1985), *Quality in General Practice*, London.

Royal College of Radiologists (1979), 'Preoperative chest radiology', *The Lancet*, ii, 82-86.

Royal College of Surgeons (1988), *Report of the Working Party on the Composition of a Surgical Team*, London.

E. Scrivens (1988a), 'Doctors and managers: never the twain shall meet?' *British Medical Journal*, 296, 1754-5.

E. Scrivens (1988b), 'The Management of Clinicians in the National Health Service', *Social Policy and Administration*, 22:1, 22-34.

Secretaries of State for Social Services, Wales, Northern Ireland and Scotland, (1986), *Primary Health Care: An Agenda for Discussion*, HMSO, London. Cmnd.9771.

C.D. Shaw (1980), 'Looking forward to audit', *British Medical Journal*, 280, 1509-11.

C.D. Shaw (1986), *Quality Assurance – What the colleges are doing*, King's Fund Centre, London.

C.D. Shaw (1987a), 'Peer review – Changing Clinical Practice'. Unpublished discussion paper prepared for King's Fund meeting on changing clinical practice.

C.D. Shaw (1987b), *Setting Standards*, King's Fund Centre, London.

I. Sketris (1988), *Health Service Accreditation – An International Overview*, King's Fund Centre, London.

N. Smith and C. Chantler (1987), 'Partnership for progress', *Public Finance and Accountancy*, 12-14.

SPRI (1985), *Swedish Medical Care Programmes*, Stockholm.

R. Stewart and S. Dopson (1988), 'Griffiths in Theory and Practice: A Research Assessment', *The Journal of Health Administration Education*, 6:3, 503-514.

Swansea Physicians' Audit Group (1983), 'Audit of Clinical Practice: Opportunities to Rationalise the Use of Resources', *Journal of the Royal College of Physicians of London*, 17:4, 235-238.

W. van't Hoff (1981), 'Audit Reviewed. Clinical Review: a Form of Audit?' *Journal of the Royal College of Physicians of London*, 15:1, 63.

C. Vellenoweth (1988), 'Fresh Start Needed', *The Health Service Journal*, 1200-1201.

S. Weiner, J. Maxwell, H. Sapolsky, D. Dunn, W. Hsiao (1987), 'Economic Incentives and Organisational Realities: Managing Hospitals under DRGs', *The Milbank Quarterly*, 65:4, 463-487.

I. Wickings (1983), 'Consultants face the figures', *Health and Social Service Journal*, 1466-8.

I. Wickings, J. Coles, R. Flux and L. Howard (1983), 'Review of Clinical budgeting and costing experiments', *British Medical Journal*, 286, 575-77.

A. Wildavsky (1975), *Budgeting: A Comparative Theory of Budgeting Processes*, Little Brown, Boston.


000 048572 020000

KING'S FUND IN

The Institute is an independent centre for health policy analy d
in 1986. Its principal objective is to provide a balanced and it
health policy issues and to promote informed public debate about them.

Assessing the performance of health care systems is one of the Institute's central concerns. Many of its projects focus on trying to determine whether health care systems achieve their objectives. The Institute is also concerned with health policy questions which go wider than health services proper. These centre on the scope of public health policy and on social and economic determinants of health.

The Institute's approach is based on the belief that there is a gap between those who undertake research and those responsible for making policy. We aim to bridge this by establishing good relations with the scientific community, and by gearing our work towards making the most effective use of existing data. One of our key objectives is to undertake informed analyses and channel them to politicians, civil servants, health managers and professionals, authority members and community representatives.

The Institute adopts a multidisciplinary approach and seeks to make timely and relevant contributions to policy debates. A high priority is placed on carefully researched and argued reports. These range from short policy briefings to more substantial and reflective policy analyses.

The Institute is independent of all sectional interests. Although non-partisan it is not neutral and it is prepared to launch and support controversial proposals.

Other publications from the King's Fund Institute

Public Expenditure and the NHS: Trends and Prospects Briefing Paper No 2, Ray Robinson and Ken Judge. £3.95.

Promoting Innovation in Community Care: From Small Scale Developments to Mainstream Provision Briefing Paper No 3, David Hunter. £3.00.

Community Physicians and Community Medicine Research Report No 1, Sarah Harvey and Ken Judge. £4.95.

Health Finance: Assessing the Options Briefing Paper No 4, Ray Robinson et al. £4.95.

Griffiths and Community Care: Meeting the Challenge Briefing Paper No 5, David Hunter and Ken Judge. £3.95.

Health Care Variations: Assessing the evidence Research Report No 3, edited by Chris Ham. £6.95.

Last on the List: Community Services for People with Physical Disabilities Research Report No 3, Virginia Beardshaw. £7.95.

Medical Negligence: Compensation and Accountability Briefing Paper No 6, Chris Ham, Robert Dingwall, Paul Fenn, Don Harris. £5.95.

Promoting Better Health? An Analysis of the Government's Programme for Improving Health Care. Briefing Paper No 7, Linda Marks. £3.95

Community Care: Reacting to Griffiths. Briefing No 1, David J Hunter, Ken Judge, Sarah Price. £1.00

Just an Occupational Hazard? Policies for Health at Work. Research Report No 4, Sarah Harvey. £6.95

Further details about the Institute and its publications can be obtained from:

Publications Officer
King's Fund Institute
126 Albert Street
London NW1 7NF
Telephone: 01-485 9589