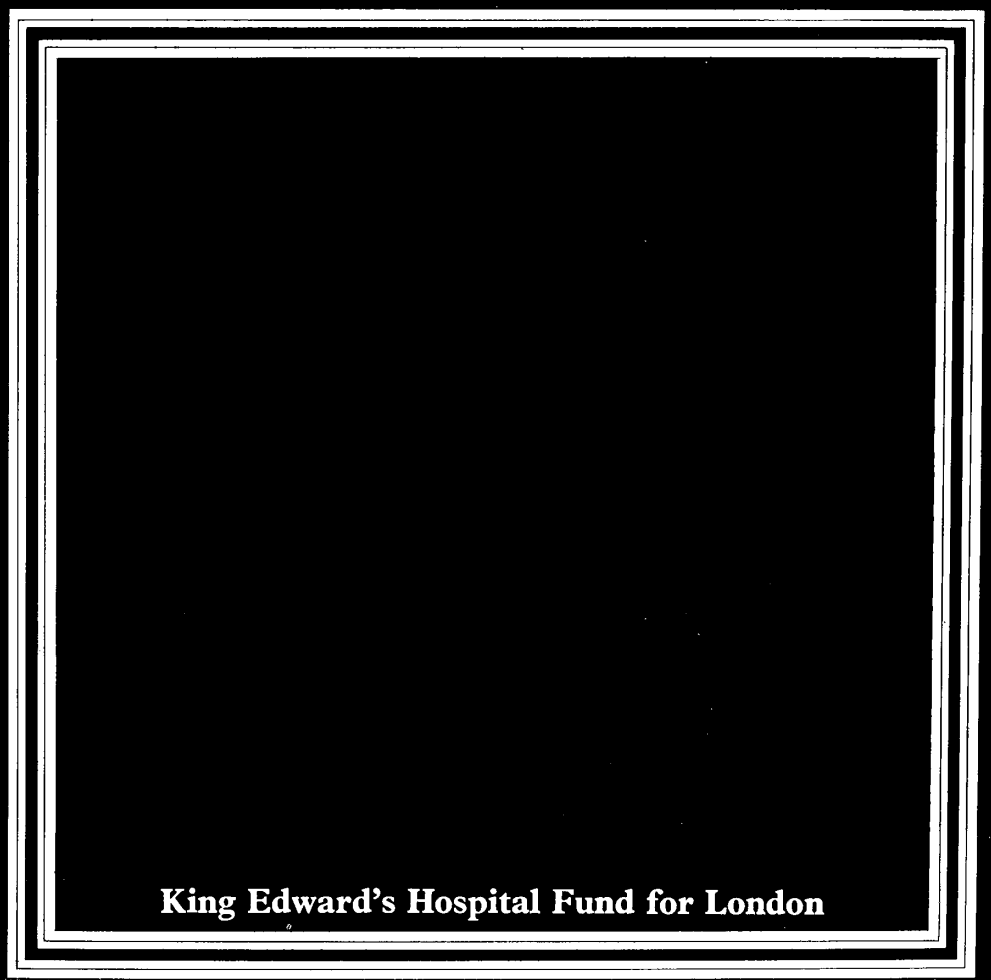
The Health Service Administrator:

Innovator or Catalyst?

Edited by Leslie Paine



King Edward's Hospital Fund for London

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The Health Service Administrator: Innovator or Catalyst?

Selected papers from a King's Fund international seminar

Edited, with commentaries, by Leslie Paine MA FHA

Foreword by Robert Maxwell MA ACMA JP

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Other Papers Given at the Seminar

It was not possible to include every paper circulated to members because the resulting book would have been too unwieldy. Since the quality of papers was very even, a decision had to be taken on which to omit, based primarily on the material that fitted best into the editorial scheme. Several excellent papers have, therefore, had to be left out. Titles and authors are given on pages 187–189 and readers wishing to read these papers are advised to write directly to the authors.

In addition, although the four keynote addresses were not (with the exception of that given by Professor Philip Rhodes) presented as papers at the seminar, two of the keynote speakers—Professor S J G Semple and Mr Robert Maxwell—have since produced written versions of their addresses which are included in this volume. The main points of the fourth keynote address—that by Professor Brian Abel-Smith—and of the papers not published here, have been included as far as possible in the introductory section, Current Health Care Scenes, and in the Commentaries on each other section. LP

Foreword

ROBERT MAXWELL

This book crosses neglected ground in examining what the role of senior administrators in the health field should be. It stems from a meeting of some 25 senior administrators from Australia, Canada, the United Kingdom and the United States. These people gathered in London for a week in May 1977 at the invitation of the King's Fund to discuss the question 'Does the senior health administrator have a role as either innovator or catalyst in

> the introduction of medical developments, choices of priorities for the community served and changes in the configuration of services?
>
> the political process as it affects health and health services? the allocation, deployment and control of the use of resources, including manpower?
>
> the appraisal of quality and effectiveness, including the handling of complaints?'

As a general rule, conference records make bad books because they lack coherence and have no single, urgent message. I hope that this book is an exception. Little of quality has been written

about health administration, and the job is indeed difficult to define. Ask most doctors what a senior administrator does and you will get an answer as blistering as Tennyson's remark that a critic is 'a louse in the locks of literature'. Part of the reason for this is low quality: a top civil servant in London once remarked of administrators in the early days of the National Health Service that they were backing into the future and were so emotionally bankrupt and intellectually constipated that discussion with them was 'like striking sparks off cowpats'. But the reason is also related to contradictions in the job, as Leslie Paine remarks in the present book. For the administrator should be an enthusiastic enabler helping individual doctors, nurses and others to overcome problems in doing what they think best for their patients, and at the same time a dispassionate assessor of competing claims for scarce resources. He also needs (like senior managers in other fields) to be both a doer and a thinker: a short-term opportunist and a long-term strategist. And faced with particularly complex and emotionally charged management problems, and with staff who are about as intelligent, independent and impatient a group as can be found anywhere, the senior health administrator has little personal authority. Small wonder, then, that some long-serving administrators are disillusioned and obstructive, while others are so shell-shocked that they can no longer say no to any request.

Yet, difficult as the role is, it is not impossible. Moreover, if it is to be done at all it must be done well. It therefore seemed wise to draw together the insights of some of those who, in very different health systems, have reached senior positions and are determined to try to fill their role well and constructively. Such a group was picked by the King's Fund for its second International Seminar for Administrators.* It could, of course, be argued that other

*The first such seminar was held two years previously and resulted in a report *Providing Effective Health Care with Restricted Resources*[17], written by Leslie Paine for the Fund, and available from the King's Fund College, 2 Palace Court, London W2 4HS.

countries in Western and Eastern Europe and Japan should be included in any discussion of health administration in the developed world. But there were some advantages in having a group which shared a common language so that shades of meaning could be discussed with some confidence, and which did not cover so wide a range of countries as to require most of the available time to be spent in describing their different characteristics. In terms of types of health service organisations the spectrum was almost as wide as it could be from the American and Australian predominantly private systems to the British NHS, with Canada in between. Thus any consensus that emerged about the nature of health administration would have to take into account enormous differences among these health care systems.

The structure of the book follows the four parts of the question posed at the beginning of this Foreword. For each part two or three of the participants' papers have been used together (in three parts of the four) with a contribution by an invited speaker, and Leslie Paine has written a summary, drawing upon other papers and upon the discussion. He also writes a concluding summary at the end of the book.

What emerges about the nature of health administration at a senior level? As Leslie Paine's summary shows, the seminar did not achieve any dazzling definition. However, those who read the book will find, as the participants did, not only a number of perceptive individual insights, but also a composite picture emerging. The seminar's theme emphasised the senior administrator's role as an initiator of change. While this is understandable because the administration of a steady state is rare in health, and is not the characteristic role of senior management in any field, the senior administrator is certainly not concerned solely with the initiation of change. He may at times be more concerned with maintaining morale and tradition in a period of fast change initiated by others. Equally, there are times when he should be an initiator of change, either as innovator or more commonly as

catalyst. One prime characteristic of his role is that he should try to see any situation whole, for he is surrounded by determined people who can only be expected to see part of the picture and he must constantly seek to broaden their perspective and complement their advocacy. Senior administrators do well to remember John Ruskin: 'Not only is there but one way of doing things rightly, but there is only one way of seeing them, and that is seeing the whole of them'. At times senior administrators must themselves be determined advocates—in budget negotiations with their funding agency, for example—but always they must try to see how their concerns fit into a larger whole.

Senior administrators should also carry constructive dissatisfaction as a private hair-shirt, next to the skin. The day when they become complacent about their own performance or that of their institution or service is a fatal one. For there is always scope for trying to do better, and the aspiration to do better is one that must not be allowed to die. It should always have encouragement from any senior administrator worth his place, as should the search for excellence. This is well illustrated in Robert Derzon's and Philip Rhodes' papers. One good place to start is in the administration itself. Sloppy administrative standards reflect very poorly on the leader of the administration.

Finally, senior administrators must work with and through others. Unless they have a genuine, deep-rooted concern for what others are trying to do, they will not be good enablers. They must be good listeners, good communicators, good at establishing the setting and the climate in which problems can be solved. They must also inspire trust. For they will frequently have to implement decisions which are less than universally popular and they will not often be able to do so by simple fiat. Like everyone else, they will make mistakes—sometimes highly visible, and often ones which it is hard for those affected by them to forgive. Along with a wholeness of vision, and an aspiration to excellence, senior administrators need a fund of other people's goodwill.

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I Current Health Care Scenes

Current Health Care Scenes *

LESLIE PAINE

This seminar, like its predecessor two years before, began with a review of the current health care scene in each of the five nations represented—Australia, Canada, New Zealand, the UK and the USA.

From the discussion of the health care scenes in the five countries at the first seminar[17] two common factors worth noting had already emerged. First, that in any attempt to provide a genuine national health service every country faces the same basic problems; and second, that the solutions to these problems involve each country in journeying on a road which must eventually lead to a service mainly government owned, controlled and financed.

While none of the other four nations here concerned has gone anything like as far towards nationalised medicine as the United Kingdom, they all display a movement in the same general direction and particularly for the same reasons—increasing demands, rising costs and the desire to plan and organise services better.

*Compiled from papers by J Boyd McAulay (Canada), John E McClelland (Australia), Ross Mitchell (UK), D N Ryan (New Zealand), Brian D M Smith (UK), Gail Warden (USA) and subsequent discussion.

Before commenting, therefore, on the current health care scenes in the five nations, it is probably worth pausing for a minute or two to read a few paragraphs from the report of the first seminar on this particular topic. Having made the point that each country was heading broadly in the same direction as far as its health services are concerned, the report went on to say

> 'What is also clear from the information presented is that in every country (including that bastion of private enterprise, the USA, which is said to be trembling on the brink of introducing some form of compulsory national health insurance) existing services already rely much more heavily on some form of public finance than many will have realised.
>
> 'The UK, of course, has had a National Health Service funded primarily from general taxation for more than a quarter of a century; and has recently (in April 1974) reorganised its administrative structure with the express aim of providing more fully integrated care through comprehensive health authorities.
>
> 'Canada, too, has had social insurance for hospital care since 1958 and for general medical care since 1966, with services received virtually free by the individual patients, and the Federal Government providing 50 cents of every dollar spent in these spheres by the ten Provincial Governments.
>
> 'State funds in New Zealand finance the whole of the public hospital system there (80 per cent of all beds), subsidise private hospitals and meet a portion of all charges made to patients by general practitioners and specialists. In December 1973 its new Labour Government published a White Paper, *A Health Service for New Zealand*[16], which, if it becomes law, will introduce a regionalised, integrated, comprehensive service on much the same lines as that now in operation in Britain.

'Similarly, in Australia where 60 per cent of all hospital beds are in public hospitals receiving three-quarters of their finance from either the Federal Government or that of one of the six States, a national health insurance scheme ('Medibank') has been introduced from July 1975. Funded from general taxation the new scheme is designed to cover the whole population for at least 85 per cent of the costs of its medical care.

'Even in the USA, where the majority of health care is still privately funded by means of group insurance, government involvement is growing. The publicly financed programmes of care for the elderly ('Medicare') and the poor ('Medicaid') have been in operation for a decade, and that for ex-service men under the Veterans' Administration, for a great deal longer than that. Indeed of the total national expenditure on hospital care in the fiscal year 1973 more than half came from public sources—the Federal Government providing 35 per cent of the cost and State and Local Government 18 per cent.'

Returning, however, to the second seminar, from what was reported both verbally and in the papers written in advance, each country's health care system obviously retains its particular national characteristics, but at the same time faces the old basic problem of how to try to meet an apparently unlimited demand for services with a limited supply of resources. Clearly in consequence it is the struggle to stem the rising tide of expenditure that continues most to trouble the minds, furrow the brows and threaten the slumbers of those whose job it is, throughout the world, to organise health care.

Indeed it would be surprising if it were otherwise, for, as the report of the first seminar suggested, even the wealthiest of nations cannot hope to satisfy the growing appetite for health services of all kinds created by the accelerating advance of scientific medicine, the natural ambitions of its practitioners

and the great expectations that these produce in the minds of the public.

Any country, therefore, which wishes to provide health care equitably to all its people solely on the basis of need is inevitably committed, as a British Minister of Health (Enoch Powell) said many years ago, to the introduction of 'a rationing system of medical care'[18], with all the distressing and difficult decisions on priority of provision and deployment of resources that this involves.

While every country must surmount the same obstacles in its search for better health care for its people, each is bound to be influenced in its efforts to this end not only by different but also by changing national circumstances. Nothing in this world ever remains the same, especially in so dynamic a sphere of human activity as that which is dedicated to the relief of human suffering. As was only to be expected, therefore, the members from each country set before the seminar in May 1977 a somewhat different health care scene from that presented in June 1975.

To start with, when money itself is steadily losing its value, health services, like everything else that money buys, must obviously be affected. For the most part, therefore, everyone present was in agreement that many of the major changes experienced during the intervening period could be laid at the door of economic inflation.

Inflation is not the cause of increasing clinical specialisation and steadily developing medical technology, nor the sole cause of the demands which have been made for both more pay for health workers and equal pay for men and women—but it certainly exacerbates these problems. In addition, the general consensus was that the sort and amount of treatment provided and the methods of its provision were influenced not solely by its rising costs, but by many other factors, and especially by changes in political and social attitudes and actions, some of which were

uncomfortably rapid and far-reaching in their implications. Feelings of pressure from these sources were admitted by all, but not everyone appeared to have reacted to them in precisely the same way.

One school of thought propounded the somewhat masochistic view that perhaps we were all better for having to suffer a little in our working life, and that the current period of financial and administrative restraint would, in the end, make us better managers of better organised services. Some UK members even went as far as to suggest that health care management—anyway in Britain—had in some ways gained in status, recognition and self-identity as a result of having to operate in a 'nil growth' situation, and thereby wrestle with and force to the attention of its clinical colleagues some of the fundamental problems of health care provision. With commendable honesty, however, the UK members were prepared to admit to themselves and to their fellows from overseas that their ability to come to grips with the major problems confronting them was more hindered than helped by the existence of the reorganised administrative structure introduced into the National Health Service in 1974.*

Health Care Systems—Some National Problems

Generally agreed now to be a bad example of a good idea, the new system designed, in theory, simply and sensibly to integrate care through comprehensive health authorities and consensus management, was seen in practice by most clinicians and many administrators as frustratingly cumbersome, bureaucratic in the worst sense of the term and of no obvious benefit to patients. In England, the fault was felt to lie principally in too many administrative tiers, and in Scotland, in too many professional advisory committees; either way, the strong and widely held belief throughout the UK

* See the Note on page 16.

was that the reorganised structure, far from streamlining the organisation of services in the interest of the sick, had in fact resulted in a committee-ridden service, with too much 'talk' and too little 'do', and in which decision-making was considerably slowed rather than hastened.

Interested in and appreciative of the frank appraisal of the new UK organisation by those who were expected to operate it, the other members were prepared to accept that there was a large grain of truth in their British colleagues' view that management under difficulties presented challenges which were not all disadvantageous. Most were ready to agree that because in each of our countries we were probably spending all that we could currently afford on health, and because we had no real claim upon a significantly greater proportion of national resources in real terms in the foreseeable future, we should be prepared to proceed on the basis that it was our prime task to do our very best for our sick people with the necessarily restricted staff, money, buildings and equipment that we now possessed.

In pursuit of this laudable intention, however, no one underestimated the difficulties that administrators in every country had to face in their dealings with the clinicians, with government and politicians, and with pressure groups of all kinds, no matter how well-intentioned.

The National Health Service throughout the UK, for example, had been affected in 1975 by acrimonious disputes between senior doctors and the government over pay beds*, and between junior doctors and government over contracts. These disputes were now broadly settled, but much ill feeling over the decision to phase out pay beds from NHS hospitals still existed in the minds of many consultant specialists, and the introduction of a new style of contract for junior medical staff had involved an expensive settle-

*The use of beds in NHS hospitals for private practice.

ment which most health authorities had found considerable difficulty in implementing.

Similarly in Australia, the establishment by the Labour government there in 1975 of Medibank—a comprehensive scheme of health insurance—was bitterly opposed by the medical profession (as was a similar type of proposal in New Zealand) even though, as it turned out, its introduction had resulted in a general increase in doctors' incomes and in the profits made by the private health insurance funds.

America's main problems with the medical profession, on the other hand, appear to centre less on disagreement between doctors and politicians and more on a trend common to all countries but seemingly more obviously troublesome in the USA than elsewhere—increasing specialisation within the profession itself. 'During the past two years,' as Gail Warden explained in his paper, 'the "supply" of medical knowledge has stimulated further specialisation of physicians, as well as other health professionals, and has generated a "demand" for physicians to seek arrangements which facilitate specialised practices.'

The USA, as a result, has a shortage of primary care practitioners which it is now trying to overcome by encouraging their production in its medical schools, and by developing the use of doctor substitutes either in the form of physicians' aides or of specialist nurse practitioners with extended responsibilities especially for primary care.[19] This latter development could well be one reason why the number of nurses with university degrees employed in American hospitals has increased since 1975, while the number of those without and of nurse aides has dropped.

In addition, members from the several other countries remarked upon the difficulties caused to the providers and organisers of health care by the absence of consistent health policies at government level.

Lack of Consistent Central Policies

The constitutional crisis which Australia suffered in 1975, and which resulted in the return to power of the Conservative parties, also resulted in the introduction of a revised version of Medibank. Strongly opposed by the trades union movement, it nevertheless required that, from 1 October 1976, all Australian residents except such disadvantaged groups as the unemployed and aged pensioners should either take out health cost insurance with a private non-profit-making fund, or pay additional income tax. As John McClelland put it

> 'The system is structured to encourage people to take out private insurance, and as such persons are thereby disqualified from "free" hospital service it is anticipated that there will be a substantial increase in private patient numbers. There is little doubt that these changes will reduce the cost to the public purse of health services, but massively increase total health costs owing to the administrative complexity of the new system which has the same open-ended characteristics as Medibank Mark 1.'

It is sad, as he says, that the great health debate in Australia over the past three years has been centred upon the funding of health services rather than upon the services as such.

Also at the level of government policy-making, New Zealand has undergone a less traumatic but not dissimilar experience to Australia. Its Labour government's previously mentioned White Paper of December 1973, *A Health Service for New Zealand*[16], now gathers not momentum but dust on the shelf of some parliamentary store-room since the new National Party replaced the Labour government at the end of 1975. With the White Paper's proposals for an organisation which followed in broad outline that of the reorganised National Health Service of England and Wales now cast aside, New Zealand today, according to Don Ryan,

appears to have no policy for health, and a set of health services whose main characteristics are their fragmentation and lack of integration.

It is ironical to note that, whereas four years ago the then New Zealand government decided to disband its royal commission on the health services and propose instead a system based on the reorganised UK structure, the UK after less than three years' experience of this very same structure now feels it necessary to appoint its own royal commission because organisationally the new system is in many ways a failure.

No wonder perhaps that the doctors, nurses, therapists, administrators and others who actually operate the services given to sick people in hospital and community in many countries tend to be doubtful of the government's knowledge of the real position at operational level and therefore to have little faith when it comes to a belief in the ability of politicians and those in central health departments to take sensible decisions designed to improve the care of patients.

This seems to be true whether you take as an example the UK, with its nationalised medicine and current disillusionment over the reorganised NHS, or whether you take another country such as Australia or Canada where there are state or provincial parliaments as well as a federal one and no national health service. The Australian member, John McClelland, for example, certainly seemed to think that his country has too much government for local good, and with a federal and six state governments, and one house of parliament for every half million electors, who is to say he is wrong? Certainly not the Scottish member, Ross Mitchell, who expressed open fears that interference in local health affairs could all too easily result from the devolution of government so devoutly wished by so many of his more nationalistic countrymen.

Many Canadian health workers, it seems, are also discontented with their federal government's current attitude to health. Indeed, apart from the need for continuing economy, Boyd McAulay envisages the essential responsibilities which health administrators in his country must shoulder in the immediate future as the retention of a political awareness and an involvement in politics so as to ensure that essential health care programmes are not compromised when restricted federal sharing is discontinued.

This is only too understandable when you realise that, come 1980 (unless there is a change of government heart in the meantime), the Canadian federal government will no longer meet half of the cost of hospital care and all the cost of most primary care.

The federal government took this decision in June 1975, giving provincial governments the required five years' official notice of its intention to terminate the present hospital cost-sharing agreement and, at the same time, to set specific limits on the cost increases that it is prepared to accept in the medical care plan (as it has since done for 1976-77 and 1977-78).

The hospital cost-sharing agreement has been in operation since 1958, and the medical care plan which covers the cost of general physicians' services outside hospitals, since 1966. Their threatened and actual restriction, as one might expect, has caused considerable retrenchment in the health services provided in most provinces. Hospital beds have been withdrawn, and patients are spending less time in hospital and more as outpatients, day patients and home care patients. The number of staff employed on health work is dropping and there is a shortage of jobs in the health services, especially for newly graduated nurses, many of whom have been forced to migrate south to the USA where there are still vacancies and the money to pay for them.

National inflationary measures have had some effect on this regrettable situation, by forcing trade unions to reduce wage

claims and companies to accept lower profits. Many hospitals are nevertheless still curtailing existing services and few if any are introducing new ones, while immigration of health professionals has been radically cut; in the case of doctors, for example, by something like five-sixths over three years—1147 immigrants in 1973, 200 expected in 1977.

Most provinces have also introduced regional health policy-making throughout their territories, with a series of advisory area health councils now set up and becoming more and more involved in examining capital schemes, requests for major items of new equipment and the general rationalisation of services.

These Canadian area health councils are obviously creatures of the same genus as the new health systems agencies (HSAs) set up in the USA. One of several examples of increasing government regulation in health care in that country since Medicare for the aged and Medicaid for the indigent were introduced some years ago, the HSAs, while officially concerned with long-term planning of hospitals in their areas, are felt in practice to be primarily interested in controlling and limiting capital expenditure on new building and equipment as well as influencing the design and development of services.

Other regulatory mechanisms introduced in the USA, especially since the passing of the National Health Planning and Resources Development Act of 1974[24], include the wider establishment in hospitals of professional standards review organisations (to assess the need for, the cost, the appropriateness and the quality of care) and, in at least one-quarter of all institutions, a system of control of the payments made to them by independent hospital rate review commissions, by Blue Cross Insurance plans and by state hospital associations.

These sorts of controls, particularly over hospital prices, taken in conjunction with a clear decline both in public philanthropy and

in the popularity with investors of capital funding of hospitals, suggest that American hospitals will have to tighten their belts and watch their expenditure much more closely in the future. Gail Warden explained in his paper

> 'During the past two years we have witnessed the replacement of some retrospective reimbursement plans with prospective reimbursement formulae which are designed for better cost containment. This is a growing trend and we believe a lot more work needs to be done in the area of prospective reimbursement which will more or less force the hospitals to operate within pre-determined budgets.'

Towards Central Control

Clearly this sort of development, taken along with the voluntary sharing of services now being looked at very seriously—not just in the USA but in Canada and Australia also—illustrates a concern over rising costs and a belief in the rationalisation of services in the interest of the patients; this is little different in essence from the more formal government-inspired suggestions made in the UK by the Resource Allocation Working Party (RAWP)[8] which are designed to control health care resources more closely and to re-allocate them more equitably throughout the country.* Admittedly, it may be argued that the USA and other countries (unlike Britain) are doing the right thing for the wrong reason—for fear of government control than because of a true belief in equality—but, nevertheless, we are all following a not dissimilar path and, oddly enough, as a result, services may improve for many people (rather than the opposite) even in such doleful times of shortage of these.

*See also Ian Beach's paper (pages 29–37) and John Hoare's paper (pages 106–112).

What the papers and the ensuing discussions indicate about health care trends, not just in the countries represented but throughout the world, is that in some ways the international health scene is reminiscent of one of those old eighteenth century maps. At each corner an identical cherub puffs out his inflationary cheeks to blow the winds of change around us all no matter where in the world we live. And although like straws in the breeze we each swirl and dance the special jig that our own particular circumstances demand, in the end we are all swept along in the same general direction by the same broad financial forces.

We all want to give our sick people better care; we all want a more equitable division of care among them; we all want to change our 'Cinderella' services into princesses; and we all want the best possible value for the money we spend.

The trouble is that we are all short of cash—and for this reason alone, whichever way you look at it, it seems inevitable that the puffing cheeks of those inflationary cherubs are blowing us into the arms of our national governments. This is mainly, but not solely, because they are the only financiers who have enough money to give us, as providers and consumers of services, anything like the standards we want. It is also because governments are, after all, the people's representatives, and in the final resort should be the ones to decide what people can and cannot have in the way of health services with the necessarily limited national resources.

So whether you follow the UK line of trying to 'rawp' your way to a more rational service; whether you do things in the Australian or Canadian style, and let your local parliament (state or provincial) each do its own health care thing in its own way; whether you play it 'Kiwi' fashion, have no health care policy at all, and just let things happen; or whether you adopt the American pattern of mainly private provision, plus a growing public service for those who cannot pay—undoubtedly with the present world

economy and in the face of scientific medicine, one of two things is bound to happen.

Either, in the not too distant future, you will find yourself with a national health service of some kind or other, mainly state financed and therefore state organised and controlled; or you will find that the alternative is to have in health care terms what the Victorian prime minister, Benjamin Disraeli, called 'two nations', with first and second class citizens getting first and second class care depending on whether they are private or public patients.

It will be interesting to see exactly where each of the countries represented at the seminar will be along these particular roads two years from now. On the admittedly limited evidence of this seminar, while some seem certain to continue for a while dabbling and dallying with the 'two nations' approach, most are more likely by then to have moved a step further towards a system financed and controlled by central government.

Note: Administrative Structure of the Reorganised NHS in the UK

For the information of readers from other countries it should be explained that the revised administrative structure introduced into the NHS in Britain in 1974 is designed primarily to provide, through comprehensive health authorities, an integrated service on an equitable basis to defined geographical communities.

Although the structure differs slightly in each UK country (England, for example, being the only one to have health regions; and Northern Ireland the only one to have health and social services under a single administration) its bases, as explained above, are essentially the same.

In each case a central government department, such as the Department of Health and Social Security in England, is concerned with

national strategy and overall financial allocation. Below central government level comprehensive health authorities administer services to given populations which coincide as far as possible with local authority areas.

In England these comprehensive health authorities consist of regional health authorities (RHAs—of which there are 14), and area health authorities (AHAs—of which there are approximately 90). Many of the area health authorities subdivide into health districts which are administered by an interprofessional district management team which works on a consensus basis and is responsible directly to the AHA.

II Introduction of Medical Developments, Choices of Priorities for the Community Served and Changes in Configuration of Services

1

An Introduction—a Physician's View

STEPHEN J G SEMPLE

It is sad that the contributors in this section are concerned predominantly with the methods of choosing priorities when resources are being cut back rather than expanding but that, alas, is the situation which most of us are facing. The excellent papers which follow, by Ian Beach, John McClelland and Bernard Snell, summarise very well the difficulties in planning the distribution of resources and in determining priorities in medical development. I shall therefore try to avoid covering the same ground. Instead I hope to present a viewpoint of a physician, teacher and researcher on these difficult matters.

'The administrator' or 'the administration' are terms often used very loosely and sometimes bordering on abuse! In this chapter I identify the administrator as a person trained and involved in the formulation of policy, planning and management of health care. The terms are used with respect and in appreciation of the important role which administrators must play in any health service.

It is surprising to me that none of the contributions mentioned the effect of undergraduate teaching, postgraduate teaching, research and the national role of teaching hospitals on

the allocation of resources. These matters are always conveniently tucked away as the responsibility of the universities, research councils and the various societies or trusts which provide money for research and teaching. No hospital which trains doctors and specialists and provides facilities for research can be denied a national role; the majority of doctors trained will move away from the area, and the fruits of research are available to all. University hospitals are the concern of the nation as well as the district, area or region they serve, however these terms are defined. The importance of medical education to the administrator is obvious, for he is concerned not only with the standards of medical care, but also in ensuring that the next generation of doctors understand more closely the importance of the best allocations of resources in medicine. It is here that the administrator can act as a catalyst by trying to persuade medical schools of the need to educate doctors in decision-making on resource allocation, whether this be at the national level or within a district.

In these days of financial stringency it might be argued that we can do without research in our hospitals and just take up the advances of medicine as they arise in other more prosperous countries. This overlooks two important points. The application of new knowledge and techniques to clinical practice and their incorporation into medical education cannot be carried out instantaneously. A country needs the appropriate experts to evaluate new advances elsewhere and to have the necessary knowledge and skill to implement those of value. Such expertise is acquired only by individuals active in the field of medical practice and in research. Only by research does one acquire the experience and knowledge necessary to detect the weaknesses as well as the advantages of an advance. In short, the decision-making process on the allocation of resources needs the participation of the expert, and no research means no experts.

I have laboured these points because the interests of the district, area or region may, and will, often conflict with the national role

of the hospital in education and research. This fact cannot be ignored and I believe it implies an acceptance of the need for centres of excellence. The cost of technical support, equipment and back-up facilities such as computers and libraries needed for present day research implies that for purely financial reasons, if for no other, research and education must be concentrated in centres and not randomly distributed throughout district general hospitals. The teaching hospitals must therefore provide a general clinical service for their catchment area, as well as specialty services for larger regions. In addition, they must provide facilities for undergraduate and postgraduate education and research. These I believe are the purposes and objectives of teaching hospitals. At the moment there are no clear guidelines from our political masters as to whether they accept these objectives or not, and if they do accept them, whether they are prepared to define the basis of priority in resource allocation which is necessary to achieve them.

The contributors to the seminar have quite rightly drawn attention to defects of the medical profession in relation to planning of resource allocation. Empire building, fear of change, fear of job redundancy, private practice and jealousy of some colleagues getting more resources than others have all been itemised. In many instances these motives have a profound influence on members of the profession in matters related to the distribution of resources. In would be a pity, however, if administrators overlooked the good motives which lead clinicians to seek to acquire resources. Pride in the clinical service provided and a wish to advance knowledge in medicine are not ignoble motives. The confidence and optimism with which a clinician faces his patient, and the quality of service he provides, must depend on the clinician believing that his resources are adequate to provide a first-rate service as well as to enable him to remain at the forefront of his field.

Like Bernie Snell I am not certain what the future norms and values for health care should be. I am absolutely certain, however, that the medical profession could make a useful and profound impact on improving the supply of resources here and now by rationalising the use of drugs and the range of special investigations. The failure to do this is a far more relevant criticism of the profession than those included in the contributions of Ian Beach and John McClelland.

In the long term I believe the profession must turn to a study of cost-effectiveness and cost-benefit analyses.[25] It is fair to criticise these techniques as inadequate now but their faults are those which attend the introduction of a discipline or science with which the medical profession is not familiar. Disenchantment with the initial results of study must not deter clinicians from trying to refine the methods so that they achieve the necessary scientific and ethical standards.

In the last 15 years there has been a profound change in the way hospitals are managed, which has been of undoubted value. The methods of decision-making and their implementation have been revised and defined anew so that hospital administration has passed from the amateur to the professional. In spite of this and the introduction of the reorganised health service good planning remains as elusive as ever.

As Ian Beach has pointed out, this should not be so. The norms for provision of health care can be, and often have been, defined and it should not be too difficult to allocate resources to meet these norms and hence the needs of our patients. Why is this not possible? Obviously one important factor here is the present financial stringency which will mean that some districts will be unable to meet the required norms. However, a financial cutback does not preclude good planning. By good planning I mean the provision of the best possible health care for the community within the limits of the resources and budget of the district.

It is now more readily appreciated that the cost of health care must be limited and even reduced in some areas, and this altering climate of opinion makes change more readily acceptable and good planning possible.

What then are the necessary conditions for good planning in a period of restraint, cutback and reallocation of resources? There are, I believe, at least three such conditions.

The first is time for change, and by 'time' I mean five to ten years, and in some instances longer. It is not difficult to run a district more economically and yet provide a good or even excellent service if adequate time is given to choose the right (and not the easiest) hospitals and services to close or curtail. Transfer of funds and resources from the well endowed to the deprived takes time if it is not to cause unacceptable hardship. Decisions made in a hurry make errors of judgment and planning more likely. Further, the recipients of transferred resources require time to make the necessary planning decisions to utilise these resources to maximum advantage. The methods used by the district management team in Leicester are fine, but are only possible in an area of growth, however limited. Provision of the optimum time for change automatically entails the provision of extra funds for health care during the transition period from one level of funding to another. Whether these extra funds should be provided is a political decision, but if they are provided and are used for the purpose for which they were intended, then the long-term benefit to the health service is likely to be substantial.

The second requisite for good planning, in a period of restraint or cutback, is appropriate administrative machinery to effect the necessary changes, as well as men of ability and experience to work that machinery. Whatever one may say of the re-organised NHS, it is certainly better placed to effect the necessary change than was the previous system. I know of no

way of assessing if there are enough able administrators for the purpose, but with the large increase in posts consequent upon reorganisation of the NHS it is likely that for some years a shortage will be inevitable.

The third requisite is the political 'will' and political 'muscle' to effect the necessary changes in the allotted time. Opposition to cutbacks in resources will come from doctor and patient alike.

In my view none of these three requisites is met, so that at present good planning and the proper deployment of resources are not possible. There will always be a difference of opinion between government and governed as to what is a reasonable length of time for good planning for change. To my mind the present time schedules for change take insufficient account of the restrictions which districts, areas and regions face when attempting to effect that change. These include no redundancies, an embargo on cuts in certain specialties and the consultation procedures required before changes are made. The length of the consultation procedures which have to be followed before a unit can be closed in the UK often means that the savings from closing a unit come long after the cut in resources has been made. In this situation temporary restrictions on vital clinical services have to be introduced to achieve the necessary savings.

Although the means for change are present in the reorganised National Health Service, there is no evidence that they are being used. Regional planning is painfully slow or non-existent, especially in the Thames regions. This makes long-term planning at area and district level very difficult, and in some instances impossible. However, perhaps the most serious deficit at present is the lack of political will to effect unpopular decisions which involve cuts in facilities to a community such as the closure of a unit or hospital. This lack of will extends from government ministers through politicians, bureaucrats in central government to those in regional health authorities.

All these factors make planning at area and district level very hard. In these circumstances there is a strong temptation to cut what is easiest, rather than what is most appropriate for good planning and the best distribution of resources. It is often claimed, on economic and other grounds, that it is bad planning to deal with cuts in finance by short-term measures such as the temporary closure of wards or reduction in clinical services. In fact, this may not be such a short-sighted policy at district level as it may appear, for it 'buys time' until the best measures for the deployment of resources can be identified, planned and executed. It is particularly advantageous when difficulties in choosing priorities are caused by delays in national or regional planning.

This contribution may justly be criticised on the grounds that it has been concerned almost entirely with the allocation of resources in relation to curative rather than preventive medicine. The need for a greater diversion of funds for research into preventive medicine is accepted by the majority of the profession, but some caution is needed when relating it to planning and health education. The impact of preventive medicine on disease in the future is unlikely to be felt for a long time; for example, in spite of considerable research, preventive measures have had only a marginal effect, if any, on the incidence of coronary artery disease. Secondly, it is unwise, for many reasons, to try to impose 'life styles' on people which they do not particularly relish if the evidence of benefit from a change in life style is not proven.

This chapter should at least go some way, I hope, to convincing administrators that they must be both innovator and catalyst. Indeed, if this opportunity is not offered to the administrator then that profession will not attract able men. I have been fortunate to be associated with excellent administrators who have triumphed, with humour, over financial difficulties, stifling and incompetent bureaucracy and fickle demanding colleagues, to the benefit of the institutions they served.

Acknowledgement

I am grateful to David Knowles for his comments on my contribution to this book and for his help in understanding some problems of administration. The views expressed in this chapter are not necessarily held by him.

2

Notes on the Decision-making Process and the Allocation and Use of Resources in the Health District

IAN H BEACH

In Britain, the comprehension now developing in management teams about the scale of need of the health service consumer and the efforts being made by the teams to refine options to meet these needs, at a time of limited or negative economic growth, are evidence that at least part of the potential arising from the reorganisation of the National Health Service is beginning to be realised. Even so, looking back to 1974, it appears that there was an over-optimistic belief that the fundamental management problem of distributing resources in the NHS would, at least, be greatly relieved and, at best, might have been cured by restructuring the service. Indeed, in 1974 this hope was manifest in much discussion about the potential for shifting the balance of resources between health care groups. At that time, the differential provision between the acute and the long-stay services, and between institutional and community care, was frequently being referred to by health professionals and politicians alike. The emphasis in the revised structure on elaborate planning mechanisms and on multidisciplinary management, embracing the full involvement of clinicians and nurses, was seen as one means of creating the climate for redistributing resources between care groups within a health district. How that redistribution was to be achieved in practical terms was less clearly defined. Experience suggests that

there was nothing inherent in the new multidisciplinary structure to make those specialties which were relatively well endowed any more willing to release their resources to the deprived specialty than they were before. Indeed, depending upon the clinical representation on the district management team, the re-allocation of funds locally may be more difficult than before.

At the time of reorganisation, when the British economy was growing, there was perhaps a reasonable prospect that management teams would at least be able to channel new monies into deprived care groups even if they could not speedily alter established patterns of expenditure. However, times have changed; stringency is the financial watchword and the recommendations of RAWP are known. With the publication of the RAWP report[8], emphasis has been given to the broader national issues.* Energy which earlier might have been put into determining the most effective local use of current assets has been diverted into wider battles over the effects of the national redistribution of funds. Teams have been set against teams in the process of defending or challenging current allocations and as much energy has been dissipated by the relatively well endowed regions in resisting the proposed reduction of their assets as has been used by the deprived, spurred on by the prospect of a more equitable allocation if only the RAWP recommendations could be put into effect.

Despite this skirmishing, the prevailing scarcity of money may still emerge as a beneficial force if it has the side effect of bringing home to health professionals as much as to the public that growth cannot be infinite, that there must be limits to the scale of provision for different care groups and that, as a consequence, choices must be made. It follows that teams must now prove themselves to be managerially able by demonstrating that they can come to grips with issues at times of stringency as well as in the days when funding is less of a problem.

*See also John Hoare's paper, pages 106–112.

Resource Allocation—Reconciling the National Formula with District Realities

It is sufficient here to highlight the essential characteristics of the national formula before contrasting these with the approach at operational level. The national concept is one of apportionment of resources according to adjusted population and morbidity rates, tempered by other factors such as local responsibilities for undergraduate medical education. The objective of these calculations is to ensure that an equitable allocation is made to each region which, in turn, will make apportionments to areas following broadly similar calculations. In the longer term these allocations will take no account of services already provided in an area but in the short term the formula cannot be strictly adhered to, as health authorities must have time to modify the scale of their services to meet the prescribed allocations.

By contrast, at operational level, different formulae are used to measure the scale of provision. Here, the approach advocated is to measure the prevalence of services, such as the number of geriatric beds for a given population, against norms of provision, thereby testing the adequacy or otherwise of the local facilities. The problem is that even if the RAWP proposals were fully implemented, the funding level in each district would still not necessarily be adequate to meet the prescribed service norms as there has been little attempt to relate the two types of formula one with another.

The district management team therefore is caught between the national formula for resource distribution, the norms of service provision and the local aspirations of respective care groups, health professionals and the public. It is this team at operational level which receives whatever allocation is finally made and which must contain the many pressures for expenditure generated both in and outside the service. It is here, close to the point of care, that the central issue in the management of the NHS is particularly

noticeable: how to deploy finite resources to satisfy a potentially open-ended demand for a service delivered by clinicians whose ethical responsibility is to the patient for proper care, and not to the state for the conservation of scarce funds.

To help cope with this problem, it was advocated in 1974 that there should be a comprehensive planning system. A draft planning guide in 1975 made clear the importance of this approach in so far as the district was concerned.

> 'District plans will provide the basis for all annual planning in the NHS. The value of all NHS planning, therefore, depends ultimately on the skill, imagination and diligence of planners at District.'[6]

Few administrators or their teams (at least at district level) would challenge the assertion that the last three years have called for 'skill, imagination and diligence', but they may be less certain that the liberal use of these qualities has yet brought order to the process of distributing resources in the district to a similar degree apparently manifest in the tidy national formula. To be fair, the situation was anticipated in the RAWP report.

> 'Resource allocation is concerned with the distribution of financial resources which are used for the provision of real resources. In this sense it is concerned with the means rather than the end. We have not regarded our remit as being concerned with how the resources are deployed.'[8]

Yet if any benefit is to accrue from the recommendations of RAWP, its theories on allocation must be capable of practical application in the districts, and, for this to be so, district teams must be able to manage change generated by national monetary policy as much as by internal initiative. However, experience so far suggests that district teams have not yet been able to prove conclusively that they can shift the balance of care anywhere

other than at the margin of expenditure, unless they are obliged by exterior forces to act more drastically. Why should there be this inertia? The reasons are many and may not always be the same in each district, but perhaps the three key limitations which circumscribe the actions of management teams are inflexibility of assets, political considerations and clinical restraint.

Inflexibility of Assets

One of the principal difficulties facing the management team is the relatively fixed nature of its finances, both revenue and capital. Some three-quarters of expenditure goes towards staff salaries but while, in the longer term, it is possible to redeploy staff, this can rarely be achieved quickly. In practice, many professionally trained employees possess an inbuilt bias towards a given type of service and represent an expensive investment in specialist skills which would be difficult to use in a radically different way. For example, the abilities of a clinician are developed over many years and cannot easily be diverted from one specialty to another, nor can the number of specialists be increased quickly. To a lesser extent, these limitations also apply to nurses—the largest employee group—who may, for example, be trained for acute surgical, psychiatric or other specialist care. Thus the service is shaped very much by the characteristics of the employees' skills, and no redeployment of financial allocations between care groups will automatically bring about a variation in the nature of care available. Secondly, the style and extent of the clinical service which can be provided are also heavily influenced by the existing availability of capital facilities. For example, many management teams administer psychiatric hospitals set in isolation in the countryside when it would be clinically preferable for some of the work of these hospitals to be undertaken in acute-care units. However, capital tied up in these fixed assets is difficult to release at local level, and while it is true that management teams have a responsibility to perceive opportunities for change, they tend to

be dependent upon regional allocations to build alternative facilities to make possible significant variations in the pattern of care.

Political Considerations

In a service concerned with human problems as intimate as personal health, it is inevitable that political considerations manifest themselves at both party and domestic level. Predictably, one of the most powerful forces in the organisation is medical opinion which, as a general rule, tends to adopt a conservative stance towards innovation which requires the redeployment of resources to less glamorous though needy specialties. Possibly this comes from the medical power structure in which the degree of influence wielded by individuals tends to equate with the levels of respect engendered by the specialty. Because, at least until now, the acute care specialties have tended to interest, and therefore to attract, the more distinguished clinicians, it has followed that they have been well placed to use their political weight to resist modifications to the extent to which they absorb resources.

Outside the institutions, political considerations are similarly manifest, especially when resource redistribution is being debated. The community health councils, whose specific role it is to review proposals for any significant change in the use of hospital facilities, ensure that such alterations cannot be brought about without the political seal of public approval, however logical the proposed variation may be. To make matters more difficult, the complexities of the various issues which bear upon decisions to redeploy health facilities are often so great that it appears that even well informed laymen find them difficult to comprehend. The consequence is that the public is often encouraged to take the simplistic view that any variation in provision is to its overall detriment. Thus, the public is unwilling to support such proposals even though the ultimate objective is the enhancement of a less well endowed

and more deserving sector of care. From this it appears unlikely that a concept such as cost benefit will be accepted any more readily by the public than by the clinical establishment as the basis of assessing the value of change in the health service. Thus, the management team, in its pursuit of the optimum use of resources, must tend to resort to more indirect measures to ensure that the patient has the level and kind of service he really requires.

Clinical Constraints

The maintenance of clinical freedom is paramount to doctors whose understandable determination to preserve it stems from their perception of the potential of the state machine to intervene in the relationship between themselves and their patients. It is the doctors' counter to any suggestion that they might modify their practices for reasons of cost. It is justified on grounds that each patient places his faith in his clinical adviser to prescribe the best possible treatment, and that this trust would be impaired if the patient believed that before deciding which treatment to specify, his doctor had to weigh the relative expense of one against another rather than their relative effectiveness. That this philosophy of clinical freedom, which is claimed by the clinician, is at least in part a myth (for each practitioner's decisions are constrained by factors such as availability of beds or operating time) does not prevent its use to counter proposals for change which might curtail the activities of the individual doctor.

It is no criticism of the individual doctor that he works within a profession which has adopted this stance. But the fact that it is the acute, and thus, to the public, the more dramatically appealing, specialties which incur the expensive treatments, does not make any easier the role of the management team which is concerned to ensure the equitable use of resources for the benefit of all health care consumers.

In addition, management teams must also cope with a further inbuilt resistance by clinicians to the acceptance of resource constraint which is induced by the nature of their training. No hospital doctor is regarded as fully qualified until he attains consultant status, and there is often emphasis in the junior grades on innovation and research which is in keeping with the continuing educational process. Thus, by the time a doctor becomes a consultant he has an inbred attitude of enquiry towards the practice of his own discipline—a fact which is particularly evident on the appointment of a new consultant following a colleague's retirement, when requests flow in for additional equipment, drugs and staff, without which it is claimed (despite evidence of the recent past) medicine cannot be practised adequately.

Conclusion

In the face of the anomalies between the national resource allocation formula and the local norms of provision, and with so many other constraints to contend with, what contribution can the district management team make to the allocation and use of resources? Structurally, it is this team which, on behalf of the health authority, is vested corporately with responsibility for managing the district's services within a prescribed budget. Yet the nature of the health service means that teams are not cast in an authoritarian role. Indeed, despite the managerial responsibility placed upon the team, there are many others, including the health authority, the Department of Health and Social Security and senior health professionals, who would claim to play a significant if not an overriding part in determining the way in which resources are deployed and used in the district. The truth is that a combination of influences determines the ultimate pattern of expenditure. But if we draw attention to the clinicians' conservative approach to changes in the pattern of care, we must stress equally that by tradition it is they who have also articulated the needs of

patients. For, as long as the doctor continues to bear ultimate responsibility for the care of his patients, it must follow that he is very largely free to determine the nature and hence the cost of the care afforded to those patients. Conversely, it is the team's duty to take a lead in creating a framework of care which is equitable in its provision for all types of patient. To accomplish this, the team must measure the adequacy or otherwise of the scale of services provided and must take steps to rectify imbalances in resource allocation. Thus, the extent of the resources given to the care of the individual patient will be determined more by the health professional than by the management team, but it is the latter who, having considered the existing pattern of care and the many proposals for change and development, will influence the scale of the provision to be made from the resources available.

3

Anomie

BERNARD SNELL

I have chosen 'Anomie' as the title of my paper because I believe it is a word which aptly describes the dilemma facing many of those who are responsible for the planning and operation of the health care system in Canada, and while my paper relates to the Canadian scene, I am satisfied that the problems arising out of anomie are not unique to our country.

Anomie is a condition of a group, or of a whole society, in which older, common values, and sometimes even common meanings, are no longer understood or accepted, and new meanings and values have not yet been developed. In other words, it is a state of standardlessness, normlessness, valuelessness. When an individual becomes anomic he exhibits behaviour which is illogical, irrational, and uncoordinated; and it appears that anomic society does the same.

Anomie has been at the root of much of our vacillation in the health care system over the past few years and, I believe, has to do with many of the problems we are discussing.

These problems are not new; they have been faced by society many times. A reference to what may have been the first time

is contained in *Wisdom of the West* by Bertrand Russell writing about classical Greece.

> 'If there is one thing that practical men have no time for it is an issue that remains open. To those who want to get things done merely to be active, an undecided question is anathema. This, on the whole, was the predicament in which the Sophists found themselves. The conflicting theories of the philosophers held out no hope that knowledge was possible at all.'[21]

The Greeks obviously found an acceptable solution, for Russell continues

> 'Since the Sophists felt that knowledge could not be had, they declared that it was unimportant. What mattered was useful opinion. There is of course some truth in this. In the conduct of practical affairs success is indeed the one overriding consideration.'[21]

There is something to be learned from this. Until a decade or two ago, the health care system was developing along lines directed mainly by professional imperatives, and the most influential profession exercising its imperatives was, of course, the medical profession. As a result there has developed, at least in North America, the term 'medical model', with its recent pejorative connotations. Initially governmental and private plans for broad health care systems and developments did not challenge past standards, but merely accepted them and created systems to implement them.

With the wisdom of hindsight, we may be able to see that some of these standards were inadequate and did not serve society's health care needs, and we may in fact agree with Adam Smith that 'People of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public or in some contrivance to raise prices.'[22]

Nevertheless, imperfect as our past standards were, they were all that we had, and in those days we followed them without doubt or hesitation and we created a level of health care in the western world which served several generations and which continued to improve.

It is true that these improvements were neither comprehensive nor spread equitably throughout our populations. Many of the advances were in technology or science and they lacked a sociologic or humanitarian dimension, so that latterly it was recognised that some advances seemed to be dehumanising to those very people they were intended to serve.

This process of gradual disenchantment with our past standards and norms occurred, of course, against the larger backdrop of a society with changing attitudes in many areas; a society becoming more iconoclastic and cynical, more critical of tradition, not necessarily because tradition was wrong but simply because it *was* tradition. The result has been a denial of the past and a revolt against a dominance of certain professions (best exemplified by those who want to get out from under the medical model). These positions are taken by many groups in our society—the poor, the minorities, the politicians, the bureaucracy, various health professions, economists and even administrators. These groups, of course, have their own strongly held beliefs and prejudices, and while one will attack the traditions, standards and norms of others, it will defend its own against all comers.

I believe it would be of value to define two other terms.

A *norm* is a rule or authoritative standard which enables us to distinguish good from bad.

A *value* is a preference which may be expressed by an individual.

Having rejected the norms and values of the past, we have been left with the problem of what to put in their places and we have come up with—nothing. Of course, there have been panaceas declaimed, many models proposed; some have appeared on the surface to be quite plausible, but for the most part they have merely served to demonstrate how inexact is the science of serving people's health needs and how much cause-and-effect relationship in health care is assumed without any real proof. As a result there has been a widespread reluctance to accept and identify with these new models and there has been a dearth of leadership in the promotion of them; so we have arrived at anomie.

I have introduced my paper with these comments because I believe that anomie has been at the root of the lack of a sense of direction in health care in Canada over the last few years.

Continuing now with the aspect of the seminar on which I have been asked to give my views, I should like to make the following points, using as supportive examples recent developments in health care in Canada.

Introduction of Medical Developments

Many of the developments in the health care system have been technological, and in the past were introduced without any soul searching. Today, however, even technological developments create their own problems. A good example of this is computed tomography (CT) in radiology. While Canada does not appear to be suffering from 'CAT fever', which I am told is a new epidemic disease in the USA, the introduction of a CT scanner has shown that, even where there is evidence of cost effectiveness in the use of capital-intensive equipment, governments are cynical and afraid to invest in them. On the other hand, it has forced a more rational and regional approach to the use of these expensive forms of care. In Alberta, where the EMI scanner has been in use

for over two years, only two such pieces of equipment were initially authorised by the provincial government to serve a population of two million people. As in many other centres, we have demonstrated quite clearly that not only have patients been able to be investigated non-invasively and, in some cases, as outpatients, but that other more invasive diagnostic tests have been obviated and some surgical procedures shown to be unnecessary. It appears clear that, with the developments in whole-body scanning and the wide application of CT scanning, capital investments will have to be made in many hospitals to take advantage of this skilled diagnostic technique, and that offsets to the capital and operating costs will be substantial.

Choices of Priorities for the Community Served

This heading reminds me of the story of a statistician who did a cost-benefit analysis of a variable number of deck chairs for the Titanic. Sometimes I wonder whether we, too, are not involved with similar irrelevancies in trying to choose priorities.

Victor Fuchs has said that it is romantic to try to distinguish between needs and wants[3], and whilst this often seems to be true in health care, many of our detailed activities are in fact attempts to separate these two closely related words. In order to help us do this, area planning councils are being set up across our country. Canada consists of ten semi-autonomous provinces under a federal system of national government. As a result, these planning councils differ from province to province. Nevertheless, they are tending to become more effective and influential in planning for the future. In most provinces, new programmes do not have much chance of being implemented unless they are first approved by area planning councils. Although hospital administrators often feel concerned because the composition of the planning councils tends to exclude experts and to include representatives of the consumer, the councils are, nevertheless,

becoming a force to be reckoned with in determining priorities in health care for each community.

As a result of the enormous increase in the cost of health care services in the first five years of this decade, there has been a general moratorium on new hospital construction. Most hospitals being built today in Canada are replacements for old and outmoded facilities rather than new or add-on facilities.

Canada's federal government, with the active support of the provincial governments and the medical licensing authorities in each province, has put a very severe restriction on immigration of physicians and, moreover, has made it more difficult for such physicians to obtain licences to practise in Canada, even if they are able to become residents.

There has been a increasing recognition of regional programmes over the last two or three years. In almost all provinces such programmes as renal dialysis, renal transplantation, open-heart surgery, neonatology, high-risk obstetrics, and other tertiary care services, are being organised regionally rather than simply being developed by individual institutions following their own institutional imperatives. Area planning councils play a significant role in this development.

At the time of the first seminar, *A New Perspective on the Health of Canadians*[15], written by Marc Lalonde, the national Minister of Health, had recently been published. It pointed out that emphases and priorities have all been wrong in the past and that our focus of attention should be on prevention of disease and health maintenance, primarily by changing our life style and by the acceptance of individual responsibility for maintaining health. Now, two years later, things do not seem to have changed very much. There seems little enthusiasm amongst Canadians to change their life style; not even the Olympics had any effect on that. Governments have been slow to implement obviously needed changes,

such as the creation of effective seat-belt legislation, ways to reduce the carnage due to drunken drivers; and legislation to reduce the incidence of industrial accidents has been inadequate and poorly enforced. On the border between Canada and the USA, international cooperation on pollution of the Great Lakes has also been slow and unsatisfactory. Mercury pollution from industrial activities affecting our Indians has become a national disgrace, and yet no major rumpus is being raised by any influential establishment or organisation. The noise all seems to be being made by people on the periphery.

It seems that there is still a lack of central direction in disease prevention; an inability on the part of various levels of government and of the professions to get together. Each seems to be waiting for someone else to act. There are a few exceptions to this, such as the recently published federal brochure on sport participation in Canada* which is the basis of a campaign towards physical fitness.

There is still no evidence that most individuals are accepting the fact that they are themselves responsible for their own health maintenance and health care, and we still have eleven separate health insurance programmes with gaps and overlaps to create work for the bureaucracy.

A campaign recently launched was exemplified by a publicity release stating that alcoholism is a problem and should be addressed, not only in relation to the 700 000 confirmed alcoholics in Canada, but also to the 12 million moderate drinkers. However, even here, the government has taken the position that alcohol is woven into the fabric of our society too deeply to be eliminated entirely. Federal government has rejected a total ban on alcohol advertising because of the effects on jobs in the industry. There are said to be 100 000 such jobs in the Province of Ontario alone.

**Sport Participation Canada 1972. Physical Fitness? Who Needs It? A Case for Regular Exercise.*

The programme therefore consists of a massive educational campaign with funds coming from government and, surprisingly, from the drinks manufacturers.

Changes in the Configuration of Services

Over the last couple of years there has been a substantial increase in the development of ambulatory care programmes based in hospitals. An example of this is in the Royal Victoria Hospital Polyclinic in Montreal. At the University of Alberta Health Sciences Centre in Edmonton, our goal is eventually for all, or most, of the physicians practising in the hospital to have offices located within the centre rather than on two sites—an inpatient practice in the hospital and an office practice some distance away. Whilst this may be the norm for many other countries, it has not tended to be so in North America.

Mental health is still a difficult area in Canada. We have so far not managed to integrate this important component of the health care system with all the others. Too often decisions are made relating to mental health without any balancing decisions in the other parts of the system. For example, traditional mental hospitals are closed or reduced in size and substantial numbers of their patients 'liberated' into society without assurance of means of caring for them other than on a demonstration model basis.

An example of a demonstration model is the development by some hospitals of external psychiatric services which enable patients, who otherwise would have to be admitted to the hospital or to the mental health service, to go to hospitals in their own communities for treatment as day or night patients. These programmes, however, are too few to deal with the large volume of patients needing help.

When unbalanced decisions of this sort are made it is hoped that the health care system will respond by shuffling its resources and patients around so that eventually the patients will receive the right treatment in the right place. This often does not happen and then the problem shrinks back into the acute hospital setting because other facilities are unable to deal with it.

General Comments

The above examples of some of the problems and developments in Canada may be matched by similar experiences elsewhere. From our experience a number of truths appear.

There is really no way to transfer the cost of health care from people. The individual will pay for it in some way: directly in the form of fees or bills, paying premiums to a health care system, through provincial or federal taxes, through sales tax with concomitant increase in price, through lowered wages because the employer has to pay for his share of the cost. And yet our governments and our professions keep looking for the magic way to make the costs disappear.

As an inheritance from the more simple age of reason and science we still seem to be unable to accept the fact that some health care problems have no known solutions. Because we no longer accept the norms and values of the past and have failed to develop acceptable norms and values today, we must recognise that we do not have the means to solve some of our problems. Many segments of our society simply cannot accept this fact.

When decisions must be made, only some of them can be made within the hospital or by the health professions involved. Others, particularly those related to certain ethical and social choices, have to be made on a broader base, or, to put it another way, at

a higher level. These decisions are made by governments and are often then imposed upon the health professions and institutions.

There appear to be some as yet unnamed laws which create a situation whereby the supply of, and the demand for, health care resources are never in balance. This year we might appear to be producing too many physicians, whereas in a few years' time, when the demand is perceived to be greater, we will have by then responded and be producing fewer. Similarly, in the past year or so, as a result of a forced closure of beds in the acute hospitals across Canada, we now have too many nurses. We no longer raid Britain and other countries for nurses, but rather lose nurses to the USA. This, too, could easily turn around suddenly.

It is also interesting to note how our various provincial governments achieved bed reductions. In one province there was a deliberate attempt by central government to close specific numbers of beds in named hospitals or even to close whole hospitals. The local community resisted the government's decision and the attempt was far from successful. Its intention, however, was to close several thousand beds in the province and to disestablish several thousand staff positions in the hospitals of that province. At the other extreme, another province simply allocated less money to the hospital system than would rationally have been allocated had the 'correct' factors been applied for inflation, allowances for full annual costs of developments and volume increases. Each hospital found its budget allocation insufficient to carry out full operational programmes during the course of the year and therefore 'voluntarily' closed some beds during some of the year. This appears to have been more successful and also created a surplus of staff in relation to jobs.

Perhaps these experiences support the belief in Canada that most regulations on health care applied by government do nothing for cost control or quality.

Many anomalies arise in times of constraint, among which is a separation of cost from efficiency. The main thrust at the present time appears to be reduction in cost. On the other hand, more efficient use of resources, which might result in a slight additional cost but a great saving in new capital development, is usually not acceptable.

Out of the problems faced by hospitals in Canada during the past two years of restraint I think we have learned one operating lesson, and that is that the name of the game is to be squeezed where it hurts the least. Each hospital, in its own individual circumstances and in facing its own different provincial game-play, has tried with varying success to do this.

4

The Role of the Chief Administrator in Relation to Change

JOHN E McCLELLAND

Despite his strident declaration of independence, the average Australian still has a considerable affection for England—the 'old country' or 'home'—and delights in the eccentrics which that country has produced. Perhaps chief amongst those eccentrics is King Canute, who is in line to become the *de facto* patron of an Australian society which prefers to pretend that change does not occur.

It has been said that when the end of the world comes, Australia will be the place to be because it will happen ten years later there than anywhere else.

However, so strongly do the forces for change operate in health care that even Australia has not been able to avoid their effect. Much as he might prefer an unchanging life of pure serenity, the health service administrator is caught up in this frenzied atmosphere of change and must learn to live with it.

Some of us had hoped that if we ignored the signs of change they would go away; others, like their cobber Canute, sought to order change to stop.

Of course, neither of these attitudes was effective and the result was that change came—undisciplined and uncontrolled to a potentially dangerous extent. The health services have been nigh overwhelmed by the changes of the past two decades, involving a tremendous appetite for resources with but marginally increased benefits.

If we measure resources in terms of money, we find that in the 1963-64 financial year $A879 million was spent on health in Australia and this had increased to $A5400 million by 1976.

These figures reflect the increased numbers and more costly nature of manpower engaged in the health services as well as the heroic efforts and vast expense involved in pushing the frontiers of ill-health back by even one centimetre.

The political reaction to this tidal wave of costs has been to force the public to purchase rafts from their own funds if they wish to ride out the flood. The philosophy seems to propose that if the patient has to meet the cost of his own raft he will either endeavour to avoid floods or accept drowning with good grace as a sort of self-inflicted wound.

The reaction of the health professionals has been even more reprehensible. They have been so busy extending their own empires, feathering their own nests and asserting their own importance that the health services have never been lower in the public esteem. The benison of caring has been replaced by the production-line.

Dr Barry Catchlove* reported a horrifying, but not unusual, episode.[1]

*B R Catchlove FRACP FACMA AHA, Director of Medical Services and Deputy Chief Executive Officer, Royal North Shore Hospital, Sydney.

'Mrs R was admitted to a large Sydney hospital on 19 January 1975.

'She arrived at casualty by ambulance, having been found in pain by a neighbour. She had no relatives and lived alone in a home unit. She had a long past history of peptic ulceration with a known gastric ulcer, episodic pulmonary oedema, pneumonia and pulmonary emboli.

'She had been previously admitted to the same hospital in August 1974 with a subcapital fracture of the neck of her left femur. A Thornton pin and plate had been inserted.

'Her past history also included a rheumatoid arthritis and advanced osteoarthritis of her hips and knees. She had also suffered from a congenitally dislocated hip.

'On the occasion of the 1974 admission she had complained of symptoms of peptic ulceration and had undergone tests and treatment in respect of this ulcer.

'On 28 August 1974 the patient stated, "I am now 84, I have had an ulcer for 30 years. The symptoms are not increasing. I can live with the ulcer but I cannot live with any more tests." She was discharged a week later.

'Between 19 January and 15 June, when the Lord or fate relieved her suffering, she had undergone five months of investigation and treatment for her gastric ulcer and the various conditions unearthed, or produced, by the miracles of modern medicine.

'One month before death, a brief truce was called and the patient transferred to a convalescence unit.

'Regrettably, she became the victim of cerebrovascular accident, followed by epileptiform seizures.

'She was readmitted and underwent investigations to elucidate the cause of her epilepsy. Mercifully, she died before diagnosis was established. During her hospitalisation she underwent the following investigatory procedures

39 biochemical profiles
45 haematological examinations
21 microbiological tests
2 bone marrow aspirations
11 chest x-rays
5 barium meals
16 electroencephalograms
1 brain scan
4 lung scans
1 gastroscopy
7 blood transfusions

'She had consultations on two occasions with gynaecologists, two occasions with surgeons and on one occasion with an ophthalmologist. At one time or another during the five months she had a total sum of 37 different medicaments.'

Every professional group in health care has been vigorously upgrading its academic requirements; no sooner is a new piece of diagnostic or supportive equipment designed than it becomes essential to the very life of our patients.

In the maelstrom of selfishness and irresponsibility the chief administrator has not played a very glorious part. He has tended to roll with the punches and to see survival as his goal.

One way to survive is to raise the expectations of his colleagues—ever to be proposing study tours and postgraduate courses,

scanning the trade literature to discover new and unheard of pieces of equipment, proposing new buildings to double the patient capacity and treble the staff satisfaction.

Are these the terms in which we see the innovative and catalytic role of the chief administrator?

If one accepts the definition that a catalyst is an agent which causes change without undergoing change, I would believe that this is not an appropriate term to apply to the administrator who needs himself to change. Neither do we need him to be an innovator if this merely means introducing new services.

If, on the other hand, by 'innovation' we mean the development of new attitudes, the administrator has a role of quite extraordinary importance. It is perhaps high time that we had our experience on the road to Damascus.

One revolutionary change in attitudes in Australia would be acceptance that health service facilities are intended to be for the benefit of the recipients rather than for the providers. We all mouth the platitude that the welfare of the patient is what we are about, but it is not always obvious from our actions.

The administrator must surely be very wary before taking any innovative role in the introduction of medical developments if by that we mean the extension of medical services. Rarely will he be clinically qualified to express a judgment on the particular development, but he could well have a healthy scepticism born of his observation of the value of so many developments in the past.

There would appear to be little need to stimulate a demand for new services—this will be done very adequately by the providers of the services. Rather should the administrator force those who raise such demands to justify the transfer of resources to meet these requirements. We are rapidly approaching the time when no

additional resources can be given to the health services and if we wish to begin some new activity we must withdraw resources from some area in which we are already engaged. The administrator can be a catalyst in forcing this decision on health service providers.

In this sense the administrator has an important, and perhaps unique, role in establishing priorities for health services to the community served.

In general, the various professional groups and vested interests will be very actively advocating advances in their own specific areas of interest, and often it is only the administrator who can make some degree of objective judgment between the competing claims.

He should first ascertain whether the proposed services are available elsewhere in his area, which is the most suitable location if they are to be situated in his area and, most importantly, whether this is the best possible use of the resources required by the proposed new service.

Apart from exercising his responsibility for discouraging unjustified services, the administrator has a responsibility to fill any gaps preventing a comprehensive health service. We have all had experience with high-powered, vocal and politically adept groups in the health services who have been able to command a disproportionate share of resources compared with other less spectacular areas which, lacking a persuasive advocate, have tended to languish.

It is the administrator's responsibility to cultivate the desirable but neglected species within the health service jungle.

The authority of the administrator in these areas, as in many others, is based upon his being accepted by the health service. If, through his judgment, knowledge and responsible actions, he earns the respect of his colleagues, he will have achieved a

position of accepted leadership from which he can have a profound effect on the health services of his community.

The modern Canute will avoid being overwhelmed, not by exhorting progress to cease but by constructing channels to direct the rising tide in an orderly manner.

Commentary

LESLIE PAINE

The question raised in these papers not unexpectedly caused the members of the seminar some difficulty. They were quite prepared to accept the proposition that if they were to be considered as genuine managers of their hospitals or services then they must have some responsibility for setting and achieving objectives and for trying to ensure, in consequence, that the limited resources were used to the best advantage of the people served.

On the other hand, as realists they were forced to admit that the facts of the matter in practice were very different from the principles so easy to propound in theoretical discussion.

To start with, the 'resources' we all talked about so airily were primarily people, including doctors, nurses and the other clinical professionals who worked with them. So that when we spoke glibly of 'redeploying resources' we were actually suggesting that we could somehow cajole, persuade or force clinicians either into changing their ways of working or, even more difficult, into ceasing some of their activities altogether in order that groups of patients other than their own might benefit.

Assuming, however, that they were capable of that amount of altruism and we were capable of that sort of managerial magic, it still begged the question of what we did with the 'spare resources' when we had them at our disposal. Were we really so certain that we knew so much better than our clinical partners who should be treated or cared for and who should not? And even if we did, were we capable, in these democratic days of industrial relations and consumer participation, of convincing not just our colleagues, their staff organisations and trade unions that we were right, but the public's representatives as well, whether boards of trustees, health authorities, politicians, consumer groups or voluntary societies?

The answer to both of these questions as revealed in the seminar's papers and discussions was imprecise but mainly negative. Our track records, it seems, do not show many administrators—except perhaps a few at government department level in certain countries—who have any dynamic and widely accepted influence in this vital sphere of health care organisation. In fact, quite the reverse.

John McClelland, as a hospital administrator for example, speaks with great candour of the 'maelstrom of selfishness and irresponsibility' into which the Australian health care system seems to have been swept in recent years by clinicians becoming overconcerned with academic ambitions and empire building. And what have his administrative colleagues been able to do about it? Virtually nothing, it seems, except to follow a *laissez-faire* policy aimed primarily at personal survival—on the basis, one hopes, of *reculer pour mieux sauter.*

For his subsequent comment—that too many of Australia's health services give the impression of being run for the benefit of providers rather than consumers, and that too many health professionals (including administrators) pay lip rather than actual service to the preeminence of the patients' welfare in their working lives—has an all too familiar ring to it. Many administrators in

many other countries would admit in their more honest moments to similar feelings of guilt and disillusionment about their own services and the contribution they make to them.

Bernard Snell, as he shows in his paper, is certainly one such although his disillusionment with the current health care system in Canada springs from a different and almost opposite view to that of John McClelland. For Dr Snell believes that, imperfect and self-centred though the doctor-dominated health system may be, it is better than the anarchy or nihilism which he suggests are spreading today, not just through the health services of the Canadian provinces but through those of other countries as well.

The anomic state of 'standardlessness, normlessness and valuelessness' into which he sees our health systems drifting reflects, he feels, the growing cynicism and iconoclasm of a changing society—restless, uncertain, suspicious and, at times, militant. Rejecting tradition, represented in our sphere by what he calls 'the medical model' of health care organisation, the new social planners, he argues, have nothing better to put in its place so that, like the anomic individual, our health care systems have become 'illogical, irrational and uncoordinated'.

He also raises the old question as to whether there are rational answers to some of our basic health care problems; whether needs and wants can be differentiated in health care and, if so, by whom. Neither government, nor clinician, nor administrator, he implies, has clear plans for the future. The broad strategy suggested in 1975 by Marc Lalonde's *A New Perspective on the Health of Canadians*[15], which reminded us yet again of the importance of preventive and health educational measures, is ignored, and health care Canadian style is something of a rudderless ship. The people, he suggests, have not yet accepted that, one way or another, they *always* have to pay for the health care they receive; and he implies that until government, the professional health care workers and the consumers get together and decide

their strategies—no one in particular will sensibly control health care development.

This was a hypothesis which the seminar accepted only in part. The Snell opinion that 'anomie has been at the root of our vacillation in the health care system over the past few years' obviously fell on sympathetic ears. But then so did the Australian viewpoint on the shortcomings of the medical model so candidly expressed by John McClelland. All of which leads one to the inevitable and unremarkable conclusion that the seminar accepted doctors to be the essential element of any health service, but felt that they should not, and indeed could not, in these inflationary days, be the exclusive planners and organisers of that service if equitable availability of care and treatment were to be its guiding principle.

Perhaps, as Adrian Evans (UK) put it, 'clinical freedom in the past meant doing what one thinks is right for the patient *without* full regard for the resource implications. In future, it should be practising expertise and skills *with* full regard to the resource constraints.'

But how, Professor Semple (keynote speaker) enquired, can the clinician and the administrator together make decisions on the allocation of resources which are imaginative, provide the greatest benefit to the community and anticipate future developments? The doctor after all, as he readily admitted (and here he seemed to mean the hospital consultant), is basically a 'curer not a carer'; he is a practitioner of specialist, modern, scientific medicine and not, as the public would like him to be, a combination of medical scientist, sociologist, philosopher, psychiatrist, economist and expert in public health. In consequence, the doctor tended to regard many of the difficulties with which administrators were concerned as problems of society rather than medicine, which would be overcome not by pills and treatment but by such things as better housing, improved social benefits, more special accom-

modation for the elderly and consolation for the lonely. His ability to help the administrators with the imponderable problems of planning the service is therefore necessarily limited by his own training, experience, background and interests; and the administrators themselves, by the application of their particular skills in such spheres as cost-benefit analysis, would have to convince him of the wisdom as well as the necessity of looking beyond the 'few paternal acres' of his own clinical field to the needs of the wider community outside it.

Education and research—the natural concomitants of change and progress—were essential, Professor Semple suggested, if medical attitudes in this respect were to be altered, and he was surprised that so little reference had been made to them by the seminar's participants. 'Swing education behind your problems,' he proposed, 'and many of them will disappear.' But exactly what research should be undertaken and by whom, and precisely who should educate whom and in what respects, I for one was not quite as clear from the Professor's address as I would have wished—although that may be my failing rather than his. One practical suggestion he made was that, as administrators, we might associate junior medical staff more closely with our problems, and through them attempt to influence their seniors. In addition, he laid considerable stress (and rightly so) on the necessity of producing hard data rather than hunches if we wished to convince clinicians of the need for important change; in this connection he again cited the possible value of cost-benefit analysis as a means of judging the comparative effectiveness and economy of different forms of treatment.

His view—that administrators should be interested in and seek ways of demonstrating the comparative costs and effectiveness of care—while fully agreed by the seminar as a generalisation, did not command universal acceptance as he had proposed it. Not all health care decisions could or should be taken on a cost-benefit basis and to try to convert into cash terms the personal, social,

moral and other judgments that had to be made when treating patients was difficult, dishonest and possibly dangerous. On the other hand, to try to set the costs of the treatment or form of care against its effectiveness assessed in whatever terms were thought most appropriate (for example, days off work, time spent in hospital), although less obviously useful for simple analysis and comparison, was certainly a more honest and possibly a more useful approach to the problems under consideration.

What was agreed without demur, however, was Professor Semple's broad thesis that one of the health administrator's main tasks at all times, but especially in the present period of financial stringency, was to help the clinician to see beyond his or her personal and professional horizons—although, as Robert Maxwell wisely added, this was not to be achieved by administrators trying to 'go it alone' in service planning. They needed instead to ally themselves with particular initiatives as these naturally appeared in the clinical field—their skill in this respect being judged by the success of their choices, which must therefore be somehow capable of measurement. They should, in other and horological words, be what Ian Beach in his paper suggests they are in practice (at any rate in district management terms in the UK service)—not the mainspring or driving force of change in the pattern of care provided but rather a regulating mechanism, a 'pendulum to govern the pace of that change'.

This role, although less dramatic than some might like it to be, was nevertheless not to be underestimated. Covertly though he may have to do so, the administrator must try to set objectives for his particular organisation (difficult though that invariably was) since if he did not no one else would. Admittedly his scope for this sort of activity was likely to increase with the seniority of his position and with the amount of opportunities his job provided for strategic action. But at every level of management he held the purse strings and even though he could not directly control the way much of the purse's contents were spent he

could always use the 'no money available' argument to discourage doubtful developments and the 'we'll get over this cash problem somehow' attitude to encourage worthwhile endeavours.

Shortage of money and the need for ever wider consultation outside the health system as well as within it were both calculated to increase the administrator's influence on health affairs—and perhaps here, some members suggested, was where the need for education came in. Administrators themselves needed education and training in order to understand and undertake a role which might best be described as individually catalytic and collectively (with their professional colleagues) innovative. Conversely, all those with whom the administrators dealt, inside the service and without, required to be educated to understand the administrative function—something of which many members of the medical and allied professions were still apparently woefully ignorant.

In the general discussion which concluded consideration of this section of the seminar's main theme, the point was made that change and innovation take place in health care all the time and the most important changes are and always should be clinical, so as to benefit the sick. It is the administrator's job to recognise that this is happening, to ensure that the effects of proposed changes are understood and those of actual ones evaluated. Whether, in order to do so, he had to be innovative or catalytic was more perhaps a problem of semantics than fact. In all probability he must be both.

What was certain, however, was that he needed the ability to inspire trust and confidence in his colleagues at all levels of operation, including the so-called 'shop-floor' where the clinicians worked and where most medical developments were liable to take place. Perhaps, it was suggested, the UK in particular needed to take note of this point.

III The Political Process as it Affects Health and Health Services

5

In New Zealand

D N RYAN

We have been asked to be realistic and specific. Therefore I comment first as a deputy permanent head of a department of state—the Health Department of New Zealand—with my own experience as a senior public (or civil) servant. Because these experiences may be restricted in interest, I then make brief comparison of the rôle with that of the chief executive of an elected hospital board.

Definitions

Rather than risk unnecessary confusion later over such terms as 'administration', 'innovation', 'the public interest' and 'the political process', I think it wise to discuss these first and define the meaning I give to them in the particular sections of the paper.

Administration

As stated in the report of the 1975 seminar[17], the role of a chief administrator will vary and there can be no universal job description; his effectiveness must depend not only on his competence

but also on his personal qualities, the environment he works in, local traditions and the attitudes of his peers. However, as the designation indicates, he will be expected to be involved in policy formulation and advice, planning, organising, personnel administration, leadership, coordination, communication, public relations, training and control. A thorough analysis of these activities, and determination of those that are the sole responsibility of the senior civil servant, or the chief executive of a board, are necessary before it can be said that a particular officer is an innovator or a catalyst.

Innovation

This may relate to changes in procedures (both simple and complex), organisation of programmes and policy. I prefer to narrow it down in this paper to policies—conscious that there will be argument as to what constitutes policy. A related contention is whether the elected parliamentary representatives—or members of boards—formulate policy and administrators implement it, whether officers in fact formulate it, or whether a partnership exists.

Public Interest

We have been asked to consider the public rather than individual or collective interests. The phrase 'public interest', particularly in social fields, can present all sorts of dilemmas. I read somewhere that an Egyptian once commented that the two worst things to have happened in modern Egypt were the Rockefeller Foundation and the Aswan Dam! By improving public health the Rockefeller Foundation had upset the balance of nature with distressing consequences for the relationship of population to food supplies; and by slowing the Nile the Aswan Dam had promoted the development of enervating parasites in the river. The consequence of these two factors was that more people lived longer in more

misery. What the public wants is a matter largely of subjective judgment. The politician determines the goal as the popular will of the people and the administrator may quite properly see the 'popular will' as something not good for the people. As Rousseau said, 'Men always wish their own good, but do not always see where that good lies.' It is accordingly in this area that the senior civil servant, and his colleague on a hospital board, require political sensitivity.

Political Process

The term 'politics' in this paper has national and local connotations. There is the member of parliament with party affiliation, guided by a party philosophy and a manifesto of intended policies. Then there is the member of a hospital board who (seldom in New Zealand) applies direct party affiliations but, being elected in local elections, is a politician. His, or her, motivation to stand for election may be an interest in health and welfare, crusader motives, a desire to manage by application of commercial principles, dissatisfaction with individual service, or representative of group protest. Political aspirations are seldom the main motivating force.

I advance the theorem that the senior civil servant in central government must be an innovator, and that the chief executive of a hospital board is essentially a catalyst and only occasionally an innovator of policy.

Senior Civil Servant

His functions are fundamentally twofold. The first is as executive with functional and hierarchical responsibilities. His second task, and the one I direct my opinions to, is as an adviser to the minister. It is in this second role that he must become a political public

servant, sensitive to the minister's and the government's philosophies and the public interest.

In examining his responsibilities and attitudes, it is necessary to observe the current functions of, first, parliament and then the political executive—that is, the cabinet, its committees and individual ministers. It is, I suggest, only by this process that we can truly determine the political character of the senior civil servant. My contentions are as follows.

Civil service administrators at the upper levels are political because the boundaries between administrative action and political power are artificial.

The political power of parliament has sharply declined at an inverse rate to advances in technology, to the increasing complexity of social issues, with intrusion of environmental factors and with the complexity of national and international economics. There has, as a consequence, been a shift of legislative functions, budget preparation and development of social programmes to the executive branch—cabinet and ministers. Evidence of this shift is seen in the issue of sets of regulations, by bills proposed and prepared by the executive, in administrative decisions reached in cabinet and its committees, and in the vesting of authority in various public corporations and statutory bodies. Parliament itself, and even government caucus, may amend, rarely rejects and usually ratifies.

The shift of political decision-making from parliament to the executive branch in turn shifts much of the power to departments of state and, more particularly and specifically, those civil servants who are advisers to ministers. Such mechanisms as the prime minister's department, a recently constituted small group of experts, have essentially a monitoring role and would find it difficult to initiate policies in the health field.

The responsibility for preparation of budgets now falls on the government executive which, in turn, leans heavily on the bureaucracy—particularly officials in the Treasury. Within a framework of broad policies, and a parameter of restraints, which are set by the Minister of Finance and a cabinet committee on government expenditure, they hammer it out—and endeavour to reach consensus—with counter-proposals. By and large, programmes of a medical or related nature advanced by the Department of Health may be rejected, deferred or pruned out but seldom altered in form. This would be the case for many programmes submitted by departments, hence the budget is essentially a presented document. The key point to this trend is that budgets have changed significantly from a strictly financial statement of salaries and expenses of government departments to a document which has profound influences on economic, industrial, agricultural and social programmes.

Planning, particularly economic planning, is not in practical terms compatible with parliamentary procedures. These procedures must, by their nature, be legalistic and generally rigid; yet planning must be flexible. Again, a three-year parliamentary term is not conducive to either the philosophies or the practicalities of planning. This means that planning is largely left to departments of state or to specially appointed bodies outside parliament.

Parliament, the executive branch (in a corporate sense) and individual ministers, lack the necessary technical expertise and the means to develop and control plans and programmes or, for that matter, to put forward practicable options to the ones submitted to them. Therefore, the formulation and development of programmes, with workable alternatives, must depend essentially on officials.

There is a considerable degree of interdepartmental consensus where officials, and committees of officials, hammer out new

policies or modify existing ones. These are then submitted to the minister who may, or may not, have asked for a submission. At this stage the minister will find it extremely difficult to dissever the proposals because of the consensus and the interwoven aspects.

Senior civil servants are generally closer to, and may have day to day contact with, pressure groups. They can consequently influence, or be influenced by, these groups. Again, the minister whose contact with these professional organisations, employee groups and the like is less regular and direct must depend to a considerable extent upon his officials to advise him on the attitudes of these groups to the various policies and programmes, and the strengths in central government decision-making.

The relatively modern trend of rotating ministers through two or more portfolios in one parliamentary term strengthens the influence of the civil service, where there is administrative continuity.

With rapid changes in government—as we have recently seen in New Zealand—new ministers and the political executive take time to pick up the thread of office, to acquire knowledge of people and groups and to learn of the activities of their departments. These changes result in a further devolution of responsibility on the senior civil servants.

This transfer of power does not mean—nor should it—that the senior civil servant is all-powerful and, as some critics claim, that bureaucrats and technocrats in effect run the country. Politics and administration are both arts, not sciences, and, being dynamic, adapt to changing circumstances.

As in Britain, the New Zealand civil servant is non-political, yet it is his responsibility to keep his minister in power. It is also obviously in the department's interests to have a strong, well informed minister. The public servant must therefore have

political sensitivity and the integrity and good sense not to usurp the power of his minister.

Ministers are not puppets—at least not in my experience of serving eight ministers in eleven years. They invariably have knowledge on a wide field, they receive information from other ministers, members of parliament, party branches and affiliates, pressure groups, ministerial correspondence, outside experts and the press. They are therefore in a position to test—at least in general terms—the advice and information received from their departmental advisers.

As the role of a senior civil servant has changed over the years from being an implementer of policies handed down from parliament, so, too, has the role of the minister in the matter of policy formulation.

In his book, *The British Cabinet Ministers: the Roles of Politicians in Executive Office*[14], B W Headey advances an interesting analysis of role expectations which would, in my opinion, apply equally to New Zealand ministers.

policy initiators
policy selectors
executive
ambassadorial
minimalists

Each has an important part to play, according to the portfolio and its expectations. It is my opinion, however, that in a largely professionally oriented department such as the Department of Health, the minister cannot (except in limited areas) be a policy initiator. His part in policy formulation must be that of a selector. Having satisfied himself on the general objectives of his department, he should be served with various proposals and, with them, alternative courses of action which are not alien to his party's

philosophy. (The exception would be proposals and programmes which are technical in nature; for example, disease control.) The minister can then make his choices as an intelligent layman, applying his 'outsider's' judgment, and testing whether they fit his government's philosophy and policy framework.

I conclude from the propositions advanced—on the shift in responsibility to the public administrator and the minister as a selector of policy—that the senior civil servant who is, among other things, administering legislation and allocating finance to the health and hospital services, must be an innovator in policy formulation. (Behaviour outside the norm—for example, a powerful, dominant minister or a power-selfish public servant—is excluded from this conclusion.)

As policy is generally medical—or medically related—in nature, the general administrator will seldom be the sole innovator. He is a member of a team of innovators and primarily in a supporting and facilitating role. For that reason he must also act as a catalyst, not only with his own staff but with professional colleagues and officials of other government agencies. Nevertheless, I conclude that his function as a catalyst is less dominant than that as an innovator and as an executive. Also, he has a much stronger innovative function than his counterpart in the local government sector of hospital services—the chief executive of a hospital board.

Chief Executive

The elected hospital board has three primary responsibilities: to constituents, to central government as trustees for monies allocated from taxes, and to govern.

Its chief executive has probably three broad spheres of action: servicing the board, as an executive with hierarchical responsibilities,

and as an adviser to the board. It is in the role of adviser that he can be compared with his counterpart in central government.

The government allocates funds and authorises major capital expenditure. These are limiting factors in policy formulation. It means that, while programmes can be modified and extended, new programmes and locally initiated policies must be restricted in extent.

Obviously, hospital administration is considerably more medically related in function and activity than that of the central government Department of Health. As a consequence, the development of programmes, with determination of community needs, must be more in the hands of the health professionals than the elected board member or the generalist administrator.

The board member must use his political judgment and, like his national counterpart, be a selector of policies.

The chief executive plays a more supportive than innovative role and, within his administrative responsibilities, there are strong elements of monitoring, control and coordination. It is as a catalyst that he can perform these tasks best, and play an extremely important part in the promotion of local policies and programmes.

On occasions he may be a member of a national committee on some aspect of health care and it is in this capacity that he can become an innovator of policy.

It is my conclusion, however, that in carrying out his normal duties the chief executive of a hospital board is more of a catalyst than an innovator—but of course is no less important in the overall scheme of health care.

6

In England

ORIOLE GOLDSMITH

Saddled with the task of trying to run a service where present organisation reflects an uneasy and, some now think, a wholly incompatible marriage between two competing political philosophies—one concerned to reap the benefits of large scale organisation and the other determined to achieve greater public participation and democratic control—it is hardly surprising that health service administrators in England are currently feeling both jaundiced and cynical about the whole political process and their lack of influence upon it.

Nevertheless, my main thesis will be that the administrator has more opportunities to influence the political process than, generally, he either seeks or takes.

How Does the Political Process Affect Health Care Services?

There are three factors which ensure that the National Health Service (NHS) remains of direct concern to Parliament and therefore more or less central to the political process.

The NHS is substantially funded from nationally levied taxation.

The Secretary of State for Health and Social Security has a statutory responsibility to provide or secure the effective provision of health services.

The NHS is one of the largest employers in the country, pay is negotiated nationally, and staff and professional associations reflect this in their own organisations.

The original National Health Service Act 1946[10] and its successors, right up to the National Health Service Reorganisation Act of 1973[11], have made quite detailed legislative provision, not only for the structure of the NHS but for the nature of its organisation and the way it is run. There is also a considerable body of subsidiary legislation dealing with the services to be provided and the standards to be met, as well as the charges to be made and those who should be exempt from paying them. On the other hand, health has seldom if ever been an electoral issue in national elections and members of parliament have therefore not needed to make political promises on health matters in order to attract or retain votes.

The initiatives taken by the present government—to begin seriously to try to equalise the availability of resources across the country; to achieve greater democratic and staff involvement in the management of the NHS; to phase out pay beds (for private practice) from NHS hospitals—stand out as being the most significant political initiatives to affect or alter the pattern of the NHS for political rather than professional or organisational reasons since its inception in 1948. Earlier initiatives included major attempts to shift resources and public concern to mental health and to shift the balance between hospital and primary health care by improving the conditions of general practice (the so-called 'GPs' Charter' in the 1960s) but these were not 'political' in the ideological sense.

The position has also begun to change quite radically at local government level since 1974 with the increasing involvement of local councillors in the running of the NHS through membership of both the area health authorities (AHAs) and the community health councils and through the emphasis being placed on the joint planning of personal services by health and local authorities. Initially, the new area health authorities created at that time—whose boundaries were, as a matter of principle, coincident with those of county and metropolitan district councils (the authorities responsible for social services in the main English shire counties and the largest conurbations)—included a small number of members appointed by the coterminous local authority. Subsequently, following a change of national government in February 1974 from Conservative to Labour, local authority representation on AHAs was increased to one-third of the total membership and provision made for both tiers of local government—county and district councils—to be represented. District councils were already responsible for nominating half of the members of community health councils (CHCs).

Although health issues are not specifically the province of local authorities and therefore have little if any place in local manifestos, health problems are among the problems brought to individual councillors. Where a councillor is a member of an AHA or a CHC, he will be expected to have both a view and some influence on health matters. Health issues as a whole cannot therefore be regarded as immune from local political debate or from *ex cathedra* statements by local politicians who have votes to win.

The emphasis on joint planning between health and local authorities, which was made a statutory duty in the 1973 legislation[11], and the subsequent introduction of a limited scheme for the actual joint financing of certain types of project—to reflect the interdependence of personal services of which health is only one—has also, inevitably, made AHAs more sensitive to local political attitudes

and objectives. To the extent that the party political orientation within local government has come increasingly to reflect the national position, so the outcome of local as well as national elections has become a matter of direct concern to health authorities. A change, for example, in the controlling party in my own county—Nottinghamshire—could mean not only a very significant change in priorities of schemes to be jointly funded in the current financial year, but an actual restructuring of the social services department itself. This contrasts markedly with the situation which existed prior to 1973 when most hospital authorities were almost completely insulated from the local political process.

Staff Interests and the Political Process

An increasingly important dimension in the interaction between the health service and the political process is the extent to which the battle to preserve or establish professional vested interests and the growing power of the public service unions are bringing health issues into the political arena. While the medical profession in the main continues to fight a staunch rearguard action against any manifestation of real or imagined political control or interference, other professional groups, battling for independent recognition and status against the predominance of the medical profession, are looking increasingly for political supporters and spokesmen.

Much more significant, however, is the changing role of the public service unions. Not only is a wedge being very deliberately driven between trade unions affiliated to the Trades Union Congress and professional staff associations, with the object of excluding the latter from the negotiating scene, but membership of a recognised trade union is being pressed as the essential qualification for staff participation in local management, whether in staff representation on health authorities or formal representation

in joint staff consultative arrangements. When, at the same time, the public service unions are taking direct action on current political issues—for example, against cuts in public expenditure and in favour of phasing out pay beds from NHS hospitals—the significance of this is considerable.

The Debate about Taking Health Out of Politics and Politics Out of Health

The setting up of the Royal Commission on the National Health Service has, inevitably and rightly, created an opportunity for those giving evidence to the commission to raise once again fundamental questions about the direct accountability of the NHS to the Secretary of State and thus to parliament. The alternative usually canvassed is the setting up of an independent commission receiving a block grant from parliament, for a period longer than the single year that direct dependence on an annual parliamentary vote entails. This device is seen as being the means of taking health out of politics. While most people working in the NHS would strongly subscribe to the sense of frustration which stems from the inability to plan health services over any period longer than a year, in a country where a tendency to regulate the economy through the public sector appears to be endemic, many—including the two main bodies representative of administrators, the Institute of Health Service Administrators and the Association of Chief Administrative Officers—would doubt whether setting up an apparently independent commission would radically alter the situation. The scale of the resources required—both financial and human—is too great for it to be reasonable to expect that tight financial controls and strong government pressures could be escaped wholly by means of such a device. There is also acceptance that the sorts of decisions that increasingly have to be made in determining priorities—which involve social and moral issues quite as much as professional judgments—are ones for the public to debate and ultimately decide.

The alternative proposition—that politics should be taken out of health—recognises that the first proposition is untenable, but none the less argues that, apart from the major issues of priorities and resources, the NHS should be insulated from party politicking and, more particularly, from vote-hunting local politicians. It is a matter of opinion whether such a view is tenable or correct. It is certainly impractical in the present social climate.

In my view, a more important issue, and perhaps the single biggest lesson to be learnt from the 1974 reorganisation of both local government and the NHS in England, is the need, as far as possible, to ensure that every major restructuring of a public service reflects a consistent political philosophy. It appears to be a characteristic of government in the UK that much the same action is taken whichever party is in office. This tends to mask, however, a very marked difference in the philosophic base from which the two parties operate, and very different vested interests. On an issue as fundamental as the restructuring of local government, and also the NHS, the solutions put forward inevitably reflected the latter aspect. Since the government changed between the report of the Royal Commission on Local Government[13] and the first Green Paper on the reorganisation of the NHS[9] and the passing of the legislation, and since a different government implemented, then passed, the legislation, it is hardly surprising that many administrators find the resulting compromise unsatisfactory to run, and lay no small part of the blame at the door of the politicians. This also explains, at least in part, the bitterness of the resentment at the way ministers have joined in the present attack on administration in the public services.

Does the Chief Administrator Have a Role—as Innovator or Catalyst—in the Political Process?

Great emphasis tends to be placed in the UK on the apolitical stance of the administrator. If health institutions, both as providers

of services and as large scale public employers and spenders, are to be seen to act with complete impartiality, those who administer the institutions must themselves be seen to embody that impartiality. There is therefore a tendency to assume not only that the administrator has no role but that he ought not to have a role in the political process.

This is accentuated in the NHS by its complete separation from the civil service, and therefore from any formal responsibility for advising the political arm of government. This is further accentuated by the minimal opportunities there are for interchange of personnel between the NHS and the civil service, and a deeply held belief that the nature of the tasks of the two services and the skills required to do them are such poles apart that interchange, other than on the basis of a shared technology, is impractical.

Stating the position in this way, however, risks failure to draw a distinction between the process of political decision-taking itself on the one hand, and the means by which it is informed and the way in which political decisions are implemented, on the other. While the administrator may have no role to play in the political decision-taking process itself, he has a significant part to play in informing the political process, and a very major part to play in the way political decisions are implemented. Indeed, it is recognition of this, and of the power which goes with it, which accounts, at least in part, for the present public attack on the power of the bureaucracy.

Although in England ministers still largely take their advice from civil servants, there is a variety of ways in which the civil servants themselves take advice. The Secretary of State and ministers in the main confine their personal contact with the NHS to meetings with chairmen of regional health authorities and those they meet in the course of official visits. However, there has been an increasing number of ad hoc committees set up to advise ministers on specific issues, on which the NHS has been fully represented,

and a whole network of regular interprofessional meetings between officers of the DHSS and the NHS, even though these tend to be confined to regional officers. Most written guidance issued by the DHSS is the subject of consultation with the NHS, and, although there is much criticism about the way in which this consultation is achieved, the principle is clearly established and the opportunities are there to be taken.

It is also important to recognise that initiatives for change and development probably originate most frequently from individuals working in the NHS and percolate by a process of osmosis into official thinking. Within this system the administrator, if he has the will, has a significant part to play both in ensuring that the views of the NHS get through to the civil service and therefore to ministers, and also in recognising the potential for innovation in others and in facilitating the process by which innovation percolates the system.

The administrator also has considerable influence, which he often fails to recognise explicitly, in his role as perpetual change-agent—the creator of an environment in which change is possible—since the impact of both political initiative and legislation is crucially influenced by the way in which it is implemented (or obstructed).

However, by far the most important and the most influential role for the administrator on the political scene is as the disseminator of accurate information, both to the politicians, who represent the public, and to the public at large. Unless this is accepted as a continuous and legitimate activity, the administrator cannot complain that decisions—whether taken by national or local governments—are ill-informed or insensitive to real health needs and priorities. In an age of mass communication, it is only by a consistent effort to keep the record straight that the public service administrator can hope to protect a service from the distortions that creep in through mass reporting. This will be

considerably reinforced if it is also linked with an open style of management and a relaxed approach to the communication media themselves.

In the last resort, power and influence will always lie with those in possession of the facts.

7

In the USA

RICHARD A BERMAN

In this paper I draw a distinction between 'institutional enhancers' (the use of political processes which tend to enhance the individual hospital), and 'system-wide enhancers' (which enhance the overall health care system).

Some examples of outcomes which benefit the individual hospital as institutional enhancers are increased revenue to the institution, reduction or elimination of burdensome external regulation or control, the addition of institutional resources which attract greater numbers and/or wider ranges of patients, and medical staff appointment policies which retain and attract superior talent.

In contrast, I define measures which attempt to improve the health status of the public through extra-institutional programmes as system-wide enhancers. Examples of such outcomes are reduction of the percentage of health care resources consumed by hospital services, reduction of inappropriate utilisation of resources, general reduction in the autonomy and independence of institutions, and reduction in the autonomy of individual practitioners.

I realise that these definitions may not always conflict; however, the hospital administrator experiences confusion over his role when they do. Therefore, I will treat them as distinct throughout this paper.

The Chief Administrator's Role

There is probably little confusion for hospital trustees in defining the administrator's role in the political process. From the trustees' vantage point, the administrator must be an institutional enhancer—catalyst as well as innovator. As a catalyst, the administrator, through the use of programmes or proposals developed by other health professionals, acts as a broker to outside funding agencies and legislative groups—locally, regionally and nationally. In other areas, such as in third party reimbursement and in programmes designed to improve the overall financial condition of a hospital, the administrator is expected to be innovative. As institutional enhancers, there are innumerable types of appropriate political activities in which the successful administrator must participate, including relating to board members, elected officials, legislative staffs, community groups, professional associations, and the like. Specific examples of outcomes of these activities include

assurance of appropriate reimbursement by third parties for the cost of serving those patients who cannot afford to pay

reduction or elimination of out-of-pocket costs for care to long-term chronically ill patients—costs which many cannot afford

successful competition with other institutions to obtain requisite approvals for the acquisition of new, useful, and often expensive equipment, such as the CAT scanner

preservation and extension of tax credits for individuals who wish to contribute to the hospital as a charitable institution.

There is great divergence of opinion on the administrator's ability to act in enhancing the overall health care system. I do not believe the hospital administrator can, or should, be expected to act as either catalyst or innovator for the health care system as a whole.

It is very rare for the chief executive officer of the hospital to be able to be the man or woman 'for all seasons'. For example, the hospital requires his services as institutional advocate. Also, there is little, as such, in the training or experience of hospital administrators that qualifies him to assess the public's health needs or to design the broad range of effective programmes to meet those needs. In addition, the present financial and peer incentives within hospitals sometimes work in opposition to policies best for the system as a whole. The public needs an advocate who embodies public, rather than institutional, goals in his actions.

The hospital system requires advocates particularly because of increased governmental financing and accompanying regulation and control. With the growing realisation that financial resources for health are limited, state and federal officials are relying on fiscal solutions which often jeopardise the provision of sophisticated hospital services that have become an American tradition. Thus, each administrator of a major institution must be a spokesman as well as a manager. This manager/leader cannot be expected to equate the needs of the system to the needs of his institution without compromising his institutional leadership and advocacy. Losing effective institutional advocates from the system, at this time of rapid technological change, budgetary stringency and increased regulation, would be disastrous.

Equally important is the fact that the hospital administrator does not necessarily have the training to serve as system designer and public advocate. Very little of the chief executive officer's

training or experience provides him with the expertise needed to appreciate the impact of non-institutional factors on the population's health. Welfare, housing, environment, occupational safety, psychological counselling and employment are all important variables which affect morbidity. Within each of these areas are many disciplines and kinds of expertise not included in the training or purview of professional hospital administrators. The vast body of knowledge required to address these problems is not the same as the knowledge required successfully to manage a hospital. It is presumptuous to think that a successful hospital administrator will necessarily serve as an effective health services planner. If anything, this situation brings to mind the Peter principle—that is, taking your best carpenter and making him foreman; taking your best institutional manager and making him resource allocator or system designer and advocate.

Incentives existing in the American hospital system are too strong to permit the chief executive officer in a hospital to be an objective system-wide allocator. Since the hospital is indeed the firm which employs the administrator, he must derive his professional rewards from the development and growth of that particular institution. His peers evaluate him in terms of how many beds he operates, how many people he employs, and so on. The physicians rate him in terms of how well he provides the services and resources required to meet their needs. There is a direct correlation between a physician's income and his ability to use new technologies. Many successful physicians attract and retain their patients because of patients' perception that the latest drugs, procedures and technology will be used in their treatment. The hospital's depth and scope of services are very directly related to the financial livelihood and concepts of practice of the physician. A hospital which does not keep up to date stands to lose its best physicians.

Most of the peer and professional incentives influencing the governing boards, the medical staff and the administrator reinforce the growth and rapid introduction of new technologies. Indeed,

there are few positive institutional, personal or financial incentives for being the chief executive officer of a declining business. In addition, there are definite personal satisfactions to be gained from knowing that every patient who comes into the institution can receive the best, latest and most sophisticated medical therapy and support services.

Effective presentation of the public's interest cannot be accomplished through delegation to one with vested interest in the production of the good or service in question. In the USA, the bulk of hospital services is provided by private vendors. In most other industries, there are public or quasi-public bodies responsible for controlling expenditure levels or protecting the public's interest, so that their chief executive officers do not serve simultaneously as the public's spokesman and as the industry's manager.

Society does not expect the chief executive officer of the gas and electric companies to advocate policies to retard the introduction of new and unnecessary pieces of equipment or machinery that consume precious limited resources. The public would be surprised to hear the chief executive officer of the electric utility company promoting controls on the consumer's ability to purchase and/or use electric can-openers, air-conditioners, ice-makers in refrigerators microwave ovens, and so on. We do not expect the chief executive officer of the telephone company to advocate the sale of basic telephone equipment on the basis of need and to support regulations aimed at reducing unnecessary long distance and local calls.

In those public services which we consider to be rights, such as police protection and education, we would be shocked if the police commissioner recommended that half the number of policemen be laid off and the money saved be used as gifts to the low income populace in order to reduce the financial motivation for crime. We would think it inappropriate if a school principal advocated a 50 per cent reduction in the number of teachers,

with the savings spent on purchasing books and funding day care programmes for the children in the community.

In transportation, we do not expect the president of a combustion engine company to promote legislation or support political activity which will result in the development of the electrical engine or the diversion of highway funds to mass transit programmes, even though we value the benefits of clean air, energy conservation and environmental protection.

The public needs advocates and innovators in health's political process. However, in my judgment, it is difficult at this time to find the empirical, conceptual or financial incentives within the present organisation of the American health care system to support such a broad role for the chief executive officer of a hospital.

Commentary

LESLIE PAINE

We have seen that every health care system involves rationing, whether open and obvious as in the UK, of the crisis variety discernible in Canada and to some extent in Australia, or of what one might call the 'leaking' sort taking place in New Zealand. Even the USA seeks some form of rationing by federal government regulation.

This well known fact of health care life was iterated yet again by the keynote speaker, Professor Brian Abel-Smith. The topic was the administrator's involvement and influence (if any) in the politics of health care, and the speaker was anxious to demonstrate to a somewhat doubtful audience the importance of, and need for, people such as themselves to become so involved.

Politics, he reminded us, impinges on the way that health care is organised and provided in many ways—obvious and otherwise—depending, of course, on the type of system in operation. In every country, however, the system is bound to be affected by two things: first, by the style, strength and permanency of government, of the civil service and their respective senior officers, especially the Minister of Health or his equivalent; second, by the amount of

participation allowed to, or seized by, the consumer, whether as user of the services or their financer.

Don Ryan suggested that in New Zealand senior civil servants were already the innovators and policy-makers rather than their political masters, because the government had recently changed too often to produce a coherent and acceptable national health policy. The devolution of health responsibility to provincial governments in Canada, and recent reduction in the powers of the Australian Commonwealth Hospitals and Health Services Commission which made it an advisory rather than a controlling body, could well result in the creation of inequalities of service in both these countries rather than the desirable opposite. All three were simple examples of the indirect but obvious effects which politics could have on the care and treatment that any one of us might receive as individual patients.

Furthermore, if you wanted examples of a more direct political influence, you only had to look at the record of UK ministers of health. Enoch Powell had produced his 'mental million', Kenneth Robinson his 'general practitioners' charter' and Richard Crossman his special interest in the problems of the mentally handicapped. Even Australia's Medibank system of national health insurance had resulted from the federal Minister of Health's interest in the scheme as originally propounded by a university department, and in the USA powerful political pressures would be needed to introduce any changes in the present system which were not favoured by such reactionary bodies as the American medical profession or tobacco companies.

It was a moot point whether bringing government closer to the people—and therefore to the health administrator—as in the Canadian provinces, the Australian and American states and the UK's proposed devolution programme, created a better or worse climate for consultation between politician, civil servant and

field health administrator. Ken Weaver, of the British Columbia Medical Centre, suggested in his paper that it had not.

'One can assume from this paper,' he concluded, 'that I have very little belief that the administrator has much opportunity as an innovator or catalyst to influence the political process as it affects the delivery of health care, and this is certainly so.'

To alter this situation would, in his opinion, be a long and arduous task involving, among other improvements, better education of better administrators, a strengthening of their collective voice through provincial associations and a much closer working relationship with their civil service colleagues.

A similar sort of situation existed in the USA, as Richard Berman was at pains to point out both in discussion and in his paper. Broadly speaking, in the USA senior health administrators are chief executive officers of hospitals and are therefore concerned almost exclusively with their own institutions rather than with the community around them. As institutional enhancers rather than system-wide enhancers (to use his terms), they do not pretend to be health service managers capable of estimating the community's health needs, so that their ability to advise and influence politicians on broad health matters, and even their inclination to try to do so, are both minimal.

On the other hand, as Oriole Goldsmith says in her paper, as John Blandford also said in his paper presented *in absentia* and as Professor Abel-Smith firmly believes, it is one of the local health administrator's responsibilities to see that the facts of the situation at operational level are known to those who, although higher up and further away from the sick person, nevertheless set the strategies and make the policies which broadly govern his care. Apolitical in attitude though all those who administer health services seem traditionally to be, it is their duty to become

politically involved to some extent, in the interests of the services they manage and the patients who need them.

For if the chief administrators locally will not advise on the state of the services with which they are concerned, when they, also by tradition, are the coordinators and integrators of these services—the men with the wide view able to bring dispassion to bear on the welter of special pleading—who will do it better?

After all, everyone, irrespective of his depth of knowledge, practical experience and personal bias, is currently trying to get into the political act on the health care stage—academics of all kinds from anthropologists to sociologists, consumer bodies, voluntary societies, trade unions, staff associations, and local and national organisations of every kind in the health and related fields.

Was it not better, Professor Abel-Smith therefore implied, for the administrator to accept his coordinating role in this sphere as he did in his daily work, so that he could represent and weigh the views of patients, professionals and pressure groups before using whatever means he thought best—publicity media, consumer association, local politician, trade union—to bring these views into the orbit of government thinking and so help to improve the lot of the patient and possibly also the health system's share of the national income?

It was a seductive and flattering argument hard to resist, and most seminar members seemed happy to give in and accept it, although as far as the North American members were concerned this seemed to be in principle only—something to which they could theoretically subscribe in an ideal situation rather than a practical proposition applicable to the real world in which they work.

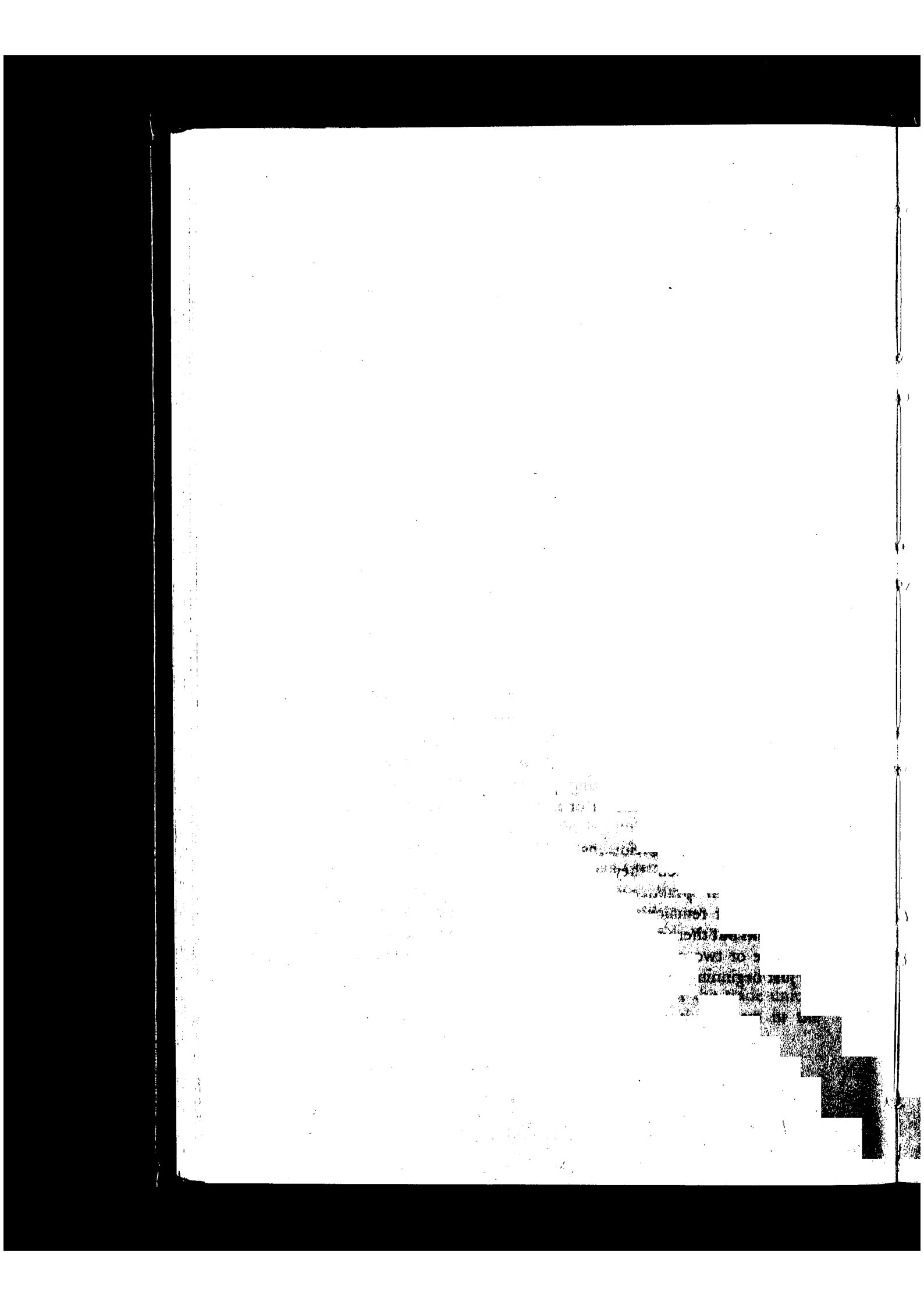
Some members, too, were reluctant to consider the trade unions as colleagues who might be genuinely helpful partners in the

political arena, largely because they were sceptical of the altruism and orientation toward patients attributed to the unions by the Professor.

Once again the Canadian and American members felt strongly on this particular point, as Dr Harvey Barkun's paper in the next section demonstrates. But all members expressed some cynicism over the sporadic outbursts of 'industrial action' in the health service in most countries in recent years. Certainly in the UK the latest industrial legislation tends to clog, frustrate and make very difficult the work of the administrator.

With these provisos, however, the seminar, despite its original doubt, came gently and genuinely to the conclusion that the health administrators of today, and of whatever kind, have certain responsibilities in politics. They should primarily make factual information on the state of health services, and upon contentious issues concerning them, available publicly, voluntarily and dispassionately in order to ensure that both the people and the politicians understand the situation and cannot misinterpret it for personal, self-delusional or political reasons. It is also their job to advance, often collectively, responsible solutions to national as well as local health problems, and they should always be prepared to speak out as individuals on those subjects upon which they have strong personal views, using for these purposes the publicity media or any other means at their disposal.

So presented, the conclusions sound obvious, sensible and unremarkable—as indeed they are. Whether they will make much impression in practice on the traditionally apolitical health administrator remains to be seen. It takes time to teach old dogs new tricks but there are perhaps some signs (such as these seminars) that one or two of the elderly administrative canines may at least be just beginning to learn to wiggle their ears.



IV Allocation, Deployment and Control of the Use of Resources, Including Manpower

8

An Introduction

ROBERT MAXWELL

Among the facets of health management explored in this book, resource allocation, deployment and control represent the heart of administration. Some people may question (wrongly, in my view) whether the administrator has much of a role in helping to select priorities for medical development or in the evaluation of care. Nobody is likely to question that one of his key functions concerns resource management. That may be why more participants wrote papers on this topic than on any other.

A Dual Role

What, then, is his role in resource management? First it is nearly always a dual one, at once supplicant and steward, advocate and judge. For the administrator has to obtain resources before he can allocate them. Even at national level, the Department of Health has to make its case for public funds to the Treasury, and at each organisational level between central government and a hospital or community agency the administrator must act at different times on each side of the budget negotiation process.

In this he is basically no different from any doctor who seeks the resources for his own field of interest. Both, as petitioners for funds, are likely to be expansionists: they make the best case they can. Having obtained what they can, they seek to optimise within the limits imposed on them. It is wrong to assume that, simply because administrators are allocators and controllers within their own institution or agency, they should not also be effective budget applicants. Indeed, *unless* they are, they are not fulfilling a part of their responsibility to those who work with them and to the community they serve, nor will they earn their confidence.

Perhaps, however, there should be a difference in attitude between administrators and clinicians. It is this: the clinician will naturally seek to equip himself to cope with the exceptional. Ideally no patient should receive less than perfect care. In economist's terms, the clinician is likely to press his case to the point where the marginal benefit of further expenditures is zero. The administrator's attitude, even as a budget advocate, is less extreme. He must pursue his case sensitive to the reality of the need for choice. Resources taken by his institution or agency will not be available for use by others; resources preempted for health care leave less for the community in other ways. Thus the administrator should understand that, far short of the limit where the marginal benefit of further expenditure is zero, there is a point where the benefit may be substantially less than in alternative uses. Clinicians may have this awareness. Senior administrators worth their salt must have it.

Creating the Structure

A particular administrative responsibility is to see that the way in which resources are allocated, deployed and controlled is sensible. If not, the administrator should set out to change it. Thus he should be an innovator, not for the sake of change, but because

change is sometimes necessary. He should act whether the barrier to good sense exists in his own institution or elsewhere in the system, and whether or not it can be quickly removed. For example, in some European countries, and at times in Canada and Australia, hospitals have been excluded from the development of community-based alternatives to institutional care; and hospitals have sometimes had every incentive to keep patients longer than necessary because they were reimbursed on a daily basis. Such barriers and disincentives should be removed. Too often, administrators concern themselves with the immediate budget problem to the exclusion of creating a structure and climate in which such problems could be avoided, or more easily solved. This preoccupation with crises as they arise is certainly not peculiar to the health service. On the contrary, there seems to be a management law—resembling Gresham's law of banking that debased coinage drives out coin of higher intrinsic worth—which constantly distracts senior managers in all fields to deal with whatever reaches their in-tray. Yet, given time to reflect, each of us can see the elements of a sensible sequence of resource management. For example (without being exhaustive), among the elements should be the following.

A Rational Basis for Sharing the Available Resources

One astonishing aspect of the recent attempts, outlined at the seminar, to allocate finance on a more equitable basis in England and Scotland is that they were not made long ago. In saying this, I am not suggesting that the formulae now proposed are necessarily right. Indeed, working in an apparently well provided teaching district of a deprived urban community, I can see grave danger in a search for territorial equity in the distribution of resources without regard for quality of care, concentration of specialised services and critical mass. Nevertheless, there is at least a rational basis for what is being proposed, and one which can therefore be analysed and challenged. There should also be a strong link between

the basis on which resources are shared and a long-term vision and strategy for health services. Resource distribution, though tremendously important, should always be secondary in health; it is part of a senior administrator's duty to ensure that there are long-term objectives and strategies, and that these make sense.

An Organisation Appropriately Composed and Informed to Make the Difficult Choices

Resource management in the health service inevitably requires choices: almost never, at any level, are resources so abundant that everything which is worth doing can be done properly. Although there are occasions when the decisions about the use of scarce resources can, and should, be taken by one person, the more complex choices usually call for several people. Thus there should be involvement on behalf of the community in deciding to develop one service rather than another. Provided it is responsible and informed, such participation must be needed since it is not for the providers (whatever their discipline) to decide on their own what is good for the community they serve. And on the provider side, several disciplines need to be involved, including crucially some of those whose prime role is clinical. It is not only that the knowledge required often calls for the involvement of several disciplines, but that everyone's commitment is needed to work with the resulting compromises. It is relatively easy to blackmail a health agency if you are determined to do so whether you are a surgeon, a labour leader, a senior nurse or a fire officer. This is a depressing truth for anyone in health administration. The encouraging converse is how responsible and ingenious these same people can be when they find themselves in the position of managing scarce resources at a level they can understand.

A Budget Broken Down to Responsible Budget-holders and Relating Means to Ends

It seems obvious enough in principle that the way to obtain value for money from a health budget is to decide how much to spend on particular functions or services and to entrust to a named individual or group the task of running that function or service within the budget limits to achieve stated objectives and standards. Yet it is almost never done. Sometimes this is because it is politically uncomfortable. For example, provincial governments in Canada have been ready enough to set budget limits but most unwilling to accept the corollary that discussion must also take place on what can, and what cannot, be done with finite resources. In the UK, which has much longer experience than any other Western country of living with tight budget limits in health care, there are gross inadequacies in the financial information system at the level where most money is actually spent. People simply do not know what it costs to give effective care (partly, in the UK case, because patients seldom have to be charged), nor what the relationships are between costs and levels of service.

A Real Control of Expenditure and a Review of Results against Budget and Plan

Nothing more totally undermines efforts to manage resources than sudden changes in funding limits, or a failure to enforce the limits. You cannot expect people to be parsimonous for eleven months of the year, if you reveal to them in the final month that their efforts have turned out to be unnecessary, or that others who have exercised no such restraint have escaped penalty. There has to be a credible and orderly discipline. Moreover, the review of results should not merely be against budget, but of what has been achieved with the budget. Such a review against plan is in fact rare in the health field and, even when it occurs, generally uses the wrong measurements. Output measures such as inpatient

admissions, or days of care, are conceptually inadequate when what we ought to be discussing is the tangible contribution made to people's health.

This description of the structural framework of resource management is certainly incomplete. Nor would I necessarily defend every item in it. What I would defend is the case for senior administrators to spend a substantial amount of time and effort thinking about the framework within which they manage resources and trying to improve it.

Educating and Informing

A second aspect of a senior administrator's role in resource management is, in a broad sense, educational—often as a catalyst of change. He has a duty to see that those involved (whether as trustees, members of committees or budget holders) have a coherent part to play, and that they understand what their part is. He must help them specify what information they need, and see that they obtain it. Furthermore, he must continually challenge them to do better, and encourage them to challenge themselves, since they should be their own most perceptive critics.

Part of this educational role is to encourage experiment, in the certain knowledge that some experiments will go wrong. Risk-reduction may be proper adminstrative concern, but risk-evasion is not. Senior administrators should be prepared to bend systems and procedures to ease the path for innovation. You may know the remark of the old professional cricketer when asked if W G Grace ever went outside the rules. 'Well, no,' he said, 'but it was wonderful what he could do inside them.' My only scepticism about that story is a suspicion that from time to time W G *did* go outside the rules; administrators should be prepared to do the same in a worthwhile cause.

There is also a gap which administrators should do their best to close between indigestible, unused data and information stimulating people to manage. It is appalling how many potentially useful health management data are in an incomprehensible form. For example, in the UK, hospital activity analysis provides a vast number of figures, which is for the most part ignored. The neglect is not in the main wilful, nor is it because people are unaccustomed to using scientific information. It is chiefly because time, thought and imagination are needed to transform a mass of statistical data, often computer-based, into something relevant, useful and comprehensible. I enjoy quoting the story of how Napoleon was once asked why, among his talented marshals, he had one obviously stupid man. He is said to have replied, 'I know that when he understands, the rest of you understand'. Thus the administrator, whether clever or not, can play a constructive role by insisting that available data are in a form which he understands and which is relevant. There is then a good chance that the information will be used.

Lastly under the educational heading, the most important factor of all is attitude. If the senior administrator genuinely seeks excellence in the performance of the services and institutions of which he is a part, and has curiosity and perseverance, his attitude will influence others.

Seeing the Resource Situation in Whole

Being a senior administrator in health care is a little like being a gardener. What matters is not the gardener and his efforts, but the garden. Moreoever, the most important things that go on in a garden depend on forces over which the gardener has no control. Nevertheless he has an important enabling role in perceiving the overall effect of the garden, in guessing the likely result of changes, and in selectively encouraging and restraining growth. To some extent the administrator's role, like the gardener's, is a compen-

sating one. That is, he needs to cajole new ideas and developments in some fields, and to restrain exuberant, dynamic growth in others. He must always be concerned about balance, about comparing one need with another and about the use of resources throughout the institution or agency for which he is responsible, and in the broader network of services of which it forms part. He must not think about resource bids from any single department or service without relating that bid to a broader vision of the whole. Even apparently small bids may have major implications for other departments, and may also be a small beginning of a much more major development. As Sir George Godber put it, 'In our present situation all concerned must see that a decision to put a major—and almost certainly expensive—effort behind some part of the service is a decision to reduce or at least not increase the effort given to something else, which others may think more deserving.[14] Moreover, he must be concerned not only about new bids and the spending of development monies, but about value for money in a whole budget, including long-established activities.

Changing the balance of resource use to any significant extent in health services is extremely difficult, as all leaders in this field have found. This is partly because these services are personnel-intensive: once appointed, a person's function may be hard to change, and you are committed to the financial implications of his appointment. Also, the more complicated and expensive services have a voracious appetite for growth. Many ministers for health, in different countries, have talked about changes of priority away from expensive acute care to prevention or primary care or the care of neglected groups. Yet often, as Robert Nicholls reflected in his paper from a district containing a major medical centre, their intentions are not borne out in practice: the acute services still grow faster and absorb a larger share of the total resources available. To achieve a big change of balance in the medium term requires either fundamental (and perhaps unlikely) changes in the organisation of health care, or an inflow of development monies sufficient to finance the advance of acute service while still leaving substantial

sums to be spent in other services. However, it is worth remembering that small annual changes in balance, of the order of one or two per cent of total expenditures, are achievable and that, when sustained over a period of five or ten years, they in fact lead cumulatively to a substantial shift of strategy.

Senior administrators should never forget that effectiveness is what matters most in health care. Efficiency has its points, and is usually much easier to assess. But high efficiency combined with low effectiveness adds up to low achievement and an improper use of scarce resources. Effectiveness is therefore always the more important criterion. It should be applied to fashionable strategies—such as the switch in balance away from the acute services—since any strategy, no matter how plausible, can be judged only by its results. So, in resource management tasks, the control of expenditure is never as important as what the expenditure has achieved and whether more could have been done had the resources been applied differently.

9

The Year of the Formulae

JOHN HOARE

Since mid-1976, administrators have been accustoming themselves, in a manner not known before, to using, making or examining formulae for the allocation and deployment of resources. Some examples from national and local experience are national and regional revenue allocations for 1976-77[5], revenue and capital allocations 1977–78[8], control of managerial costs and capital investment boundaries.[7]

The formulae are all related in the following sense: they share a pursuit of equity in the distribution of resources. They aim not to establish norms or standards of provision of particular health services in particular places, but to ensure a fair share of the limited resources available. There are two ironies in this.

First, it was commonly supposed in 1948 that the main object in creating the National Health Service was to redistribute resources to correct some notorious imbalances (roughly, between the home counties and the rest) between regions of the country. In 25 years, despite a growth increment in every year and despite manifold improvements in staffing in the poorer regions, the imbalances remain largely uncorrected. For example, in 1972 NHS spending was £48 a year for each person in the North West Metro-

politan Region and £30 in the Sheffield Region: a staggering difference of 60 per cent in resources between the richest and the poorest regions. It must seem strange to overseas observers that a total system with unlimited capability and authority to effect change should take so long to move purposefully to this end.

The second irony is that at the very moment that the country's national economic position reaches an unprecedented low, and we have to contemplate minimal growth (or none) in the service, we finally produce a considered and ingenious method of equalising funding and other resources. For obvious reasons, this is a most difficult time to equalise. The initiatives towards these formulae were partly political and partly managerial, but they did not derive from the darkening economic situation, which was unfortunately coincidental. The giant among the formulae is called 'RAWP'.

In this short space, no summary or history of RAWP is attempted, but the following notes aim to give overseas administrators an impression of the significance that the policy has in the eyes of English administrators.

RAWP

The word is an acronym formed from resource allocation working party. The working party was created by the Department of Health and Social Security in May 1975, its members drawn in roughly equal parts from the department and from the NHS. The working party produced an interim report in August 1975[5] and a definitive report in October 1976.[8] The interim report had a strong influence on the distribution of funds to the NHS in the financial year 1976-77 and it is likely that the definitive report will, in large measure, be adopted by the Secretary of State and will determine the direction and the method of funding by national, regional and local health authorities for 1977-78 and for many years to come.

The report sets out what is potentially the most important policy for change to have emerged since the National Health Service Act of 1946[10] (not excluding the National Health Service Reorganisation Act of 1973[11]). Since late 1975, the word RAWP has come to mean the policy and system advocated by the Working Party, and it is used in that sense in this paper. RAWP has formulaic antecedents in the NHS dating from 1971, with similar aims but largely ineffective tools and application.

Purpose

'. . . the underlying objective is . . . to secure, through resource allocation, that there would eventually be equal opportunity of access to health care for people at equal risk.' To do this, RAWP seeks to define '. . . criteria which are broadly responsive to relative need, not supply or demand, and to employ those criteria to establish and quantify in a relative way the differentials of need between different geographical locations.'[8]

RAWP is concerned with the distribution of exchequer funds to health authorities in England and Wales. It does not deal with the use of those funds—only the division of the funds into capital and revenue streams and the definition of a special weighting for teaching hospital allocation. The funds exclude those spent on family practitioner services (about 20 per cent of the total). In 1976-77 the total under RAWP review was about £3.4 billion.

RAWP is not concerned to define the proportion of the national public expenditure claimed or requisite for the health service. It is an instrument for dividing whatever total is available. It aims to answer the question: How should the funds available in any given year be distributed?

Redistribution

RAWP proposes that the DHSS and NHS should adopt certain formulae to determine targets for the future and equitable allocation of all revenue and capital to the NHS regions, and from regions to areas and from areas to districts. These proposals are in stark contrast to the traditional methods, which relied almost entirely on a base of 'historical' funding.

Because the effect of applying the formulae will be a significant redistribution in present levels of funding—at the extremes eventually requiring one region to lose 17 per cent and another region to gain 12 per cent—the results are presented as relative targets to be attained over a period of years. The rate of movement toward targets is not specified by RAWP: one determinant of that rate in practice will be the amount of development which can be made available to the NHS in the next few years. Other determinants will, of course, be political judgment and will.

The Formulae

For Revenue Allocation

For any given year, and any given region, the divisor of the total NHS money available will be the relative size of population of that region. The crude population count is to be weighted by a number of factors—age and sex, standard mortality ratio, index of fertility rates—and adjusted for interregional 'patient flows', utilisation of outpatient, community and psychiatric services, together with a special allowance for teaching hospitals. The weighting is intricate and significant, producing differences to crude regional populations in a range from 0 to 12 per cent, with an average swing of 5 per cent increase or decrease.

For Capital Allocation

In the long term, a formula very similar to the revenue formula is proposed. In the medium term, because of considerable differences in the capital inheritance of each region, a valuation of existing capital stock is used in combination with the amount of new capital money, and is matched against a weighted population to determine which regions fall short of their targets and thus require additional funds.

Distribution of capital in any year is according to a two-part formula: the major allowance to be by weighted population; a variable minor allowance to correct historical deficiency.

Violent controversy within the service (virtually none elsewhere) has followed the publication of the RAWP proposals. Predictably, those who foresee loss reject the policy, those who stand to gain in resources support it.

There is a remarkable unanimity of agreement about the principle of allocating according to need, expressed in terms of the size of population served, and gross disagreement about its application. The London regions (with one interesting exception) with their great teaching hospitals oppose any application of the principle until there are substantial development funds available nationally. Their case is simple: by all means redress the balance, but it would be folly to do this at a time when it can only be done by reducing important centres of excellence. It takes little imagination to guess how the deprived regions respond to that view.

Approach to resource allocation by formula is now ingrained in the service: variations and developments of the theme marked the attitude of most regions, and many areas, to their capital and revenue allocations in the year 1976-77. Whatever the national decision on RAWP, this approach is certain to be intensified in the next years at regional level and below, not merely in funding

arrangements, but also in manpower planning and the use of other resources.

Effect on Administrators

What are the implications of the equitable formula for NHS administrators in the future? These are difficult to foresee, but the following hunches are offered for discussion.

There will be a gradual but profound change in one traditional role of the administrator: that of making the case and battling for more resources, as we move from historical funding to formula funding.

On the other hand, there is the danger of assuming that the notion of targets preempts executive decisions at national, regional or local level to aim wide of targets, for any one of a host of pragmatic reasons. Nothing in RAWP or comparable formulae should be seen to imply mechanistic allocation.

There is no doubt at all that the discipline imposed by the formula and, even more, the discipline of the finite amount of cash that follows, provide incentives (sometimes an imperative) to reduce, eliminate or redeploy expensive facilities long acknowledged to be superfluous—however convenient and acceptable they may be to staff and to the community—but hitherto protected by historical funding and the lack of a compelling incentive. This applies as much to the gaining as to the losing regions.

The deployment of resources at regional and local level depends mainly on the planning system, upon which RAWP and its sons will act forcefully as a constraint or a guideline. It is the control of resources which has received least attention since the reorganisation of 1974 and which may be described politely as being weak and incoherent. Under the banner of monitoring of services and perfor-

mances there are signs, in parts of the country at least, that the establishment of new policies, frameworks and systems of control is becoming a major preoccupation of administrators.

10

Resources in Scottish Health Services

ROSS MITCHELL

Because our resources are limited and the demands virtually unlimited, consideration of the deployment of resources rapidly resolves itself into a study of objectives and priorities.

While it would be wrong to state that no thought has been given at national level to objectives and priorities—the current emphasis on preventive medicine and the care of the elderly shows this not to be the case—it is true to say that the subject has never been approached in a systematic manner. From time to time attention has been drawn by the central department to the need to develop certain aspects of health care or to take certain remedial measures. The origins of this advice may be found in reports of working parties, committees of enquiry and so on, and the central department is usually not slow to react to pressures of this nature. It has come to be realised, however, that reactive management of this sort is not good enough, especially in these troubled economic times, and that a more explicit and systematic approach is necessary.

The current emphasis on the non-acute aspects of health care may be the correct one but it is difficult to avoid the conclusion that it owes more to political judgment—if not hunch—than to any objective assessment of needs and resources.

Reasons for Lack of Progress

It is easy to see why little attention has been devoted to this difficult exercise of priority setting for, until recently at least, the incentive has, for a number of reasons, been lacking. For example, the service has become used to the provision of development monies which allowed health care facilities to expand. Attention was focused on how to spend these development monies while the use of the existing financial allocation received scant notice. This approach gave rise to the much quoted 'disjointed incrementalism'.

Even given the will to tackle the setting of objectives in a more explicit and systematic manner, practical barriers remain.

There is no 'clean slate'. Patterns of health care have emerged over the years and changes can be effected only at the margin. The cumulative effect of such changes should not, however, be underestimated.

There is an absence of appropriate health indicators. Measures of input to the service are easily obtained; output figures are much more difficult, especially when some indication of the quality of care is needed.

In a period of severe financial restraint, many developments will be achieved only by cutting back less essential services. Any study has, therefore, to identify not only where development is needed but also where some reduction is possible.

Factual studies go only so far and then value judgments take over. A case in point is the current controversy over the fluoridation of the water supply.

The basic economic problems of resource allocation—what to produce, how to produce it, for whom to produce it—are difficult

enough in themselves without having superimposed upon them considerations of the kind listed above. It is little wonder, then, that no radical and systematic appraisal of resource allocation has been attempted at national or any other level.

The Role of the Public

Any appraisal must concern itself with values because choices will have to be made. Do we save life, reduce morbidity, or provide care and comfort? But whose values do we adopt? Ideally it should be the values of the consumers but it is extremely doubtful if these can be canvassed except, perhaps, when a specific or local issue is considered. Assessing priorities is a difficult exercise and requires knowledge of resources and needs, alternative uses of these resources with their consequent gains and opportunity costs; for example, benefits foregone by not investing in the next best policy. Making this essential information available to the public would involve a complex and expensive educational operation and the likely end result would be an emphasis on the hotel, rather than the medical, aspects of the service.

Local health councils have the statutory duty of representing the views of the public to health authorities, but it is difficult to see them having any meaningful role in the setting of priorities at national level.

If this analysis is correct, decisions about priorities will, of necessity, be made by professionals—administrative, medical or political—even if this introduces an element of paternalism.

Possible Approaches

Development monies which allowed the service to expand steadily over the years have, as already suggested, masked the inadequacy

of our approach to priority setting. Any new approach will require a detailed analysis of the facts of the situation based on up-to-date and reliable data. The objective might be regarded as ensuring, so far as possible, that every person has an equal opportunity of securing access to the health facilities they need.

There are several possible approaches to this complex problem of priorities.

By Area

Much thought has been given recently to the concept of territorial justice by working parties on resource allocation in both England and Scotland. A recent White Paper on public expenditure (Cmnd 5879) stated, 'Further efforts will be made to reduce the inequalities in standards of service which exist between different areas, to ensure that the services available in any area are more closely related to its particular needs . . .'[12]

Throughout the UK generally there are undoubtedly some geographical areas which are more deprived than others in terms of health. One major difficulty, however, is the absence of meaningful data on morbidity.

The English resource allocation working party finally proposed a complex formula which takes account of crude population weighted for age and sex, fertility rates, standardised mortality ratios, patient flows, and so on.[8] There is obviously a temptation to include as many factors as possible, but the reliability of the data becomes increasingly suspect, the administrative workload increases and the risk of double counting becomes greater.

The Scottish resource allocation working party has, to date, produced only an interim report* but it has already become clear that the English formula could not, for a number of reasons (for example, wide variation in the size of Scottish health authorities), be 'imported' without substantial amendment.

No matter what the formula is, it can achieve only a rough form of justice, but at least it offers some prospect of breaking with a long tradition of incrementalism.

By client group

In Scotland, programme groups have been established at national level under the auspices of the Scottish Health Service Planning Council to review child health, care of the elderly and of the mentally disordered (significantly the underprivileged sectors). Each group is, however, to some extent in competition with the others and, consequently, any recommendations made by them will have to be considered in the context of how they fit into the total strategic pattern for health care.

While these are possibly the two main approaches, others present themselves: balance between acute and long-term care services, between hospital and community services, between curative and preventive measures.

No matter what the approach is, difficult decisions have to be taken and, despite the mass of factual data which will be available, value judgments of a sociopolitical nature are bound to play an important part, just as they are when the NHS 'slice' of the national 'cake' is being determined. It is perhaps worth pointing

*Report of the Working Party on Revenue Resource Allocation, published May 1977 and popularly known as SHARE (Scottish Health Authorities Revenue Equalisation).

out that in Scotland a health priorities working group has been established under the auspices of the planning council with the remit of reviewing health priorities in Scotland and recommending any changes required to make the most effective use of the resources available. The recommendations of this working group will, of course, have to go through a political hoop but it is hoped that decisions will be made in the light of factual data and with a clear knowledge of the opportunity costs involved.

Allocation of Resources

Any reallocation of resources will, in the first instance, be effected by adjusting the financial allocations made to health authorities by the central department. If the basis for any change in resources is simply that some health authorities need more money than they have been allocated in the past, the allocation of additional funds is relatively straightforward, although some form of phasing will be necessary to make the transition for both gaining and losing health authorities as painless as possible. If, however, the switch in resources is being done on some other basis, by client group for example, the matter is more complicated because each authority's share of the client group will require to be quantified and a proportional allocation of funds made.

Control and Evaluation

If we are not very good in this country at answering the question, What is your objective?, it is true to say we are even worse at answering the question which ought to follow: How do you know when you have attained your objective?

Planning should be a cyclical process beginning with the identification and anticipation of problems (or opportunities), proceeding through the various stages of problem definition, objective setting

and so on, to the final stages of monitoring, control and review when one is trying to ascertain what progress is being made towards the attainment of objectives. The problems of measurement will certainly arise at these final stages. If the basis for any reallocation of resources is territorial justice, possibly the central department will monitor only in very general terms and be content to see an increase in the input of manpower, buildings, and so on, to those areas which receive additional funds. But we return to the old question: How do we measure output, bearing in mind that many improvements in the state of the nation's health depend more on alterations to life style (smoking, alcoholism, obesity) than to the National Health Service? It will be extremely difficult, if not impossible, to say that additional input X led directly to improvement in health status Y.

While there may be a gain in specificity, it is doubtful if the problem of measurement will be any easier if the reallocation of funds is done by client group, or similar. Admittedly, if priority were being given to, say, maternity and child health services, one could look for a drop in maternal deaths and perinatal and infant mortality rates. Even in these cases, non-NHS factors, such as smoking, play a part.

If, however, we turn to the care of the elderly, what do we measure? Average life-span is too general and tells us nothing about the quality of life. Additional geriatric beds may be welcomed, especially if a particular area is well below standard in its scale of provision, but taking any one factor in isolation could be dangerous—possibly the patients occupying the additional beds could more appropriately be accommodated in a local authority sheltered housing scheme.

All this leads to the view that it is very difficult at national level to monitor and evaluate in any precise sense. A more meaningful exercise could perhaps be mounted closer to the operational level but this line of thought eventually leads to some kind of medical audit—and that is another subject!

11

The Role of the Chief Administrator

HARVEY BARKUN

Most of us present at the seminar were brought up in the traditional sense of management. Our role has been that of the manipulation of manpower, material and money. More euphemistically, it is called the allocation of resources. For many years, resources have been distributed according to needs and priorities established within those needs. I would venture to say that in the past two to three years, the scene has changed radically. Management in the health service currently consists of distributing resources not in accordance with needs, but in accordance with availability. Every health administrator in the Western world has been faced with the problem of the management of shrinkage, and where formerly we would cajole, persuade, convince and juggle priorities, today we have to look at work we are doing and decide what else we can do.

The pressures are varied and enormous. The community perceives its needs, and damn the resources available. People demand service since governments have been prone to promise these services. Agitation is rampant; services must be provided in their most sophisticated state, 24 hours a day, and in a very human fashion. The health professional must be an expert in preventive medicine,

a specialist in CT scanning, an angel in human relations, and at the same time be the most productive worker on earth.

Governments insist on efficiency, as they see it, and adherence to bureaucratic norms, a willingness to complete endless forms and a balanced budget at the end of the fiscal year.

Trade unions are convinced that the hospital exists only to provide jobs. Institutional objectives do not interest them. Negotiations, grievances, arbitrations, never mention the patient. The worker and his well-being are the ultimate objective.

Medical staff, at least in the Canadian context, are in a curious position. They make up a parallel structure of administration in the hospital and are in the envious position of authority with virtually no responsibility. However, it should be noted that, in recent years, enlightened medical staff have realised the import of their decisions within a given institution and have demonstrated much more profound responsibility in terms of the impact their decisions carry. The seemingly endless requests for more personnel, more equipment and more space appear to be diminishing and, we must hope, this trend will become contagious with other groups in the health community.

Caught in the dilemma of allocating and deploying resources to meet the perceived needs of all these groups is the chief administrator of the health institutions. His perception of need will be highly coloured by his own background. In the long term, he will be held responsible for the results obtained, depending on who is evaluating results. The community will demand more services with no regard to available resources. The government will demand a balanced budget. The labour movements will demand more jobs. The medical profession and the paramedical workers will demand more sophistication, and professional advancement. For those of us involved in teaching milieux, our universities and colleges will demand more facilities for providing teaching programmes. How,

then, can the chief administrator arrive at rational decisions which will help him meet the true objective of the health institution—service to the sick and, in the case of selected institutions, the teaching of medicine and allied professions and research?

I believe there are certain basic elements which enter into the decision-making process in rationalising available resources to meet perceived needs.

The chief executive officer must be a first class communicator. He must involve himself in dialogue, and idea exchange with all those who make up the health system. His inhouse role of manager must be subservient to his function as the person in the hospital who relates to all groups. He must be able to listen to what others perceive as their priorities and, at the same time, impart to the same participants the context and the constraints with which the hospital has to operate.

He must involve himself, his administrative team and others in the establishment of priorities for the allocation of resources. The complexity of any hospital will not permit the formulation of ideas in isolation. Call it a domino theory or musical chairs. Rarely does a single decision not effect myriad other areas, both in and outside the hospital.

The chief executive officer must put effectiveness before efficiency. The latter constitutes the most economical way of performing a task; effectiveness is guaranteeing that the task is the correct one. There is really no point in being efficient and applying that efficiency to the wrong goal.

For years, we have gone through the same exercises in the allocation of resources. We develop budgets within various cost centres. We collate these and then establish priorities. We submit these budgets to funding agencies which, in Canada, are our provincial governments. We ask for money for people, material and new

programmes. We invariably get less than we ask for and then a great debate begins with those responsible for providing us with our resources. We get into great statistical wrangles and we compare with similar institutions on the basis of man-hours, paid hours of what-have-you, cost per patient day, meal, and any other factor you can think of. I believe the time has come, given the diminution in available resources, to look very hard at the origin of our cost generation.

We traditionally do many things in our hospitals. Rarely do programmes disappear; we seem to know how to add, but rarely how to subtract. In the hard light of today's diminishing dollars and pounds I suggest that we in Montreal General shall need to do four things without further delay.

1 We must apply the principle of zero-base budgeting and look at everything we do. If the objective is still valid, we must look again at the way we are doing it.

2 We must explore very carefully with our sister institution various ways in which we can really share services. For years, we have been duplicating services and comparing notes. Empires will have to be destroyed and new entities rise from the ashes. In the Province of Quebec, the predicted dire consequences of the regionalisation of obstetrics have not materialised. On the contrary, infant and maternal mortality have decreased sharply and, to my knowledge, there has been no untoward effect whatsoever from this regionalisation.

3 Governments and funding agencies will have to be convinced that the brave new world resulting from health education, preventive medicine and a new life style will not eradicate illness over night. Most preventive health programmes other than vaccination and water purification, still have to prove their worth in the reduction of morbidity and mortality.

Epidemiologists still have to prove that health education can change the life styles of mass populations.

4 We health administrators will have to begin to speak up and respond to the dreadful tales being recounted about the soaring costs of health care. Despite all the scare headlines, financial resources in Canada allocated for health care expressed as a percentage of gross national product have actually diminished over the last two years. I believe we have been the whipping-boys long enough and it is time for us to respond both as individual institutions and through our collective associations.

The sound operation of today's health centre, be it a community clinic, a hospital, a regional health council or any other health facility, results from the input of many highly specialised and highly differentiated disciplines. Patients, or 'clients' as they are called in some societies today, are dealt with by physicians, nurses, technicians, managers, clerks, social workers—the list is almost endless. These comprise the manpower resources who need the support of both material and monetary resources. With the structures available to us it is up to the chief administrator of the health facility to mould these resources in the best interest of our patients.

Commentary

LESLIE PAINE

Mention the deployment and control of health resources to a group of senior health administrators almost anywhere, and you can count on a fairly standard reaction. What is almost bound to result, as a sort of reflex response, is a series of dissertations on the deficiencies of the existing arrangements which will be unusual if they do not include the following. First, acute hospital treatment is overemphasised to the detriment of that much supported but ill-defined concept 'community care'. Second, the way resources are currently allocated fails to take adequate account of the needs of such disadvantaged people as the old and the mentally afflicted. And third, far too little attention is paid to some of the roads—such as preventive medicine and health education—which could lead us much nearer to health care salvation.

All of these, as the papers and discussions on this third aspect of the seminar's theme exemplified, are valid criticisms of the way that many of the industrialised countries currently try to bring adequate health care to their people. But what emerged equally clearly was that we as administrators have a long way to go yet before we can claim to have established, let alone fulfilled, the practical part we can play in helping to meet these criticisms.

The core of the problem, as Bill Lawrence from Australia stated in the paper presented in his absence, is well known to us all. Change in the use of health resources is a highly complicated and inevitably slow process which, in its broader aspects, frequently involves government action, and which, even when confined to narrower local issues, can seldom be either forced or totally resisted by any single group of health care workers.

This is one explanation for John McClelland's proposal in the earlier and related discussions on medical developments and service priorities, that time's ever-rolling health care stream bears all its administrators away, fully engaged in keeping their own little, personal canoes afloat in a spate of waters forever swollen by cloudbursts of clinical aspiration and public demand.

It also helps one to understand Bernard Snell's gloomy hypothesis that our present difficulties as organisers and planners of health services are merely reflections of the sickness of the society in which we live, and through which stalks his dreaded 'anomie' like Edgar Allan Poe's 'red death' through the House of Usher.

It undoubtedly gives credence to Dr Snell's other argument that some of our major organisational problems in health care may not be susceptible to any obvious or straightforward solution. And it certainly supports Robert Maxwell's view as chairman of the seminar, that one lesson to be learned from events such as the publication of Marc Lalonde's report on the future of Canadian health care, which appears to have risen like a rocket and now fallen into oblivion like the stick, is that while we as administrators all know well enough what we should be doing about these problems, we have little real idea of how to go about doing it.

As Robert Maxwell said, the difficulty of resource deployment in the health service is that it is like certain clinical conditions—easy to diagnose but difficult to cure—a truism which members felt they had no option but to accept. However, from the tenor of

their writings and discussions they also felt that, despite the difficulties involved, the time had come for them seriously to push forward with some kind of new administrative action in this sphere—even though it would probably have to be, at least for the time being, palliative rather than curative.

Paul Hofmann, for example, said forthrightly in his paper that a senior administrator today is not worth his salt unless he is capable of demonstrating creative thinking by formulating progressive plans, by recommending challenging short- and long-term objectives, and by stimulating his colleagues into helping him achieve these. Merely to drift with the tide and ensure that no one rocks the boat is, to use his words, 'defensive management . . . practised by a static and non-productive figurehead'.

His colleague from across the Canadian border, Dr Harvey Barkun, expressly states in his paper that the traditional role of the administrator is 'manipulation of manpower, material and money'. This, he points out, demands that the modern senior health administrator be a good communicator, capable of imbuing governments and other funding agencies with a sense of reality in their thinking and planning of health services.

Bill Lawrence reminded us that the control of existing commitments in the health service is a major task in itself with which the administrator has to be concerned if only to be sure that the systems he has designed to achieve such control are reasonable. 'To be more specific,' he said, 'the system in which I work [with seven central and 240 local agencies concerned with the health care of five million people], could even be over-administered in terms of inputs to resource decisions'—a view which is echoed very strongly by the current and rather coyly entitled 'management restraint exercise' now under way in the UK.

Managers, too, as Robert Nicholls pointed out in his paper, are directly responsible for the operation of the so-called 'hotel and

support services', which in themselves gobble up a vast amount of resources, accounting in his Southampton Health District of England, for example, for almost one-third of the district's total annual expenditure of about £30 million.

Bob Nicholls also argued that the administrative contribution to the operation of the UK health care system is wider than the control of certain non-clinical resources, and involves strategic, tactical and political influences as well. Strategically, he believes that although others may usually initiate the ideas for development, it is the administrator who produces the forward plans and sets down the objectives of the organisation. Tactically, it is the administrator whose job it is to see that the strategic plans are balanced and that the objectives are practically attainable. Politically, it is the administrator's task to advise upon, organise and usually participate in the consultation necessary to achieve these plans.

But however else we go about attempting to define the administrator's role in this particular and fundamental area of health care organisation, it is probably as providers of facts and information, as planners and seekers after measures of effectiveness, and as influencers of our clinical colleagues by these means, that we shall find a most satisfactory role, both for ourselves and for those we exist to help.

This is why John Hoare quite rightly says that the report of the UK resource allocation working party (RAWP)[8] contains (in his words) 'what is potentially the most important policy for change to have emerged since the National Health Service Act of 1946[10], not excluding the National Health Service Reorganisation Act of 1973.'[11]

For RAWP sets out to tackle (and is showing signs of some success in doing so) one of the basic problems of the NHS in the UK since

its inception—and almost certainly in every other country in the world also—the problem of inequitable distribution of resources.

Its objective therefore is to redeploy resources so as eventually to give equal opportunity of access to health care for people at equal risk. In order to do this, the formula has sought to define criteria which can first determine need and then somehow quantify it in all its varieties, in town and country throughout the land.

But, as John Hoare says, RAWP is concerned only with how government funds are distributed to health authorities and in no way deals with how these funds, once received, are used—except to divide them into capital and revenue pockets and to give special allocations to hospitals concerned with teaching. At best, in consequence, it remains a form of rough justice which, while it spreads the money more evenly and possibly also more fairly, certainly, when we are hard up as we are now, spreads a limited and—as Harvey Barkun suggests in Canada—a dwindling amount of cash more thinly in many areas.

As might be expected, therefore, the RAWP proposals, as Robert Nicholls suggests, are currently the biggest source of debate within the NHS. 'Few have been brave enough to take issue with the key principle in the proposals that people at equal risk should have equal opportunity of access to health care, but some of the deductions being made from this would require a neurological unit, if not on every corner at least in every district.' He, like Ross Mitchell, sees dangers in clinging over-rigidly to the principle of equity upon which the RAWP formula is based.

He also, in his view from the health service trenches rather than the staff officer's armchair, has other doubts, especially when from a serious attempt to plan ahead in his health district in Southampton the following emerged.

> 'It was disturbing to find that with the district's commitment to developing facilities in support of the emerging medical school, and no major changes envisaged in the level of support for regional and other special services, the proportion of expenditure projected over ten years for the various health care groups showed a fall in primary care, mental illness and mentally handicapped, and a further rise in acute services.'

Little wonder perhaps that Robert Nicholls questions not only the quality and accuracy of the data upon which RAWP allocations have to be based, but also the severance from the whole procedure of the family practitioner committees—whose expenditure accounts for something like 20 per cent of any health district's annual budget, and through whom the general practitioners, and other providers of primary and family care on an independent contractual basis, are retained.

Like Ross Mitchell, he also cannot overlook the simple fact that improved national health stems from many other sources than the National Health Service, and is concerned with a variety of factors of which RAWP cannot take account—how and where we live, how we were educated and fill our leisure time, how fast we drive our motor cars and how much we smoke, eat, drink and worry. 'A man,' Charles Pierre Péguy said, 'dies not from his illness but from his whole life.'

For this and other equally obvious reasons, as we all know, the war against illness and deprivation will be waged for as long as mankind exists, and our job can only be to deploy as many troops as possible in such a way as to win as many battles as possible to the benefit of the greatest number of our disadvantaged colleagues. The important thing is that we go on fighting, and continue to try to deploy our forces in the most effective manner possible.

Ross Mitchell believes that 'While it would be wrong to state that no consideration has been given at national level to objectives and

priorities—the current emphasis on preventive medicine and care of the elderly shows this is not the case—it is true to say that the subject has never been approached in a systematic manner . . . The current emphasis on the non-acute aspects of health care may be the correct one but it is difficult to avoid the conclusion that it is more a political judgment—if not a hunch—than any objective assessment of needs and resources.'

Furthermore, since none of us, he says, can 'wipe the slate clean' and start again, we have to make our changes painfully and slowly on the margins of care. There are too many people in too many countries waiting for far too much urgent treatment for anything other than that, whatever the politicians may preach, promise or pontificate upon.

All of which left the members of the meeting musing, and perhaps a little bemused, on just a few of the general issues raised by this very broad and complex subject.

Asked to consider such varied but connected aspects of the problem as how administrators can try regularly to examine their organisations' whole budgets rather than just the developmental increments, how strategies can be formulated and prevention and health education approached, and how they might best fulfil the role of advocate for their institution or service, they had little new to add to what has already been said on these topics, not only in the papers and discussions of the seminar but by many other health care thinkers and critics elsewhere.

Is it possible, they debated, to set down a national strategy for a health service that is anything more than a general and somewhat meaningless statement of intent? In this connection the members from the USA were particularly doubtful. America, they pointed out, is unlike the UK in that it has no clear national objective to provide care and treatment to its total population on an equitable basis. Most American hospital administrators in consequence have

to continue to work on the assumption that what is best for their particular institution *is* best.

This came as no surprise, even to the UK members whose transmogrification from hospital to health care administrators is after all but recent. However, most members were intrigued by the further comment, made by Sister Irene Kraus in her paper, that some hospitals in the USA may even have to 'market and promote' their services in order to survive in an area where health care provision is completely unplanned.

Nevertheless, the feeling of the meeting was that broadly speaking most countries, even though their systems differed, had the same basic health care aims, and should be capable of producing common strategies of a general nature. There was a need, however, to decide which strategies should apply at which level of service, and whether the objectives of some planning (such as dealing with addiction, self-care or road accidents) should be more actively interventive; that is, designed to invade and influence life styles and public opinion, rather than merely providing a kind of safety net for people when their own actions had caused them to be in trouble.

It was also necessary to recognise the obvious obstacles to strategic planning, for most large health institutions and agencies, like the major health professions, tended to be somewhat reactionary and slow to change, especially when times, as now, were financially hard.

It appeared that despite its faults and current difficulties, the reorganised UK health service—with its emphases on integrated care, comprehensive health authorities, service planning, RAWP and joint financing arrangements between health and social service authorities—offered greater opportunities than elsewhere for administrators to participate in and to help produce strategies, objectives and policies applicable at different levels of service provision. But even here, as the UK members themselves remarked,

it was sad to have to say that the RAWP proposals and the government's published policies on priorities in the NHS showed little sign of being in any way coordinated.

While, therefore, the seminar came to the firm conclusion that strategic planning and resource deployment were undoubtedly activities which should be of vital concern to the professional health administrators and their colleagues, it also agreed, at least by implication, that the administrator's problems inherent in this conclusion were legion. Educating and motivating clinicians of all kinds to accept changes and possibly reductions in their budgets; convincing providers and consumers that resources really are limited and likely to become more so; supporting and encouraging the 'weaker' specialties and clinical activities against the strong; and educating politicians to be fully aware of the implications of their decisions—these were all formidable tasks. Promoting health education and preventive medicine and teaching people to live healthily and use the health service properly, were equally difficult and could only be successfully carried forward if tackled seriously on the widest possible front—including full use of the mass media and the introduction, wherever necessary, of legislative and taxation measures.

Confronted by so dense and thorny a thicket of difficulties, where did the seminar feel that the administrator could start to make some small step forward? One proposal was that, like charity, the best action for resource distribution should begin at home, and the administrator should in consequence demonstrate to all concerned his ability to achieve cost effectiveness in the expensive hotel and other supporting services which he manages directly. On such a simple and practical note it is perhaps right to end a summary of so imponderable a subject as this.

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V Appraisal of Quality and Effectiveness, Including the Handling of Complaints

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12

An Introduction

PHILIP RHODES

How to appraise the quality and effectiveness of services and handle complaints about them, like many of the most interesting questions, has no ready answers. My job, as I see it, therefore is to set the scene a little for subsequent discussions and perhaps to be provocative, sometimes with my tongue in cheek and sometimes not.

When you have a difficult question to answer, it seems to me to be no bad thing to look at the terms in which the question is asked. The reason for doing this is that it may reveal some underlying assumptions by the questioner, which show that his question is unconsciously loaded. The way in which he frames the question tells you something of the sort of answer that he is expecting. This, I think, is very important. Nearly all our arguments and misunderstandings arise because each disputant is proceeding from a different set of assumptions, which he has not defined to himself or to others.

Is Appraisal Possible?

In our appraisal of quality and effectiveness, what exactly is implied by 'appraisal'? It suggests a kind of cool judgment of facts, which can be collected, collated and given various degrees of weight, so that you can say that a particular piece of medical intervention was of good or bad quality and was or was not effective. But unprejudiced facts are hard to come by. Facts are collected only when somebody thinks that they can be welded together to be given some meaning. This applies as much to so-called exact science as to everything else. Scientists do not just collect facts and hope that a pattern will emerge. They make a hypothesis first and then collect facts to substantiate it. The best among them also try to collect facts to disprove the hypothesis, but such is the weakness of human nature that there are not many people capable of searching for facts which will destroy their cherished beliefs. But, as Karl Popper has pointed out, the essence of science is that it is falsifiable, not that it is verifiable. As he puts it so well, you can have a hypothesis that all swans are white, and this will hold true with every succeeding example of a white swan, but the hypothesis must be modified as soon as a black swan appears on the scene. This concept is now vital for understanding what modern science is about. It injects dynamism, impermanence and flexibility of thinking into all sciences and, indeed, into all life, so that a dogma discarded or overthrown is a sign of strength and of progress in human thought.

I would therefore suggest to you that a true appraisal of the quality of care is not possible. By true appraisal, I mean that the real situation in an act of health care is fully understood by anyone. A patient feels unwell and decides he must do something about his sensations. Modern genetics teaches us that every individual is unique; because the writ of the genes extends so far, this means that everything physical about him is unique. It is not, of course, that each separate process of which he is made up is different from everyone else's; it means that the blend of all

these processes is his alone. And every psychosocial environment is unique too. So this unique person takes himself off to a unique primary care physician, who, although he has received some kind of formal education, has various gaps in his understanding, skills, knowledge and attitudes. The doctor may be in his surgery or office and his resources may consist only of himself, his senses and a few simple tools, or he may be surrounded by all the panoply of technology in the modern internationally renowned teaching hospital. Can you really compare the quality and effectiveness of health care for a peasant in Bangladesh with that for a high-ranking politician in the developed Western world?

I would suggest, therefore, that the quality of health care is not a truly measurable phenomenon. The facts are too elusive. In every clinical situation the possible range of circumstances is infinite. At the least, there is the patient, the doctor and the resources which each may command. You may say that the doctor and his resources may stay the same for each confrontation, but the patient and his resources do not. The patient has his resources in his knowledge, understanding and attitudes towards his illness, and he has very real powers of affecting the doctor in how he will behave. These come broadly from his education, circumstances, job, approach to the doctor, use of words and all the paraphernalia of his non-verbal communication.

Of course it is for the observer—you—to be the appraiser of the quality of care, but how prejudiced are you in your understanding of medicine, patients, the particular doctor and the resources with which he works? What sort of assumptions are you making? Do you know what medicine is for, what it is about and what its limits and limitations are? What do you think you are trying to do? Do you think the particular doctor will agree with you? Do you think the patient will? When you look closely enough, the expectations of everyone in the drama are slightly different from everyone else's.

I should, of course, make it plain that I have taken the simplest example of the doctor and patient, but it is applicable to all health care professionals and, indeed, to all encounters of any depth between two or more people.

We try to measure quality of health care by a series of methods with which you are all familiar. My aim, so far, has been to show that they are still very crude and leave much out of account, and that they can never be perfected, because of the nature of the primary transaction. Any measure that you use must inevitably ignore a great deal which is important in the affective feeling of what is good quality care. One may try to keep emotions, values and judgment out of the equation, but it cannot be done. You are all very well aware of this in your daily dealings. But it really must be emphasised and re-emphasised, for otherwise we can come almost to believe, as demonstrated by our actions, that we have a special independence of judgment which is not vouchsafed to others. If you are forced into the position of being a judge, bear in mind that famous injunction of Oliver Cromwell's. 'I beseech you in the bowels of Christ, bethink you that you may be mistaken?' That is the best recipe for judgment of quality; its essence is humility, with a willingness to look for the evidence which falsifies the apparent conclusions to which you are heading.

Traditional Forms of Health Care Measurement

Are we content with the traditional forms of measuring health care? The trouble with these is that they are all inevitably of a statistical nature, and the collection of statistics always means some sacrifice of an understanding of the total individual situations of which health care is made. There is no escape from this. But what we can do is prevent statistics from taking on a life of their own, as often they seem to do. Statisticians always warn us of the abstractions that they have made, and draw attention to the potential drawbacks of interpretation to fit into preconceived

hypotheses, but let him without sin cast the first stone. We have all been guilty of misinterpretation of statistics, to suit what we believe to be true on other grounds. We have used and continue to use statistics to support our ingrained prejudices, and I am not exempting myself from that stricture. Especially is this true of lay bodies who, one way or another, so often have the final control of our health care services. The chances for misunderstanding and misinterpreting such things as bed occupancy, length of stay, turnover interval, size of waiting list and so on are legion. The professionals must constantly remind their committees of this and keep it in mind themselves.

Leadership

Measuring quality, as far as that can ever be done, demands the establishment of some standard for each particular incidence of health care. All too often this means taking someone else's published work and rather indifferently comparing the results of one's own institution with it. But individuality affects not only the individual man or woman; it affects institutions, too. None is like any other in any exact sense. There can be no escape for each institution establishing its own standards and this involves hard work. Someone in each place must take the lead, and frequently this must be the administrator. He must constantly consult, preferably formally, with all his medical and other colleagues and present them with the information about the health care in his institution and try to draw his conclusions from it. This demands an immense amount of tact and a very thick hide, but if you wish to improve the quality of care it has to be done. The leader must somehow develop a team spirit. He must not be an inquisitor, a role which too many people take on too easily. Most health care professionals really do wish to improve themselves and their care for patients. It should be made morally obligatory that each one seeks for himself how to do this, and recognises that he may need help from a variety of colleagues in doing it.

Information about various facets of the institution reach the administrator. He should give it in some palatable form to his colleagues, and they should be encouraged to ask what the information means and then they may be prepared to act upon it and perhaps even test their own hypotheses and assumptions. This is not the administrator acting like a high priest giving judgments from above; it is a person trying to give a lead in an intellectual endeavour, which, with persistence, begins to delight those who are taking part.

I sometimes wonder if quality in health care is like happiness in other spheres. If you seek it directly, it may elude you. If you work hard and in the right spirit, you may be surprised that in the process you have been happy, or, to change the metaphor again, that your health care has been very good. In fact, what we are looking for is team spirit, that elusive *esprit de corps,* which all good army units strive for. It is much harder to achieve in civilian operations because of lack of formal discipline, such as is enshrined in the Queen's Regulations. But many teams pull together and, if I may use football as an illustration, it is astonishing how certain team managers always seem to make their sides successful, even when they take over a team entirely and change none of its members. Some people have the ability to win affection, esteem and to get the best out of everyone around them so that the outfit they lead positively sings. You must therefore look hard at yourselves and also at the leaders of opinion within your institution. It is they who set the tone of everything that goes on.

If you want to improve the quality of care, you must see that you and your staff are not only efficient, but also considerate, kind and helpful. The working end of your hospital or other health care agency must not be given the opportunity to define a 'we versus them' syndrome. Those at the workface of any industry always think that those 'up above' do not seriously contribute to the real work, but only get in the way and increase

the burdens. They will have no incentive to break down the barriers, so you must. You are all aware of the fact of group psychology that the group's cohesion increases if it can identify outsiders and make them appear as a real or apparent threat. It increases the loyalty within the group. It is therefore you and I and others like us who must try to make our total institution a whole group and not allow it to fragment into a lot of smaller ones. Of course, this can never be fully achieved, for group will fight group within any institution. After all, resources are always limited; some sacrifices always have to be made by one group in favour of another, and this can lead to a sense of deprivation. It is then for the administrator to keep the main aims of the institution clearly before the eyes of everyone and to try to make everyone see that a particular decision, in all the circumstances, is the best compromise that can be achieved.

What I am saying is that the lead in quality must come from everyone, with administration and management as much involved as all the rest. For, while they may not themselves be at the bedside, they must always be looking for ways of making things easier for those who are. It is vital that administrators should see themselves as fully a part of the team and not as controllers, monitors and managers of it. If their work is above reproach, they can draw attention, without offence, to the shortcomings of others. Quality, I would therefore suggest, is essentially a matter of *esprit de corps,* with every member of the staff motivated to achieve the highest quality possible. I need hardly point out that it is the motivations from within that matter, not those imposed from without. Pressures of a harsh kind breed only resentment and non-cooperation.

But, if you achieve this spirit of cooperation, not only does the information of a statistical kind that you can feed back to the various members of staff become palatable; they begin to relish it. We have seen that the so-called 'facts' with which we can regale our colleagues about the quality of health care are nebulous and

disputable, and critics can always draw attention to things which have been left out of account, when only numbers are being considered. We have all seen our edifices of statistics crumble under these sniping criticisms. Indeed, to be fair, we have all indulged in this sort of criticism when we have been faced by statistics whose import we did not like very much because it threatened our interests.

Summarising, in consequence, the points so far made

There are no final answers to anything. There is only a series of processes with temporary solutions to problems, such as those of deciding on what is the quality of health care. Patients, doctors, other health care workers, resources and, above all, expectations of what is good, better or best, change.

There is never any certainty that we understand each other. It is vital, therefore, to try to define underlying assumptions, not least our own.

Because science is falsifiable rather than verifiable, the important question is not what is right with the quality of health care, but what is wrong. This generates a lot of emotion, so how the data are presented to those involved at the sharp end of health care requires enormous tact and consideration of feelings.

Each institution must generate its own criteria of quality by examining itself, though these must be compared with the best practices in comparable institutions. We must be sure to try to compare like with like.

Beware of the interpretation of statistics of all kinds, but particularly where there must be value judgments, as there are in trying to appraise the quality of health care.

> The way in which any administrator can start the process of some kind of appraisal of health care quality is by generating *esprit de corps* in his institution. He must first look to the way in which his own departments carry out their functions, especially in terms of human kindness as well as efficiency, then identify those with moral and actual power to change quality, and then persuade them of what is intended. This means that the administrator must have a clear idea and firm definition of what he is aiming to do, so that he may see if it accords well with what others think, too. All must start from the same base. You will be aware that this is just good administration, defining assumptions first, then aims and finally objectives.

Measuring Effectiveness

In the matter of effectiveness, very similar arguments apply to what has been said about quality. Only in the most clear-cut clinical situations can effectiveness of an episode of health care be measured with any degree of accuracy, so we must be careful not to read too much in the way of interpretation into any evidence, particularly numerical evidence. The one thing to which, it seems on the surface, everything can be reduced is money. But certain people, who fit Oscar Wilde's definition of a cynic, know the price of everything and the value of nothing. Numbers, or money, often have an appearance of spurious accuracy, because they leave so much out of account. Not uncommonly, it may be just what is left out of the measurement of effectiveness which is the most important factor for the patient, and perhaps the doctor.

A patient may live or die. He may recover from appendicitis after operation. But just what do you mean by recovery? Some patients may have very unpleasant sequelae of appendicectomy, and yet they are said to have recovered from appendicitis. Some experts try to escape this dilemma by saying that an episode of health care

has been fully effective if the patient is restored to health. But what is health? Most people answer that question by giving the WHO definition of complete physical, social and psychological well-being. I believe that this definition is one of perfection which can never be approached by anybody. Are you now in a complete state of physical, psychological and social well-being? Do you have any slight aches and pains? Did you sleep well last night? Have you a headache? Do you have no anxieties of any kind? Is it comfortable to be sitting there, or, as they say in some parts of the North of England, is your bum numb? Do you have any tickles or itches? When you yawn because of boredom or in response to your changing blood gases, are you in full health as demanded by the WHO definition? It seems probable to me that the definition has done more to distort the delivery of health care than almost anything else. It has set the sights too high and made perfection of health the aim. All must die, and in the process of dying most are usually ill and diseased. I think it can be fairly said that only on very rare occasions does any of us display that bursting of health which is implicit in the WHO definition. Most of us function, even in full health, slightly below par.

A Working Definition of Health

The problem for measuring effectiveness cannot, with limited resources, be perfection. And always, in some degree, resources are not quite adequate for the job. The WHO itself, in the fine work that it does, recognises this. In backward countries it does not try to restore a given area to health. It attempts instead to rid the area of a prevalent disease, such as malaria, bilharzia or onchocerciasis. Please note that those are still infectious diseases, whereas so many of ours are nowadays of the degenerative and neoplastic kinds. So I believe that the definition of health should be changed, and I would suggest that health is the optimum possible adjustment of the individual to his physical, psychological and social environment. The reason why this is probably a more

valuable definition than that of the WHO is that it implies that health is not simply a state which is attainable, but is a dynamic process of adjustment between the person in all his processes and his surrounding processes or environment. Both sides of this equation are changing all the time and cannot be held still, so the only certainty is change to which constant adjustments must be made.

The point I am trying to make is that health for a man of 70 with hypertension cannot be the same as health for one of the same age with crippling arthritis, nor can someone with multiple sclerosis in any way be equated with one with rheumatoid arthritis, or a young healthy athlete, or a child crippled by thalidomide. Yet in some sense each of these can be made healthy by helping them to make the best possible adjustments to their environments and to make the best of their lives within limitations which can never be lifted or removed.

So an act of health care has been effective whenever the optimum possible adjustment of the individual to his environment has been made. But who is to decide when that point has been reached? And how is it to be decided? At present it usually depends upon mutual agreement between doctor and patient that nothing further can be done for that particular episode. This is when the patient is discharged from care. However, the patient may be dissatisfied even though the doctor feels that he has therapeutically shot his bolt. Then the tensions between them may begin and, at best for both of them, the patient may go to another doctor. You cannot please all the people all the time. The doctor may feel that he has helped the patient obtain his optimum health in all the circumstances, but the patient does not believe him. Is there any real answer to this?

Looking at effectiveness in the mass, can you really compare the unit costs of herniorrhaphy with pneumonectomy? Of course you

can, but in the end whether you believe you have achieved effective care is, once more, a value judgment.

This does not mean that I think we should discard efforts to measure the quality and effectiveness of health care. I have only tried to draw attention once more to the basic difficulties of such measurements and, even more, the difficulties of interpretation of any evidence produced. Until the sorts of questions I have raised are answered we must just go on striving for better measures of what we are doing; we must try to recognise value judgments for what they are and not attempt to give them spurious accuracy. As soon as you know that you are making such judgments, at least you know there may be quite legitimate grounds for disagreement and this should not generate a lot of emotional heat. We must not try to bludgeon people with data which, when they are examined closely, dissolve before our eyes and are no longer acceptable as facts. And if they can be accepted as facts, they must be seen to have a much more limited range than we at first imagined. Just because a phenomenon can be measured does not give it significance, though we often act as if it did.

I remember a time when blood clotting disorders after childbirth were first recognised; they were all attributed to lack of fibrinogen, and the reason for that was that it was only possible to measure fibrinogen in the total mechanism. Now the whole matter has become incredibly more complex and several factors can be measured. We were temporarily misled into forgetting all the important factors in blood clotting because only one of them was measurable. I suggest that we can be similarly misled in other complex problems in institutional administration, and it is wise always to remember this.

Again I will try to summarise.

All measurements leave things of importance out of account. This applies particularly to money, so be careful when you are considering health care effectiveness.

Be careful about comparing the outcomes of health care in different diseases, in different patients, given in different institutions with different resources.

When you make a value judgment, recognise it for what it is and try not to back it up with spurious science.

Handling Complaints

Complaints about health care can come from a variety of sources, though nearly all are initiated by the aggrieved patient. He may, of course, have recruited someone else to help him in his complaint, such as a lawyer or a member of parliament, and it is from this last that there comes the dreaded ministerial enquiry. Undoubtedly, however, you have all developed written guidelines giving the proper procedures to be followed whenever there is a complaint about any of the services with which you are concerned. If you have not, I urge you to do so. There are many books, booklets and reports giving suggestions which you can apply to your own institutions and services, although one circulated about three or four years ago almost seemed to wish to encourage complaints and that is surely unwise. The world has enough troublemakers without encouraging more.

The point is that when there is a complaint, whether later shown to be justified or unjustified, those impugned feel under attack and insecure. There is a feeling of guilt, whatever the rights and wrongs of the case. The administrator must tread very warily indeed. Several of them, of whom I have personal knowledge, give the impression that they believe every word of the complaint and that they have prejudged the issue so that the doctor or other

health care worker, against whom the complaint has been made, must certainly be guilty. If the complaint embraces the workings of a whole or large part of a department it is even easier for an administrator to appear to adopt this stance, for then he is dealing with a corporate body in which the guilt may rub off on to everybody without any one person bearing the brunt of the blame. I need scarcely remind you to try to avoid such unfortunate impressions, but it has to be realised that they will in part always be engendered and all you can do is try to minimise them. It is vital that you should not appear to be a prosecutor for the complainant, and yet you must also not too swiftly spring to the defence of your possibly errant colleagues. It is a very difficult task and calls for a great deal of tact and care in the way you behave.

A small point that I personally have appreciated in the past is when the administrator has sent the records of the patient to me together with a copy of the formal complaint. It is enough of a shock to get the complaint without having to wait for someone else to find the medical notes for you. On the other hand, I know that some of my colleagues have been incensed by this, for they make themselves believe that the administrator has already looked over the notes and made his decisions about where the error lies. In this situation the administrator always has 'but a losing office'. There is no way in which he can always get it right. So, whatever the ground rules of how a complaint should be investigated, the administrator has to apply his personal touches, trying not to inflame the passions either of the complainant or of the workers against whom the complaint has been directed.

Once the investigation of a complaint is in hand, the administrator should probably insist that all communications in either direction should go through him, but he must make it plain to his colleagues in the institution that he is doing this for their protection, checking to see that wording is accurate and not incriminating in any way, and keeping a wary eye open for any possible legal problems. It is

also the administrator's function to see that a doctor informs his own defence society or union of any serious accusations made against him.

All this applies with especial force to younger doctors and other health care workers, who may get very upset and badly need advice on whom to consult. Their medical chiefs may be of some help in this respect but may not always foresee the problems which can arise in this difficult area. The administrator, on the other hand, can give independent advice on what to do and how to do it, without in any way derogating from his proper task of investigating the complaint. But he does not have to act as the patient's advocate and prosecute his colleagues. He has instead the very difficult job of trying to be scrupulously fair and give proper advice to both sides. He is not, however, an advocate or a judge; he is more like an independent commissioner of investigation, and even he may get beyond his depth and have to call into being an official enquiry or take advice in several quarters. As you well know, a committee of enquiry has to be kept strictly in hand. It is not a court, meting out justice; it is merely a group trying to establish the facts of the problem, formulate a view upon them and report to the body finally accountable for the institution, so that it may decide what action to take upon the evidence presented to it.

I would therefore beg you to handle as many of these problems yourselves as you can and try your best to avoid their coming before tribunals of any kind. Careful personal intervention is best whenever that can be done. 'The soft answer turneth away wrath.' Heavy handedness in calling together tribunals too easily always leaves someone with a nasty taste in his mouth, however carefully the whole thing is dealt with.

We do not all agree on what medicine and health care are about, and what we are trying to achieve and why. What you think medicine is about is determined by what you think life is about,

and therefore expresses your philosophy, which is not just scientific. Your scientific approach is fine, but how you use science is dependent upon quite other things, and especially on your deep beliefs, which are rarely made explicit and almost never spoken about. A major function of philosophy is to go on asking the question: What do you mean?

Do not be content with superficial answers and those that go round in circles.

The real value of a seminar is not the exchange of detailed ideas it allows—an exchange which can occur without either side being affected by it—but the opportunity it provides fully to rethink your own bases and examine yourself and your relationships. If you do this you will probably modify the practices in your own institution and your own behaviour will be changed. And I would remind you that the best definition of education is that it is a modification of behaviour. If you change your attitudes, you will change your actions, and if you do that you have been educated.

13

The Pursuit of Excellence in Health Care Services

ROBERT A DERZON

In my closing remarks at the seminar in May 1975[17] I mused that it was a special privilege for Americans to be invited to a seminar of English-speaking nations. Fortunately this year I can open this paper by asserting unabashedly that Webster and Oxford agree at least one important definition. 'Quality', they concur is 'a degree of excellence'. High quality therefore, becomes synonymous with very genuine excellence. What, then, can be said about the administrator's role in the pursuit of excellence?

In more tranquil and reflective moments, the thoughtful chief operating executive can begin to form views on the special missions of his organisation and, indeed, upon his role and the inevitable opportunities that lie ahead. Several years ago, early in my term with the university, I began to evolve somewhat subconsciously but deliberately, a theory that the University of California's hospitals and clinics could be moved forward most quickly on the theme of 'excellence'—in an absolute sense, in a relative sense and in a competitive sense. The theme was a comfortable and familiar one; consistent with a medical faculty which espoused excellence in the rigours of bioscientific investigation, in postgraduate education and even occasionally but surely not constantly in undergraduate education. The goal of excellence in the care of patients

remained curiously undefined, vague in scope, conceptual and idealistic rather than operative and pragmatic. In the first years its slogans were

> Can we match the excellence in patient care to our preeminence in research?
>
> Medical education is only as good as the clinical environment in which it practises.
>
> To preserve referral patterns and build a dependable flow of clinical activity, we must be substantively more effective than our neighbouring enterprises.
>
> We must develop an administrative core that can match the energy, imagination and intellectual capacities of our faculty.

Those early personal convictions stimulated over time a broader institutional commitment, as I reflect now, a climate of internal restiveness to do better. An unspecified set of values became an evolving set of unspoken marching orders. We would pay attention to detail, we would make decisions based on their value to patients and we would begin to address as best we could 'quality of care' as a clear objective. This was an administrative initiative that bonded the hospital management with the care givers. In retrospect, we had created an internal climate to work on quality.

External Forces

As one passes through a second decade as a health care journeyman, he recognises he has become a part of history and, if he is inclined, he develops a sense of history. There have been extraordinary changes in our profession during the last 20 years. Perhaps the most powerful changes have come from outside. In the USA there is a powerful array of sources driving the quality

theme into our hospitals where they can affect administrative behaviour.

First is the accreditation movement with its genesis in public health's epidemiological approaches and reinforcement by the American College of Surgeons. After World War II the Joint Commission on Accreditation of Hospitals (JCAH) was formed as a voluntary effort of five national groups to establish standards and to monitor. At the outset there was heavy reliance on sanitary practices, physical plant adequacy, crude mortality measures, staff licensure or credentialling, and institutional and medical organisation. By the late 1960s the JCAH was moving into medical review through the medical record, assessing departmental procedure manuals and broadening the range of factors that were to be examined. In the 1970s quality assurance, limitation of staff privileges and due process disciplinary practices have been new themes. We are moving accreditation from only stipulating input characteristics, through midstream process factors, to a strategy of outcome improvement and corrective action.

American law has been a second external force. Since the mid-1960s hospitals have seen their charitable exemption from liability removed and replaced with harsh alternatives. The American hospital is now legally responsible for virtually every action which takes place within it or under its auspices. Sins of omission as well as commission have become the hospital's responsibility. For better or worse, the hospital's governing board has now become the standard bearer of quality. There is a new and different relationship between the trustee, the administrator and the physician—and many physicians are discomfited by the growth in power of the administrator and his board.

Coupled with the legal onslaught on quality is the growth in malpractice activity, a uniquely American custom it seems. Our citizens have become tort conscious, seeking relief from mistakes, bad judgment and bad (but expected bad) results. The settle-

ments are extravagant at a time when, in an age of high technology, potent medication and high risk surgery, a simple mistake can destroy a life or cause serious injury.

The upward cost spiral has been another significant force pressing upon hospital quality. Utilisation review emerged in 1966 with Medicare, has been extended to Medicaid, and its techniques adopted by many private insurance carriers. Quality has been defined in terms of admission appropriateness, length of stay and appropriateness of accommodation. The theory of utilisation suggests that quality is generally achieved when the right patient is in the right place for the right time and at the right reasonable cost. Utilisation trends are departing from retrospective chart review to concurrent on-site review and prospective intervention by outsiders into the conventional decision-making process of the admitting physician. Early utilisation programmes were managed by hospital medical staff representatives with somewhat uneven results.

The Social Security amendment of 1972 (92-603)[23] specified professional standard review organisations (PSROs) as a cost-saving quality enhancer. PSROs were to be organised regionally, be outside county medical societies, supported by a majority of physicians in the region, and be the final arbiter of whether Medicare and Medicaid should cover all, a part of, or none of the services provided to nearly 50 million beneficiaries of these huge programmes. Regional norms are being developed, studied and matched to individual practitioner's results. Self-regulation and continuing education through feedback are implied. Hospitals may be delegated full review powers and be fully financed by the public programmes if they have a sound conforming utilisation programme and their physicians are willing to develop standards of care and measure their own staff's performance.

While internal momentum developed within the University of California, there is no doubt that the environment around us had been forcing quality initiatives upon us.

The Administrator—Catalyst or Innovator?

The skilled administrator aggregates those uncontrollable external pressures and harnesses them to an internal agenda for his institution. Thus, it was unremarkable that one could harmonise a serious institutional intent to excel with those concurrent external initiatives mentioned above. They blended well and we have in fact enjoyed the fruits of our labours. At least part of each week and part of our organisation is devoted to improving care. The quality initiative focuses attention—in large, potentially impersonal institutions—on the patient: his needs, his care and our capacity to care. It is the relief period for the administrator from the dollar problems, building planning headaches, personnel management and the like.

The administrator's role is clear: he has accepted the responsibility for quality enhancement—he has anticipated, organised and concentrated some of his energies to move toward excellence; and he has forced the process of professional interaction and external environment into working machinery.

What have been some of the more useful organisation and monitoring strategies?

Medical Care Organisation

There should be a well organised medical staff supported by administrators who are genuinely interested in the quality of care. Standing committees of our medical staff, led by carefully selected committee chairmen with staff resources applied, provide

a starting point. Resident, nurse and social worker involvement in utilisation and audit committee deliberations are important.

Risk Prevention Programmes

In 1970, a medical staff committee began to examine every claim against the hospital, physicians on the staff and all incident reports. This committee advised the administrator on settlements and continuously suggested areas of policy, procedural and managerial weakness.

Education of Patients

Hospitals ought to strengthen the patient's ability to monitor his hospitalisation. One approach is the patient's bill of rights, mandated into state law in parts of the United States. Nurses' efforts to inform patients about their care is another vehicle. So, too, are the larger efforts in group education in clinics and outpatient departments, and hospital ventures into community health education. It seems likely that better informed patients have a better chance to monitor and control their therapy and care.

Ombudsmen

Quality of care rises when patients can be relieved of their complaints. Tracking patient complaints, resolving them promptly and watching trends comprise an essential ingredient of a quality of care programme.

Effective Nurse - Physician Relationship

This is the key to the quality of inpatient care. The partnership must be collaborative and tight, with partners who willingly monitor each other and constructively share the principal care responsibilities. In our best US hospitals nursing has become an equal, not junior, partner and physicians welcome the change. Nursing has increased sophistication in monitoring nursing performance applied to patients' needs and is beginning to audit carefully its nursing outputs.

Audit Breadth

Hospitals must transcend physician and nurse auditing mechanisms affecting patients' care. Audit techniques, historically applied to business functions, can be utilised for all hospital operating units provided quality benchmarks can be identified. It is that search for benchmarks of quality which is the important process. Units which should have been thinking about patients can be redirected when benchmarks are set.

Critics of quality assurance efforts wonder whether the results are worth the expense and effort. No one, however, wants to form barriers to improving quality and pursuing excellence. As with other industries, we have chosen to develop a quality control unit and then engage the workers. While sceptics shoot from the sidelines, we have had new satisfactions and energies from pushing toward excellence. Those who engage in this programme earnestly believe that this is not the time to abandon or even lessen the efforts.

14

Appraising Quality and Effectiveness in Australia

JOHN BLANDFORD

It would be as well to acknowledge from the outset our indebtedness to Professor Cochrane for his exposition of the distinction between effectiveness and efficiency, and to recognise that quality appraisal may have no regard to either.[2] A future medical historian may be able to tell precisely how many useless procedures were carried out in our time with great technical skill; at the moment we have little more than doubts and suspicions. While it may be helpful to look at the issues of quality and effectiveness separately, it is necessary first to recognise the limitations on the influence of the administrator, regardless of his qualifications, in the appraisal of clinical work.

Much has been written about the special nature of the relationship between doctors and patients and the various roles expected of them. The following points on the concept of clinical autonomy are made with acknowledgment to the work of Rowbottom and his co-workers at Brunel.[20]

The duties of a doctor in hospital can be performed only if he has the discretion and authority to make the necessary decisions. This discretion and authority are not delgated to him by a superior; they are the consequence of the duties derived from his role as a

professional. By looking at the constraints on this freedom, it is possible, however, to determine some difference between salaried and private practitioners. Both groups share the common constraints of the norms of professional conduct, and of civil and criminal law. The salaried doctor will have a contract which will prescribe hours and place of work, standards of behaviour and probably the area of medical practice for which he is employed. In that sense a salaried doctor is accountable to his employer for his work; he is responsible to his profession and his patient for his clinical work in the same manner as a private specialist. His employer becomes responsible for the quality of his clinical work and is vicariously liable for any acts of negligence, jointly with the doctor himself. In this way, hospitals incur responsibility without authority. Hospitals, therefore, aim to select employees through rigorous selection and appointments procedures because they cannot control clinical work but become responsible for its performance. In the USA that responsibility has been extended in some recent cases to private practitioners, the courts having decided that the hospital has a duty to vet the competence of private practitioners seeking the right to work there. By granting him beds and facilities the hospital has indicated to the public that he is competent to provide the service.

The autonomy enjoyed by a specialist is widely recognised in the English-speaking world. This, linked with an extensive private practice system, has had the effect of forcing American and Australian hospitals into increasingly strict procedures for the delineation of privileges in hospitals and peer review. This process has been hastened by the high standards of many of the institutions and by litigation, especially in America.

The use of these two mechanisms highlights the dilemma faced by hospital administrators in running hospitals where clinical autonomy is accepted and where private practice predominates. The administrator can specify his objectives and standards in a staff post which is to be advertised; he can select a candidate who

meets those requirements even if he has no clinical control over that specialist after appointment. He has some limited executive control in so far as he can limit the provision of resources and insist on compliance with the contract. Where private practitioners have rights of access in an 'open' system—that is, every private practitioner has access provided he has the appropriate qualifications—the administrator has two additional problems. The objectives of the doctor are mainly subjective and he will suspect any attempt to ensure compliance with hospital objectives as unwarranted exercise of executive power. The degree of scrutiny over qualifications is less than is possible in an appointments system, and control over standards is more difficult. The only legitimate authority which a specialist will accept in relation to his clinical work is scrutiny by his peers. The only way this can be made the uniform rule in practice is if it is a condition of granting visiting rights which are renewed on a regular, say triennial, basis. With utilisation and quality reviews policed by the profession itself, it is possible for the administrator to be satisfied that he will soon learn if efficient, high quality work is not being carried out.

There is, however, some evidence that the extensive peer review systems in the USA have dubious value, at least in a cost benefit sense, and that is a timely reminder to those of us in Australia who are involved in establishing such procedures. The federal minister has given the Australian Medical Association an ultimatum to have such procedures established in conjunction with his department within three years or else he will take direct steps to introduce them.

Formal arrangements are being made through a joint working party of pathologists and state and federal officials to introduce a system of pathology accreditation which has three objectives: to improve the standard of pathology services, to improve educational services and to prevent abuse in laboratory operation.* The

*Hospital and Health Services Commission, Canberra, 1975.

scheme relies heavily on American experience. Voluntary schemes introduced by the Royal College of Pathologists of Australia have attracted interest only from the laboratories which could demonstrate a good performance. The current proposal is to link the payment of pathology insurance benefits to proof of accreditation. Apart from the administrative burden and cost of such a scheme, the main difficulty lies in specifying quality standards where measurable scientific tests of accuracy are inapplicable. A scheme for hospital accreditation is also being developed by a joint Australian Medical Association and Australian Hospital Association working party based on Canadian experience. Indications so far are not encouraging because of methodological difficulties.

All these schemes are the response of administrators and, especially, insurers to the problem of ensuring that their clients receive value for money or that public expenditure is justified by the provision of an adequate service. On examination, the mechanisms appear to be clumsy, expensive and uninformative in relation to the criteria which a good administrator applies in a well run hospital. The problems with those criteria are that they are subjective and are based on a mass of unrelated bits of information which only experience can put together into a coherent picture.

However, some of the trends which emerge from practical experience are good guides to the administrator who is concerned about quality. The emphasis I put on these trends is that good organisation structures, routine procedures and planning will lead to quality performance. The problems of measurement, mainly methodological, remain. This is similar to the problem of measurement of the state of health of a population. Morbidity statistics are a guide, but in the absence of reliable measures of health status we concentrate on health services themselves as a surrogate: so we measure such things as access, comprehensiveness and efficiency. There is a direct correlation between highly organised medical structures in hospitals and quality in the delivery of service. The components of that link are familiar to managers: strict selection

procedures for defined tasks, an ordered communication and authority system, an emphasis on teaching and so on.

In Australia, as in Britain, the medical profession itself, through the undergraduate medical schools, the General Medical Council and the royal colleges, provides a system of services and controls which determine the quality of graduate and postgraduate training. I have been involved in working out with the profession how continuing education should be financed and organised in Australia, and a large part of that effort has been directed towards the maintenance and updating of skills.

Given this background, the administrator has to ask himself what the relationship is between formal review of standards and the complexities which go with it, and the reliance on good organisation structures, selection, training and retraining. What is clear to me is that the former is of little use without the latter and it is important to identify the reason. The historical development and traditions of the medical profession and the nature of the work mean that the profession has to be self-regulating. The most effective peer review system is that which operates in the 'firm' or a special unit in which colleagues of equal status work in close cooperation and share many responsibilities, including the training of future specialists. That has to be the basis for consistent high quality along with opportunities for and expectation of continuing education. I believe the administrator can be a catalyst in achieving that; the more he has to innovate by introducing formal review systems the less return he will get for his efforts. The problem for the insurer is whether common venality can be circumvented by formal quality review mechanisms which may well be effective in providing an analysis of the administrative implications of clinical work, such as length of stay.

While I have argued for informal methods of achieving quality, I have to agree with Professor Cochrane that effectiveness is properly a quality which has to be measured on some objective and scientific

basis. Whether a randomised controlled trial is in all cases the right approach I am not competent to comment. The methodology for analysing the scope, extent and causation of medical problems has now been developed to a fine art by generations of epidemiologists. The analysis of the consequences of therapy is a problem of a different order; but the answers are important if, for instance, an operational research study is to be based on meaningful assumptions. The importance of a double blind trial in clinical research is well established but how much influence has been brought to bear on the work of ENT surgeons and cardiologists by the numerous studies carried out on the effectiveness of various forms of therapy for the conditions they treat? I observe locally a continuing demand for more operating time for tonsillectomies and bigger and better cardiac intensive care units.

The administrator finds himself in the middle of a major problem here because he has to advise politicians and boards on policy and resources. Should he encourage the development of a major radiotherapy facility, a home dialysis programme or further coronary bypass surgery because it is technically possible, sought after by a powerful medical lobby and expected by the public? And how do those services relate to the more mundane problems of the old and chronic sick in the ordering of priorities? If in the past the political process has taken the matter out of his hands, the demands of medical technology, the increasing scepticism about modern medicine and government involvement in providing funds, will surely force administrators into finding answers to the question of effectiveness.

The emphasis in Australia is still directed towards rationalising the distribution of resources without having much evidence on which to test their efficacy. The injection of substantial new money into the health care system through community health grants provided by the Hospitals and Health Services Commission is based more on an act of faith that comprehensive primary care services will be better and cheaper, than on hard evidence that

they will be effective in the sense of reducing or alleviating community morbidity. As the provision of universal, compulsory health insurance takes effect, it is likely to become even more important. In short we are, as administrators, innovating in the medium with which we are familiar—the organisation of services. The real test, of course, is what, in a clinical sense, is effective in therapy and prevention. The abysmal lack of answers to that question seems to me to point administrators in the direction of being the catalysts for more activity in finding the answers.

Commentary

LESLIE PAINE

Once again, as they tackled this fourth and final aspect of the theme of the seminar, members found themselves confronted with issues which appear to be largely imponderable.

The question of assessing the quality and effectiveness of the services they help to administer is one that many have considered and no one has ever satisfactorily answered.

Professor Cochrane, as John Blandford points out, has probably gone further than most in finding, through the use of randomised controlled trials, a solution to the problem within certain but limited areas—such as the value of coronary care units or nurses working in general practice. But as he reminded us in the 1971 Rock Carling Lecture to which John Blandford refers, effectiveness, efficiency and quality of health care are not necessarily either identical or compatible.[2]

High quality care may not always be effective, and ineffective care may well be undertaken with great efficiency. The sick person—in the words of one old cliché—may recover because of or in spite of the care he receives. And as an equally old and

well known aphorism has it, the treatment was successful but the patient died.

So, like Professor Cochrane before him, Professor Philip Rhodes, in his excellent keynote address, says quite unequivocally

> 'I would therefore suggest to you that a true appraisal of the quality of care is not possible. By true appraisal I mean that the real situation in an act of health care is fully understood by anyone . . . The facts are too elusive. In every clinical situation the possible range of circumstances is infinite. At the least, there is the patient, the doctor and the resources which each may command . . . Of course it is for the observer—you—to be the appraiser of the quality of care, but how prejudiced are you in your understanding of medicine, patients, the particular doctor and the resources with which he works?
>
> 'We try to measure quality of health care by a series of methods with which you are all familiar. My aim, so far, has been to show that they are still very crude and leave much out of account, and that they can never be perfected because of the nature of the primary transaction.'

The primary transaction, as he rightly indicates, is something which takes place between two individuals, each essentially unique. There is the sick person about whom, as the Professor puts it, 'everything is unique', and there is the doctor who is also unique not only in his personality, education, training, knowledge and skills but in the resources available to him also—this last being of great importance. Which causes Professor Rhodes to pose the very pertinent question: 'Can you really compare the quality and the effectiveness of health care for a peasant in Bangladesh with that for a high-ranking politician in the developed Western world?'

Looking at the methods we may use to try to measure the quality of the health care we provide, how can we, even within the

narrowest confines of one patient's treatment, keep out (as he says) personal emotions, values and judgment? Which is why statistics, useful though they may be, are in one sense a snare—not for what they include but for what they leave out. The trouble with them, as the Professor says, is that they always involve some sacrifice of our understanding of the total individual situations which make up health care.

> 'There is no escape from this. But what we can do is to prevent statistics from taking on a life of their own, as they often seem to do . . . We have all been guilty of misinterpretation of statistics, to suit what we believe to be true on other grounds. We have used and continue to use statistics to support our ingrained prejudices . . . Especially is this true of lay bodies who, one way or another, so often have the final control of our health care services. The chances for misunderstanding and misinterpreting such things as bed occupancy, length of stay, turnover interval, size of waiting list and so on are legion. The professionals must constantly remind their committees of this and keep it in mind themselves.'

As with the quality of care, so with its effectiveness. When resources for its provision are—as everyone agrees and reiterates ad nauseam—limited, there can be no question of ever achieving perfection. Improvement can, therefore, be our only aim and no one can ever be, in the strict sense of the term, completely healthy. The true definition of health, as the Professor says, is 'the optimum possible adjustment of the individual to his physical, psychological and social environment', so that health is not a static but a dynamic process as we continually adjust to the changes within ourselves, in our environment and in the various processes which affect both.

Assessing the effectiveness of this adjustment is therefore very much a matter of opinions rather than facts. To quote Professor Rhodes once more

'The doctor may feel that he has helped a patient obtain his optimum health in all the circumstances, but the patient does not believe him. Is there any real answer to this?

'Looking at effectiveness in the mass, can you really compare the unit costs of herniorrhaphy with pneumonectomy? Of course you can, but in the end whether you believe you have achieved effective care is, once more, a value judgment.'

While, therefore, we must not cease in our efforts to measure the quality and effectiveness of the care we provide, we must continually be on our guard against making and basing decisions upon false assumptions. Personal opinions and value judgments must not be cloaked with spurious science, and the results of the comparisons we may make between various forms of health service must take account of the simple but inescapable facts that diseases and the patients suffering from them, the clinicians, the institutions in which they work and the resources at their command are all different.

The same dilemma that appeared in some of the previous discussions on medical developments and resource deployment inevitably therefore reappeared here. Clinicians and those who work closely with them in their daily tasks, as Professor Semple indicated, are basically scientists, often highly specialised and always concerned directly with the sick individuals whom they are treating or for whom they are caring. Administrators, on the other hand, as Paul Hofmann proposed, should be concerned with the broader issues of forward planning, objective setting and assessment of priorities—all of which involve attempts to analyse, measure and compare what is going on in the institutions or services they are helping to administer.

The particular danger of this dilemma, to use John Hoare's words, is that it is likely to sever the close links that should exist between the direct providers of care and those (the administrators) whose

job it is to strive to ensure that at one and the same time, the clinicians and their patients have as far as possible the freedom of operation and the resources they require, and that they understand why this cannot always be possible for everyone in every case.

All, it seems, are agreed in consequence, that one of the administrator's main tasks in the sphere of quality control and value for money is—to iterate Professor Semple's views—to help the individual clinician to see beyond his personal and particular horizons.

It is certainly the administrator's job, Professor Rhodes suggested, to keep the main aims of the institution or service clearly before the eyes of everyone concerned with it, so that they can understand why each particular decision has been taken and why in all the circumstances it may well be a compromise but at least it is the best compromise that can be achieved.

Good quality and effectiveness of care therefore become, as Professor Rhodes argued, and as Robert Derzon agreed in the third paper included in this section, a team job, a matter essentially of *esprit de corps* with every member of the staff involved, and all motivated to put the patient first and achieve the highest possible level of service to him or her. True excellence, in other words, comes not from any individual but from everyone, and administrators must not see themselves as quasicontrollers, managers or monitors of the health care team but as members of it with a specific conjoint task to perform. Many of our clinical colleagues after all, as Bob Derzon suggests, are imbued with just as great a spirit of self-evaluation and enquiry as we are.

One of our prime tasks as administrators, therefore, is to ensure that what we and our various administrative staff do is done not only efficiently but in such a way that it helps to fulfil the basic function of any health service—the betterment of the patients.

It is also important, as Professor Rhodes emphasised and Bob Derzon illustrated in his paper, to understand that the team job of providing a high quality of service to patients is also very much a team effort, which involves the hard work and continual vigilance of everyone. This led some members, and particularly Adrian Evans, logically to suggest as a result that any such group seeking genuinely to improve the quality of service given must include some representative of those—the patients—who are the *raison d'être* for the very existence of the institutions and services in which we all work.

But if we are to progress from the general to the particular, what are we doing now and what more can we do in the future, apart from putting our own administrative houses in order, to show that we are attempting to assess and improve the quality of effectiveness of our patient care?

The USA, Robert Maxwell proposed, seems to favour the use of audits and yardsticks (such things as accreditation schemes, peer and utilisation review systems) perhaps because, in Paul Hofmann's view, too many American doctors are concerned with malpractice rather than good practice—a situation due perhaps as much to American society as to the doctors themselves.

The UK, on the other hand, as Robert Maxwell also proposed, tends to pin its faith more on the education of the individual clinician to develop a self-critical faculty which then becomes a key factor in the creation of higher standards of care. Boyd McAulay, of Canada, argued that there was great value in the sort of teaching rounds done by specialists in the teaching hospitals, where the best senior doctors could demonstrate to their juniors and others, not only the highest quality of clinical treatment but also the importance of creating a natural, human, caring relationship between the patient and the clinical team.

Robert Derzon agreed that the secure, self-critical attitude of the best teaching hospital doctors went a long way towards assuring us of the quality of service we all desired; and Professor Rhodes thought that this could well become more widespread throughout whole health regions in the UK through the efforts of regional postgraduate deans and their colleagues. But despite this, and the considerable efforts in America to ensure, as Bob Derzon put it, that 'the right patient is in the right place for the right time and at the right reasonable cost', his contemporary, Richard Berman, still argued the necessity for someone or some body (probably from outside the medical profession) to keep a close eye on medical and clinical standards provided by doctors and their clinical colleagues.

Bernard Snell, too, asked reasonably enough whether the evaluation of the work of clinical departments or individual clinicians could in practice be done on a self-criticism basis, by a peer group, or by some body with wider public representation? Furthermore, if you were to bring into the study people other than professional colleagues who might act as spokesmen for the public or the patients, would you need to turn to consumer groups or voluntary organisations which were inevitably, by their very nature, pressure groups anyway? If not, how could the patients' views be brought to bear—and was this in fact a job for the administrator who might act, either directly or indirectly, as a representative of that otherwise anonymous and often inarticulate individual—the sick man in the street?

Harvey Barkun agreed with Bernard Snell that in attempting any practical appraisal and evaluation of care the administrator's role is primarily to cajole, encourage and exhort his professional colleagues. On the other hand, as both doctors suggested, the administrators will always find it very difficult to get past the clinical barrier which will arise whenever a doctor has taken some action which others see as wrong, but which in his clinical judgment is correct. Many medical acts, after all, are matters of opinion,

and in certain circumstances both diagnosis and treatment can be subjective. Bernard Snell felt, therefore, that it is difficult for one specialist to question another in this respect; perhaps even more difficult for a group of his peers to do so (with or without non-medical involvement); and not necessarily right for either to take action of this kind except in the grossest cases of negligence when legal proceedings might be involved.

The basic question posed by this section of the seminar was therefore, and not unexpectedly, left somewhat open, but the general feeling was that the administrator in this sphere should be both a professional adviser to and educator of his clinical colleagues as well as being, to some extent, the patients' representative, just as he is when complaints by patients or relatives are under consideration.

The administrator's function in dealing with and evaluating complaints was, members agreed, clear enough. The administrators should always attempt to stand dispassionately between patient and professional colleagues, do their utmost to elicit the facts and, without taking sides, attempt to settle differences, correct mistakes, remove misunderstandings and right wrongs, in the interests of all immediately concerned, of future patients and of the institution.

This was much less easy to do than it sounded, for, as the keynote speaker had implied, there was probably a full-time job for someone in a hospital just trying to ensure that staff were always polite, courteous and kind to those who sought their help, difficult and unreasonable though sick people sometimes could be. For staff attitudes and actions set the tone of any institution and it was important for the administrator to keep his eye on such things and influence them by identifying problem areas and by ensuring that they are always investigated. As Brian Smith pointed out, you should not only be naturally kind and polite to everyone—and especially to sick people—but you should also be ready to explain

to them everything that they wanted to know in order to allay their fears and uncertainty. Indeed this is a duty owed to them; yet despite all efforts to this end, it is still a common experience in hospitals to find patients and their relatives left worried, sometimes over the most trivial things which could be explained to them in a moment by a sensitive doctor or nurse.

Returning, however, to the major issue under consideration, the seminar, if it achieved no magic formula for quality assessment, came to the conclusion that quality of care depended on a number of factors, some of which the members had attempted to isolate. First and most important was the achievement of *esprit de corps* and team effort embracing everyone in the institution or concerned with the services provided, from professor to porter, with the instillation in them all of the belief that excellence means only one thing—excellence in every way that the patient is treated. Second, teaching and research should be recognised as contributing to quality just as much as direct clinical service. Third, that outside influences through such things as professional journals and societies also play their part, while licensing and accreditation bodies, together with professional organisations which train and educate doctors, nurses and others, also have influence. And finally, the patients themselves in a number of ways can and do bring pressure to bear on the way that the health team does its job.

There was, however, a strong feeling among many members that, human nature being what it is, clinicians would not in general be inclined to be self-critical unless there were pressures from elsewhere to make them so. There was also a further fairly general opinion that we as administrators have neither the data, experience nor knowledge to measure the quality of care, and that to expect us to do so, when many doctors were more interested in treating patients to the best of their ability than in pursuing such elusive questions as quality appraisal, was unrealistic and unrewarding.

This did not mean, the supporters of this view hastened to add, that the quality of care now provided is necessarily poor. Indeed, in most hospitals the general feeling was that from the clinical viewpoint it is not. Inevitably, it is as good as the people, buildings, equipment and money available can make it—but if we were honest it is unlikely that as administrators and managers we have much real hope of ever being able accurately to measure either the quality or the effectiveness of the care provided.

That, of course, must remain a matter of opinion, but even if it is true, at least, as Bob Derzon said, if we cannot measure the quality of what we do, we can—and indeed always must—make it our basic task to do our utmost to make everything about our service the best possible for the patients. To put it another way, and to close this brief review most appropriately with a comment from the keynote speaker Professor Rhodes,

> 'I sometimes wonder if quality in health care is like happiness in other spheres. If you seek it directly, it may elude you. If you work hard and in the right spirit, you may be surprised that in the process you have been happy, or, to change the metaphor again, that your health care has been very good.'

Summary and Conclusion

Summary and Conclusion

LESLIE PAINE

From the opening session of the seminar when the current health care scenes in each of the 'member' nations were reviewed, it is obvious that the basic problems of health care provision in our various countries remain the same. We are still primarily concerned with rising costs, with a demand which outstrips supply, with the consequent necessity of regularly reviewing the order of our priorities of provision, with attempts to assess the comparative effectiveness of different forms of care and treatment, with the possibilities of redeploying limited resources, and with the pressures of times that are fast changing—not just economically but politically and socially as well.

What the changing times demonstrate, as the seminar discussions showed clearly, is that while our fundamental problems may not alter, our reactions to them and the ways with which we try to deal with them—do.

In Australia, Canada and New Zealand, for example, political changes during the past few years have revised the style of service both provided and planned there. In every one of the countries represented at the seminar it was also patently obvious that the rise of consumer representation and the wish of the public to

participate more closely in the sort of health services offered are affecting the relationship between provider and consumer and the attitude of each to the other. The creation in the UK of the new community health councils is one formal example of this; while informally, as most participants agreed, the increased activities of trade unions, staff organisations and various other public and private bodies grow apace everywhere.

Increasingly, too, as the deliberations indicated, we are coming to realise the elementary fact that any kind of health service is but a system to get help to sick people as swiftly, effectively and economically as possible; the administrative structure designed to do this must therefore inevitably affect the actual care and treatment received by the patients—something which the recent and current problems of the reorganised NHS in the UK exemplify very clearly.

The recent introduction of RAWP into the UK service, and Medibank in Australia, are also examples of the growing desire in many countries to try to achieve a principle of equity of provision of care on a national basis. Meanwhile, the problems of inflation and cost containment, with which all members were greatly concerned, serve as a continual reminder that 'nil growth' is likely to be the standard background against which we must all expect to have to work and plan in the foreseeable future.

What, then, in these times of rapidly changing societies, systems and public attitudes is the true job of the administrator?

The general role of senior administrators in health care was examined at some length in the report of the 1975 seminar[17]; not unnaturally, opinions on this fundamental question tend to differ somewhat in different countries, primarily because of the varying ways that nations choose to provide for the health of their people.

In all the countries represented at the seminar except the UK, most senior administrators are essentially chief executive officers of hospitals; in the UK they are now, for the most part, members and often coordinators of health management teams. Either way, however, they cannot avoid the basic conflict and paradox which their job involves.

On the one hand their *raison d'être* is to produce an environment in which the clinicians of all kinds may flourish, and have the freedom and resources they need to achieve their full potential and utilise their increasingly specialised skills to the greatest possible benefit of their individual patients. On the other hand, since these same clinicians are inevitably the 'big spenders' of our health resources, it is clearly the administrator's duty to remind them regularly that those resources are finite, and that all health services are rationing systems of medical care which must be seen to be fair to the whole of the sick population.

As Sir Francis Avery Jones reminded participants during his after dinner speech, no country can afford the health service it wants; consequently, as both Professor Semple and Professor Rhodes confirmed, it is the task of the administrator to help individual clinicians to see further than their personal horizons to the wider service implications beyond.

In practice, therefore, there is no escape from the cleft stick which forces those who attempt to administer health systems, both to serve the individual clinician as 'enablers' and at the same time to control and if necessary restrict his activities in their capacity as planners of services to a whole institution or community.

Each country, of course, approaches the problem in its own way; some, like the UK and possibly New Zealand, attempt to solve it by reserving the various policy-making processes to different levels of administrative authority—from central health departments, through regions and areas to local districts and institutions.

Despite the style of system, however, the dilemma remains, and this was undoubtedly the underlying cause of the seminar's difficulty in reaching clear and unequivocal conclusions on the role of the administrator—innovator or catalyst—in the various aspects of health care organisation which it considered.

'Have we talked too much about what other people should be doing in our field and too little about what we ourselves should be doing. Have we been sufficiently self-analytical and positive?' asked Bryan McSwiney in his summing-up session.

Do we really try to set objectives and, if so, do we plan for the attainable or for the impossible ideal? And are we genuinely prepared and able to demonstrate our abilities in this direction by measuring and improving our own performances?

Are we prepared to become more 'political' in our working lives and really face our labour relations problems?

Do we honestly believe in, or only pay lip service to, the public's right to help shape the form of health services they receive? And are we so certain that community services should be developed to relieve hospitals because this is not only cheaper but better for the patients?

Can we really achieve the cost containment we talk about so much and, in this connection, are we able to influence the clinicians (both in the way they work and their education) or is this just an administrative pipedream?

Can we produce, or help to produce, a health policy for each of our nations? If not, should we not at least be pressing for and assisting to produce such policies for our own institutions, services or communities?

Do we really motivate and lead in our field—as we seem to think we do (or should)—or are we merely observers of a situation over which we have little real influence?

Finally, if we really believe in ourselves and the work we do, have we thought enough about the characteristics, training and education that *we* require if we are to undertake that work properly and prove ourselves worthy of the sort of top jobs we believe ours to be?

The questions are all fair and valid, and reflect the main issues discussed throughout the seminar. But in their replies to Bryan McSwiney's catechism, the national groups made it abundantly clear that they saw his questions not as just rhetorical but as themselves open to question.

Yes, of course we should be self-critical in everything we do, said John Hoare, on behalf of the UK members. That way lie rising standards, improved quality of service and the likeliest opportunities of a better deployment of resources. Professor Rhodes had made that clear enough, but, as he had also hinted, one could spend too much time worrying and philosophising over one's own role rather than relying on taking action which would demonstrate the worth of that role to one's colleagues.

If, therefore, some administrators were suffering from a genuine crisis of identity, then surely the remedy for it lay in their own hands. We in the UK could start the rehabilitative process by taking a long, hard look at our current ways of working, and particularly at our overcomplicated processes of communication and consultation. Every inessential report, circular, memorandum, discussion, working party or committee meeting was an unnecessary and unmixed evil which should be ruthlessly excised from our already overloaded administrative system, so as to give us more time to devote to activities of greater direct benefit to our clinical colleagues and their patients.

Improving the efficiency and economy of those services for which we were directly responsible was also not just an obvious means of providing more funds for patient care, but could do a great deal for general staff morale as well as demonstrating, in the clearest possible fashion, the true value of good administration and management to effective health care.

The Canadian members, only too well aware like their Australian colleagues, of lowered staff morale in the variegated systems operating in the different provinces and states within their countries, were strong supporters of this simple, obvious but eminently practical proposal. Inevitably, therefore, they and the rest of the seminar members accepted as sound commonsense the suggestion made by some UK delegates that the effects of NHS reorganisation on the hospitals required reexamination to ensure that these institutions which consume the lion's share of resources were not left in the inexperienced hands of the most junior managers.

The Canadians, too, were quick to comment on the need for health service administrators to be more politically aware. Only the administrators and the politicians, they pointed out, attempted to take a genuine overview of health services, and it was incumbent on us, with our direct knowledge and practical experience, to see that government health policies were based on our advice rather than on political vote-catching or expediency.

Professor Abel-Smith had advocated a closer involvement by health service administrators of all kinds—from central departments to local hospitals—in politics at all levels, and we should heed his advice. This did not necessarily mean, as the members from Australia, New Zealand and Canada added, that we need abdicate completely from our traditional apolitical attitudes and become avid party politicians.

What it means, however, is a greater readiness to accept the power of political influence, no matter how much we might dislike party politics. For only by so doing could we, as the Canadians had rightly suggested that we should, bring our own influence to bear on those government decisions which affected the services for which we were responsible and, through them, the sick people for whom they were designed.

In the interest of those same sick people, as Paul Hofmann reiterated, we must become more assertive in the future, in order to help our clinical colleagues accept changes that would sometimes be unpalatable, by diverting their attention away from just their individual corners of the health care canvas and towards the complete picture. Only by taking such a lead could health institutions, especially in North America, as Dr Barkun, Ralph Moore and their North American compatriots agreed, be made less introspective and more 'community conscious'.

But as Mr Moore correctly pointed out, such changes in attitudes would not be achieved overnight. Most senior administrators had been brought up in a health care world which, to use Robert Derzon's phrase, 'was centred on acute care and its institutions'. Before those institutions came to see themselves as the 'hubs' rather than the 'centres' for all services, a great deal of effort would be required, especially in education. This applied as much to administrators as to clinicians, politicians and the public, but it was a task in which once again the administrator could, if he were prepared to do so, take the lead. Otherwise, in a country such as the USA—deeply wedded to the principles of free enterprise and individualism—who, as Richard Berman asked, would have a hope of convincing providers and consumers of care that they should pursue a policy of complete equity in health care provision?

Mention of the need for all concerned with health care to educate and be educated to take the broad view in planning and giving

their services to the sick, brings one back to a remark of Professor Rhodes with which it seems most appropriate to end this brief summary of the seminar's deliberations.

The quality of any health service depends ultimately, he suggested, on continuous self-criticism and self-evaluation by the individuals involved; and their behaviour and actions will be modified for the public good essentially by this and by improved education.

This seminar was perhaps one small example of the Professor's theory being put into practice.

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The Chief Administrator as Innovator and Catalyst in the Appraisal of Quality and Effectiveness

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Health service administrators from Australia, Canada, New Zealand and the United States were invited to the King's Fund to join British colleagues in a seminar to study their roles in the introduction of medical developments, choosing priorities, bringing about change in services; in the political process as it affects health services and the allocation, deployment and control of the use of resources; in appraising quality and effectiveness and in handling complaints. Their papers, selected by Leslie Paine, demonstrate the many common difficulties which administrators face in tackling these important issues of today's health services, and his skilful commentaries enable a wider audience to share the flavour of the ensuing discussions.

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