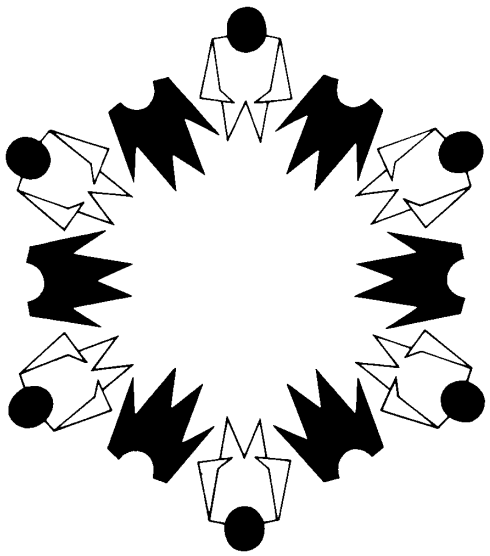
Working with people



Edited by Robert J. Maxwell

People working in health services in Australia, Canada, New Zealand, the United Kingdom and the United States have contributed to this study of three important aspects of working with people.

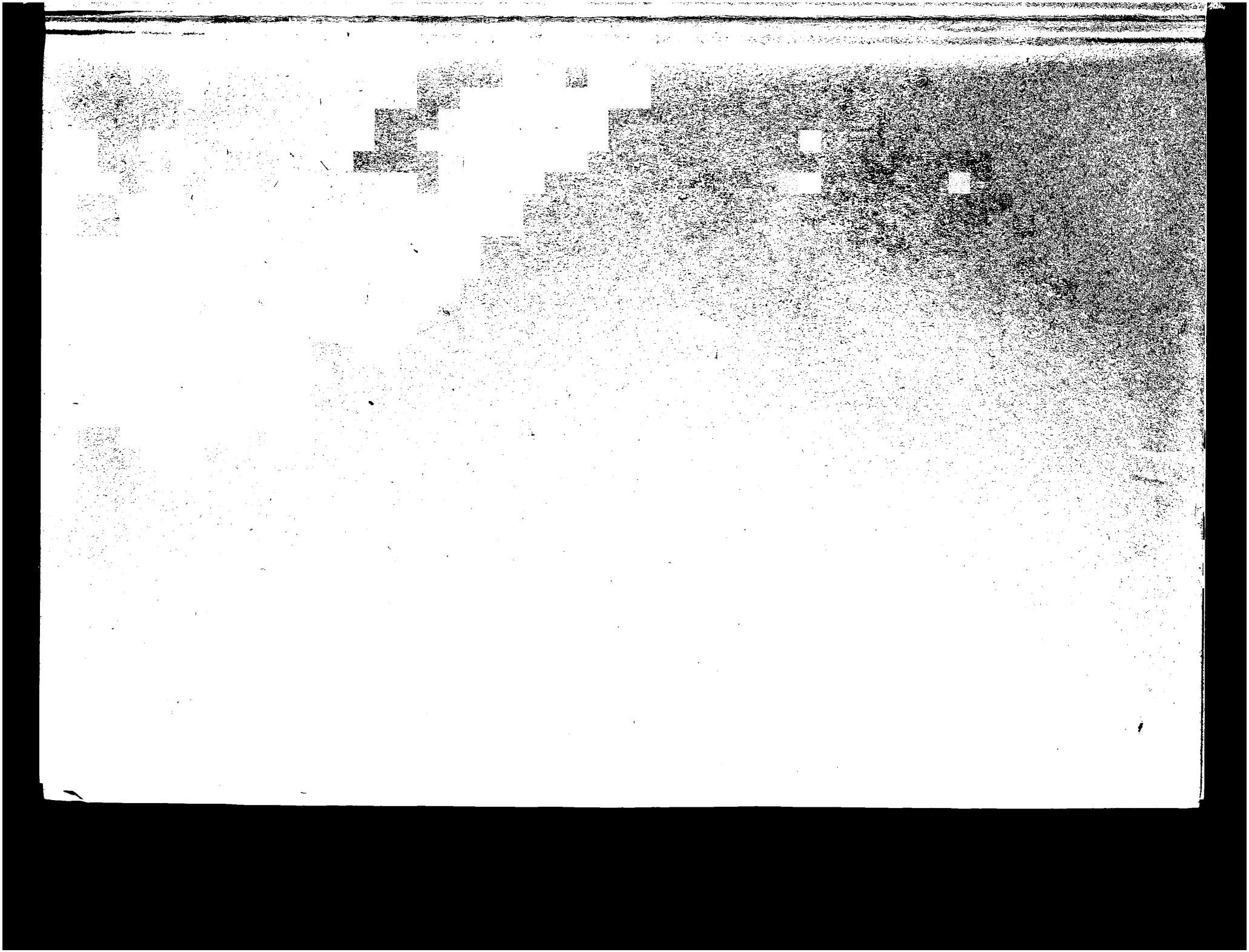
The first is that of integrating the efforts of diverse groups concerned with the delivery of services; for example, trying to reconcile the bids of different departments in a hospital, overcoming conflicts among them, and balancing and integrating their work.

Conflict between management and staff organisations is the second aspect. In recent years, throughout the English-speaking world, conflict of this sort has become common and at times has threatened to put lives at risk. Developing ways of handling such differences is of the utmost importance – not merely in the immediate aftermath of the dispute but in the context of mutual understanding and cooperation in the longer term.

Thirdly, and most fundamental of all, are communication and cooperation between those working in health care and the people they serve: patients, their families and the public generally. This involves questions of balance between curative services, care of chronic conditions, prevention, and issues of public accountability.

A particular aim has been to illustrate concepts with cases and examples drawn from the practical experiences of the writers. The commentaries and epilogue attempt to summarise the arguments and conclusions and place particular emphasis on the role of senior managers, not only as enablers and umpires in their own institutions but as advocates and interpreters in health services generally during a particularly difficult decade.

0 19 724620 6



WORKING WITH PEOPLE

King Edward's Hospital Fund for London

Patron: Her Majesty The Queen

Governors: HRH Princess Alexandra, The Hon Mrs Angus Ogilvy GCVO
Lord Cottesloe GBE TD
Sir Andrew H Carnwath KCVO DL
Treasurer: R J Dent
Chairman of the Management Committee: Lord Hayter KCVO CBE
Secretary: Robert J Maxwell JP PhD

King Edward's Hospital Fund for London is an independent foundation, established in 1897 and incorporated by Act of Parliament 1907, and is a registered charity. It seeks to encourage good practice and innovation in the management of health care by research, experiment and education, and by direct grants.

Appeals for these purposes continue to increase.

The Treasurer would welcome any new sources of money, in the form of donations, deeds of covenant or legacies, which would enable the Fund to augment its activities.

Requests for the annual report, which includes a financial statement, lists of all grants and other information, should be addressed to the Secretary, King Edward's Hospital Fund for London, 14 Palace Court, London W2 4HT.

WORKING WITH PEOPLE

Edited by
Robert J Maxwell and Victor Morrison

King Edward's Hospital Fund for London

Typeset by Rowland Phototypesetting Limited
Bury St Edmunds, Suffolk
Printed in England by
Hollen Street Press Limited
Bound by Hunter & Foulis
Distributed for the King's Fund by Oxford University Press

ISBN 0 19 724620 6

King's Fund Publishing Office
126 Albert Street
London NW1 7NF

Contents

References will be found at the ends of the chapters to which they refer.

Introduction

This book deals, in the context of health services administration, with three important aspects of working with people. The first (addressed in Part I) is that of trying to integrate the efforts of diverse, heterogeneous groups concerned with the delivery of services. Take, for example, the classic case of seeking within a hospital to reconcile the bids of different departments, to overcome conflicts among them, and to balance and integrate their work. Similar issues arise outside the hospital, particularly if the whole range of health agencies in a geographic area is seen as interdependent.

The second aspect (Part II) is that of conflict between management and unions or other representatives of staff interests. In the 1970s, throughout the English-speaking world, conflict of this type became common and at times threatened to put lives at risk. In view of the damage that can be done – not merely in the immediate context of the dispute, but to mutual understanding and cooperation in the longer term – the handling of such differences is of the utmost importance. Moreover, while there will be calm periods, differences will recur.

Thirdly, and most fundamental of all, are communication and cooperation between those working in health care and those whom they seek to serve: patients, their families and the broader public. This aspect is addressed in Part III, including questions of balance between curative services, care of chronic conditions, and prevention.

Each part contains chapters by contributors from several countries in the English-speaking world. These contributions originally formed part of an International Seminar sponsored by the King's Fund at the University of Toronto in May, 1981. We are grateful to the University for providing the base for the meetings, and to several sponsors for their support, particularly the Kellogg Foundation. Not all the papers from that seminar are reproduced here, but a list of the unpublished papers and of all the conference participants is included at the end of this book. This seminar was the fourth in a series that began in London in 1975 and has continued, with changing membership, at two year intervals, since then. The second seminar formed the basis for the King's Fund publication *The Health Service Administrator: Innovator or Catalyst?* in 1978.

Contributors to the book work in health services in Australia, Canada, New Zealand, the United Kingdom and the United States. Each of these countries has its own health care system or systems,

including (within countries) a range of different provincial, state or regional arrangements, and a mix between the public and private sectors. None of these systems can be understood without reference to the society, culture and historical traditions in which each exists. Despite the shared background (apparent for example in the common foundations of medicine, nursing and the laboratory sciences in all these countries), the organisation of services, and the principles underlying their organisation, could scarcely be more varied. They range from the essentially nationalised and quite strongly centralised UK National Health Service at one extreme, to the complex mixture of funding sources and delivery systems of the United States at the other.

Looking across these systems, both the differences and the similarities are striking. Typically there are the same fundamental issues to be tackled. Mortality and morbidity patterns are very similar, as are the health care skills available; those who provide services have to be reimbursed in some way; levels of charges, and of wages and salaries, have to be negotiated; new technology and equipment are introduced and diffused; when something goes wrong, or someone is dissatisfied, there have to be methods of seeking redress. But there are among the systems great differences of ambience, determining what is acceptable in current patterns of service and in innovations intended as improvements.

It is, for example, no accident that in the United States health care is spoken of as an industry, in which there is competition among providers to meet consumer demands. The United Kingdom debate, on the other hand, is much more likely to be conducted in terms of health care as a service, aimed at meeting consumer needs effectively and equitably. The two poles represent strongly divergent sets of values, making it highly unlikely that – even when similar problems are perceived – similar solutions to them will be equally appropriate. And yet it has seemed at earlier international seminars not only that people were preoccupied with many of the same problems, but also that the trend everywhere was away from pure consumer markets. Health care for serious or long lasting conditions had become far too costly for any but the most wealthy to be able to risk paying for it without insurance. The preferred insurance mode was one that did not discriminate against people on the basis of their health or handicap, and that sought to protect the poor. Increasingly government was involved, at least in regulating such insurance, and often in subsidising it from taxation. Increasingly too, government was involved in regulating the providers of health care services. Decade by decade from the Second World War to the early 1970s, each system has become more

reliant on public sector finance and more regulated or administered by government.

There were signs of a change of direction in the late 1970s, which will continue into the 1980s, with every country concerned to curtail further rises in government expenditure on health care. Depending on their political values, some governments will try to reduce the extent of government involvement in the funding, regulation and administration of health services. Others may accept the extent of government involvement, or even increase it, while seeking to achieve better value for money within the system as a whole. Directions of movement may therefore become more divergent in the 1980s than they were in the period from 1950 to 1975.

So far as concerns the matters dealt with in this book, however, the differences of opinion are by no means solely along national lines. And even when differences of opinion are strongest, there is great benefit to be drawn from practical experience elsewhere. While it would be foolish to import slavishly from a different culture, it would be just as silly not to learn from one another's strengths and weaknesses, successes and failures.

A particular aim in this book has been to combine some discussion of concepts with a number of cases and examples, the latter being based on the practical experience of the participants. In the commentaries on each section and in the epilogue we seek to draw together the strands, emphasising conclusions about the role of senior health service managers, not only as enablers and umpires in their own institutions, but as advocates and interpreters in the broader context; the requirement for them to handle conflict constructively, to live with the reality of conflict and not necessarily to seek to suppress it; and the obligation to foster and strengthen the public governance of health care institutions. The whole adds up to a formidable but exciting prescription for health service administration in the 1980s.

I Integrating the efforts of heterogeneous groups

I

Development of hospital objectives – a medical staff view
by Charles H Hollenberg

Introduction

This is written in the context of the Canadian health care system in which health care costs are shared by the provincial and federal governments but the constitutional authority for health care rests with the provinces. In this system, all operating and almost all capital costs of hospitals are borne by government; private funds often augment government grants for capital construction. Hospitals receive their budgets directly from provincial governments but nonetheless are rarely owned by these governments. Usually, hospitals are owned by hospital corporations formed by citizens in the local community and are governed by boards of trustees derived from that community. Such boards retain considerable, although continually decreasing, authority for independent action. Trustees are responsible for the hiring of hospital management and appointment of medical staff and have ultimate authority for all aspects of management and medical practice.

Forces influencing the development of hospital objectives

Of the many forces that can influence the objectives of a hospital, two are of paramount importance, government and the institution itself. In a teaching hospital, the university is often a third important factor. Recently, regional health care bodies have been established by some provincial governments and the views of these organisations are beginning to be influential in shaping institutional objectives. Finally, hospital policy can be dramatically, although usually evanescently, influenced by the media.

Government is responsible for the establishment of the major priorities of the health care system and does not often become directly involved in local or even regional decisions involving institutional ambitions except where these ambitions have 'big dollar' implications (for example, renal dialysis, cardiac surgery). Inter-institutional regional organisations (regional hospital councils, district health councils) can influence the pattern of institutional goals, although this influence is exerted much more by persuasion and by offering advice to government than by organisational fiat. These organisations function in an intensely political fashion and it is unusual for hard, unpopular decisions to be made at this level. Universities and faculties of medicine

have had great influence over institutional goals by virtue of the power of academic appointment and of allocation of the university budget. Further, government frequently turns to universities, as the honest brokers in the system, to advise on distribution of specialised services. However, recently there has been a perceptible weakening of the ability of the university to influence institutional objectives; this has resulted in part from a reduction in university funding for hospital-based academic activities but also from the emergence of regional health organisations that involve both teaching and non-teaching hospitals.

Unquestionably, in the Canadian setting, the organisation that should be most effective in the shaping and meeting of institutional goals is the institution itself. Those hospitals that have evolved effective ways of developing clear-cut, well-planned institutional objectives, have harnessed the process to a private fund-raising capability and projected an appropriate public image, have prospered in both academic and service terms, despite government parsimony and the hostility of other institutions. The key to this prosperity is the internal development of institutional goals that have the support of the professional staff, are viewed by the hospital administration as realistic and seen by the board of trustees as meeting the public interest. This process requires the reconciliation of many diverse internal interests and is never easy. However, there are certain principles of management that have been found useful in this regard. They are set out below.

The intra-institutional establishment of objectives

Within a large teaching and tertiary care hospital there are, of course, three estates that are influential in shaping hospital policy: board of trustees, management and medical staff. The work force and other professional staff influence policy by the effect of their wages on the budget but do not have direct input into the process that establishes institutional objectives. The public input is officially through the trustees although, in practice, all estates are sensitive to what each considers as being the public interest. Agitation for new initiatives usually arises within the professional departments, although occasionally management and/or board of trustees will take the lead. Very often there are wide divergences of opinion within a single professional department about priority of objectives and almost always there is interdepartmental conflict in this area. It is absolutely essential that these differences be resolved if institutional objectives are to be identified; indeed, lack of such resolution is the most common cause of

stultification of hospital development. Obviously, the development of hospital objectives requires the resolution of differences between professional departments as well as the development of an effective relationship between staff and hospital administration. These two issues will be dealt with sequentially.

Elements required for identification of objectives by medical staff

EFFECTIVE DEPARTMENTAL LEADERSHIP

While the head of a clinical department in a large teaching hospital has many responsibilities, his most important are: to lead in the development of departmental objectives and standards; to recruit and promote first-rate staff; and to manage departmental resources, both physical and fiscal, in order to ensure the meeting of objectives and of recruitment standards. Thus, the head must be not only a respected practitioner and academician, but an effective executive capable of management decisions influencing the use and expenditure of tens of millions of dollars. It is surprising how frequently the inability of an institution to establish and promote wise and realistic goals can be traced directly to a weakness in the executive capacity of key clinical department heads. The present method of selection of heads, which is usually via a university selection committee in which a balance of interests (old versus young, clinical versus research) is considered essential, all too frequently leads to the appointment of compromise candidates chosen because of their wide acceptability rather than their executive capacity.

EFFECTIVE DEPARTMENTAL ORGANISATION

Obviously the development of departmental objectives requires an organisation that encourages the input of new ideas and initiatives, allows their wide discussion and evaluation and ultimately places them in priority. Very importantly, this organisation must ensure that these priorities have wide departmental acceptance so that when they are brought forward to interdepartmental discussion, they are seen as emanating from the entire department and not one section of it. In departments housing many disciplines, the organisation is usually based on disciplinary units headed by an executive committee consisting of the unit heads plus the department head who must have no disciplinary bias. The jurisprudence governing the organisation must be crystal clear and it is essential that there be no ambiguity about the authority of the department head, the executive committee and the

department as a whole. Conflicting objectives developed by different disciplines must be reconciled by the executive committee with the department head taking a strong leadership position. In matters of significant controversy, it is very important that the decisions of the executive committee be taken back to the department for departmental discussion and ratification; this process ensures wide input and discussion, and crisp decision-making, and also makes it difficult for those whose views do not prevail to claim unfair treatment and to attempt to subvert the decision.

Increasingly, as university budget support of hospital-based academic programmes wanes, hospital departmental group practices are being developed. These practices serve to ensure fiscal stability and potential for growth by harnessing practice incomes to the overall objectives of the department. While these practices have been very important in allowing departments to develop and maintain academic as well as service initiatives, they are a source of intra-departmental conflict. Conflict exists between the high practice earners and those primarily in teaching and research, and between staff who want early gratification of fiscal needs and the department head who frequently wishes to limit present income in favour of future growth. If serious and debilitating disagreement is to be avoided, it is absolutely essential that the spheres of responsibility of the department head, the management committee of the group practice, the executive committee of the department and the department members be delineated. The department head must retain enough authority over the operation of the group practice to ensure that he can discharge his academic and management responsibilities. In practical terms he must be able to veto any group practice decision with which he disagrees. He must be able to initiate and complete recruitment without interference from the management committee (except for receiving its advice as to the capacity of the group practice to absorb new members); and he must retain ultimate authority over assignment of individual incomes. In return the department head must be prepared to accept ultimate responsibility for the fiscal stability of the operation.

RESOLUTION OF INTERDEPARTMENTAL CONFLICT

Serious divergences of opinion about institutional objectives are much more apt to arise between professional departments than within departments. Departments often differ greatly in their ability to deliver ambulatory versus inpatient care, in their devotion to research and in their desire to extend services into the community. Such differences often lead to widely divergent recommendations concerning allocation of present and future hospital resources. Changes over the last 10

to 20 years in governance of medical staff have not helped the development of effective machinery to resolve such disputes. Medical advisory committees contain representatives of many constituencies – from nursing to dentists to housestaff – and it is very difficult to resolve complex issues in a body containing such varied vested interests.

The group primarily responsible for resolving interdepartmental differences and developing, at least in the broad sense, institutional objectives is that composed of the heads of the major clinical and laboratory departments and the chief executive officer of the institution. Within this group, the chief executive officer has primary responsibility for resolving serious interdepartmental conflict. In so doing, it may be useful for him to work with the chairman of the board of trustees and a senior representative of the university. To be effective he must be well informed and totally objective. A chief executive officer can completely destroy his usefulness by becoming involved in an interdepartmental dispute without a detailed knowledge of the facts or with an obvious bias.

In the vast majority of instances, senior department heads meeting with the chief executive officer can orchestrate a series of compromises that will result in the establishment of institutional objectives. These objectives must then be taken back to departments for ratification and then brought to the medical advisory committee for final approval. Departments must make every attempt to agree upon institutional goals, at least in a general sense, before goals go to the medical advisory committee. Public dispute within this committee on an issue as fundamental as institutional objectives always leads to hardening of positions and long-standing bitterness.

The recent development of large interdisciplinary research and patient care programmes has already had a significant impact on the hospital planning process and will undoubtedly have a greater impact in the near future. Interdepartmental oncology, cardiovascular, renal, and musculo-skeletal groups are now commonplace and their ambitions – as opposed to those of unidimensional departments – increasingly influence the objectives of large tertiary care hospitals. In hospitals where the professional organisation is departmental, it is difficult to place these groups within the administrative machinery in a way that enables them to influence decision-making. At the very least, each interdisciplinary unit must have a clearly defined head and it is often useful for this position to rotate amongst the contributing departments. It is also useful for the unit head to report to a 'programme' committee consisting of the chiefs of the departments primarily concerned, rather than directly to the medical advisory committee; this ensures that the plans and concerns of the units are

coordinated and dealt with by those who directly control the resources supporting the units.

Finally, it is useful to consider the role of the medical advisory committee in establishing the objectives of the medical staff. In most teaching and tertiary hospitals, this committee is very large and its work is done by a myriad of committees, most of which are involved in 'nuts and bolts' issues. The medical advisory committee serves as a parliament-like forum where all departments have an opportunity to comment on major issues and where such issues are brought for final disposal after they have been explored in detail at the committee and/or department level. Of all the functions the medical advisory committee serves, two are of paramount importance: supervision of the standard of medical care and of academic programmes in the institution, and representation to the board of trustees of the point of view of the medical staff. It is the second function that frequently produces tension between the medical advisory committee and hospital administration. While some tension is inevitable, appropriate arrangements can keep it under control.

Elements required for agreement between medical staff and hospital administration on hospital objectives

ATMOSPHERE

Development of institutional objectives almost always involves conflict between the medical staff and hospital management; each estate has different responsibilities and views problems from different perspectives. Management must ensure that the innovative and entrepreneurial ideas of the medical staff are converted into realistic programmes that meet the interests of the public as well as the doctors. Medical staff must ensure that administrative patterns, necessary for efficient management, do not shut off the implementation of new concepts. Thus, tension between medical staff and administration is inevitable, constant and, to some extent, desirable. However, when this tension is allowed to rise to the point where the atmosphere of the institution becomes charged with distrust and suspicion, the ability of the institution to set and attain goals is severely compromised. Hence, it is essential that the medical staff and administration develop arrangements that encourage an atmosphere of trust and mutual respect.

JOINT COMMITTEES: 'NO SURPRISES'

One of the more effective ways of enhancing the ability of medical staff and hospital management to cooperate in the establishment and

achievement of objectives is to ensure that representatives of both estates are included in all important medical and administrative committees. Of particular importance is the presence of medical members on the budget committee and of representatives of senior management on those medical staff committees concerned with the initiation of new service and academic programmes. At the very least, this approach will reduce the likelihood of either estate being uncomfortably surprised by the impact of decisions taken by the other. Nothing is more certain to undermine the confidence of the medical staff in administration than the presentation (usually for fiscal reasons) of administrative edicts significantly affecting medical practice and/or academic programmes which have not been subjected to thorough medical staff review. Similarly, nothing is more apt to confirm in the minds of hospital administrators the administrative irresponsibility of the medical staff than to find, part-way through the budget year, that a new patient care programme has been quietly introduced within a department without careful consideration of its resource implications. By having doctors and administrators consider major issues together at the time they are identified, input from both sides is assured from the outset and neither is faced with the unpleasant task of responding to a *fait accompli* orchestrated by the other in isolation.

Above all, it is important to have joint representation on the hospital budget committee. Such representation ensures that knowledge of the hospital's financial position is shared by the medical staff. This usually promotes a greater understanding of management's problems by the staff. More importantly, it ensures that priorities identified within the medical staff are presented in a knowledgeable and energetic fashion to the body that will determine their implementation, and that due consideration is given to the impact of these priorities on patients, students and research, as well as on the hospital's budget and administrative structure.

DELEGATION OF ADMINISTRATIVE RESPONSIBILITY TO PROFESSIONAL DEPARTMENTS

The effectiveness of medical and administrative staff working together can be enhanced by bringing certain professional departments directly into the management sector of the hospital. They are assigned administrative as well as medical responsibility for the operation of certain patient care functions. Traditionally this is done with most laboratory departments, but with other departments it is unusual. Dialysis and transplant units and cardiac catheterisation teams depend on medical input to ensure proper instrumentation and proper training and

assignment of nursing and technical staff. In such instances it is logical for the clinical director to assume responsibility for preparing, advocating and managing the administrative budget of the unit. By so doing, the head will become intimately aware of the fiscal limitations of the programme and be better able to make judgments concerning the potential for growth. Further, the clinical director is often more able to hire and deploy staff intelligently than is a management figure not intimately familiar with the needs of the programme.

DEVELOPMENT OF AUDIT PROGRAMMES

If used properly, the current vogue for the development of audit procedures can be directed to enhancing the ability of medical staff and administration to establish congruent objectives. Audit should be able to delineate areas of patient care that need attention and isolate diagnostic and therapeutic initiatives that are of questionable cost effectiveness. Thus, a critical, objective audit process can identify areas of hospital activity that require attention from a clinical and an administrative point of view. Its objectivity should make it easier for everyone to agree that the issues identified need to be dealt with as matters of high priority. The process should help avoid a debilitating conflict between administration, which may have very good reason to question the cost effectiveness, *raison d'etre* and professional quality of certain programmes, and the medical staff, who resent and distrust administrative review of clinical activities. However, for audit to play an important role in the identification of hospital objectives, it must be oriented to outcome rather than process. This requires availability of greater statistical and epidemiological resource than most hospitals, up to now, have been prepared to allocate.

ROLE OF CHIEF EXECUTIVE OFFICER

While the heads of clinical departments are of crucial importance in establishing departmental and, hence, medical staff objectives, the chief executive officer is the most important single individual concerned with the identification of institutional objectives. The board of trustees is unlikely to accept initiatives that do not have his approval, irrespective of the position of the medical staff. The atmosphere in which medical staff and management attempt to work out issues is largely determined by the personality and management style of the chief executive officer. He naturally identifies with his management team, the members of which he has selected and promoted. Medical staff are correctly regarded by the chief executive officer as independent professionals, not easily subject to administrative control and not well informed about hospital budgets and administrative routine.

However, this entirely understandable attitude need not lead to a 'we-you' atmosphere provided the officer has enough personal and administrative channels to the medical staff to appreciate their thinking and is able to respect, intellectually and emotionally, the ability of the medical staff to contribute to all aspects of decision-making.

This requires an unusual person who does not always come from a conventional background of hospital administration. Recently some large teaching hospitals have chosen chief executive officers from the ranks of senior university administrators with clinical and research backgrounds and in a number of instances these appointments have been outstandingly successful. Whatever the background of a potential chief executive officer, it is essential that he be selected for his ability to understand the medical staff, and to gain their confidence, as well as for his professional qualifications. No chief executive officer can succeed without having the confidence of the medical staff.

Role of the board of trustees in the establishment of institutional objectives

As previously mentioned, the board of trustees of a voluntary hospital in the Canadian health care system is ultimately responsible for all aspects of hospital management and patient care. In practice, most boards, despite feeling very much under the shadow of government, monitor carefully the administrative and financial progress of the institution. However, they rely heavily on the medical advisory committee to supervise the quality of medical practice and establish service and academic objectives. The board usually becomes involved with these objectives late in their development and its involvement becomes intense only if a significant financial commitment has to be made, particularly one involving private fund-raising.

Recently, however, medical staff in most teaching hospitals have pressed for the involvement of certain members of the board at an early, rather than a late, stage of the process of establishing new goals and directions. This recognises the contribution trustees can make to a definition of the public interest and their ability to propose programmes which will capture public attention and attract private funding.

Intra-institutional establishment of objectives – summary

The development of wise and carefully planned institutional objectives requires clearly defined mechanisms for arriving at departmental goals, for reconciling differences between departments and for pro-

moting joint planning by medical staff and hospital management. Many techniques are available to further and sharpen the setting up of priorities and the planning process. New developments such as interdisciplinary groups and objective audit programmes will undoubtedly affect this process in ways that are not yet completely clear. Nonetheless, the entire enterprise is very dependent on the quality of the individuals who head the major clinical departments and of those who hold the most senior non-clinical management positions. Chiefs of professional departments must have outstanding executive as well as professional qualifications, and the chief executive officer of a large tertiary care hospital needs to have an intimate grasp of medical attitudes, as well as outstanding administrative skills. More attention must be paid to the procedures used to select clinical heads and chief executive officers. The future of an institution is more dependent on the quality of these people than on the tidiness of its organisation chart.

Development of regional objectives

While the Canadian health care system has individual hospitals continuing to interact directly with government, and hence retaining significant freedom to establish their own objectives, government is turning with increasing frequency to regional hospital or health councils for advice on the distribution of services within a geographic area. This advice is particularly sought where 'big dollar' services are involved or where the government has decided to make new funds available for expansion of existing services or for the development of new ones. Thus, an institution taking initiatives that would have a significant impact on regional care must expect to have them reviewed at regional level before government will consider them.

Hospitals, particularly tertiary care institutions, have not greeted this development with much enthusiasm. The regional authorities are viewed as intensely political institutions that act as a buffer for government, allowing it to delay indefinitely the implementation of badly needed programmes. However, if used wisely, regional authorities can serve to improve and rationalise care within a district, although at the moment this is more of a hope than a reality.

It is important for regional bodies to take the lead in identifying needs in an area and not simply to respond to government requests for studies of problems that are governmental priorities. Once a regional authority has identified a need and adopted a widely accepted plan for meeting it, the authority can advocate its solution far more effectively than an individual hospital. Because the regional council can mobilise

greater public pressure and attention than single institutions, it should be more effective in producing a governmental response.

By virtue of its diverse membership, a regional body should be more capable than a single institution of identifying and addressing broad issues that affect the health of a large section of a community. This is particularly true of those issues that cross geographic and jurisdictional boundaries. If the regional group focuses on these issues and does not attempt to second-guess decisions taken by individual hospitals within their areas of competence, it has at least a fighting chance of gaining the confidence of the hospital community.

Finally, when a regional body is called upon to distribute the elements of a new service amongst hospitals, or to 'rationalise' the distribution of an existing service, it is essential that it acts as objectively as its political nature will allow. It is particularly useful for the regional organisation to establish and publicise positive criteria that will be used to determine how a service will be distributed among competing institutions. Everyone expects the ultimate decision to be heavily influenced by political factors since the solution, to be effective, must be politically acceptable. However, confidence in the solution will not be achieved unless it is based on logic and a sophisticated knowledge of the problem under study.

2

Integrating institutional and medical staff goals
by Ralph D Moore

Introduction

Hospital boards and managements have as their primary goal the provision of high quality patient care in a broad sense and are responsible for use of available resources in a manner which provides the best level of care for all patients. Physicians on the medical staff, by virtue of their professional training, are dedicated to the highest level of care for each patient. The introduction of health insurance in Canada and, more recently, limitation of funding by provinces have increased the conflicting relationships between management and medical staff in hospitals and there is every likelihood that this situation will continue throughout the 80s. There is serious questioning as to whether the traditional hospital organisation can meet this challenge. The following explores possibilities of reducing conflict and integrating institutional and medical staff goals through organisational change.

The setting

The basic organisational structure of hospitals in North America in terms of medical staff has been unchanged since the evolution of the community hospital. The dual approach in Canada – paid hospital staff under a hierarchial 'hospital organisation' and medical staff, as professionals granted privileges, under a medical staff organisation – has stood the test of time and the introduction of government funded health insurance. There have been some changes in methods of physician remuneration, such as the academic medical centres, and moves to unify the organisation through the corporate management concept, but the fundamental status of medical staff as independent professionals with a separate organisation still applies in the vast majority of Canadian hospitals.

This separate organisational approach has served the interests of the medical staff well, providing a strong power base from which to inform the hospital board and administration about their views on patients' needs and a means of preserving their professional independence. Before government health insurance, the hospital boards passed on the costs of additional needs recommended by the medical staff to the patient, the municipality or a private insurance organisation in

the form of increased charges; or to the community through fund raising programmes for equipment and/or new buildings. During the early years of hospital insurance in Canada (1959–1972), additional funds, both capital and operating, were available through cost-sharing with the federal government but, since the mid-70s, the cost restraint programmes of provincial and federal governments have relied on the traditional hospital organisation and, in the writer's judgement, it has been found wanting. A system in which physicians exert major influence on hospital costs and make demands for new equipment while standing free of fiscal responsibility creates conflicts between themselves and management and will not, in my judgement, meet the challenge facing Canadian hospitals in the decades ahead.

The groups involved

The key groups involved in institutional and medical staff goals are, of course, the boards, chief executive officers and physicians. It would be helpful, I believe, to review the expectations of the chief executive officers and physicians in their respective roles as bureaucrats and professionals.

Some of my colleagues will undoubtedly object to my referring to the chief executive officer as a bureaucrat, but the typical hospital organisation fits clearly within Weber's[1] classic outline of the features of a bureaucratic form of organisation, including emphasis upon rational organisation ordered by rules, a high degree of disciplined behaviour, an established hierarchy of offices and clearly defined area of authority for each office. The emphasis is on organisational loyalty and the source of discipline is the hierarchy of authority. As Solomon[2] put it, 'the superior has the right to the last word because he is superior'.

Greenwood[3] defines a profession as 'an organised group which is constantly interacting with the society that forms its matrix, which performs its social functions through a network of formal and informal relationships, and which creates its own subculture requiring adjustments to it as a prerequisite for a career success'. He goes on to state five distinguishing attributes: first, a body of systematic theory; second, professional authority based on knowledge; third, community sanction of the authority within certain spheres; fourth, a code of ethics; fifth, a professional culture which includes values such as the worth of the services, norms of behaviour and symbols as part of an image.

Out of these attributes come the role expectations of a professional. One of the key expectations is that of autonomy and self-control by

peer groups of colleagues as opposed to the superordinate control of the bureaucratic employer. The idea of a group of equals is strongly held by professionals, and even where one appears to be the senior, say chief of service in hospital, the relationship is that of a *primus inter pares* rather than that of a superior. As a consequence the role expectation of a professional is towards authority for the individual who is free to make professional decisions within a recognised sphere of competence and bows only to the superior knowledge of a colleague, not to the holder of a superior office.

Further expectations, particularly in relation to clients, come from the code of ethics and the professional culture with its informal norms. They include the duty to offer service whenever and wherever it is required, to give only the best, to respect the confidence of clients and colleagues. Solomon[2] writes that the professional 'will not attempt to get the better of his clients, as is the case in other relationships, but rather to give the best possible service to all clients wherever and whenever they require it'. This contrasts with the expectation of a bureaucrat who is expected to act in the best interests of the organisation and its goals.

Goss[4] in her study concludes that a professional can work without conflict in a bureaucracy and accept its system of authority in administrative matters as long as no attempt is made to interfere with the system of professional authority in his special field of competence.

The foregoing, I believe, helps us to understand the dual authority system in hospitals. The commitment of administrators to institutional goals and physicians to professional goals is a natural development based on their roles. When this is understood, differences of opinion are much easier dealt with by both groups. The separate medical staff organisation and the concept of self-government were evolved as a means for professionals to maintain their professional freedom within the hospital walls. Better understanding of this need by administrators, and acceptance by the physicians of the administrator as a management professional in his own right, will help to resolve conflicts based on misunderstandings, of which there are many.

The problem

One could argue, and many of my colleagues will, that the traditional hospital organisation is still valid for the future, the often conflicting roles of the physician and administrator being a necessary and important part of the system. This argument sees current difficulties in Canada stemming from under-funding of hospitals by provincial governments. It might be valid if we could expect increased funding for

hospitals from the funding agencies or directly from the public, but all indications are that health, and particularly hospitals, will continue to have low priority in government funding. The reason is the current rate of inflation and, in my judgment, an attitude at government level, sparked by Lalonde[5], that the high technology needs of hospitals are insatiable and that additional monies, if available, should be channelled into alternative health programmes instead. Judged by the recent British Columbia government reaction to extra billing, it is unlikely that additional public support, over and above contributions through premiums or taxes, will be forthcoming. Recently, hospital foundations have been successful in raising capital but were categorised by one corporate citizen as a means to perpetuate hospital inefficiencies. Rightly or wrongly, the image of hospitals has deteriorated somewhat with the advent of public funding. Issues which once remained within the hospital walls are now considered public by the media and public accountability has increased.

Assuming a continuation of tight budgets, lack of substantial supplementary funds, at least for operating purposes, and increasing public accountability, hospital authorities in Canada (ie, hospital governing bodies who look to their provincial and national associations for leadership and to their chief executive officers and medical staffs for advice) must develop a strategy for economic survival. Such a strategy should focus on the need for greater participation by physicians in the development of institutional goals, and greater commitment by the medical staff to these goals.

The options

One option is to maintain the status quo, the traditional organisational arrangement with physician accountability to hospital administration being indirect compared with other staff. The outcome would no doubt be a continuation of the patterns of the last five years, during which there has been progress in the efficiency of hospital operation – industrial engineering methods, for example – but lack of progress in the evaluation of effectiveness or efficacy of patient care programmes. Weisbord[6] estimates that improvements in efficiency, while essential, yield minimal savings; perhaps $100,000 a year on a $10 million budget. Advocating the involvement of physicians in management, he quotes a UK study which showed that nine per cent of inpatient time was taken up by avoidable delays in admission routines, waiting for consultations and scheduling operating theatres. Continuing the existing arrangement would also encourage and accelerate plans of the funding agencies to implement, at their level, such measures as zero

based budgeting and formal evaluation of existing and new programmes. Actions such as these from outside the hospital would lack effectiveness and probably be resisted by the medical staff, putting the administration in the position of either siding with the medical staff or supporting the funding agency. This would increase conflict between the two key leadership groups within the hospital.

A second option is for trustees, administrators and medical staff leaders to join together in the restructuring of their hospital organisations in order to integrate medical staff management and hospital management, the medical staff leadership being actively involved in the development of, and commitment to, institutional goals.

With progressive leadership from administration, the predictable outcome of this approach is that systems for the evaluation of efficiency and effectiveness of existing and proposed programmes will evolve inside the hospitals and will complement efforts to greater efficiency by the administration. Concern might arise that the commitment of medical staff leadership to organisational goals will weaken the traditional role of the medical staff organisation as advocates of individual patient care and defenders of professional freedom. However, strong medical leadership could, I believe, convince the medical staff that this approach is essentially one of self-government and is the best defence against involvement by forces from outside the hospital.

The final option takes note of the fact that hospitals are caught between public expectations and government funding restrictions and proposes that hospital boards resign and pass management responsibility to provincial governments or regional/area health boards as their agents. The probable outcome would be a change from a voluntary health care system, underwritten by government, to a 'state' operated system with loss of interest and contributions from the community and voluntary bodies. This might achieve the government's objective of containing health costs within a fixed percentage of the gross national product but could significantly affect the quality of care through loss of professional staff and lowering of standards. On the other hand, it might resolve problems of duplication and lack of coordination of services which exist within the individual hospital board system.

The preferred solution

There may be additional possibilities but in my view the second is the approach needed, and it is long overdue. The current organisational approach will not survive this decade and may well lead to the third option prevailing in some provinces. Therefore, I would like to offer

some views in support of option two, relating to the integration of the goals of the physician and the institution.

The dual authority system has created a we/they relationship between physicians and administrators which does not exist between other professionals in the hospital and the administration. Asked what constitutes physician goals within the hospital, a physician colleague said it was to practice his profession 'unhampered'. His response to the favourite criticism that physicians are primarily interested in making money was that high income stems from a high volume of referrals by colleagues, and is thus (in part) a measure of professional reputation and success. In his opinion high income in itself was not the primary goal for the vast majority of physicians.

In reflecting on this conversation, I wondered whether there is not a need for administrators to consider medical staff like other professionals; as individuals who are motivated by a hierarchy of needs, including self-actualisation. Perhaps the concept of two staffs, medical and hospital, is outdated and we have to give the new physician the same help with orientation and sense of belonging as is given to other staff. My physician colleague, referring to his earlier experience, confirmed how surprised he was to learn that a notice to 'hospital staff' did not include him. The concept of physicians being individual entrepreneurs allowed to practice in, perhaps, more than one hospital is, in my opinion, outdated. Most physicians now identify in a major way with one institution. They are interested in the care of their patients and in the image of the hospital generally. In many instances they play leadership roles over and above the directing of care of their own patients. My perspective may be biased by a teaching hospital background but it is high time, in my judgment, that we discarded the concept of a separate 'organisation for medical staff' and integrated the medical departments and physicians into the hospital organisation. This will require a change in attitudes as much as, if not more than, a change in organisation charts and it can be done, in my opinion, without loss of professional freedom or of status by the medical staff.

A literature review for this paper revealed many articles advocating a greater involvement of the physician in hospital management but few instances of practical success. The Johns Hopkins' experience of giving clinical chairmen fiscal responsibility is an interesting approach and the Mid-Maine Medical Center system – a part-time chief of staff functioning as vice-president for medical affairs – raises an interesting point. It is contrary to the corporate management method of a full-time administrative physician as vice-president responsible for medical affairs and has, in my opinion, better potential for integrating medical staff into management of the hospital. Larsen[7] in his article on

the English hospital study of elected/appointed, full-time/part-time clinical chairpersons noted: 'Another advantage of a short tenure is that chairpersons step down by the time they have become identified with administration and, therefore, are mistrusted for not being objective enough to represent the physicians' interest.'

In any move towards a greater involvement of physicians in management which means looking at the utilisation of diagnostic facilities, standards of practice and so on, the role of clinical department heads is vital. There is a need to rethink the roles of physician leaders: should they be appointed, paid officers with authority vested in them by the board, or elected, voluntary leaders with authority from the medical staff. In examining the use of the corporate organisational model in hospitals, Johnson[8] quotes Chester Bernard, 1939: 'An individual's authority can be exercised only to the extent that those over whom he or she is exercising it accept his or her right to do so'. It is important to maintain the basic principle of self-government in medical staff management as the move continues towards the greater involvement of physicians in management with, perhaps, the elimination of the separate organisational philosophy.

Summary

The challenge appears to be to involve physicians, through *their* leaders, in an institutional goal oriented decision-making, while convincing them that freedom from external interference in their profession lies in leadership from within on matters such as utilisation of resources, and efficacy and effectiveness of patient care. This is the real challenge for hospital administrations in the 80s. Some may be successful with a unified corporate management structure but there are strong indications that medical staffs are not yet willing, nor should they be, to see their power base weakened. As Johnson[7] states: 'The requirement is now on leadership rather than authority, on sensitivity rather than control and on persuasion as the preferred administrative skills'. It will also be necessary for the hospital chief executive officer in the 80s to acquire and/or develop new knowledge and skills in epidemiology and the evaluation of health care in order to persuade the medical staff to assume increasing responsibility for the efficacy and cost-effectiveness of patient care programmes. This is a vital change if self-government for the medical staff and the voluntary hospital system is to be continued in Canada.

References

1 Weber, Max. *Essays in sociology*, translated and edited by H H Gerth and C Wright Mills. London, Kegan Paul, Trench and Trugner, 1947.

2 Solomon, David M. *Professional persons in bureaucratic organizations* [from] *Symposium on preventative and social psychiatry, 15–17 April 1957*. Washington, Walter Reed Army Institute of Research, 1958. pp 253–269.

3 Greenwood, E. *Attributes of a profession*. In Nosow, S and Form, W H eds. *Man, work and society*. New York, Basic Books, 1962. pp 206–218.

4 Goss, Mary E W. *Influence and authority among physicians in an out-patient clinic*. American Sociological Review, vol 26, no 1. February, 1961. pp 39–50.

5 Lalonde, Marc. *A new perspective on the health of Canadians: a working document*. Ottawa, Government of Canada, 1974.

6 Weisbord, Marvin R and Stoelwinder, Johannes U. *Linking physicians, hospital management, cost containment and better medical care*. Health Care Management Review, vol 4, no 2. Spring, 1979. pp 7–14.

7 Larsen, John G. *Physician participation in a teaching hospital's planning: the English experience*. Health Care Management Review, vol 5, no 1. Winter, 1980. pp 69–75.

8 Johnson, Richard L. *Revisiting 'the wobbly three legged stool'*. Health Care Management Review, vol 4, no 3. Summer, 1979. pp 15–22.

3
The pursuit of institutional objectives: making it everyone's business

by Harvey Barkun

Much has been written and said about the chief executive officer's role in the administration of a health care institution. Innovator, catalyst, balancer of budgets, marketer, public relations expert, labour relations expert, educator – the list is almost endless. However, one indispensable characteristic must be demonstrated by this person if he is to succeed in the attainment of the overall objectives of the institution; and that is the ability to meld the energy of all of the people working there in a direction which will reconcile these objectives with both group and individual aspirations. The task is not an easy one, and before examining some of the courses available to the CEO, we should identify some of the differences which exist among the various groups together with the goals (stated or unstated) they pursue.

The groups

The variety of groupings is of enormous proportions. They exist both within and without the institution. For purposes of clarity, it might be useful to list some of them as an illustration of the dimension of the problem.

WITHIN THE INSTITUTION

The board of directors (a diverse group in itself).
The physicians (who exhibit their own departmental loyalties).
The nurses (sometimes torn between their profession and their union).
All other health professionals (divided by profession).
The non-professional workers.
The educators (university or college, medical, nursing, technician, and so on).
The students.
The researchers.
The public – for whom the institution exists.

OUTSIDE THE INSTITUTION

The State which promises health care, teaching and research to the public, and tries to provide appropriate resources.
Other similar institutions who compete for resources.

Other health care institutions who not only compete for resources, but whose basic approach to health care may be quite different.
The regional 'authority' which must try and adapt its planning role to these diverse institutions.
The central unions whose purposes clearly are geared to the goals of the individual and the selected group and who may even be ideologically at odds with the institution.
The educational institutions who require the health institution as a necessary asset for teaching, but who may be unable or unwilling to share in fiscal responsibility. The same holds true for the research establishment.
Organised professional associations who pursue their own objectives, sometimes at the expense of harmony within the health institution.

The goals

The ultimate goal of any health care institution is the provision of health care to the individual. This involves both curative and preventive care; health education; rehabilitation; social services; and all of it within the context of an efficient, effective, well maintained, clean and happy environment. Some institutions, in addition, include teaching and research within their mandate and here again the same environment is necessary. In order to achieve these goals, all of the groups mentioned must be involved to varying degrees. Each has its own priorities, running a gamut which can include cost containment, ideological pursuits, self-actualisation, financial gain and empire-building, most of which are never expressed overtly.

Quality care, which will be both effective and efficient, is ostensibly the objective, but at times the other priorities loom so large that the ultimate goal becomes very nebulous.

The perception by one group of another group's objectives also serves to complicate the picture. We have had recent blatant examples in Canada. The Canadian Medical Association in a brief to the Hall Commission accused hospital administrators of only being interested in balancing their budgets. Hospital boards in Quebec have damned unions for striking for personal gain at the expense of the health and safety of patients, and in a recent class action suit brought by patients against the union (which pulled its members out of hospitals) the union settled out of court for $145,000 in damages. Several provincial governments in the past year have accused the medical profession of being 'greedy' in demanding higher tariffs and the right to overbill.

The examples are numerous and, needless to say, certainly do not encourage a harmonious team approach within the institution.

The choices

What courses, therefore, are available to the CEO which will allow him to coordinate and direct the efforts of all of these groups in a direction aiming to attain common and well recognised objectives?

There are many of them and not all are necessarily contained within the institution. Frequent attempts have been made to correct diverging paths by changing organisational structure, and I am far from convinced that any has been successful. Such structural changes may certainly be a valuable tool, but without modifying organisational behaviour I fear we stand little chance of success.

EDUCATION

There is no doubt that professional organisational behaviour can be modified in the process of educating the individual and the group. At one point, several universities attempted to instill a sense of understanding and team approach by creating a common stream of instruction for all the health science students under its jurisdiction. Budding nurses, physicians, laboratory scientists, dentists, physiotherapists and so on took their first courses together and remained together until each profession began to branch into its own clinical milieu. To my knowledge, the experiment was a failure in terms of how well integration took place at the later institutional stages.

Students in the health professions are taught by and look up to the role models who are their teachers. In recent years, fortunately, curricula have not only begun to include exposure to ethics, efficacy, effectiveness and interdisciplinary approaches, but some teachers have begun to practise and demonstrate by their behaviour their understanding and respect for the individuals and groups who contribute to the institution. It is a necessary first step, and must be encouraged at both the health care and the educational institutional level.

STYLE

Just as the new student should be exposed to the role model just mentioned, the CEO must demonstrate a style of management compatible with the pursuit of common objectives by any member of diverse groups. This style should permeate the management and administration at all levels. Style comprises a number of factors which, when combined, express goals and objectives towards others in a fashion which render them more attractive and understandable. The

ambience generated by such style would hopefully make for better communication, and vice versa.

Communication A hackneyed, overused, misused and abused word, communication remains probably the prime quality which, when properly utilised, can prevent any number of misunderstandings, arguments and problems.

The sharing of information, aspirations, hopes, fears, desires makes for an atmosphere which can only improve through their being communicated. Even the type of communication is important. A written memo is never as good as a telephone call, which is never as good as a personal visit. There must be written records of course, and time is of the essence; priorities must be established since one cannot meet everyone. But the investment is well worth it; visibility is a most important element in the make-up of the CEO. It is assuredly an oversimplification, but I sometimes wonder if the success of an operation is not inversely proportional to the number of memos issued by the manager.

Involvement Call it involvement or call it participation, it can only enhance the productivity of an operation. The current success of Japanese industry is surely the most telling example of the times. Involvement means a sharing of information, discussion with other groups, an appreciation of other points of view, an ability to listen, and a willingness to compromise if necessary. Much of this will occur in committees. Although the definition of a camel as a horse designed by a committee may still often apply, there are many occasions when firm, reasonable decisions are made by committees. This provides yet another link to participating groups and individuals, that of sharing responsibility, and is a far from negligible factor.

For the CEO such involvement must transcend his institutional boundaries. The influence and authority exercised upon his establishment by other agencies such as government, regional structures, educational institutions, and professional associations, make it imperative for him to participate in order to have the proper input to and, at the same time, to keep himself fully informed.

Feedback A lot of decisions are made by managers which are different from personal decisions since they involve other people as well as resources (material and money) which are provided by others. It is therefore necessary to communicate such decisions and, where possible or necessary, provide reasons for them. Only too often divergences arise because participation and involvement in discussion are followed by the decision being made at a different level. Thus, the need for communication *back* to the participants.

STRUCTURE

In order to 'flesh out' these various elements, an appropriate structure should be created which would allow for the style advocated. Committees should be set up where appropriate, standing or ad hoc. They should have clear mandates or terms of reference. Their membership should include representatives of those who can *contribute to* and are *affected by* the discussions and decisions of the committee. There should be an interlocking mechanism between levels and among disciplines, and time frames should be laid down, as well as mandate and composition. Authority and responsibility should be vested with certain committees, but never at the expense of the legislated authority of the Board and its CEO.

Education, style, structure – a proper combination of the three can go a long way to achieving harmony and a common pursuit of goals and objectives by the many diverse groups active in the health care institution. Proper vigilance in recruitment will serve to strengthen the ideal. Current adversary positions will doubtlessly continue overall, but inside any establishment or related institutions there are definitely steps which can and should be taken to reach common objectives. The alternative is increasing hardness of positions; pathways will diverge even more and the purposes for which our institutions were established will become even more difficult to achieve.

4
Problems of integration at the district and unit levels
by Duncan K Nichol

Historical background

Before and immediately after the birth of the National Health Service in 1948, hospitals in the UK were fiercely independent. From 1948 to 1974, hospital management committees and boards of governors sought to weld groups of hospitals into coherent entities responsible for providing comprehensive hospital care to a given population. The concept of the district general hospital emerged as either a single hospital or a group of hospitals providing a service to a population of approximately 250,000. In planning district general hospitals, efforts were made to incorporate a substantial proportion of the provision for geriatric and mental illness within the environs of the major acute hospital or hospitals.

As a result of this pressure to take an overview across hospitals, management machinery developed during the 1970s at the group level to the detriment of the strength, influence and status of hospital managers. For example, group administrators appointed hotel service managers with accountability for budgets across hospitals. Similarly, hospital medical advisory machinery established specialty divisions across hospitals (in surgery and medicine for example), at the expense of the influence of the hospital medical staff committee representing all clinicians within a single hospital.

This evolution in the management of hospitals was consolidated in 1974 when the National Health Service was reorganised to integrate hospital, community health care and family practitioner services under one management structure. The new health authorities centralised major decision-taking on policy and resource allocation and developed integrated planning machinery at a level above the individual hospital, health centre or community clinic. Although the optimum range of population served by these authorities was considered to be in the 250,000–500,000 band, the size varied widely. The hospital administrator was relegated to the status of a third-in-line officer, or below, in the administrative hierarchy.

At the start of the 1980s an attempt is being made to shift the balance of power back to the institutional base of the hospital and community services. It stemmed from recommendations of the Royal Commission on the National Health Service, which followed complaints, particularly by the medical profession, about slow and ineffec-

tive decision-making, and from recent government initiatives. The debate so far reflects the fluctuating fortunes of management at the hospital and community services level, called *unit management*, and at the level of *district management*, which is defined as the lowest level at which the major proportion of comprehensive and integrated health care can be delivered for a given population.

The problems which this paper addresses lie where these two levels meet and are concerned primarily with integrating care at each level. What is the optimum organisational design of health care services which is able to achieve maximum decentralisation; and what is the nature of delegation to unit management? A fundamental dilemma is how to ensure continuity of care for some groups of patients (geriatrics, for instance) across different institutions, while acknowledging the importance of improving clinical practice by closer links between clinical specialties (for example, geriatrics and acute medicine) within hospitals. In order to relate the paper to an example, a profile of Salford Area Health Authority is printed opposite.

Unit management

A unit of management may be defined as a single large hospital or a group of hospitals (the geographical pattern), a combination of hospital and associated non-hospital services for particular groups of patients (the patient care group pattern) or a mixture of both. A variety of factors determine the units of management within a district, but the following are likely to dominate.

The size, distribution and morbidity of the population.
The type of care provided in hospitals and by community services.
The proximity of hospitals.
Historical patterns of organisation, such as the district-wide organisation of community services.

Consequently, units will vary considerably in their scale and range of responsibility.

Some administrators are enthusiastic about adapting management arrangements to fit the organisation of clinical services. Coupled with this, and carrying great weight, is the argument in favour of deploying resources across the full spectrum of care, from prevention through primary and secondary care to rehabilitation. This applies particularly to the mentally ill, the elderly and the mentally handicapped, all of whom are likely to suffer at the crossover points along the care spectrum. Although planning mechanisms have evolved to integrate

SALFORD AREA HEALTH AUTHORITY (TEACHING)
PREVIOUS MANAGEMENT ARRANGEMENTS GROUPED INTO SEVEN UNITS

1 *Hope Hospital*

General acute	430
Maternity	125
Geriatrics	38
Mental illness	30
	623 beds

Budget £10.9m

2 *Salford Royal Hospital*

General – mainly acute	209
Skin Hospital	
Dermatology	56
	265 beds

Budget £4.5m

3 *Royal Manchester Children's Hospital*

General acute	209
Swinton Hospital	
Mental handicap (adults and children)	107
	316 beds

Budget £5.1m

4 *Ladywell Hospital*

General non-acute	159
Geriatric	226
Eccles and Patricroft Hospital	
Geriatric long stay	32
	417 beds

Budget £3.2m

5 *Prestwich Hospital*

Mental illness	1478
Peel Hall Hospital	
Psychogeriatric	39
	1517 beds

Budget £9.3m

6 *Community Services*

88 Health centres
13 Community clinics
Budget £2.8m

(Social services: not managed by the National Health Service – liaison and joint planning only)

Residential
- 11 Children's homes
- 19 Homes for the elderly
- 2 Homes for adult mentally handicapped
- 1 Home for adult mental illness
- 1 Mental health support unit
- 1 Residential home for the physically handicapped

Day Care
- 3 Family centres
- 1 Centre for mentally ill
- 6 Care centres for the elderly
- 4 Adult training centres for the mentally handicapped
- 1 Day care centre for elderly physically handicapped

7 *Family Practitioner Services*

120 doctors
56 dentists
52 chemists
54 opticians
Budget £9.6m

aspects of health care across the spectrum and to link related services outside the National Health Service – for example, social services, housing and education – there are, in fact, few examples of management units organised to deliver care on an integrated patient care group basis with corresponding budget support systems.

If we turn to the Salford profile, which had a geographical pattern of organisation below district level, it is clear that the single specialty hospitals in mental illness, mental handicap, geriatrics, paediatrics and maternity lent themselves to the option of integration with associated non-hospital services.

In debating this option, the following provisional units of management emerged.

MENTAL ILLNESS

Consisting of the large mental illness hospital, community psychiatric nursing, hostels, group homes, and liaison with social services' day centres. A strong planning responsibility, but not site management responsibility, for the mental illness beds in the main acute district general hospital. Site management responsibility would include, for example, hotel services, estate maintenance, fire, and health and safety matters.

MENTAL HANDICAP

Consisting of the mental handicap hospital (children and adults), community nursing, hostels, and liaison with social services' adult training centres and special care units.

MATERNITY

Consisting of the maternity hospital, which is on the same site as the main acute district general hospital, ante-natal care and family planning in hospitals and primary care centres, and community midwifery. Site management responsibility would fall to the management unit for the main acute district general hospital.

GERIATRICS

Consisting of the predominently geriatric hospital and geriatric day hospital, day centres, community nursing defined as the liaison nurses in geriatrics and the night nursing service, and liaison with social services. A strong planning link to the 38 geriatric beds in the main acute district general hospital.

An integrated geriatric unit of management would be contrary to Salford's commitment to a policy of increasing the number of geriatric beds in the main acute district general hospital. This policy encourages

the view that all geriatric beds should be managed in the same unit as the acute beds in order to facilitate improved clinical working between the acute specialties and the long-stay element of geriatric hospital care.

PAEDIATRICS

An argument in favour of linking the single specialty paediatric hospital with community child health clinics and school health services is outweighed by other features of clinical organisation. The responsibility of the paediatric hospital for providing a region-wide paediatric specialist service, as well as a district service, might dominate an integrated unit of management to the detriment of the community services. In addition, community health visitors have a generic role: although paediatric care is a particularly important part of their responsibility, there are no specialist paediatric health visitors in post. Similarly, the concept recently advocated in the UK of a general practitioner paediatrician specialising in the primary care of children has not been received favourably. Therefore, it is proposed that the paediatric hospital should constitute a small management unit with strong planning links facilitating coordination with community paediatrics, which would form part of the management unit for community services.

ADULT ACUTE

The question of whether to form one or two adult acute management units is contentious. Welding the main adult acute hospital and the supporting acute hospital into a single unit of management would be a benefit. General surgeons and physicians and consultants in other specialties work in both hospitals.

The high technology support services such as scanning and intensive care are located in the main hospital but utilised for all acute services, and there is pressure to centralise accident and emergency services in the main hospital with important consequences for the admission policies of both hospitals. The nursing service is managed by a single divisional nursing officer. The two acute hospitals are therefore interdependent. There is, however, strong local clinical pressure to preserve the identity and status of the supporting hospital. Its historical traditions lie in the much prized voluntary hospital heritage, attracting 'Royal' designation, in contrast with the main hospital which originated as a Poor Law municipal hospital. Also, site management demands on the two sites would make single unit management particularly difficult.

COMMUNITY AND FAMILY PRACTITIONER SERVICES

Consisting of preventive (including health education) and community medical services, community nursing (excluding psychiatry, mental handicap, midwifery and geriatric liaison), health centres, and liaison with social services. A strong planning link to the community health components of the other management units – family doctor, dentist, chemist and optician services.

These provisional units of management illustrate the dilemma: should the patient care group approach to management be applied wherever feasible, or do the constraints and demands of managing institutions require a more geographically oriented approach?

It may be helpful at this stage to summarise the strengths and weaknesses of the patient care group approach.

Strengths

Facilitates the delivery (as well as the planning) of care across the spectrum and the liaison between health and other services, such as social services, housing and education.

Fits more naturally the medical and nursing model of organising clinical care; for example, groupings of geriatricians, psychiatrists and the corresponding nursing specialties.

In some instances fits more naturally the emerging patterns of paramedical organisation, such as specialisation within occupational therapy, physiotherapy and psychology in geriatrics, mental illness and mental handicap.

Facilitates a more single-minded approach to care with a higher commitment by staff.

Reduces the problems of integration. People are more easily persuaded of the group's common purpose and objectives. Consequently, the coordinating demands on the administrator's role are reduced, allowing him more opportunity to take up an adaptive/innovative management role.

Mirrors the approach to policy and resource allocation at national and regional level where guidelines and priorities are directed towards patient care programmes across the spectrum. Thus, it assists planning.

Weaknesses

Relies on future tentative developments in the formulating of budget control and clinical costing systems on a patient care group basis.

Reduces the investment of management time in the large institution.

Does not fit the model for organising hotel/commercial services, which is geared to an institutional/geographical approach.

Does not fit the organisation of some community services where the assignment of responsibilities is not unit-based.

Fragments management geographically because the component services for most patient care groups are geographically dispersed.

Challenges traditional allegiances.

The optimum level for organising services

Although it has been resolved to delegate decision-making to the lowest possible level and to strengthen the local units of management, there is a problem about services that are best organised on a district or even supra-district level.

Thus we have not only to weigh the merits of geographically based units versus units defined in terms of patient care groups, but also to choose whether to manage a variety of services at the unit (however defined) or the district levels.

Non-clinical services

Most of these services – catering, cleaning, portering and medical records, for instance – operate effectively at unit level. They are in each major workplace and should be managed by unit administrators, with the possibility of a level of professional/technical advice being provided above the units.

Other services, such as central sterile supply, laundry and transport, usually have a single base within a district and need to be accountable at district level, although they may look to the unit administrator for day-to-day management support (for example, industrial relations), in order to free district officers from being involved in purely operational issues. Unit administrators would have the authority to approve the quantity of a district-based service provided in their units and also to monitor its quality from the viewpoint of users.

Estate management is best organised at unit level for day-to-day maintenance with strong professional links to district where large programmes of work are best planned and executed.

Paramedical services

Therapy services in short supply such as occupational therapy,

physiotherapy, psychology, speech therapy, chiropody, pharmacy and community dentistry are best deployed flexibly across a district, or even, in some instances, on a supra-district basis.

However, if services like occupational therapy and physiotherapy maintain a sizeable and stable presence in a major unit it can be argued that they should be managed on a unit basis.

Diagnostic services such as radiology and pathology rely on expensive high technology equipment and have developed sub-specialties. Their optimum level of management must be at the district or supra-district level. Again, the unit management level must be involved in negotiations about the quantity and quality of service provided.

Paramedical professions have tended in recent years to press for self-management with a professional manager accountable at district level either to a doctor, an administrator or a management team. They are concerned that services managed on a unit basis would be accountable to a unit administrator, who might not understand their aspirations so well or be sympathetic to the priorities within their profession across the units.

Nursing services

Nurses have developed a strong hierarchical organisation up to district level with one or more acute service divisions (usually including paediatrics and geriatrics), divisions of midwifery and psychiatry (usually covering the spectrum of hospital and community care), a community division and an education division. This typical organisation of nursing services lends itself in some respects to a client-based approach for the non-acute services.

Senior nurse managers are concerned that deployment of nursing resources across a district will be threatened by the devolution of budget authority to management units.

Framework for delegation to units of management

The basic objective is to devise a framework of delegation within which units of management are able to sanction expenditure on staff and equipment within predetermined limits, provided that the expenditure is consistent with district policies and can be contained within the total unit budget for all services. There should be no need for districts to become involved in the routine sanctioning of expenditure within approved budgets or with the routine approval of day-to-day management matters. In order to promote this relationship between unit and district, clarity of procedure and authority in the financial

arena is paramount. The following are some of the implications.

District authorities must give to each unit of management a financial target which represents an apportionment of existing and likely future resources. The apportionment should be based on the demand of a given population for the categories of care provided by the management unit at agreed cost levels, taking account of the overall constraints faced by the district. The target may have been adjusted to comply with a policy decision, such as a decision to discriminate positively in favour of community services in inner city areas of multiple deprivation. Thus, while managing its own affairs a unit will know whether over a long period it can expect to receive more or less money. The pace of movement towards the target as determined by the annual allocation to units will depend on the resources made available to the district as a whole or on its success in redeploying money from one unit to another. Broad strategy for developing, rationalising or curtailing the level of care in any unit of management is a district planning responsibility; but to manage effectively on a day-to-day basis unit managers must be party to these policy decisions and be aware of their longer-term financial effects. This may seem obvious but experience so far is that district strategic plans have often not been translated into targets for individual units of management. Decisions have been made at the district level to adjust budgets annually across a range of district-wide subheads of expenditure without spelling out the full effects. Strengthening unit management will make it possible and necessary for unit managers to be involved in district planning.

In planning the next year's expenditure, units will be obliged to consider the balance between budgets within an overall unit allocation which takes account of district priorities, its own unit objectives and the needs of one service against another. For such a process to succeed, management units must have the authority to *recommend* the deployment of resources across all services.

Individual budgets will be drawn up for each unit of management for services organised solely at unit level (for example, portering, cleaning); here there is no difficulty in budgeting for a unit and expenditure can be controlled directly. However, where services of a commercial type, like laundry, are managed at district level, it will be necessary to set up a trading account allowing individual units to purchase a service as required. This also applies to paramedical services managed at district level, the unit being able to negotiate a level of service which it can afford. Methods need to be devised for accounting for the level of service provided by paramedical departments, apportioning it either on the basis of episodes of treatment or of staff time.

The powers of virement between budget heads within a unit and between units of management will need to be explicit. If units are to set a stable course while taking account of future target expectations, the temptation to adjust allocations between units during the course of the financial year must be resisted. The power of virement within a unit is a sensitive issue. The concern of district managers, particularly in services such as nursing, estate management and paramedical, is to maintain consistent standards across a district. They resist losing financial control of individual parts of their service through the fluctuating fortunes of the virement process within units. Nevertheless the new philosophy of management encourages negotiation of issues at a local level, and it can be argued that the district still retains the ultimate safeguard of the power of intervention in unit management if district policies are being disregarded by the unit, or financial control is not being maintained. There is also concern about the use of a unit's unplanned savings; for instance, should money saved through the inability to recruit staff remain available to a unit for use on a non-recurring basis? Some argue that a proportion should go to district and be used for dealing with problems at a district level or for items which units cannot afford – major equipment replacement or a backlog of maintenance, for instance.

The following are arguments in favour of substantially more financial delegation than at present.

Restricting the control of cash and the exercise of virement to the district level *only* has caused unit managers to forget habits of good financial control. Overspending has become a district problem because real control can be exercised only at that level.

There has been little or no incentive to make savings because the resulting benefits accrue to district.

Centralised control of management discourages unit managers from committing themselves to policies and plans which they think they cannot influence.

Because unit managers ask for money without knowing about the overall position, they (and through them the medical and other staff) become disillusioned when the remote district exercises priorities which do not favour them.

Those parts of a budget susceptible to clinicians' demands (drugs, for example) have become open-ended because there is no incentive at local level to control them. This has an increasingly detrimental effect on the overall resources of a district.

District managers would become free to concentrate on the tasks of strategic planning and the development of care policies.

The following problems are associated with proceeding on these lines.

The required accounting systems at unit level have not been fully developed. They hardly exist for patient care group units.

Standards of individual services across the district will suffer if not managed directly by a district manager.

Without management at district level, some support services (catering, for example) may cost more or fall in standard.

The degree of delegation allowed will have to depend on the skills of individual unit managers.

If units become too autonomous, comprehensive planning for the district will suffer.

Summary

The current debate within the National Health Service is aimed at striking a balance between the requirement for comprehensive care planning and accountability at district level, and the desire for maximum delegation to units of management. The development of the necessary systems poses questions which have not been fully answered so far.

5
The development cycle of multihospital systems in the United States
by Donald C Wegmiller

The development of multihospital or multi-institutional systems in the United States is a phenomenon of the 1970s. Systems now represent approximately 30 per cent of all of the community hospitals in the United States and about the same percentage of the total beds in community hospitals. Hospitals become a part of these systems through a variety of arrangements, most generally through the system owning the assets of the hospital or through the local owners leasing the hospital to the system, or, a rapidly developing arrangement, a contract for the system to manage the hospital.

The reasons for the formation of multihospital systems in the United States are many and varied. Most writers group them into two categories; factors external to the hospital, and internal factors within the hospital organisation. Some of these factors and a brief description of each follows.

Factors influencing development of multihospital systems in the US

EXTERNAL FACTORS

Planning laws and controls Public Law 93-641 identified ten national health priorities. Four of them strongly encourage and urge the development of multi-institutional relationships. In the first, Congress asks for the 'development of multi-institutional systems for coordination or consolidation of institutional health services.'

Health systems agencies (HSAs) have established strong planning controls as part of this law and have urged hospitals to consolidate services in all areas possible.

Government programme reimbursement As the federal and state governments' share of the total hospital cost increases, the regulations governing reimbursement of these costs have to be, and will continue to be, more stringent. Having to deal with these reimbursement regulations, and having the strength, knowledge and expertise to maximise the reimbursement, has placed tremendous demands on the financial staff of the single free-standing hospital.

Rate regulation Pressures on the health care industry to contain costs have led to an increasing number of states instituting rate controls or regulations. Financial instabilities become a key threat to

hospitals. High interest rates and inflation will continue to cause more hospitals to get into financial trouble when rate controls prevent them from increasing revenue.

Growth of medical technology As physicians, allied health personnel and communities learn more about the availability of high technology in medical care, the demands upon the hospital to provide that technology increase. This brings with it the economic pressures of capital needs to acquire equipment, the need for personnel to operate the equipment, and sufficient volume of service to sustain the operating costs. The difficulty that the single free-standing hospital has in providing all of this is another external factor leading to contract management.

Emergence of allied health professions A factor not usually recognised is the increasing availability of a number of allied health professions. As these become available and begin to make their services felt in the larger teaching and urban hospitals, the demand grows to have the same level of service in all hospitals. This places tremendous demands on the smaller hospitals to recruit these professionals, to sustain their high salaries, and to maintain a strong professional motivation. Management contracts tend to make these professionals available on a shared basis from the hospital manager or hospital management firm.

Shrinkage of size and capacity of the hospital sector The very survival of the hospital when under pressure from planning agencies, competing hospitals and financial burdens forces it to look for additional resources to survive and meet these demands.

Rising consumer expectations Informed community groups expect that hospitals will develop meaningful programmes to enhance their ability to adapt to changing social and economic conditions and to major population shifts. The ability of a single hospital to meet these expectations is decreasing.

INTERNAL FACTORS

Need to acquire and pool capital Capital needs in the hospital industry are on the increase. Sources of capital supply are becoming more restricted. Costs of capital are increasing rapidly. A recent study by a Wall Street investment firm predicted that by 1990 not-for-profit hospitals in the US would be at a 60 per cent debt to asset ratio. This would place them, essentially, outside the debt equity market. The need for hospitals to continue to acquire capital has caused them to look at alternatives which would allow them in the short run to pool and share capital with other institutions.

Recruitment of management personnel The two health care re-

sources which are needed most by the nation's small one-hospital communities are physicians and skilled, experienced and well-trained managers.

Cooperative ventures and shared service organisations recruit manpower more successfully than individual hospitals because volume of work provides more attractive career prospects and financial rewards, closer peer relationships, and opportunities to develop professional skills and apply them to diverse areas of practice.

Increasing complexity of health care management As administrators face the demand for increased technical skills not available on their own staffs or in their own background, the need increases to acquire the expertise. The availability of another organisation to provide these complex skills is one of the major reasons for the development of management contracts.

Need to develop and implement 'marketing' programmes One of the hottest topics in the health care field today is health care marketing, involving techniques which are not, on the whole, well-developed in today's administrator who does not have the time or the staff to devote to a sophisticated marketing programme. Hospital management firms can develop the sophisticated staff necessary to carry out a marketing programme on the local hospital's behalf.

Need to acquire a political clout As hospitals face increasing pressures from health systems agencies (HSAs), state rate review programmes, reimbursement programmes, and state legislatures, the need to combat these forces increases. The time to do so and the size of organisation necessary to command attention are usually not present in a single hospital organisation.

The need for increased operating efficiency The 'economics of scale', or critical mass, necessary to achieve efficiencies in purchasing, materials management, and a number of other areas are not present in the average size hospital. Although shared service organisations take care of this need quite effectively, they are generally not felt to be as responsive or as comprehensive as the services available under a management contract with a management firm.

Quality of care Hospitals are concerned about their ability to maintain high-quality patient care, attracting and maintaining a qualified medical staff, and reaching the volume of cases necessary to maintain these skills in specialised areas.

The life cycle of multihospital systems

The act of establishing a multihospital system may well solve in large part the 'founding problem' that gave rise to its inception. Once the

system exists, however, it evolves activities that in themselves would not have been reason enough to bring the system together. These then become a justification for its continuing support.

For example, many systems were formed to solve a capital financing problem, but, once formed, they also took over the centralised operation of management and support activities and the coordination of clinical programmes. In other words, descriptions of systems in their formative years would be quite different from their descriptions as mature organisations. This 'life cycle' of multihospital systems is worth some discussion.

THE SHORT RANGE OR EARLY DEVELOPMENT STAGE

In the formative stage, usually about the first five years, multihospital systems tend to concentrate on four basic general areas: development of the organisation's mission, organisation concerns, personnel development, and some basic shared services.

In mission development, the organisation's primary role is to determine the reasons for its existence. It should be understood that the hospitals who have come together to form the system may have widely differing ideas as to its purpose and, in most cases, are quite fiercely independent of each other and, perhaps, even of the broader system. The challenge to the system's managers is to develop a mission that can be representative of the founding organisations and yet provides an overall broader purpose for the system itself.

Development of the mission is not independent of the many organisational matters that must be addressed in the early stage of the system's development. Issues concerning the governance structure, the management structure, the interaction of the various individual hospitals, the roles of the medical staff, and other organisational matters, take up a great deal of the organisation's time and effort in this first five-year period.

Selection, appointment and development of key leadership personnel for the system's executive staff is also a time-consuming matter in the early years. This is definitely related to the organisational matters as well as to the continued discussion about the services that will be shared among and between the hospitals in the system.

Which services should be shared and on what basis is a continuing discussion in multihospital systems that occupies a great deal of time and effort in the formative stage.

IMPACT OF THE SYSTEM ON THE HOSPITALS IN THE EARLY STAGE

Many of the systems anticipate, and most receive, some cost savings by the combining of efforts and the sharing of services in the early stage. However, at this stage, these cost savings are generally offset by the organisational costs inherent in the development of the new organisation. The effect is usually one of no net cost savings at this stage of system development.

At the institutional level, there are significant concerns among local hospital governing board members, and administrative staff members, about the degree of autonomy that the local hospital can retain in the overall system structure. These concerns are sometimes openly expressed, but in many cases are acted out in a number of indirect and subtle ways. It is incumbent upon the system management and government to be sensitive to these concerns and to attempt to respond to them before they become unmanageable.

As with many growing organisations, numerous individual egos are involved in the creation of the new system. Governing board members, usually leaders in their communities, have some concern that their role in the overall system will be lessened since there is usually a system-wide governing board of considerable influence. Administrators who have been the chief executive officers, clearly the key players in their institution, now see other management staff emerging whom they perceive as taking away some of the limelight previously focused upon their own efforts and achievements.

The members of the medical staff of the individual hospital express concerns, even fears, over their ability to retain control of medical staff appointments, clinical privileges, and the control of their own medical practices. Although in most instances these matters are rarely considered on a system-wide basis in the early stages, if at all, the fears of the staff nevertheless remain high in the early years.

THE MID-RANGE DEVELOPMENT PERIOD, FIVE TO TEN YEARS

At this stage of development the system's efforts are directed towards sharpening its management capability and performance, additions to shared services, attempts at structured evaluation of the system's programmes, and further development of personnel at the system level.

The system is attempting to refine its management of the organisation through the development of management processes and procedures on a system-wide basis. This is often viewed as threatening

to the individual hospital's autonomy and is, therefore, sometimes resisted or not supported wholeheartedly.

As the original set of shared services has now been in place for approximately five years, additions are made in this mid-range development period. Usually, these do not enjoy the same overall agreement or acceptance by the hospitals, since the 'easy' services were developed in the formative stage. The second set of shared services usually has a lesser return on its investment and may involve people at a deeper level in the organisation's structure. This requires the local hospital administrator to work harder at achieving consensus within his organisation about sharing services with other hospitals in the system, a course of action with which, in some cases, he may not agree.

The system's governing body is now becoming interested in evaluating the results of its early years. Some attempts at structured evaluation are being made. Usually these are not very precise because measurement tools and performance indicators for hospital systems are not well developed. Also, these attempts raise questions about an individual hospital's participation in system-wide efforts which resurrect some of the fears and concerns evident in the early stage.

In this mid-range development stage, the system's management is still undergoing personnel development, adding specialists to its staff. These specialists may be in some areas of shared service or may be part of the management refinement process described earlier.

CONCERNS OF THE INDIVIDUAL HOSPITALS IN THE MID-RANGE STAGE

At this point, many of the basic shared services developed in the formative stage are beginning to yield more savings than the original costs of development. This has led to some overall net savings to the individual hospitals. What are lacking in most systems are precise and agreed means of measuring these savings. There remain some disagreements between the individual hospitals and the system's staff as to whether these shared services have actually yielded savings or are merely an additional overhead being allocated to the individual hospitals.

The fears of the hospital governing boards and administrative staff about loss of autonomy are lessened from the formative stage but are still definitely in existence. Some concerns are now expressed over how the individual hospitals can integrate their efforts with those of other hospitals and that of the system as a whole, while retaining their individual identity.

Some of the concerns of various individual egos have lessened. In

most cases people's fears of being left out of the decision-making process, or of a lessened importance for the individual hospitals, have not materialised. Of course, this is highly dependent upon the system's governance and the sensitivity of its management since, without attention to these concerns, it would be easy to make these fears real.

The fears of the medical staff have also lessened somewhat from the formative stage, usually because very little has occurred at the individual hospital which would threaten local medical decision-making. Very few, if any, systems attempt to change the process of medical staff appointment, clinical privilege assignment, or medical practice patterns. After a number of years without interference in these processes, the fears of the staff begin to subside.

LONGER RANGE DEVELOPMENT STAGE

This stage is more difficult to describe since very few multi-institutional systems in the US are much more than ten years old. However, some patterns of these more mature systems have begun to emerge and some results can be anticipated.

The systems begin to give evidence of early maturity in this stage of development. Their activities begin to differ somewhat from the early years, in corporate staff development and specialisation for instance. Other areas of concentration include: increased sophistication of reporting systems, improved management techniques and evaluation of systems, extension of the sharing of services into the consolidation of certain services between hospitals, with some emphasis on clinical sharing in geographically proximate areas, and the beginnings of a re-evaluation of the organisation's mission.

At the corporate staff level, the individual functions established during the first two phases of the system's development are now becoming increasingly specialised: for example, in the area of finance, specialists in reimbursement, capital finance, investment and cash management.

The management information systems or reporting systems used within the hospitals, as well as between the hospitals and the corporate staff, become increasingly sophisticated. Most of the systems are computerised and are monitored for variance between actual and expected results.

All techniques and processes of management show considerable improvement compared with the formative and mid-range stages. A good deal of evaluation of results takes place with a common use of results monitoring systems. Models used in forecasting results on the system's computers are becoming common in order to give management the ability to look further into the future on a system-wide basis.

The sharing of services is now at a stage where some services have been consolidated, and duplicated services in certain hospitals have been eliminated. This stage of development sees the beginning of interest in the sharing of clinical services. This is, of course, truer in geographically concentrated systems than in those which are geographically dispersed.

After ten or more years of development and many changes in the structure and activities of the system, the governing board and corporate management usually begin the process of re-evaluation of the mission or purpose of the system. The 'founding problem' is usually well under control by now and many additional purposes and activities have been developed.

CONCERNS OF THE HOSPITALS IN THE LONG-RANGE STAGE

The fears of lessened autonomy for the individual units have mostly disappeared, a change which is due less to altered attitudes than to the turnover of administrative personnel. The newer administrative personnel, brought in at the second or third stage of development, are usually selected for their attitude towards a multihospital system administration. Those selected usually possess an understanding of the system concept and express an interest and willingness to participate in its administration.

The concerns of local hospital governing boards and administrations have now shifted from autonomy and integration to the size of the system, its rate of growth, the amount of debt which has been accumulated, and the power of the corporate governing body and the central administration. Usually by this stage of development the system has grown to encompass several dozen hospitals and has considerably reduced the impact or power of the founding hospitals. The original mission has perhaps been modified. Many of the founders of the system have left and considerable change in governance and management processes has taken place. All of this can be very unsettling to some individuals who will worry about the size, growth, debt, and power of the central organisation.

On the other hand, medical staffs at the individual hospitals have seen little negative effect by the system on their individual medical practices or the activities of the medical staff as a whole. They have begun to recognise, however, that the multihospital system is perhaps a permanent fixture and not merely a passing organisational fad. They also see the system developing some programmes, services and power that could be beneficial to the medical staff collectively or to the individual practitioner. This is particularly true when additional hospitals are brought into the system representing potential referral

sources for specialists. Once they have recognised these advantages, physicians begin to seek corporate involvement at both management and governance level. It is common to see practicing physicians represented on governing boards at the corporate level in multihospital systems as the systems begin to mature.

Management challenges in the development stages of a multihospital system

Keeping in mind that the institutions which come together to form a multi-institutional system are heterogeneous groups with their own personal objectives and priorities, there are many challenges facing the management of a multihospital system as it develops and matures.

First, it is important for a system manager to recognise the differing goals and objectives that governing boards and managements of local hospitals have for joining or forming a multihospital system. To assume that these purposes are necessarily similar is incorrect and can lead to serious management problems in the initial stages. The system manager has to identify these differing purposes and to reconcile them to the maximum extent possible with the common overall purpose or goal. This reconciliation requires skills in role and programme identification and in human relations, but particularly in group dynamics. These are skills not necessarily inherent in hospital administrators and they need careful nurturing in any manager, no matter what his level of skill.

The second challenge is the personal recognition by the system manager that he is no longer an institutional manager, but rather a manager of managers. This change calls for a whole new set of skills and responsibilities, again not necessarily present in most hospital administrators. The management of other chief executive officers, each of whom has continuing responsibilities to a local governing board, needs skills in management by objectives or results, sophisticated processes of evaluation – both of performance and of individuals – and analysis and problem-solving through individuals instead of direct problem-solving.

The third challenge to the system manager is the development of appropriate control mechanisms. The control processes and techniques that are successful in individual institutions may no longer be applicable on a system-wide level. Control through personal intervention, through intimate knowledge of personalities and through the use of friendship, and control through detailed mastery of the working procedures of the individual organisation, are not available to the system manager as readily as they are to the individual hospital

administrator. The system manager must rely instead on such processes as control of programme development through power of approval; overall performance evaluation of the chief executive officers of the individual hospitals; and management of the interaction between the local governing board and the corporate governing board. This latter skill is one which is rarely gained by the local administrator in the management of a single free-standing hospital.

The fourth challenge to the system manager is the mastery, or at least working knowledge, of management processes not normally developed in the individual hospital setting. These include sophisticated financing mechanisms which require day-to-day management rather than widely spread, episodic involvement; cash management; and the development of investment policy for handling multimillion dollar sums as opposed to tens of thousands at the local hospital level. A working knowledge of sophisticated computer forecasting models and intricate management reporting systems is also required and is seldom present in the traditional hospital administrator.

The fifth challenge is to develop the ability to assure dozens of organisations within the multi-institutional system that their individual interests, priorities, and concerns are, in fact, of great importance to the system's management. To appear not to know of their problems or, worse still, not to show evidence that they are of significance to corporate management, will bring about a weakening of the linkages between local hospitals and the overall system.

These are examples of the many and different challenges which face the manager of a multihospital system compared with those which face the individual hospital administrator.

Due to the different nature of these challenges, many multihospital systems in the US have looked for a different type of preparation when choosing their managers. Masters in business administration and graduates with experience in financial organisations and large scale industrial or business firms are more frequently found in multihospital system management, particularly in the investor-owned field, than the traditional graduate in hospital administration.

Very little has been written about the maturation of multi-institutional systems and the demands or challenges it places on system managers. A recent article does a fine job of describing the development stages of multihospital systems as they mature.* At the end of this paper is a summary of these stages set against twelve different areas of development. They are described on a scale of nine different levels of

* Jones, Wanda J. *Multihospital systems' goals and structures change as they mature.* Modern Healthcare, vol 10, no 4. April, 1980. pp 94–95, 98.

development in a multihospital system, from the 'infancy' stage to maturity. Although this summary may not be representative of all the systems, and may not even be representative of any one particular system's development, it does offer considerable information about systems which now represent a larger element in the hospital sector of the United States.

Assuming that a chief executive officer's role is to help integrate the sum of the parts of the institution for which he is responsible in pursuit of the institution's goals, the issue of reconciling heterogeneous institutions within a multihospital system should increasingly occupy our attention in the 1980s.

Development cycle of multi-institutional systems

Level	A Control Ownership of assets	B Chief executive officer of MIS	C Staff	D Board composition
IX	Single corporation: owns all assets, central borrowing, against total asset base	Recruitment of two or more top corporate officers, at least one of whom has corporate experience outside the health field	Adds inside legal staff	Board composed of representatives of communities and large employers who purchase health services
VIII			Adds specialists in regulation, political action, reimbursement, and healthcare policy	Board is composed of business representatives and expert specialists from relevant fields
VII	Umbrella organisation, subsidiary corporations, assets mutually pledged	Recruitment of CEO with MIS experience from outside system	Adds specialists in medical and nurse manpower planning, recruitment, and management	
VI		Recruitment of CEO without MIS experience from outside the system	Formation of specialists into internal and external profit center with direct billing to users	Board composed of representatives of communities served only
V	Inter-institutional borrowing and pledging Central ownership of separate corporations		Adds full-time marketing staff	Board composed of outside directors, not representatives of boards of member hospitals
IV		Replacement for original founding, CEO promoted from inside the system	Adds full-time specialists: in finance, personnel, fund-raising, public relations, for example	Board is combination of at-large members and hospital board, management, and medical staff representatives
III			Full-time planner hired	CEO becomes president of the board
II		Hospital administrator/MIS founder promoted to full time MIS CEO	Part-time consulting staff in planning and finance	Combination of hospital board representatives and new at-large members
I	Central management services only, separate assets base and control	Hospital administrator assume additional duty as MIS CEO	Hospital staff assumes additional duties	Each board member represents the board of a member hospital

Development cycle of multi-institutional systems

Level	E	Board function and authority	F	Shared services	G	Planning focus	H	Position in the market
IX		Also takes responsibility for health care delivery system for defined service area		Adds shared facilities (Condominium)		Local system organisation and development strategy		Sole provider, all aspects of care and payment
VIII		Also influences public policy decisions on economics of health care		Adds shared middle management		Total funds flow and use in system by target group		Major provider of most care plus manager of dominant payment system
VII		Adds authority to plan and develop new insurance and reimbursement approaches		Adds shared physician program managers		Medical and nursing manpower management		Major provider of all levels of acute care of pre-acute and post-acute care
VI		Adds authority to reprogram individual facilities		Adds shared personnel services		Institutional market position and strategy		Major source of all levels of acute care plus mental health
V		Adds authority to hire and place CEO in each member hospital		Adds shared financial systems		Primary care base, organised and unorganised		Major source of primary, secondary, and tertiary care
IV		Adds authority to evaluate performance of each hospital and CEO		Adds shared specialist in manpower		Tertiary programs in the local system		Dominant provider of tertiary care and secondary care
III		Adds authority to approve new programs and services		Adds shared purchasing – capital equipment		All programs at individual institutions		Dominant provider of tertiary care
II		Adds authority to approve operating and capital budgets		Adds shared logistical services and equipment		Single services/programs at individual institutions		One of several competing healthcare delivery systems in the market
I		Acquire and supervise allocation of capital funds and project asset base		Shared purchasing of supplies		Single high technology projects		Only provider, but large part of local market seeks care elsewhere

Development cycle of multi-institutional systems

Level	I	Control of system	J	Basic strategies	K	Management systems	L	Medical staff organization
IX		Authority for local system planning, development and resource allocation		Establish continuing relationships with cohorts or people at risk – to assure that services needed are received		Medical care management systems, all programs, on line		Medical staff of hospital same organisation as major medical clinic
VIII		Certification/franchise for specific service area of population, some or all programs		Serve the healthy resident through consumer-oriented services		Interactive system status data bank		Medical staff open to other professionals
VII		Direct payment relationships with a high proportion of local purchasers of healthcare services (business, unions, and government)		Tie patients to the system through payment mechanism		Total information system – financial, medical, operations		Medical, staff organisation converted to program categories, decentralised functions
VI		dominant position on local/regional/state regulatory authorities		Retain patients in system longer through adding pre and post acute care		Financial modelling, major risk capital decisions		Program advisory committees or task forces
V		Joint ventures with other providers, purchasers and payers		Capture entry point at workplace by adding screening services		Financial modeling, operating budgets and rates		Program directors, all programs
IV		Management and other ties with majority of organised providers in the area		Capture entry point at primary care level		Monitoring of financial ratios and efficiency standards		Program directors, tertiary programs
III		Active community/target group-oriented program planning with board support		Compete through service and program additions, enrichment of existing programs		Budget review with centralised feedback		Salaried chiefs of service, part-time and full-time
II		Active emergency service, including ambulances and communication systems		Compete through selective recruitment to the medical staff		MIS-wide budget approval process		Medical director(s)
I		Strong medical staff		Maximise share of growing market through early growth in capacity		Single system at each hospital, primarily financial		Individual medical staffs

6

Pivots and links: ways of improving the partnership between centre and periphery in the National Health Service

by Robert M Nicholls

Background: the nature of the problem

The National Health Service is in the middle of its second major structural upheaval in eight years, and the relationships between centre and periphery are being altered yet again. Indeed it is one of the objectives of the present reorganisation to make the service more sensitive to local needs and to delegate both functions and responsibility from the Department of Health and Social Security to regional and, as far as possible, to district health authorities.[1] The 'centre' has tried to do this before, of course, and the 'Grey' Book[2] was eloquent on 'delegation downwards' and 'accountability upwards'. It does seem very difficult to achieve and the 'suction pump' effect of higher authorities in decision-making continues to be commonly observed.

This may be partly because there is an inherent paradox in the way the National Health Service is organised. Government collects, and parliament allocates, most of the funds required to run the NHS. The secretary of state and his accounting officer – the permanent secretary of the DHSS – are then held to be accountable for the proper use of those funds and, in theory, for everything that happens within the NHS. Not only is this clearly impossible as the Royal Commission on the National Health Service pointed out[3], but the service is essentially a very local one – it is really about the interactions between professionals (doctors, nurses, and so on) and patients. The statutory authorities (regions and, in the future, districts and family practitioner committees) and their officers, stretching between the front line professionals and the secretary of state, are the 'bureaucracy in between' which can either tend to suck up decision-making or push it down, depending partly on the policies of the government of the day.

Unless the service is to be financed in a completely different way it is hard to see how this vertical chain can be broken. The problems of organisational 'distance' between the centre and the periphery will remain unsolved. The difficulty is to find means of improving the vertical integration of the National Health Service – in a way that develops relationships between the parts so that the whole moves in a more cohesive fashion – as a partnership rather than a hierarchy.

The DHSS was recently criticised by the relatively new parliamentary watchdog – the Select Committee on Health and Social Services –

for not having a comprehensive policy.[4] It may be that the DHSS has a policy but it finds it very difficult to get sufficient commitment to it throughout the service to ensure that much of it ever gets implemented. In fact, the National Health Service is an 'inverted organisation' in many respects. The key 'operatives' in the service are the general practitioners, with virtually complete freedom to commit resources and choose their own clinical policies in an open-ended demand-led system, and the consultants who, although subject to some rationing of such key resources as beds, nurses and operating theatres, nevertheless exercise considerable influence on the initiation of new forms of treatment and services, which are not necessarily within the priorities or policies advocated by the 'centre'.

Given that it is the people and processes in the system which really determine what happens, it seems unlikely that simply to remove one management tier or even to strengthen local management – to sub-district managerial divisions or 'units' – will make much difference to the tendency for the centre and periphery in the National Health Service to polarise. What seems to be needed are a greater awareness of the forces at work by those involved in management and the further development of mechanisms which will encourage a more collaborative approach between the centre and the periphery to the development of health services.

In most team games there is a player, or even group of players, whose main function is to provide a link between the main sections. In soccer they are called 'the midfield' and they link the attack and defence; in basketball the same function is performed by the 'pivot', while in Rugby football the linkmen between the forwards and the backs are the 'halfbacks'. These players integrate the parts of the team in the interests of the whole, and there are individual officers and groups who fulfil similar roles in the NHS, but whose importance needs further emphasis, recognition and, perhaps, supplementation.

This paper explores some examples of central policy initiatives which do not seem to be getting the desired response at local levels, and examines the role of the chief administrator, particularly at district level, in trying to overcome conflicting central and operational pressures. Finally it looks at one or two possible mechanisms for assisting the process of vertical integration in the National Health Service.

The gaps between central policy aspirations and local achievement

Despite the intention of successive ministers to delegate the management of the National Health Service to the 'field' authorities, it is only natural that their being in a centrally funded service for which they are

held accountable to Parliament will encourage them to want to set priorities and see things happen. One of the unique features of the British health service as it was conceived was the *national* dimension, the attempt to plan the development of services so that there would be equal opportunity of access to broadly equal standards of health care across the country. While there have been major successes in this policy – for instance, the spread of consultant manpower, professional training standards, and the generally high quality across the country of the emergency ambulance service and the accident departments – there are still wide variations. One danger of the new philosophy of the centre 'standing back' or, as one minister has described it, 'stopping being nanny' to the service, is that there will be a greater fragmentation of aims, results and standards. It will no longer be a truly *national* service but a loose conglomeration of *local* health services.

It is reasonably argued, however, that earlier ministers have not been particularly successful in getting national priorities implemented. For well over a decade, successive ministers have been urging the development of the so-called 'Cinderella' services and there is a veritable library of DHSS reports laying down standards, promulgating good practices and exhorting shifts of resources towards services for the elderly, the mentally ill and mentally handicapped.[5] Even the current administration has produced its 'priorities' document, *Care in Action*[6], again urging authorities to concentrate on developing services for these groups, although there is a noticeable shift in the style of the document from its predecessors.[5a] The latest version talks in general terms. For instance, on services for the mentally ill: 'This group is frequently provided with services of inadequate standard and services need developing in more accessible facilities.' Earlier versions were very much more specific in laying down objectives and targets and whereas authorities are now expected 'to give priority to the further development of services . . . for the needs [of the priority groups], AS LOCALLY ASSESSED' previously they were set targets to be achieved by certain dates.

It will be a fascinating study for social historians in the twenty-first century to examine which approach had the bigger effect, but a brief look at the results achieved for these three priority groups in the last decade in one local health authority, which are apparently mirrored nationally, suggests that the national guidelines/exhortation approach has had only limited success.

For the elderly, Newcastle has for some time been demonstrably deficient in the provision of hospital beds, particularly long stay, and day facilities. For a while these deficiencies were perhaps masked by a high level of provision of residential places by the local authority, by

good community services and by above-average acute hospital services, including beds for acute medicine. However, against the norms published by the DHSS[5] and the standards promulgated by the professional bodies[7] and the government[8], Newcastle is grossly deficient in hospital services for the elderly. So far little improvement has been achieved, although the planning system has made people conscious of the problem and the health authority's plans now feature prominently the development of services for the elderly. Indeed, a specific 'long stay reserve' has recently been created by savings on other services in order to begin to build up the capital and revenue needed to improve services for the elderly. It has been a slow process, however, and has failed so far to meet national policy targets.

A similar intention exists locally to develop provision for the mentally handicapped where official documents[5d] have, since 1971, urged the provision of more, smaller, locally based homes and well developed community services. For some years after the promulgation of such policies nationally, Newcastle has been content to rely on a small community service backed by the services, admittedly of high standard, of the neighbouring authority's large hospitals for the mentally handicapped.

There are still no locally based health service facilities for the mentally handicapped in Newcastle although joint plans have now been developed with the local authority and implementation is to begin in the current year. Even the DHSS[6] accepts that progress has been slow nationally in implementing the policies and targets previously advocated and that 'resource constraints' will make the achievement of the previous 20-year target 'difficult to achieve'.

Although Newcastle has a problem with both the quantity and quality of services for psychogeriatrics (ESMI), the services for the mentally ill as a whole are probably above average and less change was needed than with the other groups considered to meet national guidelines. However, much of the inpatient accommodation remains locally in poor quality accommodation in what is now regarded as an 'old fashioned' large mental illness hospital, although fortunately it is in an accessible location within the city and backed by good special units and a rapidly expanding community psychiatric service.

It is interesting to speculate why the national priority initiatives for the 'Cinderella' services during the 1970s have apparently been so unsuccessful. A clue probably lies in Newcastle's own response. Where, as in the case of the mentally ill services, the objective chanced to coincide with a local priority, was backed by the drive of those involved and had resources available, then things happened. Where the central objective fails to match a local priority or, as in the case of

the mentally handicapped, has no strong local professional advocates, then either there is no response or it is very slow in coming. The failure to shift the National Health Service's priorities away from acute medicine, as successive governments have urged, may well not be technical (for example, shortage of information, standards and policies wrongly determined); it is more likely to be due to the arguments being unacceptable to the most influential local groups. Despite the self-evident merit of the case for expanding services for the elderly, all the central guidelines and policies have not, of themselves, been sufficient, in a time of resource constraint, to achieve the necessary shift in resources locally.

In regard to capital building, 'the centre' – both DHSS and region – has arguably been more successful in influencing events locally for both good and ill. This is probably because of the more direct controls exercised by the centre on the capital building programme, through building notes and cost limits, formal stages in design approval and control of the total programme by starts. The promulgation of a new policy on hospital size in 1980[9] was accompanied by simultaneous reviews of major hospital building projects in the design stage, embracing the new policy and, in the case of Newcastle's major development, carried out personally by the minister! Very soon the hospital which, under the old policy, could not have had less than 1000 beds is being re-submitted with a maximum of 700 beds. Since this was regarded locally as both illogical and uneconomic, it would appear to be a case of the periphery adjusting to the requirements of the centre because the centre can exercise a powerful negative influence (veto) if the scheme remains unacceptable.

Other, rather different, examples of how the central department finds it difficult to delegate fully to the local health authorities are seen in the detailed questions and criticisms that both members and senior civil servants have to face from the Public Accounts Committee and the new policy watchdog, the Parliamentary Select Committee for the Social Services. The Public Accounts Committee can be very searching on quite detailed matters. Subjects examined recently have included staff catering costs and subsidies, variations in manpower between regions, and control of capital building projects. An interesting new development, which can probably be claimed as a new mechanism for improving vertical integration, is the inclusion of regional health authority chairmen and chief officers amongst the witnesses called by the permanent secretary of the DHSS to appear before the Public Accounts Committee.

The Select Committee operates on a wider brief and has so far taken major policy areas; for example, neonatal mortality[10] and, more

recently, medical education and medical manpower. It has expert advisers and takes both oral and written evidence before producing a detailed report with recommendations for improvements in the service or policy under review. While clearly this has the potential for development as another integrating mechanism, there seems a danger that it will be used as a party political device. For example, the present membership appears to be predisposed to criticise the present government.

The role of the chief administrator as an integrator

An earlier international seminar explored the role of the chief administrator as innovator and catalyst[11] but, at least in the British health service, it is arguable that it may be equally important for him to be an integrator. Particularly at local health authority level, it is important that someone sees it as part of his role to act as the link or 'pivot' between the periphery – represented particularly by the professionals at patient contact level – and 'the centre' (both the region and the DHSS). The chief administrator of the health authority, often in conjunction with his team colleagues, needs to be aware of national and regional policies, guidelines and rules, both published and unpublished, so that the needs and aspirations at local level can be most effectively developed and channelled.

To fulfil this role as 'pivot', the chief administrator has to have a well developed information network of both hard and 'soft' data. For example, it is important to know what sort of submission on a capital development proposal is likely to get a sympathetic hearing from the region in order that the work on presentation can be properly directed.

There are a number of tools available to the chief administrator in his role as an integrator and a recent development of particular importance is the NHS planning system.[12] Although subject to many teething troubles and criticisms and currently in process of revision, allegedly in the interests of simplification, the planning system undoubtedly gives the administrator, who is specifically responsible for coordinating plans, an excellent vehicle for bringing together local aspirations and matching them with central policies and guidelines, not least on resources. It gives the administrator the chance of getting options on the use of resources discussed in the open, and if he feels some aspect of regional or national policy is being neglected locally the system provides the opportunity for it to be at least identified and debated. When there are serious resource constraints and major needs unmet, the planning system, used properly, can also force discussion on priorities. For example, recently in Newcastle, faced with the severe

shortage of geriatric beds previously mentioned and little prospect of significant revenue growth for the next few years, the proposal for shifting resources into a special 'long-stay reserve' has been developed. This reserve will be built up from savings achieved by 'good housekeeping and efficiency' measures and some rationalisation of acute services. In the short term, the 'long-stay reserve' will be used on a nonrecurring basis so that it is gradually built up to provide a substantial (£1 million plus) capital sum for the development of a hospital for geriatrics and, later, to provide the running costs for the development.

This illustrates another important aspect of the role of the chief administrator as integrator in that he needs to try as far as possible to match local aspirations with central policies and objectives. He must be sensitive to the local power groups yet, if necessary, ensure that neglected national policies are debated properly. In the case of the geriatric services in Newcastle, internal pressure for additonal facilities needed to be wedded to the national policy guidelines by the development of a priority objective for the authority. This has, at least partially, enabled the need to shift resources internally to be 'sold' to the various conflicting interest groups. In addition, the 'linkmen', in this case the chief administrator and his staff in conjunction with the director of social services, were able to identify an opportunity given by central government in the form of special financial resources for innovative projects in the inner city area. A proposal is currently being worked up under the auspices of the Newcastle/Gateshead Inner City Partnership for the joint development on a single hospital site of a range of facilities for the elderly, embracing hospital beds, residential home places, day care, sheltered housing and community involvement. While there is a good deal of work still to be done to bring the project to fruition, it could turn out to be an example of vertical and horizontal integration of ideas and resources to a common purpose.

Much of the chief administrator's role requires him to have or to develop a good perspective of organisational politics. He will need not only to consult (perhaps there has been a tendency for the centre and the periphery to over-consult), he will also need to negotiate. He will have to look for 'trade offs' if forward momentum is to be achieved. A test of a good decision, as described by Haywood and Alaszewski[13], is whether parties agree so that it can be implemented, not merely that it fits with a particular objective. Leading from the front can alienate key people and in many cases the chief administrator can achieve more by setting the framework and letting others come forward with the proposals. It has certainly proved disadvantageous for chief administrators to appear to be guardians of central policy. They must be seen

essentially to support and carry forward the proposals of local interest groups, especially the professionals, if they are not to become detached and ineffective. This area is explored in greater depth by Gordon Pledger[14] but clearly it is essential for the chief administrative officer to develop ways of balancing the downward pressure from the centre with the upward pressure from the periphery.

Possible mechanisms for promoting vertical integration

In his task as integrator, the chief administrator will look to a variety of mechanisms to assist him. The planning system has already been mentioned; joint task forces or policy development teams comprising officers from different levels may also play a part.

However, with the emphasis in the current restructuring on delegation and greater local decision-making, now being boosted by a 20 per cent planned reduction in DHSS staff by 1984, there is a grave danger of the field authorities being isolated and parochial. This may well be reinforced by the drive for further reductions in management costs in the health service which, at around five per cent of revenue, are already below those for most other systems. Service and administrative boundaries could become barriers to ideas and good practice, and it is partly as a response to this problem that proposals for 'management advisory services' and 'development agencies' are currently being discussed.

A number of the proposed models are as yet ill-defined and some may become disintegrators rather than integrators, particularly if they are used by the centre as substitutes for proper monitoring and accountability through the statutory management arrangements. However, if the emphasis of such models is placed on 'collaboration' with the field authorities, possibly on a consultancy or joint development basis, then they could be valuable additions to the integrative mechanisms available. Some of the work of the Health Advisory Service[15], the Mentally Handicapped Development Team[16] and of individuals like David Towell in the psychiatric field, show what is possible, and a proposal for a number of 'regional development agencies' and possibly a 'national development agency' has recently been developed by an RIPA health services group.[17] The essence of the RIPA proposal is a collaborative venture in which experts from the development agency would work in close association with local staff to develop high standards in particular services and departments, making the most of best practices from elsewhere.

Another interesting development with some potential for improving integration in the service is the setting up of NHS committees and working parties to examine particular aspects of the service, the

membership being drawn largely from different levels of the service. Recent examples are the Naylor committee on patients' transport[18] and the Körner working party on information in the NHS. Similar shifts from the centre towards the periphery include increased emphasis on NHS inputs into Whitley and possibly the development of the Supply Council as a separate NHS authority.

Conclusions

While this paper has necessarily only touched on what is seen as a major problem area in the management of the National Health Service, the nature of the relationship between the centre and the periphery, it has tried to demonstrate the pivotal role of the chief administrative officer at local health authority level. It has also identified one or two mechanisms for achieving improvements in the vertical integration of the service. While the present tendency is to push as much decision-making as possible away from the centre and towards the periphery, it is unrealistic to think that the centre can entirely stop being a 'nanny to the service'. As a senior civil servant described it recently, the most that can be hoped is that the DHSS will become a high class, modern nanny ensuring that the children know the rules, are not too naughty, and are given room to develop without too much petty interference. The problem may be that the children are unable to use their new freedom responsibly; and, in any case, progress towards a mature development will only take place if there is real collaboration between the parties.

References

1 Great Britain, Department of Health and Social Security *and* Welsh Office. *Patients first: consultative paper on the structure and management of the National Health Service in England and Wales.* London, H M Stationery Office, 1979.

2 Great Britain, Department of Health and Social Security. *Management arrangements for the reorganised National Health Service.* London, H M Stationery Office, 1972.

3 Royal Commission on the National Health Service. *Report.* (Chairman, Sir Alec Merrison.) London, H M Stationery Office, 1979. (Cmnd 7615)

4 Great Britain, Parliament, House of Commons. *Third report from the Social Services Committee session 1979–80. Public expenditure on the social services, 2 volumes.* London, H M Stationery Office, 1980.

5a Great Britain, Department of Health and Social Security. *Priorities in the health and social services: the way forward.* London, H M Stationery Office, 1977.

5b Great Britain, Department of Health and Social Security. *Health services development: health services in England: DHSS planning guidelines for 1980/81.* London, DHSS, 1980. (HC(80)9)

5c Great Britain, Department of Health and Social Security. *Better services for the mentally ill.* London, H M Stationery Office, 1975. (Cmnd 6233)

5d Great Britain, Department of Health and Social Security. *Better services for the mentally handicapped.* London, H M Stationery Office, 1971. (Cmnd 4683)

5e Great Britain, Department of Health and Social Security. *A happier old age: a discussion document on elderly people in our society.* London, H M Stationery Office, 1978.

6 Great Britain, Department of Health and Social Security. *Care in action: a handbook of policies and priorities for the health and personal social services in England.* London, H M Stationery Office, 1981.

7 Royal College of Nursing of the United Kingdom *and* British Geriatrics Society. *Improving geriatric care in hospital: a handbook of guidelines.* London, Royal College of Nursing, 1975.

8 Great Britain, Department of Health and Social Security *and others. Growing older.* London, H M Stationery Office, 1981. (Cmnd 8173)

9 Great Britain, Department of Health and Social Security. *Hospital services: the future pattern of hospital provision in England.* London, DHSS, 1980.

10 Great Britain, Parliament, House of Commons. *Perinatal and neonatal mortality. Second report from the Social Services Committee session 1979–1980, 5 volumes.* (Chairman, Mrs Renée Short.) London, H M Stationery Office, 1980.

11 Paine, Leslie. *The health service administrator: innovator or catalyst?* London, King Edward's Hospital Fund for London, 1978.

12 Great Britain, Department of Health and Social Security. *Health services development: health services in England: review of the NHS planning system – a consultative document.* London, DHSS, 1981. (HN(81)4)

13 Haywood, Stuart and Alaszewski, Andy. *Crisis in the health service: the politics of management.* London, Croom Helm, 1980.

14 Pledger, H G. *Relationships between authorities and the medical profession.* Unpublished paper from an international seminar. Toronto, 1981.

15 Great Britain, Health Advisory Service. *Annual report for 1976.* London, H M Stationery Office, 1977.
Annual report for 1977–1978 (unpublished).

16 Great Britain, Department of Health and Social Security, Development Team for the Mentally Handicapped. *First Report: July 1976–1977.* London, H M Stationery Office, 1978.
Second report: 1 January 1978–30 June 1979. London, H M Stationery Office, 1980.

17 Royal Institute of Public Administration. *Development agencies for the*

National Health Service in England: a memorandum prepared for submission to the Department of Health and Social Security. London, RIPA, 1981.

18 Trent Regional Health Authority. *Patient transport services: a report of a working party*. (Chairman, W M Naylor.) Sheffield, Trent RHA, 1981.

7
Commentary
by Robert Maxwell

> 'The generals, the institution can select a strategy, lay it all out, but what happens on the battlefield is quite different.' Tolstoy

In one way or another all the papers in this section deal with problems of coordination in health services, and the administrator's contribution to tackling them. Coordination is, of course, a traditional component of the management task in all fields. Is health care any different? In some respects it probably is. For example, few organisations are made up of a more diverse range of small autonomous groups of people, all urgently bent on their own pursuits, than is a major hospital, let alone a health care system. Tolstoy's battlefield is much more homogeneous. On the other hand coordination between hospital departments and between health care agencies happens spontaneously, from a wide range of independent initiatives. No general needs to mastermind most of these contacts and any administrator who tried to do so would rapidly be put in his place. Nevertheless there are types of coordination that do not happen so readily. Some of the problems stem from conflicts of personality, and some from blockages of various kinds which may need resolving on a trouble shooting basis. Above and beyond these, however, are two particularly common causes. Competition for scarce resources is one. Inherent conflict of aims and interests is another.

Dr Charles Hollenberg's paper is based principally on experience in a major university hospital, the Toronto General. He states the classical case for strong, responsible leadership by medical department heads. Agitation for new initiatives usually arises within departments. Debate and decision about such initiatives typically take place at three main levels in the hospital: within departments; among departments; and at the board of trustees (or the equivalent). Dr Hollenberg emphasises the crucial role played by the chairman of each of the principal clinical departments. Within his department he must have strong authority while acting according to known rules and in ways that are seen by his colleagues to be fair. Conflict is much more common at the next level, between departments, where there is likely to be some natural divergence of interest and inherent competition. When such conflicts are serious, the administrator (chief executive officer in normal Canadian parlance) should play a key role in resolving them. In discussion Dr Hollenberg compared him to the umpire who

should have an encyclopaedic knowledge of the rules, and can sanction the players or call off the game. Umpires are not usually popular with spectators or players but sensible people acknowledge their indispensability. They must be impartial, painstaking and reasonably competent, must make their decisions stick under difficult conditions and in close run verdicts should have the wisdom not to lean (or to appear to lean) towards any one interest.

One can take issue with Charles Hollenberg's classic exposition on several grounds, but (as participants at the seminar recognised) it nevertheless contains some important and enduring truths. He could be parodied as portraying a medical, authoritarian and hospital-oriented view, in which each departmental chairman settles the affairs of his own department as a separate barony, and then bargains for resources with competing medical barons. In the parody there is little scope for developments that do not arise spontaneously within hospital departments, or for nourishing weak departments (which often include the less glamorous medical specialties), or for administrators and board members to take the initiative. Umpires, like judges, cope with what comes to them: it is the players who decide the strategy.

The parody would of course be unfair to Dr Hollenberg, who is in no way suggesting that the chairman of department's view is the only legitimate one. Moreover, whatever else people require of a health care system, they do need well-run hospital departments in which resources are used sensibly, skills are up to date and the quality of work is high, and somebody will take responsibility if anything goes wrong. Dr Hollenberg's views about the importance of the departmental chairman's role are therefore right, although not the whole truth, and senior administrators need (among other qualities) those of good umpires. If they are not known for impartiality and, when necessary, toughness in settling disputes and getting things done, their contribution is likely to be small.

Ralph Moore's paper provides a good foil to Charles Hollenberg's, not just because both stem from Canadian teaching hospital experience. The North American tradition is one where the hospital provides the setting, the workshop and the tools for physicians to ply their trades of caring for patients, training students and research. Physicians have no loyalty to any patients other than their own and may have relatively little loyalty to the institution. They are not (in the workshop model) particularly interested in the running of the hospital as a whole, and cannot be expected to be at all enthusiastic about resource allocation decisions that limit their capacity to do their work and to develop it as they think best. Yet in the real world resources are limited and decisions are needed about their best use. Ralph Moore forecasts

an increasingly sharp confrontation between medical staff and hospital, and a losing out by both in the broader political arena, unless the medical staff is more fully integrated into the hospital, participating more fully in its management and development and committed to its goals. He is surely right, however irritating physicians may find the distraction from the work they were trained for, and however irksome the constraints. He is right also to emphasise the importance of the basic principle of self-government in professional matters (the same applies to nursing and other professional groups) and to call for sensitivity in designing the linkages between the various forms of organisation. If you want the involvement and commitment of the medical staff, you have to use arrangements that command their confidence and find individuals whose leadership will be accepted. The physicians for their part have more to learn about management than they generally recognise.

As John Blandford put it at the seminar, drawing on Australian experience, there is an interplay of cohesion and divergence within any hospital: people are fundamentally united in purpose and values, yet tensions and rivalries are inevitable. In particular, there are bound to be tensions between systems efficiency (the department head's view), clinical autonomy (the prescriber's view), and the political dimension (expressed through the board and the chief executive officer). To handle these tensions there should, Blandford commented, be integrative structures and processes. It is a responsibility of the chief executive officer to see that these are in place, and that they are known to work efficiently and with justice. In his paper about the chief executive officer's role, Harvey Barkun adds, with unmistakable conviction and panache, the importance of style in management. Style must be set by the CEO and should permeate the institution. People must know whom they are dealing with, and develop confidence in the manner in which business will be done.

In different contexts both Duncan Nichol and Donald Wegmiller take us beyond the individual institution to its wider setting. Duncan Nichol deals with management arrangements in an English district of the National Health Service, and Don Wegmiller with the management challenges that arise in the evolution of a multihospital system in the United States. From earlier seminars we were aware of a fundamental contrast at present between health administration in Britain and in other English-speaking countries. Since 1974, the principal unit of management in the National Health Service has become the district rather than the hospital. Typically a district (or its equivalent in Scotland, Wales and Northern Ireland) comprises at least one general acute hospital, several long-stay institutions, a range of smaller hospi-

tals, clinics and homes, and a variety of community health services. Primary care is separately administered by family practitioner committees, ostensibly because of the independent contractor status of the providers. Relative to the other countries represented at the seminar, management at the level of the individual hospital tends to be weak in the UK. Only a few postgraduate hospitals still have their own boards of governors and chief officers. While there are substantial gains in the UK arrangements in terms of broader management perspectives and clearer links with a population served, there have also been losses. At the hospital level, senior management seems (and indeed is) more remote than in Australia or North America. The present UK government has been keen to reassert the importance of unit management as the new district health authorities, which took office in April 1982, finalise their management structures. The case for a move in this direction is widely accepted, but several questions have to be answered before it can become effective. How are units to be defined? Should some hospitals be grouped together for this purpose? Should community health services be integrated or be a separate unit of management? What should one do to link services for the same client group (psychiatry, geriatrics) that lie on different sites? What should be the management structure within each unit? What powers should be delegated to the unit level? And what should be the reporting relationships and management process links between unit and district? These are some of the questions that Duncan Nichol addresses in his paper, set in the particular context of Salford, which has a population of some 260,000 served by eight hospitals and a range of other health care facilities. He demonstrates that there are choices to be made, reviewing some of the factors to be weighed in making them, and shows that management processes (such as budgeting and financial control) are at least as important as structures in achieving a sensible balance between autonomy and coordination.

In recent years there has been a marked move in the United States towards multihospital chains, whether organised on an investor-owned or a non-profit basis. The move is an interesting example of the speed and ingenuity of American responses in the health care field. Whatever the faults (and they are many) of the American system, stagnation is not one. Donald Wegmiller is the Chief Executive Officer of a large non-profit chain, comprising 23 hospitals and providing management services to some 200 other institutions. His paper is a fascinating and original attempt to describe the phases, in management terms, through which such a multihospital organisation passes in its evolution. By implication, the top management tasks, the constraints and the possibilities, differ in the three main phases that he

describes. In the first five years the shape of the organisation has to be determined, the rules evolved and people chosen for key roles. Savings through shared services and economies are likely to be balanced by the costs inherent in the enlarged organisation. Opposition tends to be strong and distrust quite high, particularly from board members and senior administrative staff whose appointment, predated the decision to join the chain. Medical staffs are nervous of what changes may be made, but are less implacably opposed than administrators. In the second phase, between five and ten years after joining, much of the initial opposition and disquiet should have lessened, savings should exceed system costs (though that may be hard to prove), and some of the less superficial benefits of belonging to a system should be being explored. It ought to be possible, for example, to begin to develop complementary programmes or specialty strengths among hospitals, and to build up some distinctive skills, available to the whole group, that would have been beyond the reach of any one hospital. In other words, if there are any substantive advantages in a chain, they should be emerging in this phase. Very few multihospital systems have yet reached the third phase, since few were set up more than ten years ago. By the third phase, membership of the system should have come to be accepted as a way of life rather than a radical innovation. There should be real and undoubted savings, added skills and synergy. Group management systems are likely by that stage to be quite sophisticated. There should be substantial interest in evaluating the progress of the organisation as a multihospital system, and a willingness to set new goals and strategies for it.

Don Wegmiller also has some things to say about the management skills requires in a chain, as distinct from a single hospital. Skills in group dynamics, capacity to use sophisticated data systems, breadth of vision and response, and willingness to derive satisfaction through other people's achievements, are all among them. It is a prescription that people from other countries should recognise as directly relevant: commissioners in Australian health commissions, for example, and regional administrators in the United Kingdom.

Bob Nicholls (who has, like Duncan Nichol, been translated to the regional administration role since the seminar) explores in the British context this same topic of the senior administrator's contribution in the broader health care system. In the National Health Service there is bound to be tension between the centre and the health authorities. So long as the service is largely funded by central government, the Secretary of State for Social Services and his department are going to have a substantial measure of responsibility, not merely for broad policy, but for details of execution and expenditure. Yet the National

Health Service is nothing like so centralised as most people think – even people who work in it. The health authorities, and indeed the professions, have (within budgetary and other limits) a very substantial measure of autonomy from central government directive. In part that is all to the good. A more centralised system would be even more frustrating in terms of sluggishness and anonymity of decisions. Nevertheless central government's record in terms of broad policy is by no means bad. Its stance has often been in advance of the health authorities and the professions, for example in concern about failings in service for the chronically ill and handicapped, or geographic inequities, or imbalances in the medical career structure. Yet at times central government has seemed curiously impotent to persuade the NHS to move.

Bob Nicholls suggests that regional and district administrators have a 'half-back' or 'midfield' role to play in integrating the efforts of those in the front line of health care delivery (the forwards) with those who formulate national policy and allocate resources (the backs). They should be able to understand and explain what can be done, and what cannot, in terms of local implementation of national policies. Equally they should be quick to perceive how national resources, including development and research funds, can be tapped to support local initiative. The midfield is, of course, an exposed position, where administrators are vulnerable to accusations of duplicity and manipulation. The role requires more than wheeling and dealing. It calls (among other things) for quite sophisticated monitoring and planning systems to provide a database and a framework for informed dialogue, locally and between periphery and centre.

The papers thus start from a large teaching hospital, and problems of coordinating the efforts of heterogeneous groups within it, and then consider analogous questions on the larger canvas of health services in one locality (Duncan Nichol), a multihospital organisation (Don Wegmiller), and a complete health system (Bob Nicholls). In any lively organisation, and even more in any lively system, there will be tensions as people pursue different ends. Administrators therefore need to strike a balance between (on the one hand) the broader view, interdependency and good order and (on the other) a healthy independence, initiative and piracy. Which of the two one values more depends mainly, as Dr Bernard Snell remarked, on whether one is looking up the organisation or down it at the time. Looking upwards, one wants independence, looking down one sees more clearly the merits of interdependence. In this comment, as in much of the rest of the discussion, there was truth as well as humour.

Within his own institution or organisation Charles Hollenberg's

analogy of the umpire has value for the senior health administrator. Someone has to play that role calling for experience, knowledge of the rules and when to bend them and, above all, trust. Externally and upwards the administrator is not the umpire, but at once the listener, linkman and advocate – different roles requiring some different qualities. One of the particular contributions of a chief executive officer, however, is to try to see his institution or agency from the outside, objectively, to be aware of its weaknesses as well as its strengths in the broader context and to compensate for its built-in biases. He must see that the organisation he helps to lead has a strategy that makes sense in the environment, circumstances and constraints of the time, and that the strategy is understood and acted upon. It is one means of drawing people's efforts together, not merely in response to crises but in a more sustained way.

One obvious point that emerges from the sequence of papers is the much larger field in which many health administrators must now work, turning from institutions to systems. It remains extremely important that the institutions continue to be well administered, as the UK tended to forget in the 1974 reorganisation. But at all levels many of the same basic qualities, skills and virtues are required of senior administrators. One need not be too solemn about them. Breadth, humour and resilience are called for ('The first quality required of the administration is endurance', as John McClelland put it). So is speed of response – and, on occasion, as Ian Beech reminded us, masterly inactivity.

To the traditional qualities and skills there need to be added (as the scale of health administration broadens) a capacity to use data and planning systems. Most such systems are at present much too cumbersome, and the quality of their output is poor. In addition, the essential capacity to work with people of all kinds has to be extended from a single institution, with daily personal contact, into a broader system. Leadership in any organisation depends on mutual confidence and understanding. The larger and more complex the organisation, the more true that is, and the more difficult it is to achieve.

II Managing conflict

8

Avoiding conflict
by Claude E Forget

The avoidance of conflict should not be considered, in all circumstances, a proper managerial objective. Of course one can define the word conflict in such a way as to make it appear unambiguously bad, as synonymous with confrontation, with total breakdown in human relations. That is an extreme view – a view that is not only a false description of reality but also a view that would become a severe handicap to any manager.

Many of our institutions assume that conflict is natural: competition in the business world is a form of conflict; parliamentary democracy thrives on conflict. Indeed most situations and behaviour patterns that can be observed when individuals and groups interact are found in a continuum between cooperation, through competition, conflict and finally confrontation. Conflict between parties expressing different goals is not only natural but also a perfectly rational form of behaviour.

Therefore, we should think more in terms of *conflict management* than in terms of *conflict avoidance*, in the belief that a conflict avoided may be an issue left unresolved. In the area of health service management there are so many heterogeneous groups with so many different goals and points of reference that conflict is inevitable and probably the only way in which some balance can be struck among the various objectives. Nevertheless it is appropriate to consider how the chief executive officer should deal with conflicts among groups of staff; how he can minimise the damage done; and what preventive measures he can properly take.

Success in conflict management rests on a large number of different factors. For our analysis and debate to be useful, there is a need to distinguish the most salient of those factors in the context in which the CEOs of the health service organisations operate and upon which the papers prepared for this seminar throw an interesting light. I suggest that we look at the process of conflict management under three headings: *conceptualisation* of the conflict situation by the parties involved; *attitudes* of the parties to each other; and finally *behavioural dynamics* of conflict management.

* * * *

Conceptualisation

The way in which parties to a conflict behave is in part determined by the perceptions each party has formed about the issues involved in the conflict and the motives it imputes to the other party. For the moment, we shall not enquire as to the origins of those perceptions: whether they are the products of each party's natural predispositions or their prior exposures to similar kinds of conflict, or whether they stem from cultural environment or professional milieu. However, they may have a more immediate source such as the institutional framework in which the conflict either arises or must be resolved.

First each party forms its own opinion of what is at stake – for itself and for the other side. How big is the issue and how high are the stakes? It is a familiar recourse for some individuals when presented with a problem to try and make it appear bigger than it really is – so as to make it appear unresolvable. The parties' perception of the 'size' of the issue is, therefore, of fundamental importance to successful conflict management.

In Paul Hofmann's paper, as long as the ICU nurses' request for a salary increase is seen as triggering an across-the-board salary adjustment for all nursing staff and related categories of personnel, no solution is possible. In Ian Beach's appraisal of the deficiency of centralised bargaining is there not, implicitly, recognition that centralised bargaining transforms any small local grievance into a 'big' (ie, unresolvable) issue? In Haynes Rice's paper, the reported resistance to unionisation of interns and residents appears to be motivated by the fear that more than a fight for pay or working conditions is at stake, but rather the whole value system and perhaps the social role of physicians. Finally, in the paper by Barry Catchlove and Don Child, the New South Wales government's concept of what is at stake shifts suddenly from cutbacks in the teaching hospitals as a means of balancing the Health Commission's budget to concern about maintaining its political support among nurses.

Perceptions are not only related to the size of the issue but also to the objectives that each party believes the other to be pursuing. Those perceptions are akin to a value judgement on the 'worth' or legitimacy of the objectives. Haynes Rice underscores the need for management to be aware of workers' needs and to do something about them without waiting for union pressure. Ralph Moore and other writers in the first section of this book draw our attention to the professional expectations of physicians and the legitimacy of their concern to preserve the ethics of the doctor-patient relationship. In the case reported by Paul Hofmann the medical staff support for ICU nurses'

salary demands gives the nurses the legitimacy they apparently lacked before. Yet we all know of situations where managers, faced with similar problems, reacted defensively on the basis of a perception of otherwise natural requests by muttering 'they are just out to get me', 'all they want is more money', 'they show no interest in the job to be done, they are just interested in what they can get for themselves', and so on.

The point here is not whether such perceptions are right or wrong but that they are an important determinant of success in managing conflict. The worst consequences of a given outcome are not always the most probable and putting oneself in the other party's shoes may help dispel suspicions of bad faith. Perceptions, especially one's own, are things one can work at changing: ingenuity in discovering alternative solutions may help bring down the apparent size of an issue; advance commitments to leave well enough alone may increase the other party's perception of the legitimacy of one's purpose.

Sometimes perceptions – especially those pertaining to the size of the issues – may be preordained by the industrial relations framework. The British centralised wage negotiation machinery may be a good (or bad) example of that. Successful conflict management may then imply significant structural change.

Attitudes

To refer to 'attitudes' as opposed to 'perceptions' may appear as a distinction without a difference. That is not so; by 'attitudes' I mean what can be described more pedantically, perhaps, as behavioural orientation. There are two aspects of the attitudes of parties to a conflict to which attention must be drawn. First, in regard to its own goals, a party can be assertive or not. Second, in regard to the other's goals, a party may have an avoidant attitude or accommodative one.

Far from being a handicap, an assertive attitude probably is in most circumstances a positive asset. Lack of assertiveness will often be misinterpreted by the other party as a sign of weakness and a signal for adopting a hard line approach. Absence of a clear indication by one party as to what it really wants deprives the other party of the possibility of offering compensatory concessions for the advantages it is seeking for itself; or such absence can be interpreted as dissimulation and a sign of bad faith.

Haynes Rice stresses that the CEO must keep the organisation's goals firmly in mind. Ian Beach deplores the lack of commitment to managerial objectives on the management side of the Whitley Council machinery of centralised bargaining. The case study reported by Paul

Hofmann seems to me to suggest a rather low commitment by top management to get the ICU working properly. In the New South Wales case, recounted by Catchlove and Child, the government's resolve falters when the opposition of the nurses' unions becomes apparent.

My own observations of many CEOs' attitudes in the health services field would tend to support this view of a less than optimal assertiveness of management's own objectives, with 'conflict avoidance' playing the role of an ersatz objective. This is no doubt something that will be hotly disputed!

However, attitude towards the other party's objectives probably constitutes the single most frequent source of problems, and indeed stalemate, in conflict management. An avoidant attitude, 'benign neglect' if you will, allows problems and grievances to fester until they become literally unmanageable.

The papers for this session provide both an example of avoidant attitude and an admonition against it. Paul Hofmann's ICU nurses had to wait two years between the moment when their unionisation drive was beaten off by an aggressive management and the beginning of a serious attempt to resolve their initial grievance under a renewed threat to unionise and with support from the medical staff. The hospital was not spared the appearance of having acted under duress and I would bet that many lessons were learned. Haynes Rice's paper gives a clear warning about not getting oneself into such a situation.

Attitudes, like perceptions, can be changed if one works at it, but attitudes are more strongly moulded by the environment. Constituent pressure on union leaders makes assertiveness almost a trademark of union activity. Government influence has sometimes been credited with having the opposite impact on management's assertiveness of its own objectives in health services. This contrast is apparent in the New South Wales case.

Can participation in committees and departmental working groups by unionised employees, professionals and management alter the avoidant attitudes that impede the adoption of integrative solutions to conflicts: in other words, solutions that make all parties better off rather than being of the 'either-or' variety?

The behavioural dynamics of conflicts

Perceptions and attitudes, in some sense, antedate the conflict – they are, to use the lawyers' language, more or less predetermined characteristics of each party at the time the issue is joined. The dynamics of a

conflict are uniquely its own because the way a conflict evolves depends on interaction.

It would be easy – as any examination of the literature will readily suggest – to draw a very complex and, in the end, perhaps confusing picture of all the ingredients that together determine the course of a conflict. Let us keep the discussion simple by contrasting two very different dynamics: one we shall call a 'problem-solving' approach and the other a 'bargaining approach'. The first approach hardly needs to be explained: it is one where the parties work together in defining a mutually acceptable solution that leaves them both better off in terms of their own respective objectives; it is the approach that truly 'resolves' the conflict, builds up mutual trust and enables the organisation as a whole to make progress. It need not be (as some might think) an act of God or a fortuitous happening: it is an approach for which strategies and tactics have been suggested in the literature and which any CEO worth his salt should try to adopt.

However, and this tells us a lot about our perceptions of reality in the field of industrial relations, the problem-solving approach is not the one that elicits the largest number of comments and case histories. This goes also for the papers included in this section of this book.

The bargaining approach is what is sometimes described as the power play. Each party uses some 'power' it commands to win its point. Since each party has some power, the conflict is resolved by the balance of power. Neither party really 'accepts' the solution: each resigns itself to it because that is all the particular balance will yield.

The papers by Ian Beach, Haynes Rice and Paul Hofmann all refer to the use of 'coercive power' by unions, and the paper by Barry Catchlove and Don Child illustrates the use of union power at the political level. But union power is *not* the only one that is relevant to conflict management in hospitals: other groups can also use arguments that management will have to heed. This multidimensional view of power may be useful in restoring some perspective to the otherwise stark picture of the embattled CEO confronted by unions.

The papers in this section contain several references, as one would expect from writers who are senior administrators, to the power that is proper to management. Management is the legitimate authority and that is one form of power. As we all know, the raw use of authority as a management right no longer has the same potency as it once had. However it does seem as though these writers feel that there is a modern equivalent that will do just as well. I am frankly disturbed at the importance given by several of them to *rules and procedures* to resolve conflicts: Ian Beach and Haynes Rice both appear to have much faith in this new version of legitimate power. This strikes me as

exaggerated. Rules and procedures bring a legalistic attitude to human relations and may encourage an avoidant attitude vis-a-vis health workers' needs, summed up by the curt injunction 'go to arbitration!' I have seen more conflicts aggravated than resolved by this method.

9

Trade unions and the changing scene in administration and health workers relationships: peaceful coexistence

by Haynes Rice

Facing health care administration today is one of the most far-reaching developments in the history of the industry, collective bargaining. It is a monster that is feared by some, a problem to be avoided by others, and a change warmly hailed by many. The attitudes that administrators hold towards trade unions and the process of unionisation are often related to their experiences, or lack of experiences, with such bodies. At this point in the history of the American health care industry, however, little time need be spent discussing whether the change is desirable or undesirable in theory, for unionisation has been established in the system through the Warner Act of 1935 and was cemented by the Taft-Hartley Law – National Labour Relations Act of 1947 and its amendments of 1974. Since that time 'the National Labour Relations Board and the Courts have recognised that a balance must be struck between employees' rights to organise and the employers' rights to expect productivity and discipline on their premises.'[1]

Whenever unionisation of health care workers becomes a reality for any hospital or health care facility, the goal for both major parties should be one of peaceful coexistence. Once an institution develops a reputation for resistance, it will hardly be able to improve its image in that respect. Furthermore, if the history of an institution is one of strife, then future cases may receive less than fair hearing and judgment.

During the 1960s, the health care industry grew for a variety of reasons, among them being Medicare, Medicaid, improved medical technology and increased specialisation among physicians. It became more efficacious for doctors to use the expensive sophisticated equipment in hospitals than to attempt to equip their own offices for special cases. New machines needed skilled technicians to operate them. These technicians and machines displaced in many hospitals large numbers of lower paid unprofessional workers. The health care professions grew in two ways. There were more patients for a variety of reasons and also more educated employees expecting to have a voice in the governance of the institutions in which they worked.

With this growth came unionisation. The workers were now becoming more conscious of their roles and influence, and they sought recognition for their status. At this point, the administrator's role in

the health care institution had to change. No longer was he 'father' or sole 'leader'; he became a 'partner', so to speak, for the gaps between administrators and employees were closing.

As Jonathan Rakich points out, this trend towards unionisation in hospitals is due mainly to three external factors:

> 'The saturation of union membership among the blue collar segment of the nation's labour force, resulting in organisers directing their efforts towards the white collar, professional and paraprofessional segments, and, in particular, the nation's 2.5 million hospital employees; the changing mores of our society in which professionals are not averse to organising for the purpose of bargaining collectively, as exemplified by nurses, educators, and public services employees; and existing legislation in various states which has provided an environment more conducive to organisation efforts.'[2]

This argument does not diminish the age old concern of health care workers for better wages, improved benefits and better working conditions. The trend towards white collar unionisation is the materialising of an idea whose 'time had come'. Health care workers had found in unionisation a tool still repudiated by some. Many who were sceptical became vociferous supporters once they saw unionisation as a means of weakening giant administrations and of bringing greater equity to their professions. Although the causes of unionisation are primarily external, the effects are wholly internal. At first, the relationship between employees and administration is an adversarial one, but this may not be harmful in itself if administrators and employees realise that greater financial outlay should bring a greater degree of accountability and professionalism. Once unionised, employees experience a feeling of power and a sense of security in regard to wages, benefits, jobs, working conditions, and promotion. This often leads to the opposite feeling on the part of the management who become concerned about the threat of strikes, the difficulty of dismissing unproductive workers, over-emphasis on personnel administration, and the added costs that unionisation incurs. On a more idealistic plane, however, it must be remembered that an employee who is satisfied with his job, his salary and his benefits, has a voice in the decisions that affect him, and, moreover, recognises that the administration has his welfare at heart, will be a morale booster in any hospital and an intrinsic asset to his employer.

Different health care workers entertain different expectations about trade unions. For example, physicians may be most concerned with the

threat to their professional status by the large influx of paramedical personnel and may look to unions for protection of their territorial rights. Nurses are likely to be more anxious about wages, job satisfaction and opportunity for professional development. Other supporting health care workers may worry about status and fringe benefits, as well as wages. Hence the need for an industrial relations specialist in the personnel office. Coney and Barmish agree that industrial relations is one 'method of structuring personnel administration to withstand the disequilibriums fomented by national and local union rhetoric, by inflation, by volatile wage and benefit movements outside the health care industry, and by far-reaching governmental relations in the personnel area.'[3]

When designing personnel policies, evaluation criteria, and rules and regulations for promotion and dismissal, administrators would do well to consider the particular needs of the health care service worker and make sure that these important policies are constantly updated, so avoiding the cry 'the union made them do it!'

Yet another point to note is that the common ground of working in health services does not necessarily mean that all the groups concerned (even within one profession) are to be found on the same side in any dispute. For example, a ruling handed down by the US Court of Appeals in the District of Columbia in 1979 reversed a 1976 NLRB ruling and stipulated that hospital interns and hospital residents in the District of Columbia are hospital employees. This two-to-one decision, giving the group the right to collective bargaining, is expected to have far-reaching effects in the teaching hospitals.

The medical establishment is sharply divided on this issue. The AMA favours the right of house staff to bargain as employees while the AAMC and the American Hospital Association support the position of the National Labour Relations Board. Dr Arnold Relman has best expressed that position.

> 'I believe in the fullest possible participation of residents in the institutional decisions . . . but this relationship should be collegial not adversarial; professional not industrial, above all it should be tempered by the recognition that residents are both students and physicians. For the latter reason, if for no other, house officers should not contemplate the use of strikes . . .'

Dr Relman goes on to state the essence of the conflict:

> 'The systematic withholding of medical services, whatever the justification, is potentially harmful to patients and bound to be

construed by most laymen as self-serving. Strikes erode public confidence in physicians and inevitably demoralise the profession. They should have no place in American medicine.'[4]

The defeat of the House of Representative Bill 2222, which would have defined house staff as employees for the purpose of collective bargaining, has strengthened the position of those who hold Dr Relman's opinion. Despite this set back, the Physicians National House Staff Association continues in its efforts to obtain collective bargaining rights.[5]

These efforts typify the trend among white collar workers in general and white collar health care workers in particular. Among physicians, the trend is greatest among the young. It is safe to assume that interns and residents who are bent on collective bargaining now will become proponents of unionisation later on.

It may often be the case that hospital administrators will have to deal with the American Nurses Association (ANA), the National Association of Social Workers (NASW), the American Dietetic Association and other similar bodies, for the unionisation of the white collar is now in its heyday and every association that is capable of recruiting health care workers is likely to do so. An important memorandum compiled by William J Van Cleve, Senior Administrative Specialist on Personnel Labour Relations of the American Hospital Association, best summarises recent trends toward unionisation in the health care area. Basing his comments on the 1979 statistics of the National Labour Relations Board, he notes that there was a substantial increase in recruitment in 1979 compared with 1978 and identifies the unions that were successful.[6]

Seen against the background of change in the health care industry, the role of the hospital administrator in the avoidance of conflict and the neutralisation of labour disputes is becoming increasingly difficult. He faces conflicting loyalties. He must be the guardian of professional standards and ethics and, at the same time, be the trusted caretaker of the employee's rights and privileges. The administrator's dilemma is described by Gail Bentivegna:

'Resolution of the complex and often competing goals of employees, unions, coalitions, consumers, and the public sector organisation, challenges the most creative labour relations manager. This rapidly changing labour management environment presents the labour relations manager in a health care institution with an increasing number of complex issues. . . . Within the complex of a slow growth economy, rising levels of employee education and expectation,

> employee demands for more money, and more paid leisure time, public and government pressure to control expenses, and growing professional collective action, all are becoming routine concerns."[7]

Since the 1980s will be a time in which health care workers will exhibit a strong willingness to undertake extended strikes over economic and professional issues, the health care administrator must prepare for them. The nurses' strike at the Waterbury Hospital Health Center in Connecticut lasted 24 days, and, even worse, at the Englewood Hospital in New Jersey, a strike lasted 98 days. In December 1980, hospital aides at Johns Hopkins Hospital in Baltimore, Maryland, voted to end the 15 day walk-out by 1400 employees and to ratify a contract guaranteeing janitors, cafeteria workers and technicians a 16 per cent increase, although the union had sought 18 per cent. In 1977, nurses at Pascack Valley Hospital went on strike for 41 days and again in 1979 for 70 days. The issues in the latter case were not mainly economic, but included wages, shift rotation and a union versus an agency shop. However, the most interesting development in this case was the negotiating team requesting that the medical staff participate in the negotiations. Although management was opposed, physicians participated as *observers*.[8] 'Last year', reports the *New York Times*, 'one single union action in October involved eleven of New York City's seventeen municipal hospitals."[9]

For any hospital administrator to function efficiently in the sphere of conflict avoidance, he and labour must agree that 'the hospital's service *product* is patient care'.[10] All negotiations must rest upon this premise, in order to keep the major goals of the health care facility intact. The administrator should next proceed to establish the mechanisms to develop specific action plans, preferably before bargaining periods. Since bargaining periods are pressure periods, decisions made during them could be tantamount to discussions under duress. In itself, a plan of action will create a more comfortable atmosphere for employer as well as employee, who will realise that administrators are constantly aware of their needs. Kathleen Tice advises, however, that when labour organisations first begin work in a hospital, it is best to do nothing, since a flurry of activity could escalate emotions. Following recognition, administrators should actively take part in a continuing dialogue with unions.[11]

The hospital administrator is expected to study all previous contracts with his institution and their effects, since bargaining units often study their own past gains in order to negotiate new terms. Being familiar with previous contracts can aid the administrator in situations where a comparison is worthwhile, but he must not rely upon the past

when negotiating. Each situation is a product of its own time and must be seen in that light.

One cardinal precept for hospital administrators in seeking to avoid or neutralise conflicts is thoroughness in investigation, in analysis of data, and in record keeping. All grievances must be heard and investigated. Serious ones must receive attention and action, and the frivolous must be identified and pointed out to the aggrieved person. No relevant data should be neglected in any event and impartial judgements must be made consistently. Since the administrator is the responsible party in many cases, he must insist upon complete, clear, and accurate documentation from all those answerable to him. The importance of this scrupulous record keeping is made clear by Dr Edward Harrison in his study of 'The Discipline of Hospital Professional Employees.' He reports that the factors which most frequently caused hospitals to fail in defending their practices were:

Failure to properly investigate before administering discipline.
Lack of supervisory training in administering discipline properly.
Failure to warn the employee of the consequences of his conduct.
Supervisor's lack of consistency in the administration of discipline.
Poor communication.
Failure to use progressive discipline.

Of the greatest significance is Harrison's finding that where a case had never been lost to an employee, effective documentation was cited as 'the basis of their successful defence'.[12]

The case studies that follow exemplify some of the problems faced in a particular health care facility; some were resolved internally while others went to arbitration. Please note that the grievance procedure varies from one case to another. In union cases, the avenue of redress is as follows:

Level 1: The aggrieved and the supervisor meet.

Level 2: The aggrieved, the shop steward, the supervisor and a designated administrator meet.

Level 3: Arbitration. The aggrieved, his legal counsel, the shop steward and the union representative meet with the aggrieved person's supervisor, a designated administrator and the institution's lawyer.

Non-union cases go through each management level within the university hospital, beginning with the employee and his immediate

supervisor and ending with the board of trustees. Resolution is possible at any level.

Case study 1
Due process for house officers*

Setting: A full range teaching hospital

Persons affected: Resident, Tom Johnson; department chairman, Bruce Elliott; programme supervisor, John Dennis

Situation: Three weeks prior to the scheduled completion of his residency training programme, Resident Tom Johnson was dismissed on charges that his record of the patients he had seen and treated did not correspond with the clinic log; and that he failed to meet the minimum standards for residents in the department. Other charges were presented at the trial. These were:

Incomplete patient records
Moonlighting
Accepting pay for community consultation work in another institution to which he was assigned (breach of contract)
Seeing private patients at the hospital clinic

Options: Resident Johnson could have been counselled earlier. He could have been warned. A full and complete investigation could have been carried out.

Decision: The programme supervisor and department chairman were responsible for Resident Johnson's dismissal.

Action: Resident Johnson sought redress through the courts.

Response: He proved that:

> He was asked to submit his log in one hour. None of the doctors nor the defendants could testify to the purported training standards. They knew of no clinical assignments that Resident Johnson failed to carry out and they knew that Resident Johnson saw the third highest number of patients among the seven fellows in the programme. The hospital had not complied with the procedures for completion of records set down in the fellowship agreement. The supervisors knew of the moonlighting, but had raised no objections and other residents were guilty of this action. Other residents were also paid for consultation work by other institu-

* Association of American Medical Colleges, Agenda for Executive Council Meeting, January, 1981.

tions. There were no rules forbidding seeing private patients in the hospital clinic.
The resident had not been permitted to interpret his report at the staff meeting.
The committee that voted for Resident Johnson's dismissal had not seen the hospital log.

Resolution: The hospital was found to have breached its contract with Resident Johnson by revoking credit for work for board certification purposes and by terminating a resident's service prior to expiration of his contract. The court found no material breach of contract on Resident Johnson's part. It awarded:

$100,000 compensatory damages against the hospital for breach of contract.
$100,000 compensatory damages against the department chairman and the programme supervisor.
$50,000 punitive damages against each of these same physicians for the same offence.
$1,200 compensatory and $500 punitive damages against a third physician for tortious interference with the resident's contractual relationship with another institution at which he was moonlighting.
A slander charge was dismissed.
The court handed down an injunction forbidding the defendants to refuse to acknowledge the number of months of satisfactory work performed by the resident.

Comment: Failure to have adequate standards for promotion or dismissal of house staff (known and understood by residents and faculty), inadequate procedures for the application of the standards, or failure to adhere to the procedures, can have serious consequences for the resident, the faculty and the institution.

Case study 2: Non-union

Setting: Vista University Hospital is a 500 bed urban teaching hospital. The dietary service department is responsible for patient meals, operation of an open cafeteria for employees and others, a snack bar, and occasional special functions.
The chain of command extends downward from the hospital director to the assistant hospital director, to the food service director, to the multi-unit manager who is responsible for the overall management of the cafeteria and storeroom and supervision of his subordinate staff.

Persons affected: Mr Victor, multi-unit manager
Decision to terminate Mr Victor's employment rested with Mrs Berry, food service director, with the concurrence of her superiors.

Situation: Mr Victor was recommended for dismissal for technical and conceptual deficiences, his failure to perform officially directed duties and responsibilities, and failure to use sound judgement in interpersonal relationships while on duty. Among other things, problems of management existed in the day-to-day supervision of the hospital cafeteria. For example, there was frequent food shortage in the cafeteria at meal time. Since employees are allowed 30 minutes for lunch, the work schedule was often disrupted while they waited for replenishings and substitutions. For special functions, food was delivered to the wrong locations, cashiers would serve themselves before invited guests were fed and, on one occasion, guests arrived for a function to find utensils and dishes from an earlier function still not cleared away.

Decision: It was decided to warn Mr Victor and, finally, to terminate his service.

Options: Since Mr Victor had been constantly warned in writing, there was no alternative but to recommend his dismissal. The preferred solution was to terminate Mr Victor's service, for the following reasons:

> He had been twice promoted within the department. From the range and frequency of the complaints, it was clear that he was incompetent to handle this higher management position. Furthermore, he exhibited a recalcitrant attitude that made change on his part difficult.
> He had lost the respect of his subordinate workers and so had lost control. Mr Victor was dismissed. He took action against Vista University Hospital.

Resolution: The recommendation to dismiss Mr Victor was upheld in the hospital's favour. The minutes of section meetings catalogued the long sequence of events that displayed Mr Victor's deficiencies as a manager. The written complaints by cafeteria patrons as well as the copious file of memoranda on 'incidents' far outweighed the occasional letter of commendation sent to Mr Victor by satisfied patrons of special functions.

Case study 3: Union

Setting: 500 bed urban teaching hospital. The pharmacy department is supervised by a director who is responsible for all employees of that department.

Persons affected: Miss Wright, pharmacy technician, who underwent back surgery in May, 1979.
Decision to terminate Miss Wright's service rested with the assistant pharmacy director, Mr Jones, with the concurrence of the director.

Situation: Miss Wright returned to work in September after three months recuperating from back surgery. She was examined by the employee health office and certified fit to resume duties. In January, 1980, Miss Wright requested a light work assignment since she was unable to perform regular duties assigned to her by the assistant director, Mr Jones. Miss Wright was informed that no such assignments existed in the pharmacy department. She was given the following three alternatives in February, 1980:

She could request leave without pay until she was fit for work.
She could go out on disability.
She could initiate a transfer to another department where job assignments would not aggravate her physical condition.

Miss Wright then utilised the grievance procedure, seeking the following relief:

That her physician's letter written in January, 1980, regarding her disability supersedes the decision by management to have her continue normal duties.
That she be given a light duty assignment: she claims others have been given this in the past.
That Mr Jones cease to use tactics of harassment and intimidation.

At level 1 (see page 84), Miss Wright got no redress and was dismissed in February, 1980. She pursued the full range of grievance procedure to arbitration to seek redress.

Resolution: The hospital was ordered to reinstate Miss Wright to her original position and to recompense her for all the time lost.

The findings: Due process was denied and job assignments made by Mr Jones, the assistant director, along with the three alternatives given to the employee, constituted harassment. There was, therefore, no due cause for dismissal.

Case study 4: Union

Setting: 500 bed teaching hospital

Persons affected: Cafeteria cashier, Ms Bentley, and her immediate supervisor.

Situation: Ms Bentley's service was terminated because she failed to perform in accordance with hospital policy. She was insubordinate, insolent, inaccurate in cashiering, tardy and frequently absent.

Options: Ms Bentley was counselled, and warned repeatedly, so there was no alternative but to terminate her services.

Action: Ms Bentley was relieved of her duties and sought redress through the union. Although each level of the grievance hierarchy ruled that the hospital's decision to terminate Ms Bentley's service was justified, she took the case to arbitration.

Resolution: After the presentation of evidence and written remarks by both counsels, the arbiter concluded that the hospital management had provided the employee with reasonable warning, training and counsel, and had upheld all individual rights and union protocol. Therefore it was justified in its decision to terminate Ms Bentley's service.

Glenna Rowsell gives the following guide to proper documentation in the event of a dispute. The information to be clearly recorded is:

> Who is involved, the employee's full name, the department, branch or division, the employee's position, title and job classification, as well as any witness concerned in the case or anyone else involved.
> What happened, including all of the incidents that occurred from the time a problem was suspected.
> When the acts of omission took place, including times, dates, frequency and over what period of time.
> Where the incidents took place, the exact locations (the diversity of areas may be important).
> Why the problem exists, whether the employee violated the Labour Relations Act, a department regulation or a personal right, the employer must be prepared to justify the 'why'.
> Finally, what you want to accomplish; if it is suspension, the length of time must be determined and justified.
> 'Remember, cases can be lost if management does not document the facts, fails to warn an employee that she is not meeting the standards

or if regular written evaluations are not completed, signed by the employee and filed in her personal file.'[13]

In addition to the personal attributes that make a good administrator and the skills and procedures recommended for the avoidance and minimisation of conflicts, there is an extended list of precautions that need to be taken to avoid confrontation and related trade union problems. A. Samuel Cook has developed a short course in human relations and its general recommendations can be of service to the hospital administrator. Briefly, his recommendations are:

Respect the employee, his sensitivities, his opinions and his intelligence.
Be consistently fair.
Appreciate good work, acknowledge it and give credit for it.
Always explain rationale for changes ahead of time and, better, give employees a voice in decisions that affect them.
Be approachable and attempt to know employees where possible.
Maintain written, up-to-date personnel policies, rules, guidelines.
Keep salaries and fringe benefits at a competitive level.
Improve yourself, offer inservice training for others and keep communication lines open to deter rumours.
Maintain professional standards of practice and behaviour.
Provide employees with a systematic procedure for airing their grievances and foster a feeling of job security.

These are ideals that all good administrators should strive to maintain. With the overwhelming examples of successful businesses before them, hospital administrators are not short of successful models in management. There is no shortage of consultants, workshops, and seminars in the area, nor is there a shortage of literature on the subject. There is, however, a scarcity of labour personnel willing to teach health care workers about their duties and responsibilities, about commitment to excellence, about a fair day's work for a fair day's pay, about obligation, honesty, loyalty, punctuality, regularity and respect for their institution's property.

Health care administrators should not continue to sign contracts and agreements designed for Pan American Motors, or Continental Electric Company, for health care does not operate on the 'shop' principle. Health care is not based upon mass production, on five-day weeks of eight-hour days. Instead, it is based on 24 hour days, seven-day weeks, and 52-week years. It is highly labour-intensive, concentrated work, for one patient can utilise the work of four medical

specialists, several technicians, nurses, support staff and countless 'lay' workers. Health care facilities cannot increase output or reduce input. They must operate to rigid standards, and deliver quality health care to consumers who often do not understand their own consumer needs.

Conclusion

The statistics from the American Hospital Association as well as the growing number of walkouts and strikes among hospital workers indicate that a metamorphosis has taken place in the health care industry. While blue collar workers were enjoying benefits won through collective bargaining, white collar workers were still contemplating the wisdom of unionisation. The contemplation is over and, particularly for the white collar health care employee, collective bargaining is a new and powerful tool. Nurses are becoming unionised more rapidly than any other group, but house staff, technicians, aides and other support workers are all on the union train. The large urban area hospitals are leading the unionisation movements and the crest of the wave is not yet in sight.

So what is our posture as administrators, during this whirlwind of change? If we follow the recommendations in this paper we can hold our dikes against the flood, but they cannot be held indefinitely. As health care administrators we will have to re-examine what we get for our money, and I venture to suggest that in five years time we will find it necessary to request that teaching on labour relations, employee ethics and other related subjects be added to educational programmes for all health care workers. Health care facilities are a hybrid in the labour industrial world and thus need special conditions in which to flourish. They cannot be herded together with the thoroughbreds of industry, who deal in steel and rubber.

I conclude that the logical necessity for health care administrators at present is to cope gracefully with the immediate reality of unionisation of health care workers and, simultaneously, to prepare themselves to help fashion new attitudes, positive images, and greater responsibility among the workers.

A review of the 1979 statistics of the National Labour Relations Board concerning health care workers shows that 34 per cent of all new white collar union members are health care workers compared with 28 per cent in 1978. Since 1979, several collective bargaining units have devised components aimed specifically at the health care worker. The American Federation of Teachers has launched a major national organising campaign designed for health care workers; so,

too, has the Retail, Wholesale, and Department Store Union and the Service Employees International.

> 'While at the present time this [collective bargaining] movement is more pronounced among the less professionalised segments of the field, evidence suggests that collective bargaining quite rapidly will become accepted and indeed demanded by all health care professionals, including physicians. Similarly it seems logical to predict that the issues being resolved through the collective bargaining process will move more quickly from jurisdiction and salary dispute to the more important questions concerning the various roles of health professionals and the degree of autonomy that they will have in carrying out these roles.'[14]

With the future clearly foreshadowed, health care administrators must prepare themselves for administrative dualism, duelling, or peaceful co-existence with trade unions.

References

1 Elliott, Clifton L and Kaiser, Gina. *Patients, not unions, first concern of hospitals.* Hospitals, vol 53, no 21. 1 November, 1979. pp 76–79.
2 Rakich, Jonathan S. *Hospital unionisation: causes and effects.* Hospital Administration, vol 18. Winter, 1973. pp 7–18.
3 Coney, Aims G and Barmish, Ascher. *What to do when organized labor comes calling.* Hospitals, vol 53, no 24. 16 December, 1979. pp 85–90.
4 Relman, Arnold S. *Is it better with a union doctor?* New England Journal of Medicine, vol 301, no 3. July, 1979. pp 156–158.
5 Metzger, Norman. *Hospital labor scene marked by union issues.* Hospitals, vol 54, no 7. 1 April, 1980. pp 105–112.
6 Van Cleve, William I. *Union organising of white collar workers increasing.* Chicago, American Hospital Association, 1980. (Memorandum 164)
7 Bentivegna, Gail. *Labor relations: union activity increases among professions.* Hospitals, vol 53, no 7. 1 April, 1979. pp 131–139.
8 Shaffer, Franklin A. *A 70-day strike by professional nurses.* Supervisor Nurse, vol 11, no 9. September, 1980. pp 49, 51–53.
9 Thomasson, Robert E. *Nurses' growing militancy turns strikes into routine.* New York Times, 11 December, 1980. pp B1 and 6.
10 Regan, William Andrew. *Union refuses to complete charts to compel bargaining.* Hospital Progress, vol 60, no 9. September, 1979. pp 98–100.
11 Tice, Kathleen Sefeik. *The director of nursing and collective bargaining.* Supervisor Nurse, vol 11, no 9. September, 1980. pp 34, 37–38.

12 Harrison, Edward L. *The discipline of hospital professional employees.* Hospital Topics, vol 57, no 4. July/August, 1979 pp 6–9.
13 Rowsell, Glenna. *Nurses unions, professional associations and you, Part 2.* Canadian Nurse, vol 76, no 8. September, 1980. pp 30–32.
14 Kralewski, John E. *Collective bargaining among professional employees.* Hospital Administration, vol 19. Summer, 1974. pp 30–41.

10

Conflict in the context of industrial relations in the National Health Service

by Ian H Beach

Introduction

In many administrators' minds, the term 'industrial relations' is synonymous with staff unrest and union power. This may be because we are most acutely aware of the subject at times when the interplay between management and workforce, which the term implies, has run into difficulty and 'relations' have broken down. But 'industrial dispute', which is the more accurate phrase to describe these instances of conflict, is only a part of the spectrum of industrial relations, which is essentially about the framework within which management and staff can create a constructive relationship with each another. Disputes occur when the framework proves inadequate or one of the parties seeks to change it or operate outside it.

This paper starts with a brief history of industrial relations in the National Health Service from which it will be deduced that in recent years the structure in which it works has been found wanting. Later sections discuss national and local issues bearing on the subject.

Historical perspective – the last decade

A little over a decade ago the subject of 'industrial relations' was anathema to the great majority of staff in the NHS and union militancy had barely touched the service. Attitudes of both management and worker still remained traditional in character, reflecting the paramount concern for patient well-being which dominated the stance of staff groups towards each other and, collectively, towards management. The latent strength of the staff organisations continued dormant until around the start of the 1970s, when opinions began to change and a new militancy gradually emerged, as their members came to believe this attitude was more relevant to the progress of their claims than reliance upon the government's goodwill in responding to a professional ethic. This shift in emphasis was an inevitable reflection of changing attitudes in society in general, and as one of the largest single groups of employees in the county it was inconceivable that National Health Service staff could have been isolated from them. Nurses and doctors eventually engaged in their own forms of disruptive activity and, as they did so,

the final taboos were broken. By then, the pendulum had swung as far as it could go to touch these previously unimpeachable groups.

The extent of this deterioration in industrial relations is suggested by the table below, which compares the days lost through strike action in the National Health Service between 1966 and 1977. The Royal Commission Report from which it comes properly urges great caution in interpreting the data and stresses its potential unreliability, not least because it fails to reflect the effects of other actions, such as working to rule, which can be equally disruptive but which are not a part of the figures. However, the table does bear out managers' experience of the mounting tensions in the service over recent years.

Comparison of days lost through strike action in the NHS with the workforce as a whole: Great Britain 1966–1977

Year	Number of NHS staff	Number of stoppages	Number of staff involved	Number of days lost	Average number of days lost per 1,000 NHS staff	Average number of days lost per 1,000 employees in Great Britain
1966	728,838	2	500	500	0.69	100.0
1967	753,486	1	78	200	0.27	124.7
1968	761,747	1	80	80	0.11	211.4
1969	778,998	8	2,500	7,000	8.99	309.1
1970	792,307	5	1,300	6,700	8.46	499.2
1971	799,673	6	2,900	4,700	5.88	625.9
1972	831,753	4	97,000	98,000	117.8	1,104.3
1973	843,119	18	59,000	298,000	353.5	324.4
1974	859,468	18	4,070	23,000	26.84	661.5
1975	914,068	19	6,000	20,000	21.88	270.6
1976	945,877	15	4,440	15,000	15.86	149.3
1977	970,900	21	2,970	8,200	8.44	448.0

Source: Royal Commission Report on the National Health Service compiled from statistics provided by health departments and the Department of Employment.

Another measure of the perceived value to the individual employee of participation in organised trade union activities has been the substantial growth in union membership, which it has been suggested has risen from one-third to two-thirds of all staff between 1964 and 1975. In parallel, there has been an expansion in the number of recognised shop stewards, who in some instances have increased

threefold since before the reorganisation of the National Health Service in 1974. These pointers are evidence of the response of staff to external pressures affecting society in general and of their reaction to other influences related more particularly to the National Health Service.

External causes of industrial unrest

INFLATION, PAY POLICY AND RISING UNEMPLOYMENT

The 1970s have seen a rapid growth in inflation. Governments of both colours have made attempts to control it by the use of statutory incomes policies, and in turn these have led to anomalies in pay relativities, both within the service and between the staff and their counterparts in industry. In a similar vein, governments have repeatedly tried to use the employees in the public sector, and the sizeable number of National Health Service staff in particular, to set the parameters for private sector wage settlements. At the same time, health service employees have witnessed the apparent success of the industrial unions in exercising their collective bargaining strength to achieve satisfactory settlements while they have been subject to mounting restraint due to declining resources in the public sector. Finally, the rising tide of unemployment has stirred the political consciousness of many staff and provoked unrest.

EMPLOYMENT LEGISLATION AND THE INFLUENCE OF GOVERNMENT

Employment legislation has been a notable feature of the past decade with numerous major acts of Parliament giving rights to staff and endowing employers with obligations. Overlaying these has been the special nature of the political climate between 1974 and 1980. The Labour government, which was in office for much of that period, had its origins in the trade union movement and, not surprisingly, gave open encouragement to unions by its evident willingness to take account of union views when shaping its policies. Management within the public sector, as much as in industry, felt emaciated when faced by government attitudes towards, for example, their response to industrial action. In these circumstances management, both within and outside the service, tended to retreat from attempts to deal constructively with the growth in size and influence of the unions confronting it.

EXTENSION OF TRADE UNIONISM TO WHITE COLLAR WORKERS

Throughout the last ten years there has been a growth nationally in the size and influence of white collar unions. In the mid 1970s one charismatic leader of the developing Association of Scientific, Technical and Professional Staff enjoyed near cult status for bringing trade unionism within the grasp of middle management and the equivalent technical staff, who until then had felt mounting frustration over the diminution of reward for academic effort and the erosion of differentials between themselves and their unskilled colleagues. Technical staff in the National Health Service, in pathology, physics and similar laboratories for example, were in no way immune from the general rush to unionise amongst employees in these categories.

Internal causes of industrial unrest

CAPACITY OF MANAGEMENT TO HANDLE INDUSTRIAL RELATIONS ISSUES BEFORE 1974

In the early 1970s, management was generally ill-prepared to cope with the rapidly changing industrial relations climate. In those days, managers enjoyed a sense of false security and all but a few with unusual perception were oblivious to the increasingly evident signs of change. With hindsight it is easy to be critical, but the changes in climate were insidious and when the disputes of the early 1970s first occurred, managers could be forgiven for believing that such unpleasantness might soon fade away and 'normality' be restored. This attitude was encouraged by a serious lack of specialist personnel expertise within the service, a surprising fact in such a labour intensive industry. Had there been less shortsightedness the disciplinary procedures, which had remained unrevised since 1951, might have been in better shape.

RESTRUCTURING OF THE SERVICE IN 1974

The service was affected drastically by the restructuring which took place in 1974 and management in particular sustained considerable trauma from the process. Individuals were moved, structures changed and new skills had to be developed to deal with the introduction of consensus management which was embodied in the management team arrangements. This upheaval created a climate of uncertainty, fueled by a change of government two months before restructuring, and by continuing uncertainties about career patterns, caused by certain staff groups failing to achieve the enhanced status they believed reorganisa-

tion would bring them. Preoccupied with basic organisational issues and uncertain about the exercise of authority in the context of team management, senior staff remained ill-prepared to cope with the industrial action which was to be quickly upon them.

DEVELOPMENT OF PRODUCTIVITY SCHEMES

Another cause of growth in union membership and activity in the early 1970s was the conclusion of national pay agreements calling for local productivity schemes. Before then, opportunities for local bargaining were minimal; the introduction of bonus payments made it possible, albeit on a limited basis. Suddenly shop stewards could offer staff a tangible reason for union membership to which they could link their own role in the formulation of acceptable bonus schemes. By 1975 these schemes affected some 40 per cent of all ancillary staffs; subsequently they have been extended to other categories. Failure to agree on bonus schemes provided further opportunities for conflict.

INTRODUCTION OF FUNCTIONAL MANAGEMENT

Functional management, which gave managers of support services (catering, domestic, works and pharmacy) a degree of autonomy outside the framework of unit hospital management, was introduced at the time of reorganisation and led to confusion of role between functional heads and unit administrators. Disputes in a department managed by a functional head affected services in the administrator's hospital unit, but neither was clearly responsible for their resolution.

PROFESSIONAL FRUSTRATIONS

Had management been better organised it is arguable that it could have done more to contain, if not defuse, the readiness to use industrial action which characterised the attitude of staff to many issues in the second half of the decade. With the scent of power to spur them on, many staff groups were determined to use union strength to resolve matters of concern to themselves and beyond their terms of service. In particular, the single profession unions engaged in industrial action for a variety of reasons, but all broadly to do with the advancement of their own professional standing. For example, physiotherapists were concerned for the availability of physiotherapy teachers; radiographers for an increase in the period of their training; nurses for the responsibilities they had to bear in the face of unsatisfactory manning levels, especially in the long-stay hospitals.

AVAILABILITY AND REDISTRIBUTION OF RESOURCES

Many disputes had their origins to a greater or lesser extent in the problems of resource redistribution, which was a major ambition of government late in the 1970s. For example, hospital closures proposed as part of the rationalisation of the service were frequently targets for action. They provided political ideologists in the union ranks, probably a small minority, an ideal platform on which to stage dramatic reactions. Hospitals have been occupied by staff and emotive scenes played out, while pickets barricaded patients in and flying squads of ambulances, scrambled at dawn, have whisked these poor unfortunate pawns to other locations. These disputes, which have little to do with the protection of union members' employment, have clearly demonstrated that the service offers abundant scope for the activist with political rather than staff interests at heart and that in future management must be better prepared to cope with them.

These examples of the influences which have affected the industrial relations climate in the National Health Service suggest an organisation in a state of constant dispute. Certainly there have been occasions in the last few years when relationships between staff and management have appeared irreparably harmed; yet, in the long term, this has not yet proved to be the case. Instead, a balance is struck for a time. That balance depends on the state of the economy, the level of unemployment and the resolve of the parties.

FUTURE PERSPECTIVE – THE DECADE TO COME

In the past decade, management has been seasoned by the practical experience of unhappy industrial relations. In the decade to come, knowledge gained in the past should be put to good use in creating a framework within which industrial relations can be conducted with less trauma for the participants and those whom they serve. The sections which follow highlight a number of problem areas which experience suggests require attention. In the main, the first group relate to broader national issues and the second to local considerations, although inevitably there is overlap at times.

National issues

THE NEED FOR A STRATEGY

Perhaps the most disconcerting aspect of these unhappy events is that they appear to have occurred in a strategic vacuum. Many of the circumstances giving rise to disputes created, or at least facilitated, conflict. Management, which has performed increasingly well in

handling disputes once they have started, has still done relatively little to anticipate difficulties in order to move conflict out of the working environment. In that sense it has been more reactive than proactive. This suggests the need for management to devise a much clearer strategy for industrial relations. As the Commission for Industrial Relations stated in 1973 '. . . a total corporate strategy needs to include a policy defining the company's industrial relations objectives and the principles which should guide management in its every day pursuit of them'.

A number of companies have established explicit policies and objectives in industrial relations, although opinion appears divided as to the merits of doing so. In particular, it has been argued that to state the true objectives of management would be counterproductive and could render the exercise valueless. To do otherwise would be less than honest and again devalue the exercise. On the other hand, the merit of a written policy is, perhaps, that it helps to reinforce what should already be an inherent organisational philosophy which takes account of the industrial relations dimension in any managerial action and especially at the time strategic issues are being considered. But such philosophies are fine if the organisation is of a size that enables them to be easily communicated, understood and implemented. It is doubtful whether an organisation as large as the National Health Service, with its many quasi-independent constituent parts, could satisfactorily adopt a single nationally applicable policy. Nonetheless, the consequences of national policies as they affect industrial relations need to be considered before, rather than after, they are implemented, particularly in relation to legislation and salary negotiations, which are referred to below. Some new mechanism needs to be devised for this purpose.

THE NEGOTIATING MACHINERY

One of the largest influences on the industrial relations climate is the process of pay negotiations. In the National Health Service, virtually all of it is conducted centrally through what is known as the Whitley Council machinery. This mechanism consists of a number of separate 'functional' councils, each with responsibility for agreeing the terms and conditions of service for a section of the workforce. Each council comprises staff and management sides and they relate loosely to a 'general council'. The working of the councils has been the subject of much intermittent criticism and Lord McCarthy of Nuffield College, Oxford, was appointed in 1975 to review the system. Subsequently, it has been suggested that this exercise was too narrowly based and that

what was required was a review of industrial relations practice in the service as a whole in order to place the work of the Whitley Councils in a wider perspective. However, this was not to be, and the outcome was a report which, perhaps inevitably, failed to resolve the issue of the interrelationship between the central negotiating body and peripheral management. In this connection, there is concern at the composition of the management side of the councils, which is dominated by lay members of authorities whose appreciation of the managerial consequences of the agreements they reach, often under government influence, is not always complete. Allied to this, is the problem of inadequate briefing mechanisms. The view is held strongly in some quarters that a secretariat, independent of the DHSS, would bring a greater professionalism to the management side of the negotiating table. Paradoxically, some of the most able participants on the management side are trade unionists sitting as representatives of the authorities they serve!

With pay such a dominant feature of industrial relations, it is necessary that the highest skill is brought to bear on the process of negotiation. There needs to be further improvement in the links between the managers and the negotiators to achieve a better cohesion between centre and periphery and, equally important, between the working of the separate functional councils whose independent actions often create pay anomalies which automatically generate conflict in the service.

DHSS INTERVENTION

It was earlier suggested that a unified approach to industrial relations throughout the service was desirable but unlikely. However, the government of the day does have a role to play in setting the tone of relationships between management and staff. Mention has been made of the influence of the trade unions on government policy and the encouragement it gave to managers to ignore their responsibilities. Recently, the present government has tried to strengthen the resolve of managers to discourage industrial action by specifying a range of responses which can be adopted in the light of local circumstances. Because of the diverse nature of the service and its disputes, guidance has had to allow for great flexibility and local interpretation. However, the existence of written guidance reassures managers that their actions are neither out of step with broad philosophy nor likely to be undermined by being countermanded from above. This suggests that the management of industrial relations requires an understanding of limits of authority and the exercise of responsibility, and is an argu-

ment for some form of procedure document, if not for a policy statement incorporating guidance.

GOVERNMENT LEGISLATION

Closely allied to industrial relations policy is the effect of government legislation on trade union and management actions. There are two broad categories of legislation. One is concerned with what might be termed social legislation and is designed to raise the standard of working conditions. The Health and Safety at Work Acts are examples. The other is concerned with the control over the behaviour of staff in the context of trade union activity. Both types of legislation obviously affect workers in every industry and not just the health service. However, in making law the government should not fail to recognise that it is imposing regulations which must be applied to its own employees and which can have a fundamental effect on industrial relations in the industry for which it is itself responsible. It is unfortunate that these legislative initiatives tend to emerge as a part of a national political strategy and that their interrelationship with the philosophy of management for the service appears to be a secondary consideration. Certainly, it is not normal practice to seek the opinion of health authorities on the content of legislative programmes which may affect the staffs whom they manage. Development along these lines could help to ensure that legislation is relevant to the needs of the service as a major employer of staff.

LOCAL ISSUES AT OPERATIONAL LEVEL

Where the dominant concern of pay is dealt with centrally, there is always a danger that the periphery will pay more attention to preparing to cope with staff reactions to national negotiations than to the more constructive activity of promoting good local industrial relations. Coping with staff reactions is a pragmatic part of any local administrator's armoury, but it is essentially negative in character. In any event, the need for reactive strategies is likely to be lessened by a long-term investment in the pursuit of good industrial relations practices. The sections which follow are concerned with a number of factors which bear on the local industrial relations climate.

SENIOR MANAGEMENT COMPETENCE

Competent managers are central to the promotion of good industrial relations. In the way that these issues need to be taken into account at the strategic planning stage, both nationally and locally, so managers need to include them in their everyday activities. If this is to happen, middle managers are entitled to leadership from those in senior

positions. In the UK, the leadership of the district management team is important if positive attitudes are to be adopted by subordinate managers and a constructive local industrial relations philosophy is to be successfully implemented. One scheme especially designed to encourage this 'top-down' commitment is known as the 'Cascade' programme. This is an educational exercise which seeks the commitment of the most senior managers of all disciplines at team level to pass on their knowledge to the tier below, and so on down through the organisation. It requires an audit of the state of industrial relations before training begins and a willingness to resolve perceived problems. Though there have been critics of the scheme, it has been very successfully applied in Leicester, not least because previously unresolved difficulties have been identified, including the need to help middle managers to develop their skills.

THE CONTRIBUTION OF MIDDLE MANAGEMENT

Middle managers are crucial in setting the tone of industrial relations and are often the first to become involved in local disputes. For this reason they merit considerable help in preparing themselves to deal with these problems. However, experience suggests that competence in handling industrial relations goes with all-round ability in managerial skills. It is for this reason that in Leicester a programme has been initiated in which managers are helped to develop their abilities through a version of action learning which provides them with counselling on a one-to-one basis as they work through problems in their own department. The scheme utilises a management development officer who holds a joint appointment with the local polytechnic management centre. It is still in its infancy, but initial reactions are encouraging. Nationally, training courses are being provided for administrators, doctors and nurses with unit management responsibilities who, it is thought, will have greater involvement with industrial relations in the future.

THE CONTRIBUTION OF THE SPECIALIST PERSONNEL OFFICER

Before 1974 the personnel management function in the National Health Service was substantially a recruitment service and much of its activity was undertaken by non-specialist staff. After 1974, the role of personnel specialist became part of the nationally agreed pattern of management and the ground was laid for a much broader based service. The tangle of industrial relations legislation today demands specialist staff. Given high calibre personnel officers (the standard has been improving steadily) line managers have been pleased to have their advice and support. Personnel specialists are now making a valuable

contribution in a number of fields, among them joint consultation, bonus scheme negotiation, and the preparation of local agreements on grievances and disputes. Compared with many districts, Leicester has a well developed personnel function which has proved itself capable of anticipating and avoiding industrial action.

DEVELOPMENT OF PROCEDURAL AGREEMENTS

While procedures can sometimes inhibit initiative, Leicester has shown that locally negotiated agreements containing codes and procedures have helped to reduce the likelihood of conflict. In them, disciplinary codes state clearly the responsibility of managers and the rights of employees, and the grievance procedures are designed to bring about the smooth resolution of disputes. In retrospect, it is difficult to see how reasonable staff relations could have been maintained without them.

AVAILABILITY OF JOINT CONSULTATIVE MECHANISMS

Joint consultation at hospital level has had a chequered career. It suffered for many years from constitutional agreements being negotiated at the centre by the Whitley Council. Following their being abandoned, local negotiations have led to some successes. A new problem which has emerged at local level is caused by members of staff sides refusing to cooperate with staff representatives who are not affiliated to the Trades Union Congress. Despite this setback, however, evidence suggests that management should persist in encouraging joint consultation since it is the base from which local procedural agreements are often developed and potential conflicts recognised.

CLEAR LINES OF AUTHORITY AND RESPONSIBILITY

Managers in the National Health Service are often called on to operate in conditions of organisational uncertainty in the hinterland between the free ranging clinicians and the central bureaucracy where the scope for confusion is considerable despite everyone's efforts to avoid it. Responsibility has been blurred between the clinical and technical heads of paramedical services (pathology and x-ray for example) which has led to conflict. Less obvious but equally serious, have been the muddled responsibilities, lines of authority and communication within large psychiatric units, also the cause of local disputes. In Leicester, efforts are being made to clarify the roles of departmental managers while budgeting systems are being developed which reinforce their authority. Progress is slow however. An organisational design project has also helped achieve clarity about roles and relationships at a large

mental illness unit. These and similar attempts to define limits of authority and responsibility strengthen the ability of local management to be positive in its response to industrial relations issues.

INDUSTRIAL RELATIONS AND THE CHIEF ADMINISTRATIVE OFFICER

Previous seminars have proved conclusively that the chief administrative officer has a legitimate interest in and a responsibility for a wide range of activities, yet his personal involvement in each is limited by necessity and need not be described in detail. This is true of industrial relations in which it is sufficient to say that he will occasionally become deeply embroiled in a particular matter, possibly while an agreement is being negotiated or a dispute is in progress, but his involvement at other times will be slight. His long-term role in the containment of conflict must be to ensure that his organisation is aware of, and is responding to, the sort of issues raised in this paper.

The fact that a number of issues in the UK can only be resolved in a national context, should not stop the administrator pursuing solutions through his influence upon the bureaucracy, of which he is part. His leadership at local level must encourage his management team colleagues and his subordinates to pay proper attention to industrial relations as a way of reducing conflict and developing constructive relationships in the service.

Bibliography

Anthony, P D. *The conduct of industrial relations.* London, Institute of Personnel Management, 1977.

Bosanquet, Nick. ed. *Industrial relations in the NHS: the search for a system.* London, King Edward's Hospital Fund for London, 1979.

Hawkins, Kevin. *The management of industrial relations.* Harmondsworth, Penguin, 1978.

Klein, Rudolf. *Ideology, class and the National Health Service.* London, King's Fund Centre, 1980. (KF project paper no RC4)

Levitt, Ruth. *The reorganised National Health Service.* London, Croom Helm, 1976.

Marsh, A. *Managers and shop stewards – shopfloor revolution?* London, Institute of Personnel Management, 1973.

McCarthy, Lord William Edward John. *Making Whitley work: a review of the operation of the National Health Service Whitley Council system.* London, Department of Health and Social Security, 1976.

McCarthy, W E J. ed. *Trade unions.* Harmondsworth, Penguin, 1972.

Royal Commission on the National Health Service. *Report*. (Chairman, Sir Alec Merrison.) London, H M Stationery Office, 1979. (Cmnd 7615)
Great Britain, Parliament. *Report of the committee of inquiry into Normansfield Hospital*, (Chairman, Michael Sherrard.) London, H M Stationery Office, 1978. (Cmnd 7357)

11

The CEO's role in conflict resolution: a case study by Paul B Hofmann

The setting

Emory University Hospital (EUH) is a 600 bed, private, non-profit, adult, acute care referral facility located in the south eastern United States. It is one of seven divisions of the Woodruff Medical Center; the others are a community hospital located in downtown Atlanta, professional schools in medicine, nursing and dentistry, the Emory University Clinic (a private partnership of physicians who hold faculty appointments in the medical school and admit their patients primarily to EUH), and a primate research centre. The seven division heads report to the Emory University Vice President for Health Affairs who is also Director of the Medical Center.

Although EUH enjoys a strong reputation for excellence in all medical and surgical specialties, it has become particularly well known for its cardiology and cardiovascular surgery programmes. For example, an average of seven coronary artery bypass procedures are performed daily with a mortality rate of less than one per cent. The average length of stay for these patients is nine days, including less than two days in the cardiovascular intensive care unit (ICU).

The situation

During early 1977, a union organising drive (the first one in the hospital's history) is initiated by nurses in the cardiovascular ICUs. A short time later, both the director of nursing and the administrator are asked to take early retirement; each had been employed by the institution for more than twenty years. Eighty per cent of all nurses in the hospital sign authorisation cards supporting the request for a union election, but the union is defeated after an aggressive anti-union campaign is conducted by management. Most of the issues which stimulated the initial union interest, remain unresolved however. A new administrator is hired, and he initiates a wide variety of changes. As a result, more nurses are recruited and retained to staff beds which had been closed due to an insufficient number of personnel. But the cardiovascular ICUs continue to have major difficulties with recruitment and retention.

On 20 March 1980, the clinic director, who coincidentally also serves as chief of thoracic and cardiovascular surgery, informs the

Woodruff Medical Center board (the hospital's governing body) that there are not enough ICU nurses because they are paid the same as other nurses. He notes a number of cardiovascular ICU beds remain closed because of the nursing shortage. He adds that the administrator has implemented a number of programmes, but has been reluctant to institute differential pay for ICU nurses. The board asks the administrator to address the problem and report on his plan at the next quarterly board meeting on 19 June.

After the 20 March meeting, the university president tells the vice president that he should be sure the plan has been implemented by 19 June. On 29 May, the administrator receives a petition with a list of salary and other demands from the cardiovascular ICU nurses. This document is written in language with a union bargaining undertone.

The choices

The simplest and most expedient action would be a significant salary differential for ICU nurses. Such a step would be responsive to the growing pressure exerted by the cardiovascular surgeons. It would also meet the most prominent demand by the cardiovascular ICU nurses. Above all, a higher salary would probably improve recruitment as well as retention of ICU nurses. Despite these compelling reasons for proceeding with a salary differential, various factors appear to militate against it.

First, there is a general consensus among nursing directors and hospital administrators that such a step will set a costly and counterproductive precedent. They predict nurses in other specialty areas will claim that their responsibilities and unique skills similarly justify special compensation, for example in the emergency department, the dialysis unit, and operating rooms. Second, an ICU differential had been implemented in several hospitals in different parts of the country with only a temporary improvement in recruitment and retention and, as anticipated, increased personnel problems because nursing specialists in other areas felt discriminated against. Third, local administrators strongly discourage a differential because they feel they would be forced to take the same action to remain competitive with EUH.

An alternative would be to make no major decision regarding salary changes. Both nursing and hospital administration emphasise that a number of critical non-financial issues are continuing to compromise the institution's ability to recruit and retain cardiovascular nurses. These include an inordinately stressful working environment due to all the patients being in a critical condition; the unusually large number of physicians (surgeons, anesthesiologists, cardiologists and their resi-

dents) and support personnel interacting with the patient and nursing staff; overlapping and occasionally conflicting physicians' orders; and the constant pressure to transfer patients out of the ICU to accommodate others from surgery. More money will not alleviate the stressful working conditions; it would be a palliative only.

However, it is clear that some action is necessary. Efforts to stabilise the environment by designating a cardiac anesthesiologist as medical director have proved only partially successful. The appointment of a new head nurse has occurred too recently to have had a significant impact. Although the adoption of various protocols (governing the number of surgeries per day, treatment regimens, and transfer procedures) appears to be exerting a positive influence, physicians as well as ICU nurses have conveyed an unambiguous message: anything less than a salary increase will be considered ineffective in dealing with the hospital's continuing inability to recruit and retain qualified staff.

Another alternative would be to implement a salary increase for all staff nurses. Such a decision would avoid the disadvantages associated with an ICU differential, but still be responsive to the demand for more money.

This option presents both real and potential problems. The next regularly scheduled salary adjustment is not budgeted until 1 September 1980 when the new fiscal year begins. Even if all nurses' salaries were raised in June, it is quite likely that the physicians and ICU nurses would remain adamant that ICU nurses be paid more than the others. Finally, any change in salary for nurses certainly could be expected to provoke concern among nursing assistants within the division of nursing, and other employees, particularly those who traditionally have been paid at a level comparable to staff nurses.

The solution

The solution was a modified combination of the first and third options. It capitalised on an existing programme of staff nurse levels, implemented in September 1978. Three levels had been established, each with a specific job description and set of qualifications. Using acuity of care requirements derived from the hospital's patient classification system, a different percentage of positions for each level was allocated to the various groups of nursing units. Thus, a greater proportion of level II and III positions was designated for those groups of units with patients having the highest acuity of care requirements.

Given the inability to recruit or retain sufficient ICU nurses, a still unacceptable vacancy rate on other nursing units, the continuing pressure exerted by the cardiovascular surgeons, the mandate from the

governing body and the university president, and the receipt of a list of formal demands from the cardiovascular ICU nurses, two major decisions were made. First, a salary increase would be implemented for each level. Second, level I positions would be eliminated in the ICUs.

This approach had several advantages. Probably the most important was that the salary adjustment responded to the inescapable expectation that some change in pay was justified. However, the manner in which the changes were made avoided the problems that would have arisen had all ICU nurses been paid on a different scale than other nurses. At the same time, the ICU nurses in level I positions received a larger one-time increase because they were automatically placed in level II positions.

Timing was certainly a critical factor in dealing with this complex set of issues. It was originally determined during the planning activities which followed the 19 March board meeting that any decision affecting salaries would be effective from 1 June. Furthermore, the changes would probably have to be retroactive in view of the relatively brief period available to develop the plan, modify job descriptions, and process the payroll. Consequently, when the 29 May petition was received from the cardiovascular ICU nurses, most of the planning had been completed and it was possible to distribute a memorandum to the nursing staff the next day announcing the changes and a series of meetings to discuss them. When the administrator responded to the petition on 4 June, he was able to allude to the earlier memorandum and point out that several issues noted in the petition were scheduled for discussion at the previously announced meetings. Although the petition contained a number of excessive salary and benefit demands and threatened 'other remedies' if 'a response deemed acceptable' were not received, no further developments occurred.

Discussion

Predictably, there were some adverse consequences to the solution. The June salary increase was not in the budget and significantly reduced the hospital's anticipated net income. A meeting of department heads was held in June to explain the background for the staff nurse salary increases, but a number of other meetings were held at the request of nursing assistants, physical and occupational therapists and laboratory technologists. Their concerns were heard and they were assured that appropriate raises would be implemented as normally scheduled on 1 September, the beginning of the fiscal year. Requests to make them retroactive to 1 June were denied. A special meeting was also conducted with the administrators of hospitals formally affiliated

with Emory. They were disturbed about the unprecedented midyear salary range adjustment and, after several other hospitals implemented similar increases, Emory was criticised in a newspaper article for taking action which would lead to a further increase in health care costs.

It is now possible to evaluate the impact of the changes. A survey conducted prior to the spring of 1980 indicated that the average Georgia hospital had a staff nurse vacancy rate of 17 per cent. In May 1980, 18 per cent of budgeted positions at EUH were vacant, and turnover had been averaging almost four per cent a month. Currently, there is a vacancy rate of seven per cent, and turnover is averaging two per cent. In addition to having filled all previously existing ICU positions, enough nurses have been recruited to staff another ICU which was to have been activated on 1 March 1981.

This case study has implications for medical staff/CEO relationships, unionisation of professional employees, staff recruitment and retention, the cost of patient care, and administrative survival. As the potential consequences of each alternative are evaluated, the variables become more numerous and complex. Accordingly, it is difficult to avoid rationalising even marginal successes, and compromise becomes not only an acceptable strategy but the inevitable one.

12

Rationalisation of hospital facilities as a source of multiple conflict

by Barry R Catchlove and Don S Child

On Friday, 17 August, 1979, the Minister for Health for New South Wales, addressing the elite of the hospital industry, said:

> 'The New South Wales Government has decided to proceed with the programme of rationalisation, in accordance with a plan developed by the Health Commission of New South Wales and approved by the New South Wales Cabinet. The main purpose of the rationalisation programme is to enable the Government to proceed with the commissioning of essential new hospital facilities.
> 'Included in a statement to the Federal Parliament by the Commonwealth Minister for Health, Mr Hunt, following the delivery of the Budget Statement by the Treasurer, was an edict that there should be a nil growth factor in hospital services throughout Australia during 1979/80.
> 'In effect that edict means that the Federal Government will not agree to cost sharing any new beds or services introduced during the current financial year.
> 'New South Wales will have an additional 450 beds ready to come on line this year at Westmead plus some 300 beds will be ready for use in places such as Gosford Wyong and other areas and in new services such as assessment and rehabilitation centres now under construction.
> 'In many respects the current rationalisation programme will have the effect of reallocating beds within the metropolitan area to reflect shifts in population, so as to achieve a more equitable distribution of hospital beds and services.
> 'The programme of reallocation of resources is also intended to prevent duplication of services and ensure proper utilisation of resources including those concerned with highly sophisticated medical services.
> 'IN THE MAIN THE PROGRAMME WILL AFFECT THE LARGE TEACHING HOSPITALS.'

The government stated that 870 beds were to close in all. These closures were to be spread among 15 hospitals in the inner metropolitan area, the required saving to be $11.3 million.

Background

Australian hospital funding is a confused complex issue at present. The provision of services and responsibilities for hospitals is largely a matter for the six states of the federation, yet states collect no direct taxes and must rely for their funds on various methods of redistribution of federally collected income taxes.

Since 1975 there have been cost sharing agreements between the states and the Commonwealth in which the federal government bears 50 per cent of the gross operating costs. The federal share is made as a direct grant to the states who then, together with their own share, allocate hospital budgets.

The scheme, originally introduced by the Whitlam government, was modified in 1976 by the Fraser ministry to include the word 'agreed' in relation to the 50/50 sharing of costs. Between 1972 and 1976 the federal government was obliged to match 50 per cent of whatever the states decided to allocate for health. Since 1976 there has been great difficulty in reaching agreement on the operating budgets. States may allocate as much money as they wish for hospital costs but the federal government will only share that part to which it has agreed. Reasons are various but include gross variation in provision of services between states (for instance, Victoria has approximately 1100 occupied bed days per thousand population whereas New South Wales has 1400); unwillingness of states to get tough about the limitation of hospital and health services; federal/state conflict over the role of government in the provision of health services; and differing philosophies about government spending.

Concluding his presentation, the minister said:

> 'I believe that if services are redistributed in a coordinated manner not only will there be no adverse effect on the quality and availability of services overall but people will be more adequately catered for in the provision of hospital services relatively close to their home.
> 'The Government looks to the boards of directors of all hospitals affected by the rationalisation, and the employees of those hospitals to cooperate in order to bring about an orderly re-deployment of services in the best interests of the people of New South Wales.'

It is appropriate to summarise a number of key arguments in the rationalisation plan.

There were no hospital closures per se.

The programme involved an approximate 10 per cent cut back across the board of teaching hospital facilities in inner metropolitan regions.

An equivalent percentage cut back in expenditure was required, assuming that 10 per cent less services equals 10 per cent less expenditure.

Because the net effect was to maintain the same number of beds through the simultaneous opening of new services in under-serviced areas, it was assumed there would be no change in the overall demand or provision of health care services.

The industry as a whole was of the view that the government had made a firm and clear decision and that the reasons were at least understandable, even if the methodology and process were thought to be based on uncertain arguments. The simple solution of closing whole hospitals whose site, use and facilities were no longer in line with needs was accepted as unrealistic. One large inner city teaching hospital was about to celebrate one hundred years of successfully resisting attempts by governments of all persuasions to relocate it.

Most hospitals moved quickly to implement their part of the proposed rationalisation programme. Their boards and administrators believed that if a dose of medicine was necessary it was better to swallow it quickly and avoid too much speculation on how unpleasant the process would be. There was relative silence from those groups who it was suspected would be most vocal. Overall there appeared to be little unrest within the hospitals, staff having been reassured that the rationalisation would be achieved through attrition rather than retrenchment.

The most vocal opposition came from the Nurses Association who argued their concern for patient care and loss of job opportunities. As a result of pressure from the NSW Nurses Association and also the Health and Research Employees Association, the Health Commission agreed to set up a consultative committee to review the rationalisation decisions. During November the hospitals were instructed to place a moratorium on any rationalisation while the consultative process took place. The consultative committee met on a number of occasions during November 1979. The major participants were the Nurses Association, the major non-professional union and Public Service Association within the health industry, and the union representing non-medically trained health administrators. Little headway was made and at the end of the month instructions were issued by the Health Commission to proceed with the implementation of the programme.

During the early part of January there was a prolonged period of industrial unrest in the Eastern Suburbs Hospital and Prince of Wales Hospitals, culminating in a 24 hour stoppage by members of the Nurses Association on Friday, 18 January. Authorities at the hospital

felt there was little intramural support for the stoppage and that the strike had been largely engineered from outside. Despite this, the combined unions met with the Premier and Minister for Health on the day of the stoppage. (It should be appreciated that there was some belief in government quarters that the vote of nurses had been a critical factor in the election of the Labour government.)

Following the meeting, a committee chaired by Mr J Ducker, a member of the NSW Public Service Board, was set up to review the economies that had been proposed to achieve the necessary savings within the health budget. This committee was to report directly to the Premier, who removed from the Health Commission the consultative process that had been set up. The composition of the committee was to be the chairman, Mr J Ducker, three representatives of the Health Commission, three representatives of the Health and Research Employees Association and two representatives of the NSW Nurses Association.

The major term of reference was:

> 'The Committee is to examine the cuts previously determined by the Health Commission within the financial limits determined by the Government and recommend the options available for the meeting of the Budget.'

Another moratorium was placed on the implementation of rationalisation. It should be noted at this stage that expenditure requirements were related to the fiscal year ending 30 June 1979. The committee reviewed the proposed changes in each hospital but changed little overall. The bulk of its report centred on methods of improving the consultative process within hospitals. It proposed the establishment of consultative committees and mechanisms at three levels: health services consultative committee; joint consultative committee at a regional level; a consultative committee at the hospital level. Each committee to be given the right to discuss all decisions made at its level.

The programme of rationalisation continued haphazardly through 1980 with individual hospitals negotiating various options with Health Commission and unions. By the conclusion of the financial year the bed cuts and the bulk of the financial savings had been achieved.

For the financial year 1980/81 the Commonwealth government maintained its policy of no real growth and forced the states into a situation similar to previous years. Despite Commonwealth funds being made available relatively early in the financial year, hospital budgets for the year 1 July 1980 – 30 June 1981 were not available to the hospitals until 23 December. When released they required much

the same expenditure reductions as had occurred in previous years but this time without referring to a reduction of services, or to consultation or rationalisation.

In the six months to December 1980, throughput in most of the teaching hospitals had increased significantly. Occupancy figures had risen from more than 80 per cent to over 90 per cent, length of stay had fallen approximately 10 per cent and the number of patients treated had marginally increased, despite a decrease in hospital inpatient facilities. Outpatient services had also increased significantly, in the order of 13 to 15 per cent.

At the time of writing, hospitals in New South Wales, and to a similar or lesser extent in other states, are faced with a near insoluble but predictable problem. Supply has been reduced without any attempt being made to manipulate the demand for services.

The overall effect has been to create areas of conflict for the major teaching hospitals. Chief executives are in the centre of this conflict. The areas are broadly:

Budget uncertainty

Divided responsibility for health care funding between federal and state legislatures has brought diminished responsibility with political buck passing, increased bureaucracy and greater delays in determining the allocation of money.

Irrational expectations of cost savings

At the beginning of the rationalisation programme the Health Commission argued firmly that one bed closed in an existing establishment equalled one bed opened in another establishment. Two related but discreet phenomena contradicted this argument.

The Health Commission said that the opening of a new Westmead Hospital, an 800 bed teaching hospital, in the rapidly expanding, lower socio-economic, western area of Sydney, would relieve inner metropolitan hospitals of a significant caseload. Royal Prince Alfred Hospital, an inner city teaching hospital of 1200 beds, had been shown to have an average of about 15 per cent of its patients from the western metropolitan area. Therefore, it was believed that Prince Alfred could do away with 100 beds when Westmead opened without affecting the proportional demand per bed. Time has shown that the demand on Royal Prince Alfred Hospital has not changed (in fact, it has increased), while the new teaching hospital at Westmead is fully utilised, demonstrating that new services either create demand or disclose hitherto unrecognised demands for health care.

The authorities have failed to recognise that manipulating supply will not affect demand. This phenomenon has been well put by Schwartz and Joskow writing on the subject of duplicated hospital facilities in the *New England Journal of Medicine*, December 1980:

> 'From an extensive econometric literature on hospital cost functions we can derive a mean estimate of the ratio of marginal cost to average cost. The mean estimate is 0.70, and 9 of the 11 estimates fall between 0.65 and 0.90. Studies taking the average occupancy rates as the independent variable, (a method that appears to be most appropriate for our purposes) yield a ratio of about 0.80, which we considered our best guess: for every dollar saved in closing a hospital, 80 cents must be spent to treat the patients in another hospital. This figure, however could easily be as little as 60 cents or as much as 90 cents.
>
> 'These figures seem surprisingly small. How can closing 7% of all hospital beds save little more than 1% of total hospital expenditure? The answer is fairly simple: these calculations assume that the same number of patients is being treated whether the hospital sector is reorganised or not. As facilities are closed patients must seek care elsewhere and resources must still be expanded to provide that care.
>
> 'Substantially larger estimates of the potential savings seem to be based on the assumption (often implicit) that reducing the supply of hospital beds will reduce the demand for hospital services and redirect it to more cost efficient types of care. In essence, this reasoning is based on the thesis that supply creates demand. It is far from clear that this theory is correct but even if it were, it seems far more sensible to approach the problem of inappropriate demand directly than to influence demand indirectly by curtailing the supply of beds. The indirect approach, which relies on reduced bed supplies as a policy statement, offers no assurance that the available bed stock will be used for the proper patients or that the problems of misuse will be satisfactorily resolved.'*

They go on to discuss further some of the offsetting costs, including the enormous costs of regulation and the indirect cost to patients and their families.

Effect of service reduction on optimally utilised resources

The hospitals most affected by the rationalisation programme were all

* Schwartz, William B and Joskow, Paul L. *Duplicated hospital facilities: how much can we save by consolidating them?* New England Journal of Medicine, vol 303, no 25. 18 December, 1980. pp 1449–1457.

operating at occupancy levels in the 70 per cent – 75 per cent range, the length of stays well below 10 days. Staff levels had been made less than optimal by increasing technological demands with more intensive diagnostic and treatment practices and a more rigid industrial climate.

Over the 12 month period since the introduction of the programme, demands have continued unaltered with occupancy levels exceeding 85 per cent and diminished lengths of stay. The effect, recognised ironically by the trade union groups, has been to increase workloads on staff, particularly those groups with little to gain. Hospitals are being confronted with iron-clad cases for additional staff and resources. The delicate balance between patient care demands and staff needs, the ultimate responsibility of the chief executive, has been disturbed. Militancy has increased and morale decreased, and genuine concern is felt for standards of care.

It has been suggested by Maxwell and others that across-the-board constraints on expenditure can be tolerated in the short term.* The experience in NSW is that a constraint of 10 per cent cannot be tolerated even for one year.

Effect of political weakness on industrial relations

The chief executive officers of the teaching hospitals in NSW collectively adopted a policy of accepting the government's decision and moved quickly to implement proposals while the carefully orchestrated positive mood within and without the industry existed. Backtracking and moratoriums by government, precipitated by union activity, placed many of the administrators in an intolerable position and gave a number of union groups a taste of power. The Ducker Committee report has further fuelled this industrial militancy which is directed at a group that is unable to respond.

* Maxwell, Robert J. *Health and wealth: an international study of health-care spending.* Lexington, Mass, Lexington Books, 1981.

13
Commentary
by Robert Maxwell

> 'A constitution is made for people of fundamentally differing opinions' Justice Holmes

The papers in the first section of this book were about problems of coordination among heterogeneous groups, whose activities are interdependent and who may sometimes (almost incidentally) come into conflict. In this second section we are concerned with the management of conflict: particularly, though not solely, conflict between management and unions or staff associations.

Health administrators tend to be avoiders of confrontation. Faced with competing points of view they seek compromise. In the short term, compromise seems preferable at almost any price, since innocent people are likely to suffer in any contest, the unfamiliar attention of the media will be attracted, and governments stand to lose rather than to gain by controversial action. Nevertheless Claude Forget reminds us that conflict may be inevitable and even fruitful. He therefore urges us to think in terms of conflict management rather than conflict avoidance.

That implies the need for administrative skill in defining what any conflict is truly about in the minds of each party to any dispute (conceptualisation): being prepared to present a case forcefully, while listening to the other side (advocacy); and trying to find solutions that will at best leave each protagonist better off, and which at worst each side can tolerate (behavioural understanding).

Haynes Rice, Ian Beach and Paul Hofmann all write about the handling of disputes between management and staff in the increasingly unionised health services context. Haynes Rice, from the background of sensitive multi-ethnic communities in the United States, comments upon several cases involving dismissal of staff. He emphasises the onus upon the administration to know and abide by the rules; to be seen to act consistently as between one individual and another, and over time; and to document its case. In instances of dismissal, courts and tribunals will uphold the individual if there is any substantial error, inconsistency or lack of documentation on the management side.

In the United States there has been a substantial increase in the unionisation of health service staff, up to the present figure of roughly 25 per cent. In the other countries represented, the present figure is already much higher than that. For the United Kingdom, for example,

the change has been from roughly one third unionised in 1964 to two thirds today. Ian Beach describes this change and reviews the present position. He calls for sharper industrial relations skills at the local level than were expected in the past. In discussion he commented on the short-term versus long-term trade-offs (should one compromise despite the long-term risks?) and speculated as to why similar institutions have markedly different industrial relations records. Nobody disputed that such differences do in fact exist, nor did anybody claim that they are chiefly the result of accident. On the other hand, much must depend upon the previous record, tradition and atmosphere of the institution: where the record is good, the credit lies at least as much with our predecessors as with ourselves. What we do will affect our successors.

Paul Hofmann's paper is a case study of a dispute concerning the pay of nurses in the cardiovascular intensive care unit (ICU) at Emory University Hospital, Atlanta, in mid-1980. Behind this dispute lay a longstanding, unresolved grievance. There were problems of recruitment and retention of ICU nurses, for reasons that were not solely financial. As so often in such cases, the problem feeds on itself: under conditions of stress, dissatisfaction leads to poor recruitment, high absence and high turnover, which in turn worsen the pressures on those who remain.

In this particular case, the new administrator is under instruction from the board to find a rapid solution. The three options (pay ICU nurses more than other nurses; do nothing on pay, and tackle some of the non-financial problems; pay all staff nurses more, including those in the ICU) all have some substantial disadvantages.

The solution adopted – a modified combination of two of the options – gave the ICU nurses more money in a way that could be justified to nurses in other specialties. It used a grading scheme already developed in the hospital, differentiating staff nurse posts and departmental staffing levels on the basis of the acuteness of patients' nursing needs. While the solution was not without its disadvantages, it resolved the dispute and had a more rational base than the more obvious course of action, thus providing a better precedent for the future. A major factor in its acceptance by the staff was speed: by responding more quickly and more positively than expected, management was able to avoid the dispute worsening. The case well illustrates a problem-solving approach to the management of a conflict: reaching out to a better solution than is immediately apparent. It also indicates that the two main parties to a dispute are not on their own. The attitudes of others (in this case other groups of nurses, the medical staff, the Board and other neighbouring hospitals) all have a bearing.

So do the media and public opinion, once a conflict escalates. There is therefore a need to look for alliances and to explain one's case. In general, unions are much more aware of this multidimensional nature of power and are more skilled at presenting their case than is management.

On the surface, the Australian paper by Barry Catchlove and Don Child deals with a very different situation from Paul Hofmann's. Because of budgetary constraints in New South Wales and the opening of a major new teaching hospital in the western suburbs of Sydney, the established teaching hospitals are told by the minister of health that they must cut back their services by 10 per cent and close 10 per cent of their beds. Despite the difficulties, boards and administrators act swiftly and with some resolution, on the grounds that action along these lines is indeed necessary and delay will only compound the problem. They then find their actions slowed down and their positions eroded by government as it comes under pressure from unions with which its political ties are close. Cutbacks take place, but more slowly than planned. In the next financial year government again imposes budget reductions, but without seeking or authorising further cuts in service. Meanwhile demands upon the hospitals increase.

Despite the obvious differences in the situation and the much broader canvas of the New South Wales case, there are also important similarities to the previous papers. Budget cuts pose an issue of potential conflict, to be managed or fudged, in a forum where power is multidimensional, the issues are politically sensitive, and the whole is very much open to the public gaze. Some interesting economic questions are raised about the feasibility and short-term effect of budget cuts of the order of 10 per cent in a single year and, far more basically, about the interrelationship of supply and demand. In the context of this book, however, the case emphasises the political dimension of conflict management in health services. It also shows the need for everybody involved, including government, to take a strategic view rather than to deal with each conflict in isolation. The worst feature of this case is that it would appear to make the handling of the next conflict more difficult: next time the boards concerned would be much less ready to risk exposing themselves. Effectively government had sabotaged their efforts.

In discussion, there was complete acceptance of Claude Forget's view that conflict cannot – and indeed should not – always be avoided, and that administrators are often not assertive enough in their stance. His dismissal of rules and procedures was only partially convincing. To the contrary, processes and documentation are indispensable, although not by themselves sufficient. Clearly they do not ensure that a

chief executive officer has defined what is at stake on the management side, nor that he has thought himself into the minds of other parties to any dispute. Finding solutions that go beyond the stark zero-sum of 'I win, you lose' calls for more than obedience to rules. So does the need for political awareness and the forging of alliances. Game theory and contingency planning are relevant: if this happens, what next? And a strategic view of how one issue affects and interlocks with others, and of developments over time. How any conflict is handled, the nature of the solutions adopted and the atmosphere engendered, always leave a legacy.

Nevertheless there must be processes for handling disputes, and these processes must command confidence. Whenever they are tested, a bank account of goodwill is tapped. Administrators must not only handle disputes fairly and imaginatively, they also need constantly to see that that bank of institutional goodwill is replenished: that when conflict arises people want to handle it with minimum damage to non-combatants (particularly those who have no defence) and that they can continue working as colleagues afterwards.

III Individual and community involvement

14

The private government of public health?
by Rudolf Klein

Introduction: The limits of responsibility

There is nothing like exhuming yesterday's platitudes to produce today's new discoveries. One of the extraordinary phenomena of the past decade has been the sudden rediscovery of the fact that health services – defined in the strict sense of organisations concerned with the delivery of specific forms of care or cure by providers with a particular set of qualifications – have only a limited impact on any population's state of health. Suddenly, as a result, providers of health services – whether doctors or administrators – find themselves plunged into a crisis of critical self-examination.

In many ways, this critical self-examination is all to the good. Apart from anything else, it recognises that the medicalisation of social problems is expensive – although, of course, it does not follow that the socialisation of medical problems is necessarily cheap. Simply extrapolating the expenditure trends of the past two decades makes it clear that to continue with things as they are is to risk running into a financial brick wall: the momentum of past commitments and assumptions is on a collision course with the new economic reality of slow or nil growth.

But there is a danger that this re-assessment of the role of health services, and the awareness of the limits of health care, will lead to a new set of unrealistic demands on administrators and policy-makers. In other words, it may be that by redefining the aims of health policy we may create assumptions as to what can sensibly be expected from the health policy machine which breach the limits of administrative feasibility.

The fact that both good health and disease are social products is obvious and has long been recognised. A classic statement of this view can, for instance, be found in Sir John Simon's *English Sanitary Institutions* published in 1890.[1] In this he puts the case for improving the people's health not by building more hospitals, not by extending health services, but by improving housing, nutrition and education: health, in short, is seen as a function of socio-economic circumstances, a view recently reiterated in Britain in the Black report on inequalities in health.[2] Eighty years before the publication of the Lalonde report[3], Simon provided a full statement of the case for concentrating both on environmental conditions and on individual life-styles.

The dilemma is to know how far those involved in health services, whether administrators or doctors, should extend their activities in line with the logic of such an analysis. The temptation is to argue that they should pursue the causes of ill-health and disease wherever the chase may lead them: to ignore the limits of organisational boundaries and to push out into the community in an enterprise of social mobilisation and intervention. This is not surprising: the logic of the analysis would indeed seem to imply a concern with such phenomena as smoking, road accidents, environmental pollution and working conditions.

But there are a number of problems about pushing out the limits of responsibility in such a heroic way. In the first place, it is to accept, rather too easily, the present conventional case against the role of health services. If the services appear to make little or no contribution to the people's health, this may be because the wrong indicators have been used to measure their impact. By concentrating on mortality rates and life expectancy (the only statistical indicators that are available over time and cross-nationally) such analyses tend to ignore the role of health services in dealing with non life-threatening conditions and in making life more tolerable for those whose conditions cannot be cured.[4] What evidence is there to show that changes in individual life-styles or the socio-economic environment would remedy, as distinct from possibly postponing, the degenerative conditions of old age?

In the second place, the emphasis on moving out from the health services into the community (welcome though it is in many ways) does indicate a degree of utopian goal displacement. Given the apparently intractable problems posed by the present organisation of health services in an era of economic scarcity, it is all too tempting to go out in search of a new set of problems which, we hope, will prove more amenable to policy intervention. But what reason is there to think that the new problems will prove more tractable? The evidence surely points in the opposite direction. If, for example, we believe that health is a function of socio-economic conditions, then this might well imply radical income redistribution policies, whose political feasibility is far from self-evident.

Lastly, it is far from obvious that health administrators or providers have the competence to move into the field of social engineering. Moreover, while they may well have a responsibility to put the case for various forms of social intervention designed to improve health, their arguments will inevitably have to be balanced against other considerations. Policies designed to enhance health have no unique status; there may well be trade-offs between such policies and other socially valued

objectives. For example, imposing pollution controls or insisting on improvements in working conditions (both extremely desirable aims of policy) may have implications for industry's competitiveness in the international market and thus for the maintenance of employment (another very desirable aim of policy).

Again, there is a variety of policy instruments available for social engineering, and the choice may be problematic. Thus, if we are concerned about road accidents, we may legislate for making the wearing of safety belts compulsory, we may build safer roads, we can insist on motor manufacturers designing safer cars or we might even want to encourage public, as distinct from private, transport. The implications of any one of these policies, or a mix of them, cut right across the whole spectrum of government policies. Similarly, in the case of smoking, we may have to consider taxation policies. Once the arena of political discussion is widened in this way, it is clear that those working in the health services can only be one set of actors in a complex and highly populated political arena.

This might suggest that extending the responsibility of health service administrators and policy-makers runs the risk of casting them in a role in which they have little legitimacy and where they could expect much frustration. A more realistic approach might be to ask how far the machinery of central government in different countries is designed to deal with policy issues that cut across departmental boundaries: how far there is a joint approach to health and other social policies.[5] Here the American insistence on including the health implications in any proposals for legislation might provide a model. The contention is that health criteria should be integrated into the overall policy process and, in particular, into any ongoing policy analysis.

In what follows, I shall start from the assumption that health service administrators have quite enough or their plate trying to deal with their existing problems without going in search of new ones. And I shall consider the relationship between providers and public in the context of health systems, not in the context of a social engineering enterprise.

Consumerism, participation and all that

Perhaps the best starting point for any discussion of public involvement is the question posed in the paper by J R Evans: 'How responsive is a health service to the needs of society?' For this prompts a series of further questions. First and foremost, there is the issue of *who* defines the needs of society. It cannot, after all, be assumed that those needs are self-evident or unproblematic: needs are social constructs.[6] Nor

can it be taken that needs, once identified, are necessarily congruent with each other. Indeed if the inevitability of resource scarcity is accepted, it follows that needs will be competing with each other. So, secondly, we must ask how needs are organised: who, in other words, represents which constituencies of need. If we accept the proposition that needs compete with each other, then inevitably we have to explore the balance of power between the organisational groups involved.

In theory, of course, there is only one perfect model of public involvement in health care: this is that of the consumer in the market place. In this model it is individual preferences, not collective decisions, which determine the total spent on health and the pattern of expenditure. Needs are defined by demands.[7] Producers simply respond to market signals, and produce what is wanted (otherwise they would go out of business). Not only does the individual know best what he or she wants (or needs), but he or she has a direct incentive to behave in such a way as to maximise his or her health and thus to minimise the costs of seeking care.

We have long since been expelled from the Eden of the invisible hand, from the self-balancing market which produces the best of all possible worlds. But, significantly, the language of the market place lingers on, and, ironically, is often invoked most passionately by those who repudiate the underlying ideology. To talk of consumers of health care is to use the language of the market place. The consumer movement in health care makes much the same sort of demands as the consumer movement in other markets. It generates demands for more information about the goods being sold, for minimum safety standards, for legal redress against poor quality, and so on. Moreover, it could also be argued that this sort of market model is perfectly compatible – in principle, at least – both with comprehensive provision of health care and with social equity, always provided that one is prepared to make heroic assumptions about the feasibility of re-distributing income, so that those who have the greatest wants for health care also have the required resources.

However, should health care be left to the market? The arguments against are familiar.[8] Only two will be noted here. First, there is the argument that the public good is more than the summation of individual private goods; that there is a collective interest in the provision of health care, over and above the self-interest of individual members of society. Second, there is the argument that the market for health care has some unique features which distinguish it from other kinds of markets; that buying health care is not like buying a car, refrigerator or having one's boiler repaired. Specifically, the market for health care is distinguished by the fact that the consumer does not necessarily know

best and that a mistake, once made, cannot be put right by trading in the defective or unsatisfactory product for another. Many forms of medical intervention may well be irreversible. So, in short, there is presumption that it is the producer, not the consumer, who knows best what requires to be done.

My concern at this stage is not to weigh up the force of these arguments. It is, rather, to bring into the open the assumptions which underly the development of collective provision for health care, the repudiation of the market principle. It is, further, to suggest that these assumptions are inherently paternalistic in character. In effect, they substitute the judgment of the expert provider for that of the individual consumer. The language of needs is that of paternalism, while the language of demands is that of the market.

In practice, it is difficult to find a 'pure' market or a 'pure' paternalistic model of health care in the western world. Certainly the American and British health services can be taken as examples of systems which lie at the opposite end of the continuum. The American system is based on the principle of individuals buying their own health care, and to that extent conforms to the market model. The British system is based on the principle of the providers allocating health care to individuals according to criteria of need, and to that extent conforms to the paternalistic model.

However, both models suffer from internal strains and stresses. In the case of the United States, the characteristic of the market economy – the fact that incomes are very unequally distributed – mean that the political market is used to try to redress the balance. Central government is drawn first into providing insurance and then into attempts at controlling and regulating the market when it becomes apparent that the combination of collective provision for finance through private and public insurance with incentives to individual consumers to maximise their own demands has perverse consequences. In a sense, the political market is continually at war with the economic market, in a never-ending attempt to contain costs.

In the case of Britain's National Health Service, there is also an internal contradiction. Paternalism assumes the private government of public health services. If there is an overriding collective interest, a public good which is different from the aggregation of individual private goods, and if that public good is further defined by experts, then it follows that the system should be insulated from day-to-day political pressures. If there is such a thing as an ideal health policy which can be derived from looking at the entrails of epidemiological statistics and abstract principles of distributional equity, then the normal processes of pluralistic bargaining in the political market place

would seem to be a dangerous irrelevance. The attempt to insulate the NHS from politics can best be illustrated by the emphasis, from 1946 to the present day, that the lay members chosen to run it should in no sense act as the representatives of the interests from whom they have been picked. The existence of such interest groups (doctors, trade unions, local authorities and so on) is acknowledged by the method of selection, and then promptly repudiated. It is as though sex was reluctantly recognised as a fact of life by policy makers who then insist that only capons should be allowed to engage in sexual activities.

But, of course, the private government of public health services is impossible in a pluralistic society. Any organisational sub-system depends on society at large for support. There is inevitably an exchange relationship, and if the needs defined by experts diverge too far from the demands of individuals, then that support is likely to be eroded. Moreover, there is always the suspicion that expert definitions of need may become self-serving, that the public interest may come to be defined in terms of organisational self-interest or be perceived through the distorting lenses of professional concerns. For example, that need may be exclusively defined in terms of the medical imperative to maximise what can be done technically. What applies to the medical profession, presumably also goes for professional administrators: perhaps their imperative can best be described as the desire to minimise friction, or (as Claude Forget notes) to avoid conflict.

So here again there is a built-in instability. In the case of the American system, the expression of this instability is the continual political endeavour to devise some mechanisms of cost control. In the case of Britain's NHS, its expression is the continual search for some new organisational form which will resolve the strains in the relationship between the NHS and the political community at large.

Inevitably, therefore, we are involved in the analysis of political markets when trying to answer questions about the definition of needs and the responsiveness of health services. It is to this theme that the next section turns.

The politics of health care

The issue of public involvement in health care can be discussed from two perspectives. First, it may be argued that public involvement – in the sense of participation by individual citizens in the political decision-making process – is desirable for reasons that have to do with the health of the polity, not the health services. A long line of political philosophers – going back to Aristotle – have held that it is precisely such involvement which is the mark of citizenship. Second,

public involvement may be analysed from the point of view of its instrumental costs and benefits, where it is seen simply as a means to a variety of ends, not necessarily to be pursued for its own sake. The discussion that follows adopts the instrumental perspective, not in order to exclude consideration of the first point of view but in order to focus the analysis.

Perhaps the most helpful distinction to be made in analysing the political market is that between diffuse interests and concentrated interests.[9] In the first category, clearly, are consumers of health services. Their interests in health care are episodic, contingent on something happening to trigger off their use. They are not organised. In the second category, equally obviously, are the producers of health services. They have an interest by the very fact of what they do. Moreover, it is a permanent, ongoing interest. In contrast to consumers, they have low or negligible organisational costs; as a rule, they tend to be organised in professional or trade union groups. So here we have an imbalance of organisational power. When it comes to defining 'need', it is the producers who are much more strongly placed than consumers to impose their definitions.

A number of further distinctions can usefully be drawn in the case of consumers. Like all citizens, they vary in the resources they bring to any political situation: resources of education, time, competence, and so on. Successive studies of political participation tend to show that it is largely a function of education and age. If people are well educated, and if they are of working age, they tend to participate more. Similarly, it may be noted that it is precisely this group who tend to be most critical of health services.[10] Their interests may be diffuse, but at least they are well able to articulate them. In contrast, there are other groups of health service consumers whose interests are much more concentrated by more frequent use but whose capacity to articulate their interests is much more limited. In this group, we might place the elderly and also the permanently institutionalised, such as the mentally handicapped. The irony is that there is an inverse relationship between the concentration of interests among consumers and their capacity to engage in political activity.

So there is an imbalance not only between consumer and producer groups, but also within the consumer group. Moreover, in the case of the consumer, imbalances in the political market are compounded by imbalances in the economic market. It is precisely those who are least able to engage in political voice – to use Hirschman's terminology[11] – who also cannot protest by means of exit; that is, by leaving the public health services to take refuge in the private sector.

If this analysis is accepted, it would suggest that we are in trouble if

our concern is with achieving a different balance in the provision of health services to favour the least well-provided sections of the population. We need not even invoke the power of the medical profession to explain the present emphasis on acute services, although without doubt the existing prestige structure of the medical profession serves to reinforce the present distribution of resources. Identifying those consumers who have the most powerful political resources also identifies those users of health services whose immediate concern is to get the best possible acute services. Note, for example, the wide coalition of support for the maintenance of maternity services in Britain in the 1970s, when the fall in the birthrate led the government to suggest that expenditure might be cut.[12]

This is not to suggest that narrow, immediate self-interest explains everything; but it is to suggest that arguing for greater public involvement, on the grounds that this will tilt the balance of power towards the least favoured, may be over-optimistic. Indeed, it could turn out to be counter-productive by reinforcing demands for higher standards (that is, more expensive provision) in the acute sector. If the administrator is going to be cast in the role of philosopher-king, challenging the priorities of the medical profession (as suggested in the J R Evans paper), he is going to find it extraordinarily difficult to organise a powerful enough coalition of support, particularly since his legitimacy in the role must inevitably be in doubt because of its underlying assumption – that the administrator can define the public good, a very paternalistic attitude indeed.

All this not to imply that the political market for health care is inevitably, and inescapably, in a state of stasis, frozen for all time. Indeed, as we all know, new actors have arrived on the policy stage: for example, the concern with industrial relations testifies to the importance of new producer groups challenging the traditional dominance of the medical profession. Again, the multiplication of client or disease specific consumer groups is another phenomenon of the past two decades or so. Both developments underline the fact that while greater public involvement may be an inevitable trend, in that no health service can isolate itself from its host society without risk of losing support, the result is to add to administrative complexity. There are both costs and benefits in this particular equation.

The growth of consumer groups also illustrates the fact that the political market can, itself, be manipulated. To a large degree, of course, this growth has been spontaneous and is what might be expected in societies which are becoming both richer and better educated, and where, therefore, an increasing proportion of the citizens have the resources required to participate in such activities.

But in Britain, at any rate, the growth has also been encouraged by deliberate government action in funding such groups. At first sight, it would seem perverse that governments (Conservative as well as Labour) have financed organisations whose aims often are to make life uncomfortable for ministers by pointing out, and campaigning against, shortcomings in the health service; by demanding more resources for the mentally ill and other deprived client groups. But if we assume that governments do indeed want to change the existing balance of services – their proclaimed intention – then it is not surprising that they are encouraging potential political allies in such an endeavour; that they are trying to create constituencies for change to challenge the existing entrenched constituencies for the *status quo*. Much the same strategy is evident in the creation of community health councils, the bodies which are supposed to represent the consumer interest in Britain's NHS. The composition of CHCs was deliberately biased in order to give a special voice to the representatives of certain deprived groups, such as the mentally ill and handicapped, who might well have been left out if members had been chosen on the basis of producing a microcosm of the community.

This analysis of the nature of the political market also indicates two further conclusions. First, it suggests that mobilising a coalition of support for preventive health policies is extraordinarily difficult; if users of existing health services are diffused interest groups, then the potential beneficiaries of such preventive health policies are more diffuse still. As against that, the producers of ill-health – such as tobacco manufacturers – are concentrated interests. Second, the analysis would suggest that invoking public involvement is a double-edged weapon from the point of view of the administrator. On the one hand, it does create pressures for change; it provides allies for the administrator who wants to challenge the existing order. On the other hand, this strategy creates problems, particularly at a time of resource constraints; for as new actors emerge onto the stage, new demands are generated. Thus it would seem safe to predict an intensification of conflict for health services everywhere as public involvement continues to grow while the growth rate of budgets continues to fall.

In theory, there would seem to be one way out of this dilemma. If public involvement grows, then so too may public commitment. In other words, health services may be able to generate more support by accepting more demands from the public. In turn, it could be argued, increased support will be reflected in increased resources. Certainly in the case of Britain's NHS, the 1950s and early 1960s were a period in which the service successfully insulated itself from public pressures but paid the price in terms of low growth rates, while subsequent years

have seen an opening up of the health care arena with an increase (until recently) in the growth rate. But to make this point raises questions about the nature of the incentives required to increase inputs of support and this is the subject of the next section.

Levels and modes of involvement

Suppose that there was only one, overriding objective of health policy: to achieve social equity in the distribution of resources. Such an aim was, indeed, implicit in the creation of Britain's NHS. Its architect, Aneurin Bevan, argued that 'we have got to achieve as nearly as possible a uniform standard of service for all'. Only with a *national* service could the state ensure that 'an equally good service is available everywhere'. The case against local government control was precisely that it would make the achievement of this aim impossible since 'there will tend to be a better service in the richer areas, a worse service in the poorer'.[13] Further, it can be argued that such considerations of equity require national decisions not only about the geographical distribution of resources as between different localities but also about the distribution of resources as between different client groups within each locality.

If this argument were to be accepted, there would be little or no scope for public involvement at any except the central level of government. Our sole interest would be in the machinery by which national governments are held accountable by national parliaments or assemblies.

In practice, of course, policy-making in the health care arena – as in every other – is difficult and problematic precisely because there is no one overriding objective of policy: rather, we are involved in a never-ending process of search and experiment, trying to discover the most acceptable trade-offs between competing aims. When it comes to examining the locus of decision-making in health care and specifically the relationship between centre and periphery (the theme of the paper by Nicholls) a variety of other objectives come into play. There are political objectives: to centralise the credit for positive achievements and to diffuse blame for shortcomings.[14] There are organisational objectives: to try to minimise the problems of overloading the central decision-making machinery. Finally, there may be the objective of promoting public involvement either as an intrinsically desirable goal or as an instrument for providing information and support for the organisation. So we have a situation in which different actors have different objectives.

Let us, therefore, now look at the arguments about the appropriate

central/periphery balance from the point of view of public involvement. Here the most useful starting point is perhaps to ask oneself: in what circumstances do my benefits as a citizen outweigh the costs of involvement? On the credit side, it is clear that I am most likely to want to involve myself in the decision-making process if the result is to bring me some direct and visible benefits. On the debit side, it is evident that my costs will be least if I do not have to engage in a long process of information collection, if I can use the information I already have by virtue of being a user of health services.

Both these points would seem to suggest that public involvement may be in an inverse relationship to the size of the unit of health care administration. The smaller the size of the unit, it would seem, the higher the chances of public involvement. This view would seem to be supported by empirical evidence. A variety of studies of political activity has suggested that there is more participation in small local government units. In turn, this would seem to suggest that if the overriding objective of policy is to maximise consumer involvement, it might be necessary to sacrifice other aims. If consumer involvement is indeed a function of small size, there might well be a conflict with the aim of designing units of health care administration in order to maximise efficiency and quality. Currently, for example, it is held that the best way of maximising both efficiency and quality is to concentrate acute medicine in large hospitals, where there can be an adequate concentration of both technical and professional resources; witness, for example, the centralisation of maternity services in Britain in specialised units, at the expense of scattered local units. But the larger the administrative units, the less direct and visible will be the benefits brought about by public involvement and the greater will be the costs of action.

Again, the objective of bringing about more public involvement would seem to be in conflict with the objective of achieving social equity on a national scale; for the whole point of public involvement at the local level may well be to defeat attempts to bring about national equity. Indeed it may be precisely the desire either to maintain existing resources (threatened by national resource distribution formulas), or to acquire extra resources (over and above the allocations under such a national formula), or to use resources in a way different from that laid down by central government policies, which provides the incentives for public involvement. There is, after all, no point in incurring the costs of involvement if there is not sufficient scope for local autonomy to demand the right to be different.

All this would seem to imply that considerations of public involvement are not a luxury – decorative icing on the organisational cake –

when it comes to designing the administrative structure and financial base of health services. A health service designed to maximise public involvement would look very different from one designed to maximise social equity or efficiency. It would mean accepting diversity of standards, and differentiation both in the quantity and allocation of resources at the local level. It would, equally, mean smaller units of administration than might be considered desirable for the delivery of the highest quality medical service in the most efficient way.

Again, there are implications for the financing of health services. If health care is financed out of central taxation, or insurance funds, then it is obviously difficult to allow much scope for local differentiation in the use of resources. Central governments being accountable for the use of national health care budgets inevitably have to develop explicit and defensible formulas for rationing resources and for controlling the use of the resources at the periphery. So if the aim of public policy is to promote public involvement, then logically finance should be decentralised. Local units of health care should be given their own revenue-raising powers. However, decentralising the ability to raise funds weakens, by definition, the ability of central government to control the total spent. The price of generating more public support (and a greater public willingness to pay more for health care because the relationship between money contributed and services provided will be more direct and visible at the local level) may thus be a cost-explosion. Contrast, for example, the experience of Britain and Sweden. The former is a highly centralised system, low on public involvement, but very successful in controlling total expenditure. The latter is a decentralised system, based on local government and thus higher on the scale of public involvement, whose claim on the national income is 50 per cent greater than that of Britain. This may be one reason why the British government today has resisted the full logic of its current emphasis on decentralising responsibility for health services to the periphery and transferring its revenue raising power either to local government or to directly elected health authorities.

A further difficulty in the way of decentralising both administrative and financial responsibility to the periphery should be noted, however. Whole-hearted public involvement cannot be automatically assumed if health care becomes a local responsibility. If such responsibility is handed over to specially elected health authorities, then there is the problem, already noted, that most of the people have only a contingent, episodic interest in health care issues. Turning out in elections for health care authorities may therefore be seen to impose costs without any immediate benefits. So it is not surprising to find that in New Zealand (see the paper by Hugh D Evans) Massive apathy seems to be

the norm in such elections. The alternative model of transferring responsibility to local authorities may lower the costs of political participation, but reduce the specificity of public involvement. In Britain, at any rate, voting patterns in local elections seem to be little influenced by particular policy issues but rather by national swings in the popularity of the central government.

Also, it cannot be assumed that transferring responsibility to the periphery, with the aim of encouraging public involvement, will necessarily bring about a different balance in the power between producers and consumers of services. For example, international literature on the role of the medical profession shows little evidence that the power of the profession is much affected by its institutional setting. The ability of the profession to safeguard its own autonomy and to assert its right to define needs seems to be much the same in the United States and Britain, different though the two systems are. Again, taking the case of local government in Britain, it does not seem to follow that the legitimacy bestowed on members by the fact of election necessarily enhances their willingness or ability to assert control over services; thus the police, a local government responsibility in Britain, have been just as successful in asserting their immunity from accountability as the medical profession.

All this is not to suggest, nihilistically, that nothing can be done to enhance public involvement. Certainly the costs and benefits approach adopted in this paper would suggest that there are at least some mechanisms available for making the private government of public health more open and accessible. For instance, it would seem possible to lower the costs of information to the public by providing some comprehensible indicators of performance (as distinct from ambiguous jumbles of statistics). Thus it might be possible to provide a comparative analysis of the services provided by different health authorities, so that their performance could be compared not in terms of administrative data but of what they actually deliver to specific populations. Again, it is possible to lower the costs of involvement by setting up a machinery for articulating and aggregating individual points of view, so that the costs of collective action are not born exclusively by those taking part; here Britain's community health councils would seem to provide a model.

Lastly, there is public involvement of a different kind, and at a different level, from that so far discussed. This is encapsulated in the notion of citizens as co-producers of public services.[15] The application to health services is self-evident, and underlines the importance of public involvement at the point of service delivery. This, of course, is very different from public involvement seen as a political process, the

main theme of this paper, and is therefore only noted here. However, it may be worth asking whether our existing health care systems actually offer the professional producers much in the way of an incentive to use patients as co-producers. Passive patients may not recover as quickly as active, involved patients, but they are much less troublesome in terms of organisational routines. So, again, we come back to our starting point: the political balance of power which determines the way in which the objectives of organisations are defined.

All this would suggest that, in considering public involvement, we are discussing trade-offs between various desirable but conflicting aims of policy. To promote more public involvement may produce some desired outcomes. But it will, inevitably, also impose costs – on administrators and others. If the private government of public health runs the risk of distorting policy in the interests of the service providers, widening the arena of debate and involvement runs the risk of increasing conflict and perhaps also expenditure. Balancing these considerations is, therefore, bound to be a never-ending process, in which different solutions will be adopted at different times in different countries. Policy-making is thus bound to be a process of experiment – where today's solution is likely to be tomorrow's problem.[16]

References

1 Simon, Sir John. *English sanitary institutions.* Second edition. London, John Murray, 1897.

2 Great Britain, Department of Health and Social Security. *Inequalities in health: report of a research working group.* (Chairman, Sir Douglas Black.) London, DHSS, 1980.

3 Lalonde, Marc. *A new perspective on the health of Canadians: a working document.* Ottawa, Government of Canada, 1974.

4 Morris, J N. *Are health services important to the people's health?* British Medical Journal, vol 280, no 6208. 19 January, 1980. pp 167–168.

5 Great Britain, Parliament, Central Policy Review Staff. *A joint framework for social policies: report.* London, H M Stationery Office, 1975.

6 Bradshaw, Jonathan. *The concept of social need.* New Society. 30 March, 1972. pp 640–643.

7 Nevitt, D A. *Demand and need.* In Heisler, H ed. *Foundations of social administration.* London, Macmillan, 1977.

8 Abel-Smith, Brian. *Value for money in health services: a comparative study.* London, Heinemann, 1976.

9 Marmor, Theodore R and Morone, James A. *Representing consumer interests: imbalanced markets, health planning, and the HSAs.* Milbank Memorial Fund Quarterly, vol 58, no 1. Winter, 1980. pp 125–165.
10 Klein, Rudolf and Lewis, Janet. *The politics of consumer representation: a study of community health councils.* London, Centre for Studies in Social Policy, 1976.
11 Klein, Rudolf. *Models of man and models of policy: reflections on 'Exit, voice, and loyalty' ten years later.* Milbank Memorial Fund Quarterly, vol 58, no 3. Summer, 1980. pp 416–429.
12 Great Britain, Department of Health and Social Security. *Priorities for health and personal social services in England: a consultative document.* London, H M Stationery Office, 1976.
13 *Memorandum by the Minister of Health to the Cabinet, 5 October 1945.* Public Records Office, CAB 129/3.
14 Klein, Rudolf. *The strategy behind the Jenkin non-strategy.* British Medical Journal, vol 282, no 6269. 28 March, 1981. pp 1089–1091.
15 Whitaker, Gordon P. *Coproduction: citizen participation in service delivery.* Public Administration Review, vol 40, no 3. May/June, 1980. pp 240–246.
16 Wildavsky, Aaron. *The art and craft of policy analysis.* London, Macmillan, 1980.

15

How to win friends and influence neighbours
by Peter R Carruthers

Introduction

The theme of this seminar is 'Working with People', and the topic assigned to me is entitled 'Individual and Community Involvement'. As a sub-topic, I have chosen to present a case study concerning '*the interplay with community activists and lobbying groups*'. I have related the subject to the redevelopment of a large, urban, teaching hospital. All the people and institutions are real and no identities are hidden. It is, therefore, not an academic or philosophical paper for the seminar, but a true case study of 'Working with People'.

Background

As background, I would like to describe the three principal players in the drama, the hospital, the neighbourhood, and the municipal and provincial government.

THE HOSPITAL: PHYSICALLY

The Ottawa Civic Hospital, founded in 1919, is a 950-bed teaching, research, and, primarily, tertiary care hospital, affiliated with the University of Ottawa Faculty of Health Sciences. It is owned by the city of Ottawa under a 1919 act of incorporation passed by the legislature of Ontario. The trustees are appointed to the board by the city council upon application from interested citizens. The city, however, provides no capital or operating funds for the hospital and has not done so for over twenty years since the advent of universal health insurance in the province of Ontario in 1959. In effect the hospital, operates as a private corporation.

The annual operating budget is about $80 million and with its 3000 employees it is the fourth or fifth largest general hospital in Canada, serving a referral population of about 1.5 million in eastern Ontario and western Quebec.

The hospital campus comprises 15 separate buildings, totalling approximately 1,300,000 square feet, on a 25 acre site in the western part of the city. When the hospital was opened in 1924, it was on the extreme western edge of the city; today it is in the centre of the capital, surrounded by an upper-middle class neighbourhood. It is a choice residential area.

Nearby lies the 4400 acre central experimental farm of the Department of Agriculture of the federal government. The setting is most attractive.

THE HOSPITAL: ORGANISATIONALLY

In mid-summer 1978, the then executive director retired after 24 years service and his successor was appointed. At the same time a municipal election resulted in the appointment to the board of trustees of a city controller and a city alderman, both of whom were very left-wing, anti-institution, and pro-community associations.

THE NEIGHBOURHOOD.

The surrounding neighbourhood of some 400 homes had, for several years, been organised as 'The Ottawa Civic Hospital Homeowners Association'. It was difficult to tell how many of the owners belonged to the association because the executive lived on streets immediately adjacent to the hospital and were the most vocal about the hospital's redevelopment plans. The association had been a very effective lobbying group for the past five to ten years and had on many occasions stymied the hospital's plans, particularly for a car park which was the linchpin of the whole redevelopment. The homeowners were mainly younger couples with small children, were well-educated, generally employed as members of the federal civil service, and had bought their homes within the last 10 years.

THE GOVERNMENT

In Ontario there are several tiers of government. To enable projects to proceed, the local municipality must approve them. If objections are raised to any project, even from private citizens, appeals may be made to defer, reconsider, or not approve them to the Ontario Municipal Board, a quasi-judicial body located in Toronto; appeals from an OMB decision may be made to the cabinet at the legislature in Toronto. In diagrammatic form, the organisation is:

Cabinet
↑
Ontario Municipal Board
↑
City of Ottawa
↑
Civic Hospital

This appeal procedure can be very cumbersome, costly and time-consuming, to the point where individual projects may take up to four years for approval to be granted. It had an overriding influence on the hospital's plans, primarily because of the cost implications on the construction budget, and available monies, if delays were incurred.

Principles in relating to community groups

It was against that background that the hospital wanted to proceed with a major redevelopment of its facilities.

Before proceeding, however, certain principles were agreed to in dealing with, and relating to, the neighbourhood and its association. These principles were as follows:

Credibility We must be credible, not hedge, and be straightforward in explaining our plans.
Concern We must be genuinely concerned about the impact on the neighbourhood of the size of institution, traffic flow, safety of children, and so on.
Communications We must open up the channels of communication, relate to our neighbours openly, and keep information flowing freely.
Continuity We must keep our presence and visibility continuously before the neighbours; it must not be a 'one-shot' effort.
Costs We must realise that our plans will have to be revised to meet neighbourhood concerns, particularly on traffic, and that this will cost us money, including funds necessary to improve landscaping, the appearance of buildings, and so on.

These five Cs became our principles and I think can be well utilised by other organisations in dealing with community activists or lobbyists.

The redevelopment itself

OVERVIEW

But what were we trying to achieve in the redevelopment? We were basically endeavouring to bring the old 1924 buildings up to 1984 standards, as well as build four brand-new buildings on the site. A financial summary of these plans is as follows:

New	
Patient service wing	$24,000,000
Cardiac unit	5,200,000
Car park	2,500,000
Education centre	1,000,000
Renovation	
Old main building	8,000,000
Nurses residence for ambulatory care	1,350,000
Intensive care unit	1,135,000
School of nursing for research building	1,000,000
	$44,185,000

PROBLEMS

There were a number of problems but the most important was parking and neighbourhood traffic, and the conversion of an existing car park at the rear of the hospital to a community park, including grass, trees, and flowers.

Another problem was the 'floor space index' (FSI) for the institution, which is the ratio of floor space in square feet to the available land, in square feet, upon which the hospital is located. The FSI can be used, in fact, as a 'limit to growth' for the institution. The FSI is determined by the council of the city of Ottawa.

A third set of problems related to:

Our worries about the effect of inflation on our budget for construction.

The timing of the project because of winter weather conditions in Ottawa.

Possible OMB hearings and delays arising therefrom.

The public relations image of the hospital related to a public campaign to raise $8,225,000 which began shortly after the plans for redevelopment were announced.

STRATEGY

Our strategy, bearing in mind our five principles described earlier, included these items.

Neighbourhood meetings, particularly with the executive in their homes, to reassure them of our intentions and about our plans. Several

major meetings with 200 or more neighbours were held in our school of nursing auditorium to communicate and advise. At the start, these meetings were stormy, at the end they were positive and helpful; the attitudes were very much more conciliatory.

We retained a new hospital architect, Eberhard H Zeidler, from Toronto. He had designed Ontario Place and the new Eaton Centre and other major teaching hospitals at McMaster University in Hamilton, Ontario, the St John Regional Medical Centre, St John, New Brunswick, and the University Health Sciences Centre, in Edmonton, Alberta. He had a proven record of accomplishment in relating to, and defusing, community activist groups. Mr Zeidler was excellent in several meetings with the Homeowners executive.

We brought the elected officials, including the mayor, and several staff officials from the City of Ottawa Planning Department to the hospital for an afternoon, took them through the worst facilities due for renovation and thoroughly explained our complete programme. They originally agreed to give us one hour on a Friday afternoon; in fact they stayed for the whole afternoon. We felt we had to get these politicians and planners out of their offices and into the hospital in order to explain our plans to them adequately and vividly. One site visit proved enormously successful. The building permits came soon after.

We utilised our audiovisual department to prepare a series of slide presentations which outlined our plans very graphically. We showed them to our employees (3000), volunteers (850), medical staff (450), local health planning council (25), as well as to the Homeowners Association meetings.

The executive director became very visible with the neighbours, approachable and open, and utilised well the five principles which were thought to be critically important.

We arranged tours of the hospital for the neighbours, answered questions, explained timetables, discussed new traffic patterns, and agreed new entrances and exits to the grounds to keep traffic off surrounding streets.

Newsletters, some of which related to the progress of the campaign as well as to the redevelopment itself, were circulated to the neighbours to keep them up-to-date with our plans.

We agreed to spend $500,000 to renovate the internal road system on the campus, particularly relating it to the new car park and to community traffic patterns. We felt this was not only an investment in roadways, entrances, and exits, but in the means to enable the $44 million project to proceed without lengthy OMB hearings possibly followed by an adverse judgement.

We agreed to re-landscape the campus, and provide banks in areas close to neighbour's homes which were immediately adjacent to the hospital in order to hide the buildings from view as much as possible. This landscaping cost about $100,000.

Finally, we agreed to trade-off a 425 car parking lot at the rear of the hospital to the community association for conversion into a park, providing the city approved the construction of a new 610 multi-storey car park.

THE RESULTS

The results were outstanding:

The redevelopment was approved by the city, with the approval of the neighbours, and, at the time of writing, is about 50 per cent constructed, on time, and under budget.

The regional municipality of Ottawa-Carleton gave us an $8 million grant towards the $44 million cost.

The public campaign for $8,225,000 went over the top and reached $8,350,000 from more than 27,000 individual donors and vividly illustrated to the neighbours the goodwill, interest, and support of the entire community for the first class health care institution which is available to them.

The new roadways, exits and entrances were built, the car park was constructed and opened on 22 October 1981.

The neighbours dropped their interest in the closing of certain streets.

The city controller did not run for re-election, and the local ward alderman was defeated in the municipal election held in November 1980. Their replacements are more receptive to hospital concerns, yet balancing neighbourhood interests at the same time. It was this 'balance' of concern which had been lacking in the past.

Finally, no OMB hearings were required, thereby saving enormous amounts of time and money.

Summary

This was a classic case of dealing with a community activist group, seen as the 'small people' against the 'big interests' of a large hospital.

With widespread help, however, the hospital was able to turn the situation around and by using the five principles of

credibility	continuity
concern	costs
communication	

defused the problem. At the same time, the stage was set for future changes on the hospital site and a better relationship with the neighbours, to the mutual benefit of everyone concerned.

16

How can communication between the institution and the broader public be promoted?

by Sister Irene Kraus

Although this case study begins in 1966, the road to a solution taken by the institution has not yet reached its end. The hospital-community philosophy adopted by the Lutheran Medical Center (LMC) continues to guide its further development as a community health care institution and resource. The purpose of this study is to describe the philosophy of the hospital, how it came about and its ramifications, and to give a broad view of the types of activities undertaken to carry it out. The real names of the hospital and the groups involved have been used.

Setting

In 1966, Lutheran Medical Center (LMC) was a voluntary, not-for-profit, church-related hospital with approximately 300 acute care beds. The hospital served a population of approximately 300,000 people and was located in Brooklyn, New York. When first founded in 1883, the medical center's mission was to care for the Norwegians living in the area and it was supported largely by the Norwegian community it served. The economy of the area was in great part dependent on its waterfront industry.

By the 1950s and 1960s, however, much of this industry had disappeared, and the Norwegian community gradually dispersed in order to find new employment. By 1966, the hospital found itself in the middle of a rapidly deteriorating neighbourhood, serving a very different type of population. The immediate community surrounding the hospital, Sunset Park, was 85 per cent Spanish-speaking Puerto Rican, 10 per cent white, five per cent black, and largely poor. In addition to the cultural divisions the residents of the area might feel, the community had other significant social problems. The buildings they lived in were old, poorly maintained, and lacked modern facilities. The children had no place to play and therefore competed with uncontrolled traffic for the streets. The remaining industry was moving out. All in all, most observers saw it as an area with little future. In the words of the LMC chief executive officer; 'It doesn't feel "healthy" to live there.'

People/groups

The people and groups who play a role in this case study are too numerous for them all to be named. Those who must be mentioned are a new chairman of the hospital board of trustees; a new chief executive officer brought in in 1966; several medical staff leaders who support the holistic approach to health care; numerous community-based groups; and government at all levels.

Situation

The hospital had to determine its appropriate role in relation to its 'new' community, or whether it had any role at all. Several factors made this determination crucial.

First, the surrounding poverty was presenting the hospital with increasing financial problems. The patients it treated were less likely to have private insurance or the money to pay for their care, and public insurance could not reimburse the hospital fully for the services it provided. At the same time, the hospital's traditional source of philanthropic and community support – the Scandinavian-Lutheran community – was disappearing as the neighbourhood changed.

Second, the physical plant of the hospital was becoming obsolete, and a decision on rebuilding would have to be made in the next few years. Where to rebuild or whether to rebuild would depend on what was determined about the hospital's role in the community.

Third, the hospital was no longer a part of the community. The residents of the neighbourhood had not been part of its growth and expansion and, in fact, probably felt some alienation towards it. Also, the hospital was having difficulty attracting new health care professionals to work in what was increasingly being viewed as a 'blighted area'.

The hospital had to decide whether to remain in the deteriorating community and, if it did remain, how it could survive financially as a high quality health care institution.

Options

A hospital in this situation generally has three basic options: to continue as an acute care facility serving the same community, to leave the community, or to become something other than a typical hospital.

The primary advantage of remaining an acute care institution serving the same community is that the hospital would be staying in an area where the need is greatest. The hospital would hope gradually to

increase its support base in the community by continuing to provide the health care services the neighbourhood needs. It would be there to help treat people for the inevitable consequences of living in an 'unhealthy' area. The disadvantages would be continuing financial and staffing problems that could lead to bankruptcy if no additional assistance was made available.

The advantage of leaving the community would be a more stable hospital. A surburb would provide a more affluent, supportive community. Payment for services would be more assured and the location would provide a better working environment for physicians and staff. The basic viability of the hospital would be restored. The primary disadvantage is that the hospital would be abandoning the neighbourhood where the need was greatest for an area with relatively little need.

Deciding to become something other than a typical health care facility needs a re-assessment of the purpose of the hospital in the community in order to determine its role in the overall health and well-being of the people who live there. The main advantage to this approach – if the hospital were successful – would be stability for the hospital and for the community. The problems are potentially numerous. First, there are few models to follow in making these changes and the hospital would have to take many risks. Second, the hospital might face resistance from the community and its own staff. Third, if the hospital were unsuccessful, it could be faced with an even worse economic situation.

Preferred solution

In looking at the hospital's role as a major health care provider, employer, purchaser, technical resource, and educator, the leadership decided that the third option, despite its risks, was preferable. To develop its course of action, the hospital considered several broad questions:

What is a community service institution?
What is health?
What is a hospital?
What is community relations?

The way they were answered has guided the development of Lutheran Medical Center and the formulation of its operational philosophy since that time.

In defining the hospital as a community service institution the LMC said the hospital's function must be 'to serve its neighbours' and its

goals must be completely integrated with the goals of the neighbourhood. Health was defined as something more than a lack of illness or disability; it also includes housing, food, job opportunities, traffic safety, and the feelings and attitudes of people. The board said a hospital was more than a physical structure with technology inside. They decided it was a 'meeting place for health talent and energy', and that a hospital is wherever people are. They defined community relations as a partnership or a 'mutually supportive relationship between people and the institutions that serve them . . . friendship and trust between the community and institutional leaders.'

With these terms defined, the role of the hospital in the community became clearer. The hospital decided its role was to remain in Sunset Park and to help the community become 'healthy' by becoming a force for redevelopment and restoration.

Actual solution

The initial steps in embarking on this non-traditional hospital role were to upgrade the medical facilities and equipment of the hospital and regain financial stability. The medical center transformed its emergency services into an unscheduled general practice office staffed by licensed physicians paid by the hospital. This compensated for the lack of physicians practising in the area. The hospital then opened a federally-supported family health centre, providing comprehensive ambulatory care. Since its founding in 1967, LMC's family health centre has become one of the leading neighbourhood health centres in the nation and houses a training programme for directors of federally funded health centres. It is also the site of a demonstration project on the delivery of home care to the near poor and elderly. In addition to its typical health services, the family health centre provides dental services and an educational opportunities programme which offers the equivalent of high school classes and classes in English as a second language. The educational programme is assisted by the New York City Board of Education and is seen as contributing to the overall health and well-being of residents in the community.

In keeping with its emphasis on health in the broadest sense, LMC established a department of family practice in 1968 to increase the involvement of local family physicians in the hospital. By 1970, the Center had the first American Medical Association-approved family practice residency programme in New York State. It also created an intensive care unit in what had been previously the worst area of the hospital.

By 1969, it became apparent that the demands and needs of the

community for services from the hospital were extending beyond the capabilities of the old plant. In what has been considered a daring move, the hospital chose to relocate in the very worst section of the community in an effort to stabilise and 'bring back' the area and made the extraordinary decision to convert an abandoned structure rather than tear it down and rebuild. The choice of an abandoned factory not only saved money but demonstrated that the elements that contribute to blight can be used to strengthen the community. As the LMC administrator explained: 'We believe decay has momentum of its own – we also believe improvement has a momentum of its own. We are trying to turn around the tide of events in our community.' The new Lutheran Medical Center opened in 1977 with 530 acute care beds, a mental health centre, a family physician service and the family health centre. The site of the old hospital was given to a not-for-profit housing group which turned it into a senior citizen apartment complex. In this way, the old location continued to serve the community. The hospital has also sponsored another senior citizen apartment complex on the site originally intended for the new hospital.

While the new facility was being renovated, the hospital was building a partnership with the community. The medical centre helped the community form the Sunset Park Redevelopment Committee which concentrated on rehabilitating housing for community residents. The committee has renovated many two and three family homes in the worst part of the neighbourhood and is also working to rehabilitate apartments with a federal subsidy.

The hospital has lent skilled people to community organisations to assist in the development of a child day-care centre, a Head-Start educational programme for pre-schoolers, and a half-way house for abused women. A department of comprehensive health planning has been established to look at housing, unemployment, traffic patterns and safety, because all are recognised as issues affecting health. The findings of this department have played a crucial part in urban planning for the area. In addition, the hospital is involved in programmes to make legal services available in the community, to teach consumer education and nutrition, and to provide youth recreation and senior citizen programming.

The hospital is making itself a technical resource for the community, helping community groups with their projects by lending research and grant-writing expertise. It is taking an active role in alleviating high unemployment in the area by creating necessary posts, such as aides and interpreters, and training community residents to fill them.

These are some of the major programmes undertaken by the hospital in its role as a community resource. However, the real test is

not the success of individual projects, but whether the hospital has been instrumental in improving the neighbourhood. So far, the signs have been very encouraging. The area has been designated to receive approximately $10 million of community development funds and industry is returning to the waterfront near the hospital. The hospital's motto is 'plant a seed – grow a garden', and, as the community sees it, the seed planted by the hospital is helping the urban neighbourhood to bloom. A Sunset Committee is actively working to attract new homeowners and to get part of the area designated as an historic district. The city has made funds available for a plan for urban renewal around the hospital site.

Becoming a community service institution has taken the Lutheran Medical Center beyond the normal boundaries of traditional hospital services. The medical centre has concentrated on alleviating housing problems in the community rather than attempting to do organ transplants. The hospital's commitment to quality health care services is matched by its commitment to a healthy environment for the community. According to the LMC administrator, 'Whatever is needed, the hospital is rich in resources. All we do is recognise our responsibility and keep ourselves open to the opportunities to act on it. And there is a return – the aggressive support of our neighbours and their elected representatives.'

17

A community case study in New Zealand
by Hugh D Evans

Introduction

Ways in which people and communities can be involved in health services need to be built around the reasons why the community should be involved.

People need to be part of the health team, either through accepting responsibility for preserving their own health; or as patients taking an active part in the treatment process; or because they care for those who need help.

When political decisions on health policies are made, members of the community must be able to influence the way they are made. Influence can be exerted through the election of political representatives, but there must also be opportunity for people to make their views known on a day-to-day basis. This means that there must be adequate complaints procedures. It may also be possible for people to influence decisions by, for instance, providing information for use in the planning and evaluation of programmes.

To a degree, people create their own demands for involvement in both service provision and policy development. They do this in various ways, most prominently through interest groups. The typical administrative response to interest group pressure in New Zealand is to find ways of involving these groups in the health services system.

There is also a general demand for a more open approach to decision-making in the public services. This has proved difficult to meet in practical terms and experience in New Zealand suggests that it can only be achieved if people can be involved in an authentic way in making decisions about services within their own communities. The provision of formal advisory councils with little or no real authority to ensure implementation of proposals has been tried in local government and found to be unsatisfactory.

However expressed, participation confers both problems and benefits on the administrator. It increases complexity and may reduce his freedom of action, but, on the other hand, it can bring greater support in implementing policies and making services more effective.

The problem of scale

Although health services in New Zealand are now larger and better staffed than at any other time, they are, for many communities, less

readily accessible than they were in the 1920s, when there were 47 hospital boards serving a population of approximately one million. In 1950, there were 37 boards and a population of 1.8 million, with a typical board (Hawke's Bay) having a catchment area of about 60,000. Today, there are 29 boards for a population of 3.2 million. A typical board in 1980 (Northland) has a population of over 100,000. On average, there is one elected board representative for every 10,000 people.

The trend towards larger, better equipped hospital boards serving larger populations has meant that hospital services are no longer a readily accessible part of the community life and a focus for fund-raising and social activities. Board elections now arouse far less interest than in earlier years and today only about 50 per cent of seats are contested and some 35 per cent of those qualified to vote do so.

There has been a similar trend in general practitioner services, with the result that rural and suburban populations often experience considerable difficulties of access to primary care. The preventive services, on the other hand, have been increased at the community level but these services are only a small part of the whole.

Communities and health workers have attempted to improve participation in services in a number of ways. These have met with varying degrees of success, but are not sufficiently similar for a definitive answer to be given to the question of how individuals and communities can be involved in services. What experience in New Zealand does suggest is that approaches are more likely to succeed if they are structured around an existing organisation or group in the community. This ensures that community involvement is related to authentic matters of concern. If there is no focus for community expression, it may be necessary to create it.

In addition to specific exercises in community involvement, it is desirable that information be made available to people on a continuing basis and that they are able to comment on it if they wish.

Hospital management committees and community health committees

In an attempt to retain local community influence on hospital based services after six Northland boards were amalgamated in 1950, five hospital management committees were set up. These committees comprise five to seven members, including the Northland Hospital Board representative for the area and members appointed by local borough or county councils.

The committees are given the responsibility for the general manage-

ment and supervision of institutions and, in particular, have the power to:

Inquire into complaints.
Appoint and dismiss domestic and maintenance staff not directly employed in the care of patients.
Suspend employees for misconduct.

In exercising its powers, each management committee must act in accordance with hospital board policy and regulations.

As an exercise in community involvement, hospital management committees are somewhat limited. All members except one are appointed rather than elected and their direct authority is limited to oversight of maintenance work. They do, however, inquire into complaints and serve a useful purpose in this respect.

Proposals have been made to increase the effectiveness of hospital management committees by reconstituting them as community health committees. A working group set up to examine methods of achieving a greater degree of community involvement in the Northland area has stated that 'a good community feeling leads to a good personal feeling, which, in turn, is a step towards better than average health'.*

The working group suggested the following terms of reference for community health committees.

To promote the health of the community.
To encourage and facilitate health education activities in the district.
To encourage the formation of community groups and to guide and assist them in their activities.
To provide a forum for the various community groups working in the health field.
To provide information to the people on health services available in the community, district and Northland.
To stimulate appropriate community activity towards meeting the health needs of the community.
To provide information to the health board and service development groups on the needs of the community.
To receive advice from the health board on policy matters and particularly any changes affecting the community and to make representations on any such matters.

* Paper presented to Northland Health Services Advisory Committee by Communications Sub-Committee, 14 May 1980.

To provide advice regarding complaints and to forward them to the health board, as and where necessary.*

It is proposed that seven community health committees be established for a population of 107,000. Committees would be composed of elected members, representatives of community groups, members of voluntary organisations, coopted members, and members of the area health board. All except health board representatives would be elected or appointed for a two-year term. The health board representative would serve for the term of his membership of the board (three years).

Community health committees would be required to hold at least one public meeting each year. They would report on activities and progress, invite suggestions regarding services, discuss plans and elect members.

In the Northland context, it is likely that community health committees will be effective. They are not highly innovative and will act as a focus for activities currently associated with the hospital management and committees, voluntary and community groups. They will have the support of area health board services.

Community involvement through voluntary and interest groups

A large number of community, voluntary and service groups have become established as part of the health system in New Zealand. They represent expressions of community needs and, in cases such as the Plunket Society, which is concerned with the health of mothers and children, and the New Zealand Federation of Family Planning Associations, the groups are paid by government to provide a substantial proportion of services in their fields.

Other groups have been set up to support patients and health professionals in the caring and recovery process. These include the New Zealand Asthma Society, the Society for the Intellectually Handicapped, the Multiple Sclerosis Society, and a number of groups associated with the rehabilitation of psychiatric patients and alcoholics.

There are a large number of bodies with an interest in educating and instructing the public. These include the Cancer Society, the New Zealand Heart Foundation (in addition to its functions of promoting research) and the St John Ambulance Association.

An increasing number of community interest groups have been established with a concern for local rather than national issues. These

* Ibid.

are typically confined to readily identifiable urban areas with chronic problems, such as accessibility to health and other public services. They frequently serve the function of being both a political pressure group and a provider of supportive services to those with health problems.

All these groups provide some health services, they often allow those with health problems to be actively involved in the provision of services, and they are frequently a source of information on need and programme effectiveness. They are being encouraged through funding, through involvement in the policy-making process at central and district levels, and by being given access to staff and other resources.

In New Zealand, a number of voluntary and community groups have been able to obtain funds from a community health care tax on alcohol and tobacco. An example of such an approach is seen in the Diabetes Centre in Christchurch, a joint project supported by the Diabetes Society and community health care funding administered through the North Canterbury Hospital Board.

The Diabetes Centre provides an example of how an identifiable condition can be controlled by the sufferer through the effective coordination of all elements of the health care system – voluntary, public, private, users and providers. The centre also provides additional services in the field of general health education within a community setting.

The specific object of the centre is to help diabetics become, as far as possible, their own doctors and live with their health problem. It supports diabetic groups; acts as a link between existing diabetic and health care organisations; provides information for any individual or group (such as families or doctors and their patients) who want to find out more about the problem and supporting services; and helps establish new groups.

The centre is an effective part of the health services in the North Canterbury area, and is supported by funds and staff provided from the hospital board and other services.

Creating a base for community involvement

In some areas, there may be insufficient cohesion among existing organisations or interest groups for them to become a basis for community participation in the health services. In such cases, it may be necessary for a basis to be created, particularly in circumstances where there is no focus for the expression of community opinion on health matters. It is administratively easier and of greater benefit to the community if needs are expressed with one rather than many voices.

An example of such an approach in New Zealand has been the Porirua Community Health Project.

Porirua is a recently developed housing and light industrial area some 20 kilometres north of Wellington. It has grown from a population of 5763 to over 20,000 in a period of twenty years. Public services in the area have generally not kept pace with housing development and there was, for a time, particular criticism of the lack of health services. Following political decisions which resulted in the establishment of a health centre to provide a range of primary care services and an expansion of some hospital-based facilities, the Department of Health decided to set up a project with the following tasks: the formation of groups of neighbourhood health workers; the provision of free transport to medical and educational facilities; the provision of the means whereby the many communities in Porirua could voice their views on community health matters.

A description of the project will be found on page 160. In outline, it commenced with the setting up of a steering committee representing local groups and a survey of local services and problems. A large number of people from a variety of cultural backgrounds were involved in collecting information and developing proposals for improving services. Courses were organised for voluntary helpers and a wide variety of problems were tackled in a practical way. These included transport to and from services, waste disposal, drainage and various self-help schemes for those with specific problems, including asthma, child care, nutrition and rehabilitation.

In time, the project became established as a community resource with its own house, transport and core of volunteers. It ceased to be directly supported by the Department of Health and hospital board and is now almost entirely funded and run from within the community itself. Projects like this are neither tidy nor predictable. They must be allowed to develop at their own pace and move in directions determined by the community and by the interplay of personalities. They often arouse controversy and their continuance is fragile. Nevertheless this project has exercised an effective influence on the provision of health, housing and other community services.

Provision of information

A less structured approach to community involvement has been to inform people of developments taking place and to request a response by individuals or through interest groups. For instance, consultative documents have been released on such matters as health services reorganisation and regional planning schemes. These documents can

serve as a basis for discussion and objection.

Public meetings are frequently held around issues such as the closing of small maternity hospitals. The proposed reorganisation of health services in Northland (with a population of over 100,000) has been discussed in a series of public meetings which have been attended by over 2000 people. These meetings have been followed up with smaller discussion groups organised by branches of political parties, churches, Country Women's Institutes, and health-related voluntary organisations.

Information can also be passed to consumers through the media. In a local government context (the Wellington Capital Plan), a coordinated programme of presentations in local newspapers, radio, TV and pamphlets has been used to inform people of plans for services and invite a response.

Other ways in which people can be kept informed include permitting public attendance at hospital board meetings and using such facilities as community advice bureaux as a means of providing information on a more personal basis.

Responding to information

If information is provided, there must also be the opportunity for people to react to it. The most effective means of response is through membership of an interest group or partnership in a treatment/caring team. The administrator has to find ways in which such groups can be incorporated within the system. His approach will depend largely on the circumstances in which the need for community involvement arises and the nature of the community itself.

This paper has described three ways of involving people in their own care and in the provision of services: the development of suitable bodies that already exist (community health committees), encouragement of community interest groups (with funds designated for the purpose, if necessary), and the creation of a focus for community interest and activity (the Porirua Community Health Project).

There is, however, no ideal model for involving people in the administration of health services. The administrator must structure his approach according to the needs of the situation. In some circumstances, such as that described below, administrators must accept broad objectives and rely on the ability of a community to work with them in developing constructive solutions to problems.

The Porirua Community Health Project

Adapted and abridged from: *Community Attitudes to Sickness and Health: Stimulus and Response*, by J Reinken, A de Lacey and C E Salmond, Department of Health Special Report Series, 56 (Volume 3). Issued by the Management Services and Research Unit, Department of Health, Wellington New Zealand, 1980.

How it began

The Porirua Community Health Project is one in a long series of efforts made by Porirua people to improve their community. It sprang from a number of initiatives.

In 1975 a serious doctor shortage was alleviated by the provision of a health centre in Waitangirua, housing four doctors. One of these doctors was seeking evaluation of the centre's effectiveness.

Considerable public concern remained over the health services in general and a health action group was still working for improvements.

An epidemiologist at Wellington Public Hospital had been working for some years with small Pacific Island groups in Porirua and elsewhere, and had found reason to worry about aspects of their health.

From outside the city came further impetus. The publication of *Maternal and Infant Care in Wellington* had provoked considerable controversy and had aroused concern among officers about the people in Porirua.

These and other concerns found expression when a meeting was called in 1975 by the Porirua City Council to discuss the city's health problems. There was an enthusiastic response and a steering committee was formed comprising civic and government representatives, health professionals and members of community action groups.

The project's aims

The steering committee was charged with the following functions:

Supervising a community health survey in association with official bodies.
Supervising the collection of background information about health services in the city.
Identifying problems with current services and discussing possible solutions.
Providing liaison with various community groups and a focus for health discussions in the community.

The Department of Health's Management Services and Research Unit (MSRU) made available one of its officers to service the committee. This officer was aware of the danger of imposing ideas on the community from 'on top' or 'outside' and tried to avoid making decisions for people about what they needed or how to satisfy their needs. The project saw itself as a facilitative group and a communication channel between the community and institutions or systems.

Early project work

The Project's first year, 1976, was a time for the committee members to learn about each other and to work through ideas and directions for the Project.

An early decision was to use 'health' in the broadest possible sense because there could be no boundaries between health and social well-being. Before long there was agreement on the Project's basic credo – to help people define their own health needs and assist towards filling them.

Several activities were undertaken. First, the steering committee had asked the Department of Health to undertake a survey. This was not to be an epidemiological or other traditional study of the kind that the city had learned to become cynical about, but a survey asking people what they thought about their health and their health services. Interviewing took place during July and August 1976.

It was decided that a 'popular report' – a short lay summary of the results of the survey – would be produced, sent to each of the households in the sample, and made available widely in the city. *Health in Porirua** was accordingly published and distributed.

Secondly, the Project produced a health directory surprising many people with the number of services available. Community support for the directory was encouraging – a local firm, the local newspaper and the city council shared the costs.

Thirdly, the Project put together a booklet of background information on health in Porirua. Originally intended only as a resource for steering committee members speaking with groups, *A Question of Health* was soon also used by health professionals, school teachers and others.

A photographic display for use in meetings, exhibitions and schools was the fourth production. Seven freestanding panels highlighted 'seven ages in the family' each with its own particular health hazards.

Many people were interested in the Project but not able to attend meetings. To keep them in touch, their names were added to the list of those receiving

* *Health in Porirua* produced by the Porirua Community Health Project with the Department of Health, 1979. Available from the Management Services and Research Unit, Department of Health, P O Box 5013, Wellington.

the minutes of Project meetings. These minutes were written fully and informally and used as a newsletter. This proved important in holding the Project together while the production of the booklet and display were underway and while the project's principles and methods were being clarified.

It was decided that a Project member was just about anyone who lived or worked in Porirua, and wanted to come to meetings. The Project and its meetings were deliberately kept informal so that people would participate freely.

Towards the end of the first year, the Project decided to raise funds to pay someone to live in Porirua and work with groups; they decided upon a community volunteer.* The city council gave the Project $1500 and guaranteed the remainder of the $4500 set as a target. The Wellington Hospital Board, the Todd Foundation and a local firm, AWA Ltd, all contributed.

How the project worked

The first year had been primarily a time of searching for common ideas and methods. The second year began with activity in the community.

The Project has been extremely fortunate in its choice of workers, paid and voluntary. The first community volunteer, appointed at the beginning of 1977, was a medical student taking a year away from her studies. She worked mostly in Porirua East. Before long a local resident of Titahi Bay, who had been a survey interviewer, was appointed as a second volunteer. In 1978 a third community volunteer was contracted to work in the northern suburbs. There was a time overlap between the first and second, and second and third volunteers.

These and other workers managed to combine the necessary qualities for community work – patience, knowledge of the community, a low key approach, a sense of humour, endurance and drive.

Some Project members had already suggested small group discussions as the obvious way for the new organisation to move out into the community at large. The steering committee had learned something about group process while producing the booklet and the directory and display; small group discussions about health, therefore, seemed the logical choice.

The Project began with existing groups but planned to see if groups would evolve around health issues alone.

The groups contacted were chosen rather arbitrarily, although a balance of age, sex, race and geographical location was aimed for. The response was

* Community Volunteers Inc is a national organisation of temporary workers. Paid a living allowance rather than a wage, the Volunteers go into a community for a specified time, in a particular area of community work, to help people to learn to help themselves.

enthusiastic; the groups named a wide range of health needs, and asked for very different kinds of help.

Where doctors and nurses might have thought of the main health problems in Porirua as scabies, and chest and ear conditions, the groups found their most pressing health problems were transport, child care and isolation.

Some of the discussion groups met only once or twice with Project people, received some information or assistance but asked for nothing further. Others became increasingly involved with the Project.

An early group

In some cases their needs were very obvious to the people in the group – for example, one group of women said their health problem was lack of sleep because they worked as night cleaners in Wellington and had pre-schoolers at home during the day. Their need was day care, at least a couple of times a week, so that they could get some rest. This group failed; the initial enthusiasm faded, partly because the women were constantly tired. But another reason was uncertainty about committing their children, in advance, to care which was unknown to them. Besides, their group experience was limited and their goal was very ambitious; the many government regulations for day care facilities added to their difficulties.

From calorie counting to meeting the system

A more successful outcome was achieved by some other groups. One of the Project's mainstays has been the Maori Women's Welfare League. The League's representative suffered through the early days of seemingly endless committees, but went on to encourage the women in her group to join in health discussions. This was the Project's first 'success'. Health problems that this group identified included obesity and nutrition. They asked for help with these, and the Project arranged for a dietician and physiotherapist to meet them regularly at their own meeting place. This 'calorie counting group' went on to other activities – they made contact with the Wellington Hospital Board to try to speed the opening (and influence the priorities) of outpatient clinics at Kenepuru Hospital; they tried to raise board members' awareness of transport and allied problems between Porirua and Wellington and inside the sprawling city itself. Success is difficult to pinpoint but Project members valued the cooperation given by the board, and felt some satisfaction at the number and order of outpatient clinics functioning a year later.

More than one group identified its needs after question and answer periods with a doctor or nurse. For example, a group of Cook Island women talked about differences of diet and living habits among their people on coming to New Zealand, and decided that being overweight was a health problem to

them also. They too asked for visits from a dietician and a physiotherapist and these were arranged. They soon felt free to raise worries about breast cancer, and the Project was again able to help by arranging with the senior public health nurse to show a demonstration film and teach self-examination.

Some groups asked for support in such basic activities as writing letters to officialdom; while others tackled complex tasks like trying to establish contact between members of two groups (some elderly people and some young mothers) who had both decided that isolation was the health issue they were most concerned about. Friendship, however, cannot be manufactured, and most of the older people were ambivalent – while suffering from insufficient contact with people, they were still jealous of their privacy. A year later a few people from each group had progressed from stopping to speak on the street, to regular friendly visiting, and this was felt to be a real achievement.

Community health workers

When Project members first discussed the city's health needs in general, they saw the concentration of young families, and the state housing patterns, as separating young parents from the support of more experienced older relatives and friends.

The Maori Women's Welfare League members were already working in the community at large. Some of the women wanted to learn, or to share, aspects of physical or mental health. With other Project members, they drew up a 'curriculum' and helped arrange courses, with doctors, nurses and other sympathetic health professionals.

In hindsight, the wisdom of naming them community health workers has been questioned. Does putting a name to a natural community function alienate it from its context? Would it be better just to have 'Mrs X down the road, who is good at helping with marriage problems, or with sick children'?

Community health worker courses

The first course was arranged, like those that followed, in accordance with the people's own stated wishes. This first course was not planned in advance: as topics arose, a resource person was found to help. Some helpers thought the later courses less satisfying, as their pattern became more settled. Most of the first group, which finished its course at the end of 1977, were from the three local Maori Women's Welfare League branches. People in the second course had heard by word of mouth of the first course and wanted to complete one themselves. By 1979 it was decided to advertise in the local paper, so as to spread the involvement more widely.

The fourth course was based at a school near to the Project's unit and not in

the unit as before. Those taking part were asked to consider a commitment to the school when they had finished the course: they could help in the sickroom, assist in discussions on hygiene and other health-related matters. The Project was helping people to familiarise themselves with the educational system and to work comfortably within it. Other courses followed.

Exploring areas of work

Then came the question – how could the community health workers best use this new knowledge? Some community health workers have gone on to play an active and wide-ranging part in the Project's work; others have taken their experiences back to their families and neighbours.

Working in schools was only one of the possibilities seen as fruitful for community health workers. As in other Project activities, there was ongoing review of just what they wanted to do, the amount of commitment they wanted to make, the content and style of the courses and the question of payment. Long term, it was hoped that some community health workers might work with groups in the way community volunteers did early in the Project's life.

Possible ways for community health workers to work with health professionals were also discussed from time to time – within the Project and with public health nurses. The proximity of the three nursing agencies in the same area as the Project, began to be used to foster informal contact. Only by building personal contact could community health workers and the nurses find ways to work together.

Not only out in the community, but also within institutions, Project workers saw a value in the community health workers as intermediaries between health professionals and 'the public'. By 1979 some community health workers were spending time at the out-patient clinic's waiting room at Kenepuru Hospital. Serving tea and coffee, chatting to patients who might be worried or bored, they eased the way in that setting, and also found that the contacts made there led to opportunities to help with transport, shopping and visiting.

Liaison was begun not only with nurses already working in hospital and in the community but also with some of those in training. A group of student nurses from Wellington Hospital visited Project people on a local 'marae' where they were introduced to traditional medicine. Some community health workers visited the hospital to share a study day on community health with third year nursing students. Others, together with local high school students, visited the hospital to be shown around and receive the nursing students' hospitality in return.

Diversity as a necessary virtue

Project workers realised the value of diversity when they saw the different kinds of achievement won by some of the groups.

The first community volunteer worked intensively with two or three groups at a time. The calorie counters at the Maori Women's Welfare League and parents of intellectually handicapped children were two groups.

A third was a 'street group' with little previous group experience. The street in question had already developed an identity because of problems with dampness due to poor drainage, and the prevalence of rats and other infestations. (The local tip was at that time situated directly behind it.) The growth and productiveness of this group was considerable: they conducted a small survey in Wellington Hospital which showed the need for transport assistance from Porirua and some of them continued action until they succeeded two years later. This street group also measured water standing outside homes on their street and used this information to pressure the Housing Corporation and the city council to start work on the drainage problems. They raised immunisation as an issue and offered a comic strip alternative to the very official letter the Department of Health sent out to parents advising them to have their children immunised.

In contrast, the second community volunteer spread her time and energy more widely. She reorganised Helping Hands, disbanded for lack of a leader. (This group offers help with emergency transport, reading for old people, babysitting and other neighbourhood assistance.) Other achievements included getting concrete laid in a driveway where a sea of mud prevented mothers and children from using the only hall available for a playgroup.

This volunteer made a major contribution to the Project and to the community, laying the groundwork for a role for community health workers in schools, as a particular form of 'mother help'. A need was seen for assistance in school sick rooms, especially where a child's parents both work outside the home. Community health workers could also act as go-betweens for parents and teachers, especially where there are ethnic differences.

An important value seen by many in the Project is the support given within groups to encourage different people to be able to 'work the system' – any system.

Plans for the Project's independence

Up to the middle of 1977, the Project had been funded mainly through the Department of Health's Management Services and Research Unit, with additional support from the Porirua City Council, and from local firms. But MSRU could not continue this support for much longer; in order to pay a local coordinator, money was needed.

Funding decisions have big importance for such a project. Will it live off the fees of membership? Will it grow and seek other funding? From what source, within and outside government?

In the winter of 1977 Government allocated the proceeds of a new tax on alcohol and tobacco to the field of community health: the funds were to go to projects designed to reduce hospital utilisation. Much of the money was used to increase regular domiciliary services, but depending upon the particular hospital board, a number of innovative community projects could be considered eligible. What qualifications would be necessary in order to achieve funding? What strings would be attached?

If the Project was to apply for government funds it had to become a more formalised body. Incorporation was chosen as the most 'democratic' and action-oriented structure, and as the likeliest form to achieve independence. Autonomy was seen as crucial, to maintain the flexibility the Project needed in order to be responsive to the community. With time pressing the Project applied for a grant of $23,500.

There was some doubt as to whether the Wellington Hospital Board would permit this autonomy. It was fortunate for the Project that one of its founding members, Porirua's elected representative on the Board, was a strong advocate. Until this issue had arisen, there had been little close contact between the Board and its officers on the one hand, and the staff of the Department of Health involved with the Project, on the other. There was, therefore, some apprehension on both sides.

It is a credit to the Wellington Hospital Board that in the event it funded the Porirua Community Health Project with no strings attached, other than that the Project should prepare an annual report.

Financing and accountability

As time went by, Project people became aware that the main price of autonomy was lack of financial stability. With autonomy the basic funding was dependent upon annual grants from the hospital board – so long as this money was available from central government for community health projects. With a worsening economic outlook it seemed that experimental programmes would be more likely to be curtailed than established services.

The funding of community projects remains a vexed question. It has been suggested that there should be a three-way responsibility – shared equally among central and local government and the community itself. Raising a substantial proportion in the community ensures that the community acknowledges the needs, and its responsibility to do something about them. It ensures greater autonomy.

By the end of 1979, the Porirua Community Health Project obtained a substantial proportion – about 20 per cent – of its funds from donations; the

bulk of these were from the community. The Project takes its accountability to the local community seriously – periodic budget reports showing expenditure in terms of salaries and the activities the workers have been engaged in, give people the opportunity to evaluate for themselves the Project's worth. The reports were at first mailed out with the newsletters, but received so little response that they are now held at the Project, available at all times upon request.

Nevertheless, community fund raising has its drawbacks – it consumes a great deal of time and energy; and some communities obviously have more resources – in amenities, in people's confidence and skills, and in money – than others.

Process and payment

Ideally, perhaps, fund raising should be an integral part of a programme's process. Depending on the nature of the project, matching fund raising with its philosophy and activities could be one of its hardest and most integrating tasks.

Another question arises – for how long will volunteers agree that they need not be paid? The community health workers are a case in point. From the beginning they were seen as people contributing to the community they live in. Project people felt strongly that they should not be paid (though they should certainly receive out-of-pocket expenses) because payment would 'professionalise' a friendly neighbourhood relationship and thus destroy it.

However, the spread of the women's movement may well raise conflicts in New Zealand as elsewhere. Traditionally, community work, like housework, has been unpaid and has been performed by women. Many women and some men are coming to believe that this work must be paid in order for society to affirm its value, and in order that 'women's work' be made a viable way to earn a living. There are serious long-term implications in the conflict between improving women's status and community development.

Later project activities

Since it has become truly local, the Project has increasingly seen itself as a resource for people in the community wishing to take part in some activity to change or improve their situation in the community. The Project house has been made available as a meeting place for various groups in the community, whether or not they are specifically connected with health. In the space behind the Project house, in badly drained land, a vegetable garden was planted. Planned partly as a demonstration model, the garden's produce was destined to join with another Project activity – a food cooperative.

Responding to events

The Project has assisted people to make public statements over issues of concern. These statements have sometimes needed a good deal of researching. In this role the Project has fulfilled an early objective – to be a channel or voice for people who need help to speak on their own behalf.

Some groups were formed with the Project's support to influence the course of events in the community – for example local people met with Housing Corporation officials to discuss the future of empty state housing units in Cannons Creek. It was felt locally that because of neighbourhood needs, the poor drainage and the need for extensive renovations, it would be better to raze these units to make room for a play space and parking lot next to a kindergarten, than to make them into showpieces: the Housing Corporation money could be better spent elsewhere in the city.

A 'Porirua Power' protest group sprang up in 1979 in response to the nearly 50 per cent rise in electricity rates. Few state houses in Porirua have insulation, so that those least able to pay high rates would have to pay most in order to stay warm during the winter.

A group of teachers in the community, concerned about problems of hearing among their pupils, investigated possibilities of ensuring treatment. A complicated medical referral system and some parental ignorance of the need for follow-up care are matters still engaging some Project members.

Miranda House

Some of the activities supported by the Project began in a small way and grew slowly. One of these was provision of Miranda House, where people who were unemployed or handicapped, mentally or physically, could come to learn from each other at a leisurely pace with only a limited amount of teaching. Wooden furniture to be reconditioned was solicited through the Project newsletter and, in the winter of 1979, a separate housing unit was provided out of the Project funds.

Audio-visual equipment

Another tangible achievement by Project people was the building up of a collection of slide/tape sets, some made by workers at the Project, the remainder by a medical student. The topics ranged from infections, to 'Your Lungs and Smoking', to birth control; and the sets were immediately popular with schools and interested groups, including, of course, the community health workers.

The Health Van

Perhaps the single most important contribution that the Project has so far made to the community in which it works, is the health van. It is certainly the most visible. Many months of dedicated efforts produced a grant from a community organisation amounting to $2500, plus a further $1500 to complete alterations (including a ramp for wheelchairs) and to cover running costs for the first year. The vehicle itself was made available in a reconditioned state at a lower-than-commercial price, as part of a community service from the local automobile assembly plant.

Driven by volunteers, and connected to the Project's unit by radio telephone, the health van has settled to a routine of taking groups to meetings, taking visitors and patients to hospital, and acting as a backup service to the ambulance for minor emergencies. By the middle of 1979 it had proved its worth so well that money was being raised for a second health van.

The van service is free but donations are welcomed. The response has been gratifying. Sometimes people using the van have given more than a normal taxi fare. People have dropped in to the Project's house to leave a small sum towards the van's expenses.

The extraordinary commitment by 'ordinary people' to organise and to run the van, Miranda House, and the other group activities, is perhaps the best indication of the Project's success – helping people to help each other.

Discussion

Watching and participating in the growth of the Porirua Community Health Project has been an exciting experience for the researchers, and very much of a learning experience also.

Our feeling has been reinforced that 'expert' knowledge is no more valid than people's own experience. Generally speaking, people do know what they want and need. Project workers reasoned that people with special knowledge have a responsibility to make it available to the community. But to go further was to impose outside pressure. Even if done with the best of intentions, this was seen as a lack of respect for people's dignity and a hindrance to their growth and autonomy.

For community work in general, time is of the essence. For most people, it takes a good deal of time to share and examine new ideas and adapt them to their own purposes. If such projects are to become strong there is no way this process can be hurried. For community health projects, it is also important to move at a slow pace because there is, as yet, no adequate theoretical framework in this field.

We have learned that processes are as important as end results, and should in fact be part of them. That is to say, how people work and precisely what

they do should reflect the philosophy underlying a programme's objectives.

Such projects remain fragile for a long while and even writing and talking about them can make them appear more solid than they really are. This can put pressure on people who are still finding their way and can be destructive. A large degree of altruism is therefore required of any establishment if it is to be truly supportive of local projects. The dangers of publicity and the destructiveness of irresponsible media are well enough known. But even 'good' publicity can be a problem. A Project member compared the Project to a tourist spot, where the number of people visiting can destroy the very thing they come to see.

The Project's links with institutions may not always have been an advantage. Founding Project members included representatives from a variety of official bodies. In the early stages, people working with the Project might have been cheated of a sense of challenge, victory and solidarity by the use of these links, for these representatives concentrated on avoiding confrontation almost to a fault. However, as more local people began to work with the Project, the link people became less active in the Project, and now tend to be used primarily as 'resources'. The Project's stronger sense of identity is particularly a consequence.

Neither institutional nor local support, however, can ensure there will be no opposition in the community to such projects. In Porirua the ongoing criticism is mainly on the grounds that the project is a 'waste of money' which would be better spent on curing people. And it is likely that some opposition to these projects will always remain – it is a feature of taking some forms of collective action that they will be divisive.

Our last and most important conclusion is that any approach to community health projects must be flexible and responsive. There is no correct way to go about setting up community projects and activities. These will depend upon the personalities involved: people's different values, perceptions and styles influence what they see as needs and what they think should be done about these needs. Any project's character will depend upon which people in a community have the interest and energy at a given time to work for change and improvement where they live; and this is as it should be.

It is obvious then that the Porirua Community Health Project cannot be a model; each community must find its own way.

18

Involvement in health care
by William G Lawrence

Introduction

This subject is so broad as to make the author of a paper of this nature feel that the topic cannot be given any justice at all. Therefore, I have done no more than put together some views on health, illness, consumer expectation and involvement in the terms that I see them best; and then related to them the role of the senior manager in the involvement of individuals, families or communities in health care. Some examples from my own experience are quoted, not because they are spectacularly successful but because to me they show relevance and potential for some of the needs that we should address.

Modern health

As a starting point I would like to quote a view of health care from an eminent author on this subject in Australia.

> 'Health can quite properly be viewed as the outcome of a general system of social interaction of which medical science forms only a part – by no means a new notion . . . Paradoxically application of this concept may have been delayed by the phenomenal growth of scientific medicine . . . The outstanding advances of twentieth century medicine have been in the treatment of disease through action on the intimate mechanisms of the body, and the clinical achievements now so widely known have led people to expect success and to demand more and more care. At the same time they have become more exacting with regard to their ailments and less willing than previous generations to accept infirmities, discomforts and blemishes . . . Faced with rising demands for medical care, much of it for non organic illness, doctors generally have been inclined to apply those familiar methods which are a product of their biologically based training and general hospital experience . . . they lose sight of the sick patient's need to be made whole . . . they contribute to a growing ambivalence in the public's attitude to medical care. On the one hand there is the possibility of saving life and preventing disability, even of enhancing human potential; on the other hand there are rising costs and a disjointedness and impersonality which are hard to tolerate.'[1]

Dr Sax is primarily discussing some of the deficiencies he perceives in the care of illness, but he makes the basic point that health is a broader concept than illness care. The deficiencies have led to reactions by individuals and groups whose expectations or needs have not been met by these 'traditional' health care methods with their emphasis on scientific medicine.

Consumer responses

In recent times Australia has seen a remarkable development of voluntary organisations whose purpose is to be involved in health care processes, who stand up for the perceived rights of individuals or groups and confront providers with policies developed to improve services for consumers. We do in fact have a Health Consumers' Association. In many cases chief executive officers have to exercise great skill to bring together in a constructive manner these groups and the providers with whom they wish to take issue. Direct communication of the right sort can lead to creative conflict, with increased understanding of needs on both sides and the possibility of change by one or both of the groups. Failure to achieve a productive level of communication has seen 'arm's length' confrontations in which little is gained and public confidence sometimes placed in jeopardy.

One of the best known and most capably organised voluntary groups in Australia is the Association for the Welfare of Children in Hospital (AWCH). This association has had dramatic effects on the conduct of children's wards in New South Wales hospitals. It has a full time secretariat, conducts national conferences and has had its views adopted by some state health authorities as system-wide policies. AWCH's committee in New South Wales contains some ten members, three of whom are medical practitioners. It publishes newsletters for its members and the health services community. Survey questionnaires are forwarded to hospitals routinely, as are AWCH policy documents. In 1975 the Australian Medical Journal carried a special supplement on AWCH's policies on the health care of children and their families. Governments, statutory authorities and the organised medical profession have communicated with this organisation and some achievements have resulted.

An example of AWCH's present activities can be seen in a recent newsletter (AWCH Newsletter, Vol 8, No 3, March 1981). It is concerned with the organisation's reaction to the death of a five year old boy, four days after a tonsillectomy.

'THE CONCERN OF THE AUSTRALIAN ASSOCIATION FOR THE WELFARE OF CHILDREN IN HOSPITAL IN THE MATTHEW DAVEY CASE

1 'HEALTH CARE POLICY RELATING TO CHILDREN AND THEIR FAMILIES'

It would appear that important links in the chain of events leading to the death of Matthew Davey are marked by clear departures by staff from the principles laid down in the *Health Care Policy Relating to Children and Their Families* published in the Australian Medical Journal, August 9, 1975 and declared the official policy of the Health Commission of NSW, September 1, 1975.

2 'AWCH SUBMISSION TO THE COMMISSION OF INQUIRY INTO THE EFFICIENCY AND ADMINISTRATION OF HOSPITALS'

Our concern at

the high number of tonsillectomies and other elective surgical operations on children;
the place and manner of performance of the operations;
the failure to explore alternative forms of treatment;
the apparently poor criteria used for clinical judgements

was placed before the above Commission in December 1979.

The acceptance by the Commission of Inquiry of the attached recommendations would prevent unnecessary pain, suffering and even death of children.

At the same time, the acceptance of the recommendations would protect staff, particularly the inexperienced, the poorly trained and those who have no say in the formulation of the policies they must carry out.

3 'ELECTIVE SURGERY IN CHILDREN

Elective surgery means that someone "elects" to have it done. The child cannot do this; the parents can only 'elect' if they are fully informed of all options and given a choice.

The fact that a particular operation is designated "elective" indicates that the *condition from which the child is suffering is not life threatening.* Therefore, the surgeon proposing the operation has the necessary time to adequately fulfil his responsibilities, namely:

(a) to obtain a fully documented medical history of the child in relation to the proposed surgery;
(b) to inform the parents of the reasons why he thinks the operation necessary;

(c) to ensure that the parents fully understand the element of risk in all surgical operations and, in particular, the risk of the operation proposed;
(d) to inform the parents of existing alternative forms of treatment;
(e) to inform the parents of the likely prognosis for each alternative;
(f) to ensure that the parents are given sufficient understanding of the factors involved in the medical and psychological management of their child to enable them to make an informed decision;
(g) to satisfy himself that arrangements for the medical and psychological management of the child and his parents before, during and after surgery meet the highest standards of paediatric care.
In this context, facilities and attitudes to parents at the proposed hospital (ward, recovery room and intensive care) need to be fully explored.

If he is not satisfied, he should "elect" not to do the operation until such time as he is.'

Whether or not all of the views expressed are clearly right, wrong or merely debatable, the thrust of AWCH in the matter of the professional's responsibilities to inform and involve his client in decision-making is quite clear.

Another example from the Australian scene of voluntary organisations making dramatic inroads into areas previously regarded as the sole province of the professional, is the change in policies of hospital maternity units towards such matters as fathers' attendance at labour ward, the practice of 'routine' procedures, use of induction methods, 'rooming in', demand feeding and liberalised visiting hours. Although it is probable that many initiatives in this field would have come from the providers, it is quite clear that their pursuit by well organised voluntary groups brought about rapid changes, even in the most conservative maternity units. The management of this change, however, is an important issue. As a hospital chief executive officer I was twice placed in the position of having to reconcile community expectations, as expressed by voluntary organisations concerned with obstetric practice, and the perceived needs of the majority of patients and the institutions themselves, as expressed by the direct providers of maternity services.

Again, opportunity is needed for both sets of participants to communicate openly with each other so that views can be understood. Reasonable, agreed action can usually follow. In one of the situations with which I was faced, the implacable hostility of some senior hospital staff to uncoordinated approaches by individuals and groups urging changes in maternity practices resulted in virtual open warfare,

with quite divided factions appearing in the community at large. Reconciliation was only possible over a long term, with personnel changes on both sides.

In the other situation, a managed open forum approach with the providers meeting the consumer groups to discuss policy, resulted in revised policies and procedures about halfway between the diverging points of view; a result which both groups found reasonable. The chief executive at institutional level must see that such situations are managed, not avoided.

Expectations of health care

Thus far I have dealt with the involvement of groups in the behaviour of institutions and providers, but what of the situation where provider and consumer meet in a clinical or consultative setting?

There is an obvious need for medical practitioners and other health professionals to be able to communicate effectively with their patients and not merely to be technically competent. My experience of investigations into the performance of professional staff in their treatment of patients leads me to believe that technical competence was usually high but the ability to communicate was poor. It is recognised that it is not always the professional's fault if communication processes are ineffective. The process of communicating with patients seems to me as an outsider to be somewhat loaded against the professional in that it can be distorted by the expectations and anxieties of the consumer. This is consistent with Dr Sax's views on health care quoted earlier.

In this regard, several providers whom I know have argued that many of the health system's consumers seek care with a kind of ingrained dependence or faith in the 'system's' ability (represented by the professional) to remedy their problems.

It has been suggested that this kind of dependence has been instilled into many people in our community by their relatively protected family upbringing, their structured schooling and an indulgent society. Again, we come back to the point made by Dr Sax that 'health can quite properly be viewed as the outcome of a general system of social interaction of which medical science forms only a part.' The magnificent achievements of science have led many of us to feel inadequate when dealing with day-to-day health issues.

Our health care system, which provides excellent treatment for illness as its major activity, could be reinforcing any social dependence that exists. It may well be that many of these health problems cannot be resolved by 'care'; however, care is what the patient expects. Also, the practitioner may only be able to respond with active treatment.

Thus expectations are fulfilled, resources consumed, no basic change in the patient's underlying condition (or concept of health care) takes place and dissatisfaction is generated.

Understanding health

Perhaps we should recognise the widespread need for an explanation of health as a concept. (Is it really the WHO definition?) What has the care of illness to offer the individual, and what is the individual's responsibility for his own health? It must always be acknowledged that this individual responsibility requires enough support for it to be exercised, but not so much that responsibility is avoided altogether. Perhaps our traditional system of providing care needs more public examination and experiment to see if there are better ways of promoting the proper use of illness care resources and of developing a personal understanding of health as a concept.

In Australia now we are seeing a government response to making individuals more conscious of their use of the health care system by the re-introduction of 'user pays' as a broad philosophy. This may well reduce the use of health care services, although I doubt it. Certainly, it is unlikely that this isolated measure will change attitudes that equate the care of illness with health.

Promoting alternative approaches to health and illness

Promoting individual responsibility for health can widen the social perspective to such an extent that it falls outside the normal province of the chief executive. However, there are some initiatives that can only be undertaken when senior health management is adventurous enough to allocate resources to them. An example from Australia is a programme of direct grants to hospitals for health promotion activities. It is a cooperative effort between hospitals, the Health Commission of New South Wales and the Commonwealth government. In 1980/81 a modest amount of money was allocated to sponsor some 110 separate projects throughout New South Wales. The programme's literature[2] states that its purpose stems from four intersecting developments:

> 'Most modern diseases are related to the way we live or have to live and to the environment our society has created for itself;
> 'curative medicine is not prolonging life and there is growing recognition that prevention may be a more promising route to health;

'the escalating costs of illness care is creating a financial burden which the country cannot afford;
'consumerism is manifested in a burgeoning demand for more knowledge, greater participation in treatment, less dependency, demystification of medicine etc.'

While no one will accept all of these assertions without question, they are at least a positive basis for hospitals to assess their capacity for promoting greater understanding by patients of illness and its management, of measures which can be taken to prevent recurrence of ill health and, hopefully, the achievement of continuing good health.

The challenge to the chief executive is not merely finding money for the programme; he has to see that everyone providing care in the institution is told about the programme, that they discuss it and commit themselves to it in a positive way. It is counter-productive for programmes to take place in an atmosphere of open hostility.

Another example is the 'Healthcraft' programme, piloted in 1980 in part in the Illawarra Region of New South Wales. The programme was developed from a similar concept overseas by staff of the Health Commission and the school of medicine at the University of New South Wales with some financial support from the Commonwealth Department of Health. It is a thirteen session course in self care for the over 50 age group. The sessions are:

Aging
Body functioning and assessment
Home accidents and injuries
Common illnesses and conditions
Medical emergencies
Relaxation and exercise
Good food and good health
Your medicine chest
Self medication
Coping with the health care system
Coping with stress
Never too old to grow
Creative leisure

Groups of about twenty take part. Appropriately skilled session leaders were recruited and trained. They ranged from medical practitioners, pharmacists and nurses to physical education officers. Programme kits were developed so that the thirteen sessions could

be easily duplicated in other settings. In our region we could not cater for the demand generated by limited public advertising of the pilot course. First stage evaluation of the programme indicates the following.[3]

> Seventy three per cent of those visiting a doctor after the programme claimed to have an improved communication with the doctor.
> Forty one per cent of those completing post-course questionnaires indicated they were now able to avoid some medical consultations because they felt capable of handling the problems themselves (ranging from stress to the common cold).
> Sixty two per cent claimed definite changes in their style of living due to the course (for instance, increased exercise, more relaxation, improved mental attitudes and reduction in medication).
> Forty seven per cent claimed to have made dietary changes. They were eating more fibre/fruit; less fat/salt/processed foods/sugar and were taking more care with their breakfast.
> Seventy one per cent claimed to engage in moderate physical exercise for half an hour daily after the course, compared with 56 per cent before the course.
> There were major changes in the individual participants' ability to understand and carry out self measurement (temperature, blood pressure, respiration and pulse rates).

Whilst it can be said that the pilot exercise probably recruited highly motivated people and its evaluation was rudimentary, to my mind the programme has a very significant potential. The approach involves individuals in their own health and is different from other health education activities in which recipients can be passive (if not hostile) and the message conveyed in a didactic manner. It remains to be seen whether the observed changes are real (by comparing them with controls), and, if so, for how long they last. Apart from development and evaluation costs, the Healthcraft programme was conducted within existing resources in the areas in which it was piloted. The lesson is that with some reorganisation of staff use and work priorities, initiatives like this can be accomplished if encouragement and support are forthcoming from senior management.

Health outside the health sector

Another scheme seeking to develop an involvement by individuals in their own health concentrates on the school age groups and again approaches health from a broad social perspective. It uses a rural

venue called Logbridge Farm situated just outside the main centre of the Illawarra health region and involves a community voluntary group with education and health authorities in a primary prevention programme. This programme is aimed at preventing physical and mental problems in adolescents and their families, with particular emphasis on the prevention of drug abuse in young people. The New South Wales education department granted use of 135 acres of land to the voluntary committee that organised the project. It began some four and a half years ago and 8500 young people have attended. Our health education officer has contributed most of his spare time to the project. Logbridge Farm is a working farm which offers basic residential accommodation and facilities for meetings, leisure activities and social functions.

The programmes offered aim to increase physical fitness, and to develop personal initiatives and the ability to make decisions. Sporting and craft skills are also taught. The basic premise is that a positive and effective use of leisure time will encourage self reliance and reduce the potential for drug abuse or other forms of socially undesirable behaviour.

Logbridge Farm is an inexpensive exercise as it is, at present, staffed entirely by volunteers. Its success can be measured by the enormous community support it has received and its continued patronage by school children. It is a programme with a broad emphasis on health based on individual development and personal involvement. Nonetheless, like Healthcraft, it can be criticised for lack of evaluation and its broad conceptual base. It is widely accepted by involved health professionals and educationalists in the Illawarra region as a positive exercise in health.

Whether it is right to direct health care resources to this kind of venture is an issue in itself, and one that the chief executive seeking to involve communities in a broader understanding of health care has to face.

Summary

This paper is a simple expression of opinions rather than a statement of facts and it is not intended to be a comprehensive work on this very broad subject. Its base is the subject discussed at the first International Seminar in 1975: that scientific medicine, despite its wonderful achievements, is producing diminishing returns for enormous investment and leaving some needs unsatisfied.

Also, health care is not meeting the expectations of its consumers and external solutions to all health problems are not always available.

These expectations are a misdirected product of the achievements of science in treating certain episodes of illness.

I have tried to explain why senior health service executives ought to manage the way recognition is given to the expressed needs of voluntary groups. There will be more groups and individuals concerned with the processes of health care in this age of consumerism.

References

1 Sax, Sidney. *Medical care in the melting pot: an Australian review.* London, Angus and Robertson, 1972. (Studies in Australian society)

2 Health Commission of New South Wales. *Hospital health promotion funding 1981/82: guidelines for applicants.* Sydney, Health Commission of New South Wales, 1981.

3 University of New South Wales, School of Medicine. *Report to the Research and Planning Committee of the Commonwealth Department of Health, on self-care package program 'Healthcraft 1981'.* Sydney, University of New South Wales, 1981.

19

Who wants what – and who needs it anyway?

by John R Evans

The National Health Service Act of 1946 laid on the Minister of Health the duty to 'promote the establishment of a comprehensive health service designed to secure improvement in the physical and mental health of the people in England and Wales and to secure improvement in the prevention, diagnosis and treatment of illness'.

Illness and health

It is significant that even thirty five years ago it was felt necessary to draw a distinction between 'health' which, for purposes of this paper, I intend to treat as a concept, and 'illness' which I intend to treat as an entity. I have also to assume that those responsible for drafting the legislation assumed the meanings that I have given them.

Any kind of objective assessment of the extent to which the twin objectives of the NHS have been attained must conclude that, superficially at least, 'illness', although appearing second to 'health' in the Act, has certainly come first in the resource race. This state of affairs forces us to recognise that it is much easier to defend the allocation of resources to entities rather than to concepts. In fact, since social pressure demands that resources should be spent on disease entities, defence is not needed. During the expansionist period of the NHS in the mid 1960s, there was great pressure to develop hospital services and, in particular, surgical facilities. At that time the waiting list for surgery had risen to half a million cases and this was regarded as a national scandal. It is easier to show how effective use is being made of resources when consumption is related to entities, such as numbers on a surgical waiting list, rather that to the realisation of a concept such as health.

A major difficulty in any discussion about health is how it can be measured and, even if this is possible, to what to attribute apparent changes in the factors you are measuring. A second major problem is who should evaluate the meaning of what has been measured. Ideally, it should be the customers of a service designed to improve health; that is, our community at large. However, any voice our community may have is bound to be biased because it has to be representational. Even where our community tries to have a voice, it is almost invariably concerned with the entity of illness rather than the concept of health. There exists a plethora of national and local pressure groups con-

cerned with specific help for sufferers from diseases as diverse as schizophrenia and cystitis. There are other groups which do have more of a leaning towards health, such as the anti-smoking lobby, but even in the health arena there are groups like the anti-fluoride lobby which use arguments allegedly about health but in practice about human rights. The implication for this paper is that where a 'community' or 'society' view is subsumed, it will be the view of society seen from a National Health Service standpoint.

The apparent failure of the NHS to satisfy the objectives of the Act of Parliament which created it, is now, thirty five years later, being closely scrutinised and openly discussed. There is a growing body of evidence which suggests that the service is identifying for itself a need to treat a great deal of disease which would otherwise go unremarked, and generating a need to spend resources at such a rate that people who suffer from ill health (as opposed to disease) cannot receive care which would alleviate that ill health, or other social disadvantage. The growth in operating theatre facilities and the creation of district general hospitals in the expansionist mid-sixties is an example of our obsession with disease. It was not until the mid-seventies that the problem of 'deprived groups' such as the elderly, the mentally disordered and the mentally handicapped became an important policy issue for the nation. Incidentally, the completion of the new surgical facilities elevated the surgical waiting lists from half a million to 700,000 and they now stand at about a million. Supply creates demand.

The position of the medical profession in this race for resources has been most lucidly moved into the foreground of discussion in the UK by Ian Kennedy[1] in the 1980 Reith Lectures. Less recently, the Office of Health Economics published a pamphlet *The Health Care Dilemma*[2] which attempted to show, among other things, the way in which the patient tries to use his doctor to medicalise a variety of personal social problems which he, the patient, cannot or will not handle.

The sociologist's view

Much of the evidence for the willing acceptance of the dominance of the medical profession, and indeed of the whole apparatus of a health care system, can be found in research carried out by sociologists. In particular, Talcott Parsons[3] set out four principles which demonstrated the views society takes of the condition 'sick' and the penalties imposed by society on those who fraudulently claim this status.

The sick are relieved from the normal social responsibilities, in particular, working and earning a living. On the other hand, anyone who claims such exceptions without really being sick will be judged to be malingering, and will be punished by society.

The sick are not held responsible for their incapacity, and it will be assumed that they will need to be looked after. Those who poison themselves with drugs and alcohol, however, are seen as responsible for their actions and so are often treated harshly by the caring professions.

Sickness is regarded as a misfortune, and so it is assumed that the sick will want to get well. The hypochondriac, or any person who seems to delight in the possession of symptoms, does not behave as though sickness is a misfortune, and so will not be received kindly by doctors or society in general.

The sick are obliged to seek competent medical help, and to do all they can to get well. The neurotic person can be rejected because he (or she) can appear unwilling to take constructive steps towards overcoming the disabling symptoms.

These papers have received scant consideration by the so called caring professions and the health care systems within which their members work; and it is important to ask why. Some of the contributors to this book discuss relationships with the professions, and other staff interests. In this paper I want to try to establish the patient's case and that of his family and the community in which he lives. In so doing, I will from time to time be referring back to the impact of professional or other staff on the objectives of the organisation. In essence, I want to try to answer the question, 'How sensitive is the health service to the needs of patients?', and at the end of the paper try to identify what the chief executive officer can do to increase this sensitivity.

Education in self care

If you ask the man in the street to describe for you how and why his body works, his knowledge will be superficial. His own body is regarded as so complex and technical, and even foreign to him, that if anything goes wrong with it he will feel it necessary to take it to the 'health shop' to find out what is wrong. He will do much the same with his car or his TV set. He will assume that it is largely a self regulating organism which he will feed with anything, regardless of suitability, from flavoured chalk to cheese, even though he would no more try to run his car on milk than he would feed his TV set with electricity at the

wrong voltage. In short it is a job for the experts and does not even get the same maintenance as his car.

The indicators he will use in his diagnosis that something is wrong with the machine are many, but he will consider that any distortion of processes he has come to regard as normal, such as pain, or a feeling of 'unwellness', needs someone else to put it right. He will rarely today consider his own responsibilities for himself or have the self confidence to trust his own judgement. 'Self doctoring' is a phrase of contempt, and efforts made to encourage self help tend to be aimed at relieving the overworked doctor, rather than being aimed at the development of a healthy patient.

To be fair, the patient has not actually been properly taught what preventive and self help measures he should take; the advertising to which he is subjected gives little indication about what he should not do, only about what he should add to his already overloaded system – be it vitamins or cold cures.

When our patient is given advice about what to do or not to do to prevent illness or promote health he will tend to ignore it, either because he considers that 'authority' is telling him what to do and it is a demonstration of his individuality if he ignores the advice, or because it actively inhibits the lifestyle he has chosen to adopt. It is also the case that, to date, much of the education he may have received has been dull, admonitory and negative. Equally, for every expert, there is a counter expert, and people in general tend to seek out only the opinions and advice they wish to hear. The effective education packages about health have contained within them an element of the dramatic, an element of real life, which has enhanced their effect. The pictures of tar and nicotine concentrates extracted from cigarettes and applied to lungs contain this element of drama and are effective: but, sometimes, the drama becomes too unpalatable. One of the most effective national anti-smoking campaigns in the UK was carried out by the Health Education Council and used a poster depicting in profile a naked, very pregnant girl smoking a cigarette. The message was clear, unequivocal and in evaluation, effective. The campaign had to be withdrawn because the poster was regarded as offensive.

The total budget for health education represents approximately 0.1 per cent of the budget for treatment and care of sickness. Increases are proposed regularly but they are seldom implemented. Politicians are constitutionally unable to manage this change because preventing ill health is not as vote catching as curing disease. Another source of impetus for change comes from professionals in fields such as nutrition, whose opinions are customarily, if unfortunately, treated with the respect normally accorded to cranks and fanatics.

Professionals in the health service cannot escape their share of the blame for this very low expenditure figure for health education, because the professional organisations have been the ones mainly responsible for pressures on government to provide money for the treatment of disease.

Financial and technological development

At the beginning of the British health service, it was thought that taking away the financial burden from those who became sick would of itself lead to a diminution in the incidence of sickness in society. It has since become very clear that the equation is not that simple. In 1963, when Last's paper on undiagnosed diseases[4] was published, 'the iceberg' effect became recognised. Last commented in his summary that 'A considerable amount of undetected disease, some of which is serious and some controllable, might be found without adding greatly to the burden of the day's work. Ordinary clinical skills and new diagnostic aids may be used to detect cases of actual and potential disease in general practice'. Last's paper seems to have stimulated efforts by the medical profession to detect disease not only in general practice but also in hospital practice. This happened to coincide with the expansionist era of hospital building and simultaneously with developments, particularly in pathology, of diagnostic aids for the clinician.

These factors have led to greater and greater cries for increased resources to tackle the hitherto undetected disease, and reinforced the medical profession's view of the standards required by 'good medical practice'. Problems are being tackled in more and more detail, leading to the point where submolecular deviations from some normal value have to be detected in order to diagnose disease. This has the effect of greatly increasing expense in terms of staff and equipment, and correspondingly decreasing concern for the health of the patient. Yet there is little correlation between the increased expenditure in real terms and morbidity and mortality rates. The effect on the patient is that he acquires the status 'sick' and he comes to believe it. Additionally, society, according to Parsons[3], condones this acceptance. The fact that the patient could previously live with his condition until it was diagnosed is conveniently forgotten by patient and doctor alike. Discussing this situation, a local general practitioner commented: 'Most of my patients enjoy ill health'.

There is also much evidence, notably from Cochrane's work on randomised control trials[5], that treatment following diagnosis of biochemical variations from a normal range is not necessarily ben-

eficial. The response of the individual to the pressures of society and environment, the response of the medical practitioner in seeking out a diagnosis and determining a treatment regime, and the response of the patient to that regime, constitute an equation with so many variables that Cochrane's findings are hardly to be wondered at. Further comment from the same general practioner: 'The biggest abnormality in my practice is perfect health'.

Reverting to Parsons'[3] conclusions on the condition 'sick', the patient not only has a right to treatment, he has a duty to seek help from a 'competent' practitioner. Serious consideration needs to be given to the training and education of medical students and those of other professions about their perception of the role society, and not just their training institution, requires of them. It will be argued that the ever widening boundaries of medical science reduce the spare time in the curriculum for the teaching of social skills and understanding. I would suggest that the development of social skills and understanding will lead to a reduction in the need for scientific skills in the doctors and paramedical workers of the future.

At present, however, the patient's dependence on the doctor is matched by the doctor's dependence on the patient, who contributes to his status in the health society. The advent of 'Dr Kildare' has made disease fashionable and some diseases even glamorous. The more serious attempts by the media to explain disease and its treatment have contributed to the symbiotic relationship between doctor and patient, and also to the subsequent emphasis on disease and its consequent cost. The rise of the welfare state now means that we can all enjoy the luxury of being ill.

Social change and the doctors' dilemma

The transfer of responsibility from patient to doctor, a practice willingly condoned by both parties, is the result of many changes in political, educational, social and professional attitudes in the past thirty five years. This has produced the disease oriented health service which exists today. It may be that before the 1946 Act similar conditions applied, but only for those classes of people who had ready access to the health care professions and the money with which to pay them. At the time of the Beveridge report, which set the scene for social change in Great Britain and led to the 1946 Act, this would have been a very small percentage of the total population and so any incidence of dependence of doctor on patient and patient on doctor was not noticed.

The transfer of responsibility for health exclusively to the providing

service has simultaneously been accompanied by a rise in the expectation of the public that in each and every case a faultless service will be provided by the experts. Mistakes must not be made. This can be and often is translated, certainly by the courts, to a view that if you make a mistake you have been negligent and you or your insurers must pay for it either in cash or by loss of reputation. Thus has arisen a whole new development – that of defensive medicine, demonstrated by the over-investigation of patients just in case something else may be found, or in order to confirm a diagnosis about which the certainty is only 95 per cent. So costs rise again, and the amount of service provided to the whole community, in relative terms, falls. A recent comment by a pathologist: 'If I am asked for a particular test it is my duty to do it or arrange for it to be done. If I do not do so, I am failing to practise "good medicine" and may be guilty of negligence, which is a risk I am not prepared to take'.

This over-investigation by the professionals is supported by the general public who come into contact with the service. Patients tend to feel that they are being helped as long as the doctor does something positive such as giving a prescription for drugs, because, after all, anything may be better than nothing, and sins of commission are less blameworthy than sins of omission. General practitioners can deal more quickly with patients by giving a prescription for drugs than by explaining why drugs will have only a marginal or even a placebo effect. It is difficult for patients to sustain their faith in a doctor if the doctor explains that he cannot do more than hope that his treatment will be effective. It is also difficult, in the short time available for most consultations, for doctors properly to communicate their professional opinions in a way that is understandable and accepted by their patients.

By trying to fulfil his patient's expectations the doctor can face a conundrum to which he apparently does not have the key. Doctors are expected by their patients to provide a diagnosis. This diagnosis may be based on suspect information: the patient's presentation of symptoms, the medicalisation of social malaise, the psychosomatic nature of symptoms, the limited intellectual acuity of doctor and of patient, and many similar doubts and variations. This being so the doctor may choose to prescribe a placebo, to advise variation in the patient's regime or not to intervene at all. But if the patient's condition is not alleviated and if a 'proven scientific treatment' for the chosen diagnosis exists, society may hold the doctor guilty of negligence. The diagnosis is doubtful and the patient's response to individual drug therapy is as variable as his presentation of symptoms.

The divine right of health service professionals is in many instances

now being challenged by a number of groups generally acting on behalf of underprivileged sections of our society. These volunteer groups tend, not surprisingly, to be structured to align with the patient's specific problem as seen by the volunteer group. The view of the professional being challenged – and usually, not surprisingly, attempting to rebut the challenge – is likely to be different from the volunteer group. The professional worker may not be personally concerned about or interested in the specific condition. He may have responsibilities far wider than the specific condition and consider the problem to be one of many he has to face and not meriting such detailed support. For example, a consultant psychiatrist may have little concern about senile dementia because he is interested in acute neurosis and it is his colleague who has the responsibility for dementia cases. Thus, pressure groups may find themselves 'whistling in the wind' and society as a whole preferring to support a professional and assumedly informed opinion.

The response of the health service to these challenges has, generally, been one of resistance, and on many occasions aggressively so, because society may claim that since it gave the status it has the right to take it away and to follow through with claims of culpability and negligence in not managing 'health' on its behalf.

There is a further twist to the whole argument of doctor-created disease, and that is institution-created disease. This particularly manifests itself in those nations where hospital services are run as a business venture, either by private companies or by government agencies. Although mainly a product of private enterprise, the same effects can also be seen in our own NHS, although for slightly different reasons.

The reason for much of the institution-created disease is competition in order to maintain viability or to optimise resources. The institutions may not always go as far as advertising for custom, although that is not unknown, but there is evidence from the United States that hospitals are negotiating contracts with local doctors for exclusive referrals. A contract is for the benefit of both parties to the contract. The patient however is not a party to the contract but is more of a product of trade and his individual wishes may be overriden by the need to ensure the effectiveness of the contract. An example in a British psychiatric hospital is the industrial rehabilitation unit. In many cases, the rehabilitation of a long-stay mentally ill patient comes second to the contract between the unit and the local agent who requires a quantity of boxed sets of curtain fittings. The patient's interest is secondary to the contract. It should be the other way round.

Today's solutions to today's problems

I would now like to return to the original question: How responsive is a health service to the needs of society? At present, the service provides and fulfils society's apparent needs very well by removing from the individual the onus of self care. We can congratulate ourselves on our health service because we are responding to the best of our ability to the stated needs of our patients. They ask for help and we give it to them. The only limitations on our giving are either those of resource constraints imposed on us from above, or those of technology where the research work on the understanding of the disease process has not yet advanced to the point at which the disease is treatable.

But there is a paradox here in whether society knows, and is getting, what is good for it. The solution lies in whether society understands the implications of a transfer of responsibility from the individual to a bureaucracy, and is prepared to pay for a service which costs a huge amount of money but provides a negligible improvement in morbidity, which offers a great many jobs at a time of high unemployment but where conditions are thought to be bad for staff and patients, and where costs continue to rise despite a national movement towards a reduction in public expenditure. Raising public answers to these points and the possible subsequent dismantling of a monolithic structure will take a long time.

Public challenges to the NHS as it exists are beginning to come more rapidly. Signs of this can be discerned in a greater public awareness of three main areas of concern for users of the service. These are, the environment in which the service operates; the attitudes of workers in the service; and the influence of professional opinion. The first two are recognised as being fair game for consumerism. Patients expect the health organisation to be established in appropriate accommodation, to run efficiently and to meet standards acceptable to the public. The reaction of the health service to this consumer approach is predictable: 'Yes, we acknowledge that the facilities we provide are not adequate; we have plans for improving them but obviously we can do little without the necessary money'. This response is acceptable both to the consumer (usually) who feels that he has made his point and that facilities will be improved some day, he having contributed to the change, and to the provider who is pleased that it has been recognised that the system is doing its best to satisfy the needs of the patients and is championing the patients' cause against a higher, purse-holding authority. The transferred responsibility and status are maintained as they were. If, however, the response from the service were similar to that advocated by Donald Dick, the Director of the Health Advisory

Service[6], the nature of the service would change materially without any improvement in the environment. Dr Dick maintains that in psychiatric hospitals we should deliberately provide poor facilities, first so that patients who, in their own interest, ought to be cared for in a community or family setting, do not find our hospitals so comfortable that they actually like living in them, and second, because we are trying to rehabilitate our patients and should not therefore provide unrealistic and, he maintains, antitherapeutic comfort. Consumer response would be likely to be one of shock and horror and accusations that the service for which we pay our taxes is incompetent and cruel. If this kind of answer were to be given consistently and the consumer's attempt to transfer responsibility were to be resisted, the changes would be significant. It is of course not at all easy to give this alternative reply, just as it is easier for a general practitioner to prescribe rather than explain why a drug may be ineffective. It all takes longer and it rocks the boat.

The second area of concern is that of attitude of workers in the service. I have already dwelt at some length on the attitudes of patients and staff in respect of the willing cooperation of both parties to the transfer of responsibility for professional opinion. There is however a growing view in society that people who come into hospital should be able to expect certain standards of behaviour from all hospital staff. Patients expect to be treated as human beings, accorded the dignity of being called by their proper names, not by such diminutives as 'grandad' or 'love'. Patients, particularly in antenatal clinics where they are not ill but just undergoing a normal event in life, no longer willingly tolerate being treated as numbers in a cattle market, herded from place to place with no consideration of comfort, no explanation of what is happening and no thought given to the fact that many have to pick up other children from school and cannot afford the time required by systems designed by and for the staff rather than the patients. Complaints about inefficiencies in the system are met with bland rejection: 'You just don't understand the difficulties we face – the pressure is increasing all the time'; or the assumption of a professional pose: 'It is important that we give every patient the best care at our command and you must understand that we know better than you'; or patronising platitudes: 'Don't worry your head about that – the doctor is a very busy man'. The Machiavellian reply 'I know – it is bad isn't it' is becoming recognised by the clever receptionist as the easiest way of fobbing off the complainer. Honesty and an explanation to the patient is the exception rather than the rule, usually because it involves someone in the system, or even the system itself, being called to account for failure. This also takes time and an

understanding that the patient's fear of illness is most often expressed by impatience with a system he finds puzzling. Unless there is a marked change of attitude and growth of commitment to providing a service geared to the patients' interest rather than organised for staff convenience, these problems will continue. It is perhaps surprising that a service designed to support patients when they are in need does not seek the involvement of patients in making the service comfortable for them; at the same time, it is ironic that patients will accept shortage of money as a reason for a poor service but will not attribute any difficulties they may encounter to attitudes which they have allowed staff to adopt over the years.

One of the biggest problem areas currently under scrutiny is the stance a profession takes over ethics. Professional medical opinion is no longer confined to clinical judgements about individual patients, but has moved into the field of resource use, primarily as a defence against litigation, and into the field of human rights. The practice of withholding clinical information from a patient because the doctor feels that he is responsible for his patient's wellbeing, and that to reveal such facts would be detrimental to the patient, and in some cases also to his family, is now clearly being challenged by human rights groups and others who are genuinely seeking to help the individual patient retain his rights, responsibilities and dignity. Doctors are trained to treat disease and little attention is given to teaching them how to talk to patients. What teaching they do get tends to come from other doctors. Perhaps this training should be given by patients.

Without even the excuse that confidentiality within the doctor/patient relationship is being transgressed, doctors resist these challenges to their autonomy of decision making with as much strength as they resist power being given to the Ombudsman to investigate their professional activities. Patients are more educated and articulate nowadays and do not necessarily have the respect for the medical profession that they used to have. Not only doctors but other health professionals are withdrawing into their professional institutes, and the standards required by the institutes are tending to take priority over the needs of the people in their care.

Tomorrow's solutions to today's problems

Returning to an old theme, the increase of investigative and diagnostic work in hospitals as a defence against litigation is becoming a problem of such financial significance that radical approaches are required to limit its growth. First, as I have already said, public attitudes must change and personal responsibility be re-established over the medical

machine. Second, recognition should be given to the fact that time invested in explanation to a patient now will pay off later in subsequent re-development of personal responsibility. This will require considerable improvement in the education of health care professionals, particularly in the field of human relations and communication skills. Third, the service, including not only its professional and supporting staff but also the government which funds it, must move into the business of risk management. This is equally a change of attitude; what is needed is recognition that mistakes will occur, not necessarily through negligence, and these mistakes will have to be paid for by way of compensation for damage done. Culpability of the service must be acknowledged without the concomitant culpability of an individual being over emphasised. It must also be acknowledged that medical practice is not an exact science, nor is our knowledge of the process of disease complete, and it may not need to be. This should lead to a moderation of defensive medicine and of ill-judged intervention, and a consequent lessening of demand for resources for those purposes.

Lastly, a wide ranging public debate on the alternative propositions of an expensive, high technology, litigation-conscious service as opposed to a human health service, and an adequate compensation fund for service failures, should be embarked upon as a matter of considerable urgency.

So what can we do?

What does all this mean for the chief executive officer with his responsibility for overall coordination of a part of the health service?

First he is in a unique position among his professional peers in that he does not have any clinical role. His professional responsibility is for the management of resources and the application of those resources in an appropriate way. A development of this argument is that it should be easier for him to see the service from the point of view of the patient, without clinical bias. He is the only member of the team who is in a position to act as the patient's friend rather than the patient's therapist. As such he should hold a key position on the patient's behalf. He will doubtless have difficulties with his professional colleagues in sustaining that position, but it is worth trying to earn it.

Second, he is in a very strong position to influence the whole organisational objective. The nature of the institution is such that it resists change. The administrator has to contend with organisational inertia, but more importantly he has to seem to attack the very basis upon which the service has been built, by challenging, on occasion, the

individual professional whose role is enhanced by the work he has done for his patients and by the support of the whole institution. The chief executive officer must direct the organisation's objectives towards the patient's point of view rather than towards the professional's.

Third, he must change the organisational culture, and he is in a position to achieve this. In doing so, his role is at best educative and participative, at worst subversive and Machiavellian. His educative and participative contribution to this change finds its main expression when the organisation's plans and priorities are being drawn up. It is at this stage that the service's staff-oriented, institutionally-biased and self-defensive objectives can be turned towards patient-oriented, community-biased and openly-managed objectives. This most commonly occurs when budgeting policies are being discussed and agreed. Some managers in the past have never faced the fact that development of services is possible without development funds. It has been difficult even to talk about redeployment of funds from areas of lesser need to areas of greater need, let alone achieve it, and the financial climate has previously not made this necessary. Persistence in looking for redeployment opportunities, starting as a personal objective but, in time, becoming an organisational objective, must be an important quality in the chief executive officer. He will be assisted by the fact that demands for treatment services are increasing simultaneously with a decline in the economy, forcing consideration of how much technology can be afforded at a time when its value and effectiveness may be in doubt.

The Machiavellian component assumes that the chief executive officer is a good administrator, a first class systems man with a better knowledge of procedures and regulations than his colleagues. He can use 'the proper channels' in ways that his colleagues cannot. The guide to 'Effective Maladministration in the Achievement of Unstated Goals' has not yet been written but it is a book almost in daily use. There are many ploys but most tend to be derived from the need first to increase by redeployment the small amount of money available, and then to stretch it over as many of the underprovided services as possible to achieve the greatest good for the greatest number. For example, growth in a small budget is of greater proportional effect than the same amount of money applied to a larger budget. If a service wishes to expand it is at liberty to do so, but only within existing resources, that is by cutting out the less needed parts of the service. There are other examples and all need to be accompanied by a consultation process specifically designed to encourage committees to think that they have taken the 'real' decisions.

Fourth, the chief executive officer has a training role. He exercises this informally with his colleagues, but it is with his own subordinate staff that his real responsibilities can be demonstrated. He must ensure this his staff understand their role within a service whose objectives must be patient based. Their effectiveness as administrators must be unchallengeable and their motivation beyond question.

Fifth, he must continue to remind his colleagues about the dangers of extrapolating from a sample of one, and that the purpose of the enterprise is to provide services which are for the benefit of the whole community, not simply for those individuals with interesting conditions. It is particularly important to retain a healthy scepticism about miracle cures.

Lastly, he must make his colleagues recognise that health services are provided for individuals, all of whom need to be treated with compassion and understanding, and whose fear of the exclusive atmosphere of a modern hospital may cause reactions which challenge the assumption that hospital staff know best what is best for the patient. The patient does ultimately have the right to be told what his problems are and to decide what he wants done about them. We must never condone the loss of that right.

References

1 Kennedy, Ian. *The unmasking of medicine.* London, Allen and Unwin, 1981.
2 Office of Health Economics. *The health care dilemma: or 'Am I kranken doctor?'.* London, OHE, 1975.
3 Parsons, T. *The social system.* London, Tavistock, 1952.
4 Last, J M. *The iceberg: 'completing the clinical picture' in general practice.* The Lancet, vol II, no 7297. 6 July, 1963. pp 28–31.
5 Cochrane, A L. *Effectiveness and efficiency: random reflections on health services.* London, Nuffield Provincial Hospitals Trust, 1972.
6 Dick, D. *'Magic' hospitals are cruel to patients – claim.* Nursing Times, vol 76, no 44. 30 October, 1980. p. 1907.

Commentary
by Robert Maxwell

> 'No profession yet invented has special expertise in deciding ends' Rudolf Klein

This third section deals essentially with relationships between the providers of health services and those whom they serve. While the subjects covered in the first and second sections (coordination among the heterogeneity of providers, and managing conflict) are undoubtedly compelling, arguably this third topic is even more fundamental. After all, however smoothly a service may be run, it must ultimately be judged by how well it does its job for individuals and the community.

Professor Rudolf Klein's contribution provides a backcloth for the whole section. He first notes a mood of self-doubting introspection among health service providers, and indeed among the providers of other social services: people have become much less confident than they were about the impact of these services. He reminds us that there is nothing new in recognising how strongly health is influenced by factors other than health care, but argues against too heroic an extension of the attempts of health policy makers and administrators into fields where they have no credentials. He then turns to the issues of responsiveness to public needs and mechanisms for public involvement. In a sense the central question posed by this paper is what happens when market systems fail, or operate imperfectly, as they must in the health care sector. What else can we put in their place?

The question is relevant at all levels – from that of the individual patient, through the institution or local community, to provincial, state or central government. For simplicity one can select three principal levels among these; first, the patient and clinician; second, the institution or health authority; third, the government. At each level, who should decide what services to provide at what cost, and who should participate in the process? How should one set about implementing these decisions? And who should assess what happens – its acceptability, its consequences and the next steps to be taken?

Clearly some of these decisions should lie unambiguously with experts, particularly where they are technical. In the operating room, as in the cockpit of an aircraft, the expert must take total responsibility. This is by no means so clearly the case in non-technical matters, particularly those about ends. At the level of individual treatment the patient has the ultimate right to refuse treatment (except where his condition represents a hazard to others) and should be more involved

in making choices than he often is. At the local and national levels the experts, whether clinicians or administrators, cannot on their own safely decide the overall level of expenditure, nor the balance of priority between services for different groups of people.

But at each level, including the national, experts should have an input to the decision, since they should know what is achievable, and implementation will largely lie with them.

Commonsense says, surely, that there is a need for dialogue at each level between at least two parties: the consumer, or his representative, and the provider. The matters for discussion will vary, and where the final decisions must lie. Concerning ends, the responsibility lies more with the consumer, or government on his behalf. Over means, responsibility lies more with the provider.

That is, of course, oversimplified. Increasingly, other parties are involved. Where the bill is not paid by the user at the time of use, nor directly by government, those who do pay the bill (health insurance organisations, employers, trade unions on behalf of their members) have a legitimate concern. Other groups are also active, lobbying for those with particular conditions, interests or points of view. And, among providers, most services have become so complex that several different professions or agencies may well be involved.

In case that sounds intolerably complicated and time-consuming in terms of consultation – and in many instances it has actually become so – we should perhaps examine the idea that an implicit contract underlies all this talk about the need for dialogue. The clinicians or provider organisations agree (even when the agreement is unspoken) to treat the patient in his best interests within the limits of available skills and resources. The consumer and the community also have their side of the implied bargain in terms, for example, of behaviour, trust and payment. The contract does not need continuous discussion, so long as each party respects the other's need to be consulted when choices arise that call for his interpretation of the contract.

The papers by Sister Irene Kraus, Peter Carruthers and Hugh Evans are case studies of the relationships with local communities. Peter Carruthers writes about the development of Ottawa Civic Hospital and explains how necessary it was to win community support. The hospital had to go out and sell its proposals. In the process it and the community learned much about one another: one hopes that this understanding will survive the specific project and form a solid base for future partnership. Sister Irene's case, dealing with Lutheran Medical Center in Brooklyn, is a fascinating account of a novel solution to a common dilemma. The community in Brooklyn has changed radically. Should the hospital, which was founded to serve the

original Norwegian community, continue in its orthodox role as a provider of acute services? Should it move to another neighbourhood? Or should it refashion its role within a deprived and blighted community, which has many pressing needs besides those for acute services? In essence the problem is repeated in many hospitals in inner city neighbourhoods. What is unusual is the Lutheran Medical Center's response, which was to give top priority to its community role – not only by developing community oriented health services, but also by other, more novel actions. For example it is now located in a renovated factory in what was a rundown area. It has developed a variety of recruitment and training programmes to maximise local employment in the hospital. And hospital resources have been lent to community groups to aid them in housing, education and many other projects.

Hugh Evans' paper reviews attempts to strengthen community involvement in health services in New Zealand, and then describes one specific project in Poriura, near Wellington. Poriura is a relatively deprived community, including Maoris and Pacific Islanders. The project has involved assisting people who live or work there to decide what they want to do to help themselves, and has then supported them in doing it. Projects like this one are fragile, sometimes slow moving, and absolutely dependent on the personalities involved. For all their difficulties they are, surely, more likely to produce growth and resilience in a deprived community than a more paternalistic extension of services based on what providers think best.

Bill Lawrence also is concerned with links between providers and the local community, with particular emphasis on attempts to promote health and prevent disease. This is a theme taken up resoundingly by John Evans in the final paper. He argues that senior managers have a unique opportunity and responsibility to shift the emphasis of the health system from an increasingly expensive, high technology, litigation conscious service towards one that is more human.

The principal conclusions from this third part of the book are, I think, two. In the area of prevention there is only a limited amount that providers can or should do, in light of their skills, and compatible with the principle of personal liberty. To a large extent it is consumers and their representatives, including government, who have the principal responsibility to act. Second, the consumer side of the implicit contract needs conscious strengthening. At the individual level, this is largely a matter for clinicians rather than administrators, to see that individuals understand their treatment, the reasons for it and the options open. At the intermediate level of institutions and community, boards have often made a disappointing contribution, and if anything this has worsened with the erosion of authority of many old established boards

of trustees. Difficult as the task is, we have no alternative but to try to create stronger structures, help members understand their role and work better with them, for example in what goes on the agenda, the making of choices where real options exist, and in assessing results and standards. The implicit contract requires a partner to the contract at that level, not a man of straw.

IV Epilogue

In all five countries from which the material in this book is drawn, the 1980s have begun with a recession and a period of continuing high inflation. Governments have everywhere been concerned to restrict the growth of public expenditure, including expenditure on health services. That much is common, but the paths then diverge, depending on whether a particular government sees the solution lying in a reduction of public involvement in the provision or funding of health care, or in cost containment, or in more decentralisation of responsibility for health care to the provincial, state or regional level. These and other options are not mutually exclusive. Each government can choose its own package from among them, depending on its aims, values and circumstances.

At the end of the day, however, many of the issues will remain the same, such as those discussed in this book. And the criteria by which the overall effectiveness of health care in any country should be judged will also be fundamentally the same, such as access, quality of care, customer satisfaction, equity, cost, and responsiveness to changing needs and circumstances. The experience of other countries and other systems will continue to be at least as important in the future as in the past, if policy paths diverge substantially. For the different systems have different strengths and weakness, and the different policies have different dangers. There is therefore everything to be said for asking from time to time how the performance of one's own system looks to the proponents of a different system. In the next few years, for example, key questions for Australia and the United States – with their policy emphasis on cutting back public sector activities and encouraging private sector growth – will be what happens in terms of value for money, and who gets hurt in the process? Will there be lavish spending and elaborate services where private sector investment is attractive, and a massive neglect of some of the most vulnerable groups in society? The same questions could apply in the United Kingdom, if the present government is elected for a second term. In addition, the United Kingdom (and to an extent the other systems included in this book) face the question how standards can be kept high in a public sector system that is under attack, and how stasis can be avoided. For all its obvious faults, the private sector in the United States is quick to respond and innovate – as for example in the recent surge in growth of multi-hospital systems which forms the background to Don Wegmil-

ler's paper. Could something of that same flexibility, responsiveness and experimentation be captured in a more decentralised National Health Service? That would be in line with the rhetoric of the latest restructing of the NHS, under district health authorities. But it will certainly not happen automatically. Central government and the regional health authorities will need to encourage and support local innovation, and the DHAs themselves will have to show qualities of adventurousness that have been much commoner in private than in public systems.

Thus one of the principal values of international comparison of health systems is to look at one's own relative weaknesses and what can be done to remedy them. Paradoxically one may learn most from systems that are most unlike one's own, and are based on different values and traditions. For such systems may be at their best in precisely those dimensions of performance where one's own system is least satisfactory.

Moreover, despite the differences, there is much common ground. All health systems must always be intensely concerned with human relationships – relationships between patients, their families and those whose help they need; between the public and health service institutions; among different groups of staff, and between different organisational levels. This is the topic explored in the preceding chapters, against a common background of economic recession, some weakening of traditional hierarchies and disciplinary assumptions, and (as Rudolf Klein notes) a mood of doubt and introspection among the providers of health and other social services. At the risk of oversimplification, some of the principal conclusions of the preceding chapters can be stated as a series of propositions.

Coordination within institutions

Each health service institution or agency needs ways to draw together the diversity of its efforts, particularly when there is competition for scarce resources and a need to review the balance of its activities. Many forms of coordination happen naturally among hospital departments and between disciplines, without senior management intervention. But there must also be mechanisms for resolving differences, determining the balance among programmes, and formulating overall aims and strategies. It is part of the function of senior managers to see that the means exist for reaching decisions on these matters, and that people understand and have confidence in them, even when they disagree with a particular decision. Organisation is important for this purpose (see, for example, the paper by Ralph Moore), and so is

process (Charles Hollenberg). So also is the institution's management style, or way of doing business (Harvey Barkun).

Coordination among institutions

We have noted at previous international seminars that, typically, hospitals in North America and Australia have at the institutional level far greater maturity and depth of senior management than in the United Kingdom. They also usually have their own governing bodies. While the need to strengthen unit management in the UK is widely recognised, and is a specific aim of the latest reorganisation, the shift to a multi-institutional focus in health systems is timely. For there are questions of strategy, balance and resource use that cannot be handled within any one institution. The two British papers in the first section, by Duncan Nichol and Bob Nicholls, deal with this broader arena. In essence the structures, processes and style needed to draw efforts together among agencies and between levels in the system are similar to those needed within an institution. But the issues to be understood are more wide-ranging and it is even more difficult for senior managers to establish and maintain the trust that they need to handle these issues effectively. Nevertheless they must (as Bob Nicholls puts it) play an interlinking midfield role, calling for some new skills, compared with traditional hospital administration, but also for the same fundamental qualities of concern, integrity and practicality.

Management of conflict

The papers in the second section of the book all concern the handling of conflicts with groups of staff and their representative trade unions or associations. While some conflicts can be avoided, others are inevitable. Indeed, as Claude Forget maintains, administrators may be too inclined to seek to evade conflict. The management of conflict calls for the careful use of established procedures and for painstaking documentation, although these are not by themselves enough. There must also be a capacity to think strategically: to see what is at stake from each party's point of view; to envisage what is likely to happen before it does; to find solutions that go beyond the obvious; and to conduct the dispute in a way that minimises harm to non-combatants and allows people to work together constructively once the dispute is settled. Of course all that is easier to say than to do, but once accepted it indicates approaches and skills that can be developed to handle a crucially important aspect of management in health services in our time.

Individual and community involvement

People should be involved in safeguarding their own health and in their treatment when ill. In the broader local and national community the choices about policies affecting health, and about priorities for the use of scarce resources, should be public ones. Both propositions sound obvious and non-controversial. Their implications are not so straight-forward. On the one hand the consumer can become too passive, too uncritical and too lacking in influence upon how health systems are run. While on the other hand political decisions can be capricious, ill-informed and irresponsible in their impact on health services and health itself. There seems an inescapable need for more effective dialogue between consumer and provider, and at the local and national levels between public representatives and those in leadership positions in the health care professions and health services management. Many matters can properly be left to experts to decide: nobody in their right mind would want to tamper with (for example) a physician's clinical responsibility. Other matters, whether at the level of the individual or the community, are not of this kind. The manner of treatment, in a non-technical sense, should take account of consumer opinion. So should the objectives of treatment when choices have to be made.

To clarify when dialogue is needed the concept of an implicit contract seems to us to be helpful. The clinician and the provider organisation are responsible for doing their best for the individual patient within the limits of their skills and resources. The consumer and his representatives are responsible on their part for what can properly be called (by analogy with other professional fields) client decisions – the propriety of their own conduct, the objectives that they wish to achieve, how much they are prepared to spend. It is when the implicit contract calls for a clarification of client instructions that discussion must take place.

At the level of the institutional governing body or the health authority, boards must be helped to be more effective than they generally are. Senior managers cannot safely or properly work without public governance. Where it is weak, they must do all they can to strengthen it.

Health care systems have become some of the largest and most complex service organisations of the modern world. The 1980s face them with difficult and uncomfortable challenges – tight financial constraints, political uncertainty and social tensions, the appropriate use of medical science and technology, to mention only a few. The

running of health care systems must continue to be sensitive to people, both those who work in health care and those whom they serve. This book explores three areas in which senior managers have a crucial part to play: assisting in the coordination of effort by heterogeneous groups, managing conflict, and involving the individual and community. For none of them is there any magic formula. In each one, however, the quality and application of management will make a substantive difference, and are not fixed quantities.

List of Participants

Harvey Barkun MD Executive Director Montreal General Hospital	*Canada*
Ian H Beach AHA District Administrator Oxfordshire Health Authority	*UK*
John M Blandford Commissioner South Australian Health Commission	*Australia*
Peter R Carruthers Executive Director Ottawa Civic Hospital	*Canada*
Barry R Catchlove Director of Medical Services Royal North Shore Hospital	*Australia*
Don S Child Chief Executive Officer Royal Prince Alfred Hospital	*Australia*
Hugh D Evans Chief Executive Officer (Review and Development) Department of Health	*New Zealand*
John R Evans BA District Administrator North Lincolnshire Health Authority	*UK*
Claude E Forget MNA Member of Quebec National Assembly	*Canada*
G A Hart Assistant Secretary Department of Health and Social Security	*UK*
John Hoare BA AHA Regional Administrator Wessex Regional Health Authority	*UK*
Paul B Hofmann Emory University Hospital Atlanta	*USA*

	Charles H Hollenberg MD FRCP(C) Professor and Head of Department of Medicine University of Toronto	*Canada*
	Rudolf Klein MA Professor School of Humanities and Social Sciences University of Bath	*UK*
	Sister Irene Kraus President Providence Hospital Washington DC	*USA*
	William G Lawrence Deputy Regional Director of Health Illawarra Region	*Australia*
*	J Boyd McAulay Executive Director Toronto Western Hospital	*Canada*
	John E McClelland Executive Director The Geelong Hospital	*Australia*
	J C Martin President Canadian Hospital Association	*Canada*
	Ralph D Moore Executive Director The General Hospital Health Sciences Centre St John's, Newfoundland	*Canada*
	Duncan K Nichol MA AHA Regional Administrator Mersey Regional Health Authority	*UK*
	Robert M Nicholls BA DSA AHA Regional Administrator South Western Regional Health Authority	*UK*
	H G Pledger MD MB BS FFARCS District Medical Officer Northumberland Health Authority	*UK*

* Unable to attend

Haynes Rice — *USA*
Hospital Director
Howard University
Washington DC

Leonard B Schaeffer — *USA*
Executive Vice-President/Chief
Operating Officer
Student Loan Marketing Association

L A Shanks — *New Zealand*
Deputy Director (Administration
Division of Hospitals)
Department of Health

Bernard Snell — *Canada*
President
University of Alberta Hospital

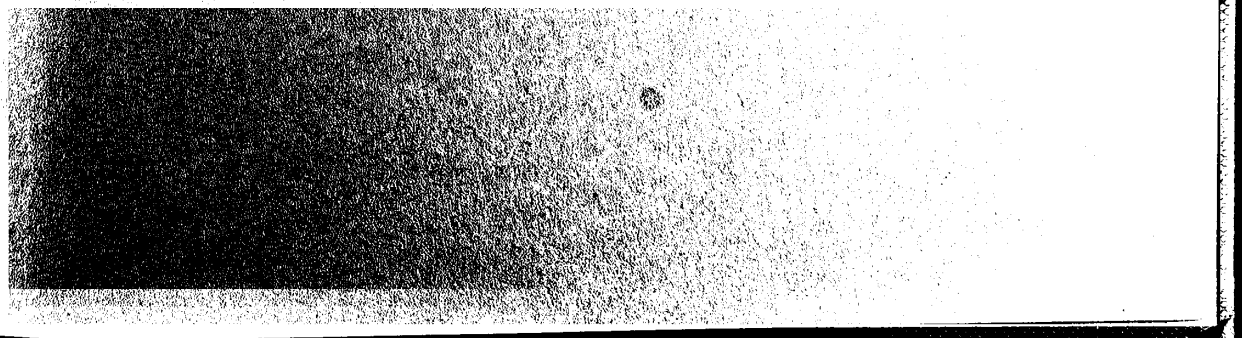
Gail L Warden — *USA*
Executive Vice-President
The Hospital Research and Education
Trust and American Hospital Association

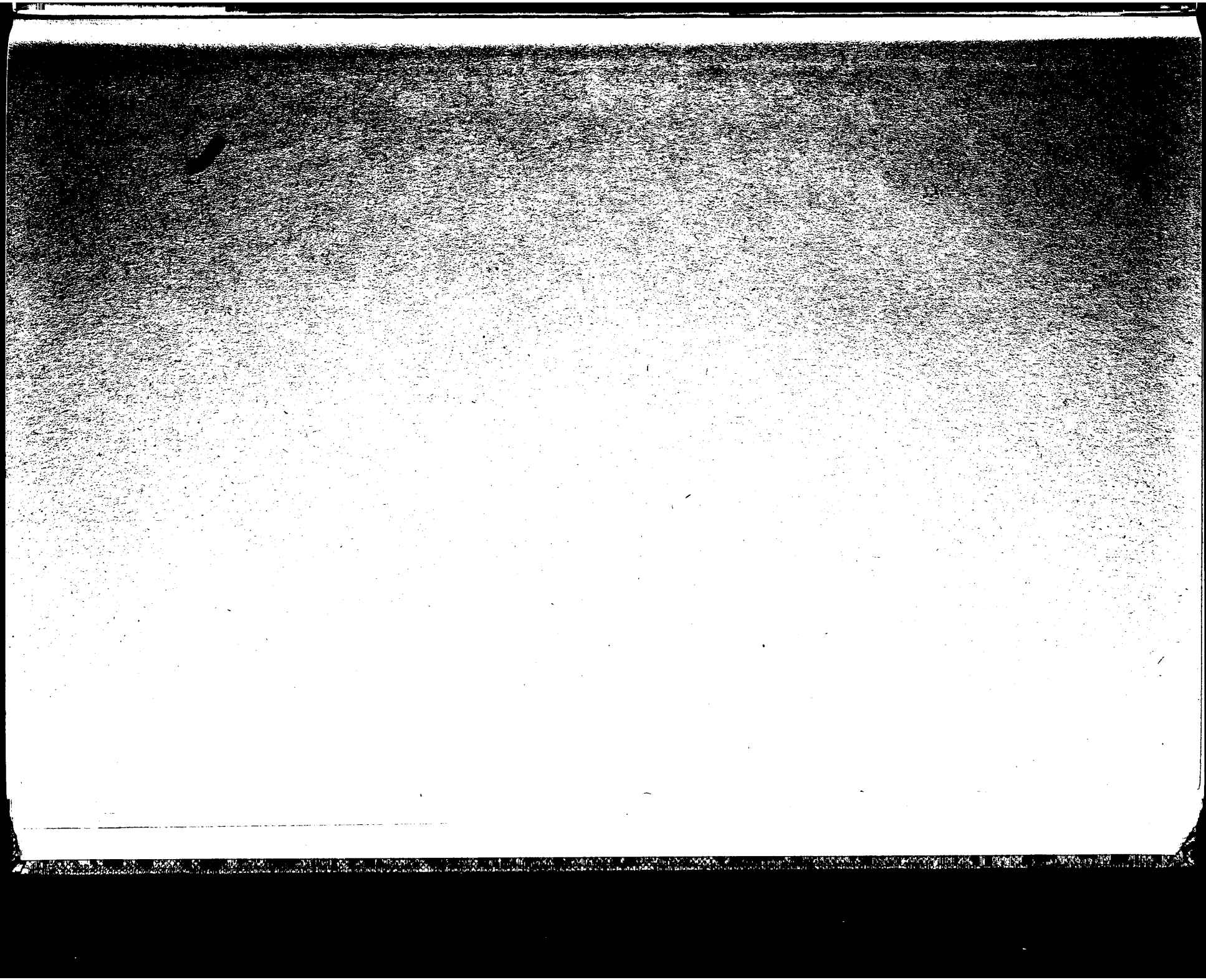
Donald C Wegmiller — *USA*
President
Health Central Inc

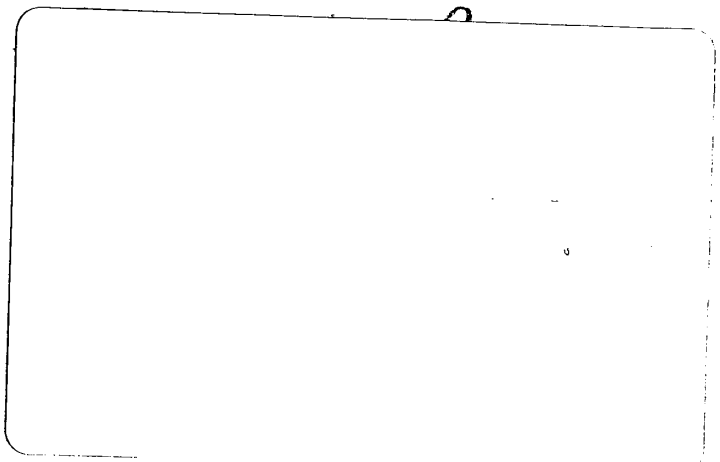
Authors and titles of other papers

John M Blandford	How does the chief executive officer integrate the work of various groups? How does he deal with conflict? What are the real causes and issues?
G A Hart	The National (or local?) Health (or sickness?) Service
John Hoare BA AHA	National update: the United Kingdom
John E McClelland	The Australian health scene 1980
J C Martin	Professional health manpower issues and solutions
	The Canadian health care system: a national update 1979–80
H G Pledger MD MB BS FFARCS	Doctors and management: the resolution of differences in power and objectives
Leonard B Schaeffer	The hospital as the 'doctor's workbench': can the US afford it?
L A Shanks	Health services in New Zealand: the national scene
Bernard Snell	Involvement of the individual in his own care, and of the family and the community and sensitivity to the wishes of individuals, families and the public in the provision of services
Gail L Warden	Health care delivery trends in the United States

Index







Other titles from the King's Fund

Industrial relations in the NHS – the search for a system

Edited by Nick Bosanquet

'. . . an informed and objective account . . . It is precisely because it illustrates so well the diversity and complexity of the subject that this study makes a valuable contribution to our understanding of it.' *British Medical Journal*

£7.50 ISBN 0 19 724604 4

Commissioning hospital buildings

by Graham Millard

This guide is the only one of its kind in hospital literature. It brings together much of the expertise now available in the British National Health Service and, although written in the context of the British health care system, the managerial principles and much of its advice are applicable to new hospitals all over the world.

Operational systems, equipment and supplies, personnel management, public relations, engineering services and financial control are the main subjects individually discussed, but teamwork and the vital managerial task of coordination are emphasised throughout as the main prerequisites for success.

£9.50 ISBN 0 19 724603 6

Living in hospital – the social needs of people in long-term care

by James Elliott

More than 150000 people in Britain are in long-term hospital care. Once admitted to hospital, many seem to slide helplessly into apathy. This is a new edition of a book first published in 1975. There has been a gradual decline in the number of long-term hospital residents since then but the book's message is still relevant, its tone is appropriate and it still has a useful role to fill.

'. . . deserves a particularly wide readership. It is concerned with the alterations to the social environment needed to transform an institution into something approaching a home . . .' *The Lancet*

£4.50 ISBN 0 19 724617 6