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INTERNATIONAL SEMINAR FOR ADMINISTRATORS

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"Providing Effective Health Care with Restricted Resources"

by

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KING EDWARD'S HOSPITAL FUND FOR LONDON

FOREWORD

As part of its policy to encourage the widest possible interest in health care management the King's Fund College has over the past 12 years organised a number of seminars with international membership. There are of course many opportunities for health care professionals to meet in international conventions or congresses. But most of these gatherings are large and proceedings are usually formal. By contrast the College seminars have been restricted to a membership of not more than 30 participants and the presentation of papers is normally restricted to the members themselves.

Most of these seminars have previously been arranged for European and North American participants but it was decided in 1975 to widen membership and to invite to the College a group of health service administrators from five English-speaking nations.

The general objectives of such international meetings at the College are to compare development and experience in the countries concerned with a view to personal and professional benefit for members and perhaps also through them to have some influence upon the health care systems of the countries from which they come. In that context it has been felt that the production of a report of discussion at this recent seminar might be of some general interest.

Mr Leslie Paine, who is the House Governor and Secretary of the Bethlem Royal Hospital and the Maudsley Hospital, London and currently editor of "World Hospital", was therefore invited to write this report of the seminar for administrators held in June 1975.

The overall theme of the seminar was to consider the provision of effective hospital services within the context of limited or nil growth of resources available to the health care system. What follows is a summary of the discuss which took place throughout the duration of the meeting.

There will perhaps be no surprise, in view of the complexity of the subject matter, that no final conclusions have been reached. Nevertheless it has seemed to the King's Fund that a publication in this form could have considerable general interest.

G A Phalp
London 1976

INTRODUCTION

The King's Fund College in London organised its first international seminar for senior health administrators from 2nd to 6th June 1975. Twenty-seven invited delegates from five English speaking countries came to Palace Court to consider ways and means of providing the best possible health care with restricted resources and the part that administrators play in such provision.

It was a theme well worn but well chosen, for the problem although old, has in recent years been given added dimension

That people seemingly have an infinite capacity for absorbing the attentions of doctors and their clinical colleagues, has long been accepted by government planners and administrators in all industrialised countries. Despite growing services (at increasing costs) the clamour for more from public and profession alike continues unabated, demonstrating clearly enough that our appetite for health care grows with feeding. But until recently, a rising demand for healt services has to some extent reflected a rising standard of living and growing national wealth. We have therefore had some extra money to pay for some extra services - even though the size of the total demand and its apparent inevitability must always give cause for concern.

Today however the situation has changed for a number of reasons but primarily because of two - inflation and social unrest. The former sharply reminds us that at those times when we are really short of money even noble institutions like Health Services are not immutable. The latter, among many things, openl questions the right of the professional providers to be the sole arbiters of what sort and amount of care should be doled out and to whom. The two trends go together, for scarcity breeds rationing, and rationing systems must be (and seen to be) fair, if some consequential suffering is to be accepted. It is therefore not unexpected that a period of world recession should be accompani by the emergence in many countries of a strong desire for new and better balanced forms of health service, more suited to public need and responsive t public demand, encompassing education and prevention in addition to treatment and embracing care as well as cure.

What is also to be expected is that this desire should pose new and considera challenges to those whose job is health care, and not just to the direct providers but also and perhaps more importantly to those whose responsibility it is to plan and organise provision. For given the need strictly to limit t resources that can be made available, it is obvious that new, expanded or improved services are only possible if better use is made of the people, buildings, equipment and money that exist already. The time has indeed come when, as Lord Rutherford used to say, 'we have no money so we must think'; a undoubtedly the next few years in most countries will provide the planners an administrators with ample opportunities of proving that necessity really can be the mother of invention.

But although administrators are theoretically expert in the organisation, allocation and control of resources can they be so in practice in the health care field? The real battle for health after all is waged not in the office or board room but in homes, doctors' consulting rooms, health centres, clinic wards and operating theatres - and it is there that the money is spent and th manpower deployed. Practically speaking therefore what sort of contribution can administrators make to the solution of the difficult problems now facing the services which they are supposed to manage?

This is what the seminar was designed to examine and its participants tackle the task in typical administrative fashion. Presenting papers on and discus both in syndicate and plenary session, various aspects of how health service are currently provided, they first looked at the health care scenes in the

countries represented - Australia, Canada, New Zealand, UK and USA - reviewed the systems in operation there and examined the role that administrators play in them. Then in greater detail they considered how each country produces, allocates and attempts to control its health manpower, tries to set standards of care and evaluate its effectiveness. Finally in conjunction with Mr Robert Maxwell, author of a recent McKinsey survey report: "Health Care: The Growing Dilemma", they looked at some of the pressing problems of provis including the achievement of a proper balance between primary, secondary and long term care; making the best use of the district general hospital, and h the politicians who finally control the services may be advised and influenc

THE HEALTH CARE SCENES IN THE FIVE COUNTRIES

Starting then with a general look at health care in the five countries, two common factors worth noting seemed to emerge from the presented papers and discussions at this stage. First that in attempting to provide health care equitably to all its people, every country faces the same basic problems; and second that the solutions to these problems involve each country in journeying on a road which must eventually lead to a Service mainly government owned, controlled and financed.

This latter point is not just a personal opinion or one that has come out of this seminar alone. It has appeared quite clearly in discussions during recent years on the Health Services of Europe and of the EEC countries. And at the 19th IHF International Congress in Zagreb in June 1975 the same point was made by Dr Russell A Nelson, President Emeritus of the Johns Hopkins Hospital, Baltimore, Maryland, USA, when he said during his René Sand Memorial Lecture on "Physicians for the Future":-

> 'Our countries differ as widely in systems of health care as they do in anything else. In general though, most countries have moved, or are moving, towards national systems under government financing, ownership and control in order to meet national goals. The most significant goal is to provide equitable availability of care for all citizens without regard to anything else but need.'

This is not to suggest of course that all countries have travelled far or are travelling fast along this particular route. The rate of progress in each individual case is obviously governed by many factors of which history, geography, size, population, political beliefs and social and economic conditions are but some. Certainly none of the other four here concerned has gone anything like as far towards nationalised medicine as the United Kingdom. But all seem to be moving in the same general direction and broadly for the same reasons.

In particular, as already mentioned, they are goaded forward by the basic problems of increasing demands and rising costs, brought about largely by the continuing advances of scientific medicine and the great expectations that these tend to produce in the minds of the people. In addition because most of them in the past have developed their services piecemeal, there is now a general concern that these services are unnecessarily separated or fragmented, unevenly distributed and in a state of imbalance especially as between hospital and community.

What is also clear from the information presented is that in every country (including that bastion of private enterprise, the USA, which is said to be trembling on the brink of introducing some form of compulsory national health insurance) existing services already rely much more heavily on some form of public finance than many will have realised.

The UK, of course, has had a National Health Service funded primarily from general taxation for more than a quarter of a century and has recently (in April 1974) reorganised its administrative structure with the express aim of providing more fully integrated care through comprehensive health authorities.

Canada, too, has had social insurance for hospital care since 1960 and for general medical care since 1966, with services received virtually free by the individual patients, and the Federal Government providing 50 cents of every dollar spent in these spheres by the ten Provincial Governments.

State funds in New Zealand finance the whole of the public hospital system there (80% of all beds), subsidise private hospitals and meet a portion of all charges made to patients by general practitioners and specialists. In December 1974 its new Labour Government published a White Paper on "A National Health Service for New Zealand" which, if it becomes law, will introduce a regionalised, integrated, comprehensive service on much the same lines as that now in operation in Britain.

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

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

Accepting therefore that while the health services of the five countries have their obvious national differences, they also have certain aims, trends and problems in common; how, if at all, does the way the services are managed help to achieve the desired aims, influence the trends and overcome the proble Is it, for example, true to say of health services as Alexander Pope said of other sorts of public service, that 'what is best administered is best'? Or does the form of administration matter little as long as it is unobtrusive and not too expensive?

What, in other words, do administrators do now and what can and should they do in the future to help make the organisation of the health care received by the man and woman in the street more efficient (i.e. more cost beneficial) and the care itself more effective (i.e. more appropriate to their needs)?

The question is a broad, not to say vague one, if only for the reason that many people at many levels of seniority and of many professional backgrounds are concerned in or with the administration of any health care system. Fortunately, the limited time available precluded the members of the seminar from attempting to study the whole administrative scene, even if they wanted to, and forced them to concentrate their attentions on one aspect only - albeit a major one.

Not unexpectedly, and quite rightly, they chose to examine the sort of administration they know best and which most of them practise. They looked at the general administrator holding a senior paid post directly concerned with patient care, rather than at his voluntary committee members, his more specialist or more junior colleagues, or his civil servant associates in government health departments. And since in most countries, except the recently reorganised UK (of which more later), administrators of this kind usually work in hospitals it was mainly the role that the health administrator plays as a hospital manager that came under the burning glass for more detailed examination. Even so, the seminar found the task of defining what his role is today and should be tomorrow, difficult enough to be described by one member as 'like trying to grab a column of smoke'.

To start with, there is no job description that can be applied universally to all the Administrators, Executive Directors, Presidents, General Managers, House Governors - call them what you will - who fill the senior managerial posts of the hospitals and health services of the world. In practice, as we all know, the job an administrator does (or is allowed to do) will differ according to his personal qualities and the circumstances in which he finds himself. His status with his professional colleagues and his Board of Committee, and their readiness to accept him into the policy and decision making councils, depends not only on his ability, experience and personality but (among other things) on local traditions, the ambitions and attitudes of his peers, and the wider social and administrative framework within which he works.

In every country, as a result, the responsibilities and authority of individual senior hospital administrators or those concerned with broader aspects of health care, are likely to vary widely - some having considerable power and influence, others being little more than book-keepers or minute writers. 'Each non-physician administrator', as one participant put it, 'has had to barter on an individual basis with physicians and Board members in his institution with the hope of "buying" a share of the substantive actic Although his comment referred to the current position in the USA, it describe a situation known and understood by health administrators everywhere. Like

God in William Cowper's hymn, the administrator in the health field has ofte to work in mysterious ways to achieve such little wonders as he is capable of performing; with stealth and exhortation being as necessary to his success as facts and figures.

'Thus', as the American participant just quoted went on to say, 'to talk at this time about the "role" of the health administrator in the USA as if it were a well defined or well accepted position is significantly to misinterpr the current state of affairs.'

Most of his seminar colleagues were prepared to say 'amen' to that, although the British contingent suggested that the situation he described is beginninc to change in the United Kingdom as a result of the new administrative struct for its health services introduced during the past two years. These structu while not identical for each National Health Service of the four United Kingc countries (England, Wales, Scotland and Northern Ireland) are all now design on the same basic pattern.

In each case the country is geographically sub-divided into regions and/or areas, and districts; with appointed Health Authorities at region and area responsible under the general direction of the central Health Department for the provision of comprehensive, integrated health care to their populations. Management on a consensus basis is undertaken by interprofessional teams of senior officers (administrator, treasurer, nurse, doctors) advisory to their Authorities at the two upper levels of the Service and directly responsible for the administration of services at the lowest - district - level. The public interest function is no longer undertaken by the Health Authorities and has been placed instead in the hands of new consumer bodies, the Communi Health Councils - one for every health district.

It is obviously too early yet to say whether or not the reorganised UK syste still to some extent blundering in the dust of upheaval and transition will more successful than the old. Probably it will never be possible to prove point one way or the other. Clearly its aims - integration of services so to provide better and more comprehensive care to the individual - are good a logical. But clearly also, on the evidence of preliminary reports, the new structure is expensive to run. Many critics believe in consequence that th benefits of coordinated planning and the ability to use resources more flexi may have been bought at the unacceptable price of a top heavy, cumbersome, costly and stultifying bureaucracy that will make good management impossibl

Leaving that for time to decide however and returning to the vexed question the true role of the health administrator, the UK participants put forward view that the introduction to the United Kingdom scene, of the health management team, although something of a compromise, may provide an indicat of what this role should be.

'Turning finally and modestly to the position of the administrator in the te one said (quoting freely from the manual describing the theory of the new N administrative structure) 'he is required to manage the "institutional supp services" and apart from his work as a member of the team, is accountable f the "the general administrative coordination of the work of the team". In last and very dull phrase is contained a major change in the explicit recognition and the work of the administrator.'

The seminar generally was prepared to accept this view of the administrato a 'coordinator of those who manage' even though most members were sceptica about the wisdom and likely efficacy of the UK's consensus management teams. The first they felt did not necessarily have to be coupled with the second and a single Chief Executive Officer could probably do the job just as wel without a team to support (or restrict) him. Indeed the opinion from Austr

(where the trained hospital administrator is a comparatively new development) was that a good administrator assumed the coordinating role anyway and as the professional manager among the amateurs, the generalist among the specialists, and the full timer among the part timers, automatically became the natural leader of the management team, whether formally constituted or not.

On the other hand as all agreed, we must never for one moment overlook the fact that good management, important though it may be, is not the prime function of a health system. Patients come to be treated not administered, and management must be the servant of the Service not its master. Certainly this is so in America as its representatives pointed out. The health administrator there is essentially a business manager concerned with financing and organising institutions and services primarily run for and dominated by, doctors.

Everyone in fact acknowledged that whatever else they may be, health administrators are financers and enablers with responsibilities for 'getting and spending' wisely in the interests of the sick and those who treat and care for them. The general opinion was that the clinicians of all professions recognised and accepted this, realising that someone who is not a direct provider of care like themselves and can therefore afford to be dispassionate, is a useful person to be involved in the allocation and often rationing of resources. Otherwise, to quote a Canadian comment, you might just as well put the fox in charge of the chicken coop and set the rabbits to guard the lettuce.

But though the administrator was undoubtedly involved in the allocation of resources did he - the seminar asked itself - have any real control or influence in this sphere? Some members thought that the USA (whose major hospitals are voluntary institutions serving no defined population and where the patients 'belong' to the doctors) was a prime illustration of the fact that in one sense he certainly did not because he could not make decisions stick in a milieu almost exclusively under medical control. Others argued however that in a number of more oblique and indirect ways the administrator undoubtedly did influence if not actually control resource allocation. He did so as a budget maker and cash controller for example; through his knowledge of systems and structures; by means of his direct control of institutional support services (hotel, building, maintenance) and of growing importance, through his increasing concern with staff unions and industrial relations. And while it was generally agreed that his influence on the way individual doctors use the resources at their disposal was minimal, he nevertheless exerted considerable sway when major changes, such as the building of new uni and the introduction of new services, were under consideration.

Dealing with change in fact and educating colleagues to realise that in a dynamic organisation it is the only constant, was also seen by many participa as a vital administrative function. In this respect the gap between clinicia and administrators should not be blurred but recognised and bridged. It was the administrator's job to help individual clinicians to see that, whether they like it or not, they are concerned with a wider caring Service and part of its overall management system, to whose policies and decisions they must be committed by participation. And since these policies and decisions will inevitably involve progress and change they must be made ready to accept this

Hospitals and health services after all like any other form of social organisation, cannot stand still. If they don't go forward then they will inevitably go backwards, and hospitals really are in some respects out of dat by the time they are built.

The administrator has a great responsibility here to help to ensure that plar for future development are not only practical but sensitive, flexible and

adaptable. As a professional himself now, he is also in the position in some countries - Australia and Canada for example - to influence politicians in the creation of government health policy.

In all countries however, the seminar agreed, his influence was necessary and could be important, in helping to make hospitals less introspective and more outward looking; more concerned to be part of a total service to a given community; more closely linked with domiciliary, preventive and educative medicine; more responsive generally to public needs. In this respect the UK delegates again mentioned with due modesty, an element of their new system which had been introduced specifically as a means to these sort of ends. The interprofessional, multi-disciplinary Health Care Planning Teams, to be set up speciality by speciality, and which would operate in health areas and districts, had been designed to look at the past, present and future theory and practice of provision, with the aim of balancing as equally as possible the resources available and the wishes as well as the needs of the consumer. In these teams the administrator would have to play a leading part helping members to set financial factors against wishful thinking and development fancies, as they looked ahead to produce their plans for the future.

Professional colleagues were unlikely to accept change however, just because the administration thought it was a good idea. It would take more than administrative opinion or intuition to convince them to stop doing or give up something, in order to allow a reallocation of resources in the public interest. To have any hope of success in this sort of endeavour, administrators would have to present clear objectives based on sound facts. This inevitably meant seeking once more those highly elusive butterflies - measures of performance and productivity. And if we did not voluntarily accept the need in our hospitals and other services for greater cost consciousness and performance orientation, then in due course, the public might well make us do so.

'The mystique of medicine, the lack of hard data and the reluctance to submit to outside review, will no longer I suspect, be tolerated by the health care consumer in the 1980's,' said one participant from North America. 'New institutional standards will have to be developed, to include such things as convenience to the patient (e.g. reasonable waiting times) cost efficiency (e.g. cost per meal) and the quality of nursing and allied health services. We have not applied sophisticated statistical techniques and mathematical rigour to monitoring costs in the health and hospital fields, and this will come to be expected of us. Administrators will have to assume the critical stance of epidemiologists quibbling about both our numerators and denominators. Current measurements of inputs and outputs lack the sensibility and rigour to be effective management tools.'

But was necessity likely to be the mother of invention in this particular instance? Was the clear recognition by management of the need for better measuring tools any reason to believe that managers were capable of producing them? Experience answered 'no' to this question, for everyone present at the seminar was aware that the comprehensive information system capable of providing the facts which would allow health services to be effectively appraised and compared, just does not exist. Perhaps a prime function of the next seminar of this kind should be to consider whether such a system can be created or whether it is just another managerial pipe dream.

Meanwhile to summarise the long and sometimes wandering deliberations of the seminar on this aspect of its subject, the role of the health administrator as collectively viewed by the seminar members, appeared to encompass the following functions, tasks and responsibilities.

Occupying for the most part a position that has evolved somewhat haphazardly rather than being designed for him, his authority and influence inevitably varies according to his own ability and personality and to local circumstances. Basically he is concerned with the creation of an 'enabling process' (and particularly with its financial implications) which will allow the clinicians of all kinds to work to their full capacity in treating and caring for the sick. For certain institutional services comprised within this process he holds a direct responsibility, and in other ways - through his knowledge of structures and systems and through his involvement in industrial relations - he is concerned in the allocation of resources.

He certainly has a responsibility also for seeing that the money he helps to obtain and the resources it buys are wisely invested and properly accounted for. This responsibility makes it necessary for him to confer regularly with professional colleagues and understand their individual needs and points of view, while still keeping the total requirements of the whole institution or service firmly in mind. For this reason coordination - of those who manage resources; of the 'getting and spending' functions of his organisation (budgets, estimates and accounts) and of policies for the future - is a vital component of his job.

He has a clear part to play in the production and regular review of what might be called a corporate plan for his organisation, and in some circumstances may be in a position to influence government health policy. In the drawing up of this corporate plan he must be aware not just of the service with which he is directly concerned, but of its place in the wider framework of the total health care system. It is his job to ensure that his colleagues and especially his clinical colleagues are also aware of this wider framework within which they work and the need to husband resources. To this latter end he must help them to try to appraise the effectiveness of what they do.

PROVISION OF SERVICES

Turning its attention from a general review of the administrator's role to the part he might play in certain specific aspects of health care provision, the seminar first examined the way services are currently provided, how nearly they meet the needs of the public served, and how needs and resources may be more closely matched.

Were hospitals for example offering the care and treatment the public requires, the services the doctors were interested in giving, or - as seems most likely - a mixture of the two? Should every hospital, as the consumer of the lion's share of resources spent on health, be expected to accept a responsibility for providing comprehensive care to a defined local population, and if so how could priorities of current care be altered to allow this, and by whom?

Did the ways that patients gain access to care affect the utilisation of services and tend to distort demand? Was there a so-called 'cycle of deprivation', whereby because of fear, ignorance, lack of cash or other reasons, many of the people in most need of help were least likely to get it?

These and other similar and equally difficult questions occupied the members' minds and produced a variety of responses.

The Americans saw the rising costs of care rather than the methods of access to it as the main cause of imbalance between demand and supply. The swelling tide of expenditure must in consequence be stemmed by firm and if necessary unpopular measures, such as limiting capital money for new developments, modifying manpower policies to stop the production of more and more specialists, mounting determined campaigns to increase the productivity of individual professionals, and concentrating more effort on the extension of health education.

Australian opinion (supporting the proposition that taking account of ideological differences, all countries will eventually have health care systems free of financial impediment to the individual) was that some kind of regional or tiered administration would be required by every nation. The need to plan and control services, weld the private and public sectors into a complementary whole and collect the necessary service planning data would make such an administrative arrangement essential. And it was important that a strategic planning organisation of this kind should not be frustrated either by the reactionary views and restrictive practices of health professionals (administrators included) or by the doctrinaire attitudes of politicians.

Canada to some extent put a gloss on the American and Australian views with the suggestion by one representative that the three most important factors which could affect the provision of effective health services are government, the health professionals and the hospitals and their administrators.

'There are too few statesmen' he said, 'either in government, the medical profession or in hospital administration. This makes the ground rules for change difficult. Yet there are significant areas where the three groups could reduce the costs of health care over a short period, given strength of decision-making and a willingness to change for the public good. Government can legislate for the changes it needs to make. In a democracy however one cannot easily legislate change in patterns of

people's work or institutional roles. It is becoming increasingly more apparent that it will be necessary to develop better communication, coordination and cooperation at all levels in order to effect such change.'

This need continually to review our health care systems so as to adjust them to the requirements of the community was reiterated by the UK representatives who outlined in some detail the new planning cycle which was being introduced into the reorganised Health Service in the UK.

Despite the logic of the proposed planning system however one member of the UK contingent was strong in the belief that it still failed to concentrate enough attention on prevention and health education. In the latter respect he firmly supported the American view that health services should be less concerned with sickness and more with keeping people healthy. 'A man does not die from his illness' he implied, 'but from his whole life.'

But while all present accepted the principle embedded in this opinion, no-one was very clear as to how the principle might be put into practice. When it comes down to brass tacks (the collective conclusion of members seemed to be) we had little effective means of stopping people either drinking, smoking, eating or worrying too much, driving too fast or - to be brutally frank - living too long. For we had to accept that a major reason for spiralling health care costs in most countries was the increasing proportion of elderly people in their populations - people who, in the words of that harsh but factual phrase coined a decade or more ago - 'were preserved in a state of medicated survival'.

Whatever our views might be on the best ways to alter and improve the provision of health care however, the rising costs which formed the greatest threat to the amount and type of care we were able to offer were like time and tide, and would wait for no man. They certainly would not lie doggo while we happily spent our time trying to develop marvellously efficient modern styles of service planning or cost control, and more effective new methods of improving health education. Indeed if we did not wish the level of provision of services to suffer, and suffer severely in these inflationary times, we must (was the vehement view of one member) tackle the problem of increasing costs now - wherever, whenever and however possible. If you cannot do what you want then get on and do what you can, appeared to be his practical philosophy, and he certainly made his point. Large advances in cost reduction do not have to be made all at once he suggested but could well arise from a myriad of smaller actions. We should not be ashamed for example of seeking savings in such trivial ways as reducing hotel services to staff by cleaning rooms less often and asking residents to make their own beds. But neither should we shrink from taking more debatable action in the field of work of our professional colleagues. In times of extreme difficulty the 'freezing' of vacant posts, reduction of diagnostic tests and temporary closure of services might all be necessary.

Certainly in this connection we should be looking closely at any reasonable means of keeping people out of hospital beds and providing them with equally effective care more cheaply in the community - home care programmes for the elderly for example. As administrators we must also do our utmost at all times to resist being stampeded by our professional colleagues into allocating resources on the basis of shroud waving or "prima-donnaism". Equally however we must be prepared to put our own houses in order and root out ruthlessly any tendency to introduce unnecessary bureaucracy in whichever of its many guises it might appear.

We should also bear in mind that in every organisation the best is often the enemy of the good and that the planning of services (important though it may be) is not the same as providing them. Patients are helped directly by care and treatment not by planning, and whereas good planning well done may lead in the end to wiser final decisions and a better service, all planning basically delays action.

We must therefore be ready to challenge anything that we and our colleagues do at the present time so as to assure ourselves not only that it cannot be done better but also that it needs to be done at all. Professor Cochrane's recent monograph on the use of randomised controlled trials for example, had demonstrated clearly enough in some quite hallowed fields of medical practice, that fact and opinion are often, as elsewhere, far from identical.

In their consideration of these varied matters the seminar returned time and again to the fundamental points that health care professionals are generally speaking not yet used to looking forward and planning ahead; and even if they were the necessary planning data to help them take decision for the future is not available. Only in the psychiatric field in fact did there appear to be some serious attempts to collect morbidity information on regular and rational basis through the introduction of registers of psychiatric illness in some geographical areas. These profiles of psychiatric morbidity in a given community must surely facilitate the provision of more balanced community services with a proper assessment of priorities and an allocation of resources based on known needs. If the same sort of thing could be done in the field of somatic medicine might we not find answers to a number of the questions that currently baffle or concern us, and perhaps be able to decide once and for all such relatively simple points as whether people actually do require hospitals within walking distance or whether they need more health centres and a really good family practitioner service instead.

Finally discussion centred on some of the ways that service provision is affected by factors other than the needs, wishes, fear, ignorance or financial positions of patients. Just as the individual interests of doctors and methods of patient referral influence the situation so, some members suggested, do the methods used by drug companies to advertise and price their products. Provision is also affected by the way that doctors are paid, especially if this is on a fee for service basis.

In all countries represented except the UK, such a system was in operation either in whole or part, and the general view was that it tended to provide a disincentive to the creation of comprehensive, integrated care based on public need.

In Australia for example recent experience of community health centres staffed by salaried doctors providing a free service to patients, showed that this was more rather than less economic than the fee-for-service system it replaced and which, administrators believed, encouraged some doctors to provide services not always strictly necessary.

The New Zealand White Paper on a national health service for that country was also against the fee-for-service system on the grounds that it was too doctor-dominated and likely to discourage the achievement of a comprehensive, integrated, forward-looking, multi-disciplinary service.

But every question of course, has more than one side to it, and it is perhaps not unreasonable therefore to end this brief account of the seminar's review of the provision of services with a minority opinion advanced from an American source, on why the fee-for-service arrangement might have advantages. This view, expressed with some logic and force, reminded members that for all its faults, a properly balanced sytem of this kind was one way of directing doctors to areas where they were most needed and by the same token diverting them to the provision of the sort of care that the public required.

Mal-distribution of doctors and other professional health care workers of all kinds in fact, was one of several points considered when members moved on to discuss how the numbers and sorts of people required to run a modern Health Service on a national basis could be decided, provided and controlled.

To what extent - they asked themselves - should we attempt to determine the provision of manpower and types of personnel, and what is the administrator's role and responsibility here? And if such determination is possible can the way staff work also be controlled so as to allow if necessary, the substitution of one professional group for another in the interests of efficiency? Is it reasonable for the main groups of professionals to decide all questions concerning the education, training and qualifications of their members, or should those who employ them and adminster the Service in which they work also have a say in such matters?

Consideration of these and allied questions led to a lively debate the outcome of which, as might have been predicted, was a general agreement on the need for manpower planning in the health care world.

It would of course have been surprising had it been otherwise, for no-one present needed reminding that Health Services, in the words of that ugly but expressive modern phrase, are 'labour intensive industries' spending more than 70% of their money on staff wages. Lest representatives might forget this fact two papers - one American, one British; quoting national figures of four and one million health workers respectively - demonstrated clearly enough that few organisations in any country, (except perhaps the Armed Forces) employ more people. And few either employ a greater variety. For as the American paper noted, where once health care was in the hands of three professions - doctors, apothecaries and nurses - today there are more than 200 different health care occupations - a proliferation of professions, trades and callings which gives in the USA a ratio of 20 health workers per physician.

But though all were agreed on the need for manpower planning, opinions differed as to the best way of introducing it.

The basic problem, as the author of the British paper on the subject pointed out, was how to decide upon the number and sorts of staff you need without knowing what they are needed for. The implication of his proposition was that until the detailed objectives of a health care system were clearly defined and its priorities established, manpower planning was likely to be just a crude economic bludgeon used primarily to squash demands for extra staff. Most people present undoubtedly agreed with him and if questioned on the point would probably have admitted to a belief that the possibility of the weapon being given a more sophisticated use, anyway in the foreseeable future, was slim.

Other obstacles to the easy introduction of an effective manpower policy which the seminar saw as being especially difficult to overcome were Trade Unionism and professionalism, and the activities of political and public pressure groups. All were formidable, but none more so than the current power and influence of the professional bodies, staff organisations and trade unions. Demarcation disputes, and demands for higher wages, shorter working weeks, extra duty allowances, improved working conditions generally, and perhaps most important, a greater say in policy making - conducted only too often with the sword of strike action readily visible under the negotiator's cloak - were all capable of reducing even the most carefully designed manpower policy to nonsense. Similarly, the paramedical passion for professional status encouraging as it does more and more sub-specialist sub-optimisation and the introduction of ever longer and more complex training periods, posed a different, lesser, but nevertheless important threat.

Professions, as George Bernard Shaw once suggested, may safeguard the public but they also hold it up to ransom - a point touched on by an American participant. 'Do the nurses and doctors today' he asked (seemingly more in sorrow than anger) 'have a greater interest in who is going to be working for them than in whom they are going to work with?' It was an observation that appeared to express an undercurrent of opinion to the whole discussion. Control the number and variety of doctors working in the Service (members seemed to be suggesting), and you will automatically control the comet's tails of paramedicals, technicians, secretaries and clerks that spread inevitably in their wake.

And the way to do this, another American member proposed was by organising and limiting the number and allocation of medical training posts more carefully, and by closely restricting entry to the various medical specialties rather as the Central Medical Manpower Committee was now trying to do in Britain.

We must recognise the clear dichotomy which exists between the way health workers and particularly doctors are educated and the view in consequence that they take of their roles in the health care system; and the roles which the system would like them to fulfil. In the USA for example 70% of doctors had been general practitioners in the early 1930s and only 30% specialists. Today the figures were reversed and this great change had certainly not been brought about by any other body than the doctors themselves, dragooned by their education and training into joining in the march of modern scientific medicine.

To be effective therefore, as all agreed, a manpower policy for the health professionals must be planned on something more than a regional basis. It certainly required the creation of a national policy, and in the view of one Australian member, an international policy - presumably to ensure not only that hospitals do not starve communities, and towns the rural areas, but also that the provision of doctors between countries is at least made no more disproportionate than it is today.

On this latter point there was general acceptance that the distribution on staff was uneven and that shortages were often confined to certain areas. Canada was reported as having tried both financial incentives and special training arrangements in order to try to encourage staff to work in its remo areas. Neither system had been particularly successful although greater hop was expressed for a scheme in which the hospitals in cities and remoter area were being linked together.

No delegate ventured to put forward the nasty, brutish and short suggestion that the only real answer to the problems of manpwer distribution in the health care field was direction of labour; but there were hints that some countries might be moving obliquely in this direction. In the UK ways already exist of controlling to a certain extent where doctors work and further attempts are now being made through a reassessment of annual allocations of revenue and capital funds between Health Regions, to even out the standard of services available in them. British Columbia was also said to be introducing a scheme to organise and deploy its health manpower centrally.

But governmental efforts of this sort would inevitably come up against public opinion and possible resistance from pressure groups of all kinds. With so much talk in many countries throughout the world of giving the people a greater say in the planning of health services it seemed inevitable that they should play some part (even if only to be allowed to comment) in the preparation of so basic a thing as a manpower policy. But how in practice could a body of people as amorphous as "the public" be given their say in the running of health services? 'Caught between government policy and the wishes of the health professionals' asked a British participant 'how can the patient offer his view about need other than by presenting himself at his doctor's surgery with a specific complaint?'

The discussion was able to offer no detailed answer to these questions except to point out two facts. Firstly that there were now in the UK the new Community Health Councils which were specifically designed to articulate the consumer's wishes regarding local health care provision. Although as yet in their infancy, they were at leat a step in the right direction. Secondly there were in every country throughout the world public pressure groups, often in the form of national philanthropic associations and voluntary organisations, ever ready to champion the cause of those unfortunates in whom they were particularly interested. One way or another, the general opinion seemed to be, we had to face the fact that the consumer's voice was likely to be heard more and more as time goes on in the policy making councils of health services, including those that would be concerned with the preparation and implementation of manpower plans.

Somewhat daunted perhaps by the number, depth and variety of pitfalls that beset the seeker after an effective and practical method of health manpower planning, members with an almost audible sigh of relief, turned their attention to other aspects of the problem, hoping perhaps to discover at least partial solutions in the greater use of such labour saving devices as automation, voluntary workers and doctor substitutes. But even here opinions differed on the potential value of innovations of this kind.

Voluntary workers were welcomed by all but viewed as essentially a fringe benefit likely to make little significant impact on manpower policies. Automation it was agreed, was already accepted and in operation in many spheres of the hospital. It existed in departments as disparate as laundries and laboratories, and clearly there was considerable scope for its further extension. Some however saw that scope as being naturally restricted by the fact that at basis a health care system, if it is to be not only effective but humane, must also be personal.

'The health industry cannot substitute technology for manpower to the extent that other industries can' was the view of one representative from the USA. 'It is a personal service enterprise not dealing with the flow of commodities alone, or with a production line, but with individual human beings each one in unique need of personalised service.'

The use of doctor substitutes of various kinds, from specially trained medical assistants of all sorts to nurses with extended responsibilities, was viewed as an inevitable development and one which allowed some demands for care and treatment to be met at the lowest appropriate level of skill. American opinion was that as much as 40% of the work currently done by certain physicians could properly be delegated to personnel of this kind. The Seminar in consequence could hardly do other than agree that wherever cheaper labour could replace more expensive without detriment to the patient, then this should be done.

But what about the administrator's role in this area of health care organisation? Unfortunately the meeting reached no specific conclusions on this question and any attempt by the rapporteur to infer their collective views by deduction from the mass of discussion, must obviously be open to criticism.

It would not seem unreasonable however to suggest that the general view would appear to be that despite the problems to be faced, the administrator (centrally perhaps rather than locally) will have to take the lead if effective manpower policies are to be produced.

He must also be the person at all levels of the service who must try to educate the public's interest in the subject, perhaps as a sort of counter-balance to the inevitable pressure for increases that will come from the professional and staff organisations. In addition he must be prepared to try to set norms of manpower provision and to convince his professional and trade union colleagues of the necessity of adopting such norms in the twin and united interests of economy and the sick.

It will finally be his job to provide the specialist manpower planners to undertake the basic task of data collection, interpretation and presentation.

In general terms in other words it will be the administrator fulfilling his prime function as a coordinator and subsidiary functions as a provider of information and of specialist staff, who will in this sphere as in many others, need to bring together the appropriate groups of people able to make the necessary decisions and at the same time educate them to understand why such decisions are necessary in a changing health care world currently chilled by the bleak winds of inflation.

STANDARDS, ASSESSMENT AND EVALUATION

By common consent the discussion on the last of the set themes of the seminar - that concerned with standards, assessment and evaluation - was not as good as most of those that had preceded it.

Some members proposed that this was indicative of a general failure up to now of administrators everywhere to take a close enough direct interest in standards of efficiency and to press their clinical colleagues sufficiently firmly to introduce some method, no matter how simple, of attempting to set and measure standards of patient care. In this view they were supported by the writer of the American paper on the topic, two of whose many comments are appropriate for quotation here.

On the development of better standards of efficiency he had no doubt that administrators still had a long way to go.

'When the subject of standards is introduced, those pertaining to efficiency have been the most common focal point of the administrator's efforts. Nonetheless, it is apparent that the administrator has only been marginally successful in demonstrating aggressive leadership in the development of appropriate and imaginative criteria against which performance can properly be judged.'

On the question of measuring the quality and effectiveness of care he had this to say.

'Again the administrator should not be reluctant to take the initiative to influence the promotion of such standards. Too frequently the hospital administrator has been known to cling to his financial and budget documents like a security blanket, and as a result he has abandoned his vital role in improving the basic system required to conduct a rational evaluation of health services effectiveness.'

These opinions were not acceptable to everyone present however and an alternative explanation was advanced for the somewhat circumscribed nature of the discussion on this particular theme. Such circumscription was inevitable, said a number of members, when administrators were asked to consider procedures over which they had little or no influence and about which they could do virtually nothing.

To be fair to both points of view it is therefore appropriate that a support quotation for the latter contention, be provided from another submitted paper on the topic - this time from one of the two British papers presented. Discussing a previously expressed personal opinion that it would be tantamount to a confidence trick by administrators in the reorganised UK Health Service to support the concept of planning as the key management activity in the new Service, without at the same time being prepared to produce guidance on standards of activities and methods of evaluating the quality and effectiveness of services, the writer then added this paragraph.

'Even allowing for the fact that (the previous opinion) was written to provoke, it is in hindsight, laughably naive: the confidence trick has been performed and life goes on much as before. But the naivity lies not in the expectation that guidance on standards and evaluation should be provided, but that it could be. We tend grossly to underestimate the intrinsic difficulty of describing measurable standards in an area as value-laden as health care, as well as the resources which are needed to undertake the evaluation of any activity in the health field from

In essence of course each of these conflicting views has some validity. Administration has not in the past played as large a part in this particular sphere of activity as perhaps it might. On the other hand setting and measuring standards of health care is a notoriously difficult exercise upon which it is possible to spend much time and effort with no guarantee of useful results being obtained.

Few indeed would disagree with what appeared to be the general feeling of the meeting that the construction of a sophisticated, accurate system of measuring and comparing the quality of care provided by various forms of health service is still a very long way off and may in the end prove to be yet another administrative pipe dream.

The fundamental obstacle to the achievement of such a system, suggested a Canadian representative, arose from our inability readily to measure the productivity of a doctor, hospital or service when we had no definable product that could be set against the resources used and their costs. The success or failure of any particular form of care or treatment was usually gauged by whether or not the patient was better as a result. But how could you measure this "betterness." An avenue that might be explored, certain members thought, was the number of working days saved in getting sick people back on their feet as quickly as possible. But this particular yardstick would often be a matter more of guesswork than of accurate assessment; and anyway as some critics pointed out, many people are not workers, including some of the most regular recipients of health care - the elderly.

Another view put forward was that the value added to society by the return to it of the restored individual was the only genuine way to measure the effectiveness of the restorative care being provided. But while many were prepared to accept the principle of such a proposal, all were agreed that it was impossible to quantify "value added" in any meaningful way.

But even if a reasonably accurate and acceptable way of measuring health care productivity could be found, would clinicians be prepared to devote the necessary time and energy to its introduction and regular use? Is it likely in practice that through administrative action doctors will change their ways of working to those which managers may feel they can demonstrate to be more efficient or effective? Could the necessary change be brought about by discussions among peer groups, with clincial colleagues ready to criticise constructively both their own ways of working and those of others? Or finally, bearing in mind the prevalence of human nature even in the medical profession, is it reasonable to believe that physicians are unlikely ever to heal themselves in this particular respect and that any hope of achieving a method of measuring the effectiveness of care(of even the most elementary kind) is akin to whistling for the moon?

Certainly if all doctors adopt the disarming attitude of the Canadian Professor of Obstetrics quoted by one of his administrative colleagues, then this last viewpoint would appear to be the most realistic of the three. Told by the administration that certain of his patients stayed two days longer in hospital than the average patient with a similar condition elsewhere in Eastern Canada, the Professor's simple retort was - 'yes there is always room for excellence is there not?'

Yet as we all know, and as has already been proposed in other sections of this report, large and longstanding problems are in a sense like large and out dated buildings ready for demolition. It may not be possible to decimate them with one blow, but they may nevertheless be razed to the ground brick by brick. Our aim as administrators therefore should be to peck away at the problems of setting standards, evaluating action and appraising the effectiveness of what health services do, little by little and in whatever ways possib

As the writer of the British paper previously mentioned put it (quoting from Michael Warren's book "Evaluation of Services in Management and the Health Service"):-

> 'Total evaluation of a health service is complex and difficult. But evaluation of only parts of the service can be very rewarding for clarifying objectives and improving quality. It is better for the administrator to begin with simple concepts and gradually include more aspects, than never to have begun at all.'

Some of the known techniques and procedures that were already being used in this incremental approach to the problems were briefly noted during the discussion. These included hospital accreditation schemes and medical audit; quality assurance, utilisation review, and peer review programmes as practis in North America; and clinico-pathological, and admission-discharge confere which are used, albeit sporadically, in the UK.

From two other presented papers on the topic, it was also noted that conside efforts to measure and improve standards of care and practice were being mad in the UK through the work in geriatric, psychiatric and mental handicap hospitals of the Hospital Advisory Services established in 1969; and in Australia by such bodies as the National Hospitals and Health Service Commission, similar Health Commissions in individual States, and by the Conjoint Council on Hospital Standards of the Australian Medical and Hospita Associations.

But since the kinds of orgainsations interested in health care standards we many and varied (including, inter alia, not only governments, health authorities, statutory bodies like Britain's General Medical and Nursing Councils, voluntary organisations, consumer groups and the publicity media, but powerful professional and staff organisations as well) any proposed sch better to measure the quality of existing health care would have to be generally acceptable to disparate groups of people as well as more accurate and useful than present methods.

In the creation and introduction of such schemes we as administrators obviou had an important part to play, if only because we were all too well aware of the fact that despite pious hopes to the contrary, rises in standards of care all too often go hand in hand with rises in costs. Inevitably, however in this sphere of health service organisation, as in all others, progress would only come from determined and enlightened team efforts.

Perhaps, therefore, the most suitable epilogue to this section of the repor is contained in the final paragraph of the paper presented on this topic by Canadian representative.

> 'The interpretation of data and the evaluation of standards are used for many purposes. One important purpose is to enable care of inade quality to be recognised and improved. In this process the professio staff, the administrator, external organisations and government all play a part. It should be remembered that like Alice, we are seeing world through a looking glass, and our job is to try to make the reflected image as true a one as possible.'

SOME MAJOR POLICY PROBLEMS

Having completed their debate on the five aspects of the subject on which papers had been written in advance, members divided into syndicates for furth discussions of some of the important questions of policy which concern the organisation of health services everywhere. Those to which the seminar addressed its collective attention were mainly the major issues considered by Mr Robert Maxwell in chapter four ("Implications for Action") of his Survey Report published in 1974 of the health needs and resources in Western Europe, USA and the USSR - "Health Care: The Growing Dilemma".

With the assistance of the author himself who took the chair for some of the syndicate reporting sessions, members looked at five areas of health care provision, both generally and from their own particular point of view as administrators. These areas were:-

1) Developing preventive care and health education
2) Building and maintaining stronger systems of primary care
3) Improving long term care, expecially of the aged
4) Streamlining the acute hospital - including the use of "Value Improvement Project Teams".
5) The administrator's role in the political debate on health

This report will therefore be concluded by a summary of the main points made and conclusions reached by the syndicates during their deliberations. The length of the review is dictated by the space available but it is hoped that this forced but nonetheless commendable brevity has not resulted in ellipsis or significant ommission.

Developing Preventive Care and Health Education

While it was generally agreed that more attention paid to and money spent on these aspects of health care would theoretically repay themselves a hundredf some doubt was expressed (based on past experience) that this would necessar be so in practice. A comment made earlier in this report indicates that whi people should listen to and act upon the advice of health care educationalis warning them of the dangers of excessive smoking, drinking, eating, fast driving and so on, in fact many have not done so in the past and seem unlike to do so in the future. Admittedly this may be because much current activit in this sphere is vague and fragmented, but nevertheless during the current hard times large amounts of money and resources should not be diverted to th sector of health care unless they are carefully and selectively deployed, firmly supported by government action, and the results they achieve continua evaluated so as to encourage successful ventures but discontinue failures without delay.

Some areas in which further action might be fruitful were felt by members tc be anti- addiction (smoking, drugs, alcohol); accident prevention; selecti dietary advice; physical fitness; water fluoridisation; screening and immunisation. Properly mounted campaigns making full use of the publicity m could well meet with some success in these spheres, as now appeared to be th case in the USA where considerable efforts made to combat heart disease by changing dietary and exercise habits, seemed at last to be bearing fruit.

Supportive government action should include legislative and fiscal measures and the development of social programmes in spheres closely allied to healt housing, sanitation, welfare, etc. Was it also unreasonable to suggest tha the deliberate "high health risk takers", such as recalcitrant smokers and ignorers of car seat belts, might be asked to pay higher social insurance contributions?

Other benefits could accrue to existing overladen health services if the publ could be educated to use them more selectively. Such a process should logica start at home with more self help and self medication for minor ailments, and should also include an earlier detection screening programme in which the pub could have faith.

There were a number of ways in which administrators could use their influence in this particular area. Locally and directly they could help to ban smoking in hospitals; provide their captive patient audience with appropriate propanganda; and create an army of staff "evangelists" to propagate the gosp of preventive and educative measures. At regional level this approach might be indirect by advising and influencing politicians and the government.

Building and Maintaining Stronger Systems of Primary Care

Prevention and education were also seen as very much the realm of the general practitioner who had the opportunity of influencing the whole family and particularly the young. The family unit was in fact recognised by all as an essential element in a good primary care service. Surely the self help and health education there available could provide invaluable assistance to the general practitioner if properly mobilised.

But general practice - the very front line of defence in the health battle - had lost much ground for a long time now in face of the steady advance of me specialisation. Figures quoted elsewhere in this report show the decline that has taken place in the USA over the past 40 years, and similar trends were evident in the other countries represented. Fortunately that decline w now being halted and reversed, certainly in the UK and Canada and also perha although to a lesser extent in Australia and New Zealand, by judicious use o financial incentives, postgraduate education and vocational training in fami practitioner "residencies".

The movement in the UK to extend group practice and the provision of Health Centres, and to develop Community Hospitals in which the general practitione would be providing the medical staffing, were all calculated to improve the status of primary care doctors, recognise the fact that they dealt with the vast bulk of sickness, and at the same time reduce the load on hospital services by reducing admissions and accelerating discharges.

In order to fulfil his true function however a general practitioner must ha easy access to his specialist colleagues and to diagnostic services whenever necessary; and be provided with the opportunity of working in interprofess teams and in close liaison with the social services. Administrators both at unit level and above could do much to assist here by providing from hos departments, services that general practitioners require, and by attempting ensure that primary care received a fair proportion of available resources.

If a better service is to be developed however, more radical action than th was felt to be necessary. The way doctors are trained should be changed so to emphasise the importance of the primary care practitioner. The public n be educated to use primary care services properly and accept perhaps that t first point of contact with such services need not necessarily be a doctor could be a properly trained nurse or medical assistant.

Finally returning to the situation as it is today, members were reminded t primary care embraces such services as those provided in schools, industri and staff occupational health schemes. As administrators they were certai concerned in the introduction of the last, especially in hospitals, and al had an important part to play in this connection because of their responsi for the health and safety of staff at work.

Improving Long Term Care - Especially of the Aged

The vital importance of the family was again stressed during the discussion on improving the care of the chronic sick, long term mentally ill, mentally handicapped and the elderly. Among a variety of available services ranging from hospitals, (acute, long stay and terminal), nursing homes and day institutions, to hostels and home care programmes, there was a strong feeling that care by the family should have a - and perhaps pride of - place.

Caught up in the difficulty of defining "long term care", somewhat appalled by the size of the problem and a little confused perhaps by the moral and ethical issues involved, the seminar concentrated mainly on the care of the aged. Because there appeared to be such a range of services available the administrative mind turned naturally to the need for some better coordination of these - a task the administrator himself might well perform. Because also that other, ever present and necessary administrative obsession - costs - was so much in evidence here, the illogic of providing free hospital services and yet refusing to give subsidies to families who retain their elderly members, was seriously questioned. Australia was already experimenting in this sphere with the aim of reducing dependency of old people on institutional services. Other countries it was felt should undoubtedly follow suit, and administrator could take a lead in pressing for this sort of change as well as encouraging social workers and other colleagues to help them to develop allied arrangements such as neighbourhood resource groups and voluntary assistance. Again in this respect Australia was in the van of change, with Perth being reported as having organised through the teaching hospital a thousand volunteers to help care for the aged in the community.

Similar administrative leadership it was suggested might be exercised in creating interprofessional teams within the acute hospital so as to ensure a wider assessment of old people on admission; and educational groups outside the hospital designed to explain and so perhaps prevent some problems of ageing such as those of unplanned retirement. The administrator could also make a genuine contribution by helping the population at large and the health professionals to accept the need to allow people to die with dignity. Here, the British doctor-priest, Michael Wilson had shown in his books, the hospital chaplain could be the administrator's closest ally as someone who could give a new and proper perspective to the activities of the therapeutic team.

Generally speaking the seminar came to the conclusion that there was still far too little planning of services and care for the elderly and long term sick. Governments, central health departments and health authorities all seemed to have reacted to events (sometimes at the instigation of the public media) rather than innovating policies themselves. But unless the rest of the world are thought to be following Australia's line (where the expectation of life of the over-65s was said to be declining) we were all faced with increasingly ageing populations and must prepare to deal with their needs. The day might come - and even within 20 years - when we could find ourselves devoting almost half of our total health care resources to the elderly. We should therefore be thinking now of how to combat such a situation and might have to introduce "National Service in long term care" for all 18 year olds.

Streamlining the Acute Hospital - The Value Improvement Project Teams

Improving long term care and streamlining the acute hospital are as the meeting saw, inter-related and not just because both are part of a total service. The first in fact flows from the second, and in a perverse and somewhat illogical fashion stems in some measure from physicians wishing to unblock their acute beds, and the acute hospitals streamlining themselves in a spirit of what one might almost call "unenlightened self-interest". It is something of a paradox of scientific medicine that having done much to creat "medicated survival" and the need for long term care, it has managed rather less towards meeting that need.

Nevertheless as Robert Maxwell correctly pointed out, if we have acute hospitals they should fulfil their proper functions in a comprehensive Service rather than having to make good the deficiencies of other parts of the system. But if, as he rightly says, they are to be "tuned to a high pitch of efficiency in the task they are uniquely equipped to perform", we must be prepared to pay extra for this. Efficiency after all can cost money as well as saving it. Not only will we have to pay to bring the acute hospitals physically up to scratch as he suggests, but also (if they treat more patients of their rightful kind more effectively) meet the inevitably higher costs of increased turnover.

Whether or not the seminar countries will be able to afford fully streamlined acute hospitals was not however seriously considered by members. Instead they drew attention to the way such hospitals are currently run - a conglomeration of increasingly separated and sepcialised doctor's workshops - which must tend to militate against streamlining anyway. In some (Australia, for example) the way that doctors are paid could also hold up streamlining attempts. But even so, in all of them, rising costs and the desire for bette allocated resources would already appear to have forced attempts at streamlir of some kind.

In the USA this has taken the form of mergers, voluntary grouping of hospita and joint-contracting. In some parts of Australia such as Victoria and New South Wales, base hospitals serve in many respects the supply needs of smaller peripheral institutions and health centres. The UK, too, has area based services, inter-specialist care, and the proposed Community Hospitals, all as part of a genuine attempt to concentrate more on community care for the benefit of the public and hospitals alike. While the desire of Provinci Governments in Canada (for example, in British Columbia) to reduce costly acu beds wherever possible, has led to grouping of hospitals and specialities in order to overcome duplication of expensive services.

The general tenor of the discussion indicated a belief that the Maxwell app was accepted. In the complex of inter-related services that make up integr care (the seminar appeared to be saying) none can work in isolation and each must play its appropriate role. How the acute hospital could best be made do so was difficult to decide in any detail but it was agreed that Mr Maxwe Value Improvement Project Teams were a good idea and should be welcomed.

On the other hand they must be properly used since they were essentially a part of management designed to examine problems and come up with more effic solutions. They certainly required management support, and information whi management must supply. Their area of operation should cover the whole hospital in all its great variety, and if nothing else did, then pressure o limited resources would ensure their use to review clinical practice.

It was however recognised that teams studying different areas of the insti could well have conflicting aims and be strong forces for sub-optimisation. prime responsibility of administrators generally and those serving on indi teams therefore would be to remind their fellow members continually that resources were limited and that one area's improvement might mean another's reduction.

The Administrator's Role in the Political Debate on Health

This topic, inspiring in open forum perhaps the least discussion of any - clearly of greater direct interest and importance to members from some countries than others. The traditional ways that administrators had worke in the United Kingdom for example (anyway below the level of senior civil servants) made it much less likely that they could influence government he policy than could their counterparts in countries like Canada, USA and Australia which had different traditions and State and Provincial Governm as well as a Federal Government.

Despite national differences however the general conclusion of the seminar was that all health administrators at all levels should, if possible, be involved in political debate on health policies and should, if necessary, take the initiative so to be.

One basic reason for this was that our aim should be to try to ensure that Health got as good a hearing as other services when financial allocations were being discussed at government level. Another was because, recognising that in the end major decisions on health priorities are taken by politicians, at leas we as administrators should make it our business to see that such decisions were based as far as possible on fact rather than fiction or wishful thinking. Parliament may make the policies but these must be firmly based on the knowled and experience of those in the field if they are to be effective in the public interest.

Administrators who knew the facts of health care provision and who had to face the many and difficult problems involved, had a responsibility to acquaint the politicians with their knowledge in order that false promises should not be made to the public. It was important that the limitations on the services that could be provided and the restriction on the number of medical miracles they could perform, be made clear to all so that their expectations of the health care system were not exaggerated.

In particular the financial figures of the health care situation should be clearly understood by everyone. Government monopolies of Health Services always expected to buy the best of care at an unrealistic cost - as the present problems with nurses and doctors in the UK showed. All too often governments appeared to be ready to promise care of high quality to their people without really knowing whether it could be afforded or not. One of our tasks as administrators in this sphere of action was to reiterate over and over again that the provision of health care on a national basis is a costly business. We must also disabuse our politicians of any belief that just becau a national service is expensive it is necessarily good or of high quality.

FOOTNOTE

This seminar, being the first of its kind arranged by the King's Fund, provided its organisers with useful experience for the planning of a second meeting of a similar kind which it is proposed to hold in mid-1977.

One point which emerges from this report, for example, is that general administrators concerned with health services in different countries undertake such a variety of responsibilities and have so broad a field of interest, that discussion of their administrative functions, unless closely defined, is likely to be so wide-ranging as inevitably to become diffuse. Obviously, too, when some 20-30 delegates are involved in a meeting, the way in which discussion is organised is important if each participant is to make the maximum contribution and no-one is to talk too much.

It seems reasonable to suggest therefore that, while the theme of the second seminar needs to be linked to that of the first, it should be more directly concerned with the role of the general administrator, and the topics arising from it fewer and more specific, so as to concentrate discussion more closely. This end may also be served by the proposal that the 1977 meeting should have slightly fewer representatives than the 1975 gathering, with some possible changes in the actual delegates invited to attend.

Australian Delegates

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Mr J E McClelland	Executive Director The Geelong Hospital P O Box 281 Geelong Victoria 3220

British Delegates

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