Two views on the Griffiths report

The mobilisation of consent versus the management of conflict: decoding the Griffiths report

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For the past 15 years successive ministers of health have been pursuing a vision that has turned out to be an ever receding mirage. This is the vision of a National Health Service that could stretch scarce resources by improving the quality of management. It was a Labour Minister of Health, Sir (then Mr) Kenneth Robinson, who as long ago as 1968 proposed to set up a board of "directors," headed by a chief administrative officer, in each health authority.[1] It was a Conservative Secretary of State, Sir Keith Joseph, who in 1971 introduced his plans for reorganising the NHS by proclaiming that the intention was to promote effective management: "the importance of good management in making the best use of resources can hardly be overstated," he argued.[2] Now it is Mr Norman Fowler's turn to pursue the vision as embodied in the report of the NHS Management Inquiry, chaired by Mr Roy Griffiths.[3]

The main proposals put forward by the Griffiths report are deceptively simple and, by now, familiar. In essence, they are to appoint a general manager at every level of the NHS—from the Department of Health downward to the individual unit or hospital—who would be charged with overall managerial responsibility for the services provided and for giving the leadership required to "stimulate initiative, urgency, and vitality" in the process of seeking ever greater efficiency. These proposals are, in themselves, radical and contentious enough. But the implications of implementing the Griffiths proposals are far more radical and contentious still. For unless the logic of adopting a managerial approach to running the NHS is pushed much further than in the Griffiths report itself—which only hints rather vaguely at some of the major, long term implications—it seems all too likely that the hopes invested in it by Mr Fowler will turn out to be destined for the same disillusionment that followed similar initiatives by his predecessors. And it is only by understanding why these earlier initiatives failed to deliver the goods—for reasons embedded in the very nature of the NHS—that it is possible to understand just what would be involved in implementing the Griffiths proposals fully.

The cure proposed by Griffiths is based on a very specific diagnosis of the NHS's present ills. The NHS is suffering from "institutionalised stagnation." Health authorities are "being swamped with directives without being given direction." The NHS, moreover, is an organisation in which "it is extremely difficult to achieve change." There is confusion between the roles of central government and those of health authorities: "the centre is still too much involved in too many of the wrong things and too little involved in some that really matter." Consensus decision making leads to "long delays in the management process." In short, the NHS would seem to be an instrument for the mutual frustration of all those working in it, whether as clinicians or as administrators or as politicians. Only by setting clear objectives at the centre and leaving it to those on the periphery to carry them out in their own way, only by establishing clear criteria of performance and then checking that the managers are doing their job properly when measured against such yardsticks, will it be possible to break the deadlock and, by so doing, give full scope to the energies and enthusiasm of those working in the NHS.

It is an appealing vision, and for anyone who has ever been concerned in the NHS it would be difficult to avoid sharing the sense of impatience with the existing state of affairs that informs the Griffiths recommendations. But it is important to spell out what carrying them out would really mean: to identify the price tags, as it were, for moving towards an NHS Incorporated model of management. For at every level of the NHS, and for every group concerned in the delivery of health care, there are choices to be made, choices that mean trade offs between desirable aims of policy.

Dramatic transformation

If the health service is to move from a system that is based on the mobilisation of consent to one based on the management of conflict—from one that has conceded to the right of a variety of groups to veto change to one that gives the managers the right to override objections—then the process is going to mean radical and perhaps painful change. At present the NHS is rather like a feudal society in which independent authority is exercised by a number of groups, notably by the medical profession, in a fragmentary system. The Griffiths proposals therefore imply as dramatic a transformation, in the direction of a bureaucratically driven national system, as that wrought by the Tudors after the Wars of the Roses.

The point may be illustrated at each level of the NHS. Let us start with the Department of Health and Social Security itself and the proposal for creating a duo of supervisory and management boards to run the NHS, with the latter headed by someone with managerial experience outside the service. The role of the supervisory board would be to determine the "purpose, objectives, and direction for the health service," to approve the overall budget and resource allocations, to make "strategic decisions," and to receive reports on "performance and other evaluations." The role of the management board would be to implement the policies approved by the supervisory board, "to give leadership to the management of the NHS," and to control performance.

This comes near to the proposal for a health commission considered, but rejected, by the Royal Commission on the NHS.[4] Like Griffiths, the commission thought that such a body could provide "the permanent and easily identifiable leadership which the service at present lacks." Unlike Griffiths, however, the commission rejected this solution because it thought that the NHS's dependence on public funds—which, in turn, means that the Secretary of State is accountable to parliament for every penny spent—would inevitably mean a duplication of functions between the new body and the DHSS. Indeed, the Griffiths report recognises this problem if only in an aside. If the new model is to succeed, it points out, there will have to

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be major changes in the "parliamentary requirements of the NHS management process." A free translation of this gnomic phrase would suggest that, if the centre is to stop interfering in detailed management at the periphery, the ability of individual members of parliament and House of Commons committees to ask questions and seek information will have to be curtailed, since much of the department's activity at present reflects parliamentary pressures.[5 6] The role of the NHS, as Griffiths recognises in a phrase of classic understatement, is "very politically sensitive." So one of the radical implications of the Griffiths proposals is that the whole relationship between the NHS and parliament needs to be changed: that the NHS should be treated rather like a nationalised industry, where the constitutional convention is that members of parliament may ask questions about overall performance but not raise specific cases or question specific decisions.

Role of district health authorities

Much the same line of thought is implicit in the Griffiths report's discussion of the role of district health authorities. Here again the report seems to be using the same model that it applies in the case of central government. The role of the authority members would be to take on the strategic responsibilities of the supervisory board, while leaving the officers under the leadership of the new general manager to carry out the tasks of the management board. By implication, authority members would not be expected to be concerned in detailed decisions, as this would be incompatible with pushing responsibility down the line of management to individual units and hospitals. Much of this simply restates, if in a different language, the objectives of the 1974 reorganisation, when it was argued that the role of authority members should be to set "objectives, targets, and budgets" and to monitor performance.[7] This, indeed, was the importance of the much used phrase that "delegation downwards should be matched with accountability upwards." The reasons why this has apparently not happened—as, if it had, most of what Griffiths has to say would be redundant—require exploration if we are to understand just what would be entailed in implementing the new proposals successfully.

The problems may be illuminated by looking at the water industry, which has just undergone precisely the same kind of transformation that Griffiths is urging on the NHS. In 1973 the water industry was organised as a series of regional authorities, whose membership was designed to be representative of local interests. This led to authorities that (in the view of the Department of Environment, at any rate) were both too large and too politicised. In 1983, therefore, there followed a further reorganisation. The regional authorities were transformed into small, streamlined managerial bodies, with no representative role (which is now to be performed exclusively by consumer consultative committees). In the words of Mr Patrick Jenkin, who, having reorganised the NHS in 1982, is now engaged in a similar exercise in his new department, the change would enable water authorities "to improve their performance, efficiency, and service to their customers."[8] The model is that of the board of directors, with the chief executive sitting as a member of the board.

One implication of this example of managerialism might be that health authorities should be transformed in a similar fashion. District health authorities, it could be argued, should be small managerial bodies stripped of their representative role, which could be left to beefed up community health councils. Indeed this was the original logic of the 1974 reorganisation and the justification for inventing community health councils in the first place,[9] as it was argued that the roles of managing the NHS and representing consumer interests were incompatible. It was a logic that was blurred, however, when Sir Keith Joseph also conceded the representation of the medical and nursing professions and of local government on the new health authorities, despite the rhetorical insistence that no one should see themselves as representing special interests. So, logically enough, the Griffiths report suggests that the "method and process of selecting and appointing chairmen and members" should be reviewed. Once again, the reader is left to decode this somewhat telegraphic message, but the implication would seem to be that the authorities should be more managerial and less representative in character.

"Best patient care possible"

To make these points is to underline the problems of moving towards anything like a similar managerial model for health authorities in the NHS. They may be illustrated by quotations from authority members, collected in the course of interviews carried out as part of a Social Science Research Council project on accountability in different public services. In the case of water authorities, members have no difficulty in defining their product or their objective: it is, in the words of one member, "to provide water as cheaply as possible."[10] In the case of the NHS there is not such clarity about the product and the objectives—and members can define them only in the vaguest, broadest terms such as "the good health of everyone in the district" or the "best patient care possible."

Moreover, health authority members think that they are groping in the dark when carrying out their managerial role. They suffer from a surfeit of confusing statistics and are yet starved of the kind of information that would allow them to do their job. "Members have less of an idea than officers of what is actually happening in the district," are the words of one such member. Often frustration spills over into suspicion: "the information we do get in the district is largely determined by the district management team, and the person with the information has the power." If members of health authorities often feel more at ease with the parochial visiting role than the managerial role it is partly because there is no tradition in the NHS of generating the systematic analyses of performance and needs that are required to carry out the latter. Equally, if they often translate accountability to mean calling officers and others to answer on points of detail—precisely the kind of housekeeping issues that in Griffiths's view should be left to local managers—it is because they have no general measures of how the service is working as distinct from specific instances of problems.

Right diagnosis, vague treatment

Once again, the Griffiths report makes the right diagnosis—but its suggestions for the appropriate treatment are somewhat vague. Rightly, the report points out that the NHS lacks "any continuous evaluation of its performance against criteria" of the kind that are used in private sector organisations: these are "levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff." Nor, it points out, "can the NHS display a ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves. Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question." In future, therefore, "real output measurement, against clearly stated management objectives and budgets, should become a major concern of management at all levels."

No one could disagree with this conclusion. Equally, however, no one has yet come up with ways of devising "real output measurement" in the NHS. In a sense the Griffiths recommendations are an indictment of the DHSS's own failure, over the decades, to develop instruments of assessment that carry conviction with clinicians and other health service providers: a failure of both imagination and research policy. Certainly the DHSS's own, recently published performance indicators do not even begin to fit the bill.[11] They are, as the DHSS concedes,

simply a dressed up version of "data which have been collected for many years." They totally lack the first requirement of a performance indicator in the true sense: a definition of the policy aims against which progress towards their achievement may be measured.

Administering history

Whether the definition of such policy aims is a management function in the NHS—in the same sense that it can be said to be a management function in private enterprise—is, in any case, very much open to question. The real reason why district management teams have not adopted this tool of management is precisely that the policy aims of the NHS are far from self evident: that defining them means competition and conflict between different aims. Defining performance in the NHS (unlike the water industry) is therefore a process of argument and compromise. And the district management team is not so much a management team in the Griffiths sense as an arena for managing conflict: a device to mobilise consent for whatever policies are being pursued. This is the true meaning of the consensus principle, born of the acknowledgement that implementing policies in the NHS requires the voluntary cooperation of doctors, nurses, and others. Unlike the water industry's corporate management teams, district management teams are trying to adapt their inherited commitments to new circumstances in circumstances in which their control over the most important resources—manpower—is often tenuous. They are administering history—and adapting it at the edges—rather than planning for the future. It is this emphasis on mobilising consent that also explains the "labyrinthine" system of consultation that, as Griffiths argues, further inhibits change in the NHS.

The implications of any attempt to change this bias towards compromise, avoidance of conflict, and the mobilisation of consent are profound. In part, they mean a change of style. If issues are not to be fudged or avoided, simply because they open up chasms of disagreement (whether between different specialties or between different geographical localities), conflict may have to be accepted as part of the managerial role. More importantly, however, a change in style may depend on a change in the NHS's tradition of recruiting and rewarding its administrators or managers. Here, once more, the Griffiths report only hints—in a tantalisingly vague fashion—at the kind of radical shake up that may be needed. The present system of rewarding and employing managers should be reviewed, it argues, "so as to overcome the lack of incentive in the present system and the inability of chairmen to reward merit or take action on ineffective performance." Decoding this statement, it would seem that the Griffiths report wants hiring and firing to be made easier.

Mobile managers, ruthless chairmen

In short, managers should be more mobile and chairmen more ruthless. Implicit in this would seem to be a model of managers very much in the American mould of men and women who are prepared to make themselves unpopular by forcing through change—by challenging conflict—and may then have to move on. Once more, the logic is irrefutable if the original diagnosis—of institutionalised stagnation—is accepted, but the implications for NHS managers are profound. The emphasis would shift from recruiting those who have a keen sense of the impossible—a heightened awareness of the limits on change if conflict with powerful local interests is to be avoided—to recruiting those who are not conditioned by history, and the prospect of having to live with the same set of consultants and pressure groups for the next 20 years, to accepting strict limits on their scope for action.

If priority is to be given to facilitating change, even if this means putting less emphasis on the mobilisation of consent and accepting the need to manage conflict, the NHS would certainly become a less comfortable place in which to work. But if the basic assumption of the Griffiths report is accepted the NHS should also become a less frustrating organisation in which to work. If the new style of management were to lead to the more efficient use of resources, as assumed by Griffiths, new opportunities would be created for clinicians and others: now that the NHS can no longer count on the annual dividend from national economic growth it can only look to an annual dividend from increased efficiency. Once again, however, there are radical implications for the medical profession, as for everyone else in the NHS, only touched on by the Griffiths report. For it makes no sense whatsoever to talk about evaluating the performance of the NHS without also insisting on evaluating the performance of those who take the most important decisions about the use and allocation of resources to individual patients: doctors.

Even to mention this point is to risk raising hackles. The evaluation of medical performance is all too often interpreted as a threat to clinical autonomy. In fact, a distinction needs to be drawn between making doctors accountable for the overall use of resources and evaluating their clinical decisions in individual cases. The two are linked, of course, since the use made of any given bundle of resources (whether beds or operating theatres) is the cumulative outcome of individual clinical decisions. But in practice there need be no inconsistency between evaluating the performance of any given group of doctors—say, a specialty—in terms of the services provided to patients, while leaving it to the doctors concerned to exercise their peer group judgment as to how that performance could be improved. Indeed this seems to be the drift of the Griffiths proposals, with their insistence on developing management budgets that would provide a framework within which doctors would be able to weigh up the effect of individual clinical decisions on their collective performance: something that they are unable to do within the present, antiquated NHS system of financial accounting. In short, if the Griffiths proposals are to succeed in their aims there would have to be more radical changes than implied in the report: the NHS would have to move towards being a system of producer cooperatives, each of which is accountable to management not for the individual clinical encounter between doctors and patient but for their overall performance in terms of producing value for money services to patients.

Heroic oversimplification?

Underlying all the Griffiths recommendations is the "desire to secure the best possible services *for the patient*." Good management is seen as being all about "looking after the customer," as we have already seen. So, for example, the Griffiths report suggests market research to elicit "the experience and perceptions of patients and the community." But here the Griffiths report seems to be indulging in even more heroic oversimplification than in its other proposals. If Sainsbury, or any other private enterprise, fails to look after its customers it will get not only automatic signals from its profit figures but also a direct incentive to improve performance. If an NHS hospital fails to satisfy its customers, and these take their trade to the private sector, its staff will be less overworked and its performance (as measured in waiting list figures) may even seem to improve. For while the market is all about competition in conditions of surplus—so that the threat of bankruptcy hangs over the individual firm—the NHS is all about rationing scarce resources. It exists to meet *needs* as defined by the professionals, not *demands* as expressed by consumers. In turn, the definition of *whose* needs are going to get priority in conditions of scarcity is not so much a technical and managerial as a political process, including professions, pressure groups, and parties. We therefore return to the starting point of our analysis: the difficulty of

divorcing—by the creation of new managerial bodies, whether in the DHSS or at any other level of the NHS—management from political decisions.

In the last resort, any assessment of the Griffiths proposals must depend on whether the promotion of change or the promotion of consensus, whether maximising the resources available to doctors or maximising the independence of the medical profession, is seen as the more urgent priority in the circumstances facing the NHS today and the immediate future. They certainly do not offer a painless technical or managerial "fix" for the problems of the NHS, for their implications go far beyond applying a managerial top dressing to the organisational structure of the NHS. If that were to be the only outcome of the whole exercise—if the only result were to be the proliferation of cosmetic managerial titles—it is safe to predict the same kind of disillusion that has followed all the other, earlier attempts to make the NHS more management conscious. If, however, all its implications were to be followed up it is clear that there would have to be a sustained campaign to transform the style in which the NHS has been run for the past three and a half decades and that Mr Fowler—unlike his predecessors—will have to be ready to cope with conflict.

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The consultant's role in NHS management*

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The Griffiths report[1] must be considered in conjunction with the activities of the steering committee on management budgets,[2] the joint group on performance indicators, the Körner committee,[3] and the 1982 reorganisation of the National Health Service.

The NHS management inquiry proposes radical changes that could affect the whole nature of health care delivery in this country. The changes are to take place without legislation, and though the Secretary of State has avowed that consultations will take place, the deadline for these, 9 January 1984, gives little time and implementation is planned for April 1984. The BMA has been asked for its views, but I hope that members of parliament will also have an opportunity to debate the issues thoroughly.

I think that it is satisfactory that the Chief Medical Officer is on the supervisory board proposed by Griffiths, as he has not always enjoyed a high place in the Department of Health and Social Security's hierarchy. Accountability is clearly defined lower down the scale, but it is not clear how this will work in the supervisory board. The board will be an immensely powerful body as it will have to take to itself an undisclosed amount of the role of the Secretary of State and the DHSS. With friendly government appointees there may not be cause for alarm, but what would have happened in 1974 at the time of Barbara Castle's confrontation with the consultants if such a board had existed?[4] Griffiths extols the important role of the clinician in the NHS, yet there is no formal proposal to ensure that a clinician is on the supervisory board or the management board.

The management board is also oriented to professional management and will not contain anyone who has any experience of delivery of health care at the only level where it matters—the patient.

At regional level a general manager will be appointed regardless of discipline by the chairman of the health authority. I note that he is to make explicit the main decisions reserved to the authority itself. Does this mean that an official will now decide what the authority can and cannot discuss? The abolition of functional management structures is proposed. Apart from an apparent strengthening of the power of the often politically appointed chairman I am not too worried about changes at this level from the clinicians' point of view.

The district chairman is to be given the task of appointing the district manager, who may be from any discipline but in practice is likely to be one of the existing chief officers. No doubt the chairman will have consultations before making such appointments, but the special role of the clinician envisaged in the report surely makes the consultants' views of paramount importance. If clinicians are to have greater management functions it should be mandatory for chairmen to consult them.

The proposals at unit level cause me most concern. Griffiths says that day to day decisions should be taken in the main hospital and other units and should not be taken elsewhere. All clinicians already make daily management decisions at the point of health care delivery. Shall I admit a Wertheims hysterectomy next week—will there be sufficient anaesthetists, juniors, and nurses available on that day? What is the likely effect on other patients on the waiting list? Shall we continue to prescribe a particularly expensive drug? What should I say to my senior registrar, who is being criticised by senior nursing management? Should I make yet another effort to have my secretary promoted? The decisions are endless, and I believe that we are good at them.

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