Perspectives in NHS Management

Current issues in administration: a more centralised bureaucracy?

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Since 1948 the National Health Service has witnessed a frequently shifting management pattern in the balance between centralist forces and devolutionary pressures, partly attributable to the inherent paradox in the way that the NHS is organised. On the one hand, the funding for the NHS is centrally collected (95% through direct taxation) and centrally allocated, with the Secretary of State and the permanent secretary held accountable for the proper use of the funds. On the other hand, the delivery of service is very much a local affair and essentially about contacts between professionals and patients. The "bureaucracy" lies between the Secretary of State and the front line professionals and acts to achieve effective links between the two.

In a complex institution like the National Health Service, which is providing a wide range of sensitive personal services, the administrative structure and the quality of management are bound to influence the standards of services provided. However skilled and dedicated the individual doctors, nurses, and other health professionals may be unless the environment is appropriate, the equipment satisfactory, and the financial and administrative responsibilities clearly defined the service will suffer. Doctors have not been slow to criticise the administrative structure or the quality of management as interfering with their prime task of treating patients. Not all the criticism has been fair and some has been based on ignorance or misunderstanding of administration and management. If the system is to function effectively all doctors need to understand how it should work and some need to take part to help make it work.

This series, *Perspectives in NHS Management*—of which this article is the first—deals primarily with the hospital service and is written by individuals with experience in or knowledge of NHS administration. The articles are intended to help doctors towards a better understanding of and greater participation in NHS management, and has been compiled with the help of Dr David Allen, senior lecturer in health services management, Department of Social Administration, University of Manchester.

Power of centre consolidated

The 1950s reflected doubts about overcentralisation with the Guillebaud committee advising more relaxation of central control.[1] The then Ministry of Health did not contest this advice and was content to devolve executive powers; the notion of enforcing national policy was secondary. The 1960s saw a change in this position in the direction of more positive leadership from the centre, and the 1962 hospital building plan is the principle example of central initiative.[2] The NHS reorganisation of 1974[3] consolidated the power of the centre, and centrally promulgated policy documents such as *Priorities for Health and Social Services*[4] and *The Way Forward*[5] were issued, together with guidelines, norms of provision, and minimum standards.

The Royal Commission on the National Health Service returned to the theme that the centre gave too much guidance and that the concept of the accountability of the Secretary of State and of the permanent secretary distorted the relationship between the centre and field authorities, blurring the line at which the participation of the Department of Health and Social Security should end.[6] *Patients First* unambiguously advocated minimum interference from the centre.[7] In his foreword to *Patients First* the then Secretary of State, Patrick Jenkin, strongly advocated devolution (see box, p 1319).

Yet the NHS remains confused and sceptical about whether these explicit intentions are to be translated into practice. The annual review process, the development of performance indicators, and last year's imposition of a manpower target seem to indicate a top down approach and to emphasise accountability upwards rather than devolution downwards. The political objective of more local power could become a casualty of political expediency.

In this setting, how should we interpret the Griffiths report?[8] Certainly Griffiths emphasises the importance of delegating decision taking to the lowest possible level, not only from the DHSS to regions and then to districts but also within districts to units. Griffiths also emphasises the critical importance of bringing clinicians more closely into the management of the NHS—particularly through the development of management budgets.

Within this historical context current management developments in the areas of annual reviews, performance indicators and information, and general management should be examined in more depth. There are two prior self evident observations

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that are worth restating. There is no single objective interpretation of these developments. The threats and opportunities posed are in the eyes of the beholder.

Annual reviews

The problems of achieving accountability between the government and NHS operating authorities have increased in complexity in recent years for four reasons:

- The demand for more public participation (consumerism).
- The growth of trade union activity (unionism).
- The pressure to devolve authority to the lowest effective operating level (decentralisation).
- The professional's proper accountability to his patient (professionalism), which is perhaps heightened at times of limited growth in resources.

Government attitudes towards the NHS have been characterised by moves away from fiscal accountability towards accountability for policy and programme achievement and process audit. Key parliamentary committees—particularly the public accounts committee—have intensified their concern with central performance on two fronts. Firstly, there is the achievement of national strategic policy objectives—in practice, the inability of the DHSS to change local clinical practices at a satisfactory pace—for example, towards community based care and the priority services of mental illness and mental handicap. Secondly, there is value for money in terms of efficiency and effectiveness.

There is a disconcerting public and media image of the NHS, left to its own devices, as a system of management that is not self motivated in the pursuit of efficiency. The public accounts committee expressed particular concern about the difficulty of reconciling central accountability for the whole of NHS expenditure with the greater delegation of day to day management decisions.[9]

To these issues the centre has responded by introducing a system of annual reviews to monitor each region's and in turn each district's achievement of selected planning objectives through the optimum use of resources. The process represents a pinning down of responsibility that falls particularly on chairmen of regional and district health authorities and also a focusing of the issues under review. The result is a quite specific contract for prospective improvement that will be evaluated at the subsequent review. The notion of holding individuals to account has much to commend it but of course in the last analysis does not ensure the delivery of goods in an environment as complex as the NHS. Furthermore, the contracts negotiated between ministers and regional health authorities will be of limited value unless they are also negotiated through districts in the light of local circumstances at the unit level of management and ultimately with local clinicians.

The annual review system is a logical continuum of the planning system in that it poses the question, "did we achieve what we intended and did we maximise the use of our resources and if we did not why not?" What it also highlights, however, is the paucity of tools available to measure progress in achieving health care policies and in measuring relative efficiency. Unless the questions and the performance yardsticks are credible to the professionals at the front line, the process will fall into disrepute and will atrophy.

Performance indicators and information

The aim of examining variations in performance has brought with it a new industry in the use of statistical performance indicators covering clinical, manpower, and estate management functions. It is recognised that no single indicator or combination of indicators will lead to a firm conclusion about whether the use of existing resources is efficient or inefficient. Their function is to point to outlying values of data that merit further investigation, and judgments can be reached only after detailed study of local circumstances. The national comparative set of performance indicators developed to date have been geared to questions of economy—that is, carrying out a task at minimum cost—and the efficiency measures promulgated have attempted to look at technical efficiency—for example, throughput, turnover, interval, and length of stay—while some are concerned with cost efficiency—for example, cost per case.[10] Acceptable measures of effectiveness—that is, the degree of achievement of an intended outcome—and efficacy—that is, about whether the outcome was the desired one—are in scarce supply. The essential difference between economy and efficiency as opposed to effectiveness and efficacy indicators is that the latter require statements of desired achievements, and judgments may be made only with stated objectives in mind.

"Patients First"

"We are determined to see that as many decisions as possible are taken at the local level—in this hospital and in the community. We are determined to have more local authorities, whose members will be encouraged to manage the service with the minimum of interference by any central authority, whether at region or in central government departments." (Patrick Jenkin, Secretary of State for Social Services, writing in the consultative document *Patients First*, 1979.)

The annual review process, therefore, is about clarifying objectives and measuring and reviewing progress towards them, and performance indicators may contribute to this measurement but only if the armoury of indicators includes indicators of effectiveness and efficacy. Their development will be one of the key problems for the recently established national DHSS/NHS joint performance indicator group.

The performance indicators described above rely on critical information about inputs and outputs. If information is to inform adequately the debate between managers and the prescribers of resources about the efficient organisation of clinical care its credibility to the field user is all important. In this respect the NHS is indebted to the Körner steering group on health services information for emphasising the need to improve the timeliness and accuracy of information at the district and unit levels, where the pressures of negotiating the allocation of constrained resources are most acute.[11] Information for policy development and monitoring by higher levels then becomes an aggregated byproduct of information essential for operational management and not an end in itself.

General management: the Griffiths concept

The area of key importance in the Griffiths proposals is the unit level—the level at which the nature of the "contract" between general management and the clinician needs to be explored and extended. Devolution to units and the participation of doctors in management budgeting represent the areas of maximum return from the Griffiths approach to management but paradoxically are likely to present the greatest problems in implementation.

Measures to reform the centre should be welcomed and seen in their own right as a necessary move to improve the coherence of policy making at national level that should result in

fewer uncoordinated central initiatives and a clear national focus for NHS management. Reform at the centre, however, should not be confused with revitalising the top down approach that has been relatively unsuccessful as an approach in securing national policy objectives. The NHS as a whole has shown a remarkable ability to live within cash limits, but a relative failure to switch resources between patient care groups to the benefit of the undeveloped non-acute services and community care in general. If the issues of the day revolve round confronting the harsh choices to be made across programmes of patient care in the context of increasing demand for high technology expenditure and the implications of an increasingly aging population the

Consensus on priorities by clinicians

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negotiation on these issues of balancing and choosing across the options for patient care will be focused ultimately at the unit level. Despite national and regional intentions made explicit in the annual review process, the actions that need to be taken are at ground level and require clinicians to agree collectively to abide by the consensus on priorities and to accommodate their clinical practices accordingly.

For doctors this will result increasingly in their participation in some form of clinical budgeting as a method of ordering and negotiating clinical priorities. Doctors are unlikely to settle for specialty costing alone, and patient costing—given that the relevant data in the NHS do not come as a natural byproduct of an insurance based billing system as happens in the United States of America—is an unrealistic expectation for the near future. They will expect to be concerned in management budgets that encompass not only costs directly attributable to their clinical decisions—for example, drugs—but costs that are incurred by nursing, paramedical, and other supporting disciplines, presented in a way that will allow them to influence the level of indirect or overhead costs attributable to *their* management budget. It remains to be seen whether budgets based on specialty groupings—for example, surgery—clinical groupings across specialties—for example, neurosciences to include neurology, neurosurgery, neuroradiology, neuropathology, etc—or smaller clinical groupings of one or more clinicians prove to be the more acceptable base for clinical participation in management budgeting.

The implications for the unit manager are equally radical. The picture of a unit manager planning and budgeting within the extensive limits of discretion implicit in the Griffiths scenario is a daunting one. The unit manager lies at the intersection between policy making at district level and its implementation within the unit. This calls for far more than a mechanistic approach to translating prescribed policies. It requires an interpretative ability that ensures that the unit remains faithful to policy objectives and directions in general but that allows for personal initiative and experimentation. It should also allow for the genuine exposure of a mismatch between policy and the needs of an individual unit that may emerge from a process of evaluating policy. The NHS is looking for a considerable shift in the predominant culture of management at the unit level towards an approach that can address the implications of strategic change and is purposeful, innovative, and risk taking if the resource dilemmas confronting the delivery of care are to be radically addressed.

Conclusion

Given the nature of historical fluctuations in management patterns between the centre and health authorities, it is superficially attractive to characterise current developments as a response in favour of the centralist forces. This view regards the annual review process and the thinking behind the Griffiths recommendations as primarily reinforcing accountability upwards and developing the connecting links between the centre and health authorities as a strong executive chain of command down which the policies and decisions of the centre can be promulgated. In this context performance indicators are regarded as part of the central armoury producing bullets to be fired (some would argue indiscriminately) at the field troops.

Yet the past lessons point to the limitations of the top down approach and the effectiveness of health authorities in deflecting central objectives. The alternative interpretation of current developments squares the circle by showing that explicit accountability is not incompatible with devolving decisions and that a model of control without interference can be developed. This alternative scenario regards the annual review process as producing a negotiated policy framework (including a feedback loop to the centre on the affordability and consistency of policies as perceived by health authorities), which allows authorities the space to interpret solutions in the light of local circumstances. In other words, the discipline of working through the terms of the subcontract removes the need for the main contractor to undertake the work direct. In this setting the Griffiths proposals are seen primarily as measures to reduce the need for uncoordinated initiatives by the centre and to emphasise the fundamental importance of devolution to units and the development of management budgeting for clinicians. Performance indicators and information are tools to be refined for operational management control purposes and only secondarily for monitoring purposes by a higher authority. I am still optimistic that the alternative interpretation will prevail.

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