Perspectives in NHS Management

Who makes the decisions in the NHS?

RUDOLF KLEIN

There is one simple answer to the question in the title of this article. It is that the National Health Service is an organisation remarkable for the fact that almost everyone working in it—whether as a doctor or as a nurse, as an administrator or as a ward orderly—is a decision maker. For what makes the NHS unique is precisely the fact that health care is the product of countless individual decisions made every day by men and women with a wide range of professional and occupational skills, each of whom tends to enjoy a large degree of autonomy or discretion in his or her own particular domain of activity.

The degree of autonomy or discretion may vary; so may the scope offered by the domain. Clearly the doctor has more autonomy and discretion in a more important domain than the ward orderly. But what they both have in common is that, unlike workers on an assembly line, it is they who determine by their individual decisions what is being produced, rather than having their decisions determined by the routine processes of production. There are, of course, routines and established patterns of work, but they do not eliminate scope for individual decision making. Everyone in the NHS has the power to make decisions, even if they are only decisions about the speed and energy with which work is carried out.

It is precisely this proliferation and pervasiveness of decision making that makes any attempt to anatomise the process—to identify with precision who is responsible for what—so frustrating and baffling. For when everyone is a decision maker then, paradoxically, no one is: decisions evolve or emerge over time as a result of a process of bargaining rather than being taken by specific individuals or groups. And if decision making is taken to mean the ability to impose or pursue a course of action, to make a particular solution to a problem stick, then in a real sense little decision making goes on in the NHS. Everyone's decision making domain and scope is constrained, in turn, by all the others working in the NHS.

The theory and the reality

It is therefore not surprising that the reality of decision making in the NHS is different from the constitutional theory on which its organisational charts are based. In theory, the position is simple. Decision making authority flows downwards from the Secretary of State, just as accountability for actions taken or not taken flows in the reverse direction. There is a hierarchy of authorities—at regional and district levels—who, in Nye Bevan's phrase, are the "agents" of the Secretary of State.¹ In turn, this would imply a hierarchy of decision making, with the Secretary of State taking the major or strategic decisions and each succeeding level filling out the broad framework of policies in a series of tactical or minor decisions: while

the centre takes decisions about objectives, in other words, those on the periphery take decisions about the means of achieving those objectives.

In practice, as several studies have shown, the picture is a great deal more fuzzy and confused.²⁻⁴ The relation between the central government's strategic decisions about policy objectives or priorities and local day to day decisions is often tenuous. The former often seem to be little more than hortatory noises that may or may not encourage those at the periphery to move in the desired direction. Indeed, the view of district health authorities as the agents of the Secretary of State, though often implicit in the circulars sent out from the Department of Health and Social Security, seems to rest on bluff. It is not clear that the members of a district health authority are under any legal obligations to follow the instructions of the Secretary of State, apart from keeping within their budgetary limits. Nor is it self evident that the Secretary of State has any effective sanctions if district health authorities defy him, besides not reappointing the chairman or sending in the auditors if there is any suspicion that local policies may be wasting money.

In turn, of course, the decision making scope of district health authorities is severely constrained. It is, above all, constrained by history. The most important decisions in the NHS, it is tempting to argue, are invariably yesterday's decisions. Once it has been decided, for example, to build a new district general hospital, then this inevitably mortgages future options and limits what else can be done. Given a blank slate, a district health authority might well prefer to put its money into community services. But given the need to finance the revenue consequences of the new building, this option may simply not be available. There will still be some important decisions that must be taken, such as which hospitals to close down in order to find the money. Even so, the scope will have been severely restricted.

The decision making scope of health authorities—that is, those bodies that, constitutionally, carry the responsibility for taking decisions—is further limited. It is constrained by the decision making autonomy of clinicians. As clinicians are free to determine whom they select for treatment and how they treat them, district health authorities cannot actually take any decisions about the delivery (as distinct from the financing or organisation) of services. So, for instance, district health authorities may well think it desirable to introduce more day surgery or to have shorter lengths of stay, but they cannot *decide* that this should be done. Once more, as in the case of the DHSS, they can only make hortatory noises. Finally, at the coal face of health service delivery, consultants are constrained in their decisions by the availability of resources. Their freedom to make decisions is real but also limited. It is sufficiently real to frustrate the decisions of the policy makers at the top of the hierarchy but also sufficiently limited to frustrate their own aspirations in turn.

The hierarchical model of decision making in the NHS is thus inadequate as an account of what actually happens. For in the NHS, to return to the point made at the start of this article, there is a mismatch between the distributions of nominal authority and effective power. The hierarchical distribution of

authority implies a top down view of decision taking, while the diffused distribution of power implies a bottom up interpretation.⁶ Given the degree of autonomy and discretion enjoyed by those working in the NHS, it is those engaged in the delivery of health care who have the power to determine what actually happens. To the extent that the medical model—of accountability to one's peers rather than to one's hierarchical superior—applies to the NHS as a whole, in various degrees, so it is inevitable that decision making power is diffused, and that the search for specific individuals or groups who take the decisions becomes a baffling hunt for the snark. Decisions shaping the implementation of policy are made at all levels of the NHS in the day to day business of actually running it.

This diffusion of decision making power is reinforced by another factor. Decision makers require information, though, of course, decisions may be based as much on gut instinct or log rolling among powerful interest groups as on the rational analysis of data. And one of the characteristics of information in the NHS is that its interpretation often (though perhaps not quite as often as those who do not like its message are apt to pretend) requires local knowledge. The DHSS's current performance indicators exercise illustrates the point well. The statistics collected at the centre require local know how to interpret them: as the DHSS points out, "local data and knowledge" must be used in any analysis.⁶ The same point applies all the way down the hierarchy: if members of the district health authority ask awkward questions about performance they also are likely to be told that the available information cannot be taken at face value and that special factors must be taken into account.

In summary, the NHS seems to be an example of what may be called the law of inverse decision making. Those at the top with the greatest authority to take large scale decisions often have the least power to make them effective in practice, while those at the bottom have the most effective power but the least scope. If Mr Norman Fowler at the Elephant and Castle often feels frustrated (as I suspect he does), so does the consultant at the periphery.

An alternative analysis

The discussion so far has addressed the question of "who takes decisions in the NHS?" as though all decisions were of the same kind, differing only in their scale and scope. But this, of course, is to ignore the fact that there are different "policy streams" in the NHS, as well as different levels of hierarchy.⁷ Firstly, there are policies about the NHS as an institutional structure—that is, decisions about *how* the NHS should be organised. Secondly, there are policies about resources—that is, decisions about the distribution of funds. Thirdly, there are policies about how those resources should be used—that is, decisions about the way in which any given bundle of resources is used to provide services for patients. Fourthly, there are policies about processes—that is, decisions about what are desirable (or undesirable) practices.

Putting together the organisational hierarchy and the various "policy streams" suggests that an appropriate model for the NHS would look like "Babel House"—a model developed by Dunsire to describe complex organisations in general and represented in the figure.⁸ In this the vertical lines represent different policy streams (and professional interests), while the horizontal tiers represent the different organisational levels. As Dunsire points out:

"The building is a Tower of Babel because a different tongue (concepts, vocabulary) is talked on each floor—amounting to a considerable linguistic disparity between top floor speech and ground floor speech—and different jargons and dialects are spoken on any one floor, in each of the corners and other areas. As between one floor and the next, or as between one office and its neighbour on the same floor, differences in language and habitual style of doing business can be noted, though it is quite easy for adjacent ranks and denizens of adjacent offices, to

understand one another. Messages from distant locations in any direction—from a far away corner, or from a much higher or lower floor—do not, by contrast, make much sense on first hearing or reading: the most distant, the less intelligible."

I have quoted the passage at length as it is so evocative of real life in the NHS—and could, indeed, be taken as a paradigm of the DHSS itself. But the Tower of Babel model is also helpful in analysing the decision making process in the NHS, particularly if we concentrate on the vertical lines of "policy streams"—that is, the different *kinds* of decisions that are taken.

The "Tower of Babel" (Dunsire A. *Implementation in a bureaucracy*. Oxford: Martin Robertson, 1978).

Firstly, in the case of decisions about the organisational structure of the NHS, it is clear that these are taken by the Secretary of State deploying the political authority of the government of the day. The decisions may emerge after prolonged bargaining with professional and other interest groups, but there can be no doubt about who has final responsibility. Moreover, once taken, such decisions are automatically implemented and translated into action at the periphery.

Secondly, in the case of decisions about resources, it is once again clear that the government collectively determines the total and the Secretary of State then decides its distribution to the regions. It is only at the subregional level that there may be some seepage in the decision making process. For although the Secretary of State may lay down the principles of distribution—such as the RAWP formula—its application in specific local circumstances, where there may be uncertainty or scope for special pleading about the meaning of demographic and other data, will once again lead to the diffusion of decision making.

Thirdly, in the case of decisions about the way in which any given bundle of resources is used, the Secretary of State's decision making power tends to be largely hortatory, as noted earlier. Not only is there little scope for decision making: history has already made most of the important decisions, and only marginal adjustments are generally feasible in attempts to change the mix or balance of services. But decisions of principle about priorities tend to fragment into individual decisions of practice by clinicians.

Fourthly, in the case of decisions about desirable (or un-

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SCOTTISH COUNCIL

Difficult decisions this summer, warns BMA council chairman

The president of the BMA, Dr Ronald Robertson, the chairman of council, Mr A H Grabham, the chairman of the representative body, Dr John Marks, and the treasurer, Dr R A Keable-Elliott, attended the meeting of the Scottish council on 18 May. The meeting marked the end of the three year term of office of the chairman of the Scottish council, Dr Samuel McKechnie. A successful dinner was held in the evening at which the principal speakers were Mr John MacKay, Scottish Minister for Health and Social Work, and Mr Archie Rennie, secretary of the Scottish Home and Health Department.

Mr Grabham told the council that many of the current problems flowed from the inadequate funding of the health service; in the past year the percentage of the gross national product spent on health had fallen from 6.3% to 6.2%. The BMA had surveyed the effects of the Lawson cuts in 1983 but had found difficulty in distinguishing what the actual effects were, and the emphasis had now moved to an examination of the deficiencies in the service. One that had been confirmed was that patients were waiting too long to get outpatient appointments and for operations.

Over the past three years the rewards of doctors in the health service had been falling in real terms and in relative comparison with other professions even though there was the protection of the review body system. Mr Grabham forecast that there would be some difficult decisions to take this summer. The forthcoming proposals on general practice would no doubt have effects on the hospital service. Another difficulty was that of providing

The retiring chairman of the Scottish council, Dr Samuel McKechnie.

proper training for overseas doctors who came to this country. Unless all these variables were considered carefully the BMA council was concerned that unemployment among young doctors would increase. The repercussions of the Griffiths report would mean, Mr Grabham concluded, that for many doctors the next few months would be like the start of the NHS all over again and he foresaw difficult negotiations.

Review of hospital medical staffing

A steering group has been set up to conduct a comprehensive review—area by area and specialty by specialty—of the hospital medical staffing establishment in Scotland. The review will start with a pilot study of anaesthetics. The detailed work of considering the establishment in each hospital in Scotland will be done by a small team drawn mainly from the specialty concerned. The council learnt that Dr George Roberts, chairman of the Scottish Joint Consultants Committee, and Dr Graham Scott,

deputy Chief Medical Officer, will be joint chairmen of the steering group. The royal colleges, the major craft committees, and the Scottish Home and Health Department will be represented, and the SHHD will provide the secretariat. The subgroup on anaesthetics will be chaired by Sir James Fraser. The basic groundwork is to be done by questionnaire and the subgroup will decide which hospitals will be visited. The questionnaire will be drawn up by the appropriate royal college or faculty and after approval by the steering group the report will be sent to chief administrative medical officers.

The report of the DHSS's advisory committee on medical manpower had been with the Secretary of State for five months, Mr James Kyle reported. He suspected that it would be delayed until the forthcoming green paper on general practice was issued. Any recommendations that the advisory committee might make would miss the medical student intake for 1984 and possibly that for 1985 as well.

Organisation and management of scientific services

The Scottish council was pleased that the SHHD had finally issued a circular giving guidance on the organisation and management of NHS pathology services in Scotland (17 March, p 877). This follows a long campaign by the BMA in Scotland, supported by the Central Committee for Hospital Medical Services, the Joint Consultants Committee, and the BMA council. It is not the intention of the SHHD, however, to issue a similar circular about the management of radiography services. Dr J A Ford reported that some health boards were moving towards appointing superintendent radiographers who would deal directly with the chief administrative medical officer. He hoped, as the latter had said, that this would not alter the relationship between radiographers and the consultants in charge. The Scottish Chief Medical Officer has asked for information of any difficulties that arise in x ray departments and the council agreed that an urgent meeting should be sought with the Minister for Health and Social Work to urge him to introduce a circular to cover radiology services.

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desirable) processes, it is clear that even the Tower of Babel understates the complexity of the decision making system and the plurality of decision making actors and points involved. For this is the area of professional practice, where each profession has (as it were) its own Tower of Babel and where individuals in the professions may seek the shelter of autonomy when coming to their own decisions.

The complexity of the analysis mirrors the complexity of the decision making process in the NHS. This complexity not only helps to explain the sense of mutual frustration that tends to afflict both those working in the NHS and those responsible for its overall direction. But it also reflects the balance of power between clinicians and politicians, as well as between the various groups working in the NHS. To simplify the decision making process—to make the decision makers more clearly identifiable and responsible, as proposed by the Griffiths report—would therefore require a shift in this balance of power.⁹

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This is the sixth in a series of articles on NHS administration and management, which started on 28 April.