of Europe, but the medical profession must actively work to achieve it. These challenges must be met individually, nationally, and at the European level. But it will not be an easy task. Not only are there cultural differences but the climate to discuss these issues varies between the member states. It is not possible to discuss freely euthanasia, prenatal screening, or abortion in all states. The European Society for the Philosophy of Medicine and Health Care (a neutral academic society) had to move its 1990 meeting from Germany to the Netherlands because of threats of disruption.

So unless we aim for the lowest common denominator we may find it much more difficult to reach a common ethical policy than a common defence policy or a common monetary policy.

- 1 Office for Official Publications of the European Communities. 1992—*the social dimension*. Luxembourg: Office for Official Publications of the European Communities, 1990.
- 2 Holm S. New Danish law: human life begins at conception. *J Med Ethics* 1988;14:77-8.
- 3 Isambert F-A. Ethics committees in France. *J Med Philos* 1989;14:445-56.

- 4 Walters L. Commissions and bioethics. *J Med Philos* 1989;14:363-8.
- 5 Glover J. *Fertility and the family: the Glover report on reproductive technologies to the European commission*. London: Fourth Estate, 1989.
- 6 Congregation for the Doctrine of Faith. *Instruction on respect for human life in its origin and on the dignity of procreation*. Vatican: Congregation for the Doctrine of Faith, 1987.
- 7 Council of Europe. *Human artificial procreation*. Strasbourg: Council of Europe, 1989.
- 8 Kasimba P. A summary of legislation relating to IVF. In: Singer P, Kuhse H, Buckle S, Dawson K, Kasimba P, eds. *Embryo experimentation*. Sydney: Cambridge University Press, 1990:227-36.
- 9 European Science Foundation. *Report on genome research 1991*. Southampton: European Science Foundation, 1991.
- 10 Rix BA. Should ethical concerns regulate science? The European experience with the human genome project. *Bioethics* 1991;5:250-6.
- 11 Conclusions of the council and the ministers for health, meeting within the council, on 16 May 1989 on AIDS. *Official Journal of the European Communities No C* 1989 July 22:185/4-6.
- 12 Conclusions of the council and of the ministers for health, meeting within the council, of 3 December 1990 on AIDS. *Official Journal of the European Communities No C* 1990 December 12:329/21-2.
- 13 Binamé G. Organ transplantation: a chronicle of a long-awaited law. *International Digest of Health Legislation* 1990;41:336-9.
- 14 Van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. *Lancet* 1991;ii:669-74.
- 15 Anonymous. European support for euthanasia? *Bull Med Eth* 1991;69:25-7.
- 16 Department of Health and Social Security. *Inequalities in health: report of a research working group*. London: DHSS, 1980. (Black report.)

Leading for Health: responses

Accountability and the NHS

David J Hunter

This is the third in a series of articles responding to the questions raised by the BMA's document, "Leading for Health." The document looks well beyond the coming British election and raises questions about health and health care that will be on the agenda of many countries into the next century.

At various times throughout its history the NHS has been accused of being both centralised, monolithic, and bureaucratic^{1,2} and decentralised, fragmented, and insufficiently accountable.³ At the centre of this paradox is the dilemma of accountability, an issue that is discussed in terms of local and central accountability in *Leading for Health: a BMA Agenda for Health*.⁴

At a formal level the issue of accountability is deceptively clear and unequivocal.⁵ Health ministers and their officials in the four health departments of the United Kingdom are accountable to parliament for all that happens in the NHS. The health authorities are the agents of the central department and its ministerial head. But while the theory of accountability may be clear, its practice is decidedly less so.

The chain of command

The vexed issue of accountability has exercised academic observers, former permanent secretaries, and official committees for many years. All are critical of current arrangements. The 1979 Royal Commission on the NHS concluded that "detailed ministerial accountability for the NHS is largely a constitutional fiction."⁶ The report described the gap which exists between the formal, detailed accountability enshrined in the constitutional conventions governing the NHS and the realities of managing what in practice amounts to an extremely complex and diverse set of activities.

The present NHS reforms, as with earlier reorganisations, do little to resolve this longstanding dilemma. The white paper *Working for Patients*⁷ is at pains to emphasise the importance of decentralised decision making in order to free managers to be more responsive to local preferences and the views of users. The purchaser-provider separation, managed competition, and the notion of money following the patient are intended to achieve these aims.

But the white paper betrays an ambivalence evident in successive NHS reforms when it refers to the "chain of command" operating from the coal face of health service delivery to parliament via the secretary of state

for health. It is this chain which threatens attempts to unshackle management from political constraints. Some believe this to be at the root of many of the NHS's difficulties. Sir Roy Griffiths expressed concern about the issue and attempted to solve it in 1983 by creating a management board (now the NHS Management Executive) within the Department of Health so as to engineer a separation between political and managerial accountability "to achieve consistency and drive over the long term."⁸ But a neat distinction between political and managerial accountability, sometimes portrayed as a split between policy making and implementation, is not sustainable in practice. Political processes do not generate precise, clear cut objectives or the criteria necessary for effective managerial accountability to be achieved.⁹

Finding a balance

There are other features of the NHS reforms which challenge prevailing notions of accountability. In particular, there is the position of NHS trusts, which may enjoy freedom from local health authority control, though they remain accountable to the secretary of state. If trusts grow in number it will not be realistic for the centre to be directly responsible for them. The NHS Management Executive is currently searching for a solution to this problem that is compatible with current conventions.

A little known report published by the House of Commons Public Accounts Committee in July 1991 nicely illustrates the continuing dilemma in the context of the management of the NHS in Northern Ireland.¹⁰ The committee is unequivocal in its view that as an accounting officer the chief executive of the health and personal social services, Northern Ireland management executive, is personally responsible for the funds voted by parliament and entrusted to his care. The committee was "greatly concerned" by the chief executive's answers to its questions and by his arguments that as "day to day management responsibility had been delegated to the Boards . . . [this] absolved him from

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Ministers are unlikely to be willing to forsake their positions of command in the health service

being answerable [to the committee] on his full accounting responsibilities, although he accepted that he is responsible for ensuring that the services are provided in an efficient and cost effective way and provide good value for money.¹⁰ The committee did not accept the implication that in requiring the accounting officer to discharge his duties it was assuming centralised control of the health and personal social services in Northern Ireland. The committee argued that: "Delegation to others in any large organisation, regardless of management structure or style, or whether the delegated authority is to an agent, in no way removes the requirement for ultimate accounting responsibility to be accepted."¹⁰

The committee regarded the situation with such gravity that it recommended that the chief executive "should inform the committee within three months of the actions which he considers necessary in order to demonstrate that he is discharging his accounting officer responsibilities."¹⁰ This example encapsulates the essence of the dilemma of accountability, which is to find the optimal balance between top down political oversight on the one hand and devolved managerial freedom on the other. Similar concerns underlie much of the work of the House of Commons Health Committee.¹¹ It has also been analysed by a former permanent secretary of the Department of Health and Social Security.^{9 12}

Little seems to have changed since the infamous phrase in the 1972 DHSS grey book, which set out the management arrangements for the 1974 NHS reorganisation: "Delegation downwards must be matched by accountability upwards."¹³ The phrase perplexed observers then and still does. As another former permanent secretary at the then DHSS put it, "No clear prescription was given as to how this [principle] was to be achieved."¹⁴ For Sir Kenneth Stowe the key to the future development of accountability and the NHS lies with parliament, which may need to rethink its role "so as to accept less uniformity,

rigidity, and constraint in the bodies for whom it votes resources."¹⁴ It is probably an illusion to expect parliament, and therefore central government, to back off in such a manner while the NHS is funded largely from Exchequer funds.

Given the acknowledged failings of, or, to be charitable, ambiguities evident in, the present arrangements, does a better model exist? Or should we accept the royal commission's verdict that the present system is not without its virtues?

Alternative models

The four alternative approaches appraised by the Royal Commission on the NHS, in ascending order of major disruption to the status quo, were: strengthening the arrangements for monitoring the quality of services, which are the responsibility of health authorities; devolving power to health authorities; establishing a health commission or corporation; and transferring the NHS to local government.

MONITORING QUALITY OF SERVICE

There have been numerous initiatives aimed at improving and monitoring quality of service, and activity has intensified in recent years. Quality assurance, audit, accreditation, total quality management, medical audit, performance review, and related concepts are all part of the common currency of health service management. There is increasing emphasis on making services more consumer driven rather than profession led, thereby placing a greater emphasis on forms of accountability exercised downwards to local communities. It is a role which has generally been adopted by community health councils, although under the reforms they are no longer the sole channel by which health authorities and managers are expected to communicate with the public. There is now much more diversity as consumer views are sought directly through public surveys, user panels, public meetings and forums, and so on. Whether they offer an appropriate form of accountability exercised downwards to the public is arguable.¹⁵

DEVOLVED RESPONSIBILITY TO HEALTH AUTHORITIES

The royal commission's favoured option was that the direct and detailed accountability for the NHS required by parliament could best be exercised by health authorities themselves. The commission proposed that in England the regional health authorities should become accountable to parliament for matters within their competence.

This proposal has not been enacted for several reasons. Firstly, ministers are reluctant formally to relinquish their power. Secondly, there is continuing uncertainty about the role and functions of regions. Thirdly, the introduction of the NHS Management Executive at the centre has led it to assume central responsibility on behalf of ministers for the operation and management of the NHS. However, it is possible for health authority chairmen and chief officers to be called as witnesses by the parliamentary committees with health interests.

Local health authorities could lead to improved local accountability if members had a legitimate power base in local communities, but they do not.¹⁵ While members, even those appointed under the 1991 reforms, may see their role as more than mere agents of central government it is difficult for them to have legitimate local community accountability when they are appointed rather than elected. However, as noted above, there may be other ways of opening up channels to enable a dialogue to take place with local communities.

The suggestion that the NHS be established as a public corporation and become less prone to political interference has generally met with a lukewarm response. The royal commission was equivocal on the issue, neither wholly supporting the proposal nor rejecting it outright. Nor did Griffiths support it in his management inquiry. The general perception is that a major structural change of this kind would achieve little in terms of the NHS enjoying an arm's length relationship from its political masters. Given the vast sums spent on the NHS and the highly political and sensitive nature of health care, it is unreasonable to expect ministers to exercise a self denying ordinance.

The purchaser-provider split offers an opportunity to reconsider the notion of an agency model to provide services while the purchasing or commissioning of services rests with health authorities or newly elected all purpose local authorities (see below). Under the government's "next steps" initiative it would be possible to reconstitute the NHS Management Executive as such an agency with NHS provider units becoming its local arms.¹⁶ The initiative began with the Ibbs report in 1988¹⁷ and is intent on improving the management capability of governmental functions and to distance these from the policy dimension. Of course the issue of accountability would remain to be resolved since, as has been emphasised above, the move to devolved management is no guarantee that the requirements of accountability can be adequately met within prevailing conventions.

LOCAL GOVERNMENT OPTION

There are both strong advocates for the local government option^{18,19} and committed opponents.¹³ The Royal Commission on the NHS opposed it on the grounds that there would be great resistance in the NHS to a local government takeover. But the commission did not rule out local government control over the NHS in the longer term.

A proposal for the local government of health has recently been put forward by the Institute for Public Policy Research.¹⁶ The principal advantages of unitary local authorities are that they would approach their health responsibilities from a wider vision of health rather than from the narrow confines of health services; provide a local democratic base for the articulation and implementation of a broad strategy for health; and end the present division between health and social care which is proving so detrimental to the development of coherent, seamfree community care services.

Under the Institute for Public Policy Research proposals unitary local authorities would function as purchasing or commissioning agencies. They would not be responsible for employing health care professionals, who would operate from NHS provider units managed by the management executive, which would function as a "next steps" agency. This would remove at a stroke the longstanding opposition by NHS doctors to becoming local government employees.

Conclusion

Of all the proposed models only the last confronts the issue of accountability in a way that truly challenges

current orthodoxy and firmly shifts the focus of attention from the national to the local level. None of the other proposals gives grounds for believing with any confidence that central interference can be avoided. Local government control of the NHS through purchase of service contracting contains the seeds of a more effective system of control and of accountability to local communities. The arrangement is less imperfect than the present muddle, in which members of health authorities, in theory the agents of the centre, see themselves as primarily accountable to their local community. It is not the fact of election itself which is the guarantor of effective accountability but the combination of election and control over policy priorities and the services provided through the contracting process.

Solutions to the accountability problem do not reside in structures or local government alone. They need to go hand in hand with a modification of existing processes and practices. In particular, there is the position of parliament and the means of financing health care. If it is inconceivable to envisage a radical shift in the funding basis of the NHS from general taxation, then it is to parliament that we must look for hope of change. Parliament should be less concerned with accountability from the point of view of a narrow focus on fiscal regularity and on resource inputs and more concerned with reviewing the outputs and outcomes resulting from these inputs. So far, it has not shown itself capable of adopting, or being willing to adopt, such a focus.

Assuming that as a society we believe that a vibrant local government is worth nurturing and defending—and there must be doubts given national politicians' dislike of local government—then the case for bringing the responsibility for health within its embrace would seem to be overwhelming. It is unfortunate that this option is furthest from the political agenda.

1 Department of Health and Social Security. *Patients first*. London: HMSO, 1979.

2 Owen D. *Reflections on the royal commission. The Trevor Lloyd Hughes memorial lecture*. 25 October 1979. (Mimeograph.)

3 Committee of Public Accounts. *Financial control and accountability in the NHS*. London: HMSO, 1981. (17th Report, HC255.)

4 BMA. *Leading for health. A BMA agenda for health*. London: BMA, 1991.

5 Day P, Klein R. *Accountabilities*. London: Tavistock Publications, 1987.

6 Royal Commission on the NHS. *Report*. London: HMSO, 1979. (Cmd 7615.)

7 Secretaries of State for Health, Wales, Scotland, and Northern Ireland. *Working for patients*. London: HMSO, 1989. (Cm 555.)

8 Department of Health and Social Security. *NHS management inquiry. Report*. London: DHSS, 1983. (Griffiths report.)

9 Nairne P. Managing the DHSS elephant: reflections on a giant department. *Political Quarterly* 1983;54:243-56.

10 Committee of Public Accounts. *The control of administrative manpower in the Northern Ireland health and personal social services*. London: HMSO, 1991. (32nd Report, HC441.)

11 Health Committee. *The organisation and management of the Department of Health and the Department of Health and Social Services (Northern Ireland): minutes and evidence*. London: HMSO, 1991. (HC409.)

12 Nairne P. Managing the National Health Service. *BMJ* 1985;291:121-3.

13 Department of Health and Social Security. *Management arrangements for the reorganised NHS*. London: HMSO, 1972.

14 Stowe K. *On caring for the national health*. London: Nuffield Provincial Hospitals Trust, 1989:44.

15 Hunter DJ. Managing health care. *Social Policy and Administration* 1984;18:41-67.

16 Harrison S, Hunter DJ, Johnston I, Nicholson N, Thunhurst C, Wistow G. *Health before health care*. London: Institute for Public Policy Research, 1991.

17 Efficiency Unit. *Improving management in government: the next steps*. London: HMSO, 1988.

18 Regan DE, Stewart J. An essay in the government of health: the case for local government control. *Social Policy and Administration* 1982;16:19-43.

19 Association of Metropolitan Authorities. *Local government and the NHS: time for a change?* London: AMA, 1991.