COMMENTARY

Who decides? Patterns of authority

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Some of the difficulties of decision-making in the NHS are, of course, peculiar to the health care system: there are few other organisations which are so complex, where the output is so ill defined and which concern so many interdependent professional and other groups. But it is important to put these problems in a wider context. To a large—perhaps crucial—degree the way in which the NHS develops over the next 30 years depends on the way in which British society evolves over the same period.

For, in many respects, the NHS's problems now illustrate—if in a particularly florid form—the problems of British society. Its institutional structure reflects an attempt to reconcile three potentially conflicting aims of policy: to accommodate the demands for national policies designed to share out scarce resources in a fair and rational way; for participation in decision-making by those actually working in the organisation; and for responsiveness to the views of the users of the service at the point of delivery.

In all these respects the NHS reflects some general trends. Firstly, there is a widespread consensus that social policies should be egalitarian in intent: that there should be *national* policies for the distribution and use of resources.¹ Secondly, there is widespread acceptance that—whether in the social services or in industry—the trend is towards greater participation for workers in decision-making.² Finally, there is general support for greater consumer participation. The problems that stem from trying to reconcile these various aims of policy are, again, in no way peculiar to the NHS. The emphasis on *national* policies implies centralisation: on strengthening the ability of central government to determine priorities. Yet the emphasis on participation—whether by workers or by consumers—means that the ability to resist change is being reinforced and institutionalised. Hence the development of what might be called the stalemate society which combines a high degree of centralised bureaucracy with the diffusion of the ability to resist, delay, and block change.

This conclusion can be illustrated from the experience both of the NHS and of British industry. If it is difficult to close down redundant hospitals, if management tends to be deferential towards organised labour, precisely the same is true of attempts to close down redundant factories and to increase productivity by introducing new machines or methods (witness the newspaper industry).

Medical participation

The fact that the NHS is a particularly well-developed example of this general problem is, of course, no accident. It was the medical profession which—right from the initial introduction of health insurance in 1911—insisted on participation in decision-making. Not surprisingly, other professional groups and trade unions in health have taken their cue from the doctors, and are increasingly demanding an institutionalised voice in policy-making. It is unlikely that this trend will be reversed in the next 30 years, and it seems more plausible to assume that it will become stronger. The real question, therefore, is whether the pressure for participation can be accommodated in a way which does not reinforce organisational sclerosis. If everyone is concerned in making decisions, will any ever be taken? Must universal participation mean universal deadlock? Can a consensus style of management be made compatible with organisational efficiency?

The diffusion of power is a reality. The assignment of responsibility for the consequences of the exercise of that power remains to be achieved. This, indeed, is probably the central task over the next 30 years. In the case of industry it is often argued that only a larger dose of participation can cure the disease. Only if the workers actually take part in policy-making (so the argument runs) will they accept responsibility for the consequences. Imposed decisions will be resented decisions, so the need is to move towards a form of consensus decision-

making: it was no accident, after all, that the management consultants responsible for introducing the idea of consensus teams into the NHS had developed this concept in the context of their experience in industry.

In industry, however, there is at least some sanction against the self-indulgent use of power. If the workers in a firm use their power to improve their own conditions of work, rather than the efficiency of their production line, then in the last resort bankruptcy will make them all redundant: there is presumably a limit to the willingness of governments to bail out inefficient firms. In the NHS, however, it is difficult to see an equivalent sanction. In theory it might well be possible to design a health-care system which allows for worker participation (in its widest sense, to include all staff) and at the same time ensures an efficient and responsive system. If the NHS were abolished and replaced by a system of health vouchers,³ the consumer could shop around for the most efficient health care delivery organisation in the market: there would be a direct system of incentives to discipline health-care providers. Hospital porters who went on strike too often would find themselves out of a job as consumers took their vouchers elsewhere.

Unfortunately there are several problems about such an approach. Most conspicuously it makes optimistic assumptions about the information available to consumers and about the willingness of health-care providers to engage in competition. Still, it does offer a theoretical alternative: indeed, the irony is that it brings together the views of both left-wing and right-wing radicals, since the former want more worker participation while the latter seek a market economy in health. Consumer sovereignty in the market would thus balance producer sovereignty in the workplace.

Living with the consequences

But assuming (as one probably must) that the main structure of the NHS will survive over the next 30 years, are there any other changes that could be introduced which promise to break the present stalemate? One way forward, clearly, might be to try to create a working environment in which all those concerned—whether doctors, nurses, or ancillary workers—have to live with the consequences of their decisions. In short, it would mean replacing the present system of functional management (where the lines of responsibility disappear over the horizon into the administrative stratosphere) by a system based on accountable units: where the buck stops with the people actually engaged in delivering the service.

Clearly the key to such a system would be devising budgets for self-contained (and self-governing) units. Some progress has already been made in this direction experimentally, which suggests that it is possible to move towards "clinically accountable teams"⁴ responsible for their own budgets. There are obvious problems about basing the entire organisation of the NHS on a multiplicity of such units—for example, there is the problem of common services (should a clinical team be free to contract out its laundry to private enterprise if the hospital fails to provide an adequate service at the right price?). But at least some progress in this direction should be possible over the next three decades. Indeed, one model of self-governing units is already in existence. This is the group practice of GPs, whether or not based on a health centre (although in this instance the problem of other health workers demanding a say in decision-making has not as yet arisen). In this particular case, the health-care providers are responsible for providing a contractually defined service.

But to cite this example is also to point to a central difficulty. How are the responsibilities of accountable units to be defined and enforced? What, in other words, does accountability mean in the context of the NHS? Some progress has already been made towards

defining accountability in terms of the quality of clinical work done. But, clearly, this is only one form of accountability. We lack at present any concept of accountability in terms of the service provided for a particular population. Indeed, improving the quality of clinical care through accountability could, paradoxically, even lead to a decline in the quality of service provided to the population at large: by improving the standards of the care actually provided to patients it could diminish the amount of care provided in total (since it directs attention exclusively to the quality of the work that is done, and by definition ignores the work that is not done).

The price of moving towards greater decentralisation of responsibility may therefore be devising some form of accountability for the services provided to the total population of potential, as well as actual, clients. Thus the quality of the service provided by a group practice, for instance, might be measured in terms of such criteria as the proportion of elderly at-risk patients seen, the number of appropriate screenings carried out, and so on. Similarly, the quality of work provided by an accountable unit in surgery might be measured in terms of such criteria as the appropriateness of the selection of cases in terms of the defined needs of its catchment population, and the efficiency with which resources are used (since by definition an excess of resources devoted to one patient must mean a deficit for another, given fixed budgets).

Scope for greater flexibility

Given such a development, there would be scope for much greater flexibility in the organisation of the NHS. And, arguably, the greatest need over the next 30 years will be to increase the scope for flexibility. For, to return to the theme enunciated at the start of this paper, what happens in the NHS will largely be determined outside the NHS. If there is another reorganisation of local government (as there might well be) then it will be as well if the NHS has not become too wedded to the present pattern of districts and areas: if there is a more basic set of building blocks, whether at the level of individual institutions like hospitals or units responsible for delivering care to particular patient groups in the community, then these can be rearranged in a new pattern without too much pain or turmoil.

Again, developing a more advanced system of accountability (by which I simply mean explicit criteria for assessing the service provided) could open the way to a changed relationship between central government and the periphery. One of the reasons why central government control over the NHS takes the form it does at present is precisely the lack of an accepted currency of accountability. If there is no way of telling whether a particular authority is delivering an adequate service, then inevitably control is likely to mean following up individual complaints or questions from MPs. Detailed supervision is likely to be displaced only when there are more general tools for analysing what is happening at the periphery. Thus the paradox would seem to be that a better system of accountability, far from limiting the scope for health service providers, is the necessary precondition for enhancing their freedom to act within the agreed limits of policy.

Given such a system of accountability, given a consequent ability to exercise central control over the main thrust of policy without detailed intervention in its execution, it might then be easier to adopt some of the other proposals for changing the structure of the NHS that have been advanced. For example, a NHS corporation—on the model of the Steel Corporation or the other nationalised industries—might be more acceptable if there were some measures of performance (although it would be silly to pretend that there will ever be such simple indicators as return on capital in the case of such a diverse and complex service as health) which would allow the Secretary of State to concentrate on strategic decisions, instead of occupying himself with the implementation of policy in detail. Such an option might become more attractive still if Britain's membership of the EEC—and the consequent emphasis on the harmonisation of social policies—obliged the Government to finance the Health Service on the basis of earmarked social security contributions rather than out of general taxation: this would weaken the argument that it is im-

possible to transfer responsibility for running the Health Service to a corporation while it is financed out of general taxation.

In general, therefore, I would expect the NHS to move in a pluralistic direction over the next 30 years, with co-ordination exercised increasingly by better instruments of information and assessment rather than administrative supervision (and where co-ordination might also conceivably be encouraged by means of the development of an internal NHS "market," with different specialised units buying services from each other). To this extent, it would be a more flexible, adaptable, and innovative organisation.

But, as emphasised at the beginning, the other side of pluralism will be a far more complex balance of power within the health-care system. Indeed, my initial assumption—that the complexity of the service, in terms of the skills required to deliver it, will inevitably mean participation in decision-making by a multiplicity of groups—stands unqualified. Here I would suggest that the training of medical students should reflect the facts of life as they will be when they become consultants: that they should learn the anatomy and physiology of organisations, as well as of the human body. Similarly, given the facts of interdependence, there may be a case for moving towards a shared common core in the training of Health Service professionals, since eventually they will have to share in decision-making. If the present Royal Commission does not recommend such a development then—to risk a prophecy—its successor, in the year 2000 or thereabouts, will certainly do so.

Growing asymmetry

The other long-term problem—given greater participation by Health Service producers in decision-making at the point of delivery—is that there may be a growing asymmetry between local and national power. If it is accepted that national decisions will continue to be taken on major issues—such as the balance of resources to be devoted to different client groups—then there is an obvious danger that Health Service providers, unless they take part in the process which shapes such policies, will use their power at the periphery to obstruct their implementation. This, indeed, is the current pattern. For instance, the trade unions are free to block the implementation of RAWP at the local level precisely because they are in no way committed to the introduction of the policy at national level.

This would suggest that the logic of greater worker participation at the work place (syndicalism) is also greater participation nationally (corporatism). In other words, it seems safe to predict that—over the next 30 years—there will be much the same developments in the field of health policy-making that there have been in the fields of economic and industrial policy-making, where governments (Labour and Conservative) have involved both sides of industry in framing major national decisions on such issues as incomes and investment. Given such a development, it would seem reasonable to expect Health Service policy to be increasingly shaped in a special national producers' forum—where the medical profession and all other Health Service providers would be represented—with Parliament left to play the part of national community health council, representing the interests of the consumers.

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