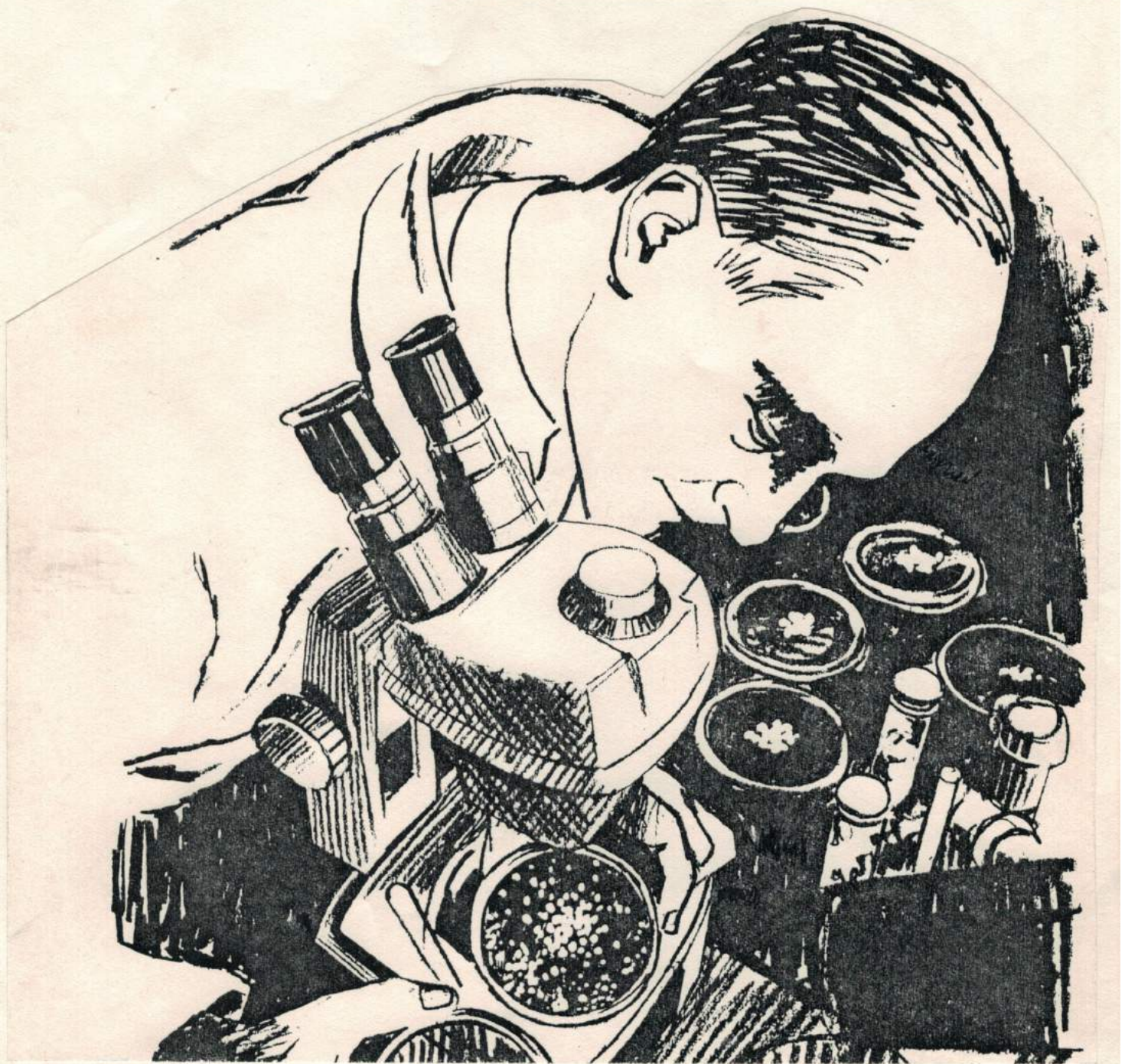


TOO BIG TO MANAGE



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INTRODUCTION

Britain's National Health Service is a large organization. Indeed it is larger than many countries. Its workforce of approximately one million persons puts it at about the population of Namibia, rather larger than Guyana or Botswana. It is about one and a half times the size of Cyprus, or four times that of Iceland. This is without counting the patients.

The NHS budget of roughly £22 billion puts it respectably high in the league table of economic powers. The NHS is roughly twelve times as wealthy as Sri Lanka, ten times Tanzania, nearly four times Bangladesh, or twice as rich as Egypt.

With its great size and wealth, the NHS has some of the character of a centrally planned economy. It is run rather like one of the Socialist countries, in that its budget is determined centrally and allocated by overall plan. Market economies have much of their information at the periphery, where it is acted on from day to day as it changes from day to day. The NHS, by contrast, takes its information through layers of bureaucracy to the centre, from where the major decisions are issued. Like many of the Socialist countries, the inadequate information that there is reaches it too late and in too diffuse a form to be acted upon effectively.

In market economies much of the information is contained in signals such as prices, and many of the imperatives to act are contained within incentives. The lack of these is less damaging in small organizations, but in huge centrally directed economies it can be a critical restraint on performance. They are less efficient and less responsive. It is no accident that they are characterized by shortages and queues, just as the NHS itself is. They lack an effective means whereby demand can express itself and set in train the provision of an appropriate supply.

The possibility suggests itself that the National Health Service may literally be too big to manage, too large a body to operate as a centrally directed unit. If this is so, then the most thoroughgoing review in the forty year history of the NHS comes not before time. Government now has the opportunity to alter both the structure of the NHS and the ways in which it is organized.

The authors of this report point out some of the theoretical and practical difficulties that are involved in trying to organize and manage a national industry -- particularly one with so complex and sensitive a function as delivering health care.

Victor Serebriakoff, the International President of Mensa, has been studying the theory of organizations and of information

management for many years, and applies his understanding to an analysis of the UK National Health Service.

Each individual is a special case, he argues. People's medical histories and their current health needs, expectations, and desires, are all different. They cannot be divided into neat pigeon-hole categories, but populate every conceivable point on any continuum that can be specified. The decisions which NHS staff must make each day about whom to treat, what procedures are necessary, and how much effort should be invested on each one, are inevitably a matter of judgement and degree.

Unfortunately, however, the adoption of any national strategy for such a service automatically requires that arbitrary categories must be imposed upon the continua. National managers, attempting to manage such a large and complex organization, cannot know and deal with the particular circumstances of each individual case. They cannot begin to understand the complicated structure until they have reduced it to a few key elements, and cannot begin to make decisions until they have divided the continua into arbitrary steps. As a result, they lose a great deal of vital information about how strong are particular needs and about how best those needs could be met.

Inevitably this cookie-cutter approach is unsuitable for many of those who depend upon the organization. But today they have no choice, and cannot force it to adjust its service by simply shifting their custom elsewhere. The only effect they can have is by complaining, and the better they are at promoting their own cause, the more able they will be at making it address their particular needs. But this only puts more pressure on the NHS staff who are caught in the middle between dissatisfied patients and national managers. And allocating resources according to the degree of clamour that particular groups can muster is not, concludes Serebriakoff, a humane or rational strategy.

Dr John Paulley is a noted consultant who takes up the management problem from the practical point of view of one who works within the National Health Service.

He argues that one of the most popular proposals for improving the NHS -- putting more money into it -- will not in fact achieve much good. It will not, for example, boost the morale of those who work in the NHS, who are still under the pressures that Victor Serebriakoff has identified. It will not make doctors and hospitals more responsive to patients' needs. Only new incentive structures and new management approaches could achieve that.

Dr Paulley suggests that one way of stimulating such structures and approaches is to make the NHS compete more openly with the private sector. Some hospitals have already made a financial success out of running their pay-bed wings, but Dr Paulley has something more fundamental in mind: changing the style of service delivery completely so that it is a more equal choice for people who are tempted to go private -- with single rooms, privacy,

better catering, and all the other details that people desire so much when they are ill.

The decline in the morale of nursing staff is another practical example of the deficiencies of global management that Victor Serebriakoff has identified. Unable to deal with the diversity of grades and titles that abounded in hospitals before the creation of the NHS, national managers and strategists have reduced them to a national system. The identity of local hospitals has been lost, even uniforms have been standardized. NHS staff no longer feel part of a team that they can identify with and influence.

Bed closures is another policy that has been pursued as a national strategy. While clearly bringing efficiency benefits in some areas, it has been inappropriate in others. Once again, nurses find themselves under increasing pressure because they have no beds available should emergency cases come in a spate.

Dr Clive Froggatt hints at how we might overcome some of these problems caused by the sheer organizational size of the NHS. Certainly the 'internal market' has a role, promoting as it would a closer scrutiny of costs and practices between different NHS districts. But more local management decisions are also possible, and can be achieved by adjusting, rather than throwing out, existing institutions.

In this regard, Dr Froggatt points to the general practitioners, who, he says, have an important but largely unrecognized role as gatekeepers. Being located close to the patients, they can assess different needs more sensitively, and could help ensure that the right decisions are made about who can best be helped by the secondary sector, where public demand is undersatisfied, and where NHS resources could be most effectively deployed. At present, there is little incentive for GPs to expand and improve their gatekeeper role: but that could be changed without great difficulty.

In other publications in this series, many more new options in health policy will be explored. Managing Better Health by Dr Michael Goldsmith and Dr Madsen Pirie looks at some techniques which have improved the delivery and value for money in health care in the United States, and analyzes which of them might be helpful in the UK context. The Mixture by Dr Tony Newton MP, Dr David Green, John Peet, and Dr Arthur Levin, examines the public-private mix for health care and how the existing balance might be changed.

Health policy in the UK is being subjected to a fundamental scrutiny more completely perhaps than for four decades. The views and ideas unveiled in this series of publications should be a positive contribution to that debate.

Victor Serebriakoff

Size and understanding

In one of the largest centrally controlled organizations in the free world there are about a million workers connected up in a vast complex network occupying many thousands of highly equipped buildings. The capital involved is over £12 billion and the annual spending is over £21 billion. Every person (including children) in the region served has over £228 invested and is made to pay on average £400 per year. The organization's workers are engaged in providing an enormous range of very complex services in every part of the British Isles. A vast array of high-technology machinery and chemical substances have to be provided to them from second to second, often under desperate emergency conditions. To give satisfaction every one of them has to be expert a one of a vast range of difficult specialist skills. To avoid complaints, demands for the services have to be met in full and instantly, although the demands arise unpredictably anywhere and everywhere.

Now any large institution is difficult to observe, understand, grasp and evaluate even if it has simple predictable and comprehensible aims, but what has been described is almost impossible to comprehend as a whole at all. Any account of it, any attempt to judge it or understand it can only come from a series of highly condensed summaries, averages, and statistical data which tell us all that can be known strategically.

What is the outcome of this great and diverse effort? From the beginning there has been little satisfaction, and a great deal of complaint from the media, the unions, and the political opposition of the day. There is always a long queue of people waiting for service and ceaseless vociferous complaints from the specialists and workers within the service about overwork low pay and poor conditions.

It will be clear by now that the National Health Service (NHS) is the institution described. At the top, the strategic level, the organization is almost unknowable but the observer who looks at the bottom end, the tactical level, who probes what is happening down at the grass roots, will find instances of every possible kind. Absolutely anything can be argued from findable individual cases. Continua on every parameter of variation can be found. Researchers will find cases where problems have been found diagnosed and remedied quickly and efficiently at negligible cost, together with cases where treatment has been slow, faulty,

expensive, and fatal.

Every variant in between can surely be found. It would be strange if the former cases received as much attention as the latter.

But strategic, central level, political discussion of the problems is always a dialogue of the Government quoting statistics, the only centralist way of knowing, and the opposition quoting dramatic anecdotal cases which can always be found and which cannot be dealt with at a strategic level.

The great problem of any very large organization is that the informational flow is so poor and centralized. Judgments are based on the extremes of the many continua of variability. Those demanding changes and improvements will always be selective in the example they choose. Those defending the status quo will be equally selective. And the rest of us, the public, will be confronted by what seem like but are not in fact irreconcilable contradictions.

Historically the National Health Service is quite new. It was set up in 1948. All the rich industrial societies have developed similar systems over the last 40 years but the British NHS is deviant in that it is more puristically centralist than most of the others. It is also less expensive as perhaps befits a country with a lower national income than the average of that (rich) group. There has also been an accepted political paradigm which has limited and reduced the amount of money families spend to supplement the national tax-based expenditure. There are countries which spend up to 50% than the UK more on medical services with the help of such voluntary contributions.

It follows that the special problems of the NHS are likely to be associated with these deviations from the usual practices in the richer countries. And so they are.

Quality and organizational environment

Every organization which is a provider of services has to have, in some form or another, a system of monitoring, of quality control and quality assurance. Without it there must be decline in efficiency and rise in cost.

In commercial organizations this aspect takes place at the periphery in a thousand places, day-to-day, in the reactions of managers, buyers and sellers. In the NHS the systems which provide this function are not very visible or available. Since the service is free, the clients have little choice. Many are too unwell to insist on what they need, even if they understand what they need (which increasingly they cannot). The normal interactions between mutually benefitting providers and receivers who understand their needs is absent. The recipients are robbed of the purchaser role (despite the fact that most are paying.) Thus all the receivers of the service find themselves necessarily in the "applicant" or "suppliant" role. This does nothing to

encourage sensitivity to need or quality of service by the service suppliers.

Further, the system inevitably exaggerates demand because even the best of us tend to be less economical in our demands when there is no mutualist effect, no price to be paid. We even exaggerate our demands and their urgency when we have to compete only for attention to our particular needs.

Strains within the organization

This absence of the mutual adjustment mechanism that we find in commercial structures simply reinforces the widespread incomprehension of the service and the dissatisfaction with it. Demands for its extension and improvement are made by the public -- and even more, very naturally, by the providers, those employed by the system, who get all the complaints and have no response option except to pass them up the ladder of authority.

So the people who work in such a public service are in a no-win situation. They have no quantitative method of expressing the strength of the need signals which they are supposed to channel upwards. They simply try to make more vociferous competitive claims than the rival services which are trying to attract tax funding towards themselves. But the more they spend the more trouble they get from above; the more they economize the more trouble they get from below. Dissatisfaction is not resolved at the tactical level by the normal free exchanges with mutual cost and advantage, between people who have equal bargaining power, face to face. Discontent and disappointment can only be "promoted" up the hierarchical strata until it converges on the top level. That is where the money comes from; but that, unfortunately, is where the understanding and evaluation of the needs and the methods of meeting them is least, because it can only take the statistical form mentioned above.

What follows is what we see. All dissatisfactions converge in to one undifferentiated stream which forms a cataract delivered to the top level. It is a universal and ubiquitous call for more "resources" (never for such a "commercial" thing as money) and a complaint about "underfunding". In any large system, there must of course be errors of underfunding and also errors of overfunding; but we do not reel back in surprise when we find that only underfunding is reported to the authorities and the media. We would be foolish to suppose that there exists a finite level of funding which would stop the clamour for more of it. No hospital manager could ever dare to report a returnable surplus. The Year-End Spend-Up which is needed to avoid a budget cut next year is a common feature, and a common source of waste, in centralized organizations.

These are the problems of centralism. When the needs and desires of many people are met by any large single organization there arise an entirely different class of problems from those that prevail when people arrange things for themselves as they do by

locally motivated, mutualist, contractual relationships.

MUTUALIST SYSTEMS IN HEALTH

Is there a way of restoring mutualist incentives to the NHS? Mutualist systems where the provider and the receiver perceive a mutual benefit from each transaction have their own faults, but these are resolved and dispersed unnoticed and ubiquitously. The provision of most goods and services (including essentials such as food and clothing) do not present a social and political problem. The informational system is face-to-face, the perceptions and judgement are on a case-by-case footing, there are always a range of options, and an element of competitive choice exists for all parties. Problems do not have to fit predetermined classes: they can be resolved by local experienced judgement instead of by reference to often inappropriate bureaucratic rules. Thus the essential incentive, quality control, and cost control elements are all provided and the whole system is constantly self-adjusting and self-optimizing. The enormous richness of the informational exchange ensures that there are operational adjustments at many levels. Trial-and-error optimization is easy to achieve.

Can this mutualist principle be re-applied to medical treatment without creating an unacceptable inequity? This is the central problem. It is a very difficult one. But we must note that the problem arises only concerning a fairly small section of the community. Nearly everyone pays via compulsory taxation and National Insurance Contributions as much towards their medical costs as it would cost them to insure privately. But we have to deal with the minority where this is not the case. So let us look at the special difficulties, the case for a change.

In exact aims

Most large centralist organizations such as an army or a big industry have a small and simple set of comprehensible aims. They try to optimize on one or a few parameters (like victory or maximizing profit) which are easily quantifiable. In medicine we are dealing with a very large number of people who want to improve health and delay death as long as possible. That involves providing remedies for a thousand diverse conditions -- and each case is different.

The aim of extending life alone could be the source of infinite demand. The cost of delaying death rises exponentially in three ways. The medical cost per life-year gained rises with age. The population of survivors expecting that more costly treatment rises with success. Third, the discoveries of new technology make treatment ever more expensive and increase rather than decrease the number of treatable cases (as shown by the enormous rate of increase in cases treated shown up by statistics: outpatient cases have been rising by 13 percent per decade, inpatient cases by 22% and day cases by 81%).

In almost all other fields, effort and expenditure reduce the problem. We have here a game plan where the more effort, money, and ingenuity we expend, the bigger the problem grows. Meeting need increases it. It is a no-win game because mortality remains at its original figure of 100 percent. Normal industrial and technological progress decreases the cost of goods and services. In medical matters the reverse is the case. This does not mean we should stop trying. It means that we should face the implications and plan for them.

Another problem with any service where payment is unrelated to demand is the problem of shifting borderlines. In medical matters we are dealing with continua so all category borderlines in medical affairs are fuzzy. If one service is free and another means spending your own money, it is natural to try to take advantage of the fuzziness of borderlines.

There are non-therapeutic medical desires and needs. People want cosmetic surgery or to improve (or reduce) fertility. There are other treatments such as those for the pathological results of behaviour errors (drug abuse, reckless driving, overeating and so on). Many of the people taxed to pay for these treatments might consider them marginal or improper as a free service. But the pressure from those who want the service is always stronger and more persistent than the counter-pressure from those who pay. The list of permissible services and provisions will inevitably grow longer. Medical workers who have to make these borderline judgments, and those who gain rather than lose by extensions of the service are unlikely to be very assiduous in the taxpayers' interest. So, inevitably, the borderlines move away from economy and towards extravagance.

The insurance principle

The original concept was that the Health Service should be funded by compulsory insurance to which all employees contribute, so that those who could not pay did not have to feel like recipients of charity as had been the case in the previous methods of medical provision for the poor.

But due to the enormous and unexpected expansion of the whole scheme the "insurance" contribution via National Insurance has gradually shrunk until it is now only 13% of the cost. It is paid only by regularly employed workers and their employers. Unacknowledged, the NHS has returned to the earlier principle and has become, once more, largely an instrument for charitable redistribution of wealth, most of its funds now coming from taxes, where ability to pay is the criterion. Even the token NIC contribution is not equitable because it is charged to employers, making the employment of labour more expensive and less competitive, and thus increasing unemployment. Further, there is a gradient by which the payment goes up with income but only to a certain level so that the very highly paid pay a lower proportion of their income than the intermediate earners. There

is no payment on "unearned" income. This clumsy and unjust system has lost its earlier psychological justification, and could be impossible to reform without creating an impossible "winners and losers" problem.

Bureaucratic roles

The problems of any large monopolistic, producer-controlled system of meeting needs and desires are the problems of inappropriate incentives and priorities, bureaucracy, cost-benefit inefficiency and uncontrolled demand. The usual way of dealing with these problems is to try to install a system of rules to govern the allocation of resources and to regulate and contain expenditure. This involves an exercise in classifying the unclassifiable and comparing the incomparable.

Again the problems are informational in nature. They are the problems of dividing continua by inserting arbitrary steps.

To resolve the priority and incentive problems by means of a rule book in such complex cases involves the construction of ways of breaking down continua without appearing to be inequitable. But rules simply cannot be devised so as to cover every possible kind of case. Looking at the whole background of each medical case soon shows that everyone is unique and that any system of classification will be full of fuzzy borderline anomalies. Each of these tend to become a dispute area and a source of friction when one is dealing with a free but not infinite provision.

From these disputes emerges a new principle of resource and service allocation: by interest-group clamour. Interest groups that combine to make the loudest clamour get the better budgets so all those in responsible positions tend to exaggerate needs and dramatize deficiencies on the theory that if you ask loudly enough for ten you will get five.

STRATEGIES FOR REFORM

That is the state of the NHS today. We need to ask how we can decentralize it and get its need-signalling system into the state where matters can be resolved by dispersed face-to-face mutualist discussions and judgments rather than by trying to fit cases into predetermined slots.

The method of trying to switch resources like a fireman's hose from one group to another as the outcries flare and die down is inadequate and will produce a bad service at the cost of a great deal of money. The need is to snatch the enormous money hose away from clumsy hands, divide it by a million or two and get many small sprays back into hands of the clients. If their wishes and needs and their share of funds can come down as rain on the system instead of as an ill-directed untimely torrent on bits of it then the system will grow more healthily into a learning system which can adjust and optimize its responses at all levels related to real need and real cost.

Goodwill assets

There is a good and positive climate towards the Health Service at the moment, perhaps partly because the real cost is not fully perceived. It feels like a free service. But as the clamour from its employees continues it may be only a matter of time, as the cost rises, before this will begin to be seen as much more self serving than it may really be. This is when we may expect a change of perception which may be quite sudden.

There is an example. In the early years of the century, teaching and the civil service, both centralized services, were perceived as high-status, respected professions. Their workers are now often seen as self serving organized groups, and even their self-perception is much lower than it was. They feel less valued, they will not become better valued if they complain loudly and win more pay as a result.

It has been sad this year to see the Health Service beginning to go down that road and begin to draw heavily on its great stock of public goodwill. The attitude of the leaders of the medical trade unions (with honorable exceptions) does not appear to have been helpful here. The bad communications system and the absence of multi level mutualism has tempted some of them into a vociferous aggressive clamour competition which has served them and their members ill.

Unsustainable

In summary, in advanced democratic countries generally and in Britain in particular, there seems to be a serious social and political problem which is getting worse and which will not go away. An enormous, diverse, uncontrollably growing institution has developed very rapidly and is now directing the expenditure of six percent of the national wealth. We cannot at the moment see what forces will limit its further growth or ensure its quality control and sensitivity to need. It is not aided in this by having an extremely inefficient internal audit system if only because its objectives are so diffuse as to make their quantification almost impossible.

It says much for the goodwill and professional high standards of those employed in the NHS that it has not become much more self serving than it is now.

It would be a reasonable expectation based on past experience that such a vast organization should become parasitical in the course of time. It has been set an impossible goal, that of meeting infinite need in such a manner that the better it is at its job the bigger the job grows and the more money it must attract. This is clearly unsustainable and a change must be made. The matter is now high on the public agenda.

Policy options

There has been a great deal of discussion of the case for a large increase in spending from taxation as the solution. But for the inherent organizational reasons cited above, this is unlikely to bring lasting benefits. However, many other reform plans have been proposed and widely considered.

The Adam Smith Institute has set out some of the policy options to deal with this enormous and growing problem. Some of the broad policy options which are explored by its report The Health of Nations, included the following.

1. Action to improve the information base for future decision making.

What has been said above about the difficulty of capturing and understanding of large complex systems makes this a risky approach.

2. Consolidating current initiatives for improving efficiency.

Again this approach can only have diminishing sporadic and largely without measurable results. However there seems to be a need for some crudely generalized measure of achievement such as the cost per quality and probability adjusted life year gained. The QAPALY/£1,000.

3. Increasing supplementary revenue by income generation schemes.

This approach cannot have any but a marginal effect and it has no efficiency push.

4. Increasing public expenditure through general taxation.

In every public service debate, this is the approach of every political opposition and of no government. For the long term, is not a policy at all since it does not address the problems outlined above.

5. Moving towards a more fully funded social insurance scheme.

A great deal would depend on the detail but good versions are working well in other first-world countries.

6. Establishing an internal market approach by a return to the payment principle.

There are many ways of doing this and almost all of them would be an improvement but a some would involve too sudden a change in political perceptions.

7. Extension of charges at the point of use.

Anything which introduced a method of sensing need so that priorities could be based -- rather than queue-length rationing -- would be good as long as the small class of really poor people were provided for.

8. Encouraging the provision of private health care beside the national scheme.

This method would have beneficial effects on many of the problems but would meet very strong political and public objection until the present climate changes.

9. Replacing District and Regional Health Authorities with competitive but publicly funded Health Management Units and thus re-introducing a market approach.

This seems the most promising approach in the present climate of popular opinion. Decentralization would introduce a competitive co-operative paradigm and the multi-level information system that is essential. The service remains centrally funded and so would fit in with what the public wants.

The HMU idea overcomes a very serious and often unperceived problem. With the rapid progress of medical science and given the great complexity of the human body and its pathology, it is increasingly difficult for the consumer to express his or her desires because non-experts simply cannot have the informational background. This suggestion preserves the relationship of the general practitioner as the expert who can be trusted to know the client's needs and act professionally on the client's behalf. However the GP as the agent will be able to have a market-style impact on the system because, in effect, the medical service suppliers, the proposed Health Management Units, will be competing for his orders. The vital mutualism of advantage will be partially restored to the system and the correct cost-benefit incentive pressures restored. The need to create counter-productive public clamour will be removed and calm judgement will tend to replace the present fire-fighting approach.

By no means will all the problems be overcome, but at least judgments will be made locally and sensitively by those with all the information, both of the case and of the medical and financial constraints concerning it. Human judgement will be restored to its proper beneficial role and the rule of the rule book ended.

10. Compulsory private health insurance with publicly financed insurance credits or vouchers.

This is a possible approach and versions are working elsewhere. What is doubtful is the political acceptability in the climate of political opinion that prevails. It may be

too radical a change to take at one step.

Moral issues

There is a strange new moral pressure associated with this subject that does much to confuse people and make sensible decisions difficult. While there has always been an undercurrent of opinion which favours the extension of a simple nursery "equal shares for all" ethos into the entire nation, (and even beyond it to the world at large), the impossibility of this has long been clear in both theory and practice. However, another principle, that of exerting social pressures upon group members to serve their groups via incentives and disincentives of various kinds, has been universal. In earlier societies these pressures used to include harsh physical punishments for the unsocial and gifts and privilege for the social. In more advanced societies the punishment element was reduced and the positive reward element increased. The latest form is that social reward should take the form of spending power, the right to command services in return for services. By and large, we tend to push people into working to provide what we want from them by giving them money or the right to command services themselves.

This principle is almost universally accepted and works well in almost all spheres. But since 1948 in Britain there has arisen an entirely new moral principle which says that it is immoral to use your money for your comfort during or for health care. No one would deny a person the right to use his or her money to buy comfort, good food, holidays, travel, any kind of luxury anywhere except in a hospital or a prison. We tolerate and strive for a system of multiple tiers of consumption from bare sufficiency up to plutocrat luxury in any other sphere. The world approves. Even the right to use your spending power for pursuits that risk or undermine your health and do you harm are widely conceded. I may buy slow poisons like tobacco or drink and ask my neighbour to foot my hospital bills but if I pay the bill myself it is considered immoral and I am accused of supporting an unacceptable "two tier" system of health care.

The problem enhancing effect of problem solving in this difficult field are going, sure as fate, to grow. As they do the difficulty of maintaining this new moral principle will become worse and it would be safe to predict that eventually it be seen to be what it is, a false moral principle, one that must damage the society which supports it. As long as mankind is as it is now; as long as there is the present distribution along the continua of selfishness and altruism, sociality and individualism, competitiveness and co-operativeness, we shall never have a functioning society without incentives, and inequality of rewards to provide them. There does not seem to be the remotest possibility of preventing those with the power and/or money that must be the result of this from finding ways to use it to buy health care somewhere in the world. The attempt to brand a person who chooses to buy extra health care for himself, his children, parents or friends as a moral leper will happily never

get very far. People must not only be permitted, they must be encouraged to use what they earn to buy the most precious gift of all, good health. Those that cannot must be provided for but not by such absurd rules as those which allow me to buy sickness but forbid me to buy health for those that I love and for myself.

NHS DISCONTENT AND ITS SOLUTIONS

Dr John Paulley

Are more funds the answer?

With an economic performance comparable to that of our continental neighbours it will in future be difficult, either politically or ethically, for this country to spend substantially less a share of GNP than they do.

However, while some minor increases in NHS funding out of tax revenue may be needed in the short term, demands that additional sums should be provided indefinitely are unacceptable for the following reasons.

Firstly, it would perpetuate the sterile yearly haggle with the Treasury in which other players, such as Education, Health and Social Service, Housing and Environment, participate;

Secondly, the morale of the NHS personnel, whatever they are paid, will not improve much until the other real causes are identified and corrected -- years of insensitive administrative policies. A government about to restructure the Health Services would be wise to make this clear at the outset and to distance itself from the more damaging of those policies.

Thirdly, it would do nothing to make general practice, or hospitals, more responsive to the the consumer's needs. Instead, it would compound inflexibility of working practices and the attitudes of staff: patients would continue to see themselves as recipients of charity and staff would continue to treat them as such. That was the inevitable consequence of an act which contained no incentives for consumers or providers to change entrenched perceptions of each other. Overmanning, as a result of weak management, trade union pressures and the imposition of a large bureaucracy would also continue.

Advocates of change at the present time should recognize the NHS's early achievements. Informed visitors from overseas in the 1950s acclaimed the quality of its medical and nursing care. What surprised them was that it was possible despite primitive buildings in which much of the work was done. Unfortunately, many standards of excellence, which the NHS inherited in 1948, have been destroyed.

The alternatives

Because the NHS is regarded as a 'sacred cow', any change will

arouse emotional responses. This is partly because the public has been misinformed about the NHS's performance compared with other countries' arrangements for health which are, in some ways, superior -- but not all. People with vested interests, such as politicians, civil servants, doctors and nurses, have been responsible for this, their propaganda being so successful that even Conservative voters have been deceived by it. But things are changing. More people, even left of centre, are at last recognizing that soaring costs of new advances, new scourges, such as AIDS, and the need for care of more and more elderly cannot be met effectively from taxation alone.

Alternative funding needs careful consideration; methods used in Holland, Germany and France, for example, by requiring those who can afford it to insure themselves and thus complement state subvention for health, have been politically acceptable there. The lesson for us seems to be that although two tiers are almost unmentionable here, two tiers, or even multiple tiers, seem to be acceptable on the continent because the quality of the standard care available has been levelled up and not down as has been policy here. In my view, the United Kingdom should broadly follow the example of the countries mentioned.

Although people now know that all is not well with the sacred cow, its falling milk yield cannot be blamed solely on a lack of fodder. Certainly, more is needed: but it cannot expect to feed only on choice pastures, and to turn up its nose at turnips and sulk. For the NHS, this sulking is reflected in the 'unavailability' of a GP who knows your case, or scientific medicine's neglect of common afflictions which are not very interesting but cause much suffering, or operating theatres closing at 5pm despite long waiting lists.

And the yield of a cow depends as much on sympathetic handling as on how much it eats. The implications of this in terms of NHS morale seems to be poorly understood today: forty years ago, the pride and comradeship of a hospital staff was recognized to be as important as the morale in any regiment, ship, or squadron.

High morale and competence in the NHS is in the interest of every citizen, however comprehensive his private insurance, because it will avail him nothing if he suffers a severe injury or illness anywhere beyond a few miles from the centre of a large city with a private hospital large enough, or sufficient enough, to cope. Dr Butler and Dr Pirie have recently pointed out in The Health of Nations that even if the private sector was expanded to double, or even three times, its present size, it would still leave 70%-80% of the country dependent on NHS health care for years to come.

A successful inter-marriage will depend on the reversal of Mrs Castle's folly of trying to drive private medicine out of the NHS. Therefore, current rumours that consultants may be asked to choose between whole-time work in the NHS or private work outside it are disturbing. Even Mrs Castle did not quite achieve it,

although she did her best. It would be far better if consultants took up what is known in the USA as a geographical whole-time contract, which means that both their private work and NHS work has to be done on the hospital campus. In return for foregoing the right to work outside such able consultants are compensated by greater scope for research and teaching than is usually likely to be present than perhaps for some years in private hospitals.

Clearly, the NHS will have to offer some new attractions to compete with the private sector outside, for example single or double rooms, and possibly a better than average cuisine, but patients wanting caviare for breakfast would probably do better to look elsewhere.

The loss of leadership

I now turn to the problems of policies which have damaged hospital morale and leadership. In 1948 the first leaders to be lost, in all but teaching hospitals who kept them a little longer, were house governors and secretary superintendents. The best of these were appointed at once as secretaries of hospital management committees and went to offices outside the hospitals. Unfortunately the new management structure at district level has not yet done much to remedy the situation -- because there are too many hospitals in charge of one manager. It would be cheaper and more effective to pay one man or woman of stature and ability a very good salary for the post of house governor than to continue to employ officers of limited ability who are rarely on site. If hospitals were again to become autonomous units presumably this would happen, but those who favour a compromise will find that the bad old ways will be difficult to eradicate.

It was not until the 1960s that the anti-elitist ideas of some sociologists and psychologists penetrated to the corridors of power. Experienced ward sisters were the first target; it was alleged they were autocratic and out-of-date old battleaxes. A few were, but the majority had always been the linchpin of hospital nursing. It had been conveniently forgotten by their detractors that continuing education was not then on offer. The first attack on their authority came in 1966 when their domestic and cleaning staff were placed under the control of newly appointed domestic superintendents, or supervisors. Ward cohesion and efficiency have never really recovered; from then on the sister, if she criticized a cleaner's shoddy work, would be reprimanded.

Next came the meal service which some sisters resented as an interference in an important part of patient care. Worse was to follow when nurses were forced to give up the distinctive uniform of their hospital, which had always been important to them. In place of it they were offered, and indeed forced to wear in many instances, a drab shapeless national sack. The cash saving was trivial -- it was really a piece of social engineering to make cleaners and cooks feel happier (which of course it did not).

The next attack on the ward sister's position was when directors of nursing appointed clinical tutors to teach the nurses in sisters' charge about patients on her ward. Gradually nurses began to be taught less and less at the bedside and more and more in the training school, by nurse educators who had often not nursed a patient for years. In the process, much essential modelling was lost.

The final, and most serious, blow to leadership and morale among nurses was the imposition of the top-heavy salary structure of nursing by numbers in which the ward sister was grade number six out of a total of ten. Matrons were lost and in their place chief nursing officers were appointed who were rarely seen inside hospitals and, like numbers eight and nine, set their nurses a poor example by not bothering to wear uniform.

The inevitable result of these measures was growing cynicism and unhappiness amongst some very competent nurses with whom doctors had worked in partnership for years. In turn this affected the morale of the doctors.

Meanwhile leadership among some hospital consultants had been stealthily undermined by a series of DHSS policies from 1966 onwards. One of these was the introduction of overtime payments for junior staff, which led to clock-watching mentality and reduced sense of professional responsibility and fragmentation of care. Better ways could have been found for dealing with the problem of very overworked junior staff in some departments.

Bed closures: a policy carried to far

Bed closures was a policy carried too far. The policy was initiated in 1960 when cures for infectious diseases and tuberculosis had resulted in too many unoccupied beds. Ever since, administrators have tended to use statistics -- such as bed occupancy, throughput per bed, turnover time -- as if they were the sole measures of efficiency in hospitals. One quarter of the nation's acute beds have been virtually lost since 1966, and half of those in the past ten years. For some time now it has been the experience of doctors, nurses, and patients in most parts of the country that this unremitting squeeze on acute beds is causing inefficiency and is a major factor in destroying staff morale and increasing patients' distress and discontent. When anyone complains they are usually told that it is all due to government cuts rather than this monocular concept of what constitutes efficiency.

In the past, a few empty beds in an ordinary hospital cost very little. It is only since they have been so reduced in numbers that their costs have risen toward that of intense care units: and on the way, the important principle of progressive care has been lost sight of. The reality is that an acute hospital; which does not have a few empty beds to cope with emergencies, is inefficient, and the same applies to the need to keep an empty ward for patients to be moved into when redecoration and cleaning

has to be done in their own ward. What happens now is that admissions are restricted and, therefore, resources go to waste. Acute beds are now so scarce that doctors and nurses are under constant strain, having to turn away acutely ill patients requiring hospital care, or having to move patients to unsuitable wards or to send them home without warning before they are fit. Patients booked for elective operations suffer by having their admissions cancelled at the last moment because their beds have been filled by an overflow case during the night, leaving surgeons' and nurses' skills wasted as well as other costly resources such as operating theatres.

The situation has become worse since health authorities, faced with overspending, have closed even more acute beds instead of tackling areas of overmanning in administration, stores, domestic staffing, overblown dominions of nurse education, and the top-heavy salary structure -- all remote from the patient. With 75% of hospital revenue taken up by salaries and wages, this is the only area where really worthwhile savings can be made. Maintenance was pared to the bone long ago. Why then do administrators go on closing beds, which saves very little money but creates misery for doctors, nurses and patients? Is it to promote the maximum emotional response from the public?

The Dutch, French, and Germans have 15%-20% more beds per capita than we have. To restore the morale, and recruitment of nurses and reduce patients' unhappiness, an increase in the number of our acute beds is urgently needed to bring us nearer to the level of our continental neighbours. A 15% increase on present figures might be enough.

As doctors, nurses, and patients know well, an unremitting pressure over long periods leads to unacceptable errors, exhaustion, loss of job satisfaction, falling recruitment, and disillusioned nurses deserting their profession. Before it is too late, health economists and politicians should recognize that there is more to efficiency in nursing, medicine, and surgery, than too rigorous a pursuit of statistical measures such as 'through-put', or the maximum application of costly techniques which might prolong life but not necessarily enhance the quality of life enjoyed by the patient or the patient's family.

PRIMARY CARE - THE GATEKEEPING ROLE

Dr Clive Froggatt

Research Officer, Conservative Medical Society

Let me run through what I believe the objectives of the government's current review are.

Firstly, it seems to me, that it must resolve the central dilemma which has existed ever since the Health Service began -- that in matching the needs to resources will probably require a redefinition of the principles on which funding, and the use of resources, are currently based.

Secondly, I see it as an opportunity to improve the relationship between the outcome for patient health and the input in terms of both resources and personnel.

Finally, I hope that it will achieve the encouragement of greater responsibility to be taken by those working within the Health Service, and to reduce considerably the role of central government.

Relationship barriers

Those are my objectives, and the barriers to progress, that I believe exist at the present time, are essentially to do with relationships.

Consider, first of all, relationships between health workers and government. I do think it is sad that the medical profession, particularly, and the nursing profession, (to a lesser but increasing extent) have fallen out with the government. It is certainly unfortunate at a time when the government is reviewing the fundamentals of the Health Service, however; and I would appeal to all those thinking workers within the Service to consider again whether or not they should be talking to the government when such important matters are being considered.

The next problem relationships are those exist between health workers (that is to say, clinicians and nurses) and the management of the Health Service at district and regional levels.

The third relationship problem is that which exists between general practitioners, or the providers of primary care, and those working in the secondary sector; very often they forget the common objective of the patient and talk about their own

professional roles and aspirations within them.

Finally, and very critically, I believe that we have a disruptive relationship between DHAs, FPCs, RHAs, and most particularly of all, the Department of Health and Social Services.

Much has to be done to improve those relationships if we are to get anywhere in improving the efficiency of the Health Service. We have insufficient incentive for change, and I hope that whatever comes forward will provide greater incentives for change, but we must all be prepared to look more closely towards what is best for our patients.

Primary care

The general practitioner, family doctor or primary care physician, represents the interface between the patients and the National Health Service. Some 99% of patients in this country are registered with a general medical practitioner, and 90% of all medical episodes are dealt with outside hospitals -- the majority by family doctors themselves.

Consultations with elderly patients represent a very substantial part of our work, since 50% of consultations with patients over the age of 75 take place in the patient's own home. Over the next 25 years we expect the number of patients over the age of 85 to double and the increase in those between 65 and 85 is increasing at a rate twice that of the general population.

There are 30,000 family doctors, and £5 billion worth of NHS resources are spent on family practitioner services, which represents 24% of the total.

There is no denying, therefore, that the family doctor, the principal point of contact between the public and the Service, is a very important gatekeeper. Similarly, with the doctor being responsible for the vast majority of referrals to the hospital sector, he is, in a sense, also the gatekeeper to the secondary care sector.

I believe that the gatekeeping role of the family doctor has been largely unrecognized, and certainly undervalued, for the past forty years. The development of this role could have profound significance for the future of health services generally, both in the public and in the private sector.

Not much development has occurred, except in certain isolated pockets of excellence. Generally, however, there has been no incentive. GPs have been free to contract with family practitioner committees, irrespective of merit, just under half their income being guaranteed whether or not patients joined their list. Dissatisfied patients have found it almost impossible to change doctors, or to find out very much about their GP in advance of selecting one with whom to register. But enough has been learned from the pockets of excellence for us to

say that if those lessons applied universally, it could have a very considerable impact on the quantity and quality of patient care.

With the changes proposed in the White Paper on primary care, and in the Health and Medicines Bill currently before Parliament, incentives are at the top of the agenda. Their introduction will promote the sort of radical reshaping required to effect a fundamental change in the role and attitude of family doctors. Incentives will be created to encourage doctors to take greater responsibility for providing a service to their patients.

An internal market in primary care is about to develop. As a result of the changes, family doctors (I believe) will soon begin to compete for patients by providing a higher quality of care. Those who provide better services, tailored to patients' requirements, will be rewarded financially. Furthermore, because the quality of care is as important as the quantity of care, FPCs have been given the responsibility for monitoring much more the content of care provided by general practitioners.

The government's intention to reward further enterprise by general practitioners who take on more responsibility will extend the competition which will develop between general practitioners into competition between the primary and the secondary sector. The shift of responsibility for patient care, from the expensive secondary sector to the more cost-effective primary sector, will continue for general economic reasons alone; it is part of an international trend and is one of the reasons why so many developed countries envy the system of primary care that we have already established in the United Kingdom.

However, the recent government initiatives will accelerate that shift towards primary care by the introduction of incentives, hitherto absent, that will urge the primary sector to assume greater responsibility. For instance, accident and emergency services will be relieved of some of their patients as well as of their responsibility for minor operations. Diabetics and hypertensives, hopefully, will be followed up in general practice instead of in expensive hospital clinics. But of even greater significance, the gatekeeping role of general practitioners will be significantly enhanced as they begin to reduce their referrals to hospitals and specialists, both for in-patient and out-patient appointments.

GPs and the reform proposals

There are wide differences in rates and patterns of referral, and many of these differences have to do with the lack of incentives and the failure of general practitioners to take more responsibility for their patients' care. I have to say that I find all the reform proposals based on HMOs that we have seen to date are devoid of convincing evidence that they will produce more cost-effective, better-quality patient care. They all have the potential to reduce choice for both the patient and the

doctor, and seem to promote the exchange of quality for quantity in patient care. I believe also that they may well reduce incentives for doctors, particularly in the primary sector, to compete for patients.

However, it is the area of referral that bothers me most, firstly, because the reform proposals seem to be a relatively rigid construction which dictates rates and patterns of referral on economic grounds. Secondly, HMO-style arrangements seem to reduce the availability of choice for different types of specialist care that might well be better recognized by a patient's GP.

It may be that the HMO-style solution does have a place in certain areas, but this has to be decided locally rather than centrally, and this is why I am in favour of an extension of the internal market and, in particular, of the proposals set out by Einthoven in his remarkably foresighted Reflections on the Management of the National Health Service. His proposals could be accommodated today, although just three short years ago he himself did not believe this to be possible. I mention my support for them because the enhancement of the gatekeeping role of the general practitioner goes hand-in-hand with the devolution of responsibility for health-care provision away from central government and the Department of Health, into the District Health Authorities. Furthermore, by extending Einthoven's principles, it would actually be possible for all District Health Authorities to decide for themselves the method of delivery of services most suitable to the demands of the local patient population.

It is therefore imperative the DHAs have the autonomy within which to operate and to choose for themselves; it would be a matter for local authorities to take the responsibility for such decisions, close to the point of delivery of services, and therefore a mechanism that is much sounder than having central government dictate a solution throughout the country.

Conclusion

Let me reiterate the points I have made. The gatekeeping role of general practitioners can be identified in two situations: primary contact between the patient and the Health Service; and the entry/exit of patients from the expensive secondary sector.

The opportunities thus presented have been ignored, largely through the absence of incentives. Recent government initiatives will have a profound and positive impact on the quantity, quality, and cost-effectiveness of health-care provision at all levels, in both the public and private sectors. Any further reforms must ensure that the development of the gatekeeping role can and does continue.

OTHER PUBLICATIONS ON HEALTH POLICY

Good Health: The Role of HMOs

By Dr Eamonn Butler

The Health of Nations

By Dr Eamonn Butler and Dr Madsen Pirie

Health Management Units

By Dr Eamonn Butler and Dr Madsen Pirie

Managing Better Health

By Dr Michael Goldsmith and Dr Madsen Pirie

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