COMMENTARY

Reflections of an ex-AHA member

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Now that area health authorities are part of the history of the National Health Service, there may be a case for reflecting on what we can learn from their experience before completing the final burial rites. In my study stand three crammed box files: memorials to the three years I spent as a member of an AHA. What did I learn from this experience? And what are the implications for the future? This paper attempts to draw some cautious conclusions about the role of authority members in the running of the NHS on the basis of my own three-year stint.

It is, self-evidently, dangerous to extrapolate too recklessly from limited experience of one AHA. In particular, it is important to emphasise the special characteristics of my own AHA: Wiltshire. It lacked the sort of acute social and economic problems that afflict some inner cities; it did not mirror the political tensions generated by such problems; it had been fortunate enough to attract a highly competent team of chief officers who commanded the support and confidence of the members.

The authority's style reflected these characteristics. The emphasis was on achieving consensus; at times the chairman had to make quite deliberate efforts to ensure that important issues were given a more than perfunctory discussion. Only rarely did the members vote, and then usually on matters that did not affect the AHA directly. For example, the question of whether or not the AHA should back legislation to make the wearing of seat belts compulsory aroused strong passions. But such passion was exceptional. To the extent that members felt strongly, it was usually about issues that united them: in particular, about what they saw as the region's insensitivity to the area's claims to extra resources and its rigidity in seeking to impose regional policies and plans.

Overall, it would be difficult to conclude—on the basis of my short experience—that authority members played a large part in either formulating or executing policies. With some exceptions, discussed below, their role tended to be reactive and concerned with the small print of local implementation rather than grand strategy. Nor can this be explained by Wiltshire's special characteristics: my experience was in line with other studies.¹⁻³ Instead, my experience suggests that the relatively recessive role of authority members may be explained by some of the problems built into the role itself. And it is these problems that I shall explore. For, though AHAs may now have disappeared, their abolition has not automatically solved the difficulties faced by the members of health authorities. And the experience of AHA members may, therefore, still have implications for the new district health authority members.

The first discovery I made as an AHA member, no doubt like all other new recruits, was the extraordinary difficulty of my role—even for someone like myself, with a professional interest in the NHS, who should in theory have come reasonably well equipped for the task. The difficulties had little to do with the organisational structure of the NHS—the number of tiers and their relation to each other—but reflected the peculiar nature of health services. Being an authority member is a never-ending, often frustrating battle against history, ambiguity,

and uncertainty in an environment of exceptional complexity.

The 1972 "Grey Book" on the management of the NHS⁴ defined the role of AHA members in ambitiously, and optimistically, comprehensive terms: "The AHA will itself take all decisions on policy, planning, and resource allocation and control the performance of its officers." The main role of the member turned out to be, however, to judge by my own experience, the ratification of decisions imposed by the logic of history and the organisational dynamic of the Service itself. In practice, most decisions about "policy, planning, and resource allocation" have been pre-empted by the past. At any one point in time the scope for taking strategic decisions is constrained. Becoming an authority member is rather like boarding a train: the passengers can decide where to get off, but they have no say in its destination. Specifically, most developments flow from decisions about the capital investment programme: so, inevitably, given the long lead time, authority members are the prisoners of past planning policies now embodied in concrete.

Irony of long-term planning

The irony is that while long-term planning may seem rational, it may actually make it more difficult to adapt rationally when the circumstances that shaped the original plans change. The more comprehensive and specific the plan, the more difficult it may be to react flexibly to new challenges—such as the realisation that the plans were based on assumptions of economic growth that were out of date almost as soon as they were incorporated into the planning documents. Fast budgetary growth may provide scope for decisions about "policy, planning, and resource allocation." So, paradoxically, may brutal budgetary cuts, since these necessarily enforce choices about priorities. But slow growth, whose dividends are mostly committed by past decisions, limits the scope for debate.

An authority member quickly becomes aware of the constraints imposed on decision making by the nature of the organisation. The NHS is, above all, an organisation where what you can do is constrained by the people you have got. The point is as obvious as it is central. Given freedom to prune out dead wood, and to recruit new staff, there would be little difficulty in improving efficiency. But it is precisely this freedom that the NHS (like the universities and other, similar institutions) lacks. Furthermore, the NHS is also an organisation where managerial authority tends to be based more on persuasion than on command: it is an organisation where the introduction of change depends on the mobilisation of consent. Once again, the point is familiar: it applies with special force to the medical profession.

The implications for the role of the member are profound. If members of health authorities tend to be diffident about challenging managerial or professional judgments, this reflects only in part their deference to what may be perceived as the authority of expert knowledge. It also reflects their awareness that such managerial or professional judgments are constrained by what is feasible, given the nature of the organisation. If change depends on building up coalitions of support and on massaging sensitive egos it becomes difficult for those not directly concerned in implementing policies to impose their views. So even if authority members are confident enough to

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assert their own views about what ought to be done—to reject, perhaps, the priorities of the managers and professionals—they are in no position to show how their policies can actually be carried out. The real power of the managers and professionals, I am tempted to argue, lies in their ability to define what is administratively feasible. This is where they have a monopoly of skill. And by defining what is possible they may also effectively determine policy choices. Contrary to the conventional wisdom, which sees the aims of policy determining the means, it may be the ability to implement different options that actually determines the policy decisions in the first place.⁵

Ambiguity of information

Reinforcing the diffidence of authority members is the ambiguity of so much of the information that is available in the NHS. Take the example of waiting lists—a matter of continuing concern. Here, clearly, the statistics may be manipulated. To an extent, at least, consultants may be able to inflate (or deflate) the figures by encouraging (or discouraging) GPs to put their patients on the waiting list. Whatever the waiting list figures indicate, it is not direct demand from the customers—contrary to the assumption frequently made.⁶ Rather, they measure demand as filtered by elastic perceptions of what is available. So, authority members start off by being uncertain as to what to conclude from the figures. Equally, however, they are uncertain as to what can be done about them. If it seems that bed occupancy rates are low or if a particular consultant seems to be doing less than his colleagues what are the actual policy implications? How can bed occupancy rates be increased or how can a recalcitrant consultant be persuaded to mend his ways? Apart from raising such questions, there is little that authority members can themselves do about answering them. At best, they can hope to inject a greater sense of urgency into the consideration of these issues by the officers—perhaps a not unimportant contribution. Moreover, adding to their problems is the complexity of the NHS; the extent to which waiting lists, for example, may reflect bottlenecks in the rest of the system, such as operating theatres. If it is difficult to get NHS providers to use existing resources more efficiently it is much easier to persuade authority members that the only solution to difficulties lies in deploying extra (but, unfortunately, unavailable) resources.

The problems of interpreting the available, usually ambiguous, information and of deciding what to do about it in conditions of uncertainty do not stop there. For example, authority members are regularly flooded with financial information. On the face of it, nothing could be more “hard” or unambiguous. If a district is overspending its budgetary allocation that is a clear danger signal. Something, self-evidently, must be done about it. But there is nothing self-evident at all about precisely what should be done. Suppose that much of the overspending has taken place in the pharmacy budget. Does this automatically mean that prescribing has run riot and should be cut back? Or does it mean that the budget was set at an unrealistically low level in the first place? Given the lack of any benchmarks against which to measure what is an appropriate level of spending, the questions permit no easy answer: comparisons with the spending levels of other districts may help to give some clues, but they provide no precise answer—given the difficulty of finding any measure of the total activities that generate the expenditure. In any discussion of this sort the authority member is quickly introduced to the dominating principle of the NHS: the principle of infinite diversity. No two sets of patients, no two consultants, no two hospitals are the same; thus no inferences for action can be drawn from any comparative statistics. At best, he soon learns, such comparisons may only be used to prompt further inquiries—and the odds are that the inquiries will uncover some particular reasons why, in fact, the statistics cannot be used at face value (clinicians, of course, are specialists

in devising such reasons, conscious as they are of the uniqueness of their own problems, techniques, and patients).

Again, authority members conscientiously scrutinise the detailed information about the performance of the hospitals for which they are responsible. But, again, they are sharply brought up against the problem of making sense of the figures. If spending per case is rising does this mean that there has been a drop in efficiency? Or does it mean that the quality of care provided has improved? And how can they come to a judgment either way without knowing more about the case-load itself? In addressing themselves to such perplexing questions they cannot look to the Department of Health and Social Security for guidance. For the DHSS itself seems to be somewhat confused on this issue. As the Social Services Committee of the House of Commons pointed out: “In the case of the acute services, the presumption is that a fall in costs is a sign of improved efficiency. In the case of the services for the chronically ill, the presumption is that a rise in costs is a sign of improved quality.”⁷ The DHSS’s injunction to the members of the new DHAs “to cut out waste and to find ways to use money more effectively”⁸ has a fine ring to it—who, indeed, could disagree? But it does not really help when it comes to assessing the available information about performance.

Probe and challenge

All this is not to suggest that authority members spend their time groping helplessly through a fog of ambiguity and uncertainty. They may not be able to “control the performance” of their officers. But they can certainly test their ability. If authority members feel reluctant to make the life of their officers even more difficult than it already is, by trying to unscramble the complex network of policy decisions taken, they can and do probe and challenge. They can test whether the officers have done their homework before putting up their proposals to the authority; they can use visits to hospitals to generate their own source of information about what is going on. They can get to know, and to discount, the biases of particular officers. In all this, however, their role is not so much that of taking decisions “on policy, planning, and resource allocation,” in an active sense, as of making sure that the managerial processes that actually generate the decisions are appropriate, that account has been taken of the various factors (and lobbies) concerned, and that the analysis of the options has been competently carried out.

Like all generalisations, this one needs qualifying. There are circumstances in which authority members do become concerned in the process of decision making, as distinct from decision ratification. When things go wrong—when, for example, a budget crisis disrupts the quasiautomatic implementation of past policy decisions—then authority members come into their own. The reason for this is illuminating. Crisis also produces conflict. And conflict, in turn, generates new information. Consultants threatened by cuts lobby authority members; so do other affected groups. While officer consensus in normal times tends to insulate authority members from the grassroots debate—and decisions reflect the deals struck in behind-the-scenes negotiations—conflict reveals the fissures and disagreements behind the consensus. Paradoxically, therefore, a sense of crisis may be needed from time to time if authority members are to have an opportunity to open up major issues: normal politics all too often mean spending time on the trivial but manipulable issue (because officers do not mind about the outcome) as distinct from the important but settled issue (because officers have already laid down the railway track).

Indeed, reflecting on my three-year stint, I am struck by the fact that what was not debated was as important as what was. For example, there was little discussion of the community services—not because these were neglected in Wiltshire but because they lacked public visibility. A hospital is an institution

for creating drama: if a ward has to be closed, this is a highly visible (and controversial) issue. Community services lack such dramatic visibility. If a few more elderly people have to wait longer for their toenails to be cut there is no clear-cut constituency to protest. Again, if for different reasons, there was virtually no discussion of family practitioner services. This was perhaps a tacit recognition of the fact that the 1974 rhetoric about integrating these services into the NHS had turned out to be a sham in practice, and that there was little that the members of an AHA could do to influence independent contractors intent on maintaining their autonomy and determined to repel any inquisitive intrusions, such as requests for information, into their domain.

In this, as in other, respects, it is difficult to see that the replacements of AHAs by DHAs will make a great deal of difference to the role of authority members. Where abolishing AHAs has meant splitting up a large area into smaller units, authority members will be more accessible to local pressure groups (professional and lay) as well as being better placed to acquire first-hand knowledge about the actual services. To what extent this will make it easier for them to be "more clearly responsible for meeting local needs," in the words of *Patients First*,⁹ remains to be seen. Greater accessibility will certainly add to their information, and decrease the sense of remoteness that afflicted many AHA members. But it will also increase the risk that the information itself will be biased by the differential ability of various interest groups to make use of access to define "local needs."

Gladiatorial system

Lastly, the abolition of AHAs may weaken authority members in at least one important respect. The two-tier system of officers at both the district and the area level was much criticised because of the duplication of responsibilities and the consequent

delays and administrative costs. But for authority members it did represent an important safeguard. The gladiatorial system meant that area officers would support the members' role in challenging, testing, and probing the plans and policies being pursued in the districts. In a sense, the members had an independent course of advice. In future, they will have none. Moreover, the fact that policy formulation and policy execution now fall to the same set of officers will inevitably inhibit members: if they challenge the policy formulation, they will risk undermining the authority of those on whom they depend for the smooth running of the district services. As so often, the solution to yesterday's problems—those created by the 1974 reorganisation of the NHS—promises to create a new set of problems.¹⁰

References

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National Insurance contributions 1982-3

The BMA has updated its guidance note, *National Insurance contributions*, in the light of the new rates and earnings levels, which come into effect on 6 April. Many doctors, particularly general practitioners and part-time consultants, may have to pay contributions in excess of the prescribed annual maximum unless they make certain arrangements, which are described in the note. The guidance note contains advice for self-employed doctors, including those holding salaried appointments,

and for salaried doctors, including those with private practice earnings.

Notes on taxation and National Insurance aspects of employment by doctors of their wives has also been updated in the light of the Budget.

Members may obtain copies of the guidance notes from their local BMA offices. They should quote the title of the note required and current membership number. A stamped-addressed envelope (9 in × 6½ in) would help speed dispatch.

BMA Notices

NHS reorganisation—changes in division titles and boundaries

Notice is hereby given that, with effect from 1 April 1982,

(a) the title of the Cambridge and Isle of Ely Division will be changed to "Cambridge, Huntingdon and Ely Division";

(b) the boundaries of the Barking and Havering Division will be conterminous with those of the London boroughs of Barking and Dagenham, and Havering and the district of Brentwood in Essex;

(c) the boundaries of the Mid-Essex Division will be conterminous with those of the districts of Chelmsford and Maldon and, in the district of Braintree, the parishes of Bardfield Saling, Black Notley, Bradwell, Coggeshall, Cressing, Fairstead, Faulkbourne, Feering, Finchingfield, Great Bardfield, Great Saling, Hatfield Peverel, Kelvedon, Panfield, Rayne, Shalford, Stisted, Terling, Wethersfield, and White Notley, and the areas of the former urban districts of Braintree and Bocking, and Witham.

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Pay-bed increases

From 1 April the charges for pay-beds in NHS hospitals will go up by an average of 13½%. There will also be increases of about 8% for non-resident private patients (day cases and outpatients). The charges are legally required to be reviewed every year and to reflect the total estimated cost of providing hospital services in the year ahead. A contribution for capital is added. A daily charge for a private resident patient in a provincial teaching hospital occupying a single room and paying the consultant(s) separately will be £106.50; in a London teaching hospital it will be £133.60; in a mainly acute (non-teaching) hospital it will be £85.60; and in a psychiatric hospital it will be £37.10.

Income from private inpatients in England in 1980-1 was £42.6m and from private non-resident patients £3.8m. The estimated total income from all patients in 1981-2 is £52m.

Correction

From the GMS Committee

In the report on the manpower debate in the middle column of p 761 (6 March) the first sentence below the section on "University departments of general practice" should read: "Of these, 1985 had been from overseas, 358 were men born in the UK, and 1109 were women born in the UK."