COMMENTARY

A policy for change

RUDOLF KLEIN

The National Health Service today presents a curious and somewhat depressing paradox. Everyone is agreed that the NHS must change to meet the challenge of financial crisis: that there must be more adaptability and flexibility in the use of resources in order to make the most of what is available. But nobody has yet produced a policy *for* change, addressing itself to the problem of how to identify and remove the obstacles which inhibit adaptability and flexibility.

In this the NHS is in no sense unique; if anything, it is the microcosm of a national problem. The need for change has become a national cliché, without producing any coherent national policies designed to encourage it. While some Government departments promote measures designed to promote the movement of labour from declining to technologically advanced industries, other departments pursue policies calculated to discourage mobility: current housing subsidies, which encourage council tenants to stay put, are a case in point.

Too much consultation?

But if the NHS is not unique, its symptoms are exceptionally well-developed. If one were to set out with the deliberate intention of designing an institution resistant to change, something remarkably like the NHS would doubtless come off the drawing board. This is not because it is too managerial—the common criticism made against reorganisation. It is because the NHS is, if anything, too participative—because it puts so much emphasis on consensus and consultation. For example, one of the consequences of reorganisation has been the proliferation of advisory committees and consultative bodies at every level of administration. The effect of having so many tiers—in itself guaranteed to produce delay and slow down the pace of change—is compounded, because each tier is in turn festooned with a clutch of committees.

This is well recognised. Indeed, there has been much talk about the waste of medical time in sitting on committees¹ and much resentment at the consequent delays in reaching decisions. But to think of the system as a kind of bureaucratic conspiracy against the NHS is to miss the point. Committees have proliferated largely because the medical profession insisted on being concerned with the decision-making process; in turn, the other professions and trade unions represented in the NHS have pressed for similar rights. The result has been to increase what might be called the “participation costs” of everyone concerned: of those who have to sit on the committees and of the administrators who have to circulate papers and wait for reactions.

This, then, is the dilemma for the medical profession and everyone else concerned in the running of the NHS. Is it possible to maintain the benefits of consultation while lowering its costs? Advisory committees vary greatly in their activity; many of them seem fairly dormant. Would it be possible, therefore, to simplify the system by eliminating those committees where lack of activity suggests lack of interest? Perhaps these could be given an opportunity for voluntary euthanasia. Again, conceivably it might be possible to speed up the process of consultation by imposing a strict timetable, on the assumption that any advice which did not emerge by a given date could legitimately be ignored.

But, of course, it is not only those working within the NHS who have to be consulted. The full complexity of introducing

change—and the many opportunities that exist for slowing it down—is shown in a recent circular² from the Department of Health and Social Security. This lists the bodies whose comments should be sought before an area health authority may close or change the use of a health building. These are: community health councils, local authorities, joint staff consultative committees, family practitioner committees, appropriate local advisory committees (including the statutory medical advisory committee for the area concerned), local medical committees, and “any other body or person not covered by the above which the AHA considers should be consulted—for example, voluntary organisations.”

Admittedly, this circular does impose a timetable, with comments to be submitted within three months. There are, however, additional tripwires before any change may be carried out: if the community health councils object, the matter may have to go up to the DHSS for the Secretary of State's decision. So perhaps it is not altogether surprising that, for example, many maternity wards and hospitals are half empty and the NHS has been so slow to reallocate its resources in line with the fall in the birth rate.³

Unacceptable timelag

But it would be a mistake to suggest that the organisational arrangements of the NHS are the only obstacle to change. It would be interesting to study, for instance, the timelag in obtaining decisions from the DHSS itself. One of the penalties of having a centralised NHS—where the Secretary of State may have to answer for any decision taken in the House of Commons—is that even minor matters may have to be referred to the Elephant and Castle. When the Fulton Committee on the Civil Service⁴ was taking evidence about the workings of the central bureaucracy it was swamped by laments from the then regional hospital boards about the obsession with detail. Oxford RHB argued that “the civil service appears to see the protection of Ministers as its primary task, with the result that the only issue on which the Ministry of Health regularly acts with a sense of urgency is in obtaining information for an answer to a Parliamentary Question”; Manchester RHB complained about the “very trivial matters” which had to be referred to the centre, quoting as an example the need to get approval “to pay fees amounting to 45 shillings each for 13 officers of the board wishing to attend a course of 10 lectures after working hours, designed specifically to illustrate the use of computers in the hospital service.” These examples, admittedly, date from the late 'sixties. Just conceivably the situation may have changed since, but it would be reassuring to get some evidence on the nature and timetable of the decision-making process at the DHSS.

But change is not just about administrative decisions. It is about people. Reallocating resources—whether by switching funds from one region to another⁵ or by redesigning the hospital map of London⁶—is a euphemism for reallocating men and women. It involves cutting existing jobs. It means doctors, nurses, porters, and others uprooting themselves, perhaps moving house, if they are to remain employed by the NHS. Again, this problem is by no means unique to the NHS. But it may require some solutions specific to the NHS.

For example, the NHS trade unions—NALGO and COHSE

—are currently mobilising against the threat of redundancy. This is understandable; the BMA would presumably consider doing the same if the jobs of doctors were at risk. But change does imply redundancy; relying on wastage to cut numbers is an unsatisfactory option, since there can be no certainty that those who leave are also the most dispensable. So clearly there is a case for reviewing policies to see what measures are needed to promote greater flexibility in the deployment of manpower.

Real employers

For example, in one crucial respect, the NHS is not a *national* service in any sense: it is the individual authorities, not the NHS, who are the employing agencies. The willingness to accept change might increase if those who were redundant in any particular AHA or RHA were guaranteed a job within the NHS, provided they were prepared to move, and provided also they were given adequate financial compensation. At present this point applies particularly strongly to the NHS employees represented by the trade unions. Nevertheless, it may also apply in future to consultants: thus waiting for a consultant to reach pensionable age before changing the use of beds could be more expensive than offering generous incentives either to retrain in a shortage specialty or to accept early retirement.

All this seems to suggest that an investment in promoting policies designed to encourage change—and to compensate the

inevitable casualties—could pay dividends. There is, therefore, a strong case for Mrs Castle to appoint without delay a working party to examine the obstacles to change and to report, within a matter of months, on ways of smoothing and accelerating the process. We cannot wait for the Royal Commission to report. Certainly all the indications are that, if such a working party were appointed and if it were to call for evidence about delays in decision-making and grit in the machinery of change, it would get an embarrassingly large response.

¹ Brown, R G S, Griffin, S, and Haywood, S C, *New Bottles: Old Wine?* University of Hull Institute for Health Studies, 1975.

² *Closure or Change of Use of Health Buildings*, DHSS. HSC(IS) 207, October 1975.

³ *Inflation and Priorities*, ed R Klein, Centre for Studies in Social Policy, 1975.

⁴ Evidence submitted to the Committee under the chairmanship of Lord Fulton, *The Civil Service Vol 5 (2)*. London, HMSO, 1968.

⁵ *First Interim Report of the Resource Allocation Party: Allocations to Regions in 1976-7*. London, DHSS, 1975.

⁶ *Rationalisation of services: a revised hospital plan for London*. Paper presented to the London Coordinating Committee by the Department of Health and Social Security, 30 September 1975. LCC (75) 13.

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Devolution to Scotland

Both the Scottish Council and the Scottish Committee for Hospital Medical Services debated devolution at recent meetings. After a full debate on 14 January the Scottish Council issued the following statement:

"The Scottish Council . . . felt that the proposals in the White Paper left many functions unclear. In general, members of the Scottish Council were not satisfied that devolution would bring advantages to the NHS in Scotland.

"Matters which concerned Scottish Council were (1) the block grant of money from Westminster and as to how it would be divided, for example, between medicine and other services; (2) that the General Medical Council should continue to function on a UK basis and, not least; (3) a fear that devolution would make medicine an even greater pawn of Government. The profession would prefer medicine to be taken out of politics."

At the consultants' meeting on 6 January the MP, Mr M Rifkind, addressed the committee. There was unanimous agreement that if the Scottish administration was to be responsible for health in Scotland it was important that pay and conditions of service should continue to be negotiated and decided on a UK basis. Any differential between England and Scotland would result in a flow of scarce medical skills from one to the other. The committee thought that the arguments in the White Paper* for the maintenance of a unified Civil Service could be equally applied to the medical staff of the NHS in Scotland.

Scottish Council

Dr A W Wright was in the chair at the Scottish Council
 **White Paper on Devolution to Scotland and Wales*, Cmnd 6348. London, HMSO, 1975.

meeting and there was a discussion on the progress made on the BMA's recommendations on the medical implications of oil related industry. The Council learnt that an emergency helipad would be provided at Foresterhill, Aberdeen. But the multiplicity of Government departments involved in North Sea oil had led to difficulties in making medical arrangements and, although it was understood that an interdepartmental committee had been set up to co-ordinate various departments, there was no evidence that it had started work. The Council also criticised the slow progress made with the Institute of Environmental and Off-shore Medicine at Aberdeen University.

The Council was told that as a result of representations from the Committee on Medical Officers in Colleges of Education college medical officers would receive a salary of £9180. Further representations were being made for assistant medical officers to be placed at the top of the senior lecturer scale at £7716.

The Council repeated its dissatisfaction on the matter of computers and confidentiality and did not accept that printouts should be made containing the patient's name. It was agreed to refer the matter again to the Scottish Home and Health Department.

Scottish CHMS

The meeting of the Scottish CHMS was chaired by Dr G B S Roberts. The committee expressed concern at the introduction of the operating department assistant grade especially at the way in which staff had been assimilated to the grade. The matter had been referred to the Scottish Joint Consultants Committee and to the Scottish Home and Health Department.