COMMENTARY

Accountability in the NHS: whose head on the block?

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From time to time horror stories about waste, inefficiency, and incompetence in government departments or public services hit the headlines. Almost invariably their source is either the Comptroller and Auditor General or the Public Accounts Committee of the House of Commons. The former is responsible, with his staff of some 400 people, for checking the accounts of all government spending departments. The latter is responsible for following up these inquiries by summoning and cross-examining relevant civil servants. Between them, the activities of the Comptroller and Auditor General and of the Public Accounts Committee provide a unique insight into the processes of government, by forcing the officials responsible to explain their miscalculations and mistakes.

It is therefore worth analysing in some detail the two most recent reports which have dealt with the spending record of the National Health Service: that published by the Comptroller and Auditor General at the beginning of this year¹ and the subsequent inquiry by the Public Accounts Committee.² For the second of these reports in particular provides a rare and revealing glimpse of how the top decision-makers at the Department of Health and Social Security perceive the structure of responsibility and accountability within the NHS.

Small change of public expenditure

By the standards of some of the past scandals in the misuse of public resources, the examples of lack of financial control in the NHS do not rank very high. The overall record of the NHS in containing its spending within the budgetary limit set at the beginning of each financial year has been extremely good. And, compared with the tens and hundreds of millions spent in the 'fifties and 'sixties on weapons which never fired a shot and missiles or planes which never took to the air, the latest revelations by the Comptroller and Auditor General about the NHS represent the small change of public expenditure.

Even so, the examples of original spending estimates being wildly exceeded and of money being spent on non-viable projects are not negligible in absolute terms and certainly cannot be ignored at a time when the NHS has to make every penny count. For instance, there is the case—raised by the Public Accounts Committee—of the Liverpool teaching hospital, which was originally estimated to cost £11 700 000 and now looks like running up a bill of £48 million.

Again, there is the case of the DHSS's experimental computer programme, where the initial estimated cost has doubled after allowing

for inflation and where some of the individual projects had eventually to be abandoned. Indeed, the Public Accounts Committee's report tells the extraordinary story of how £1 400 000 was spent on an experiment at King's College Hospital designed to feed notes on patients directly into a computer. This was scrapped when it was discovered that junior hospital doctors did not have time both to write up their own notes and to provide information for the computer: a point which, it might have been thought, could easily have been established by a preliminary survey costing a few thousand pounds without the installation of an extremely expensive computer. Moreover, this particular project continued even when it became clear that it was in trouble. As Sir Patrick Nairne, the relatively new Permanent Secretary of the DHSS, told the committee: "I must say frankly that when the hospital saw that they were in difficulties, they were anxious to solve the problem on their own and, in effect, they concealed the position from the Department."

Crucial questions

These examples—and they are only a small selection—raise two crucial questions about the running of the NHS. The first is: what happens within the DHSS if a civil servant blunders? What sanctions are applied against officials who approve projects without sufficient attention to their feasibility or who permit the escalation of costs? The second is: what happens within the NHS if someone, whether at regional or area level, makes the same sort of mistake—or tries to conceal what is happening from the central department responsible to Parliament for public expenditure?

In trying to answer the first question there is no information to be gleaned, unfortunately, from the reports of the Public Accounts Committee. It could well be that given the tendency for DHSS decisions to be taken by committee and the fact that civil servants tend to rotate rather rapidly from one post to another it may be difficult to attach responsibility to any individual. If this assumption is correct it helps to explain some of the weaknesses of the decision-making process at the DHSS. But it is not so comforting for those who believe that officials ought to be held accountable for what they do instead of being sheltered, as at present, by the constitutional myth that Ministers are responsible for all the decisions taken in their name—a moth-eaten myth, the credibility of which disappeared with the publication of the first volume of the Crossman diaries.³

In trying to answer the second question—about the accountability for decisions taken down the line of the NHS's administrative

hierarchy—the Public Accounts Committee's reports offer some help but little reassurance. For this is a point which, rightly, has been worrying the MPs who sit on the committee. Thus it was explored in a report, published last year,⁴ which examined the escalation of building costs for teaching hospitals. The then Permanent Secretary, Sir Philip Rogers, tried to explain both the reasons for the lack of control and the sanctions against failure. On the rising costs Sir Philip argued—in effect—that the boards of teaching hospitals were not particularly well equipped for the task of building new institutions and, moreover, that they were "more open to pressures from medical and nursing staff for late changes in design precisely because they had the prestige of a teaching hospital." In other words, they did not stand up to their own consultants.

Too tender?

The cost of such failures can—as already noted in the example of the Liverpool teaching hospital—represent a heavy burden on the public exchequer. But it is far from clear, reading Sir Philip's evidence, that any heads rolled as a result. The sanction of dismissal, or formal reprimand, he felt, "is a formidable one for persons of the standing involved," which is why no doubt it is so rarely invoked. "I think that we have been too tender, and this is a criticism of us, in seeking the disciplining or the dismissal of officers who were at fault," he conceded. "One of the complications has been that they are officers employed by authorities with a right of appeal to the Secretary of State and therefore the Secretary of State must be careful of prejudging his or her duty on appeal by saying in advance that dismissal must take place."

Giving evidence on the same point a year later, Sir Patrick Nairne was equally guarded. In theory, he pointed out, the Secretary of State had absolute power: "he can if he wishes dismiss a complete regional health authority. He can if he wishes dismiss the chairman of an area health authority." But Sir Patrick did not explain how this power is used. In practice, the Secretary of State's right to sack appears to be rarely used precisely because it is so draconian and therefore politically embarrassing: a sort of administrative nuclear weapon which may have a deterrent effect but cannot be fired.

The problem of holding people accountable for what they do within the NHS can be illustrated in another context as well, which has nothing directly to do with financial management. Earlier this year national attention was, fortuitously, directed at the affairs of the Rochdale Area Health Authority. This

followed the death of a small boy (where the consultant concerned has now been cleared of all culpability) and the apparent anxiety of some members of the administrative staff to dissuade some nurses from giving evidence at the inquest. Subsequently, and for a variety of other reasons, the region set up a special committee to inquire into the affairs of Rochdale AHA.

Some awkward questions

This report⁵ again raises some awkward questions about accountability. For, reading between its very discreet lines suggests that this particular AHA was suffering from several symptoms of administrative pathology. The AHA excluded press and public from the discussion of over half the items on its agenda, in defiance of the spirit of the legislation governing such decisions. Furthermore, the report concluded that the "Area Management Team has not so far developed the same working relationships that obtain in teams in other parts of the region" and, lastly, it pointed out that "the problems which have plagued the Health Service in the Rochdale area are, in many ways, due far more to the shortcomings of human beings than to any deficiencies which we have identified in the formal structure of management."

Accountability

This conclusion may help to explain the puzzlement of the Public Accounts Committee, as its MP members have groped towards an understanding of the structure of accountability within the NHS, and also indicate a possible solution to the problem. The NHS combines a structure where in theory there is a rigid chain of accountability but where in practice it is difficult to make accountability stick to individuals, because the structure of employment does not mesh with the structure of responsibility. In other words, the logic of central accountability is also central employment: an NHS which is a truly national service in the sense of being a single employer. In such circumstances it would be feasible—without invoking cumbersome and difficult disciplinary procedures—to switch an incompetent official to some less responsible job or to change the membership of an area or district team which was clearly failing to work effectively.

Additionally, moving towards a national staff structure for the NHS might have the advantage of permitting the exchange of administrators between the DHSS and active service in the field. At present, as Dr David Owen has pointed out,⁶ there is no way of promoting the outstanding regional or area official to take part in central decision-making, while those at the Elephant and Castle can all too easily become isolated from the real-life world of the NHS. Indeed, it might be no bad thing for the morale of the NHS if, for example, those DHSS civil servants responsible for the mistakes catalogued by the Comptroller and Auditor General were sent off to run, say, the laundry services in Slagthorpe or the outpatient clinic on Wigan pier.

Encouragement of efficiency

All this may seem to be a long way from the specific affairs of the Liverpool teaching hospital or King's College Hospital's computer. But accountability is not just about the prevention of waste in a negative sense. It is also about the encouragement of positive efficiency in the use of resources. And this, in turn, implies a system of incentives and penalties for the people who take part in making decisions.

There has been much discussion in recent years about the need for a system of medical audit to check the quality of care delivered by the medical profession. The findings of the Public Accounts Committee, this analysis of their reports would suggest, indicate that there ought to be at least equal concern about developing a system of administrative audit to reinforce the present system of parliamentary accountability.

¹ *Appropriation Accounts*, Vol 3, 1974-5, HC79. London, HMSO, 1976.

² *Sixth Report from the Committee of Public Accounts*, Session 1975-6, HC584. London, HMSO, 1976.

³ Crossman, R, *The Diaries of a Cabinet Minister*, Vol 1. London, Hamish Hamilton and Jonathan Cape, 1975.

⁴ *Third Report from the Committee of Public Accounts*, Session 1974-5, HC374. London, HMSO, 1975.

⁵ *The Organisation and Management of the Health Service in Rochdale Area: report of the special committee*, North-west Region. Manchester, September 1976.

⁶ Owen, D, *In Sickness and in Health*. London, Quartet Books, 1976.

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From Scotland

The Scottish Council and the Scottish CHMS met during October, and we report their proceedings briefly here.

Council

On 12 October Dr A W Wright was reappointed chairman of the Scottish Council and Dr W Keith Davidson deputy chairman. The Council repeated its concern at the slow progress in arranging insurance and medical defence cover for medical staff assisting at off-shore oil installations. Ordinary life insurance does not cover doctors on unscheduled flights—for example, from Aberdeen to an oil rig. American nationals can sue doctors working either on or off-shore for damages and an action in an American court would preclude the doctor concerned from working in the United States.

The chairman reported on a useful informal meeting with representatives of the health service unions, including NUPE and COHSE. He hoped that another meeting could be arranged.

An intensive recruitment drive for BMA members will be launched in Scotland. Although Scotland has the highest percentage of BMA members in the UK the Scottish Council thought it was important to increase it even more.

Consultants

Dr G B S Roberts chaired the meeting of the SCHMS on 20 October when the main item on the agenda was the consultant contract. Various types of contract had been discussed by consultants in Scotland. The proposals produced in a discussion document from the CCHMS (11 September, p 655) was the first choice in five areas; five favoured a continuous commitment contract; and a ten session contract was the choice in two others. The largest areas, Greater Glasgow and Lothian, had opted for the CCHMS contract and the committee resolved to support the negotiation of this contract.

The committee hoped that at the same time some of the items in the shopping list could be secured. These were the proposals agreed with the Government in April 1975 (26 April, p 202) which had brought the consultants' work to contract to an end.