PRIME MINISTER

7 March 1988

From time to time I receive comments, criticisms and pet designs of the NHS from doctors and other medical staff. Even when the administrative designs are unconvincing, the writers' knowledge of the NHS means that it is well worth reading their suggestions. Dr Crawley's piece (which I enclose) is just such a contribution. You may be interested in reading it over the weekend.

John O'Sullivan

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(GP's) ✓

ORGANISATION AND MANAGEMENT STRUCTURE IN THE NATIONAL HEALTH SERVICE

Present Structure - The Unit

The Unit Management Team is like a eunuch in the male voice choir. Largely ignored, works hard and does all the difficult bits. The unit actually looks after patients. In fact, the more patients that are seen and treated, the more efficient but costly and financially embarrassing it becomes. My own hospital is one of the most efficient in the country and it has the highest throughput and occupancy and the lowest mean patient stay. We have met our budget every year until now. Where are the thanks, the accolades, the acknowledgement? Certainly there have been no rewards. Not personal rewards but the opportunity of being able to develop our services here even further. Projections for the next year show a 1.25 million deficit while close neighbouring districts, who have been overspent for years, receive handouts from the Region.

The District

At District level, we have a Rear Admiral who is District General Manager. He is a charming man; he is certainly no fool and I suspect he knows the answer to many of our problems. However, he and the District Management Team have to gain the approval of the District Health Authority for any sweeping changes and the Authority is too easily swayed by local political opinion. All too often the failure to be decisive is preferable to a radical or effective decision. Many members of the Authority are representative of local pressure groups, for example a union or the Community Health Council, the General Practitioners etc. Thus, they represent factions and not the community at large.

The Regional Health Authority

The Regional Health Authority is responsible for monitoring the Districts. It has a small budget for sub-regional specialities such as renal medicine etc. It controls the distribution of capital funds for building etc., and is responsible for policy decisions Region wide. It does not treat patients.

Department of Health

The Department of Health is self-sufficient.

PROPOSED CHANGES

The Department of Health should be separated from the Social Services. The acute services should be totally separate from the provision of chronic medical care, care of the elderly, the mentally ill and the handicapped.

The Department of Health should directly fund chronic medical care such as renal transplant programmes etc. It should monitor the provision of care throughout the country and in particular, the provision of facilities for the elderly and the mentally ill and the handicapped. It should have a budget for capital projects for the above and it probably has a statutory duty to provide advice and help to a number of other bodies such as medicine in industry etc.

Clinical Areas

Administratively, Districts are too small to administer funds. They are too sensitive to fluctuations in the number of unemployed locally, and the number of elderly people in a small local community.

Clinical areas of perhaps 600,000 or more would be much more effective and services could be distributed in a more rational way. The Clinical Area Board would be responsible for the monitoring and provision of funds to acute general hospitals and to general practice within that clinical area. It would be responsible for monitoring these services and it would also be responsible for the provision of specialist facilities such as cardiac, thoracic, neurosurgical and paediatric units. It is possible that these facilities might be shared between one or more clinical areas as appropriate, or, with the private sector.

Small Units

Throughout the country there are numerous small units such as small town hospitals and pseudo-specialist hospitals. For example, an orthopaedic unit or the so-called isolation or fever hospitals. There are also some isolated ENT and eye units. These are expensive, inefficient and in addition, they use other resources such as medical cover at night, extra transport costs and often satellite services of radiology and pathology. All such units and hospitals should be sold and the money reinvested in large central acute hospitals.

Acute General Hospitals

A recent study by the Royal College of Surgeons on the provision of accident and emergency facilities has suggested that casualty departments should only be sited in large general acute units. Surely the same argument should be used for any of the major specialities. Acute general hospitals would be managed by hospital management committees and run by a manager, together with medical, nursing and lay input; in fact reverting to the old hospital management committee structures. Managers should be sensitive to local needs but ultimately be responsible to the Clinical Area Board.

Acute care in general hospitals should cope with the acutely ill from all sources but only with the right of return so that the beds can be used efficiently and costs kept to a minimum.

Budgeting

Given a fixed budget, and if priorities are no longer changed from year to year, then sensible planning in acute health care becomes feasible. Large acute hospitals should have a fixed budget and be responsible for the acute care of all the various groups in that clinical area, as illustrated in the diagram. The care of the elderly and mentally infirm or handicapped should be adopted and funded by the Local Authority and this could be a levy on the rates or poll tax. Chronic medical care should be attached to acute units in order to share facilities such as x-ray and pathology but they must be separate entities and their beds should be delegated to that purpose. Examples are transplantation and programmes for immuno-incompetence. Chronic care should be funded by the Department of Health from central funds.

Management

Although facile, the concept that managers should manage is nevertheless true and there is no place for medical specialists taking on executive positions within the structure described. Managers should manage the hotel; clinicians should manage patient care. Both should be subject to peer review. Managers should be responsible to the Clinical Area Board who, in turn should be subjected to an inspectorate from the Department of Health. As in previous communication, there could be an ombudsman at Clinical Area Board level to whom patients could

refer and he would act in their interests. The concept of clinical managers developed recently at Guy's Hospital is not new but there is no reason at all why front-line clinical practitioners should not take on budgetry management for their departments. There would have to be some flexibility because of the unpredictable nature of emergencies, ie major accidents, plague, pestulence etc., but the average clinician has a very good idea from year to year what the numbers and demands on the department are going to be. All these services and facilities are very effectively costed in the private sector and I see no reason why this should not occur in the Health Service. A hospital manager, given this sort of information from each department, should be able to work out annual budgetry needs.

Out-patient attendance and admission should attract a basic fee and then remuneration could be assessed on the number of days in hospital and procedural based costing. Allowance would also have to be made for the age of hospital buildings, refurbishment, updating and special equipment in the medical budget each year.

Priorities

The provision of resources and of services is a managerial and political decision. Priorities may be medical, moral or ethical but they are not political. Another myth which needs to be dispelled is that high technological provision will ultimately reduce costs. It has never done this and is unlikely ever to do so in the future.

Summary

In essence the acute services should be singled out and brought as near a profit and loss situation as possible. Therefore, the more efficient units can then develop their sites, make more facilities available and become more attractive for patients. It would also provide a more attractive medical climate for physicians and surgeons to work in.

Regions should disappear and their role be taken over by clinical areas. Long term care should be delegated to Local Authorities and should be funded from rates or poll tax.

Funding for acute care should come from the income of the working population; in other words a straight percentage of income. Chronic medical care should be the responsibility of the Department of Health and be funded centrally.

Capital projects within a Clinical Area Board could attract loans from the Department of Health, with capital funds ultimately coming from the health tax originating in income. The scheme overleaf describes these ideas graphically.

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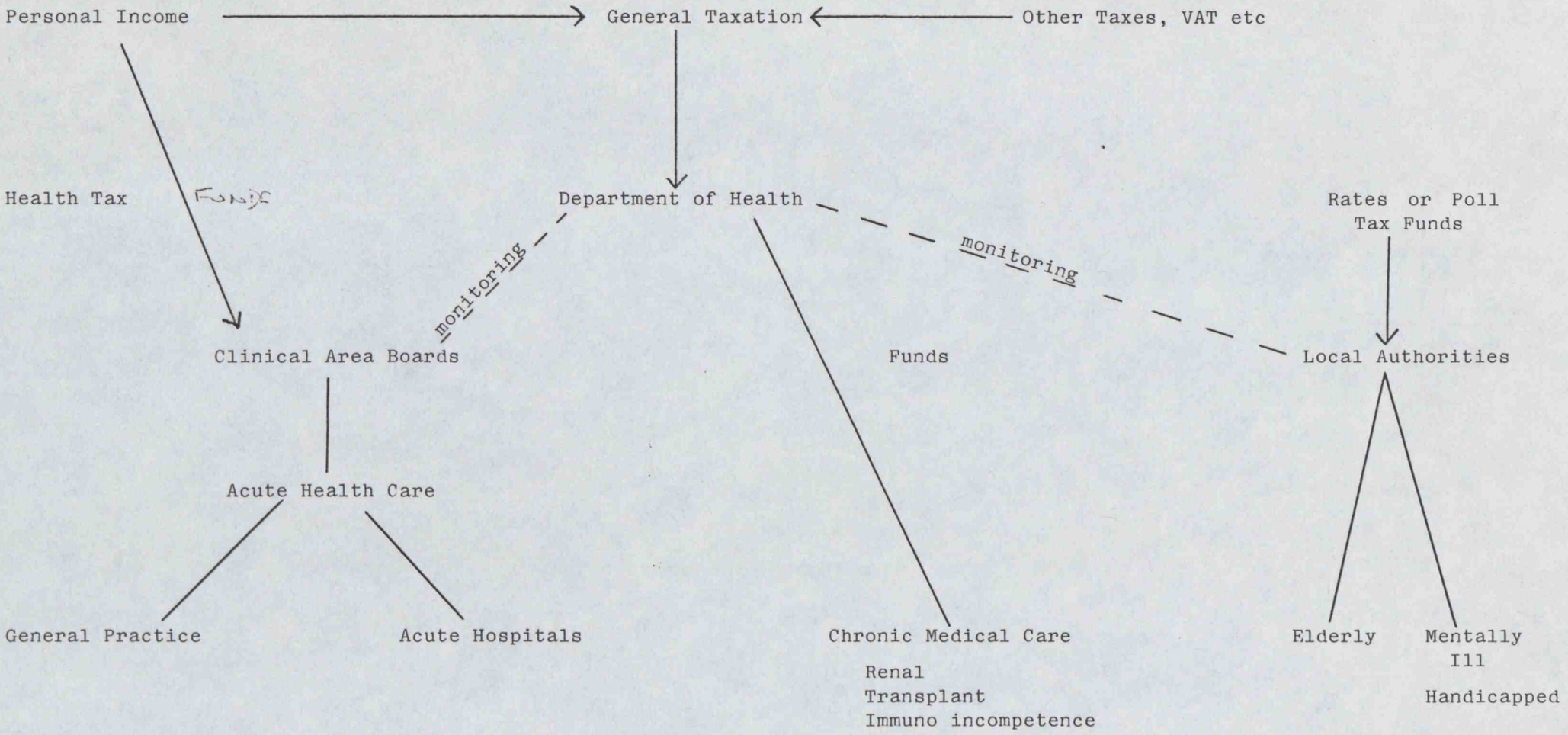
Personal Income
General Taxation
Other Taxes, VAT etc
Health Tax
Fund
Department of Health
Rates or Poll Tax Funds
monitoring
monitoring
Clinical Area Boards
Funds
Local Authorities
Acute Health Care
General Practice
Acute Hospitals
Chronic Medical Care
Renal
Transplant
Immuno incompetence
Elderly
Mentally Ill
Handicapped