American Medical International

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SBL/BT

The Rt. Hon. Margaret Thatcher,
Prime Minister,
10 Downing Street,
London. S.W.1.

Dear Prime Minister,

In response to your request for my personal views on the salient features necessary to improve the National Health Service I am attaching a report highlighting the problems which are causing me considerable concern.

I shall be as brief as possible; however, I believe these fundamental issues so important to the future of both the public and private sectors that I would be happy to elaborate in discussion.

FUNDAMENTAL STRUCTURE

The following is an over simplified account but the N.H.S. does require simplification. Let me say at the outset that it is my firm belief that quality care in the N.H.S. can be achieved without substantial additional finance.

The N.H.S. must be approached as any other major business. Too much nonsense has been talked and is still being talked by people who have a totally unrealistic attitude towards the achievement of the end product. In order to provide quality care it is essential to have quality control. Therefore, the N.H.S. must be taken out of politics.

This would be best achieved by setting up a National Health Board under the control of a Chief Executive who has a proven business record. This person would be directly responsible to the Secretary of State.

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The National Health Board, which he would Chair, would have representatives from the medical, dental, nursing, legal and accounting professions, the Trade Unions and representatives of the community who have an interest in the health of the nation. Its responsibilities would be to determine the philosophy, policy and financial distribution within the Service. It would also be necessary to agree with government the basis and level of funding of the Service as a whole.

Such a Board would ensure continuity of forward planning and its back up staff would have top management experience within the N.H.S.. This would be a preferable option to the involvement of the D.H.S.S. which, in the main, consists of career Civil Servants without previous hospital experience.

DECENTRALISATION

In direct line with the National Health Board would be no more than 30 regions throughout Britain, each under the control of a Regional Executive Officer. It is absolutely imperative to eliminate the present 'management by consensus' approach which has proved so inefficient and frustrating over the past few years. 'Management by consensus' slows down decision making and is a vehicle of compromise. An organisation adopting such an approach can never hope to succeed.

Therefore this Regional Executive Officer would have, not a committee, but experts available in every field who would be called upon by him in a consultative capacity. Within his region he would be totally responsible and have control over all hospital facilities and community health services. He would have a number of assistants depending upon the number of hospitals within his region. This would create a vastly improved management structure.

GRASS ROOTS

Directly responsible to each Regional Executive Officer would be the most senior person in charge of the hospital and its small satellites, previously called 'The Administrator', but called by myself the 'Managing Director' for the following reasons:

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1. He would have complete control of all his various departments such as nursing, radiology, pathology, catering, housekeeping, business office, and so on, and the heads of these departments would be directly responsible to him.

2. In order for him to make his hospital function to its best advantage he would also be responsible for the various medical ancillary services within the vicinity of his hospital such as ante-natal clinics, district nurses, district midwives, 'meals on wheels', etc. This would be a more efficient and more realistic contribution to the community health services within his precinct.

COMMUNICATIONS

There would be a streamlined communication system, programmed by modern computers, which will create a rapid interchange of essential information between the Regional Executive Officer and all his Managing Directors within the region. Emphasis would be placed on performance and the monitoring of results and there would be penalities and bonuses awarded accordingly.

QUALITY CONTROL

The emphasis in monitoring would be twofold; quality of care and management performance. The activities of the National Health Board would be monitored by a Select Committee of the House of Commons, Chaired by the Secretary of State. The Board, in turn, would monitor Regional Executive Officers who, in turn with their team of specialist consultants, monitor the performance of the Managing Directors of hospitals in each region. Proper sanctions against poor performance throughout the Service must be built into the system.

THE MEDICAL PROFESSION

The attitude of my colleagues, which frankly has been accepted without question since the inception of the N.H.S., needs to be re-examined if the medical profession it to reach its full potential within the health service.

They must develop within the profession their own methods for monitoring the efficiency and application of their medical colleagues working within the N.H.S. at all levels.

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For example, consultants working in the hospitals must satisfy the Regional Executive Officer and his team of medical advisers that they are giving value for money.

It is not difficult for information to be gathered by the N.H.S. management as to how much time and throughput is effected by consultants. This would not then be a matter of opinion, which could arouse resentment, but would be a matter of fact.

There should be a similar monitoring of the work of general practitioners but this is more difficult to achieve. However, it should be compulsory for general practitioners to attend regular refresher courses and to take regular examinations, say, every three to five years to assess their current knowledge of what facilities are available within the N.H.S. and how best they can use them for the benefit of their patients. Merit awards should also be supplied to the general practitioner.

Finally, I would recommend that general practitioners should be required to take a more active role in their local hospitals with their compensation based on a fee for service basis. This would benefit both the general practitioner and help considerably the staffing of the hospitals.

PAY BEDS

This subject must be looked at from three points of view; the patient, the consultant and the people responsible for providing alternative hospital facilities.

1. The Patient

   Private patients no longer relish the thought of occupying a pay bed in the N.H.S.. Many have experienced embarrassment, sometimes harrassment, neither of which are conducive to the peace of mind necessary for their recovery.

2. The Consultant

   The consultant will always prefer using his N.H.S. hospital for his private patients. It is more convenient, he has no journeying to make, he also has his own staff of doctors, technicians, nurses, etc. with whom he works. However, the people who support him in the N.H.S. hospital work full-time, are paid full-time by the N.H.S., and should be giving their full time to the N.H.S.. By taking private patients out of the N.H.S.

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hospitals it will remove the one justifiable criticism that exists at present. It will also avoid an unnecessary confrontation with the unions.

3. The Private Sector

Under the last government private medicine started to develop rapidly because, finally stability and security had been created and thus considerable investment could be contemplated with confidence.

The private sector was no longer in the hands of local government officials, employed by the N.H.S. and often openly antagonistic to private medicine.

The creation of the Health Services Board ensured a fair and impartial attitude which local Health Authorities cannot guarantee because of local political pressures. Thus the Health Services Board at least ensured that local government could only reject proposals on purely town planning considerations and not political ones.

It takes five years to produce a modern hospital. A 100-bed hospital, fully equipped at today's prices costs approximately £5 million and when finished nearer £8 million. It is totally unrealistic, therefore, to believe that the private investor is going to consider building private hospitals in competition with the N.H.S., especially in view of the comments I made earlier regarding consultants. The viability of these expensive projects depends entirely on what other private beds are available in the vicinity.

Private enterprise has to take into account the next ten to twenty years in any major investment, which is beyond the expected life of most governments. It goes without saying, however, that where pay beds or ancillary departments cannot be replaced economically by the private sector then these must remain.

INDUSTRIAL RELATIONS

The establishment of a National Health Board would enable all matters relating to pay and conditions of service to be taken out of the central government arena. This should help to minimise the desire of Trade Unions to play politics. A no-strike agreement should be given priority. The present so-called "bonus" schemes are not truly performance related and

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hence wasteful of resources. A new bonus/incentive award related to the achievement of cost effectiveness should be negotiated.

## HOW THE PRIVATE SECTOR CAN HELP THE PUBLIC SECTOR

There are numerous ways that this can happen. From a cost effective point of view there can be considerable savings of N.H.S. resources by extending contractual arrangements to the private sector.

Holland and Norway have already found that it is cheaper to send their patients to this country for major heart surgery.

The private sector can offer a range of services to the N.H.S., for example, management consultancy, medical and financial systems, computerised hospital design and functional layout, maintenance programmes. Many more of these can be listed.

The private sector should contribute trained personnel by establishing training colleges for nurses and technicians and to a lesser extent doctors.

When the private sector offers services this has the advantage of cost effectiveness as private enterprise, unlike the N.H.S., must have regard to the level of investment, protection of asset values and the need to achieve quality of service within a price subject to market considerations.

I can hardly believe that recommendations are now being made that voluntary organisations without any professional expertise whatsoever may be asked to administer hospitals on a "do-it-yourself" basis. The results will be catastrophic.

## CONCLUSION

If some of the principles that I have advocated are considered worthy it will be necessary to invest in training programmes for the expertise that will be required in making the service a success. This is the only area where evolution and not revolution should apply.

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I understand that you asked for my personal views and that these views could be expressed frankly in confidence, in which case I would like to say that so much nonsense has been talked about the re-organisation of the N.H.S. and so many schemes are now being mooted, which are not practical, and I do urge you with the greatest respect to gather around you advisers with their feet on the ground and who have a proven track record of success in the organisation and management of a major industry.

With kindest personal regards,

Yours sincerely,

Stanley Balfour-Lynn

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