Consensus Management in the British National Health Service: Implications for the United States?

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MAJOR CHANGES ARE UNFOLDING IN THE DELIVERY and organization of health services in the United States that have important implications for management decision processes. One current phenomenon is the transformation of health services from autonomous free-standing hospitals and practitioners into large multisystem arrangements. Over one-third of all nonfederal community hospital beds in the United States are owned, leased, sponsored, or managed by another organization (American Hospital Association 1984). Existing hospital systems are merging as well, encouraging predictions that most hospitals will eventually be a part of fewer than 100 national systems in contrast to the approximately 7,000 relatively autonomous institutions in the past. Health systems are also merging vertically into health maintenance organizations (HMOs) and preferred provider organizations (PPOs) in response to pressures of payers for competitive bidding. Moreover, diagnosis-related group (DRG) reimbursement systems increase hospital management's dependence on medical staff practices, adding further impetus to vertical integration of physician and hospital services.

A second major change is the advent of financial constraints in the face of increasing demands to apply advancing health care technologies

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to an aging population. This will represent a reversal of a rapidly expanding health economy since World War II. Moreover, a projected surplus of medical practitioners is expected to exacerbate the problem. In other words, instead of having a growing pie of health care funds, managers will somehow have to divide shrinking resources among more people with expanding expectations. Consequently, gains for one sector are likely to be at the expense of others, and this may well lead to increasing conflict and confrontation. It, therefore, seems essential that consideration be given to management strategies that are able to cope with such conflict while integrating micro-medical and macro-system interdependencies.

One source of ideas for such strategies is the study of other large-scale health care systems, such as the British National Health Service (NHS). Although the NHS has become of less interest as the United States has retreated from commitments to explore national health insurance and expanding entitlements, the starting point of this paper is that, at least for the limited area of decision-making practices, such a comparison is of value. The primary basis of this assertion is that the NHS has substantial experience of both resource scarcities and multi-institutional systems. Hospitals have been managed as horizontal systems since the inception of the NHS in 1948, and vertical integration of hospital and community health services was introduced as part of the 1974 reorganization. Second, Britain has experience of increasing resource constraint; health care spending actually declined as a proportion of the gross national product during the period 1975 to 1977, a time at which it was still rising in the United States (Maxwell 1981).

This is not to argue that the NHS can, in any sense, be seen as a complete parallel to the United States health care delivery system. There are enormous, and obvious, differences in ownership and funding, as well as cultural and political differences, though such objections to comparison can easily be exaggerated.

This paper focuses on one management practice, that of consensus decision-making and its relevance to a changing health services management environment in the United States. Organizational features and consensus management in the NHS from 1974 to 1984 are described in the next section. The section that follows presents the results of the authors' survey of the operation of consensus decision-making, and the final section examines the implications of the findings for management of rapidly changing health service systems in the United States.

The British National Health Service

The British NHS as originally introduced in 1948 had little by way of provision for vertical integration of services; hospitals, general practitioners (GPs), and community services were organizationally separate. Nor was there initially much concern about integration of the work of the different health professions since each medical and surgical specialist (called hospital consultant in Britain) was responsible for coordinating diagnostic and therapeutic services for his or her patients. Nursing management and general hospital administration operated largely independently, though most hospitals were managed in multihospital groups with hospital managers reporting to a group administrator. From the 1950s onwards there was considerable pressure for more attention to be paid to both these areas of integration, and there were many informal changes aimed at this. It was not, however, until the 1974 reorganizaton of the NHS that both these concerns received recognition in the formal structure of the service. From that date hospital and community services were organizationally integrated, and general practitioner services partly so. Integration of the major health professions at the multi-institutional level was attempted by means of multidisciplinary management teams.

A further reorganization of the NHS occurred in 1982, in which the above aspects of organization were substantially unchanged. However, a further change will occur by 1985 when a general manager will be inserted between the management team and health authorities.

Figure 1 represents the organization of typical English health authorities following the 1982 reorganization. (We will limit our description to the system in England as there are substantial differences of detail, though not of basic philosophy and framework, in Wales and Scotland.) England is divided into fourteen regions for health service purposes, in each of which the NHS is the responsibility of a Regional Health Authority. This agency is headed by a mostly lay body of members who are appointed on a part-time basis by the Secretary of State for Social Services. The Regional Health Authority employs a full-time staff headed by the five top managers shown in figure 1, who collectively form the Regional Team of Officers.

The next level of organization is the District Health Authority (DHA), of which there are 193 in England. Again this is a mostly lay body (though including a number of health professionals) with a

part-time paid chairperson appointed by the Secretary of State and about 16 other unpaid members nominated from various sources. Each district is responsible for providing integrated health care to a population of ideally 250,000 (though there are wide variations in actual size), but there are a number of complicating relationships with other agencies:

(1) General practitioners (unlike specialists who are salaried) are self-employed contractors to the NHS. They are remunerated on national scales of capitation fees, item-of-service fees, and certain allowances. The general practitioners' contracts are held by a substantially autonomous, locally based Family Practitioner Committee.
(2) Provision of services such as social work, nonmedical residential care and home help, is the responsibility not of the NHS, but of multipurpose local government authorities. As an aid to intersectoral collaboration, Joint Consultative Committees exist between the two kinds of authority.
(3) Each district has a Community Health Council whose unpaid part-time members represent a variety of local interests. Its task is to act as a public voice on behalf of the health service consumer, and to this end it has rights to information, powers to visit NHS premises, and, in certain circumstances, to delay hospital closures planned by the DHA.

The Management Team

Each DHA has the four full-time chief officers shown in figure 1. The roles of administrator, finance officer, and nursing officer are not dissimilar to their American counterparts, but the medical officer is intended to be a "community physician," involving himself both in liaison with the medical and paramedical professions and in epidemiological assessments of community health care needs. These four officers are joined by part-time elected representatives of hospital specialists and general practitioners in the district, and the six from the District Management Team (DMT). Although the four full-time officers retain their individual responsibilities for the services provided within their respective disciplines, the DMT has corporate responsibility for the total provision of services. Since these regional and district teams were introduced in 1974, consensus has been their mode of

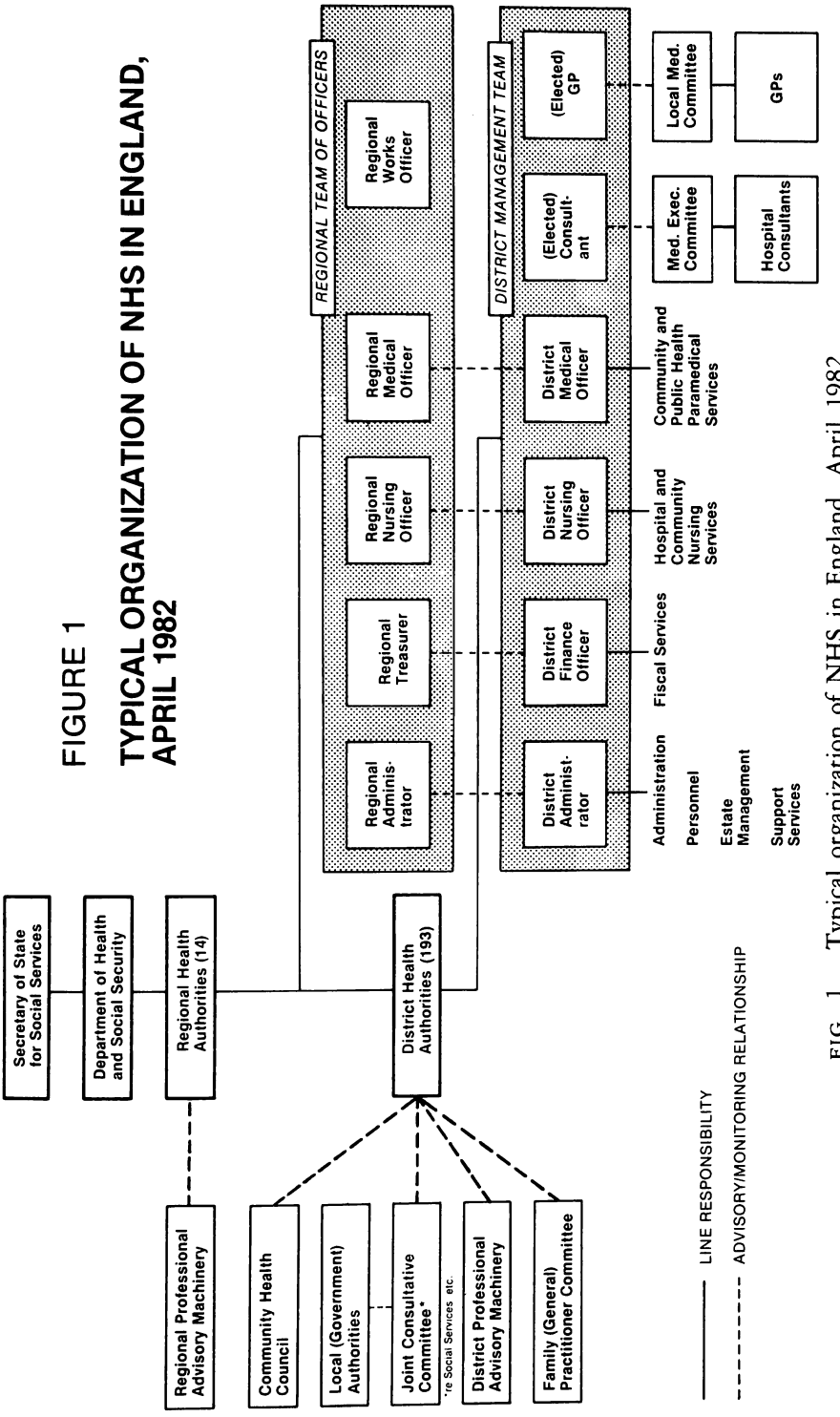

FIG. 1. Typical organization of NHS in England, April 1982.

decision-making. Consensus has been officially defined as a situation where "decisions . . . need the agreement of each of the team members" (U.K. Department of Health and Social Security 1972, 15).

Sources for Observations

Observations reported in this paper are based on a survey of management teams conducted between January and April 1981. At this time there existed in many parts of England an additional level of management (i.e., the Area Health Authority) between region and district. In anticipation of the abolition of this level in 1982, the study concentrated on those parts of the country where the additional tier did not exist. There were 38 districts which met this criterion and one half of these were selected for survey. All districts that were approached agreed to participate in the study. In selecting the 19 for survey, attempts were made to obtain a mix of sociodemographic characteristics, geographical features, and relative resource positions.

Findings reported below are based on interviews with each elected hospital specialist, general practitioner, medical officer, finance officer (called area treasurer at the time of the survey), nursing officer, and administrator member of the management team. Only 8 out of a potential 114 members were unavailable for interviews. All interviews were carried out by the senior author, based upon a set of specific questions to control for comparability. Management team meetings in seven of the districts were observed. Statistical, financial, and staffing data, and strategic and operational plans were obtained from all districts in the study.

Findings represent personal descriptions and perceptions by team members interviewed. The scope of the survey did not permit validation with persons outside the team itself though responses were mostly consistent with the documentary data obtained. Most responses were quite consistent between the different districts studied and with literature review of more detailed case-study research in the subject area. (A more detailed comparison of findings with those of other NHS studies may be found in Schulz and Harrison [1983].)

Consensus Management in the NHS

A management-consulting firm and a university group of organization theorists were responsible for much of the developmental work leading

to the 1974 NHS reorganization, which originally introduced team-consensus management. The primary purpose of that reorganization was to integrate a broad scope of medical and other health services at the local level. While consensus management was presented as theoretically desirable, it was also politically practical. The nurses had already established their own separate management hierarchy and medical officers, i.e., community physicians, were largely ex-health officers who were transferred from local government. Both these groups and organized medicine opposed a chief executive officer (CEO) arrangement with an administrator in charge, and neither doctors nor administrators could accept a medical CEO.

There were at the outset a number of skeptics about consensus management and many questions, such as: Could a consultant, general practitioner, medical officer, administrator, nurse, and finance officer ever agree on anything? Might the clinical side of three doctors and a nurse dominate, or would the full-time officers of the administrator, medical officer, nursing officer, and finance officer overwhelm the consultant and general practitioner? Would needed decisions be delayed by interminable discussion? Would team members or others bypass the DMT, or on the other hand, would there be too many trivial items consuming endless hours of discussion? Might individual officers use the team to avoid their own executive responsibilities? And, what about the status of each? Administrators and medical officers in particular were apprehensive about sharing some of their former personal authority and status with others.

How Has Consensus Management Functioned?

The details of what decisions were to be the subject of consensus management and what behavioral styles were to be adopted were left to individual teams and, consequently, there is no single pattern. Nevertheless, certain generalizations can be made based on this survey and a review of other studies.

Team members appear to relate well and group processes function effectively. Recognizing that team members are heterogeneous in terms of training, status, and goal representation, and that they were selected by others, it is somewhat remarkable that they get on so well. Many team members noted that a socialization process to develop a good working relationship required up to two years. In most cases the socialization period did not result in acrimonious arguing, but rather

members tried so hard to be compatible that they glossed over the real issues. However, once members felt comfortable with each other, they could argue strongly over major differences while still retaining a good working relationship. Nationally only two teams were reported to have had major problems of compatibility whereby the team could never get together and had to be replaced (*Hospital and Health Services Review* 1977).

It seemed that participants were open and frank in their discussions. Nurses seemed to be more defensive than others, perhaps due to their relatively lower pre-1974 status. For example, in one meeting, doctors argued against district nurses receiving two-way radios until general practitioners could have them—clearly an open discussion over relative status expressing feelings as they are, even though a stranger was in attendance. In addition, nursing services represent 40 to 50 percent of the budget and nurses may feel more threatened by cuts than others. Insertion of humor when discussions became tense was often mentioned and witnessed as a key to team harmony and effectiveness.

Only rarely were teams unable to come to consensus. Of the teams surveyed, most could only think of one or two times since 1974 when consensus could not be reached and decisions had to be made by the Health Authority. Team members reported that while they might not totally agree with other members on all decisions, they seldom felt strong enough that they could not at least "agree to agree," or "agree not to disagree." Matters over which they felt strongly could almost always be resolved within the group by persuading others to their point of view, or finding some common ground upon which they could all agree. A number of teams mentioned they would bring in the chairman of the authority as a mediator when there was strong disagreement and such conflicts were worked out so that the team could bring a consensus decision to the authority. One might expect that teams and their members would be reluctant to expose themselves to the DHA as being regularly unable to agree; hence, there has been a strong pressure to at least not disagree.

Consensus slowed the decision process. However, this seems to be related more to what is brought to the team than to weaknesses of the consensus structure. It was frequently reported that some members, rightly or wrongly, bring decisions to the team for them to say "no" when the individual heading the responsible unit should have said "no." While there are instances when it can be helpful to obtain group backing for an unpleasant decision, abuse can lead to the team consuming

considerable time on what some of its members might regard as trivia. On the other hand, if it is an important and tough issue affecting all parts of the system and it is not an emergency in terms of hours, group decisions are important in order to obtain a quality decision and commitment among responsible parties for implementation. Unilateral decisions in such cases may be faster but if they are not the best decisions, and commitment for implementation is lacking, they may cause more delay and problems in the long run.

Another factor related to perceived slowness of decision-making might be that the management team was the lowest organizational level of formal integration of disciplines (Haywood 1977). The 1982 reorganization has attempted to introduce integrated decision-making at organizational levels below the district so that coordinative problems should be resolved at these levels and need not reach the DMT. A number of teams that had already implemented such management teams of an administrator, director of nursing service, and a senior member of the medical staff reported improved coordination.

The amount of time spent in team meetings varied widely. DMT meetings in teams visited ranged from about three hours every other week to over nine hours weekly. Even three hours attendance every other week, plus associated responsibilities, represents a major commitment, especially for general practitioners and consultants with their clinical responsibilities. General practitioners and consultant members receive a modest honorarium and they serve limited terms, though they may be reelected.

Although agenda items differed between just presenting items for information or approval to those requiring joint problem solving, the allocation of meeting time was frequently unrelated to the importance of the issue as so often happens in committees. Meetings could have been expedited if different group processes were used for different item requirements.

If someone was officially designated chairman, the discipline of that person made no discernible or reported difference. Some individuals were more adept at expediting meetings than others. In many cases the administrator who was more experienced in chairing meetings ended up as chairperson.

What Issues Were Addressed by Teams?

Haywood (1979) reported that in a 1977 study of four teams, about 90 percent of the items concerned information transfer, routine decisions,

or process items of how an issue should be handled. Only about 10 percent concerned either taking a position or dealing with nonroutine substantive issues. The scope of the survey reported here did not include large-scale structured analysis of team meetings. Only seven meetings of seven different teams were attended, and agenda and minutes of other meetings were difficult to interpret. However, impressions gained from such a review and from discussions with team members suggested that most teams in this study spent most of their time with issues related to hospital facilities, staffing, or budget allocations which have an important bearing on programs. Sometimes seemingly minor issues, such as the previously mentioned two-way radio system purchase, became policy issues when important actors felt strongly about them. However, in practice most agenda items appeared substantive even though they might be transferring information or determining how issues should be handled. In Haywood's 1977 study, teams had just emerged from their socialization period; by 1981 one might expect maturation into more substantive issues.

In most cases, accountability is perceived to rest primarily with individual officers and doctors and not the team, authority, or region. While team members seemed to be free to raise any problems they saw with services which were the responsibility of another officer, what went on in a specific service was, in most districts, guarded by the respective officer. For example, budgets, staffing levels, etc., within nursing were the responsibility of the nursing officer in most districts, not the team as a whole. And as described previously, the use of beds and other services are in most places the prerogatives of individual specialists, neither the medical staff organization nor the management team or any other organization.

Health authorities may wish to examine some team recommendations. The Community Health Council reviews complaints, regional officers review the work of their district counterparts, and all review operating data which certainly implies some accountability for the DMT collectively. However, there was little evidence that any of these groups set any sort of expectations for health service outcomes of efficiency or effectiveness in the district other than for facility retention or improvement. As long as there are no glaring complaints, each practicing doctor and each officer's discipline is relatively autonomous. Thus, whatever a priori arguments are raised concerning the tendency of consensus management to obscure accountability, it is very clear that

respondents felt a keen sense of personal rather than corporate responsibility.

Allocation of additional resources and coordination of functions appears to be a primary role of most management teams. Only a few focused on objectives or expected outcomes for health services. When asked how they evaluated the effectiveness of their health service for its accessibility, quality, or efficiency, responses suggested that few teams thought in such terms. Indeed, most team members admitted they really did not attempt to evaluate or manage effectiveness.

Information transfer and joint problem solving to coordinate efforts has been an important role of management teams; however, the most important role appears to be allocation of resources. Each district is allocated a specific cash limit for the year and the team recommends to the authority how district funds will be spent. Seldom does the authority not approve the team's recommendations. Most budgets are committed-based on historical developments of ongoing staffing, facilities, and programs, though there is some indication of modest reallocations toward the "Cinderella" services. Relatively little has recently been available in new money to be allocated for new facilities, programs, and/or staffing. On the contrary, in a number of districts, particularly those in London and southern England, there have been budget reductions. Strategies for dealing with such budget reductions were primarily what might be described as "decrementalism," that is, across-the-board percentage cuts, the freezing of job vacancies, and the closure of older hospitals. There was no attempt to zero-base budgets or to question whether particular services were worthwhile. In other words, most teams coordinated plans and negotiated allocation of budget increases or decreases between units, but they did not evaluate and attempt to improve efficiency or effectiveness of health delivery services unless specific problems were raised. Most management teams seemed to be reactive rather than proactive in finding ways to improve health and the delivery of health services, a finding confirmed by the work of Hunter (1979) in regard to Scottish teams.

In short, only a few teams attempted to manage either efficiency or effectiveness of health services; a more descriptive title for most management teams surveyed would be "coordination and allocation teams."

Teams used different approaches to reach resource-allocation decisions. Theory suggests that consensus decision-making will be effective if there is

a joint problem-solving rather than a solution-choice approach (Filley 1975). A solution-choice approach is one where participants enter discussions with their own answers to what they perceive as the problem. They then negotiate on a win or lose basis or on a compromise basis where everyone has to sacrifice. In a problem-solving approach, the group considers the root of the problem, jointly examines alternatives to meet the problem, sets some sort of common objective and priorities, and then mutually agrees on a solution that best meets common objectives. Without being able to trace decisions from initiation to resolution it was difficult to determine the actual processes used to reach decisions, but interviewees' descriptions of resource-allocation decision-making processes with case examples suggest several different approaches, largely dependent upon whether resources were increasing or not.

Where there was still developmental money, i.e., a budget which was still growing in real terms, each officer presented his or her bids and there was a lengthy period of negotiation and compromise. A few teams reported especially active interdisciplinary planning groups which sorted out problems and presented solutions whereby the team had to settle priorities between proposals. Teams which had to cope with reduced cash limits tended to reduce everyone proportionately, close a unit or units, postpone service reductions by transferring money from other funds such as capital or joint health/local government projects, or pursue a combination of the above. Such budget reductions seemed to call forth a joint problem-solving approach based on an implicit agreed priority of organizational maintenance. A few teams, however, had established explicit priorities for services which were the bases for allocation decisions.

Who Controls Health Services in the NHS?

Figure 1 portrays a typical hierarchical and bureaucratically controlled organization through which central government (Parliament through the Secretary of State for Social Services and the Department of Health and Social Services [DHSS]) sets policy and allocates resources to regions and districts. This is ostensibly true, with overall monies available for each geographical division being allocated through each level. The DHSS has policy statements that resource priority should be given to services for the elderly, mentally ill, mentally handicapped, disabled, children, and for maternity. Financial allocations to regions and districts

are largely based on demographic factors and standardized mortality ratios. Actual allocations within total district budgets are the prerogatives of the DHAs, based on management team recommendations.

However, in contrast with the formal organization, in none of the districts surveyed did respondents perceive the DHA as having primary influence over patterns of delivery of health services—for example, the extent to which hospital, primary care, geriatrics, etc. are emphasized. In a few districts the management team was perceived as having primary influence, but, in the majority, hospital specialists as an aggregate of individuals were seen as having primary influence. In the remainder the DMT and specialists were seen as about equal in influence. Regional Health Authorities were seen as having less influence than specialists. Community Health Councils were perceived as having almost no influence except in the two districts where they were reported to have been a positive counterforce to clinician pressures for expansion of acute services. Our findings support those of Haywood and Alaszewski (1980) who also found that specialists, rather than the DHSS or managers, have primary power in the allocation of resources.

Sources of power of specialists can be attributed to the sanctity of clinical freedom in the NHS, i.e., freedom to order whatever available service the doctor thinks is best for the patient, and individual specialist control over hospital beds, admissions, length of stay, etc. Furthermore, in most districts there is little formal peer review such as medical audits of medical and surgical services (Van T'Hoff 1981).

In summary, it cannot be said that any one group controls health services in the NHS. For while individual doctors have a primary influence through clinical decisions, the government has a major influence in terms of what total financial resources are put into the system, and the region and the DMT have control over budget allocations. DMT influence also increases as resources decline and decisions have to be made for reallocating scarce resources away from some services to maintain others.

Which Team Members Seem to Have the Most Influence?

While members of teams are ostensibly equal, some are seen to be more equal than others. As might be expected, status of different members of the team varied as did their perceived influence over decision outcomes. Historically, doctors have been considered captains of the team with highest status and salaries. In terms of influence

over decisions many expected that the specialist's status and his influence over the other three clinical members on the team would dominate.

Each of the six team members was asked to rank the relative influence of each team member, including themselves, over decisions related to allocation of resources. (Resource-allocation decisions were used as they appeared to be among the more dominant team-decision activities.) Table 1 presents composite rankings by team member position for eighteen of the nineteen teams surveyed. Only three of the six members of the remaining team were available for interview; consequently, results from that team were inconclusive. Each person on the team was reported to have a unique source of expertise and influence; ranking of influence among the officers seemed to relate primarily to their perceived skill in using their sources of influence and communication skills. However, 5 of the 18 teams were perceived to really function as a team of equals with influence of each actually being equal.

The district administrator was perceived to have the most influence on 12 of 18 teams surveyed. Members of two-thirds of the teams perceived the district administrator to have the most influence over more of the decisions related to allocation of resources than anyone else on the team. On two of the teams there was only a slight difference in rankings, with a number of the team members perceiving the team to be really equal in influence. On the other ten teams the administrator was clearly seen to have more influence.

Sources of influence of the administrator appeared to relate to his or her having information about the total picture of the issue discussed, having a direct line of communication to the Authority chairman, preparing the agenda for team meetings, and generally being more articulate in group-management settings (perhaps due to management training and experience). Another reason why the administrator was seen to be most influential in most of the units surveyed was that those administrators tended to define their role on the team as organizational maintenance, i.e., facilitating and expediting decisions. When asked what they saw as their role and what they were trying to accomplish, most responded in terms of "seeing to it that things get done, that decisions get made, whatever the decision may be." It is possible that administrators anticipated the direction decisions were taking and brought discussions to conclusion rather than having primary influence on what was decided or initiated, while at the same time conveying the impression of being influential.

TABLE 1
Composite Rankings of Influence by Team Members

		Rankings by team member position					
		Administrator's rankings	Finance officer's rankings	Nurse's rankings	Medical officer rankings	Specialists' rankings	GPs' rankings
Most influence	1.	Adm (98)*	Adm (88)	Adm (78)	Adm (75)	Adm (85)	Adm (56)
	2.	Fin Off (83)	Fin Off (78)	Cons (65)	Med Off (64)	Fin Off (74)	Med Off (47)
	3.	Nurse (72)	Med Off (70)	Nurse (63)	Fin Off (57)	Med Off (55)	Fin Off (45)
	4.	Med Off (63)	Nurse (52)	Med Off (60)	Nurse (56)	Nurse (51)	Nurse (36)
	5.	Cons (53)	Cons (52)	Fin Off (53)	Cons (50)	Cons (33)	Cons (30)
Least influence	6.	GP (30)	GP (35)	GP (39)	GP (40)	GP (26)	GP (21)

* Total points. Six points were given when a person was ranked most influential by the person being interviewed, five points for the next most influential, and so forth.

The medical officer, finance officer, and nursing officer were perceived to be most influential on the other six teams. While the medical officer (i.e., community physician) was perceived as being most influential on three teams, on eight teams they were seen as having the least influence of all the officers. The role prescribed for the medical officer as identifying district health needs and serving as the catalyst to marshall services to meet such needs and giving him or her status comparable to consultants might have suggested that the medical officer would have more influence. However, most medical officers were recruited from the ranks of former public health officers and such persons have had trouble exerting much influence over their clinical colleagues or others. Those who did display more influence appeared to be more achievement-oriented and more skillful at influencing others rather than relying on their formal training to exert authority.

The finance officer was perceived as most influential on two of the eighteen teams. When asked who had most influence over decision outcomes, a common response on those two teams was "the finance officer tells us what capital and services can be provided with the available money, or where reductions can be made to meet cash limit allocations." Such statements suggest that, in these districts, program priorities are determined by budgets rather than budget allocations being determined by program priorities. The nursing officer was perceived to be most influential on two teams. On one of the two, the nursing officer was just slightly above the finance officer in influence, but in the other the nursing officer was seen as clearly being most influential. The source of influence for the nursing officer seems to be that nursing represents the largest single expenditure. The nursing officers were also reported by a number of teams to be the most defensive in that they held out for what they wanted longer than other team members.

Specialists and general practitioners (GPs) were seen as the least influential over allocation-decision outcomes. One might have assumed that with the great power of specialists and because hospital issues dominate team discussions, the specialist member of the team would have more influence. Indeed, the work of F. Eskin and P. Mann of the University of Manchester (personal communication, 1981) suggests that specialists frequently dominate team discussions. However, no team ranked the specialist member as having primary influence. Indeed, only eight out of the 106 team members interviewed ranked the specialist as most influential. No two were on the same team and there was, therefore, no consistent identification of any individual as influential.

On most teams the specialists were ranked fifth in influence among the six members. General practitioners were ranked the least influential on fourteen of eighteen teams.

Reasons for their apparent lack of influence might be:

- Specialists and GPs are part-time members of the team. Their preparation for team meetings is frequently limited to reading supporting documentation a few minutes before the meeting. Officers frequently discuss matters between meetings.
- They do not have line responsibility for other specialists, or GPs, whereas officers have direct authority over their units.
- Specialists and GPs are representatives, and have limited terms of office, usually three years, although they can be reelected; they are, therefore, less likely to act decisively on collective matters.
- Specialists elected to serve on the team are frequently not the most influential specialists. It was often reported that the most influential specialists were too busy to serve on the team, and/or that by electing less influential representatives there is less pressure on specialists at large to be bound by any team actions. Alternatively it may be that such representatives can be easily controlled by the more powerful doctors, who will in any event have other channels of access to sources of decisions.

Quite possibly, specialist or GP members on the team might dominate discussions because they had more questions than other team members and formal meetings are usually the only forum for expressing their views.

It was frequently reported that when specialists and GPs initially join teams, they might crusade to correct all the problems they saw as practitioners. However, after being on the team and recognizing other dimensions to issues, they become supportive members while contributing an important practitioner viewpoint.

Specialists and GPs frequently noted that they were much closer to the actual site of delivery of health services. In other words, they are the only members of the team who actually see the micro-patient issues of health services delivery, whereas all other team members have a more macro-system and population view.

Most team members, including GPs themselves, perceived GPs to have the least influence on the team. One might expect GPs to be least influential as not only have they most of the same characteristics listed above for specialists, but 70 to 80 percent of meeting time

concerns hospital matters, in spite of the fact that a primary purpose of the 1974 reorganization was to focus more attention on other services. Nevertheless, with increasing interest in the contribution of primary care to meeting total health needs, GPs provide such a focus for the team. Moreover, attention to community services would arguably be even less without their presence.

Clinicians perceive more role conflict than other team members. In describing their role on the team—that is, what they hope to accomplish—practitioner members see some conflict between their representative, personal, and corporate roles. While most responded that their primary objective is to represent the medical viewpoint on the team, they were quick to add that they did not see themselves as delegates for their colleagues. Reports from other team members validated that they will represent the medical view, and ensure that the doctors' views are clearly understood, but in the final analysis they will support the team position if they believe it is in the patients' and system's best interests even though it might be counter to views of most doctors.

Most specialists and general practitioners reported that they had difficulty in acting as delegates for the medical community because practitioners themselves are usually widely divided on issues, especially those dealing with resource allocation. Almost all team members indicated that doctors represent a very powerful negative influence to prevent something from occurring but seldom will they represent a united front for a positive position. On the other hand, a few of the teams delegated budget allocation questions, or fixed budgets for allocation to medical staff committees for decision; the latter were usually in the area of medical equipment.

Is Team-consensus Management Favored over Other Alternatives and What Are Seen as Strengths and Weaknesses of the Arrangement?

Of the 79 team members asked if they favored the team-consensus arrangement, only 17 preferred the previous or some other arrangement. All finance officers and all but one nursing officer favored consensus management. Administrators and medical officers favored consensus management least. One can understand that, as hospital administrators and medical (public health) officers, they perceived themselves as

having had more personal authority in the pre-1974 structure. Nevertheless, the fact that two-thirds of both administrators and medical officers preferred the current structure even though their authority may have diminished is persuasive evidence of strong endorsement for the current arrangement.

A number of team members responded that they would prefer a chief executive officer (CEO) arrangement—if they could be the CEO. However, they were not at all confident that a "good" CEO would be appointed no matter which discipline that person might represent; consequently, they preferred the team-consensus arrangement. It appears that it may be very difficult to move away from consensus management once it has been adopted; it was widely seen as a legitimate mode of decision-making.

Better decisions was the most frequently mentioned advantage of consensus management. The primary benefit from consensus management was perceived to be more input for better decisions. While few respondents indicated explicitly how decisions were better, they seemed to mean a more thorough consideration of the various dimensions to issues. This finding is consistent with those of Hall (1971) who found that group decisions are better than average individual decisions, and with training and effectively managed conflict, group decisions are better than even the best individual decision. Other research on group decisions would suggest a higher quality outcome in terms of satisfaction with the decisions, more creative decisions, and possibly a greater willingness to take risk than if decisions were made unilaterally (Van DeVen, Delbecq, and Koenig 1976; Filley, House, and Kerr 1976, 153–57; Clark 1971). Most respondents spoke of benefits from increased medical input especially from the general practitioner, which was interesting in view of general practitioners' alleged lack of influence.

The second most frequently mentioned benefit was that consensus provided for a greater commitment to implementing the decision. Greater commitment to implementation is consistent with other research findings that persons who participate in decisions are much more committed to seeing them implemented (Hage and Aiken 1970). Moreover, when the team can point to doctor representatives favoring the decision, it, no doubt, enhances confidence to see the decision through to implementation. Other advantages mentioned included that it "provided a better forum for expression, aided my status and voice, aided coordination, and provided for more innovative decisions."

Consensus management was criticized for delaying decisions. While there was strong general support for consensus management, some problems were reported. The most frequent criticism of consensus management was that it delayed decisions, though this seems to be a problem attributed to a missing coordination structure at lower organizational levels rather than the consensus team concept per se. Survey respondents also reported a few other criticisms, including the inability of the elected clinicians to commit their colleagues, too much influence on the part of disciplines other than that of the respondent, team domination by "aggressive personalities," inability of the part-time members to devote sufficient time to the process, and lack of union representation on the team as they, too, have de facto veto power over a number of managerial issues.

In summary, there was strong support for team-consensus management, findings which are consistent with those of the Royal Commission on the National Health Service (1979), which gave high marks to the process. Since 1983 there has been a resurgence of criticism of the consensus process, and particularly its focus on marginal resource distribution and responding to immediate problems rather than upon issues of value for money and strategic development of services. A recent report (Royal Commission on the National Health Service 1983) recommended that a general manager be identified to take decisions where consensus has not been reached and to place issues of effectiveness and efficiency on the agenda. In spite of both academic (Harrison 1982) and political arguments (U. K. House of Commons. Social Services Committee 1984) that the alleged shortcomings are not a product of the consensus process per se, but rather of the distribution of power and interests within the service, and that similar criticisms can be made of health care systems (such as in the United States) that do not employ consensus management, the government has decided that the general manager will be appointed.

Although the ten-year period of formal consensus decision-making is about to come to an end, it seems likely that the practice, which survived a period of exceptional economic and political pressure upon the NHS, will continue on an informal basis. These considerations suggest that there may be some lessons in the British experience.

Consensus management has, therefore, been accepted as a successful innovation.

Implications for the United States?

Scott's (1982) three models of control for managing professionals provides a helpful framework to consider the implications of consensus management in relation to massive changes underway in the delivery of health services in the United States. Scott describes his models as 1) autonomous, 2) heteronomous, and 3) conjoint. In the *autonomous* health service organizations, micro-care to the patient is the focus of attention and primary control rests with the individual physicians responsible for that care. In the *heteronomous* organization professional participants are clearly subordinated to the administrative framework and focus is on macro-care of populations of patients. Scott observes that health services in the United States are moving from autonomous to heteronomous organizations as health maintenance organizations (HMOs), surgi- and emergi-centers, and other investor and not-for-profit multisystem arrangements develop. This trend appears to be accelerating since 1982 with the implementation of DRGs and the resulting hospital management influence over treatment of patient population groups, increasing salaried physician positions, and HMO and preferred provider organization (PPO) hospital-physician alliances. Scott proposes a *conjoint* organizational arrangement to consider the importance and interdependence of both micro- and macro-care issues. He describes it as a possible rather than an existing model. Consensus management appears to be a structure coming closest to portraying conjoint arrangements.

Although a nationalized system, the NHS has functioned in an autonomous organization framework. A primary purpose of the 1974 consensus structure was to link system parts to facilitate macro-organization considerations. Individual doctors have had effective veto power in implementing many system changes. With declining resources there was a need to bring them into the formal system decision process. Consensus management appears to have been an effective beginning of a movement from autonomous to conjoint organization orientations in the NHS.

A formalized team-consensus management structure, at least between physician and system management, could possibly prevent micro-system obfuscation of heteronomous health organizations in the United States. As practicing physicians and health service managers explore

organization structures to cope with accelerating system changes, a team-management consensus structure is worthy of consideration. For example, the development of HMOs will likely give more collective power to physicians in relation to hospitals than they have had in the past; as this study has shown, consensus management is a reasonably effective method of operation when power is distributed among several actors. The medical staff hospital (MeSH) partnership, proposed by Paul Ellwood (1983) to link growing hospital-physician interdependencies, suggests a consensus team structure.

A consensus structure may also be a way to help integrate nursing into the hospital management structure to meet objectives of the recent National Commission on Nursing. Commenting on the commission report, American Hospital Association president Alex McMahon (1983) has said "a working partnership of hospital executive management, including nursing service administrators, doctors, and trustees is essential to achieving long-term solutions to nursing problems. The management team cannot only begin to create a different environment for nursing, but also can address basic patient care."

It is likely that many hospitals already have an informal consensus management structure. While the formal organization chart may show a single president in the hospital hierarchy, that person may not make major decisions without group consensus among the chief medical staff, nursing and fiscal officers, and trustee chairperson.

Theory on organization decisions (Schulz and Filley 1979) suggests that group decisions are favored over individual decisions where:

1. The objective quality of the decision cannot be readily measured at the time the decision is made; in other words the decision requires a judgment, rather than computation.
2. Group acceptance and understanding of the problem and its solution are required.
3. Implementation of the decision requires acceptance by group members.
4. The quality of the decision is enhanced by group interaction.
5. It is important to broaden the system horizons of group members.
6. There is time for a group decision.

Strategic and many other top management decisions in health services appear to meet these criteria. Moreover, the experience of team-

management consensus in England suggests that while some group process training is warranted, there is ample evidence that:

- Consensus can be achieved;
- Participants are generally pleased with the quality of decisions and their implementation;
- Participants are generally pleased with their own status in processes and in the organization;
- The team structure helps to integrate interdisciplinary groups;
- The team structure is effective in large-system organizations;
- Team-consensus management works in health systems with declining resources.

Massive changes currently underway by health services in the United States in reimbursement incentives, delivery systems, and management needs suggests considering bold experiments with management structures. Team-consensus management appears to be worthy of such consideration.

References

American Hospital Association. 1984. *The Directory of Multihospital Systems.* Chicago.

Clark, R.D., III. 1971. Group Induced Shift toward Risk: A Critical Appraisal. *Psychology Bulletin* 76(4):251–70.

Ellwood, P., Jr. 1983. When MDs Meet DRG. *Hospitals* 57(24):62–66.

Filley, A. 1975. *Interpersonal Conflict Resolution.* Glenview, Il: Scott Foresman.

Filley, A., R. House, and S. Kerr. 1976. *Managerial Process and Organizational Behavior.* 2nd ed. Glenview, Il: Scott Foresman.

Hage, J., and M. Aiken. 1970. *Social Change in Complex Organizations.* New York: Random House.

Hall, J. 1971. Decisions, Decisions, Decisions. *Psychology Today* 5:51–54.

Harrison, S. 1982. Consensus Decisionmaking in the NHS: A Review. *Journal of Management Studies* 19(4):377–94.

Haywood, S. 1977. *Decision Making in the New NHS.* King's Fund Project Paper no. 17. London: King Edward's Hospital Fund for London.

———. 1979. Team Management in the NHS: What Is It All About? *Health and Social Service Journal* (October 5):54–60.

Haywood, S., and A. Alaszewski. 1980. *Crisis in the Health Service.* London: Croom Helm.

Hospital and Health Services Review. 1977. Consensus Management 73(7):229–30.

Hunter, D.J. 1979. Decisions and Resources in the Scottish NHS. In *The Ethics of Resource Allocation,* ed. K.M. Boyd. Edinburgh: Edinburgh University Press.

McMahon, A. 1983. Policy Role Urged for Nurses. *Hospitals* (July 1):24.

Maxwell, R.J. 1981. *Health and Wealth: An International Study of Health-Care Spending.* Lexington, Mass.: Lexington Books.

Royal Commission on the National Health Service. 1979. Cmnd. 7615. London: H.M. Stationery Office.

———. 1983. NHS Management Inquiry, October 6. Report to Rt. Hon. Norman Fowler MP, Secretary of State for Social Services.

Scott, W.R. 1982. Managing Professional Work: Three Models for Control for Health Organizations. *Health Services Research* 17(3):213–40.

Schulz, R., and A.C. Filley. 1979. Hospital Management Decisions: Unilateral, Consultative or Group? *Administrative Briefs of American College of Hospital Administrators* 13(3):1–6.

Schulz, R., and S. Harrison, 1983. *Teams and Top Managers in the National Health Services.* London: King Edward's Hospital Fund for London.

U.K. Department of Health and Social Security. 1972. *Management Arrangements for the Reorganized NHS.* London: H.M. Stationery Office.

U.K. House of Commons. Social Services Committee. 1984. Griffiths NHS Management Inquiry Report. House of Commons Paper 209. London: H.M. Stationery Office.

Van DeVen, A., A. Delbecq, and R. Koenig. 1976. Deluminants of Coordinating Modes within Organizations. *American Sociological Review* 41:322–38.

Van T'Hoff, W. 1981. Report of Results of an Inquiry Conducted by Questions about Audit. Paper given at a conference, Medical Audit: Monitoring Practice and Learning from Mistakes, Royal College of Physicians of London, January 23.

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