HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Miles C. Hardie

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In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Produced in Cooperation with
American Hospital Association Resource Center
Library of the American Hospital Association
Asa S. Bacon Memorial

Sponsored by
American Hospital Association
and
Hospital Research and Educational Trust
Chicago, Illinois

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Miles Hardie

CHRONOLOGY

1924	born New York City, February 27
1943-1946	Royal Air Force
1949	Oriel College, Oxford University, M.A.
1949-1952	National Health Service, training in hospital administration
1949-1950	Westminster Hospital, London, training
1950-1951	Hospital for Sick Children, Administrative Assistant
1951-1955	Victoria Hospital for Children, London, Secretary
1956-1958	Bahrain, Government Medical Department, Secretary
1958-1962	King Edward's Hospital Fund for London, Staff member
1963-1966	King's Fund Centre, Deputy Director
1966-1975	King's Fund Centre, Director
1975-1987	International Hospital Federation, Director General

MEMBERSHIPS & AFFILIATIONS

British Hospitals Export Council

Honorary Secretary, 1964-1967;

Member 1967-1975

National Association of Leagues of Hospital Friends

Council member, Member 1970-1975

MIND (National Association for Mental Health)

Council of Management, Member 1968-1985

National Corporation for the Care of Old People

Member, Advisory Council 1973-1976

Overseas Course in Hospital Administration

Director 1961-

Salters' Company

Court of Assistants

Spinal Injuries Association

Management Committee, Member 1975-1979

Volunteer Centre

Member, Board of Governors 1977-1980

World Health Organization

Adviser 1978-

HONORS & AWARDS

American Hospital Association

Honorary Member 1983-

Institute of Health Services Management

Fellow

WEEKS:

This is the story of your professional life and the events that have taken place with which you have had some connection. We also hope to talk about other topics that may come to your mind.

In my notes, I have that you actually were born in New York City.

HARDIE:

Yes.

WEEKS:

Of British parents, in 1924. Was your father in some kind of service?

HARDIE:

Yes. My father was working with the Metropolitan Life Insurance Company at the time and he was based there when I was born. So that's how I came to be of American birth.

WEEKS:

Then I have a note that you were in the Royal Air Force during the war. You went in that quite young, didn't you?

HARDIE:

Well, I was eighteen when I joined up. I spent a very happy year, or most of a year, in 1943 learning to fly down in Florida. It was a great experience in the middle of the war. Then I came back and I just caught the tail end of the war in 1944-45, based in Europe.

WEEKS:

That must have been an exciting thing to come to Florida for. There was a lot of training being done in this country.

HARDIE:

There were I think six or seven of what they called British Flying

Training Schools in the U.S.A. and this was one of them. It was down on the edge of Lake Okeechobee. It was very good to be paid to learn to fly in Florida in the midst of the war.

WEEKS:

Yes. That must have been interesting.

After leaving the Air Force you went to Oxford?

HARDIE:

That's right, yes.

WEEKS:

You received your master's there in 1949?

HARDIE:

Yes. I studied what is called litterae humaniores which is history, literature and philosophy, Latin and Greek. So it was the traditional Oxford education. It doesn't immediately fit you to be anything except a teacher or a civil servant or something like that.

WEEKS:

The typical classic education that the university is so famous for.

When I read this in some notes that I have, I then was asking myself how did Miles get into health administration?

HARDIE:

As I said, in some ways the options for you with that education are fairly limited and many people go into the civil service in Britain. At the time that was certainly one of the options. But I thought that going into the National Health Service, particularly at the time it was just starting, would be a more exciting form of civil service, also a much more personal one than would be the case in the civil service. I made some inquiries. My father-in-

law, who was a professor of anatomy at Oxford, put me in touch with people who were acquainted with the field of health service administration. And I was one of those who was fortunate enough to get one of the bursaries, a form of scholarship offered by King Edward's Hospital Fund for London immediately after the war for people who were interested in going into the health service. So I took one of those bursaries and that's where I got my initial training. That was before there was any school of hospital administration in Britain at all.

WEEKS:

We had one at Chicago in 1934. That was the first we had. For a long time there were no others. What form did this training take?

HARDIE:

It was really almost what you might call planned movement. You were expected to study for the examination at the Institute of Hospital Administrators, as it was then called. That was an essential part of it. You enrolled and you did part-time study of that. I spent my first six months attached to Westminster Hospital, one of the London teaching hospitals. Then for the second six months I went to the Hospital for Sick Children in Great Ormand Street. Then before I finished my six months there I was offered a junior administrative post on the staff of that hospital. I then stayed there for two years as a paid employee in the National Health Service.

WEEKS:

Was that the same as the Victoria Hospital?

HARDIE:

No. After my two years at Great Ormand Street, there was a post advertised for the secretary of the Victoria Hospital for Children in Chelsea.

I took that post and I was there for a bit over four years.

WEEKS:

When you say secretary, would that be...

HARDIE:

Administrator. And that was part of a bigger group of hospitals, St. George's teaching hospital.

WEEKS:

Is St. George's still on Hyde Park?

HARDIE:

No, no. The building is still there, but they moved out ten years or more ago down to the outskirts of London to a suburb called Tooting. Because, as I'm sure you know, there was a terrific concentration of teaching hospitals in the center of London -- far more than were needed. So with much heartburning St. George's decided to move out to the suburb of Tooting, which is a long way from Harley Street.

WEEKS:

I visited there in about 1964. I was amazed to learn that it was built in the year that our George Washington was born, 1732 or there about.

HARDIE:

That's right, yes.

WEEKS:

I was amazed at how well they had kept it up.

HARDIE:

Yes. They got a special allowance of money for keeping the external part of the building in good shape because it was right there in the heart of London. Interestingly, it started back in 1732, as you said, with a dissident

group of doctors from the Westminster Hospital which is just about a mile away, down the hill by the river. They weren't satisfied with the way things were going at Westminster and they decided to move out into the country, as they called it at the time. They set up St. George's Hospital there at Hyde Park Corner. That's how it started.

WEEKS:

That's very interesting to hear. I was very much impressed. Who was the famous matron?

HARDIE:

Muriel Powell.

WEEKS:

Yes. I was fortunate enough to meet her.

HARDIE:

I was there when she was the chief nursing officer for the group. She was a great lady.

Just a small story about St. George's. It always had round the top, just under the roof, a great banner carved into the walls saying, "Supported entirely by voluntary contributions." Soon after the health service started some medical students climbed up the walls of the hospital and they added "in" before the voluntary so it said supported entirely by involuntary contributions.

WEEKS:

Students are the same anywhere you go, I guess. I was very impressed with what they were doing with this. I met the hospital planner who showed me some of the plans that they were hoping to use in building a new hospital.

HARDIE:

That's right. There was a competition for the design of the new St. George's Hospital. This was just before the war. There was, at that time, a young architect called Alexander Gray who won the competition for the new hospital. But then the war came along and of course all of the building plans went into limbo. But it made his reputation and he then became the principal partner in a firm called Watkins-Gray, which is one of the leading hospital architectural firms in Britain. It all started from a hospital that was never built.

WEEKS:

That's a very interesting story.

How did you happen to leave Victoria to go to Bahrain?

HARDIE:

Well, that was a job that was advertised in the Times. They wanted a secretary for the Bahrain government medical department, administrator that is. I applied for it because I wanted to get some experience overseas. I was fortunate enough to get that job.

WEEKS:

That was...

HARDIE:

1956.

WEEKS:

There was great wealth coming out of the Arab states then, wasn't there?

HARDIE:

Well, Bahrain was the first place in the Middle East to find oil. But they never had very much. They just had a modest amount. I think that was a

very good thing because they weren't extravagant in their health services. I think they had, and still have, probably one of the best health services in the Gulf. I was very lucky to be there at that time.

WEEKS:

Americans have gone to the Arab countries too, particularly the oil countries. Even some of the for-profit hospitals are going there too, aren't they?

HARDIE:

They are now, yes.

WEEKS:

Then you came back and joined King Edward's Hospital Fund for London as a staff member?

HARDIE:

Yes. That was through Philip Constable, whom I haven't mentioned before. He was the chief administrative officer of St. George's group. He and Muriel Powell were really, I suppose, the outstanding team in London at that time. They were bywords for the standard of administration. When I was out in Bahrain, as my two-year contract came to an end -- it was only two years: the idea was to help train some of the local people -- Philip Constable wrote to me and said he heard there was a post coming up at the King's Fund and suggested I should write to them and say that I would be interested. So that is how that came about.

WEEKS:

I have a note here to ask you about Mr. Constable. In 1964, my wife and I came over and we went to the Centre and Mr. Constable was very kind and took us out to his house in the green belt for supper. We met his wife and his

son. He impressed me very much. He was a very fine gentleman.

HARDIE:

He was a wonderful man. I wish he could have been interviewed for one of these oral histories because he was recognized at the time as being one of the outstanding administrators of his generation, probably the outstanding one. He was a wonderful person to work with, and I owe a very great deal to him. Of course he was associated with the Centre after I went there, so it was over many years that I knew him.

WEEKS:

Can you give me some background on King Edward's Fund?

HARDIE:

Yes. It started in 1897, as a thanksgiving fund for the Diamond Jubilee of Queen Victoria. It was started by the Prince of Wales, as he then was. The idea was to raise money for the support, benefit, or extension of the hospitals of London. Until the National Health Service started in 1946, it was very largely concerned with providing funds to help the London hospitals keep afloat. But at the same time, it was always very much interested in the standards of those hospitals particularly in the field of management and planning. So they had a considerable reputation for being not only generous benefactors, but for being people who were very interested in seeing that the money was well spent.

When the Health Service came into being in 1946, they were able to concentrate their money not so much on giving grants, although they still do that on a big scale, but on improving education in particular. They established, in the few years after the start of the Health Service, first a college for ward sisters, then a college for matrons, then a college of

hospital catering, and then a college of hospital management. Each one of those was the first of its kind in the country. The idea was that they would only do this for a relatively limited amount of time, really to set a pattern that could then be taken up by the Health Service itself. That's exactly what happened over the years. Those four colleges eventually became merged into one college of health service management. Then they also set up what they called the Division of Hospital Facilities, which was really an information and advice center on hospital planning and management. That was the job that I took when I came back from Bahrain. I joined the staff of the Division of Hospital Facilities.

WEEKS:

Who contributed to this fund?

HARDIE:

When it started the Prince of Wales made a national appeal for money, and they raised quite a bit of money in the terms of the time. Then when he became king, it became known as King Edward's Hospital Fund. Ever since then they have gone on the principle of not touching the capital, but living on the income. From relatively small beginnings — I suppose they must have raised about a million pounds in the first two or three years of its existence. Now they have a capital, I think it's something approaching sixty million, which is considerable by British standards, although peanuts compared with say the Kellogg Foundation.

WEEKS:

Just as an aside, talking about the Kellogg Foundation. I was at the Kellogg Company annual meeting and they made mention of the fact that the Kellogg Company had borrowed a vast amount of money to buy fifteen million

shares of Kellogg stock owned by the Foundation. Now the Kellogg stock in the last four or five years has quadrupled or more than that. So the Foundation has a lot of new money now to work with. I think the stock is selling for nearly $50 a share. You multiply that by fifteen million and you've got quite a sum of money. They didn't seem to think too much of it. They thought it was a good opportunity to buy stock.

You were on the staff of the Fund proper. Then you moved over to the Centre. Is that autonomous?

HARDIE:

That's an integral part of the Fund. The Division of Hospital Facilities started soon after the war, about 1948. In fact, the director of that, Captain Stone, was also honorary secretary of the International Hospital Federation. As time went on the work of the Division expanded and it was decided to look for bigger premises where they could establish what became known as the King's Fund Hospital Centre. That was a direct offshoot of the Division of Hospital Facilities.

WEEKS:

What does the Centre do? I have been there a couple of times. I know you have a library.

HARDIE:

Yes. You could say that the Centre's chief role is information. But overall -- I always used to say when I was director of it that its aim was to promote the introduction of good ideas and practices into the planning and management of hospitals and health services. So it never really concerned itself directly with clinical matters, except so far as they impinged on planning and management. It was really aimed at those who were managing the

health services.

WEEKS:

Being there, I remember some men behind drawing boards, making plans.

HARDIE:

Yes. That was the catering advisory service which had been set up round about the same time as the Division of Hospital Facilities. They were concerned solely with improving standards of catering. They had a very good catering advisory service for quite a number of years. But, again, the Fund's intention was that it should only be for a limited period and they would like to see the regions and the Department of Health and Social Security setting up its own catering advisory service, which is what happened. So the catering advisory service wound up round about the end of the 1960s. Really it had done its job and done it extremely well.

WEEKS:

The Centre holds seminars and meetings of different kinds?

HARDIE:

Yes. If you look at the Fund as a whole -- there is a headquarters organization, and now, on the one hand, there is the King's Fund College of Health Services Management and then the King's Fund Centre. The college is very much concerned with residential courses, namely short courses of anything between three days and a month or so, having multi-disciplinary courses involving doctors, nurses, administrators, and so on. Whereas the Centre is mainly concerned with information services, research, and conferences -- day conferences -- particularly aimed at the promotion of good ideas and practices. In the course of a year they have a very large number of meetings there, round about fourteen or fifteen hundred. Of those, I suppose half

would be generated by the staff of the King's Fund themselves. The other half would be outside organizations working in the field of health care who use it for meetings of their own.

WEEKS:

You have quite a nice library.

HARDIE:

Yes. One of the best libraries in its field on planning and management.

WEEKS:

Do you circulate books?

HARDIE:

The library is not a lending library. It's very much of a reference library, and it is widely used by people coming from outside. They used to have a system of lending folders whereby if somebody wrote in for information on a particular subject, say medical records or one sort or another, they would put together a selection of cuttings in a folder and send that out. That activity has dwindled to some extent now because, with the development of libraries within the Health Service, they would be more concerned now with producing bibliographies and references that they could circulate to people.

WEEKS:

Have they gone into data processing as far as storing information?

HARDIE:

To a limited extent. They are linked in with one or two networks like Medlars. There is also a European network called Heclinet with which they are linked.

WEEKS:

I worked with Keith Morton a few years ago trying to set up an

information exchange system. I was impressed with the library and I was impressed -- as I remember you had a space on the wall where there were pockets where you had reprints. This must have been in the time when you were supplying a folder of reprints on a particular subject that someone was interested in.

HARDIE:

Yes.

WEEKS:

We were trying to find out if there was some way — Keith Morton and the group that he was working with were trying to find a means of bibliographical retrieval of articles so that you could get an international bibliography in many languages. But then the question became, we Americans are not very adept at foreign languages and I suppose in Britain and Europe you are faced with needing to know other languages more than we are here. So nothing, I guess, has come of that.

HARDIE:

Well, I referred to the European network which they call Heclinet. There are about six or seven countries in Europe that are linked with this. It is aiming to provide the sort of service that you are describing. It hasn't mushroomed, but it's still plugging along.

WEEKS:

The Germans had a computerized set up of their literature the last time I was there, in 1974, in Dusseldorf. They were finding trouble getting the different countries to agree on what approach to use and what method to use.

HARDIE:

They are now part of the Heclinet network. There are several countries

-- Switzerland and the Netherlands, Sweden, Germany -- about five or six including Britain.

WEEKS:

It will be interesting to see how this can be worked out because we need some sort of system. I was impressed with Sweden's system in their general libraries. They can locate a book anywhere in the country.

HARDIE:

They are very good.

WEEKS:

We couldn't find any way to become a part of it. Our Cooperative Information Center at the University of Michigan was trying to. The best we could do was to publish our abstracts journal. Those were interesting years and must have been interesting years for you too.

First you became deputy director of the Centre. That must have been when I first met you because I was there during those years.

HARDIE:

Yes. It was 1963 that I became deputy director, which was at the time that we moved from the early King's Fund premises to the ones in Nutford Place on Edgware Road.

WEEKS:

You were right off Edgware, yes. That's where I went. I've never been to the new one. And you are no longer there either, are you?

HARDIE:

No.

WEEKS:

Would you tell me something about the International Hospital Federation?

HARDIE:

Yes. This was started, the Federation, soon after the end of the war although there had been an international hospital association set up here in America in 1929. I think its first meeting was held in Atlantic City at that time. That went on on a fairly low scale of activity until the war, starting in 1939. Then it went into a kind of voluntary hibernation. At the end of the war it was resurrected, largely due to the initiative of a Belgian, Dr. Rene Sand.

As I mentioned earlier, Captain Stone who was on the staff of the Division of Hospital Facilities of the King's Fund was very interested in international affairs. He undertook voluntarily to be the unpaid secretary of the Federation. At that time, of course, he was working in the King's Fund premises. For nearly forty years the Federation was in fact based in the premises of the King's Fund.

After a few years, from 1947, the American Hospital Association gave a grant -- I think it was 5,000 pounds a year over a period of five years -- to enable the Federation to appoint a paid director. That post was taken in 1962, I think it was, by Derek Harington Hawes who had been on staff of the King's Fund. He became the first director general of the Federation in 1962. He remained in that post until 1975 when he retired and I became director general.

The aims of the Federation from the start were to promote improvements in the planning and management of hospitals and health services. Although the title is International Hospital Federation, constitutionally it's aim is to promote improvements in the planning and management of hospitals _and_ health services. That was how it started. Being so closely linked with the King's

Fund, it did offer an information service based on what was available in the Fund's Division of Hospital Facilities. For many years its chief activity was to organize a big international congress once every two years, in the odd years to arrange a study tour for up to two hundred people in different countries. That was the original basis of its existence.

WEEKS:

Are most of the countries of Europe...

HARDIE:

Yes. I think now there are about a hundred and fifty countries that are affiliated with the World Health Organization, which represents most of the countries in the world. Today the IHF has members in some ninety countries. That includes most of the countries in Europe, both Western Europe and Eastern Europe. Of course Canada and America. Many of the Latin American countries. Then we have Australia, New Zealand, Japan, and quite a number of countries in Asia and Africa. Quite a number of the very small countries in Africa and so on are not as yet members.

WEEKS:

I was impressed with the publication that I will call your Yearbook. That is a very impressive publication. Does the sale of this help finance the IHF?

HARDIE:

No, it doesn't. We entered into a contract with the publishers. They undertake all of the risks. We have editorial control and they undertake the production, and they send it automatically to all our members. In addition, it goes out to about 3,000 people concerned with hospitals and health services in different parts of the world. Then we follow that up and try to get them

to become members as well. We don't get any direct financial profit from the Yearbook itself, but it certainly gives us a vehicle for getting a lot more of what we hope are useful reports and articles published. Also we hope that it serves to boost the membership through people joining. We say, "If you want to continue getting this, join as a member."

WEEKS:

Do you have other publications?

HARDIE:

We have a quarterly journal, World Hospitals. If we have grants or projects of one sort or another, that may lead to a publication. I suppose a good example is the one that we produced at the end of 1984 on hospitals and primary health care. This was due to a grant from the Kellogg Foundation. They gave us quite a sizable grant, by our standards, for some fellowships concerned with primary care and health care in big cities and management training. One of the offshoots of that was this report on hospitals and primary health care.

WEEKS:

I neglected to ask you when we were talking about the King's Fund about the status of the publications there. Don't they have a publishing division?

HARDIE:

Yes, they do indeed.

WEEKS:

I got the impression in an article I read which was speaking of the fact that you had to move from the Centre to new quarters and that this was an expense of twenty-five thousand pounds. The thought was that you were being subsidized somewhat, directly or indirectly, by the Centre. Where do your

finances come from?

HARDIE:

Our finances come from membership subscriptions almost entirely. Except that we certainly aim to make a surplus on our major activities, and particularly the congresses. Thanks to some pretty successful congresses over the past seven or eight years, our reserves have increase quite considerably which is good.

WEEKS:

In this country the associations that have been depending on publishing profits, such as AHA and their Hospitals journal and their books and so forth, are finding that there is less advertising available due to the slowing down of hospital service because of the new laws. Most of them have to depend on their conventions or their congresses to raise some money, along with other activities that they have. So I was wondering -- you undoubtedly go to foundations or to other people who might give you a grant for a special purpose. Plus whatever monies you raise in your membership.

You didn't mention how many members you have.

HARDIE:

It's difficult to quantify this precisely because we have different categories of membership. The American Hospital Association is a national member. That represents 7,000 hospitals in the U.S.A. Then we also have individual members. In fact, we have four categories of members. What we call the "A" members, which are the national members. In the case of the U.S.A. that is the American Hospital Association. In Britain it is the Department of Health and Social Security. Depending upon the type of health care system a country has the national member will be either a hospital or

health service association or the central government department of health. In our case, of the countries that are members, about half have their "A" members as hospital and health services associations and the other half are ministers of health. So that's the top category. Representatives of those "A" members have voting rights at our general assembly.

Then we have corporate members which can be individual hospitals or groups of hospitals or, as in the case of Britain, health districts.

Then there are individual members which can be anybody concerned with the planning and management of hospital and health services.

Then there are corporate firms of architects, engineers, or companies involved in the health care field.

So if you add all of those different categories together we have about eighteen hundred members.

WEEKS:

And they in turn may subdivide into memberships of their own.

HARDIE:

That's right, yes.

WEEKS:

What sort of working relationship do you have with WHO?

HARDIE:

We are one of the 150 or so organizations that are called non-governmental organizations that have what they call official relations with WHO. That means that we are listed in their list of non-governmental organizations (NGOs). We don't get any financial support at all from WHO, but of course we get their publications and we can be represented at the World Health Assembly. We get invitations to send representatives to the regional

meetings of WHO.

I have served from time to time as what they call a temporary advisor on different WHO projects and activities. So, in fact, we have good working relations with them. Every three years WHO undertakes what they call a tri-annual review of every NGO affiliated to them and we have to say what our activities are and how they relate to WHO's interests. We have a good relationship with them.

WEEKS:

I have been in Geneva only once. It seemed to me -- I guess I was confused at all of the nationalities working there. I was wondering how they could pull all the nationalities together and work well. The librarian at that time at WHO was a Briton. I think he is now dead. I was quite impressed with his grasp of things.

You have been in this post at IHF since 1975. I understand you have announced your retirement for 1987?

HARDIE:

Yes.

WEEKS:

I have a note later on to talk about your future but how about the future of the International Hospital Federation? Do you see any changes in the future?

HARDIE:

Oh, yes. I hope there will be changes. I think when you get a new director general in it gives a great opportunity for reviewing what has been happening over the past 10 years and what directions might be taken in the future. I certainly hope that the IHF will continue with some of the

activities and interests that I promoted during my stay with the IHF. But I would be very disappointed if the new director general didn't have some new ideas of his own so that he could start new projects while we still maintain what has happened in the past.

WEEKS:

In looking back, what innovations did you introduce that you are happy about?

HARDIE:

There are a number of things that I have been very interested in. It was really the time that I spent in Bahrain in 1956 to 1958 that got me interested in international affairs. One of the things at that time was the question of initiating training for people from developing countries because in most of them there was very little activity in that field.

Soon after I came back from Bahrain I was able to persuade the King's Fund to let me start a course for senior hospital and health services managers from overseas. We had the first one of those back in 1961. It was very good of the King's Fund to let me do that because they were really the hospital fund for London. They had to stretch their terms of reference pretty far to let me run a course for people from all over the world.

To begin with they said, "Well, really, we'll have to restrict it to the Commonwealth." Because at least King Edward was in favor of the Commonwealth. It was only for Commonwealth people for the first two or three years. Then we had a lot of requests from people from other countries wanting to come in. To cut a long story short, I continued running the course but I did it under the auspices of the International Hospital Federation which was based in the King's Fund. I continued to do as I had done before but it was publicized,

and still is publicized, as an IHF course. That has been going ever since. I haven't been personally directing that course now for about 10 years, I suppose. But I still take a great interest in it. That was one of the things I was very interested in.

Since I joined the IHF, I think one of the main interests -- one that led to a number of spin-offs -- is the subject of health care in big cities. One of the reasons for the interest in this is partly that I was working with King Edward's Hospital Fund for London so I was always interested in that and concerned with what was happening in London. But also, many of our IHF members live and work in big cities all over the world. Before I joined the IHF -- the year or two before -- I initiated a survey of health services in London. It was really aimed at finding out what the providers and consumers of health care in London thought about the state of London's health services. What were the main problems? What were the things they thought were going well? What changes would they like to see for the future?

This was in some ways rather like the Delphi approach. We circulated about 70 people in London, then we got their replies, then we re-circulated them. Then we produced a report on it. It was interesting that from the new survey in London the main problems that emerged were primary care in the big city, secondly care of the elderly, thirdly care of the mentally ill, and fourthly, the sheer complexity of planning a health service for a city of approaching seven million people. This identified for us what were some of the main problems in London.

Then, we were due to have a congress in Tokyo -- IHF Congress in Tokyo -- in 1977. So we tried to do a survey of other cities along similar lines. We had good contacts in many of them. There were about twelve cities that were

involved in that. There was London, New York, Sydney, Toronto and Paris. Then there was Hong Kong, Tokyo, Manila; and Bogota, Mexico City, Rio and Sao Paulo in Latin America. They were each asked to do a similar sort of survey in their cities, like to the one that we had done in London. It was really very interesting that whether it was a developed country or a developing one, the number one problem in all of those cities was primary care. Second was the sheer complexity of planning and managing a health service for a really big city. Then in the so-called developed countries, care of the elderly and care of the mentally ill were also very much to the fore.

So following on from the Tokyo congress, we have promoted activities particularly in the field of primary health care and also on care of the mentally ill. In this connection we have initiated a consortium of European cities of medium size, because apart from London and Paris there are not many European cities with more than a couple of million people.

Since 1978, we've had an annual meeting of representatives from the planning and management side of eleven European cities. Alphabetically they are Amsterdam, Barcelona, Bordeaux, Copenhagen, Dublin, Edinburgh, Lisbon, Lyon, Stockholm, Warsaw, Zagreb. They have an annual meeting to exchange information with each other about problems and progress in their cities. In between that they have quite a number of bilateral exchanges and projects amongst themselves.

As regards mental health, one of the things that struck us from virtually all of these cities was how gloomy were the reports about the state of mental health in the cities. They were always saying how bad things were. And saying very, very little about what was going well. Yet we knew from other sources, particularly in London, that there were in fact some very interesting

initiatives going on in the field of mental health. We thought we would start an exercise whereby people could start talking about what was going well in mental health rather than forever reacting to criticisms in the press and elsewhere.

We started this project in the middle of London in what is called the City and Hackney Health District, which is right in the heart of London. We knew people there, both in the health and social services and in the voluntary services,who were interested in mental health in one way or another. We started off by getting a small group of these, only about five or six, to talk about what they thought was going well in mental health in the district.

They were quite enthusiastic, first, about the projects that they knew about and secondly, that somebody was actually interested in finding out what was going well instead of looking for dirt under the carpet. That was followed by a bigger meeting where we had about thirty people from the mental health field in the heart of London who had been chosen by this initial core group, as we called it, of five people as being ones who would be interested in this project. In advance we had told them that, to begin with, each would have not more than three minutes to say something about the project or projects which they thought are worthwhile mentioning in mental health in this area.

It was really a very exciting meeting. They were so surprised to have somebody interested in what they thought they were doing well that they responded very readily. The other interesting thing about it was that half of them didn't know of the existence of the other half. So they were all doing their own little thing there. Apart from anything else, it did an immense amount just to improve the sheer networking of people in mental health in that

district.

So we had that meeting and then we appointed somebody to be what we called the information gatherer. Her job was to go around to these different projects and then write up the results in a standard format. They did that. The amount of money involved in this whole exercise was minimal. I think it was less than a thousand dollars. She then produced this report on good practices in the city of London. It really started from that. From that example, we went forward. We got a grant from an organization called the City Parochial Foundation which is a charity which is concerned exclusively in projects for the benefit of the poor in London. They were quite attracted by this. With that initial grant of 5,000 pounds, we were able to appoint a lady called Edith Morgan, who had been Deputy Director of the National Association for Mental Health in Britain. She came from the association to work full time on this project. She did quite a superb job on it.

We are now at the stage where over forty percent of the health districts in Britain have started these projects. There is now a big data bank of good practices in many aspects of mental health.

After the City Parochial Foundation had given us that initial grant, we got other grants. Some from the King's Fund, some from other trusts in England. Then after the second year of it -- it started in 1977 -- the Department of Health started giving us grants.

Anyhow, to cut a long story short again, it now has substantial funding. The Department of Health has given it over 300,000 pounds over recent years to keep the project going. From our point of view, we have been very pleased with it because it is now established in its own right as a charity in Britain and it's going forward under its own steam. Although the main emphasis has

been on good practices in Britain, we have in fact had similar studies in Vancouver, in Montreal, and in Christchurch in New Zealand, and in Geneva in Switzerland. We had one in Maine in the U.S.A. too, quite early on. We hope that this project will continue because undoubtedly those who take part in it find it a very useful exercise. And it leads on to other things like the whole network of mental health people in a district becoming much more involved in the planning of services for the district. And the consumers getting more involved.

That has been to me one of the most rewarding projects we have been involved in. That stemmed from the big cities project.

Then, apart from that and no less important in some ways was the grant we got from the Kellogg Foundation in 1981. We were encouraged to apply to them for it for a limited number of fellowships related to hospitals and primary health care and management training and health care in big cities. I mentioned earlier the report on hospitals and primary health care. This was due to the fellow appointed on the Kellogg money, a Filipino resident in the U.S.A. at the time called Rufino Macagra, a doctor. He devised a questionnaire to find out what hospitals are doing. He had very good support from our member hospital associations and also from WHO and its regional offices. he worked on this over a period of three years, part-time. Then he produced this report on hospitals and primary health care which we published. As a result of that, several of our hospital associations have initiated similar surveys in their own countries, recording what hospitals are doing to promote, support, or provide primary health care.

The Indian Hospital Association, for example, started off by doing a survey of every one of the sixty-five hospitals in Delhi. An interesting

feature of their study was that they appointed one postgraduate health administration student to every one of the sixty-five hospitals in Delhi as part of their training program. There are three schools of health administration in Delhi. So they had no difficulty in getting the sixty-five. Again, they produced a very interesting report on what the hospitals were doing. I think people were surprised, both in Macagra's report and in the Delhi one, that hospitals were doing more than many people expected in primary health care. But equally, it was clear that there was a great deal more that could be done. So we hope that this has started a movement to accelerate the work that hospitals are doing in primary health care. With the new Kellogg International Fellowship Program in Health, this is going to be the topic that some of the fellows will be concentrating on.

Last December I was invited by WHO to take part in what is called a WHO Expert Committee on the role of hospitals at the first referral level in support of primary care. It has now become acceptable to talk about hospitals having a role in primary health care rather than being an ivory tower above it.

WEEKS:

Could we go back a moment to the overseas course?

HARDIE:

Yes.

WEEKS:

Could you tell me something about the format?

HARDIE:

Yes. This started as a twelve week course. It's now ten weeks. Really, our basic philosophy about it is that the basic training for hospital and

health service management is much better given in the country or region where a person is going to work. At the time we started the course in 1961, there were very few training programs at all in developing countries. But we intended to go for the senior managers rather than the very junior ones. What we hoped was that they would improve their own standards of management and that they would also go back and start agitating to get something done about management training in their own countries.

To some extent that's still the philosophy, because in certain parts of the world -- notably Africa -- there's still a great need for developing indigenous training programs. More and more we are aiming for more and more senior people who can initiate further changes in their own countries.

They come over to London for ten weeks. They spend, now, half the time based in London and half at the University of Birmingham in the Health Services Management Center there. It's encouraging that they still find the course worthwhile, although we have adapted it enormously since the first one. We hope that they do go back and promote changes and certainly we try to keep track of them. Many of them now, obviously, have much more influential appointments than they did when they first came to us.

WEEKS:

These students, are they working in hospitals usually before they take the course?

HARDIE:

It's a mixture. I would say at least half of them are people of the level of directors of hospitals. But others would be people from ministries of health or regions. We also aim to have a mix of medical people and non-medical and also nurses. So it's a mixture of the three.

WEEKS:

They have an exchange of ideas among themselves then.

HARDIE:

Yes.

WEEKS:

This is quite an accomplishment.

HARDIE:

Well, it was great fun getting it started. We have had some very good people working on the course, the faculty that we take from different sources.

WEEKS:

I was wondering when you were speaking of Kellogg, is Bob DeVries your contact person?

HARDIE:

Yes.

WEEKS:

There are a few items on your CV about which I want to ask questions. For instance, I saw the British Hospitals Export Council mentioned. I'm not familiar with that.

HARDIE:

This again stems from my experience in Bahrain. When I was there one of my jobs was to help commission a brand new hospital there and to help arrange for the equipping of it. I got pretty disappointed with the performance of some of the British manufacturers who would send stuff out without any instructions about how to assemble it or maintain it and so on.

When I got back to England from Bahrain, I started making a bit of a fuss about how we were losing out to competitors from other countries which

provided much better services. I was in touch with the chairman of the management committee of the King's Fund, Lord McCorquodale who was a big name in business and also a member of the House of Lords. I talked with him on a number of occasions about it and I said I thought really there should be established something that we might call the British Hospitals Export Council which would try to do something to stimulate British manufacturers to do a better job overseas. He was quite interested in it. Again, this is one of the delights of working with the King's Fund. They were so flexible in their approach. I would say that King Edward might be turning in his grave to see the King's Fund for London getting involved in commerce overseas. But then they were able to rationalize it by saying they were sure he would approve, particularly if it is going to the Commonwealth.

Anyhow, Lord McCorquodale got in touch with the government Board of Trade. All of the wheels tend to move very slowly in such matters. By 1964, which was six years after I got back from Bahrain, it had got to the stage where sort of an official approval was given for the establishment of the British Hospitals Export Council (BHEC). The King's Fund let me be the unpaid secretary of it. We started off with a grant of what would have been about $500 at the time to meet the incidental secretarial expenses during the first year. So we started off on that little shoestring.

We then got companies to subscribe and it began to take off. By 1967, we had enough income to be able to hire somebody to be a full-time director of it. It went on from there. Of course, when I joined the IHF in 1975, I had to sever my connection. I had to become international. It's now an organization in its own right, and I think it has about 250 companies in Britain subscribing to it.

WEEKS:

And they have increased their...

HARDIE:

Oh, there's a lot more happening. I'm not saying that it's due entirely to BHEC, but it has helped.

WEEKS:

But they have set higher standards or improved their procedures?

HARDIE:

Yes. And there's a very big business now in exports of hospital and medical equipment. And also of expertise. It wasn't just equipment. It was the skills of architects and engineers as well.

WEEKS:

I was impressed in your IHF annual publication with the ads. Many of the companies I was not familiar with, but I was very impressed with the quality of the work of the publishing. I know now that there are many companies that I had no idea existed. I can see where this would be a very important thing to Britain.

HARDIE:

Yes. And of course if you look through the ads there only a relatively small percentage would be British firms. They are truly international. I think the publishers have done a very good job. They specialize, in fact, in producing yearbooks like this for different organizations. I think they must produce now about twenty or twenty-five. They do one for the Royal College of General Practitioners, and one for the National Association of Hospital Supplies Officers. They've really got a very high-powered team of people engaged on this. Something that we couldn't possibly envisage doing

ourselves.

WEEKS:

No. It's a tremendous undertaking, especially if you weren't geared up for it.

I have also listed the National Association of Leagues of Hospital Friends. Is this a volunteer association?

HARDIE:

Yes. Most hospitals in Britain have a League of Hospital Friends, which I suppose is like your candystripers and that sort of thing. The people who run the hospital shops and so on.

I was invited to come on the council or committee of some of these organizations, not really because of any merits of my own but because I was working on the staff of the King's Fund and they all knew that the King's Fund was a honey pot and it would do them no harm to have somebody from the King's Fund on their committee. I enjoyed it. There were several organizations like that.

WEEKS:

I was wondering what volunteer groups, what benefit they get out of combining? The exchange of ideas?

HARDIE:

Oh, yes. In the National Association of Leagues of Hospital Friends it was mainly concerned with exchanging information amongst themselves about new activities and new ways of raising money and new ways of using volunteers. They serve quite a useful function.

WEEKS:

You have spoken about the mental health activities. Is there something

more you might want to say about MIND?

HARDIE:

Yes. That was another organization which initially I was asked to join I am sure because of my links with the King's Fund. In fact, I have been on the on the council of MIND now for over fifteen years. I've enjoyed that. That's again a voluntary organization concerned with mental health. They have had some very fine people working for them. They've done a lot to promote improvements in mental health. In many ways they have particularly represented the consumer. They have had a lot to do with promoting the legislation that is about mental health in Britain which has done so much in many ways to make life easier for mental health patients and to promote improvements in the planning and management of mental health services. That's been very interesting. It was through that, of course, that I got in touch with Edith Morgan on the good practices in mental health project.

WEEKS:

They tied in well together.

One name that intrigues me is Salters' Company.

HARDIE:

This is one of the city livery companies in London. These are these ancient guilds really that go back to the 1200 or 1300s. It started off with the various crafts who were engaged like the goldsmiths and the vintners. The salters were concerned with the salting of meat and fish. That was their background. Now, of course, there isn't a great need of salters. They have paid particular attention in recent years to industrial chemistry, which is a fairly logical development from salters. They still have a lot of the old traditions. They do have some voluntary funds, as it were, income that they

can use for promoting projects. They've done a great deal to try and promote interest in schools in industrial chemistry. Also they have provided quite a number of scholarships and fellowships for graduates to do postgraduate work in that field. It's an interesting organization. I was on what they call the Court of the Salters, which is really the council of it, for about ten years. Then soon after I joined the IHF I just had to resign from that because I was abroad so much that I really couldn't do it properly. I still attend some of their functions. They are great fun. They are a very interesting group of people. About half of them would be associated with the chemical industry and about half would be there because their ancestors -- my father-in-law had been a salter and his father had been a salter so I came in. I'm not an industrial chemist.

WEEKS:

You came in...

HARDIE:

...through the back door.

WEEKS:

We have talked a little about the care of the elderly. This brings up the National Corporation for the Care of Old People. We both know that this is going to be a growing problem. What does this National Corporation do?

HARDIE:

This again is another voluntary organization which I was invited to join because of my links to the the King's Fund. They have now changed their name, and it is now called the Centre for Policy on Aging. I can't remember exactly what it is now. They have been concerned specifically, really, with research into the problems of the organization and delivery of care for the elderly.

Their funding comes quite largely through the Nuffield Foundation rather than through the King's Fund, although they have had some grants from them. They have a nice system. They have an advisory committee which is concerned with how to dispense the money they have. You can only serve on that for four years. So there is a good turnover. I think in many ways I learned much more from them than they got from me. Because they were a very interesting group of people on that advisory committee representing the medical profession, social work, nursing and a whole range of people. It was a very, very interesting experience.

WEEKS:

It's a problem that isn't going to go away.

HARDIE:

What I would like to mention, that was also on the list, is the Spinal Injuries Association. That was one where I got involved in a different way in that they wanted to form a spinal injuries association and they applied to the Fund for some money. I was involved in the processing of that application and getting it through. It's a very worthwhile organization.

It is basically an organization of people who have been spinally injured, who are either paraplegic or quadriplegic. They are a very interesting group of people because so many of them are injured because of their extrovert, adventurous nature. Many were horsemen or horsewomen; others were swimmers or divers or this, that or the other, who got badly injured in the course of doing what they wanted to do. So you have some very lively, bright people there. It's quite astonishing how many of them have come to terms with their disability and how they have really made something of their lives.

What they wanted to do was to form an association amongst themselves to

help promote their own interests and to help each other. One of their prime functions is to prepare and circulate a newsletter to all of their members. This newsletter consists almost entirely of articles and short reports by spinally injured people and about how they have been able to overcome their difficulties. Whether it's to do with incontinence or mobility or sexual problems. It is really quite fascinating. Once they've been stabilized medically after of their injury, they really get far more help from each other than they do from the doctors or the nurses. Because it's a question of actually living. There is not a great deal more that the medical profession can do. It's interesting that the medical advisor is very much of an advisor to the patients. Of course the doctors learn a great deal from what they do. They are really a very powerful organization in their own terms.

Interestingly enough, they also have a powerful lobby in Parliament, because there are at least four members of the House of Lords who are spinally disabled. One, Sue Masham, who injured herself horse riding, is the president of the Spinal Injuries Association. She is continually fighting in the House of Lords from a wheelchair, not only for the spinal injured, but for the disabled generally. I have a great admiration for her and for all of the people who are concerned in that field. They are a very good example of how people can help themselves.

Then at the other end of the spectrum there's another organization that I was involved in helping get formed called the Association to Combat Huntington's Chorea. You probably know that this is an absolutely devastating illness that doesn't manifest itself usually until middle age. If you were married, as a person with Huntington's chorea, there is a fifty percent chance that your children will develop it. But only a fifty percent chance. It is

something that manifests itself in ways that are so socially very unpleasant and unacceptable.

When you compare that association with the Spinal Injuries Association, it is really tragic to see how one group can really fight for themselves and really make great strides and the other represent a very depressed group and ones who by the nature of their illness can't hold down a good job. Many of them are very close or below the poverty line.

Again, they are doing quite a lot now through their own newsletter to help themselves. They need much more support than the spinally injured who can look after themselves.

WEEKS:

I can see where that would be an unusual group.

I also have a note on the Volunteer Centre.

HARDIE:

Yes. This stemmed from the initiative originally of a lady called Geraldine Aves who had been chief social worker of the Department of Health and Social Security. She was appointed chairman of a committee that was set up to look at the contribution of voluntary services in the health and social services. It's so typical -- I can't remember the exact name of the committee now because it was always known as the Aves committee. One of the recommendations that came out of that report was that there should be set up a national volunteer body to promote the interests across the whole field, not just the health services, of voluntary support. Again, because I was involved with the King's Fund, I was invited to join a small group of five people who were given the remit really to set about the establishment of this new body. Over a period of about eighteen months, I suppose, we met periodically to

formulate plans for this. It all resulted in the establishment of the Volunteer Centre. Again, I was on the council of that for about five or six years after its establishment. And again, it's now pretty well established with a staff of about thirty people. It promotes discussion and debate. It provides information on different aspects of volunteering. And it produces quite a number of publications. It gets public support for particular activities. It's certainly still active in the health and social services. It's also active in probation work and in promoting volunteering in schools and so on. It acts as something of a national focus for voluntary activities.

WEEKS:

We did mention WHO. Is there anything else you would like to say about WHO?

HARDIE:

No. Except to say that we do have good relationships with them. They take part in our conferences and present papers, and we get involved in activities that are relevant to us like management training, and health care in big cities and hospitals and primary health care. So we have a good relationship with them. But we don't get any money from them. They are really quite limited in their funding.

WEEKS:

Could we talk a few minutes about the National Health Service before 1946? And the changes that have taken place. The latest change was in 1982?

HARDIE:

Well there have been a lot of changes. There's now the district general management concept which has been implemented over this past couple of years or so.

WEEKS:

Could you begin giving us a picture -- many Americans don't have a very good picture of the National Health Service.

HARDIE:

Before the National Health Service -- and remember I didn't join until a year after the start of the health service -- before the National Health Service and before the war, the health services in Britain were divided. There was the general practitioners' service, the financing of which stemmed from the 1911 act of Lloyd George which introduced the panel insurance system. Then you had the private hospitals, they were nearly all voluntary hospitals rather than for-profit hospitals. Then you had the municipal hospitals which were public hospitals, developments from the poor law hospitals, covering both mental health and public health.

During the war all of the voluntary hospitals, of course, got themselves into deep financial straits because of the war. During the war plans were made for the reformation, as it were, of the whole health system. It's interesting that the Beveridge report in 1942, right in the middle of the war, and also the negotiations about the start of the health service, started long before the end of the war. It's always a nice thought that even in those dark days people were assuming that the war was going to end and that we were going to be victorious and we could do what we liked. That was a nice touch I thought.

By the end of the war it was quite clear that the voluntary hospitals were in no position to revive themselves financially without support from the government. There were negotiations between the medical profession and the government and the nurses and also the former health authorities. It is

always a moot point what would have happened if it had been a conservative government that got in at the end of the war rather than a labor one. But I think most people felt that whichever got in there would have been something quite similar to the National Health Service (NHS). There had really been multi-party discussions within the government because it was a coalition during the war. So the final shape that it took, I suppose, was largely determined by Aneurin Bevan, the colorful Welshman who was the Minister of Health.

It was accepted by the medical profession at the time largely because they realized that the financial situation was such that this was really the only way to get it going. So that's how it started immediately after the war. All of the hospitals were in effect naionalized. There were a handful that stayed outside the NHS. Some of the religious ones, for example.

WEEKS:

What happened in the nationalization process? Were these people paid or did they take over their debts?

HARDIE:

Yes. The debts were more or less wiped out. For the ones that were the local authority hospitals, of course, it just meant a transfer from local government money to the national government money. The pattern that was established then was the regional breakup of England into first thirteen, then fourteen regions, plus Wales and Scotland and Northern Ireland. So you had those regions. Then, beneath that you still had local authority involvement in public health services, although not the hospitals.

The hospitals were all taken over by the government and became organized under hospital management committees, each of which served a population of

about 100,000 people, perhaps rather less, in defined geographical districts. So that was the basis of it. You still had your general practitioners who now became paid by the state on a capitation basis. You had your hospital doctors who were employed by the regions and the hospital management committees, and they were paid on a salary basis. Then you had the public health services that were still organized by local government. That's how it operated for many years until the 1974 reorganization. So that was nearly thirty years of that system.

There was pressure then, not to change the structure of the National Health Service in the sense of the way the patient went about getting treatment, but to change the organization and to bring closer together the three branches, the family doctors, the public health system, and the management committees. The aim of the 1974 reorganization was to bring these all together under area health authorities, which were under the regions and then in districts below the areas. So you would have the situation of say, five or six districts reporting to one area, and there were about 200 districts altogether in the country. Then there were about 90 areas and still the fourteen or fifteen regions.

That system crept along for several years. It was an improvement in some ways, but it was a very cumbersome administrative structure. So then, before many years were out, there was further discussion about eliminating one of the tiers and in the event it was the areas that went. Now you have the system whereby you have the fourteen regions and nearly 200 districts in Britain. But still the general practitioners, although they relate to the area of a district, they still have their own family practitioner committees (FPCs). So they are still a little bit independent.

WEEKS:

The family practitioner committee has direct access to the Department of HSS don't they?

HARDIE:

In a sense. Though there are FPCs for every district. Then there is a national negotiating body for it. That was the pattern of the new districts and FPCs. But at that stage, both in 1974 and later, there was great emphasis on the consensus management or district team of officers. With the new government that came in, the Thatcher government, they wanted to move away from that and to have one person appointed as the district general manager with a team supporting him. That is what has been the latest reorganization within the health service. That has been implemented over the past couple of years.

WEEKS:

If we can go back a bit -- the health service is free for all citizens, right?

HARDIE:

Yes. It is free consultation with the doctors, both with the general practitioners and the hospital doctors.

WEEKS:

He's sort of the gatekeeper?

HARDIE:

Yes, the GP is the gatekeeper. You can only get to a hospital consultant through the general practitioner.

WEEKS:

Am I correct in saying that there is a determined number of consultants?

HARDIE:

Yes. Each region has the responsibility for deciding how many consultants there should be in each specialty for all the hospitals in its region.

WEEKS:

From the educational standpoint, what is the difference in educational requirements for becoming a general practitioner and for becoming, finally, a consultant?

HARDIE:

It is the same basic medical education up to the stage of qualification for all doctors. Then when you've qualified, as over here, you have to do a year or two of rotation in hospitals and so on. If you then decide you want to become a general practitioner, then you get yourself attached to a general practice as a trainee. Increasingly, you are expected to do some vocational training in general practice over a period of three years or so. Many GPs now sit for the qualification of the Royal College of General Practitioners. But it is not compulsory. You don't have to take that, but most GPs, or an increasing number of GPs, aim to take that qualification.

If you want to specialize as a hospital doctor then you stay in the hospital circuit, if you are accepted on it, as a registrar for a couple of years. Then as a senior registrar for four years minimum. In that four years as senior registrar, you are really training to be a specialist in your chosen field. Then, depending upon the vacancies that arise through retirement or death, you can apply for a consultant post as it becomes advertised. So that's the route to becoming a consultant. There are relatively few who become consultant immediately at the end of their four year spell of training.

And depending on the specialty you may have to wait quite a while.

WEEKS:

I saw a reference to some thirty-six specialties?

HARDIE:

Something like that.

WEEKS:

In this country we have so many specialties and sub-specialties that it gets to a point where it is very confusing. Yours is more definitely defined.

HARDIE:

Yes. You would have this limited number that would be listed, but of course once you've got your consultant post, or even before it, you may have a particular subspecialty that you follow.

WEEKS:

Is there a great deal of difference in the income of a consultant and a GP? I realize the GP is working on a capitation basis.

HARDIE:

I think you could put it this way, a top consultant who is also earning one of these so-called merit awards is certainly much better paid than the average GP. On the other hand, if you take the lifetime earnings the difference is not so great between the average GP and the average consultant, because the GP starts earning near the top of his salary quite soon after he becomes a partner in a practice. Whereas a hospital specialist may have to wait ten years or so from the time he starts specializing until the time he becomes a specialist.

WEEKS:

But he does have these special awards?

HARDIE:

They have these merit awards. The general practitioners have set their faces against having merit awards. They had the opportunity to do it if they wished, but they declined to do so. But the specialists do have them and it does mean that there are quite a number of specialists -- about 15% perhaps -- who have the top so-called "A" award. And then there's "B" and "C." In addition, of course, if they choose they can have private practice as well.

WEEKS:

As you know, in the States there is really no restriction on what specialty you go into or how many, as long as there is a post where you can serve your residency. It seems a more sensible way to handle manpower and talent to have some assignment plan. How about the location of a general practitioner? Can he locate where he chooses to?

HARDIE:

Well, the position is this. So far as general practitioners are concerned the country is really divided into three categories. There is the top category, if you can put it that way, where if anything there is a surplus of GPs in relation to the estimated needs of the population. At the other end of the scale there are areas of the country where there is a shortage of GPS. And in between there is a very broad band where the balance is about right. If you take the top category where it's oversupplied, if a GP retires or dies in one of those regions, he cannot be replaced. There is a hold until the balance gets down. For the GPs in the other districts, the ones at the bottom of the pile, there are some financial incentives to encourage GPs to go and work in the underserved areas. This may include some of the more remote rural areas, although increasingly I think people are attracted to that sort of job.

The big problem is in the less pleasant parts of the inner city areas of some of the big cities. That's where the real problems are.

WEEKS:

You have the same problems we have then. Only we have no means of directing people to those rural areas or the inner cities.

HARDIE:

I think the general practice system in Britain has many good features. I think most of the GPs are of good quality. My chief criticism of the system is that it is very much a sickness system, not a health system. You go to the GP if you are sick. They are not so much involved in the promotion of health or prevention of illness. One of my particular hobby horses now is what one tends to call the patchwork approach to health care, on which I think we can learn quite a lot from the developing world.

If you take the average general practitioner in the urban areas, he'll have an average size list of about 2,000 patients. But he can take those 2,000 patients from anywhere within a catchment population of about 50,000 people. What it means is that you will have a situation, say, of a block of apartments in one of the poorer parts of London where there may be 1,500 people living and you can find as many as a dozen different general practitioners having patients in that apartment block. No one of the GPs really has a clear idea of what the overall health needs are of that segment of the population. Whereas, if you take places like Mexico City or Manila, they have this system of really dividing the population up into units of about 300 or 500 families -- say 1,500 to 3,000 people -- then recruiting people locally from that population as community health workers, who are really in a sense the primary gatekeepers. They know every family in their patch, as it's

called. They have a map in their office of every household, and they know where the pregnant ones are, where the old people are, the mentally ill and so on. They really provide a very good basis for an effective health care system.

Amongst the activities that we now have, which I haven't mentioned before, is the special study visits we have in different countries as opposed to the major study tours where we go and look at a particular country's health system in greater depth.

I well remember back in 1981, we had one of these study visits in Mexico City. It was the first time we had been there. There were twenty-five to thirty people on that. We were looking particularly at how Mexico City was approaching this problem of urban health care. We went to places where they had these little health posts with these community health workers. They had their maps and they knew exactly what the health situation was.

One of the visitors was a district medical officer from St. Thomas Hospital in London, which is in one of the more deprived districts of London. He, like myself, was very enthusiastic about what he had seen there. Since then he has been beavering away trying to get something of a patch system started in that part of London.

Then only last year, we had a similar visit in Costa Rica. They were really amongst the pioneers of the patch approach. They started it about ten or twelve years ago. Their infant mortality is the lowest in Latin America. It's better than it is in some cities in the U.S.A. and some cities in Britain and Europe. I won't say it's entirely attributable to the patchwork approach, but it's certainly been influenced by it.

We had somebody else from London from another deprived district of London

on that. She's gone back no less enthusiastic about trying to get things changed in London. To me this is one of the most satisfying aspects of our work. We tend to think that we have lessons to teach the developing world. In our big cities, I think, in Europe and North America we have a lot to learn from the way they are doing things there.

WEEKS:

Do you think that the British and the Americans are thinking too much of freedom of choice in physicians?

HARDIE:

Yes. In Britain, I think the GPs hold greatly to the idea of the sanctity of freedom of choice. I can understand that. But in our context this doesn't mean that if you develop patchworks that you've got to have restricted choice. Because if you take a group of five doctors serving 12,000 people, you can have a choice between those five. In fact, that's exactly what happens in our small towns and villages in England. You have a restricted number of GPs working there, and you have a natural patchwork. It's the difficulty of applying this to the cities where the need is greatest.

I'm interested now that increasingly the cities in the developing world are doing this, and in the Communist countries of course -- Cuba and China and Eastern Europe -- it's standard practice.

WEEKS:

This is an aside. In your travels you must run into Milton Roemer quite often.

HARDIE:

Yes, I have come across him from time to time.

WEEKS:

I interviewed him. He's a very interesting person.

When I was in Britain the last time they were talking about the health centers they were going to build. Has this movement flowered at all?

HARDIE:

Let me put it this way. Increasingly general practitioners work in groups. Now some of them may work from a health center. Some may work from group practice premises. There is something of a distinction between the two because the health center usually has attached to it a range of services -- promotion of health, public health. Group practices tend to be just groups of general practitioners.

I think now the figures are something like 17% of general practitioners work from health centers. There's certainly a dwindling number who work in solo, single-handed practice. More and more work in group practices. The big problems are still in the inner city areas where there are a lot of doctors, single-handed general practitioners. Another problem is that there is no retiring age for general practitioners. You have quite a number of the inner-city doctors in London and elsewhere, single-handed doctors aged seventy-five and over. One is sometimes a little bit dubious about the quality of the clinical care.

WEEKS:

Just their physical ability to keep going might be something.

You did mention the capitation and the 2,200 or 2,500 average. The general practitioner also is paid fees for vaccination and that sort of thing too, isn't he?

HARDIE:

Yes. The basic capitation fee is -- I don't know what the average percentage of total salary is, but it may be as low as a half for some of them. Because they can do other work. They can take sessions at hospitals if they are particularly interested in a particular specialty. There is one personal friend of mine, for example, a general practitioner, who has two sessions a week in the radiology department of the local hospital. Others will do immunization, vaccination and all of that sort of thing. There are various ways of supplementing their basic income.

WEEKS:

How prevalent is the private patient?

HARDIE:

In general practice, I would say not many GPs have private patients. Though there are some in London who do have private practice and some of those are entirely in private practice. But by-and-large, relatively few general practitioners have private practice.

With hospital consultants, on the other hand, it is more widespread. Doctors working in hospitals have a choice of working either full-time for a hospital in which they can have no private practice. Or they can work part-time for the hospital and have part-time private practice. What it means in practical terms is that notionally the hospital doctor's working week is divided into twelve. He can contract with the hospital to work for twelve twelfths, full time, or he can contract to work seven, eight, or nine twelfths. That means that he can do private practice in his time away from the hospital.

WEEKS:

Does this apply only to consultants?

HARDIE:

Only the consultant.

WEEKS:

The other medical officers...

HARDIE:

They are full time, on salary.

WEEKS:

In the health centers, they may be equipped differently from what an office would be. Is there some subsidy?

HARDIE:

Yes. There are various allowances for setting up practice. Then the GP gets an allowance if he employs a nurse or receptionist. Also there is some subsidy for equipment.

WEEKS:

It's a very complicated system I assume, from what I've read.

HARDIE:

Well, it's complicated to the outsider. I guess if you're a GP it probably takes you only about two days to know all of the angles and the various sources of finance. They are pretty adept now at knowing how to organize their lives and their staff and equipment.

WEEKS:

The financing of this is mostly from general taxes?

HARDIE:

Yes. I think it's about seventy-five percent from general taxes. Then

their patients make a small contribution through payment for prescriptions and so on.

WEEKS:

Was this revoked at one time?

HARDIE:

It has been. It's a political football. When a Labour government comes in they either reduce or abolish the prescription charges, whereas when the Conservative government comes in, they put it up. There are a lot of exemptions. I think that about half the patients are exempt from prescription charges either because they have children, or are pregnant mothers, or because they are over retiring age.

WEEKS:

Then some of them pay a small co-payment for prescriptions or eyeglasses?

HARDIE:

Yes. They pay so much for prescriptions and spectacles. They pay on a fee-for-service basis for dentistry.

WEEKS:

Isn't there some special dental work for children?

HARDIE:

They will get it free as children. I'm afraid that the emphasis in dentistry is still very much on filling and extracting, rather than on preventive dentistry, which is a great pity.

WEEKS:

This is true in this country too. It's changing, but it has been true in this country.

The gifts to the health service have decreased in years, haven't they?

HARDIE:

Yes. Although the League of Hospital Friends generate quite a bit of money. And you'll often get special appeals for funds, say for a CAT scanner or renal dialysis equipment. But people are pretty careful about that, because the health authorities are reluctant to accept a gift of a CAT scanner or other such equipment unless there is money to pay for its staffing and maintenance.

WEEKS:

That's an interesting point too. Where are the decisions made on the type of equipment that can be bought such as CAT scanners or other expensive equipment?

HARDIE:

The really expensive equipment is decided regionally. In other words, if a district hospital wants a CAT scanner or MRI or something like that it can't just go ahead and buy it. It's got to be cleared with the regional authority. They decide at that level, in consultation with the districts, where this equipment is to located.

WEEKS:

Do they transfer patients if necessary by ambulance or whatever?

HARDIE:

Yes. The pattern is that they have some specialties at the district level. Then they have so-called super specialties which would be, for example, one burns unit serving so many districts. That sort of pattern.

One interesting sidelight about the prescription charges of which we were talking. Virtually ever since I started this course for overseas people in 1961, at the beginning of the course I have given them a talk about what I

call patient's progress. It's how a patient gets into the health care system, what route he follows. I remember thinking when the 1974 reorganization took place, "Oh, crumbs! I'll have to rewrite this talk with the reorganization." Then when I got down to it, the only thing I had to alter in the whole talk was how the patient paid for his prescriptions. Then with all the subsequent reorganizations, going from area to districts only, and then district general management, the only thing I've had to alter is the prescription charges -- as far as the patient is concerned. There has been virtually no change in his access to the health care system.

WEEKS:

I have read somewhere that in a survey made it shows that about 95% of the patients are quite well satisfied. Would that be fair?

HARDIE:

Yes. I am not sure whether it's quite as high as that -- but it's certainly a very high proportion who express themselves satisfied with the general practitioner's service. Again, it tends to dwindle in the inner city areas. But in the small towns and villages people are very well satisfied with it. They're generally pretty well satisfied with the service they get in general hospitals, except they are not happy with the waiting times for certain disabilities, particularly with things like hip replacements and varicose veins. There is a lot of leeway for improvement in shortening those waiting lists.

WEEKS:

I have often read the statement that although there is waiting for elective surgery or elective treatment, there is no waiting for a true emergency.

HARDIE:

I would say that is perfectly true. If you fall down with a heart attack on the street or have a motor accident, you go straight to the nearest appropriate hospital without any question. There is no question of payment or anything like that, of course.

WEEKS:

You were talking about the three different categories or the three different territorial concentrations of GPs. Let's assume we are in the proper concentration. Can a GP sell his practice?

HARDIE:

No. Not now, because it's part of the system. Although I think I might have to qualify that. If there's still some GPs working who were at the start of the health service -- there couldn't be very many now except possibly some of the very old ones -- if they had their own practice and they bought it before the start of the NHS, when it comes to retirement they can sell that. But they wouldn't really sell it to another GP, they would sell it to the system.

WEEKS:

That's a reasonable answer.

Somewhere I read that one of the methods used to initiate the National Health Service was by favoring the consultants over the GPs, dividing the doctors. Is there any truth to that?

HARDIE:

Yes. I think there is. Because there is no doubt that the consultants came into the health service on much better terms than the general practitioners. This again was due to Aneurin Bevan. He realized that he

would never get the health service off the ground if he didn't have the consultants playing a full part in it. There was a famous remark that he made, which I'm sure you've heard, that he "stuffed their mouths with gold." In a sense this is true. The consultants came into the health service on much better terms financially than the general practitioners. For the first fifteen to twenty years of the health service, general practice was a very much subdued, or submerged branch of medicine. Although there were many general practitioners doing a very good job, the number of students leaving medical school who wanted to go into general practice was relatively low. There was difficulty in getting enough doctors. Of course at that time, the option was open for doctors to go abroad if they wished and to work in the U.S.A. or Canada or Australia. This really meant that we had a very uncomfortable time in general practice in particular in those days.

Then there was what became known as the Doctors' Charter in 1965. This was really a radical restructuring of the financing and so on of general practice. Since then there has been a very sharp turnaround. Now, I think at least half of the students graduating opt for general practice as their first choice of career, which is a complete turnaround from what it was in the days of the 1950s and early 1960s. So now there is no shortage of good people wanting to go into general practice.

WEEKS:

There is no longer danger of the so-called brain drain?

HARDIE:

Not so much now because there are not many places that they can drain away to, you see. So many countries are now oversupplied with doctors. That's putting severe restrictions on people going overseas.

WEEKS:

What has been the role of the British Medical Association in this?

HARDIE:

They have been staunch defenders of the position of the doctors. I remember hearing one minister of health over a lunch table once saying that "All I ever talk to the BMA about is money." That may be a bit unfair, but he said it. So much of it is taken up with negotiations about salaries and payments.

WEEKS:

They really represent the GPs then?

HARDIE:

They represent the GPs and the hospital doctors. They have different sections.

WEEKS:

But they are active representatives?

HARDIE:

Oh, very active indeed. As in most countries I think.

WEEKS:

I have a figure of about 2,700 hospitals.

HARDIE:

That would be about it, yes.

WEEKS:

And 450,000 beds?

HARDIE:

That's about it, yes. If anything it's dwindling.

WEEKS:

Has your length-of-stay been dropping?

HARDIE:

Yes. Both acute and mental.

WEEKS:

When you were speaking of the mental -- just to insert this -- I can remember speaking to a Kellogg fellow, a physician who had been in this country and I had been referred to him when I came to see something of the health service. We were talking about the relative merits of the two systems, the British and the American systems, particularly in specialties. He said he felt that Britain had two specialties in which they were better qualified, or did a better job let's say, than in America. One was psychiatry and the other was neurosurgery.

HARDIE:

I'm not really well qualified to talk about neurosurgery, except I know there are some absolutely first class neurosurgeons in Britain. On psychiatry, yes. I think it's probably true. I think one of the reasons is the nature of the health service in Britain. It is a national health service, people don't have to pay to get psychiatric treatment. And you do have a number of very dedicated psychiatrists, as well as very qualified ones, who because of their freedom from financial worries about the treatment of the patient can be very innovative and develop community activities. Also, for example, making use of community nurses, psychiatric nurses, in situations where it would be more difficult, say, for a psychiatrist who is working on a fee-for-service basis to release some of his time, as it were, to a psychiatric nurse. I think because they are free of that sort of constraint,

there are some very, very interesting psychiatric developments in Britain in the organization and delivery of health care. And great involvement of the nursing profession and also of volunteers.

But having said that, there are still big problems. Particularly for the long stay psychiatric patient for whom there is very little prospect of really being able to live a reasonable life in the community.

WEEKS:

We make the mistake of releasing a great number of these with sedatives thinking that they can adjust to living in the community again and it hasn't worked out very well in many cases.

I interviewed Dr. Frist of the Hospital Corporation of America. He was telling me about their hospitals in Britain. How are these for-profit hospitals doing, particularly Americans coming over?

HARDIE:

There is a market for them. There is no doubt about that. Partly for British people, but also for people from outside, particularly the Middle East, who can pay for it. At the moment, if you take the private insurance schemes in Britain, they provide cover for six to seven percent of the whole population. It is a very small percentage. Certainly, the private for-profit hospitals are taking some share of that. I don't necessarily see it expanding very rapidly even though the present government is giving some encouragement to it. I know that some of the insurance schemes are now beginning to have difficulties in that they are having to put the premiums up so high to meet the current costs of private treatment that there's not a rapid increase in the number of people taking up that sort of insurance. Except possibly through group insurance schemes, with some companies, and so on.

WEEKS:

The Hospital Corporation of America hospitals are not large are they?

HARDIE:

No. With the private hospitals in Britain, by and large, there are pretty few with over 100 beds.

WEEKS:

This is the impression I got. But they seem to think there is still part of the market they haven't covered yet.

HARDIE:

I think that may be true, but I don't think there's an enormous market in Britain for it.

WEEKS:

Somewhere I've read that the private medical care is about five percent of the total.

HARDIE:

Possibly six percent.

WEEKS:

But you have managed to have the National Health Service at a much lower rate of the GNP than we have and we don't have the coverage that you have. I think we have to convince our doctors possibly.

HARDIE:

I think we are underfunded at the moment. I think we should be spending a higher percentage of GNP because we do have problem areas, and some very antiquated hospitals. Certainly in some of the long stay institutions I think we could do with better staffing and better facilities. But by and large I think we do give good coverage. Sometimes I look at it by saying that you can

measure the quality of a country's overall health system by the standard of care it provides for the bottom twenty percent of the population. I think in that respect we probably compare pretty favorably with most countries.

WEEKS:

I wanted to ask you if you define teaching hospitals differently from what we do in the states?

HARDIE:

To us in Britain, a teaching hospital is one that is concerned, with the teaching of medical students to become doctors. If you have a hospital that teaches nurses but doesn't teach undergraduate medical students, then that wouldn't be called a teaching hospital. We do have some postgraduate teaching hospitals, specialty hospitals like eye and orthopedic. But there must be an undergraduate medical curriculum.

WEEKS:

I read there were about 36 of those teaching hospitals?

HARDIE:

Yes. And about a dozen of those are in London.

WEEKS:

So there is a slight difference.

A few years ago -- would it be under the 1974 reorganization -- there was to be a district general hospital, a large hospital?

HARDIE:

Yes. That was part of the plan for the 1974 reorganization, that within each district there would be one hospital recognized as being the main district general hospital for that district. In some cases where there was a teaching hospital, that would also be the district hospital for the district.

It's complicated in London because of the number of teaching hospitals. But outside London that tends to be the way it works.

WEEKS:

I was wondering about the referral process. For instance, a patient goes to the GP and the GP refers that patient to -- is it the nearest hospital?

HARDIE:

It depends on the problem and on the specialty for which he needs treatment. Technically the GP can refer his patient to any hospital he likes. By-and-large he will refer him to the nearest hospital that has the specialty for which he needs advice.

WEEKS:

If he is not certain, they would do the screening?

HARDIE:

That's right. He would go as an outpatient first of all to the district hospital.

WEEKS:

Then if that particular hospital was not offering the service that was needed...

HARDIE:

He could refer to another hospital. Particularly say in the case of the super specialties.

WEEKS:

Are patients still given rides to the hospital if they need a ride?

HARDIE:

Yes, if they need to be taken by ambulance they are taken by ambulance.

WEEKS:

I can remember seeing people sitting up in an ambulance like they were riding in a bus.

HARDIE:

Yes. They have those as well. That's a mixed blessing, because with some of the distances that they have to go they have found that the ride to the hospital is doing them more harm than is being done good to them by the treatment that they receive when they get there and they are quite exhausted by the time they get back. But that is exceptional.

WEEKS:

That service and the ambulance proper service are part of the local...

HARDIE:

It's part of the National Health Service. The ambulances are organized really on a district basis.

WEEKS:

Somewhere I read that about 60% of the total National Health Service expense is in hospital care.

HARDIE:

That's about it.

WEEKS:

What is the National Health Service doing about shortening the length of stay?

HARDIE:

Well, particularly nowadays with the cost restrictions on the hospitals there is obviously a great incentive not to keep patients in hospitals too long. Although some would argue that that's a two edged weapon because if you

have a person in for acute surgery and you discharge him in five days instead of six it means that the next patient coming in is also high cost for those first few days. In one sense it doesn't overall reduce your costs.

But there is certainly the incentive to reduce the length of stay.

WEEKS:

As you know, we are having difficulties with our DRGs. In thinking of DRGs and thinking of my meeting with Dr. Affeldt — is there anything like the Joint Commission, PROs or anything?

HARDIE:

Not at the present time in Britain. There are certainly some people who are very interested in quality assurance and in their own way are doing something about it. But there is nothing approaching the accreditation system that you have here or in Canada. In fact, there are really relatively few countries that do have this. I've been involved in the past few years with the Joint Commission and the Kellogg Foundation in helping to organize international seminars on quality assurance. Really there's only a handful of countries in the world that have anything approaching the accreditation system that you have in the U.S.A.

I think one of the faults of our health service is that we have been a bit too complacent about quality assurance. Hospital consultants, once they are appointed, hitherto have been answerable virtually to no one except themselves and their peers. The business of being in a sense answerable to their peers does have some effect in maintaining standards. But we certainly don't have the system that you have of people having privileges to hospitals that would be withdrawn.

WEEKS:

I remember there were pay beds in the National Health Service hospitals. Sometimes they were private rooms and sometimes they were...

HARDIE:

Amenity beds, yes.

WEEKS:

The general patients stayed in the open wards unless -- are the new hospitals built with open wards?

HARDIE:

Not many with the real open wards, twelve beds down each side and so on. But there are very, very few double rooms. I know that in the U.S.A. it is very common to have double rooms. That's virtually unknown in Britain. We have quite a lot of the four bed bays and the six bed bays. Then you always have a proportion of single rooms, say about fifteen to twenty percent for those who need them on medical grounds.

It is quite interesting, this difference between the nations. If you take St. Thomas Hospital in London, where the Florence Nightingale ward had its origin, and then recently they have had two big new ward blocks built, one has basically four bed bays with single rooms and the other has six bed bays with single rooms. About three years ago, they carried out an evaluation of the patients and the staff in the three different types of ward in the same hospital. They had the old traditional Nightingale ward and the other two. This was done really quite scientifically and rigorously. It was very interesting that when the results of that were published the preference was for the old traditional Nightingale ward.

WEEKS:

Is that right?

HARDIE:

Now this may be something to do with the patients from that particular part of London, but certainly the staff preferred the old ward because the visibility and observation was so much easier. By-and-large the patients preferred that open ward too. One point is that every bed had curtains so they could be shut off. When they analyzed the reasons, there were a variety of reasons. One was that in the four bed rooms at least you had a corner to yourself, you could turn your face to the wall. But, on the other hand, there were three other people in the room and you couldn't ignore them. In the six bed bays, again, four of the six had walls to turn to if they wanted to but the person in middle didn't. They were never very happy, those ones in the middle. But the people in the open ward felt that if they wanted privacy, they could just have the curtains drawn. As Florence Nightingale said, in a ward of thirty-two beds it is much easier to be private than if you are in one of two or three or four beds, because you can just shut yourself off, in a way that you couldn't get in a small room.

Another reason was that in the open wards there was a mixture of patients getting well and those who are not so well. There was a terrific sort of camaraderie between the patients themselves. Those who were getting better would go and help the ones who were not so well. Those who were in there waiting for an operation could talk to people who had had the operation and be reassured in that way. Of course they could help each other if somebody gets into difficulties or falls out of bed. They can immediately alert the nurse.

Although the report was published, the emphasis now is still on the four

bed and the six bed bays. But it was a very interesting study.

WEEKS:

In line with that study, I read one done in Britain about the choice between a one, two, three, or four bed room. A study was made and the patients were questioned. A majority ruled out one bed because of loneliness. They ruled out two beds because you might have some disagreeable person. They ruled out three beds because it might be a situation where two would be against one. But they said that four would be preferable. Certainly with four persons the chances are you could find somebody you could talk with.

HARDIE:

Yes. There are a lot of stories about that. You have a large number of the two-bedded rooms in the U.S.A., the semi-private ones. I have a completely untested theory about that. It is that in your universities here you usually share rooms as a university student, don't you? I think my impression is that most people, when they go to university in the U.S.A. share a room. In Britain, you don't. You have a room to yourself. I just have a feeling that all of your architects and all of your doctors, are all university people who at the formative stage of their lives have been quite used to sharing with another person and making the best of it. Whereas in Britain, as a university student you don't. You generally have a room to yourself. I just have a feeling that this is carried over into your design of hospitals -- you have a semi-private ward. That's just like you used to have -- you are used to that sort of situation. Whereas it's generally foreign to an Englishman to share a room with anybody else except his wife.

WEEKS:

There may be another aspect too. Blue Cross and the insurance companies

have always paid on a two bed room and have not paid full charges on a one-bed room. This may have something to do with it too. I think that what you are mentioning about being accustomed to being in a room with another person may have a great bearing on it. It would be an interesting question to research.

HARDIE:

Yes, it would be.

WEEKS:

Speaking of that, one of our nieces was in Ann Arbor at school. She invited us up to the dormitory one day. They were crowded and they had four persons in the room. And about six visitors when we got there. We asked, "How do you study?" "We have to go to the library," she said. We have coed dormitories too. I don't know if you have them in Britain or not. We have women and men in the same dormitory and maybe adjoining rooms sometimes. Apparently they have been able to control things fairly well.

We started to talk about quality control and the Joint Commission and PROs. Aren't there any kinds of inspections at all?

HARDIE:

We have what is called the National Health Service Advisory Service which was set up about 15 years ago now, or even a bit more. That is concerned principally with long stay hospitals, psychiatric and geriatric. They've done a pretty good job of going round to these hospitals and talking with staff about problems and progress. That has been in a sense a sort of inspection. But it only comes around to any one hospital every five or six years or so. So it's nothing like your regular review procedure.

WEEKS:

I was wondering how the system handles complaints. There must be

patients who complain.

HARDIE:

Oh, yes. That's quite well recognized. A patient can complain to anybody he likes, really. He can write to the hospital and complain, or he can write to his M.P. (member of Parliament), which is another way of doing it. So there are very good channels for getting complaints aired. And also, of course, there are now community health councils which is another channel. So anybody who is dissatisfied has perfectly easy means of making their dissatisfication known.

WEEKS:

In this country we have, in most hospitals, annual or frequent reviews of the privileges of the physician. In your case they would be consultants, I suppose.

HARDIE:

As I said earlier, once you are appointed as a consultant you are virtually answerable to no one except your own peers, informally. There is no formal review of their work. There are now, with the latest general management arrangements, going to be more reviews through performance indicators of cost and so on. But still nothing to approach the regular formal review that you have over here.

WEEKS:

One of the arguments we have is that doctors are not likely to complain about what other doctors do. So it is very difficult to set up a medical peer review unless you bring in peers from outside the area who are viewing people that they don't know.

HARDIE:

I think that makes a lot of good sense. There are certainly some pressures now for arrangements like that to be made in England, but it is a very slow process of convincing the medical profession. The King's Fund itself is now taking something of a lead to do this in England. And it is providing some financial support to get some quality assurance review mechanisms introduced.

I think traditionally one of the reasons why it hasn't been pushed so hard in Britain is the method of payment of doctors. In the health service there is no incentive to do unnecessary surgery or overtreatment. It brings no financial benefit to the doctor at all. So those temptations are not there. I think the medical profession has said that with our system there aren't the incentives to do unnecessary and we don't need that form of inspection. But on the other hand, there is very little safeguard against lazy doctors who don't do things they should do.

WEEKS:

Would there be a doctor who sees, we'll say, surgery as the treatment for many things where other doctors might not view it the same way? And since he views it this way, might he do unnecessary surgery because he believes that this is the proper way to do it?

HARDIE:

It could be. Unnecessary by other peoples' standards, but not by his own. That would be a risk certainly.

WEEKS:

It seems to me that in this country we have had many surgeons doing unnecessary surgery. In one hospital in which I took part in a study we saw a

doctor doing an operation, we'll say, time and time and time again. Ten times what his peers were doing. One time in our country we had every doctor taking out tonsils all over the place. Then it was appendixes were taken out. Everybody had his appendix removed. I don't know how you control that.

HARDIE:

No. Again there is now an increased concern about this sort of problem in Britain. They are now getting much more sophisticated indicator performances between different hospitals and different specialties. With the new district general management arrangements I think this is going to figure much more largely than it has in the past.

WEEKS:

How about second opinion? Is that a built-in factor?

HARDIE:

Not a built-in one, no. Any patient can ask for a second opinion if he wants to.

WEEKS:

I don't know how well it's working in our country but certainly the insurance companies and the government are...

HARDIE:

With some of the Medicaid patients you have to get a second opinion, don't you?

WEEKS:

Yes. And Blue Cross is trying to sponsor the idea of getting a second opinion.

How many medical schools do you have?

HARDIE:

Well, the teaching hospitals -- we have a dozen in London, and we have one for each of the other regions outside of London. So you have about two dozen undergraduate teaching hospitals. Then there are about ten or eleven postgraduate teaching hospitals.

WEEKS:

This is part of the educational process? Is this preceeded by say four years at the university?

HARDIE:

It's about seven years from start to finish before you start on your specialty training. The same as it is here.

WEEKS:

How soon do they get into the clinical work?

HARDIE:

It tends to vary from school to school. I don't claim to be the expert on this, but I know some of them start introducing the students to clinical work rather earlier than others. The more traditional ones tend to leave the clinical work until later.

WEEKS:

In reading some of the reports of medicine in America back at the turn of the century when many men became doctors without having laid hands on a patient -- it's appalling, isn't it?

HARDIE:

Yes. I think, again, there are some interesting developments in some of the developing countries. I know there are some medical schools there where within the first week of starting his medical training a student is assigned

to a particular family and, although he doesn't live with that family, in effect, he stays with that family through the whole span of his medical training to see them both through sickness and health. Of course they pick families where there is a mother in the fertile age. So they see a lot of normal babes as well as sick babies and young children. That's a good system, I think.

WEEKS:

It would seem that way. That brings to mind a question. How many of these countries have house calls as part of their regimen?

HARDIE:

In the developing world?

WEEKS:

In the developing world and in Britain. Do you still have house calls?

HARDIE:

We still have house calls for the general practitioner. It has certainly dwindled since the health service started, but it's still part of the general practitioner's contract that he will go to visit the patient in his home if it's medically necessary. So it does play a part.

WEEKS:

The point I was bringing up and which would refer to this student following a family through his educational period is that in going into a home you can see the conditions which may be causing the disease.

HARDIE:

That's right, yes.

WEEKS:

We were studying a home nursing program at one time and I rode around for

about a week with nurses visiting patients. I was surprised at what they did in the home or what they observed in the home and how it affected the care of that person. I thought then, since we have practically no house calls in the states, that we have lost something. The physician has gained time to do more work of course.

HARDIE:

This, of course, is where the patchwork system that I was talking about earlier has its advantage. It means that there is someone in the community, a health worker, who knows every family. When we had this study visit in Costa Rica last June, I remember that we went to visit one of the poorer parts of the capital, San Jose. I asked especially if we could do that because it hadn't been included on the original program. All of a sudden on the last afternoon of this visit we went along to this little health post. It had all been arranged less than twenty-four hours earlier. We went in there, a handful of us, and sure enough they had a couple of community health workers there to see us and a nurse and a doctor. The community health workers each had a map of their little patch of San Jose. What they didn't know about the people in that patch wasn't worth knowing. They visited everyone in every family, or household, at least twice a year. If they had problems, they visited more often.

What was interesting was that they had five community health workers, each with a responsibility for between 1,000 and 2,000 people. Of those community health workers that we saw, one had been working in that area for seven years and the other for eight years. The head nurse had been working there for six years. The doctor in charge had been working there for five years. It was really a quite remarkable team. This was all without any

advance notice at all. They weren't putting on a special exhibition for our benefit.

WEEKS:

That would be a wonderful thing. I don't know whether this could be transplanted to Britain and the United States or not, but...

HARDIE:

The way we are thinking about it in Britain is that our district nurses or health visitors could fulfill this role because general practitioners do have nurses attached to them. But, their patients are scattered over this wide catchment area. I know there is one study being done in one of the London boroughs and they found that the district nurse, on average, had to relate to eleven different general practitioners because of the scatter of her patients. When you got on to a thing like the geriatric health visitor, which covers a wider span, they were relating to thirty-seven different general practitioners. That means that any sort of teamwork concept is very difficult to achieve.

WEEKS:

It would seem that we are going to have to come to a point where we are told that -- this is your physician.

HARDIE:

Not necessarily. You can choose from one of these five physicians. But I think that you might well be told that this is your district nurse or this is your community health worker. If it's a person living on the same street -- one of the strengths of the system in Costa Rica and Mexico is that these community health workers tend to be chosen by the local community, not appointed from outside. So they have a say in who they want to be trained as

a community health worker. It'll be somebody who lives in the neighborhood and knows it well and is respected.

WEEKS:

I think that would be a wonderful system if we could just transplant it some way.

HARDIE:

I would have thought that in London's inner city where we have got heavy concentration of black people or colored people from other parts, I think there would be considerable scope for getting them to decide who from their number they would like to have trained as a community health worker and be this first link. I've talked to white health workers and district nurses who have been working in these areas and they are very conscious that they come from a completely different environment and culture and they don't understand all of the nuances of the discussion. I think many of them would welcome having somebody from the community to whom they could relate and who in turn the local people could relate to.

WEEKS:

Thinking of this, I would ask you about midwifery. What is the state of that in Britain now?

HARDIE:

That's strong and thriving. Quite different from the U.S.A. The midwives play a great part. They deliver many of the babies.

WEEKS:

Do they deliver in hospital or do they deliver in homes?

HARDIE:

No. Most of the deliveries are in hospital. Always, of course, with a

doctor on call. But there are a very low percentage now of deliveries in the home.

WEEKS:

This is something that we may be coming to here in this country because of the high insurance rates for the OB-GYN men and women.

I wanted to ask you before we finish here about women in the health services. We have always considered the nurses, naturally, as being an integral part of the health system. I think I have read that you have about 415,000 registered nurses?

HARDIE:

Yes.

WEEKS:

Is there just one level of nurse? Like we have the practical nurse and the RN.

HARDIE:

We have what are called the state enrolled nurse and the state registered nurse. The main category of nurse is the state registered nurse who has taken the full three-year training as a nurse. Then the state enrolled nurse is one who is much more akin to the practical nurse who has just a two year training. Then there are nursing auxiliaries who don't have anything like such a long formal training. It's left very much to the individual districts.

WEEKS:

As you know, we have two, three, and four year training courses for RNs and one year courses for LPNs. There is quite a movement among the upper echelon of nurses to make a four year degree course complusory. Is there any movement like that in Britain?

HARDIE:

Not of the same strength. There certainly are now degree courses in nursing, but only a relatively small proportion of the total nursing staff train for that degree.

WEEKS:

Are they going for administrative work then?

HARDIE:

Either that or specialized clinical nurse work.

WEEKS:

Like the psychiatric nurse you were talking about?

HARDIE:

Not so much. I think there are psychiatric nursing degrees, but it would be mainly in the general nursing field.

WEEKS:

Are women entering medicine?

HARDIE:

Yes. I think it's probably at least fifty percent now. I'm not sure of that, but it is certainly a high proportion. It's the same in management too.

WEEKS:

We find that women are getting into many professions aside from nursing and teaching and secretarial work as it used to be. Someone has said that this is likely to affect the number of nurses that we have especially if we raise the requirements to a four year course. The nurse may say, "I may as well be a doctor. I want to work with people. In another three years I could be a doctor."

I have a feeling when I go in hospitals now sometimes that the physician

has not entirely accepted the nurse as a partner. He is more likely to think of her as a hand maiden. Is that the feeling in Britain too?

HARDIE:

I would say it is not so widespread in Britain. There are certainly some who do take the view that the nurses are handmaidens. I think there are others who think of them more as a member of the team. I think again, this might be partly due to the methods of payment. When your hospital doctor is on salary and the nurse is on salary, there is greater freedom for the doctor to say, "Well, look, I think you're capable of doing this, rather than myself." Whereas, with a fee-for-service system, the doctor must always have in the back of his mind if I give the nurse this job, that's one less for me. think a good example of this is one country, let me say in the common market without having to get down to names, where until about seven years ago the general practitioners in that country were all paid on a capitation basis like they are in Britain. Then about seven years ago the medical profession, the association in that country, said we want to go over to a fee-for-service system. They persuaded the government to do this. It became law. They found that within six months the GPs were doing many of the jobs that had been done perfectly satisfactorily for years by the public health nurses, because the GPs could now get paid a fee for it. I think this is a good illustration of how important the financial mechanisms are, either as an encouragement or a discouragement from teamwork in health care.

WEEKS:

We have opposition in this country for setting fee schedules, where something comes up under insurance. But I was quite surprised the other day. I heard of a case of surgery, quite involved surgery, other bills that came

along from consultants and so on. Everyone of those fitted into the Blue Shield fee schedule. Before, two or three years ago, they would have said we'll take the fee schedule plus we need another two or three hundred dollars. I'm just wondering if physicians aren't beginning to realize that they had better be careful and stay within schedules and not be too greedy. As individuals, these people can be fine friends or you know them well, but as professional people they seem to draw a line between the laity and themselves. It's hard for me to understand.

Is there a loan system in Britain for educational loans, student loans?

HARDIE:

No. Because in most cases, virtually all cases, they are subsidized by the state. There are means tests for university education. If your parents can pay a proportion, then you pay according to your means. There has been talk about a loan system.

WEEKS:

As long as there is a means test.

HARDIE:

There is no financial bar to anybody becoming a medical student or any sort of university student.

WEEKS:

That's better than we have here by far.

How have administrators done as far as salaries are concerned?

HARDIE:

They've done pretty well, particularly in recent years. Although they don't get paid as much as a top consultant, they do get pretty well paid compared with the doctor. Not better paid than them, but certainly it is

quite an attractive job financially.

WEEKS:

There was a man from Yorkshire here a few years ago. He came to visit me in Ann Arbor because of a person I had met there. I invited a small town physician to lunch with this visitor from Britain and some other people from the university. They were talking incomes. The income of this British practitioner in United States dollars was about one-fourth of what our local physician made.

HARDIE:

This was an administrator?

WEEKS:

No. This was a small town physician. The Yorkshire physician was earning about one-fourth what an American physician would get. The American said, "Well, why don't you come over here and work with us...

"I think you are looking at it in a way different from what I would," he said. "I am making about the same amount of money as my social acquaintances, the attorneys, the engineers and so forth. I can live on the same scale as the people I like to associate with." That was his answer. He was quite satisfied.

By the way, he was working in a group practice.

HARDIE:

I think that's very true. That's the sort of answer I give when people ask me how a doctor is paid in Britain. One knows that they are paid less than they would get in the U.S.A. or Canada. But compared with other professionals in Britain, they are pretty well paid. I think that's very true. You adjust to the situation in your own country.

WEEKS:

It certainly seemed that way to me.

One of the big questions today in America is malpractice. Do you have the same difficulties we have?

HARDIE:

We have some difficulties, but no where near on the scale that you do. Certainly when one reads of the premiums, insurance premiums, that obstetricians and surgeons have to pay in the U.S.A., that's quite unheard of in Britain. There certainly is some litigation, but only a fraction of what you have over here. It's hard to analyze why there isn't more of it in Britain in the sense that I'm sure there are instances of malpractice. But the British people are not so litigously minded, I think, as they are in the U.S.A. There's certainly none of the business of the lawyers acting on a contingency basis. That's illegal in Britain.

WEEKS:

This seems to be the answer. I think it's true in Canada. Contingeny fees are not allowed apparently in Canada. So they have very few suits. The awards seem to be much lower than they are in our country. I saw something yesterday. Last year there were over four hundred judgments of a million dollars or more in the United States -- risk insurance, you know. They are talking about closing down schools, playgrounds, police departments.

HARDIE:

Yes, I read about that. It's terrifying really. I know in one or two countries -- I think New Zealand is one -- they have a sort of arbitration system. When a mishap has happened in a hospital, the hospital doesn't try and cover it up. They really negotiate direct with the patients, with a third

party present, to arrive at a satisfactory settlement without both parties having to go through the hideous business of a prolonged legal case.

WEEKS:

We have a saying in this country about deep pockets. The faceless insurance company or the faceless government has deep pockets and they have all kinds of money and nobody is being hurt by taking this out of the pocket and giving it to somebody. We've got to do something in our country because OB/GYN men in New York City...

HARDIE:

They are opting out of it all together, aren't they?

WEEKS:

$100,000 premiums. Or neurosurgeons. And it varies a great deal from one part of the country to another. It's much worse in the east than it is in the midwest. I don't know how it is in California. It's probably even higher there. They do things in the extreme in California.

I was reading something about a hospital and the difficulties that took place in setting wages and things. One hospital had representatives of fifty-some trade unions. Would that be possible?

HARDIE:

I wouldn't have thought as many as that. There may well be a large number of different grades within one salary.

WEEKS:

This may have been what it was then.

HARDIE:

Yes. Because the wages and salaries in the National Health Service are negotiated nationally and there are what they call Whitley councils for the

different things. There are really only about, I suppose, average around about ten unions represented in that -- in any one Whitley council. The BMA would be one for the doctors, and the Royal College of Nursing for others. But there are certainly within the ancillary staff, the domestics and so forth, there are an enormous number of different wage levels and gradings. But not all that number of different unions.

WEEKS:

Will you explain the significance and difference in green papers and white papers? I run across this quite a bit.

HARDIE:

Broadly speaking, a green paper is really a discussion document that is produced under the auspices of the government. In a way you could say that is an exploratory document setting out different alternatives to the solution of a particular problem. So that is really open for consultation and discussion and so on. But when the government has got to the stage of making up its mind about what it wants to do, then it will produce a white paper, which really sets out the government of the day's view about what should be done.

Although that is still open for consultation, it very much represents the government view, not a disparity of different views from different organizations. In some cases you may well get a government of one complexion producing a green paper and then having a general election and you have a different government coming in and producing a white paper but based upon the discussion around the original green paper.

Now you have the civil servants, the same civil servant who one month will be preparing the case for a Labour government policy and then three months later he will be the same civil servant having to prepare the statement

for the Conservative government policy. A completely different one. Sometimes I think the civil servants are almost like chess players, one time they are white and the next time they are black.

WEEKS:

I suppose while they are doing one version of this they can be thinking of the other.

You are an honorary member of AHA now.

HARDIE:

That's right, yes.

WEEKS:

The Institution of Health Services Management, I note that you are a Fellow.

HARDIE:

Yes. That's by examination.

WEEKS:

I'm not quite sure that I can picture the Institute.

HARDIE:

It is now called the Institute of Health Services Management. When I joined the Health Service it was called the Institute of Hospital Administrators. It's the professional association of administrators, rather like the American College of Healthcare Executives. You become an associate of the Institute only by passing their examination. To sit for the final examination, you have to have had at least five years actual working experience in the Health Service. In other words, you can't study for it outside the Health Service. You've got to be employed in the Health Service before you can sit for the final examination.

WEEKS:

This is a quite similar process to the American College then.

HARDIE:

I think so, yes.

WEEKS:

An intriguing thing was your recreation of fell walking. Does that mean walking on the moors?

HARDIE:

No. It means walking on the hills. Traditionally the fells refer to the hills of the lake district in northwest England. Funny enough, the way I got introduced to them was at the end of the war -- after the end of the war in Europe and before VJ day -- I at that time was serving with a glider pilot regiment. There were great plans for invasion of Japan by gliders, which I viewed with very little enthusiasm at all. The country most closely resembling the terrain in Japan was, in fact, the lake district. So there we were. We were living in tents up there and learning how to fight in mountains and so on.

I didn't care for this too much because I was trained originally as a pilot, not as a soldier. Anyhow, despite that, I really fell in love with the lake district at that time. Ever since then I've been going back there almost every year and walking these fells and getting up to the top of every hill. That really has been one of my main recreations every year, to go fell walking in the lakeland fells.

WEEKS:

What community is your favorite in the lake district?

HARDIE:

Well, really I like to visit every part. I have a map at home and I have penciled in every route I've been on, and then I tend to go and try to stay at a different part so I tackle some other ones.

WEEKS:

That's a beautiful district. I can understand how you would be enthusiastic about it even if you were planning to invade Japan.

Before we talk about your future, would you care to say anything about the future of health care in Britain or in the world?

HARDIE:

That's a very broad canvas. I think that the health service in Britain will basically remain as it is. I think in the sense that there will continue to be access, free of charge, to the general practitioners and hospital consultants. I think there may be some moves to introduce more payments, say for board and lodging although I think that's very unlikely. I think things like charges for prescription and spectacles and so on. I would have thought that the sentiment in Britain, whether you are Conservative or Labour, is really basically in favor of the principles of the Health Service. I think most people would be very upset at any prospect of it being dismantled. That would be my feeling there.

In other countries, there is increasingly the move towards some form of universal coverage for the whole population, whether you have a fee-for-service method of payment for the medical profession or the capitation or salary. I would have thought myself that the tendency would be more towards the capitation system of payment, if not the salary method. Partly because I think it's through that sort of system that you can really develop teamwork in

health care rather than having the one profession set apart and having a different financial basis for payment. I would have thought there would have been moves toward the universal coverage through insurance or similar mechanisms.

I think particularly in the developing countries this patchwork approach to health care will develop. I was interested to read only a few months ago that it's now an official government policy in India to develop this approach. That's nearly a thousand million people already. Of course it's already established in China and other countries. I think increasingly people in the western world are beginning to see that we can't just rely on health service being something that is provided only by highly trained professionals. I think they are going to be thinking much more in terms of self-help and involving the community and promoting their own health. They will be thinking more in terms of a health system rather than a sickness system which is what is happening in most countries.

So those, I think, are some of the main trends that I see for the future.

WEEKS:

Do you see any progress in population planning?

HARDIE:

Yes. China has shown what can be done with a population of a billion people. It's absolutely astonishing what they have achieved there just through sheer persuasion, without very much coercion. Of course in a Communist society it is easier to introduce that sort of nationwide policy. In India, after the problems they had with the compulsory sterilization, they took a step or two backwards. But now on a voluntary basis they are beginning to move forward again in population control. I think, as has so often been

said, that population control doesn't depend on medical advances but more on economic advances. As populations get more prosperous, their birth rate goes down.

WEEKS:

We have a very high illegitimate birth rate in our country. I don't know how it is in your country, but it's frightening in our country.

HARDIE:

It's not so high in our country as it is in yours, but it's still very disturbing. Again, it's particularly a problem with the black population. It's not so much of a problem, in fact probably less, with the Asian immigrants than it is in the white population. But it's particularly the black population and perhaps from the Carribean where there has been the tradition of the mother being the center of the family rather than the father. That, combined with the poverty of the urban black population, makes it a very real problem there. It starts the so-called cycle of deprivation.

WEEKS:

We have a great danger from Latin America. Was it just yesterday that I heard a prediction that Mexico City would be fifteen million?

HARDIE:

I think thirty-two million by the end of the century was a fairly conservative estimate I heard. There they have the problem that it is predominantly Catholic. That doesn't help towards the growing population.

WEEKS:

We have a lot of problems in front of us I am sure.

Would you like to talk about the future of Miles Hardie?

HARDIE:

For myself? Yes. I'll be retiring next year. I'll be sixty-three then. I think it will be good for me to have a change and also for the IHF to have a change. I would certainly hope to continue working part-time in health care. The area that particularly interests me still is urban health care, both in Britain and also in the developing countries. Although I've got nothing firmly in mind, that's the sort of area in which I'd like to do something.

WEEKS:

You have many good years ahead of you. You should make the most of them and contribute all you can.

HARDIE:

I'd like to do that. I would like to spend more time fell walking too!

WEEKS:

I have really enjoyed the opportunity of talking with you. I hope you have enjoyed it half as much as I have.

HARDIE:

I have enjoyed it, and it's very good to have the exercise of collecting your thoughts on different issues. It's been good for me.

WEEKS:

Is there anything we haven't touched on that you would like to comment on?

HARDIE:

Don't think so. I am obviously proud of my two sons who haven't entered into the health care field at all. One went to Oxford and the other went to Cambridge. The elder one got first class honors in the same subjects as I got second class honors in Greek and Latin, history, literature, and philosophy.

So I don't have any superiority complex in relation to my children! The younger son is a scientist and he's been doing neurobiology for nearly ten years now solely on studying flies eyes. He had seven years in Tubingen, West Germany, at the Max Planck Institutes. He is now back in Cambridge on a five year research fellowship there on the same subject. I find it difficult to conduct a very intelligent conversation with him about his work! My elder son now also got a fellowship at Cambridge, teaching classics and has published an important book on the poet Virgil which was one poet I studied when I was at Oxford. I find it very difficult to follow it: he is so learned on the subject. But it's got a lot of good pictures in it, so I enjoy that part!

WEEKS:

This must give you a great deal of satisfaction to see this.

HARDIE:

It is. They don't make much money but I think they both enjoy their work and they are lucky to have gotten jobs where they are.

WEEKS:

I think this is the important thing in life to do something that you enjoy doing and the money usually takes care of itself.

Interview in East Lansing, Michigan

April 29, 1986

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