The NHS Reorganisation

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Cover illustration
Distribution of soup for distressed weavers
in the kitchen of St Mary's Hall, Coventry, 1851.

The NHS Reorganisation

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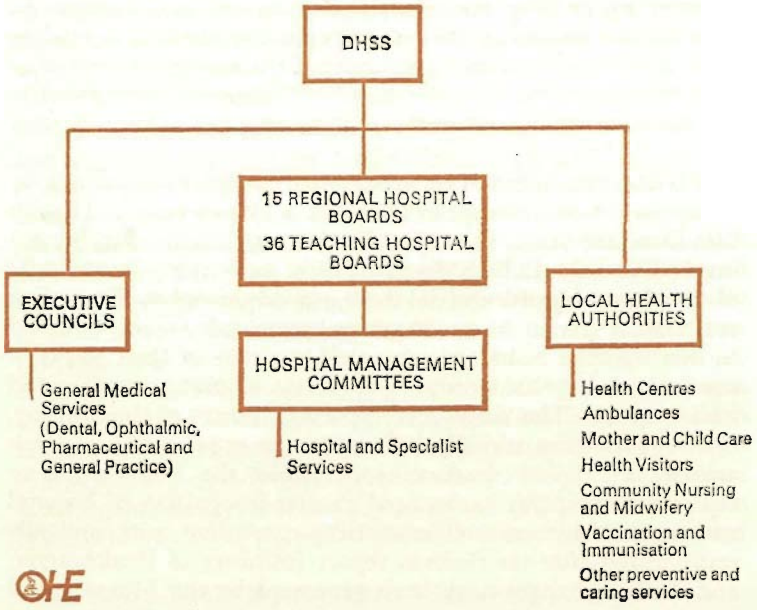
2 Glossary of abbreviations

AHA	Area Health Authority. The main operational tier of the reorganised health service.
AHA(T)	Area Health Authority (Teaching). An AHA in whose area a teaching hospital is situated.
AMT	Area Management Team. Formed from the area team officers in single district areas. Equivalent to a District Management Team.
ATO (comprised of an AMO, ANO AT and an AA.)	Area Team of Officers. Comprised of an Area Medical Officer, Area Nursing Officer, Area Treasurer and an Area Administrator.
CHC	Community Health Council. To represent the public's interest.
CHSC	Central Health Services Council. Advises the DHSS.
DMC	District Medical Committee. Representative of local doctors and dentists in both the hospital and the community services.
DMT (includes a DCP, DNO, DT and a DA.)	District Management Team. Includes a District Community Physician, District Nursing Officer, District Treasurer and a District Administrator as well as DMC members.
FPC	Family Practitioners Committee. Replaces the Executive Council.
JCC	Joint Consultative Committee. Establishes liaison between the AHAS and the local authorities.
JLC	Joint Liaison Committee. Temporary body involved in the preparations for the reorganisation.
RHA	Regional Health Authority. Intermediate tier between the AHAS and the DHSS important in long term planning and major capital investment schemes.
RTO (comprised of an RMO, RNO, RWO, RT and an RA.)	Regional Team of Officers. Comprised of a Regional Medical Officer, Regional Nursing Officer, Regional Works Officer, Regional Treasurer and a Regional Administrator.

Introduction

Even at the start of the National Health Service's existence in 1948 it was realised by many of those employed in it that its tripartite division into hospital, local authority and executive council services, shown in Figure 1, was to some extent unsatisfactory. Although the 1946 Act establishing the NHS represented a skilled and workable compromise between the interests and beliefs of the various groups involved in health care planning and delivery at that time, developments over the past 25 years have made a structural reorganisation increasingly necessary. The dominance of hospital based attitudes and values throughout the NHS and poor liaison between staff working in the community services and those in the hospitals have led to imbalances in the standards of care. The problems of the handicapped and the chronically ill in particular have received unsatisfactory attention.

Figure 1 *The NHS structure before reorganisation*



Since the beginning of the 1960s, notably with the publication of the Porrit report in 1962, overt pressure for the integration of the three branches of the NHS has been growing. In 1968 the then Labour Government expressed its intention to act towards this end with the publication of the first of its two Green Papers on the NHS. The subsequent Conservative Government concurred with the view that reform was necessary and so, after the publication of a Consultative Document in 1971 and the White Paper of 1972, the NHS Reorganisation Act was drafted and finally passed through Parliament in the summer of 1973.

There are major differences between this recent legislation and that of 1946, both in content and background. For example, in 1946 the country was recovering from the enormous social and economic trauma of the Second World War. The radical concept of a state run health service providing universally available care of equal standard to all those in need underlined the differences between pre-war and post-war Britain. By contrast the 1973 Act involved the reorganisation of an existing and widely acclaimed service into which thousands of millions of pounds have been channelled during the past quarter of a century of relatively stable national development.

There is, however, one essential element common to both the 1946 and the 1973 legislation. This is the need for compromise between an ideal pattern of health care and the constraints imposed by existing resources, both material and human. In assessing the new structure it is important to attempt to analyse its effectiveness in achieving the goals of the health service rather than to think of theoretically possible reforms without regard to the historical and current social and political limitations affecting it.

It is also important to remember that the reorganisation is by no means the only change to affect the health services and health care in recent years. For example, the 1959 Mental Health Act involved changes in both the structure of services for the mentally ill and handicapped and in their individual rights. Regarding professional groups doctors in general practice have been affected by the 'Doctors' Charter', the 1966 revision in their terms of contract, and by the steady development of group practices and health centres. The 'Cogwheel' reports (Ministry of Health 1967, DHSS 1972a) have strongly influenced the organisation of some aspects of hospital doctors' work whilst the Bonham-Carter report (DHSS 1969b) encouraged greater integration of hospital and community care. The nursing profession was radically restructured after the Salmon report (Ministry of Health 1966) and further changes have been generated by the Mayston and

the as yet unimplemented Briggs reports (DHSS 1969, Cmnd 5115). Hospital pharmacy has been restructured by the Noel Hall agreements (DHSS 1970b). And in the related world of social work the 1971 Seebohm reorganisation has had profound consequences and may be considered to have been an important step towards the restructuring of the tripartite NHS administrative system.

Hence 1974 should be regarded as a single part of the ongoing evolution of our 'welfare state' health services rather than as an isolated event. This paper describes the major characteristics of the reorganisation, confining its analysis mainly to the situation in England, in the light of the above knowledge.

The background to the reorganisation

To some degree it has been the success of medicine under the NHS since 1948 which has led to the need for changes in its structure. For example, in that early goals such as the control throughout most of the population of infectious diseases like TB[1] or the reduction of infant mortality have been achieved, the burden of chronic diseases of middle and old age carried by the community has become more apparent. Most people now survive to experience such diseases in later life. Whilst it appears improbable that average life expectancy can be very much further increased by improved health services in the absence of any major scientific advance, it is clear that the lives of the handicapped and elderly can be greatly improved within the confines of present technology.

An important point in this context is that the NHS is not merely a state run insurance scheme providing the means by which individuals may pay for independently controlled health services. The NHS itself delivers health care and it is financed mainly through general taxation. Hence rather than generating services in response to day to day direct demand it can act to provide them for those in the greatest need as measured by selected social and economic indicators. This factor may account to some considerable extent for the emphasis in the reorganisation on preventive and community services. The unsatisfactory aspects of traditional methods of care for the chronically ill and therefore often economically inactive members of the population have become more clearly perceived under the NHS than in many other

1 Achieved in part by improvements in living conditions.

health care systems because it is financed only indirectly by the economically active sections, who by definition are likely to demand mainly acute medical care.

The universal availability of health care under the NHS resulted in a number of changes in planners' attitudes. For example, Beveridge and his colleagues in the 1940s believed that there was a finite quantity of morbidity within the population, which if treated could be reduced. Figures such as those for sickness absence were expected to fall after the inception of the NHS but this was not the case. This is mainly related to factors such as the highly subjective nature of 'feeling ill' which were not appreciated in the past. There is now greater recognition of the need to treat or care for the 'whole person' and consequently more emphasis on providing health care within a normal community context.

In addition to the changes in health care goals and problems promoted in part by the NHS over the past quarter of a century, the organisation's internal structure has become more complex as services have expanded and proliferated. It is now one of the world's largest civilian enterprises employing around 900,000 people and spending over £3,000 million a year. The growth of the NHS has underlined the need for effective management to ensure that the limited resources available are distributed and utilised as efficiently as possible and the potentially inflationary nature of health care expenditure has lead to keen government interest in the management of the health services.

Indeed, although the main long term politico-social goal of the reorganisation, as implied in the Secretary of State's introduction to the White Paper, is to improve the position of health care groups such as the elderly and the chronically ill the main means by which it is hoped to achieve this is the unification of the health services under a completely revised management structure based on the introduction of a professional, objective orientated system. Any changes in individual areas of health care such as the general practitioner service, which may be considered to be the cornerstone of the NHS, will emerge in the course of longer term evolution. The reorganisation is intended only as a preliminary to this in that it may increase the health services efficiency in areas like planning or personnel management and so open the way to the achievement of its long term goals.

Initial preparations

The disbanding of all the major decision-making bodies of the pre-1974 NHS and their replacement by a new set of more closely linked authorities carries with it the danger that in the process of transition there may be a major interruption of the provision and

development of current services. To minimise this risk the authorities to be replaced were asked to prepare for each new area statements regarding existing resources, plans etc. In addition, from the end of 1972, Joint Liaison Committees (JLCs) at the new area and regional authority levels were established, comprised of members drawn from existing administrative bodies. These worked in concert with similar committees established in connection with the local government reorganisation and proved to be very effective in preparing the ground for the 'shadow' regional and area health authorities which were given about six months to organise themselves before assuming full control in 1974.

The JLCs were given special responsibility for informing and consulting existing NHS staff regarding the reorganisation. Arrangements for transferring staff to the new authorities and filling new posts were conducted with advice from the NHS staff commission specially set up for this purpose. This was inevitably a difficult area and some considerable controversy developed over it. For example, it was feared (in many cases unnecessarily) that individuals with a background of working in a particular area would be moved on and replaced by new personnel to the detriment of both the people concerned and the local health services. Also individuals with a background of hospital administration have obtained many of the key posts of the new structure because there is lack of similarly qualified persons experienced in community care. This may, in the short term at least, perpetuate the dominance of hospital based thinking in the NHS.

Despite these extensive preliminary arrangements and additional preparations such as educational courses for NHS staff designed to help them to understand and fill their new roles, some administrative disruption must be expected. It will, for instance, probably be at least 18 months after the reorganisation before any effective new planning will be implemented. And for the previous year or more some developments have been 'held over' in the light of expected changes. Such delays and the associated disorder are disquieting although they are perhaps not entirely negative. One of the essential elements for the introduction of more efficient administration into the health system may unfortunately be that the older, relatively stable procedures and personnel structures must be positively disorganised before a new pattern can clearly emerge. It is to be hoped that any sense of insecurity this may have induced in the NHS staff will not inhibit the future evolution of the reorganised structure which will be the key to the success of the 1974 changes.

The new structure

It may be seen from Table 1 that virtually all the former functions of the tripartite NHS are incorporated in the unified structure, although parts of the environmental health services remain under local authority control. These include powers relating to food hygiene and animal health and responsibilities regarding the control of epidemics of infectious diseases which involve the use of statutory provisions most desirably wielded by elected bodies.

The key operational authorities within the new NHS are the Area Health Authorities (AHAs) which are corporately responsible for health care in geographical areas conterminous with the

Table 1 *The reorganised National Health Service*

The Services brought together under the unified NHS administration are:

a) The hospital and specialist services formerly administered by the Regional Hospital Boards, Hospital Management Committees and Boards of Governors.

b) The dental, ophthalmic, pharmaceutical and family doctor services to be transferred from the administration of the Executive Councils.

c) The personal health services previously run by the local authorities through their health committees. These include:

Ambulance Services	Home Nursing and Midwifery
Epidemiological Surveys	Maternity and Child Care
Family Planning	Vaccination and Immunisation
Health Centres	Other Preventive and Caring
Health Visiting	Services

d) The school health services.

Notes

a) Extensive health education powers are to be given to the new NHS authorities although the local authorities will keep their responsibilities in this area with regard to environmental health and the Health Education Council also retains its present role.

b) The NHS will register nursing homes, although the registration of nursing agencies will remain a responsibility of the local authorities.

c) Arrangements regarding the provisions made for family planning services in the 1973 NHS Reorganisation Act are as yet uncertain.

The services remaining outside the NHS include:

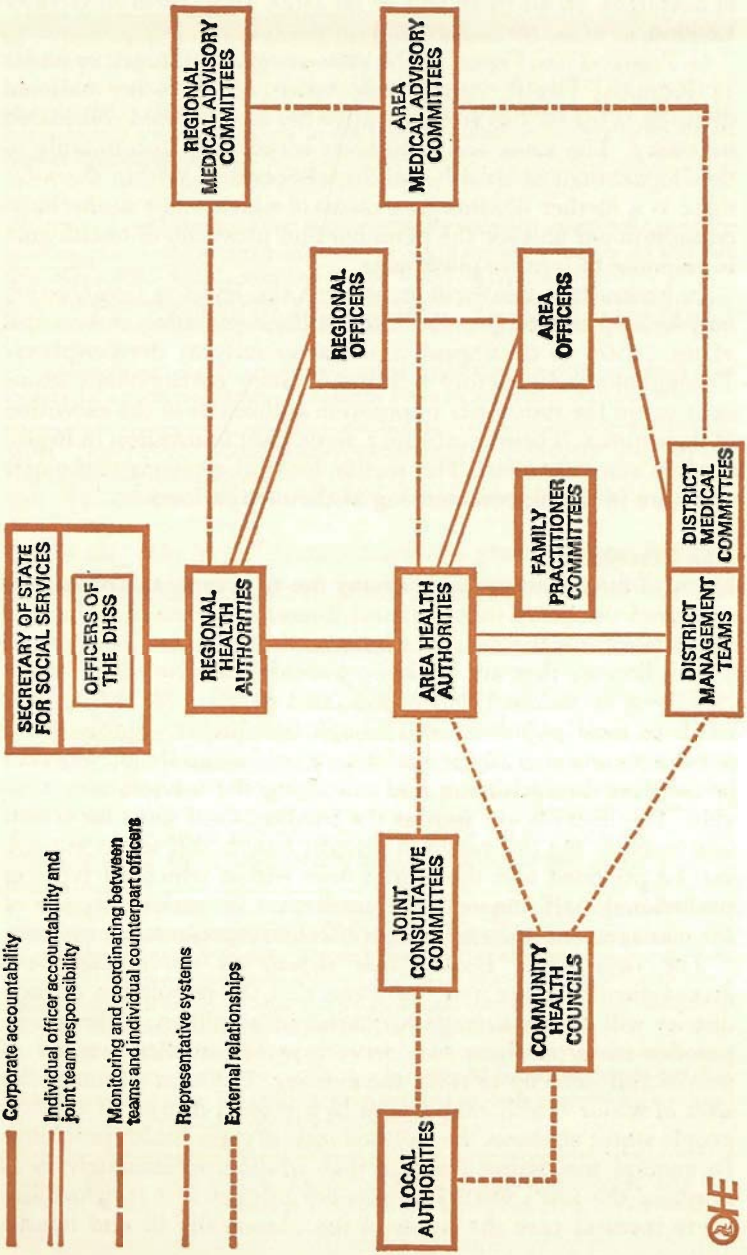
a) The occupational health services of the Department of Employment.

b) The environmental health services run by the local authorities.

c) The personal social services, including hospital social work.

d) Certain other health provisions e.g. prison health services and those of the armed forces.

Figure 2 *Framework of the organisation structure in England*



Source For Figures 2–6. 'Management Arrangements for the Reorganised National Health Service' HMSO 1972

new local authority metropolitan districts and non-metropolitan counties although in the case of London there is some grouping of boroughs. In all there will be 90 AHAs, 16 of them in Greater London.

In England (see Figure 2) the AHAs are grouped together under 14 Regional Health Authorities (RHAs). In the other national divisions of the UK this administrative tier has not been considered necessary. The RHAs are themselves corporately accountable to the Department of Health and Social Security. Within the AHAs there is a further division into districts which serve as the basic organisational unit for the planning and provision of health care in response to local requirements.

In general the relationship between the levels of organisation may be seen as a progression from strategic planning and control at the centre to contingent practical activity at the periphery. Throughout the structure multidisciplinary management teams exist to aid the statutorily responsible authorities in the execution of their duties. These constitute a significant innovation in health services administration. This section looks at elements of the new structure in detail, commencing at the district level.

The districts

Many of those involved in planning the 1974 reorganisation have expressed the belief that the most important element within the new structure is the concept of 'natural' districts for health care. This is because they are the key practical means by which health care is to be planned and coordinated to cater for the specific needs of local populations. Through the district organisational pattern members of all the health care professions should together be involved in evaluating and managing the services they provide. The districts are seen as the smallest sized units for which substantially the full range of general health and social services can be provided and the largest ones within which all types of professional staff can actively participate in various aspects of the management process through effective representative systems.

The 1972 'Grey Book' (DHSS 1972c) on the management arrangements for the new NHS states that the population of each district will be on average a quarter of a million, although in practice many of them may serve a rather smaller number of people and some up to twice the average. Table 2a estimates the sizes of major health care groups in a typical district of 250,000 people whilst 2b shows the national scale of these health problems. In general the figures indicate that whilst approximately two-thirds of the NHS's financial resources are devoted to providing acute medical care the needs of the chronically ill and handi-

Table 2a *The size of the main health care groups in an average district of 250,000 people*

a) There would be about 60,000 children of whom 500 would be physically handicapped and 200 severely mentally handicapped.
b) There would be 35,000 people aged over 65, around 4,500 of them severely or appreciably physically handicapped. About 800 would be in hospital at any one time and a similar number in old people's homes. A further 1,000 would require domiciliary care.
c) There would be nearly 2,000 severely or appreciably physically handicapped people of working age living in the community.
d) There would be about 700 people officially classified as severely mentally handicapped of whom over half would be living outside hospitals. At any one time about 300 mentally retarded people would be hospital inpatients.
e) The total number of people thought of as being mentally ill and in contact with hospitals would be around 2,500. Of these nearly 600 would be inpatients at any one time.
f) About 19,000 people would need acute medical or surgical care each year as hospital inpatients, about 550 of them being in hospital at any one time.

Source Derived from 'Management Arrangements for the Reorganised National Health Service' HMSO 1972
Note The definition of physical handicap varies between sources

Table 2b *The size of the main health care groups in Great Britain as a whole*

a) There are over 100,000 physically handicapped children and 50,000 severely mentally handicapped children.
b) There are over 1,100,000 severely or appreciably physically handicapped adults living in the community. Two-thirds (750,000 plus) are women and a similar proportion (725,000 plus) are over 65.
c) Of Britain's 7·5 million people aged over 65 over a third of a million are in hospitals or old people's homes. At least a quarter of a million require domiciliary care.
d) There are around 140,000 severely mentally handicapped people, over 40,000 of whom are in subnormality hospitals. So are 20,000 mildly retarded people.
e) Over half a million people in Britain are suffering from a diagnosed mental illness. At any one time about 125,000 are in hospital.
f) Of the roughly 6 million hospital inpatient attendances each year over two-thirds receive acute medical or surgical care. But by contrast two-thirds of the hospital beds occupied at any one time are devoted to the care of the chronically ill, the elderly and the mentally ill or handicapped.
g) Britain's 25,000 general practitioners are consulted by patients about 4 times per average patient per year, that is about 30 times per doctor per day. This amounts to over 220,000,000 consultations in each year. Women consult their GPs roughly 50 per cent more often than do men.

Sources Social Trends 1973, Annual Abstract 1973, Handicapped and Impaired in Britain 1971, Health and Personal Social Service Statistics for England 1973

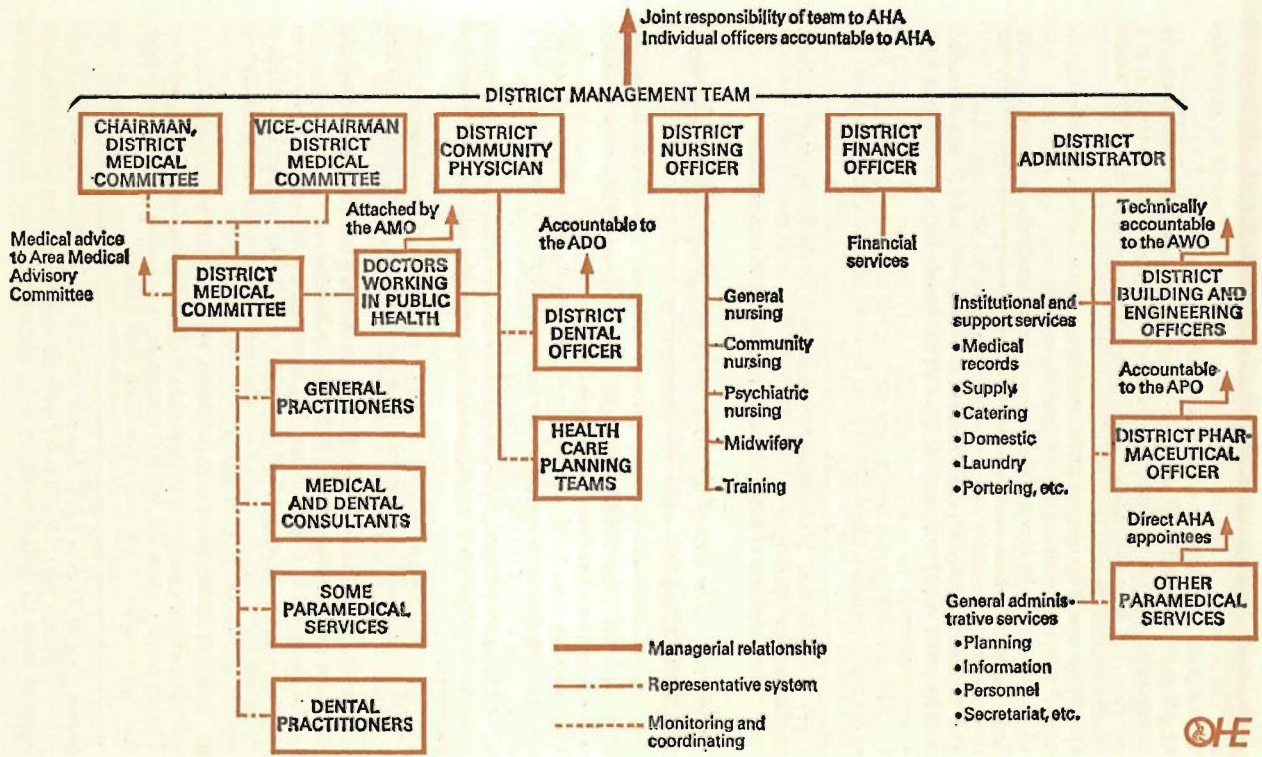


Figure 3 *Framework of the district organisation*

capped may be considered to be greater.

It should be noted that the districts are larger than and therefore not conterminous with the local authority non-metropolitan county districts through which the environmental health services are now to be administered. The same point applies to the areas covered by social work teams, each of which usually serves around 50,000 people. However, it is thought that in most cases any problems arising from these discrepancies will be dealt with fairly easily although in some of the London areas this may involve considerable administrative effort. It is possible that in the long term social work team areas and health districts may become matched more evenly.

The district boundaries have been defined 'naturally'; that is, with primary regard to the population's present use of community and hospital services rather than to the boundaries of the new health areas. Although in practice heavy emphasis has often been placed on the position of district general hospitals in defining districts, this was not intended to be the key means of identifying them. It was hoped by many of the reorganisation's planners that district communities should be seen more in the light of their common needs and patterns of health care consumption rather than in terms of the administrative convenience of hospital services.

But whatever the means by which the borders of the natural districts have been decided many of them overlap two or more of the formally defined areas or regions, particularly in the larger urban areas. To deal with the problems created by this AHAs may make liaison arrangements with one another or staff may be seconded from one AHA to another. In cases of major overlaps one AHA may act as an agent for another in delivering services, becoming fully responsible for the health care of people in the overlap zone.

Key features of the NHS organisation at district level (shown in Figure 3) include:

a) District Management Teams (DMTs)
b) District Medical Committees (DMCs)
c) Health Care Planning Teams
d) Community Health Councils (CHCs)

Each management team is composed of a nursing and a finance officer, an administrator and a specialist in community medicine (a community physician). It also has on it two members of the DMC (usually the chairman and vice-chairman) who represent local consultants and general practitioners. The team is assisted by a number of district officers. (In districts which contain teaching hospitals representatives from these will also attend and advise

the DMT meetings.) The district officers are charged with managing and co-ordinating many of the operational aspects of the NHS services within their localities and for helping to formulate policies and plans for the future. Those who are members of the management teams have the additional role of making proposals for the overall development of the district services. They are to be considered jointly responsible to the appointing AHA which means that, in the event of a difference in opinion between team members, the AHA will be called on to resolve the issue concerned. The four non-elected DMT officers will also be individually responsible to the AHA as the heads of their respective managerial hierarchies.

The 10 member DMCs are composed of both hospital and community medical staff (including dentists), so combining many of the functions of the present hospital medical executive committees with a system of general practitioner representation. The role of the DMC appointees to the DMTs is, it should be recognised, intended to be a representative rather than a delegated one. This means that they should eventually make their own decisions regarding issues in the light of all the information available to the DMT rather than following a fixed line decided by the DMC.

The Health Care Planning Teams are an important innovation. They are to be established by the DMTs and will conduct detailed local planning for the provision of integrated individual care for patient groups such as expectant mothers, children or various categories of the chronically ill.[1] They will be valuable means by which those in community care can influence the development of services although some concern has been expressed that there are not standing teams to deal with the integration problems of many aspects of acute care.

An additional element of the reorganised NHS which may be considered to be primarily of importance in the context of the district level of the NHS is the formation of Community Health Councils. These are designed to act as a public 'watchdog' and mouthpiece with regard to the development of the health services. Although not part of the formal management structure they will have access to NHS plans and premises. They will also meet with the full AHAs at least once a year and will publish an annual report to which the AHAs will be obliged to reply.

Each CHC will have between 18 and 30 members, of whom about half will be appointed by the local authorities covering the CHC's district and one-third will represent local voluntary organi-

1 Each district will have several teams, some standing and some ad hoc. In general it is those areas of care which are expected to change most which will be covered by permanent teams.

sations. The remainder will be selected by the RHAs who finance the CHCs.

The Area Health Authorities

The AHAs are the lowest level of statutory authority[1] within the new organisational structure. They have full operational and considerable planning responsibilities and will employ most of the NHS's staff, although the independent contractors maintain their direct relationship to the DHSS via the Family Practitioners Committees (FPCs) and in most cases the RHAs will employ consultants and senior registrars.

The organisation of an AHA with several districts differs from that of a single district AHA (see Figure 4a and 4b). In the latter the area team officers (ATOs) who support the AHA members and hold delegated executive powers play a role similar to that of the DMT, forming an Area Management Team (AMT).

Each AHA has 15 (except in AHA(T)s) members, four of whom are representative appointments of the local authority. The remainder are selected by the RHAs although the chairmen, who are the only members receiving direct payments in addition to their expenses, are appointed by the Secretary of State. The AHA members are, as a corporate body, responsible to the RHA for their running of services although individual officers of the ATO have delegated powers which may lead them to be individually accountable for certain services.

One of the major responsibilities of the AHAs will be to ensure that their own services and those of the new local authorities, such as the personal social services, are organised in a mutually supportive and complementary manner. Liaison and co-operation between the AHAs and LAs is to be encouraged in a number of ways. For instance, some AHA members are LA appointees. Also there will be mutual attachment of staff to act in both advisory and executive roles where appropriate. An example of this is that specialists in community medicine from the Area Medical Officer's (AMOs) staff will be attached to the LAs environmental health services.

But the most important area of liaison is to be achieved by means of Joint Consultative Committees (JCCs) set up to discuss and co-ordinate policies. In the metropolitan districts there will be one such committee to cover all services of common concern but in the non-metropolitan counties there will be two, one covering

1 *Note* The FPCs possess statutory delegated functions independently of the AHAs.

Figure 4a *Framework of the AHA organisation, without districts*

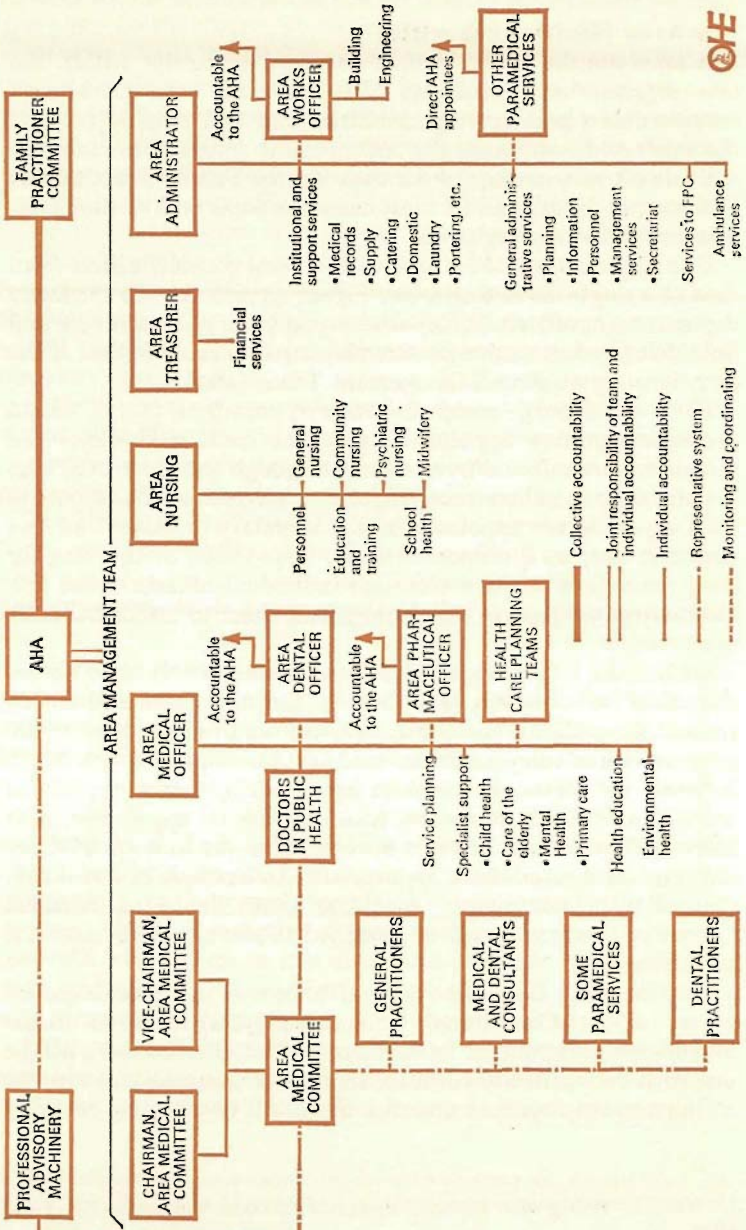
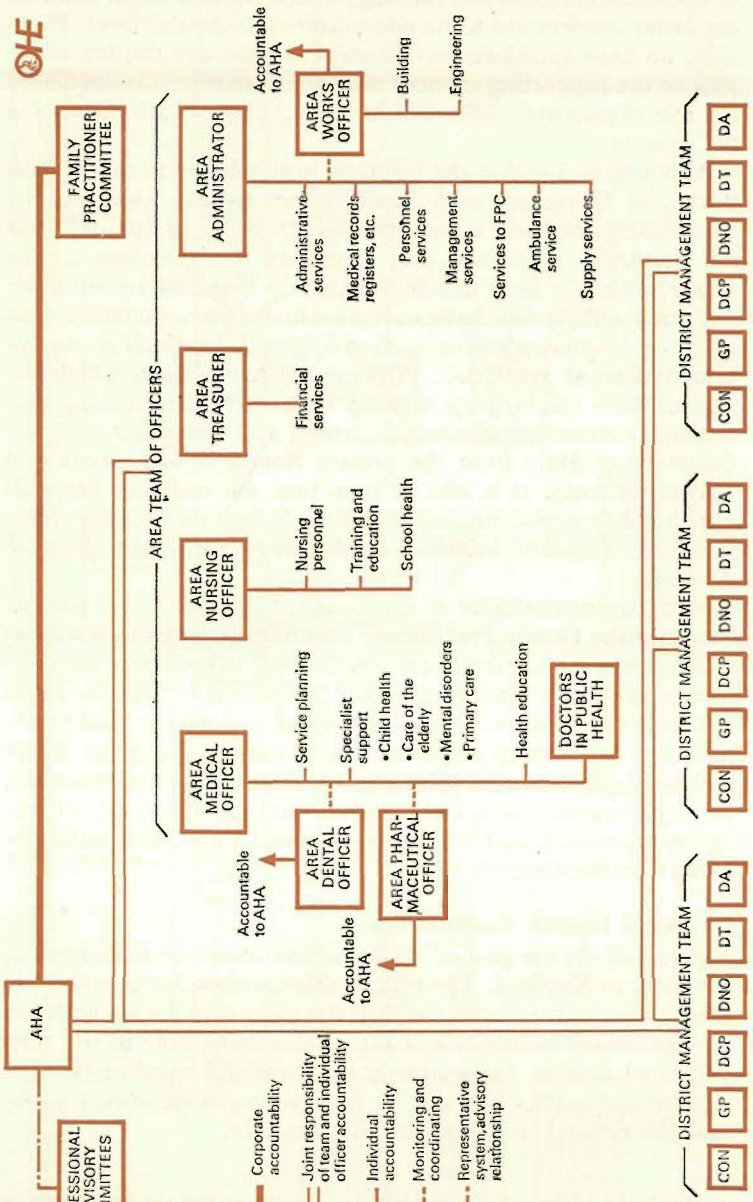


Figure 4b *Framework of the AHA organisation, with districts*



personal social services and school health and the other for environmental health and housing. This is because in the counties the latter services are to be administered at district level. However, no fixed guidelines have been set for the constitution of the JCCs or the supporting services they are to receive. Consequently the role of JCCs may differ considerably between various parts of the country.

Although in London the teaching hospitals are to retain their Boards of Governors with modified powers the AHAs will be accountable for their administration. In order to facilitate this the university concerned may nominate two members on the AHA(T)s (i.e. the AHAs in which teaching hospitals are situated) and each AHA(T) will have at least a further two members with teaching hospital experience, so giving such hospitals strong representation at area level. With regard to research, which the regions have special responsibility to finance, the teaching and research committees advising the RHAs have been selected by the Secretary of State from the present Boards of Governors and University HMCs. It is also of note that the teaching hospitals appoint their senior medical staff directly (not through the RHAs) and have a marked influence on the districts in which they are situated.

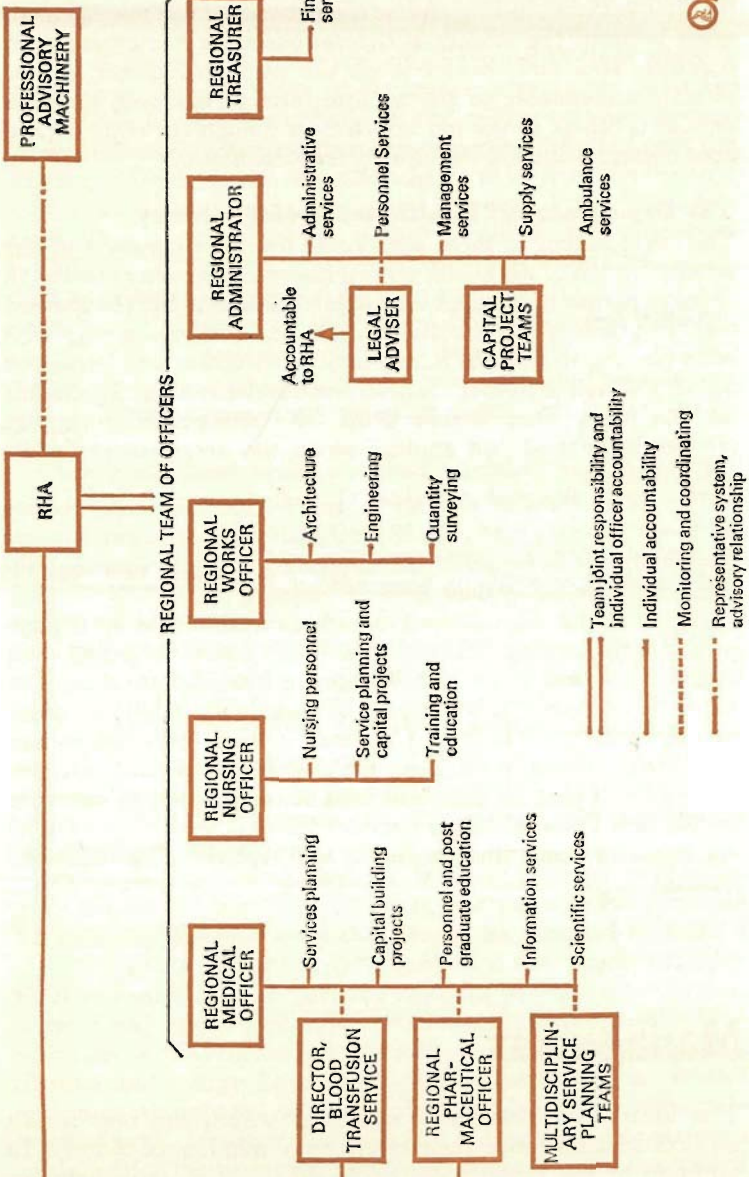
Another responsibility of the AHAs is to establish and provide staff[1] for the Family Practitioner Committees (one in each area) which are to replace the Executive Councils in providing administrative services for the independent contractors to the NHS. These will have 30 members, half of them appointed via the local representative committees of the various professions involved (there will be eight doctor members, three dentists, two pharmacists, one ophthalmic medical practitioner and one optician). Of the 15 lay members, four will be appointed by the local authority and 11 by the AHA.

Regional Health Authorities

Figure 5 shows the general organisational structure envisaged for the RHAs in England. The role of these authorities is mainly to plan in conjunction with the DHSS strategies and decide priorities and guidelines within which the AHAs will be able to use their delegated powers. Subsequently the RHAs will monitor the AHA performance. They are also to organise some services, e.g. the ambulances and certain financial operations.

1 Section 47 of the NHS Reorganisation Act suggests that the FPCs should be financed directly by the Secretary of State although in practice funds may be channelled through the RHAs/AHAs.

Figure 5 *Framework of the RHA organisation*



Like the AHAs the RHAs have about 15 members, in this case all of them direct appointees of the Secretary of State. Just as the AHAs are accountable to the RHAs as a corporate body so the RHAs are accountable to the DHSS. It is important to make clear that in most cases in England no direct chain of line management exists between the officers of the various tiers. For example, at regional, area and district levels the personnel officer will be directly accountable to the administrator at his level, not to a personnel officer in the tier above even though the regional and area officers will have monitoring responsibilities.

The Department of Health and Social Security

The organisation of those sections of the DHSS involved in the administration of the health service has recently been reviewed in order to permit its efficient working in relation to the reorganised NHS. The basis of this is a division into six functional groups with roles varying in content from financial direction and personnel advice through to research into service development and guidance for the RHAs. One section deals with departmental support services in general and another serves the Secretary of State's office directly.

The DHSS remains ultimately responsible for major policy decisions affecting the future of the NHS. It will have a particularly important role in areas like the forecasting of future staff requirements and the consequent need for training places.

Expert advice will continue to be made available to the department via the existing structure of advisory bodies, although their constitutions and terms of reference are being adjusted in some areas. For instance, it is intended to include on the future membership of the Central Health Services Council (CHSC) individuals specifically chosen to represent the patients' viewpoint. Another innovation is that the CHSC will itself be represented by members on the new Personal Social Services Council, which is replacing the Advisory Committee on Health and Welfare of Handicapped Persons.

Management

The ideas on management expressed within the new health services structure owe their origin to a number of sources. In addition to the Department of Health itself these include the

management consultants McKinsey's and the work of the Brunel Health Services Organisation Unit as well as the individual contributions of members of advisory committees and of many NHS staff. Political considerations and the pressure applied by representative groups such as the BMA have also played an important part in determining certain aspects of the reorganisation.

It is difficult to pick out any single line of thought which is consistently representative of the entire new format although throughout it there is emphasis on the concept of management by objectives. An important passage regarding the administrative thinking underlying the reorganisation is to be found in the 1971 Consultative Document (DHSS 1971). This stated that 'there is to be a fully integrated health service in which every aspect of health care is provided, so far as it is possible, locally and according to needs of the people'. It went on to say 'that throughout the new administrative structure there should be a clear definition and allocation of responsibilities, that there should be a maximum delegation downwards, matched by accountability upwards; and that a sound management structure should be created at all levels.'

Clearly all these ideas are closely related and in practice dependent on one another. It would be nonsense from a pragmatic viewpoint to have locally run services without some check on their performance and costs at a central control. Indeed, in that localities affect each other and combine to form a whole nation with interests differing from those of its parts, an overall view of the situation is essential if the needs of the people are to be met as fully as possible. Thus delegation 'downwards' coupled with accountability 'upwards' is in some ways necessary. Yet this should not be taken to imply that the hierarchical distribution of economic and other forms of social status already present in the NHS and likely to be strengthened in the reorganised structure is either essential or desirable on the grounds of organisational efficiency.

Although in an ideal situation internal personal motivation may obviate the need for any overt external coercive pressures towards improvement even this cannot be expected to work if there is no clear picture of the organisation and people's responsibilities available. This partially explains why the management 'Grey Book' (DHSS 1972c) contains such a detailed analysis of the new roles in the reorganised NHS and why considerable amounts of time and energy have been spent in patterning an overall system of managerial accountability divided into comparable levels of work. However, the principle of accountability matched by delegation has been criticised on the grounds that it has tended

Figure 6 *The annual NHS planning cycle*

to exclude from the new structure arrangements for the health service consumers, the general public, to participate directly in the control of the NHS. This issue is discussed later in this paper.

Regarding the content of the new roles established within the reorganised pattern a number of specific factors are involved. For example, considerable concern has been expressed regarding the need for the maintenance of the clinical autonomy of doctors. At the same time it has been recognised that some forms of managerial control in this and related areas are needed, possibly best provided through a system which ensures that professional people's direct managers are members of their own profession. In that some of the professions within the NHS are hierarchically organised, (e.g. nursing, pharmacy and medical administration) and others are non-hierarchical (e.g. consultants and contractors for family practitioner services) differing methods for achieving accountability have been employed, although it is probably an indicator of the power already enjoyed by the medical profession as opposed to other health service workers that such variations in autonomy exist. A final point in this context is that although the reorganisation is sometimes accused of introducing an unacceptable spirit of managerialism in the NHS this is somewhat unfair. Arrangements stemming from the Salmon, Mayston, Noel Hall or Seebohm reports, for example, tend to have promoted a more rigid system of management in certain areas than anything within the 1973 Act is likely to create.

Many innovations are introduced in the reorganisation in fields ranging from personnel and information services to health education. The three areas discussed below, the revised NHS planning cycle, the role of doctors in management and the system of public representation illustrate some of the key elements.

Planning

A close study of Figure 6 indicates that although the new annual planning cycle may at first appear to be a series of separate stages it should involve all the levels of the service simultaneously in an ongoing assessment of both national and local objectives. (Yet in practice the major influences on service development will probably stem from central policy decisions). At department level there will be an initial determination of priorities and estimates of the financial backing to the NHS over the coming four years will be made with a long term forecast up to ten years ahead. Negotiation with the RHAs at this time should result in the parameters within which regional plans may be developed being established. In the same way the RHAs will pass on to the AHAs guidelines for their planning. District level plans will then be drawn up by the

Health Care Planning Teams and the DMTs, working in co-operation with the ATOs. Throughout the preparation of the necessary reports and estimates the efforts of many individual professional advisers and enquiry teams will have to be co-ordinated for a coherent series of common goals to emerge.

The district level plans will then be passed back for review at each of the three administrative tiers, a process which should involve continuous consultation between all levels. At the end of each cycle the planning allocations for the following three years will be confirmed by the DHSS, which will then be able to present a national picture of planned development accurate in the short term and providing a general guide for up to a decade ahead.

The subsequent application of plans will be through the system of delegated powers. Each level will monitor the performance of the one immediately below it. This is a process which in some ways can be compared with that of the co-ordinating roles mentioned above in that neither monitoring nor co-ordinating roles in themselves involve direct managerial control over those being monitored or co-ordinated.

With regard to monitoring it has been suggested that the process has been too loosely described and that proper standards of scrutiny have not been satisfactorily drawn up. However, an understanding of the new planning process underlines the point that in practice the standards to be expected by those in monitoring roles will emerge as the direction and goals of the reorganised NHS emerge. They should not be imposed from above but should develop from discussions between all levels of the health services and so will at first necessarily appear vague although the present lack of clarity is disturbingly evident.

Doctors in management

As in the past the reorganised NHS contains means for professional advice and opinion to be expressed to the health service management. For example, each area has Local Advisory Committees elected by the professional groups involved in the community health services. Where appropriate members of these committees sit on the Family Practitioner Committees and provide part of the basis of the statutory medical advisory machinery at area and regional level. The Central Health Services Council with its specialist sub-committees will continue to advise the DHSS. And at the district level there are the new district medical committees, members of which are on the district management teams. The management 'Grey Book' (DHSS 1972c) argues that the DMCs will act as a vehicle through which local clinicians will be encouraged to help to determine priorities relating to their activities. They

will use their authority as self-regulating bodies to persuade individual clinicians to co-operate in plans agreed by the consensus, although this may at times prove difficult.

Also, as advocated in the Hunter Report (DHSS 1972b), individual doctors will have considerable direct managerial responsibilities within the health service. These will be discharged mainly by the specialists in community medicine – the District Community Physicians (DCPs) and the Area and Regional Medical Officers (AMOs and RMOs) and their staffs. Their duties will relate in particular to the planning process, the development and evaluation of epidemiological and related information, the evaluation of the effectiveness of services and the co-ordination of preventive services. The latter will probably be carried out by the AMOs who will act more as managers whilst the epidemiological work will be district based.

The overall improvement of the quality and quantity of the information available to the NHS is an essential aspect of the development of efficient management and of services accurately geared to the needs of the population. It is hoped that the need for comparability between statistics stemming from different districts and areas is realised from the start of the reorganised services' existence and that the difficulties existing in this area are not underestimated.

In practice the duties of the community physicians and the other specialists in community medicine will probably be more consultative than managerial as compared with their nearest equivalents in older NHS structure, the local authority Medical Officers of Health. This may entail initial disadvantages although it may in time permit the new group of administrators in medicine to establish a more flexible and widely accepted role in the eyes of their professional colleagues and the general public. In the past the position of MOSH at the head of relatively isolated local authority health service hierarchies tended to obscure the value of their work to those outside the services directly concerned.

Public representation

Complaints by the public against health services may be investigated at a number of levels. Allegations of certain forms of misconduct against an individual may be made to the appropriate professional body and in cases involving independent contractors failing to meet their terms of service the FPCs may be called on to give judgements. In others redress may be sought in a court of law. Arrangements for handling of complaints to hospitals, which number between 8,000 and 9,000 each year, have recently been reviewed by the Davies Committee.

A recent innovation has been, since October 1973, the introduction of a Health Services Commissioner on ombudsman lines who will investigate cases which are not satisfactorily dealt with by methods mentioned above. In fact it appears that the ombudsman's role will be very limited and it may also prove difficult for less educated members of the population even to approach him. An example of the Commissioner's limited field of enquiry is that he is specifically excluded from investigating:

a) Action taken in connection with the diagnosis of illness or the care or treatment of a patient if, in the opinion of the Commissioner, it was taken solely in consequence of the exercise of clinical judgement.

b) Action taken by a Family Practitioner Committee in the exercise of its own functions for the investigation of complaints against doctors, dentists, pharmacists or opticians.

c) Action taken by doctors, dentists, pharmacists or opticians in connection with the services they provide under contract with Family Practitioner Committees.

It would therefore be wrong to over-value the new post of Health Commissioner. And, in any case, many people feel that public representation implies a rather more positive expression of opinion and interest than merely registering complaints about services failing to meet prescribed standards. They argue that a strong 'public' voice should be involved in the process of establishing the standards and objectives of health care in the first place.

Yet the abandoning of the system of Hospital Management Committees and Boards and local authority Health Committees, etc, and its replacement by a reduced number of new authorities means that the number of 'lay' managers in the health services will be cut to roughly one-third of their former number. Further, they will have a more explicitly managerial role than was the case in the past. This is the result of the belief of the reorganisation's planners that members of bodies such as HMCs were divided between their roles as public representatives and health services administrators. In introducing a clearer line of managerial accountability they hoped to improve the efficiency of the NHS.

A formal structural differentiation between the managerial duties of 'lay' personnel and the role of public representatives has been created by the introduction of the Community Health Councils. Although these will only have powers of access to information from the AHAs and the publication of their enquiries it has been argued by the DHSS that they will prove a valuable means of representation. This may be so, although disputes exist on matters such as how members are to be appointed. 'Demo-

cratic' elections appear likely to select those individuals whose main aim is to become elected rather than necessarily to serve the public interests, but on the other hand there is also a danger that the choices of the RHAs and the established charities may prove pacific in their approach.

A number of problems related to the efficient functioning of the CHCs may arise. For example, they will have no powers to examine the local authority services in areas relevant to health care although it is improbable that all the CHCs will resist the temptation to do so. And a number of commentators have pointed to the need for CHCs themselves to be organised at a national level if they are to avoid directing all their efforts to local concerns which may be of comparatively little importance to the public as a whole.

Yet although similarly constituted consumer councils established in relation to the nationalised industries have not proved very successful it should not be assumed that this will be the case with the CHCs. There is strong public interest in the subject of health care and it may be possible effectively to channel this through the CHCs even though they currently appear to be virtually powerless. One suggestion for their future development is that they should either work closely with or possibly even assume the powers of the Health Services Commissioner, particularly with regard to complaints made in the community interest rather than with hope of personal redress.

Criticisms

Within an enterprise as large and as complex as the NHS, which employs about one-twentieth of the nation's workforce and one-twentieth of its wealth, any major reorganisation is bound to face widespread criticism. So many compromises between conflicting forces and interests have had to be made that it would in a way imply a disturbing imbalance if any group were to find the new structure totally satisfactory.

Yet in an organisation which relies to a considerable degree for its efficient functioning on the goodwill and enthusiasm of rank and file workers it is important to see that administrative changes, however valuable in themselves, are not achieved at the cost of alienating the 'grass roots'. A sensitive approach to the fears and uncertainties created by reorganisation is essential and there is evidence that this has not always been satisfactorily adopted.

Yet although personal worries relating to career expectations or feelings of insecurity in the face of the coming changes are an important problem area for those administering the transition they are by no means the only one. This section discusses some of the broader issues surrounding the NHS reorganisation and reviews the most frequently expressed criticisms which it has attracted.

A mechanistic bureaucracy?

A number of writers have argued that the newly formed hierarchical structure of power, with the Secretary of State and his senior civil servant staff at the summit, is inappropriate to the requirements of the health service. Some, such as Draper and Smart of Guy's Hospital (1972, 1973), have found in the literature of the sociology of organisations reason to believe that structures of the type proposed become rule-bound, inflexible, and insensitive to the needs of and changes in the world around them. In a field like health care, with its dynamic technology and changing client groups, such tendencies would be highly undesirable.

Fears have also been expressed that the concept of 'delegated powers' will be devalued in practice whilst heavy emphasis on accountability upwards will emerge. In such circumstances, it is held, individual loyalty and concern for the service could fade to the ultimate detriment of the patients.

A theme related to overall criticisms of the new organisational pattern is the suggestion that the major health care problems have been misidentified by the NHS planners. It is argued that administrative changes can do little to affect the real quality of health care for any group in the population and that what is more urgently needed is an alteration in the pattern of social relations associated with the process of medical care. Such changes could, it may be suggested, occur if the public itself is encouraged to understand and participate more in preventing or alleviating the major health problems. An approach of this nature would be of particular value in relation to chronic illness or disability but would also be of use in relation to acute ill health. A large proportion of the morbidity experienced in modern society is related to factors like smoking or alcohol consumption or to causes like accidents or occupational hazards to health, all of which could be tackled via greater public involvement in health care issues rather than through emphasising the role of professional managerial expertise in the NHS.

To underline the force of their arguments, critics of 'health service bureaucracy' point to the manner in which the proposals for the reorganisation have emerged and been implemented.

Many people working in the NHS are confused by the coming changes. Only a few have a clear idea of what they involve and many, rightly or wrongly, feel their careers to be threatened. Information about the reorganisation is obtainable mainly from obscure, complicated and authoritarian looking documents and circulars emanating from the DHSS. Despite the numerous calls for more open government in recent years much of the evidence on which decisions about the health service's future were based is not available to the public and there is a widespread feeling that unsatisfactorily explained changes have been imposed from above.

Those countering these charges argue that any practical solution to running the health services must depend on a firm administrative structure. Whilst the evolution of health care may well involve a far greater community involvement in what is currently vaguely called 'community care', this does not mean to say that those services which can only be given by professionally trained people in the context of an organisation capable of making large scale capital investments should not be efficiently run. It is certainly possible to point to many examples of poor planning and wasted resources under the old system.

It may also be suggested that a detailed examination of the reorganisation literature reveals a considerably more flexible and humane structure than may be perceived at first glance. As has already been described, the management theory behind the reorganisation rests on the concept that only through a clear pattern of role responsibilities and accountability between management levels can an organisation be made fully responsive to criticisms and shifts in its goals and can delegated powers be protected from erosion. In that the literature of the reorganisation has to defend the health service from such tendencies by defining roles in detail it may appear unnecessarily bureaucratic but the system it creates need not be so. Similarly although the members of the health authorities are mainly either directly or indirectly appointed by the Secretary of State rather than by election this does not necessarily mean that the NHS will be in practice less responsive to public feeling than would, say, a health service run via the local authorities.

It is also arguable that the imprecise use of terms such as 'bureaucratic' which may have emotive overtones does little to help when the inevitably complex organisational problems facing the health service are discussed.

Specific structural problems

Even if the general aims and principles underlying the reorganisation are accepted it is possible to criticise their application. For

example, it has been suggested that there has been an excessive concern with administrative tidiness in relationship to the need for conterminosity between health and local authority areas. One effect of this may have been that not enough allowance has been made for the differing optimal administrative sizes of health areas in thinly populated as opposed to heavily built up parts of the country.

Even where there has been some waiving of the principle of a one to one local authority/health authority ratio, as in London, the result does not appear to be particularly successful.[1] Holland (1973) has commented that in Greater London there will be an inner ring of areas richly endowed with facilities such as teaching hospitals and an outer ring of relatively poor areas. A pattern of AHAs radiating out from the centre could have avoided this.

Close analysis of the new structure reveals a number of potential problem areas. For example, at district level the management teams may prove slow in agreeing decisions because of divisions of interest between the elected DMC members and the appointed district officers or because of inter-professional rivalries which may develop. It is possible that the whole structure at this level could be threatened if, say, the DMCs attempt to bypass district management by approaching the AHAs directly. Whether such tendencies will be controllable without resort to organisational changes is doubtful.

Just as serious a problem may result from the risk that the members of the area teams of officers could, by virtue of their influence on the controlling AHAs, in effect assume line management control over those working at district level. If DMTs members come to feel that any dispute they may have with the area officers will automatically be decided in the latter's favour then their sense of local autonomy will be lost and a fundamental aim of the reorganisation, that of sensitivity to the varying needs of different localities, would be threatened.

Further objections to the new administrative structure may be raised when the relationship between the DHSS and the regional tier and the rest of NHS is examined. Meyjes (1973) has commented that, because many higher posts in the DHSS are occupied by senior civil servants whose career background often lies in the area of government departments other than the NHS, the career structure for administrative staff within the NHS is like a pyramid with its summit severed. A possible consequence of this is that the

1 In London problems may arise from single AHAs having to work with several boroughs which may have differing policies regarding their social services.

DHSS is too isolated from the operational aspects of the health service and that the new structure employs the regional tier as a 'buffer' which permits the perpetuation of this situation. It is possible both that the NHS could be run more effectively on the lines of a nationalised industry rather than those of a government department and that the regional tier could be dispensed with altogether were this approach adopted.

These points need some qualification. For example, many of the DHSS staff are professional people with long experience in the health services and it is possible for able NHS administrators to become administrative grade civil servants in the DHSS. Secondly, there would be considerable organisational problems resulting from the DHSS having to maintain direct contact with each of the 90 area administrations without the aid of an intervening tier. And finally it is probable that any government would feel reluctant to grant the NHS, which is a significant instrument of social policy and a large consumer of the nation's wealth, too much autonomy by allowing it to be run by an independent board.

But despite these considerations some authorities believe that the regional tier should and could be eliminated. Certainly it impairs to some extent the model of central strategic planning balanced by autonomous, although monitored, local administration and it is probable that all the RHAs essential functions could be carried out by either a reformed central department or *ad hoc* AHA groupings. The regions themselves have little epidemiological significance and although in the future the Kilbrandon report's (HMSO 1973) recommendations may help to clarify their political significance they do not match any local authority unit and so they do not correspond with the logic of either the district or the area definitions.

Collaboration

Although the main objectives of the reorganisation centre around the unification of our national services for health care under a single administration major divisions between related services will in fact remain. For instance, the Employment Medical Advisory Service stays under the control of the Department of Employment, as will many rehabilitative services for the disabled. These are themselves to be reorganised in 1974 on a pattern different to that of the NHS. Collaboration in this area, particularly as it becomes more clearly recognised that many of the epidemiological variations between social classes are related to occupational factors, will be important. Much more emphasis is needed on preventive measures as well as on smooth linking between health care and industrial rehabilitation.

The prison health service controlled by the Home Office is another area which might have benefited from inclusion in the reorganised NHS. Although medical services within a prison environment may be necessary and valuable there are good arguments to the effect that they should not become too separated from the provision of health care available to the community as a whole.

A third point is that resources currently employed within the armed services health systems are in some cases underused. Their inclusion within a unified NHS could have reduced such inefficiencies, although even while they remain independent arrangements may be made for sharing facilities. Also at present some doctors both in the forces and the prisons feel that aspects of their freedom could be too limited by the Official Secrets Act (*BMJ* 1973). Incorporation of medical services in these areas under the NHS may therefore be thought desirable on constitutional grounds.

However, the main area of concern is at present in the area of collaboration between the local authority services such as the personal social services, housing and education and the new NHS authorities' activities. This is hopefully to be achieved by the establishment of Joint Consultative Committees coupled with the attachment of NHS staff, where appropriate, to the local authorities and vice versa and the presence of local authority members on the AHAs.

But it is not certain that these arrangements will prove adequate. For example, in many areas there will be a split between JCCs discussing health in the light of the educational and personal social services and those looking at it with regard to housing and environmental health problems. Although this may be considered to be primarily a problem of the local authorities' structural divisions it may be difficult to derive a unified health policy in the closely related fields of the housing and the social welfare of certain health care groups.

More importantly the JCCs will not have any powers with which to back up their recommendations and it may well be that in some areas local authority and NHS policies will diverge. If this does occur it will be difficult to resolve disputed issues, particularly in view of the relative autonomy enjoyed by the local authorities. The possibility of economic incentives to local government designed to avoid any unpopular rate increases stimulated by co-operation with the NHS will have to be seriously considered. If effective collaboration between the NHS and the local authorities cannot be established it is feared that 'pirate' services may be set up. For instance, the NHS may start to develop certain social services of its own.

It is in any case possible that some tension will exist between the two sides. One cause of this could be the probable desire of the NHS administrators to release material and manpower resources formerly tied to the schools' health services, perhaps to develop a more comprehensive community paediatric service. This may be opposed by some local authorities as may measures to stop present screening programmes, such as that for TB, for the general population. Although the weight of medical opinion amongst specialists regards these as of very little value they have strong emotive and hence political appeal.

Another problem is that the synchronised timing of the local government and NHS changes will probably mean that for some time the confusion will ensure that liaison is actually impaired in the few areas where it currently exists. It is to be hoped that relationships between the NHS and local authority departments will not be soured by this and also that the importance of relatively obscure organisational issues, such as the integration of medical social workers in the post-Seebohm local authority establishments, will not be forgotten.

Although it may be suggested that a separation between the social and medical services' administration is desirable and even that conflict between the two could provide beneficial social changes this point of view has its disadvantages. In many cases social and medical care must be designed to complement one another if either is to be effective. In that many members of the medical profession are opposed to the NHS being controlled by the local authorities[1] and those in social work fear being dominated by the health services and so wish to remain under local government it is unlikely that social and medical care will be placed under a unified administration in the foreseeable future. Consequently it is essential that strong means of ensuring collaboration are established.

The influence of the medical profession

During the development of the NHS the medical profession has understandably striven to protect its close relationship with the public. However, as a direct result of this it may be argued that many of Britain's doctors have in general failed to take into account a number of trends influencing the desirability of certain of their attitudes. For example, the increasingly firm scientific basis to many of the therapies employed in modern practice coupled with

1 Other considerations relating to local government control of the NHS include the need for centrally planned and uniformly implemented national policies and the acceptability to central government of divesting itself of much of its direct power over the NHS.

changes in the nature of the social order may have reduced the need of patients, particularly younger ones, to see their doctor as a source of moral and social guidance as well as the provider of skilled medical attention. And the proliferating medical and allied technologies of recent years combined with the development of other professional disciplines within the broad field of health and social care have increased the need for doctors to recognise the limits of their particular professional skills. The efficient working of the health service now depends on successful teamwork between professional and occupational groups rather than on the leadership of the medical profession. If this is not recognised then the full potential contribution of groups such as nurses, physiotherapists, pharmacists or administrators may not be realised within the reorganised NHS.

Yet within the new structure the medical profession will retain much of its status and power, and will even extend it in areas like the administration of clinical services. Despite the claims of some doctors that their new involvement in management will mean a heavy workload it has, partly at least, been achieved through the political pressure applied by the profession itself (Abel-Smith 1971).

Although the importance of the medical profession is such that it must occupy a key position within the health service the extent of its influence in some areas is disquieting. An instance of this is that hospital consultants will retain much of their influence on the running of the services which could have the unfortunate result of perpetuating the dominance of hospital and curative as opposed to community and preventive medicine within the NHS as a whole. In certain areas such as the rehabilitation of the physically disabled or the care of the mentally ill and handicapped this could tend to negate the purpose of the reorganisation. In the teaching hospitals, which retain considerable influence over the areas in which they are situated, it could also undesirably affect the content of medical education.

Another important question is that of the administration of the general medical services which in England is to be virtually unchanged in 1974, the Family Practitioner Committees replacing, on a different geographical basis, the Executive Councils. In that the arrangements made under the 1946 NHS Act virtually encapsulated the pre-existing structure of general practice the family doctor service of Britain in the 1970s retains many of the structural characteristics of that which existed in the 1930s. Thus although the DHSS may influence general practitioners via incentive schemes encouraging, say, group practices or the movement of doctors to areas where they are needed, it has no more direct

control over this vital area of health care. (Except through the AHA's administration of health centres.)

However, it may be that this issue is not so easy to solve as it may at first appear. Certainly any inroads into the independent contractor status of the family doctors could undermine the morale and efficiency of the service they provide for some considerable time. And it is unlikely that simply abandoning the Executive Council/FPC system as has been done in Scotland and Northern Ireland will have any great advantages over the structure in England and Wales. Also the introduction of the speciality of community medicine in the reorganisation could have important long term consequences. If the community physicians and their colleagues are able to establish an adequate exchange of information between those working in the community health services and the rest of the NHS this could do much to alleviate current problems in this area.

Conclusion

The National Health Service may be considered to have a variety of distinct, if related, goals. The most obvious of these is to deliver adequate health care throughout the population. But the potential demand for its services exceeds by far that level which could be achieved using the resources available to our society. And so a secondary end of the NHS is, it may be argued, to maximise the individual or social benefits it gives rise to by being selective in its approach to supplying medical care.

On a rather broader level of analysis it is possible to postulate further aims for the health service in terms of its general effects on the society in which it exists. An instance of this may be seen in the hope of men such as Bevin and Beveridge that the NHS might promote social change, breaking down some of the inequalities which exist in our present society.

The current reorganisation of the health services is not a revision of these goals. But it does promote changes in the means by which it is hoped to achieve them. Primarily it unifies and strengthens the formerly divided NHS management structure and introduces a more rigorous philosophy of evaluation than that which previously existed. This should permit a more flexible and appropriate allocation of resources and effort throughout the health service.

There are inevitably areas of the precise format laid down in the 1973 Reorganisation Act which have attracted criticism, much of it justified. Parts of the complex pattern of managing and advisory teams and committees may prove unworkable, especially in that it may become rule-bound and dominated by the upper echelons of the bureacracy at the expense of local autonomy. The role of the public in general and of health care workers other than doctors in decision making, particularly as this relates to defining the NHS's fundamental goals and values, will probably need to be strengthened.

But despite the belief of a few critics that the restructuring is little more than a political device intended not to alter standards of health care but to impress the public with merely symbolic progress a detailed examination of the new arrangements reveals fundamental developments. At district level alone they will offer, via the Health Care Planning Teams and the community physicians, a greatly improved facility for the health service to perceive and provide for the needs of local communities within the national framework. They also represent a striking experiment in health service management through groups such as the DMTs and DMCs and provide the basis for a new system of public representation via the CHCs.

It is to be hoped that as the advantages and disadvantages of the new structure unfold during the next five to ten years a momentum for further improvement based on the initial impetus of 1974 will build up. For ultimately the reorganisation should not be seen as an isolated, static event but as a part of the long term development of the provision of medical care in this country. This is itself a dynamic process not only because of the continual appearance of new technologies and new health problems but also because the social environment in which the NHS exists is itself constantly evolving.

Thus there can never be a single optimum health service structure, only one which changes as efficiently as possible in the light of altered circumstances. Seen from this viewpoint the new NHS with its improved evaluative and planning capabilities and integrated management is in many ways a desirable innovation. Perhaps the most important test it will meet in the future is whether or not it will permit radical developments in its own structure without the trauma attached to the ending of the divided and hence relatively rigid organisation which came into being in 1948.

Appendix I

Regions and Areas with AHA(T)s in italics (England)

Regional Health Authority	*Area Health Authorities (corresponding to the new local government non-metropolitan counties and metropolitan districts, or to one or more London boroughs, including the City of London)*	*Number of Area Health Authorities*
1 Northern	Cumbria; Durham; Northumberland; Cleveland; In Tyne and Wear the districts of *Newcastle upon Tyne*; North Tyneside; Gateshead; South Tyneside; Sunderland.	9
2 Yorkshire	Humberside; North Yorkshire; In West Yorkshire the districts of Bradford; *Leeds*; Calderdale; Kirklees; Wakefield.	7
3 Trent	Derbyshire; *Leicestershire*; Lincolnshire; *Nottinghamshire*; In South Yorkshire the districts of Barnsley; Doncaster; *Sheffield*; Rotherham.	8
4 East Anglia	*Cambridgeshire*; Norfolk; Suffolk.	3
5 North-West Thames	Bedfordshire; Hertfordshire; the London boroughs of Barnet; Brent and Harrow; *Ealing, Hammersmith and Hounslow*; Hillingdon; *Kensington and Chelsea and Westminster.*	7
6 North-East Thames	Essex; the London boroughs of Barking and Havering; *Camden and Islington*; Enfield and Haringey; *Hackney, Newham and Tower Hamlets with the City of London*; Redbridge and Waltham Forest.	6
7 South-East Thames	East Sussex; Kent; the London boroughs of Bexley and Greenwich; Bromley; *Lambeth, Lewisham and Southwark.*	5
8 South-West Thames	Surrey; West Sussex; the London boroughs of Croydon; Kingston and Richmond; *Merton, Sutton and Wandsworth.*	5
9 Wessex	Dorset; *Hampshire*; Isle of Wight; Wiltshire.	4
10 Oxford	Berkshire; Buckinghamshire; Northampton; *Oxfordshire.*	4
11 South Western	*Avon*; Cornwall; Devon; Gloucestershire; Somerset.	5
12 West Midlands	Hereford and Worcester; Salop; Staffordshire; Warwickshire; In West Midlands the districts of Wolverhampton; Walsall; Dudley; Sandwell; *Birmingham*; Solihull; Coventry.	11

13 Mersey	Cheshire; In Merseyside the districts of Sefton; *Liverpool*; St Helens and Knowsley; Wirral.	5
14 North Western	Lancashire; In Greater Manchester the districts of Wigan; Bolton; Bury; Rochdale; *Salford*; *Manchester*; Oldham; Trafford; Stockport; Tameside.	11

Appendix II

AHAs in Greater London

North-West Thames RHA
Barnet
Brent, Harrow
Ealing, Hammersmith, Hounslow
Hillingdon
Kensington and Chelsea
Westminster

North-East Thames RHA
Barking, Havering
Camden, Islington
City, Hackney, Newham
Tower Hamlets
Enfield, Haringey
Redbridge, Waltham Forest

South-East Thames RHA
Bexley, Greenwich
Bromley
Lambeth, Lewisham, Southwark

South-West Thames RHA
Croydon
Kingston, Richmond
Merton, Sutton, Wandsworth

Appendix III

The reorganised NHS structure in Northern Ireland, Scotland and Wales

1 Northern Ireland (Population 1.6 Million)

In Northern Ireland the reorganisation of the health services took place on 1 October 1973, after having been delayed by six months from the original target date of April. It introduced an administration based on four new Health and Social Service Boards, each being conterminous with a group of the 26 new local government districts. As is to be the case in Wales and Scotland there is no regional administrative tier in the reorganised structure. At the summit of the NHS in Northern Ireland there is the Ministry of Health and Social Services (advised by the Central Council) whilst a consortium of the Boards, the Central Services Agency, handles matters of common interest to them centrally.

Each of the four areas is divided into districts which have a population of around 50–100,000, although in the case of those under the Eastern Board this figure is more than doubled. The District Executive Teams (DETs) correspond

to the English DMTs although it is important to note that the officers of the Area Executive Teams (AETs) have direct authority over those of the DET, unlike the English pattern. There are programme planning teams at area level as opposed to the district health care planning teams in England. District Committees correspond to the English CHCs.

Two significant differences between the Northern Ireland and English NHS structures are that general practitioners are in contract with the Boards rather than FPCs or their equivalents and that personal social services have been brought under a unified administration with health separately from local government.

2 Scotland (Population 5.2 Million)

The main operational agencies of the reorganised NHS in Scotland will be 15 Area Health Boards which are to assume their full responsibilities on 1 April 1974. Ultimate responsibility for the administration of the health services in Scotland lies with the Secretary of State at the Home and Health Department (advised by a Health Service Planning Council). Like the Central Services Agency in Northern Ireland the Common Services Agency in Scotland is to play an important role in the new NHS structure with special responsibilities in areas requiring central planning and administration, although in some fields the Scottish agency (and its Welsh equivalent) will be more powerful than its Irish counterpart. It will, for example, execute the works programme, a responsibility of the Ministry in Northern Ireland.

Each Area Health Board is itself to decide on how many, if any, districts are needed within its area (which itself will correspond to a number of the new local authority districts comprising a whole or part of one of the Scottish regions). The health boards will also decide on the management structure to be employed, with Ministry approval, and will have more direct authority over their districts than will the English AHAs.

Liaison between health and local authority services will be established between the health boards and the local authority districts with regard to most environmental services and housing and with the Regions with regard to education and social services. Public interests in the new structure will be represented by Local Health Councils analogous to the CHCs in England.

The NHS in Scotland will have no equivalent bodies to the English FPCs, each area board having a standing GP committee to deal with the administration of this section of the health service.

3 Wales (Population 2.7 Million)

The reorganisation in Wales follows rather more closely the pattern of that in England, although there are some marked differences. For example, a Welsh Health Technical Services Organisation (WHTSO) is being created to carry out a central organisational role in relation to the eight new Welsh AHAs (conterminous with the new counties) similar to that of the Scottish Common Services Agency.

Central policy guidance and co-ordination of the AHAs will be provided through the unified Welsh Office which will have similar responsibilities regarding the inter-related services provided by the local authorities although collaboration will primarily be achieved via a system of JCCs similar to that in England. The Secretary of State will continue to be advised in health matters by the Welsh Council, rather than any special new advisory body as established in Scotland and Northern Ireland.

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