The Reorganised NHS

The Reorganised NHS

This study of the reorganised National Health Service is divided into two papers. The first describes the new structure and the management concepts on which it was based and the second examines the progress of and the criticisms made about the NHS since 1974. They were designed to complement one another although readers already familiar with the health service's administrative format may prefer to confine their attention to the latter study.

For the sake of simplicity both papers refer mainly to the circumstances of the NHS in England. However, some of the more significant characteristics of the health service in Wales, Scotland, and Northern Ireland are also examined.

Office of Health Economics
162 Regent Street London W1R 6DD

No. 58 in a series of papers on current health problems published by the Office of Health Economics. Copies are available at 70p.
For previous papers see page 35.
This report was prepared by David Taylor.

Printed in England by White Crescent Press Ltd, Luton

ISSN 0473 8837

Front cover illustration:
The oldest oak in England the Cowthorpe oak near Wetherby
Mary Evans Picture Library

Part 1 The changes of 1974

Introduction

Even before the establishment of the National Health Service in 1948 it was realised by many of the individuals associated with its planning and formation that its tripartite structure was likely to form a barrier to the provision of efficient, effective health care. In as early as 1920 the Dawson Report (Ministry of Health 1920) pointed to the need for a single authority for health service administration if a balanced pattern of primary and secondary care was to be developed.

The initial proposals of the coalition British government of the early 1940s regarding the creation of the NHS showed a similar belief in the desirability of unified health service direction. But some of the groups influential in health care at that time, notably the BMA, feared that their position and the interests of their members would be undermined were such a structure to be adopted, in part on financial grounds and in part because it was thought that it might permit complete local government control of medical services. Hence it was necessary to devise a compromise which involved the administrative separation of the local authority, hospital and independent contractor sectors.

Although this was in the short term an adequate and workable answer to the problems encountered by those attempting to steer the NHS into being the history of the health service during its first 25 years of existence clearly reveals the deficiencies of the tripartite structure. In particular, patients with chronic and/or handicapping conditions requiring the provision of integrated care from both hospital and community based services appear to have borne the costs of poor co-ordination between the three branches of the NHS and its associated overall isolation from the other agencies of the 'welfare state'.

Pressure for NHS unification began to grow at the start of the 1960s, notably with the publication of the Porritt report in 1962. 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 (England) was drafted and finally passed through Parliament in the summer of 1973.[1] The reorganisation took place in England, Scotland and Wales on 1st April 1974. However, by that time Labour had regained office and so inherited the plans of the previous administration, which were at some variation with their own original intentions. This led to very early pressures for further changes in the health service.

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. To many people the creation of the NHS symbolised the 'winning' of a better world after the deprivations of the war. By contrast the 1973 Act involved changes in an established system the services of which the population had come to expect as a normal aspect of life during the first quarter of a century of the NHS's existence.

There is, however, one element essential 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 its intended goals rather than to think of theoretically possible reforms without regard to the historical and current social and political limitations.

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 alterations in both the structure of services for the mentally ill and handicapped and in their individual rights, an area which is now once again coming under review (DHSS 1976a). 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 1962 Hospital Plan, the 1969 Bonham Carter report, and various subsequent DHSS publications have all helped to influence the evolving concept of the District General Hospital. The nursing profession was radically restructured after the Salmon and Mayston reports (Ministry of Health 1966, DHSS 1969a) and further changes are to be expected from the implementation of the Briggs report (Cmnd 5115, 1972). 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 administration.

Hence the 1974 reorganisation may justifiably be regarded as a single step in the continuous evolution of health care in Britain rather than as an isolated, dramatic disturbance of an otherwise unchanging system. Indeed, the success or failure of the structure it introduced will ultimately have to be judged on the extent to which it facilitates future radical changes without the trauma attached to the ending of the divided and thus relatively rigid NHS organisation created in 1948.

Preparing for reorganisation

The disbanding of the major decision-making bodies below departmental level of the pre-1974 NHS and their replacement by a new set of authorities carried with it the danger that such a transition could lead to interruptions in the provision and development of services. To minimise this risk the authorities to be replaced were asked to prepare for each new area statements regarding existing resources and plans. In addition, from the end of

1 In Scotland a White Paper on the health service was published in 1971 and the National Health Service (Scotland) Act was passed by Parliament in 1972. Northern Ireland's reorganisation took place in the autumn of 1973.

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 prepared the ground for the 'shadow' health authorities which were intended to have about six months to organise themselves before assuming full control in 1974. The contribution of the JLCs is generally regarded as having been valuable although in retrospect it may be thought that some of their decisions were unduly affected by the local interests of their membership.

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 set up for this purpose in 1972. At the time considerable controversy developed in this field, as might be expected in a situation in which all the senior jobs in the nation's largest organisation were at stake. For instance, fears were expressed on the one hand that there would be a great loss to the service of 'grass roots' knowledge through the seemingly unnecessary movement of staff from one locality to another. On the other hand it was suggested that because virtually all the posts were filled by existing NHS personnel biases within the system, such as the predominance of administrators with mainly hospital-based experience, would be perpetuated after the new structure came into being.

However, neither of these particular criticisms of the process of reorganisation appear to have been justified. In the case of possible losses of local knowledge the new system of health service planning has already led to an awareness that under the 1948–74 pattern adequate information about local need or demand for NHS services was rarely if ever available. And it appears also that the re-selection of staff permitted by the reorganisation had positive value in breaking down older, perhaps too stable, patterns of staffing and work which had grown up in the NHS over the first 25 years.

In the event the most significant problem which arose was that the programme of new staff appointments proved too extensive to complete by April 1974, the date imposed on the reorganisation by the decision to match its timing with that of the reorganisation of local government. Thus many key staff were not properly in post in April 1974, a situation which contributed little to NHS morale. Perhaps the most serious aspect of this situation from an organisational veiwpoint in England was that the new Area authorities were slow to assume their role in the period immediately after the reorganisation. This encouraged and/or obliged the Regions to intervene in matters which should have been Area responsibilities and the service has subsequently been somewhat slow in redressing such internal imbalances.

Yet taken overall the difficult process of transition from the old service structure to the new on the appointed day was achieved with considerable success, largely due to the very intensive retraining schemes mounted by the DHSS. The main cost of that success was the build up of an impression that the reorganisation was being imposed from above through often authoritarian sounding circulars and courses and that the views and experience of people actually working in day-to-day health care delivery were being ignored. This was unfortunate since the design of much of the structure described below was intended to promote District autonomy and local involvement with the overall NHS planning process. That the introduction of the reorganised structure could so widely have been perceived as acting in opposition to such ends raises questions as to whether a less uniform and more gradual process of change, perhaps regionally rather than nationally synchronised, would not have been more appropriate in England in 1974 and whether the latter type of arrangement should not be employed in any future restructuring of the health service.

The new structure

Table 1 shows that virtually all the former branches or the tripartite NHS are now incorporated in the unified structure, with only parts of the environmental health services remaining 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. All other civilian health services are now administered through the NHS with the exception of those specifically relating to occupational health under the Department of Employment. Otherwise only those health provisions existing in the prisons and the armed forces remain separately controlled.[2]

The key operational authorities in the English NHS are the Area Health Authorities. They have statutory responsibility for the running of the health service at a local level. In theory the Districts operate in parallel with the AHAs although in practice in multi-district Areas they act almost as a fourth tier in the health service management structure. The AHAs are corporately responsible for health care in geographical areas which are on the whole conterminous with the local authority metropolitan districts and non-metropolitan counties, except in the case of London AHAs (and one in Merseyside) where there is some grouping of boroughs. In all there are 90 English AHAs, 16 of them in Greater London.

Similarly Scotland is divided into 15 NHS Area Health Boards, Wales into eight AHAs and Northern Ireland into four Health and Social Service Boards. However, unlike the arrangements in England and Wales the Area level officers in Scotland and Northern Ireland have more direct authority over those at District level and in Scotland the Area Boards played a major role in defining and structuring the Districts. It is also of note that on average the English AHAs serve communities

2 The continued divorce of the prison and armed forces health services from the NHS is a matter of concern to some authorities. This is in part due to doubts as to the efficient utilisation of the latter and in part because of constitutional considerations. The latter might be thought to be of special relevance to recent events in Northern Ireland.

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.

some 30 to 40 per cent larger than those of their equivalents in other parts of the United Kingdom.[3]

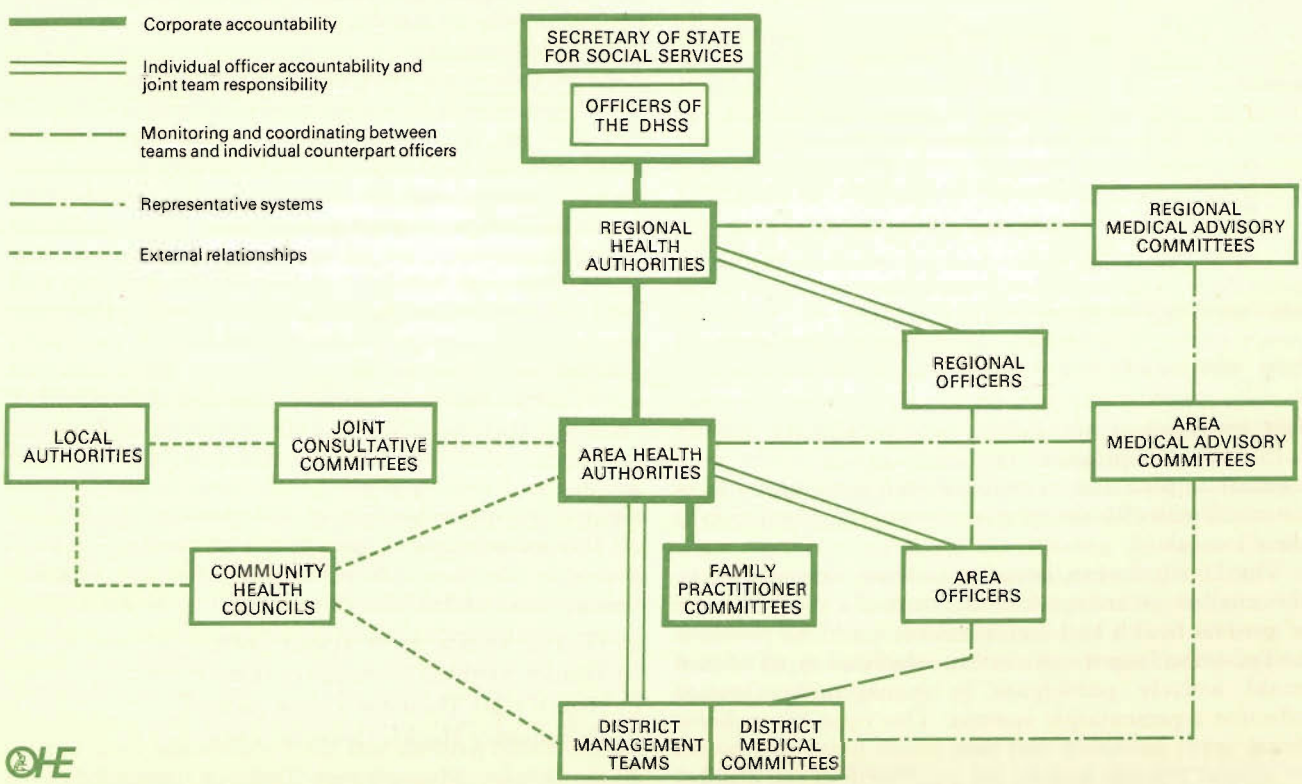
In England, as Figure 1 shows, the AHAs are grouped together under 14 Regional Health Authorities, bodies which have no direct equivalents in the Scottish, Welsh or Northern Irish NHS structures. However, the latter countries do have common Service Agencies which fulfil to a varying degree some of the role of the English RHAs. The latter are corporately accountable to the Department of Health and Social Security for the execution of their duties. In general the relationship between the levels of organisation within the NHS may be seen as a progression from strategic planning and resource allocation 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, an arrangement which constitutes a significant innovation in health service administration. This section looks at elements of the new structure in England in detail, commencing at the District level.

The Districts

In the opinion of many of the people involved in planning the reorganisation the concept of 'natural' Districts for health care was one of the most original and important elements in the 1973 legislation. For through the organisational pattern laid down at this level it was hoped

3 The value of this observation is limited because the great range in the sizes of Areas. In Scotland, for example, the Greater Glasgow Board serves over 1.1 million people whilst the Borders Board serves around 100,000 and those of Orkney, Shetland and Western Isles have populations in the order of 20,000.

Figure 1 *Framework of the NHS structure in England*



Source (Figures 1–4) *Management Arrangements for the Reorganised National Health Service.* HMSO 1972

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.

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 Britain*

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, around 40,000 of whom are in subnormality hospitals. So are 20,000 less retarded people.

e) Over half a million people in Britain are suffering from a diagnosed mental illness. At any one time about 100,000 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 3 times per average patient per year, that is nearly 30 times per doctor per working day. Women consult their GPs roughly 50 per cent more often than do men.

Source OHE estimates derived from government data

that members of the health care professions directly involved in the provision of patient services might work together to plan and co-ordinate their activities so as to cater efficiently for the specific needs of the population in their localities.

The Districts were, broadly speaking, intended to be the smallest units for which substantially the full range of general health and social services could be provided and also the largest ones within which all types of staff could actively participate in management through effective representative systems. The 1972 'Grey Book' (DHSS 1972) indicated that they would have populations of around 250,000 people, the equivalent of the number served by about ten health centres or five social work teams. A breakdown of the numbers of people in the various health service client groups in an average District is provided in Table 2a, whilst 2b gives a national picture. The 'Grey Book' also stated that the Districts would be defined 'naturally'; that is, primarily in accordance with the use by local people of community and hospital services rather than with regard to the formal geographical boundaries of the health and local authorities.

But in reality some characteristics of the Districts have proved to be rather different from the planners' original expectations. For example, there is great variation in their sizes, with some serving populations of below 100,000 and a few populations in the order of 500,000. In many cases it is also clear that boundaries were drawn in relation to the location of existing health service facilities rather than the use made of them by local people, this being particularly so in urban areas such as London where 'natural health communities' might often be thought to be merely administrative concepts rather than observable social entities. Indeed, some authorities now believe that the introduction of theories regarding 'natural Districts' into the planning of the new NHS's structure was undesirable and that it would have been better if the reorganisation had been more clearly aimed at the single objective of providing an efficient and flexible management format.

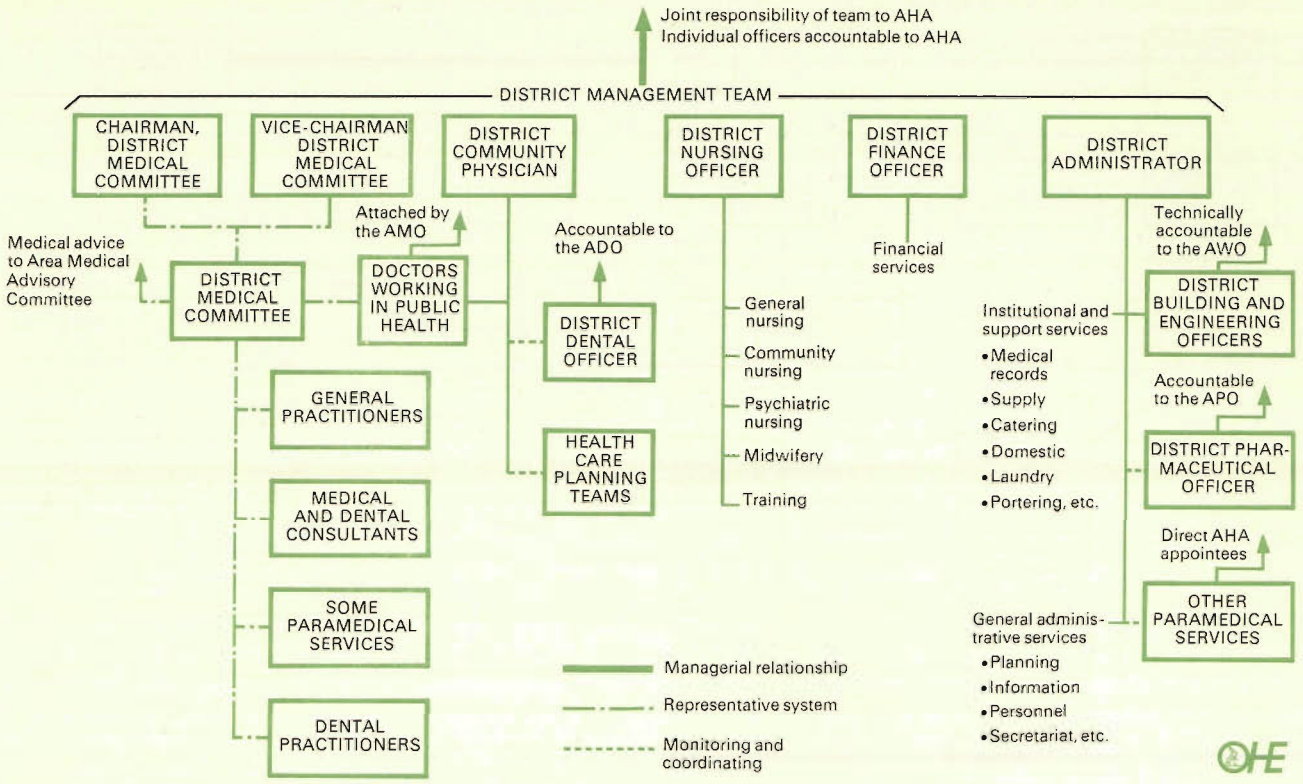
In this context a significant problem associated with the geographical boundaries of the health service authorities is that many of the Districts overlap two or more formally defined Areas. To deal with the difficulties created by this AHAs may make liaison arrangements with one another or staff may be seconded from one AHA to another. In cases of large 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.

At the time of the reorganisation it was feared that the co-ordination problems associated with overlaps and the fact that the new Health Districts were not conterminous with the local authority non-metropolitan county districts would, together with the extra complicating factor in London of one AHA having to relate to several boroughs, prove a major barrier to the emergence of closer links and better co-operation between NHS and local authority controlled services. In practice, however, the resulting problems of administration have not proved insuperable and may at times have stimulated desirable interchanges of opinion and information although they have also required effort and the extensive use of scarce manpower. It should also be noted that in London the problems of conterminosity may have received exaggerated attention because of the possible significance of District overlaps in any future redrawing of local authority boundaries. Key features of the NHS organisation at district level (shown in Figure 2) include:

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

Each District Management Team is composed of a nursing and a finance officer, an administrator and

Figure 2 *Framework of the District organisation*



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 and who are the only members to receive special payment for their position on the team because it involves work outside their normal duties.[4]

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 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 are also 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 former hospital medical executive committees with a system of general practitioner representation. The role of the DMC appointees to the DMTs is 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. Established by the DMTs they conduct detailed local planning for the provision of integrated individual care for patient groups such as expectant mothers, the elderly, children or various categories of the chronically ill. Each District has several teams, some standing and some ad hoc. In general it is those areas of care which are expected to change most which are covered by permanent teams.

An additional element of the reorganised NHS which may be currently 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 public 'watchdogs' with regard to the development of the health services. Although not part of the formal management structure they should have access to NHS plans and premises. They also meet with the AHAs at least once a year and publish annual reports to which the AHAs will be obliged to reply. Further, since the publication of the consultative paper *Democracy in the National Health Service* just after the reorganisation in May 1974, CHCs have had powers relating to the approval of hospital closures. Subsequent to consideration of comments on *Democracy in the National Health Service* the then Secretary of State for Health, Barbara Castle, announced certain other changes including the right of CHCs to have a member attending AHA meetings as an observer and the possible formation of a national body of CHCs. The establishment of the latter was finally agreed in late 1976.

4 An important difference between the NHS in England and Scotland is that there is no equivalent medical representation at this level of administration.

Figure 3a *Framework of the AHA organisation, without Districts*

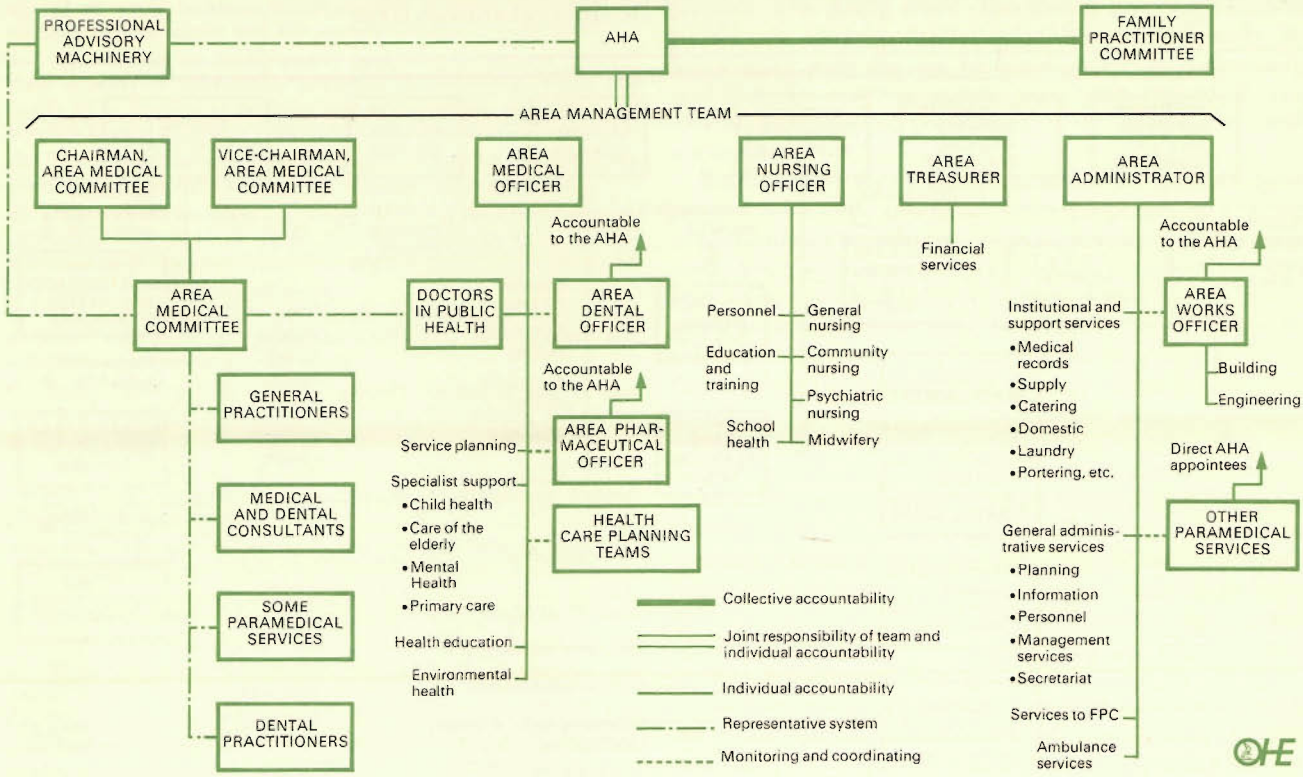
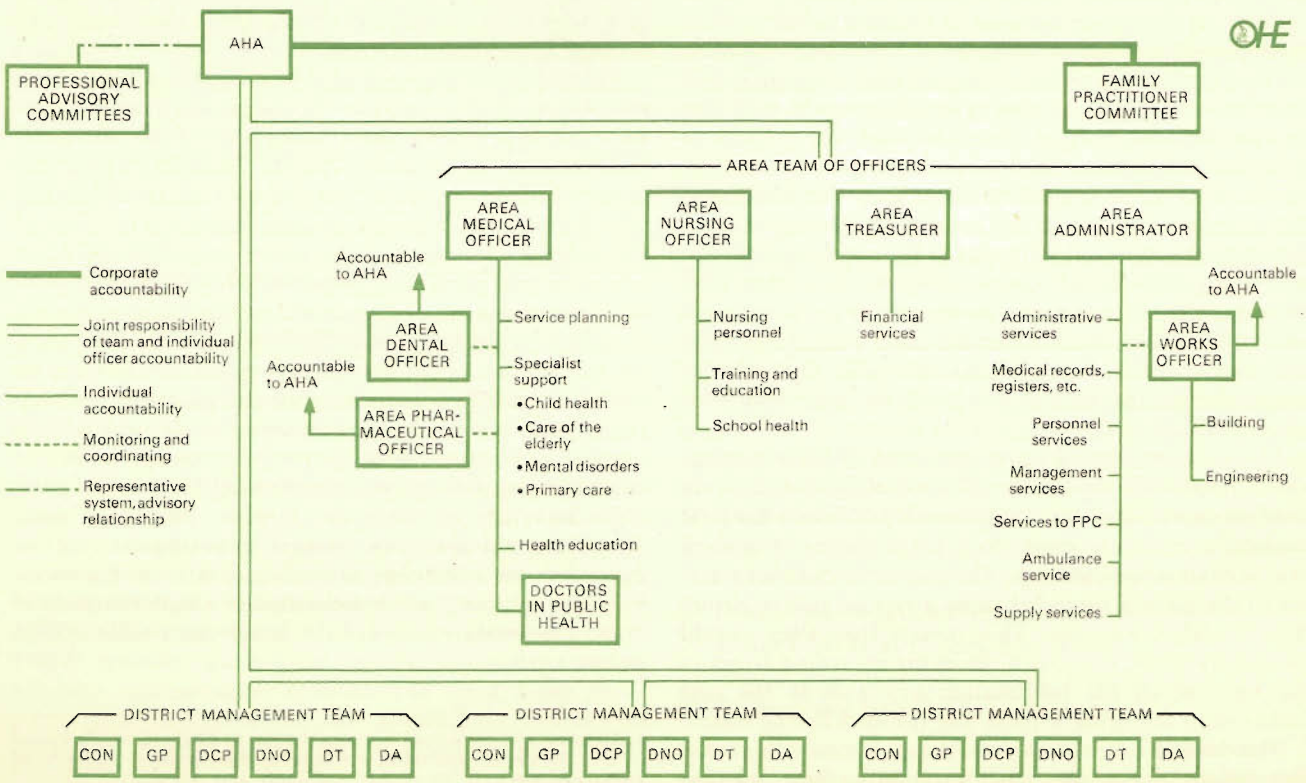


Figure 3b *Framework of the AHA organisation, with Districts*



Most CHCs have between 18 and 30 members of whom half are appointed by the local authority relevant to the CHC's District and one-third represent local voluntary organisations. The remainder are selected by the RHAs, which also finance the CHCs. Regarding membership the main change introduced since the 1973 legislation came into force is that NHS employees and independent contractors to the NHS are now eligible.

The Area Health Authorities

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

The organisation of an AHA with several Districts differs from that of a single district AHA (see Figures 3a and 3b). In the latter the Area Team of Officers (ATO), which supports the AHA members and holds delegated executive powers, plays a role similar to that of the DMT. In such circumstances it is known as an Area Management Team (AMT).

Under the original 1974 arrangements each AHA usually had 15 members (except in AHA(T)s) four of whom were representative of the local authority.[5] However, one of the changes announced in 1975 was an increase in the local authority membership of both AHAs and RHAs to one-third of the total and the inclusion of two additional NHS staff members on each authority. The remaining AHA members are selected by the RHAs except for the chairmen, who are the only ones receiving direct payments in addition to their expenses, who are appointed by the Secretary of State.

The AHAs are responsible to the RHAs for the running of services as corporate bodies although individual officers of the ATOs have delegated powers which may lead them to be individually accountable for certain services. And in practice many members of the Authorities argue that their influence on the day-to-day running of the NHS is very limited. This belief is associated with considerable discontent.

In Areas which have teaching hospitals within their boundaries the health authorities are responsible for their administration and are known as AHA(T)s[6]. In order to facilitate this the university concerned may nominate two members of the relevant AHA(T) which must also have at least a further two members with teaching hospital experience, so giving the latter strong representation at Area level. It is also of note that the AHA(T)s appoint the senior medical staff of the teaching hospitals directly rather than through the RHAs. With regard to research, which the Regions have a special responsibility to finance, the Teaching and Research Committees advising the RHAs were initially selected from the Boards of Governors and the previous university Hospital Management Committees.

In describing the functions of the health service authorities the recent report of the Devolution Working Party noted that the AHAs provide a point at which public interest in the service may be formally expressed and noted that one aspect of this AHA contact with external views is the facility for collaboration between local government and the health service at Area level provided by Joint Consultative Committees (JCCs). In the metropolitan districts there is one such committee to cover all services of common concern and in the non-metropolitan counties there are two, one covering personal social services and school health and the other environmental health and housing. This is because in the counties the latter services are administered at district level.

However, even at the time of the formation of the JCCs there was concern about their likely effectiveness, in part because there were no clear guidelines as to their precise constitution and the supporting services to be provided for them, and in part because their role was purely advisory in a situation where there was no obvious means of bridging the sometimes conflicting economic interests of the NHS and local government authorities. In response to this situation plans were announced in March 1976 to stimulate joint NHS/local authority planning services for certain priority groups, such as the mentally ill, based on a system of joint financing.

Through this AHAs have a limited amount of money available to contribute up to 60 per cent of the capital and initially a similar proportion of the current cost of joint NHS/LA projects, although the revenue consequences must be entirely carried by the local authorities after a period of up to six years. Planning in this field is conducted by Joint Care Planning Teams (JCPTs) which operate at AHA/LA level under the general direction of the JCCs. This arrangement strengthens the position of the latter in urging collaboration between the local authority social services and the NHS and also represents an extension of the AHAs' role relative to that of the Districts in planning local services, a shift which is significant in the light of recent criticisms of the Area tier and concern about District overlap problems in service planning.

Collaboration between the AHAs and the local government is also promoted by attachments between the staffs of the LAs' environmental health services and those of the Area Medical Officers (AMOs) coupled with the appointment of specialists in community medicine within the NHS whose explicit task is liaison with the local authorities.

Another responsibility of the AHAs is to establish and provide staff for the Family Practitioner Committees (one in each Area) although FPCs have their own statutorily delegated powers and function independently of the AHAs, a point which has been made clear by DHSS policy towards them since the reorganisation. The FPCs replaced the Executive Councils in providing administrative services for the independent contractors to the NHS. They have 30 members, half of them appointed via the local representative committees of the various professions involved (there are eight doctor members, three dentists, two pharmacists, one ophthalmic medical practitioner

5 In London one AHA place is filled by an ILEA representative.

6 The London postgraduate teaching hospitals retained their Boards of Governors and their direct link with the DHSS. This pattern of administration is shortly due for review.

Figure 4 *Framework of the RHA organisation*

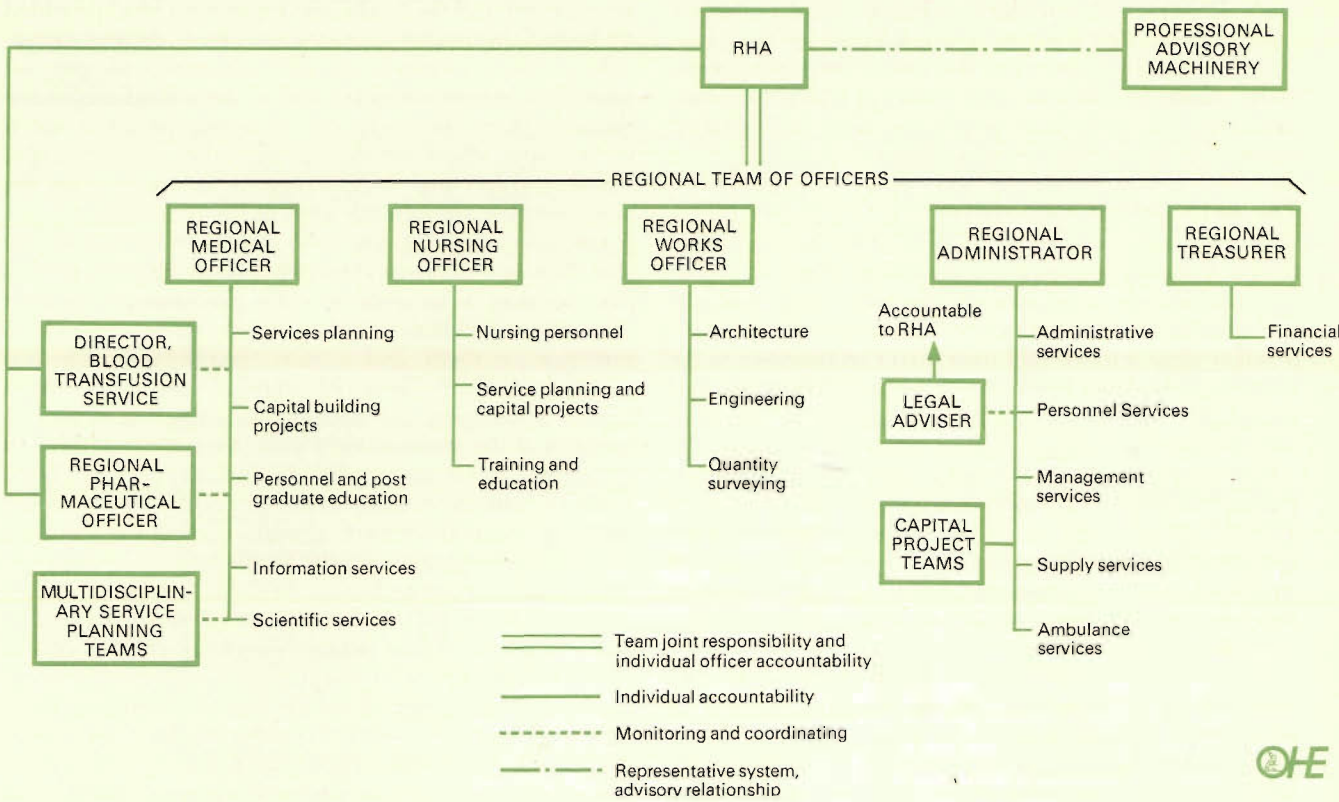
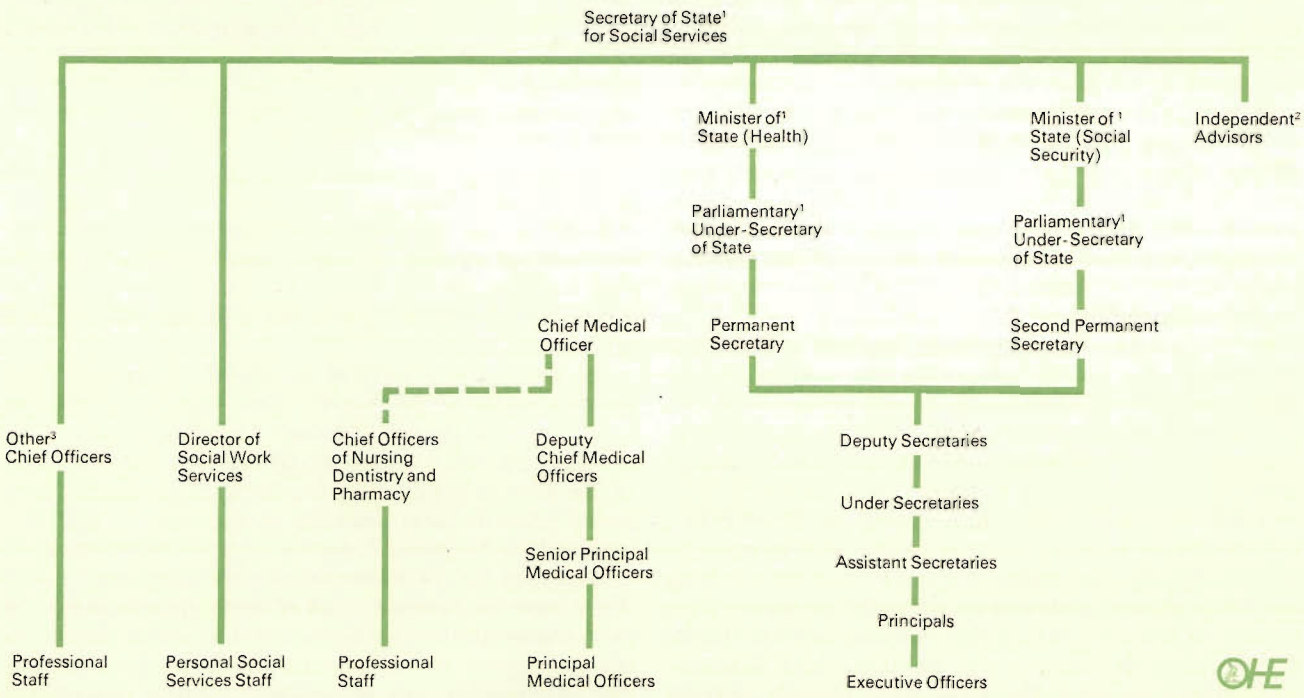


Figure 5 *The organisation of the DHSS*



Notes

1. Indicates must be either a Member of Parliament (Commons) or a member of the House of Lords.
2. Ministers have increasingly, since 1970, tended to introduce their own personal advisers who are independent of both the DHSS and Parliament. Some of them are on the civil service payroll, others are seconded from their usual employment, and some are paid for by the political party in power.
3. Chief scientist, chief statistician, chief architect, chief engineer, chief quantity surveyor.

Source Levitt 1976

and one optician). Of the 15 lay members four are appointed by the local authority and 11 by the AHA.

Regional Health Authorities

Figure 4 shows the structure of the English Regional Health Authorities. Like the AHAs the RHAs now have between 18 and 24 members. Originally all were direct appointees of the Secretary of State. However, provision has now been made for one-third of the membership to be local authority nominees.

The role of these Authorities is largely related to the NHS planning process. They translate national policies into a framework of regional objectives and strategies within the guidelines of which the AHAs may exercise their delegated powers (the use of which is subsequently monitored by the RHAs) whilst at the same time feeding back to the DHSS data about health needs and potential developments in their Regions, so contributing to the evolution of future national policies and priorities. Regional Health Authorities also allocate the capital and revenue resources available to them to the various Areas within their boundaries in the light of their long-term objectives and themselves provide certain financial and other central services (like the ambulances) directly.

Just as the AHAs are accountable to the RHAs as a corporate body so the RHAs are accountable to the DHSS. This system of corporate accountability between the English NHS authorities with statutorily delegated powers and the joint accountability of DMTs to AHAs means that officers at the various tiers are not in a line management relationship. For example, at Regional, Area and District levels the personnel officer is directly accountable to the administrator at his or her level, not to a personnel officer in the tier above even though the Regional and Area officers have monitoring responsibilities.

The Department of Health and Social Security

The DHSS was formed in 1968 when the Ministries of Health and of Social Security were merged to form one new 'super ministry'. The Department now employs over 90,000 people, although only about 5,000 of them are directly employed in the central administration of the health service (DHSS 1976d). And of the latter number not all are involved exclusively with the NHS, their duties including activities like export sponsorship and assisting the work of the Medicines Commission and that of the personal social services.

In December 1972 the health side of the DHSS was restructured with the help and advice of management consultants from McKinsey and Company (who worked alongside the civil servants in preparing the new format) in order that the Department would be able to meet the demands generated by the approaching reorganisation of the health service. The structure originally planned involved the division of the main body of civil servants in the Department, as Table 3 shows, into six functional groups with roles varying in content from financial direction and personnel advice through research to service development and guidance for and liaison with the RHAs. One section deals with departmental support services in general and another serves the Secretary of State's office directly. In fact, the structure adopted has never precisely followed the lines shown in Table 3 and

Table 3 *The six main groups in the DHSS and their primary objectives*

Top of the Office
To help the Secretary of State provide central leadership in the health and social services
To advise him on ultimate choices about the nature and scale of the NHS and national objectives and priorities
To advise him on matters of major public concern
To manage the Department's resources
Service Development
To help the Secretary of State decide national objectives, priorities and standards for the health and social services, and specifically to
– Advise on nature and scale of the NHS
– Develop policy needed to improve health services
– Promote local authority social services
– Identify and develop plans to meet needs of selected clients
To support the field authorities and the Regional Divisions in implementing these decisions
To support the Secretary of State in relation to allocated subjects.
Regional
To guide the health and local authorities on national objectives and priorities
To support and (to the extent feasible and desirable) control them in the planning and running of services
To provide specialist support to them in building and supply
To support the Secretary of State in relation to allocated subjects
NHS Personnel
To help the Secretary of State decide fair and economic pay and conditions of service for all NHS personnel, and to see agreement is reached with staff concerned.
To help the NHS recruit, train, retain and employ sufficient staff of the required calibre and experience
To support the Secretary of State in relation to allocated subjects
Department Support (to Social Security side also)
To support the Top of the Office on manpower and organisation and efficiency matters and negotiate with CSD and Treasury
To support line managers in organisation, staffing, the efficient use of resources and staff development
To provide specialist support as needed (e.g. Statistics, ADP, OR, O & M)
To support the Secretary of State in relation to allocated subjects
Finance
To represent the Department with the Treasury and the rest of government on financial matters
To provide financial advice to the Top of the Office
To provide financial advice to the Department as a whole and to review the financial implications of proposed and current policies
To exercise financial control of the income and expenditure of the Department, the NHS and other agencies under DHSS supervision
To support the Secretary of State in relation to allocated matters

a series of innovations have been made in it. Nevertheless the basic outlines remain.

Figure 5 describes the overall organisation of the Department, showing the position of the professional divisions relative to the other elements within it. The professional groups and their chief officers, particularly the chief medical officer, retain a degree of independence and are not directly incorporated in the civil service managerial hierarchy, although all DHSS employees are civil servants rather than NHS employees.

In a sense the DHSS has a dual role to play, acting both as the central policy forming, monitoring and funding body of the health service and as an arm of the government controlling the health service as just one part of its national responsibilities. Thus the individual at its head, the Secretary of State, has both the duty to present and defend the interests of the NHS within the Cabinet and to subsequently defend and implement the policies of the Cabinet as they affect the NHS.

In the execution of its functions the Department is aided by a number of advisory bodies, the most important of which is the Central Health Services Council (CHSC), the membership of which was revised in 1974 to allow consumer representation. Another innovation introduced at the time of the reorganisation was the Personal Social Services Council (PSSC) which plays a role similar to that of CHSC (which itself has representative members on the PSSC).[7]

Regarding the formation of specific health policies there is no completely external body which has an explicit duty to monitor the work of the DHSS. However, as regards its financial rectitude and administrative efficiency there are a number of checks on the way it exercises its power operated by the Treasury and by Parliament through the Public Accounts Committee and the House of Commons Select Committee on Expenditure.

Management

The ideas on management expressed within the new health service structure owe their origin to a number of sources. In addition to the Department of Health itself these include the management consultants McKinsey 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 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 at a national level on their performance and costs. Indeed, in that localities affect each other and combine to form a whole 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 essential.

However, this is not to say that the approach adopted to delegation and the maintenance of accountability in the new structure is entirely necessary and/or desirable. For example, recognition of the need for accountability to a central agency in control of national policy formation should not be taken to imply that the hierarchical distribution of economic and other forms of social status present in the NHS is either essential or desirable on the grounds of organisational efficiency. Furthermore, the principle of accountability matched by delegation has been criticised on the grounds that it has tended to exclude from the new structure arrangements for the health service consumers, the general public, to participate directly in the control of the NHS.

The content of the roles of people working within the health service varies considerably with the specific natures of their tasks. In some circumstances it may be difficult to achieve a balance between the demands of organisational efficiency and integration and those of professional practice. For example, considerable concern has been expressed regarding the need for 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 (as is the case for example, in nursing and hospital pharmacy) and others are non-hierarchical (for example, consultants and contractors for family practitioner services) differing methods for achieving accountability have been employed, although it is to an extent an indicator of the power enjoyed by the medical profession as opposed to other health service workers that such variations in autonomy exist.

An important point in this context is that although the reorganisation is sometimes said to have introduced an unacceptable spirit of managerialism in the NHS this criticism is somewhat misplaced. 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 any of the provisions of the 1973 Act have created.

7 The Health Advisory Service (originally set up as the Hospital Advisory Service in 1969) plays some part in questioning current health service policies although its role is basically concerned with monitoring the quality of care.

Many innovations were 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 (which largely but not entirely rests on the work of the CHCs) illustrate some of the key elements.

Planning

Throughout the world one of the most obvious trends in developed countries' health care systems in recent years has been an increased awareness of the importance of comprehensive health service planning. The new NHS planning system reflects this change of emphasis and is regarded by many commentators as the most significant single element within the reorganised structure. Through the procedures it embodies the reorganisation's architects hoped to combine an increased capacity for ensuring that nationally approved policies (particularly as they relate to previously deprived or 'unpopular' health care groups) are put into practice across the country with greater NHS sensitivity at the 'grass roots' level to specific local needs and problems.

The planning cycle has two main elements, one strategic and the other operational. The former provides a long-term (10–15 years) view of the objectives of the services at Area and Regional level as a background for the construction of shorter term operational plans. These are established through consultation between all levels of the health service administration on a three-year rolling basis and are revised each year in relation to factors like variations in resource constraints or changes in priorities. The revised timetables and procedures for these two complementary aspects of the planning system are shown in Figures 6a and 6b, whilst Figure 7 illustrates the intended flow of guidelines and plans in the post-1974 NHS.

Health authorities at all levels had a considerable amount of time to study the new arrangements before attempting to implement them. Several conducted full scale trials and all had established health care planning teams at District level by mid-1976, well before the first full run of the system was due to start. However, a major problem remains in that the information base on which the planning must be based is at present very limited, especially regarding the levels of morbidity experienced by individual communities and the value and effectiveness of currently employed patterns of care and treatment. Clearly much effort will be needed to expand this information base over the coming years but the extent to which this can be achieved in a time of reducing funds available for administration coupled with expanding managerial responsibilities is limited.

Once formed and agreed at all levels the application of plans is conducted via the system of delegated powers. Each tier monitors the performance of the one immediately below it, a process which may be compared with that of co-ordinating the planning inputs of the various individuals, advisory groups and care planning teams at any one level in that neither monitoring nor co-ordinating roles in themselves involve direct managerial control over those being monitored or co-ordinated.

Monitoring is widely regarded as the least successful of the managerial concepts embodied in the 1974 NHS. Whereas the arrangements for concensus management (particularly at District level where there are strong motives for DMT members to agree with one another lest their authority be reduced by the need to call in the AHA to resolve conflicts) have proved rather more effective than critics feared, monitoring remains ill defined and surrounded by uncertainty. This is doubtless in part related to the delayed introduction of the planning cycle but probably also stems from a general feeling that monitoring roles as laid down in the management 'Grey Book' would be extremely difficult to act out in practice. It has, for instance, been suggested (Maxwell 1976) that attempts to do so could restrict the willingness of NHS administrators to propose new objectives or ambitious targets for fear of failing to meet the subsequent expectations of those monitoring them.

Doctors in management

The reorganised NHS has a number of mechanisms aimed at ensuring that health service management is kept informed of medical and other professional opinions and that NHS policy is accepted by the professions. For example, each Area has Local Professional Advisory Committees formed from some of those groups involved in the community health services. These help to provide the basis of the statutory medical advisory machinery at both the Area and Regional levels. And in England above the Regional tier the Central Health Services Council and its specialist sub-committees, such as the Sub-committee on Vaccination and Immunisation, advise the DHSS on national issues.[8]

At District level there are also the District Medical Committees, members of which sit on the District Management Teams. The DMCs were intended to act as a vehicle through which local clinicians would help to determine local priorities relative to their various activities and would also use their authority as self-regulating bodies to persuade individual doctors to co-operate with plans which had general consensus approval. It was in addition hoped that they would bridge the gap between hospital and community medical interests and so lead to greater unity within the profession, an objective which it is also intended to promote on the community side by encouraging the development of multi-practice health centres which the planners believe help to breakdown the isolation of family doctors from their professional peers.

However, in practice the DMCs appear so far to be only partially successful. There is, for instance, still a strong tendency for the split between hospital doctors' and general practitioners' interests to remain in many Districts, with the use of separate representative committees rather than the DMC still being favoured. It has also been suggested that it is often the DMC representatives to the DMTs who begin to feel the stresses of becoming separated from the body of their medical peers rather than individual practitioners who retain highly personal views on service priorities.

8 Rather different arrangements have been made in other parts of the United Kingdom. For example, in Scotland the Home and Health Department is advised by the Chief Scientist's Committee and its Research Committees as well as by the Scottish Health Service Planning Council.

Figure 6a *The NHS planning system. Operational planning timetable*

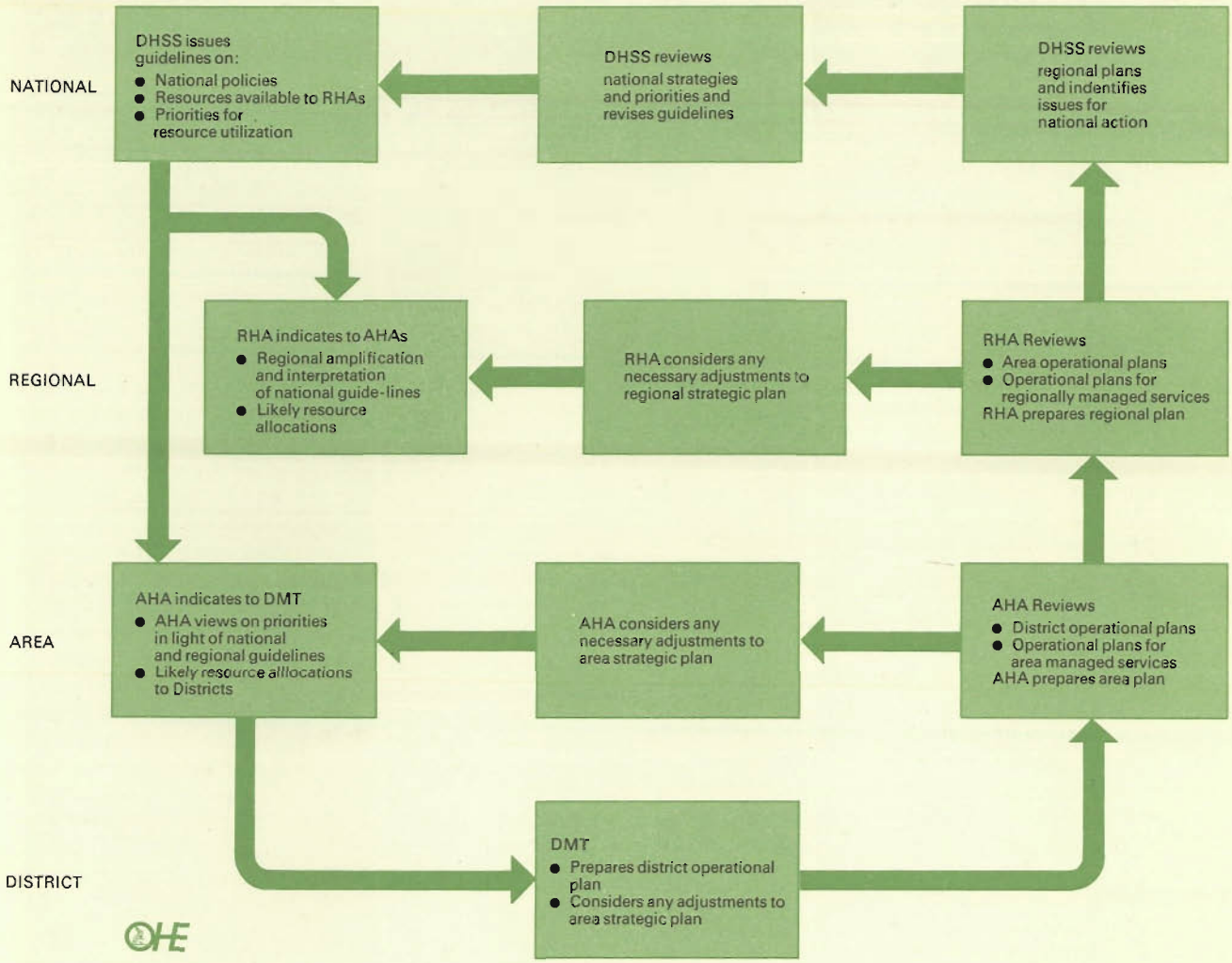
Note Continuing activities are shown in italics. Boxed items do not apply in the first year.

Source (Figures 6 and 7) The NHS Planning System. DHSS 1976

Figure 6b *The NHS planning system. Typical strategic planning timetable*

Note Continuing activities are shown in italics.

Figure 7 *The flow of guidelines and plans in the NHS*



In addition to these provisions for facilitating professional representation in management the NHS is also structured to give individual doctors considerable direct managerial responsibilities, as advocated in the Hunter Report (DHSS 1972b). These are 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 formal duties relate to the planning process, the development and evaluation of epidemiological information about their localities, the evaluation of service effectiveness, the co-ordination of preventive services and advising the local authorities.

At the time of the reorganisation it appeared that the work of most specialists in community medicine would be rather more consultative than managerial as compared with their nearest equivalents in the 1948–74 NHS, the local authority Medical Officers of Health. Yet in practice many specialists in community medicine have become relatively heavily committed to managerial or quasi-managerial activities in the first years of the new NHS's existence. This may in part have been due to a degree of under-staffing (in April 1976 some 15 per cent of community physician posts were unfilled – Heath and Parry 1976) which itself has been associated with national controls on the size of community medicine establishments imposed because of both economic restrictions and fears that too few suitable applications for such positions are currently available.

The overall improvement of the quality and in some areas the quantity of health and related social statistics capable of being used at both local and national levels is essential to the development of the health service. It is thus to be hoped that the pressures on the community medicine specialism at this stage in its development will not lead to the sacrifice of the goal of improving epidemiological data and preventive health information in favour of the direct needs of the NHS management process. If this appears to be happening it may eventually be necessary to split posts in community medicine into two types: managerial and epidemiological (Galbraith 1976). Such an arrangement could both protect the epidemiological functions of community medicine and also make it more independent from (and thus perhaps more critical of) the NHS management. It might be added, however, that it may also stimulate further debate as to

the numbers of people with specialist epidemiological skills who are needed within the NHS and whether or not it is desirable to direct a significant number of individuals with a costly medical training into purely managerial activities.

Public representation

Public interests in the health service are protected by the procedures available for the handling of specific grievances and by the arrangements within the revised 1974 structure for encouraging public involvement in the development of the NHS through the Community Health Councils in England and Wales and their equivalents the Northern Irish District Committees and the Scottish local Health Councils.

Complaints are handled at a number of levels, from internal enquiries in wards which usually resolve minor hospital issues through to the law courts in serious cases relating to matters such as alleged neglect or mistreatment of patients. Accusations of certain forms of misconduct against individual practitioners 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 judgement. These they form via the system of Service Committees established under the NHS (Service Committees and Tribunal) Regulations of 1974, a review of which was initiated by the government in late 1976.

Questions considered in this context include the structure and size of Service Committees and what maximum length of time should elapse between an event and the latest date upon which a complainant may register a complaint relevant to that event or his or her awareness of it. Points relating to the strength of professional representation on the Service Committees and the desirability of allowing the FPCs, the bodies responsible for the administration of independent contractor services, to decide whether complaints are justified and to control the procedures for their examination may also be relevant although perhaps outside the review's scope.

Arrangements for handling complaints to hospitals (written complaints number about 12,000 a year) have recently been reviewed by the Davies Committee (HMSO 1973). Amongst the proposals contained in its report was a code of practice for handling suggestions and complaints, a modified version of which was put forward for consultation by the DHSS in June 1976. This has been generally welcomed although some concern has been expressed that the Davies Committee's recommendations have been somewhat 'watered down'. It might also be suggested that a continued lack of integration between the family practitioner and hospital service complaints procedures may in some ways be inappropriate. And in the case of the former there is the additional point that to confine the complaints considered only to those which involve a breach of contract may be too narrow an approach to be of any great value.

A potentially significant innovation in the area of complaints investigation was the introduction in 1973 of the Health Services Commissioner whose 'ombudsman'-like role it is to examine complaints not satisfactorily dealt with by other means, But it was soon realised that the Commissioner's field of enquiry is very limited. He is, for example, 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 consquences 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 could, therefore, be easy to overestimate the significance of the Commissioner. However, the Select Committee on the Parliamentary Commissioner for Administration was invited by the Secretary of State for Health and Social Services in February of 1976 to review the jurisdiction of the Commissioner with regard to complaint investigation. It is possible that the Select Committee will feel that the Commissioner's remit should be widened in relation to all complaints involving clinical judgement (which the Davies Committee wished to see investigated by Regional Panels).

Such moves towards revising citizens' opportunities to seek redress in circumstances where they feel their health care has not been of an appropriate standard may make a significant contribution to ensuring that the public's interests in the NHS are not ignored. Yet too much emphasis on complaints systems for achieving this end could be counter-productive. For instance, some aspects of American experience of heavy legal involvement with clinical complaints are disturbing. And in any case the representation of public interest often demands the positive and constructive statement of fresh ideas rather than merely the registration of complaints of services failing to meet prescribed standards.[9] Thus it may be argued that what is really needed is a strong 'public voice' in the establishment of the objectives and standards of the health service.

Community Health Councils

The creation of the Community Health Councils in 1974 and their strengthening after the publication of *Democracy in the National Health Service* were attempts to provide such a voice. The CHCs are a break with the past tradition of public representation within the NHS on bodies such as the old HMCs or RHBs in that they are free from any form of executive accountability or responsibility. This, the reorganisation's planners hoped, would free them to defend the public's interest in the health service as effectively as possible whilst allowing the health authorities themselves, the AHAs and RHAs, to concentrate exclusively on their managerial role.

In the first years of their existence considerable controversy and criticism has surrounded the CHCs. It has been suggested, for example, that their membership is not representative of the general population and also that on the one hand CHCs require more direct powers within the service to be effective whilst on the other they have so little realistic knowledge of health care issues that any increase of such 'lay' influence on NHS activities

9 Although the proposed code for handling hospital complaints and suggestions does allow for some recording of the latter.

is likely to be disastrous. Further, it has been pointed out that few members of the general public have heard of CHCs and that the Councils as yet have had neither the resources nor the will to research public views on health care in any depth. In addition a few commentators believe that there is a danger they may be 'seduced' by DMTs and/or AHAs into playing a quasi-managerial role and that their secretaries may sometimes have an excessive influence on their views and activities.

But any judgement to the effect that the CHCs have proved a failure would at this stage be premature for they have had relatively little time to establish their skills and identities. It would thus be unfortunate if early investigations of CHCs and their membership, such as that by Klein and Lewis (1976), come to be regarded as definitive works on the subject since the situation is so fluid, and the rate of change of membership so rapid, that such studies may be outdated even before they are published. And criticisms of the value of CHCs by individuals within the health service executive structure (for example by some District Administrators or FPC staff or members) should be tempered by the realisation that CHCs may be seen by them as a threat to their authority.

In fact, there are already a number of examples of cases in which CHC intervention at District level has brought to light issues which might otherwise have been ignored by NHS management and many Councils can already claim a degree of success in acting as a focus of information about the health service. And it is probable that, regardless of the value of their specific contributions, the existence of the CHCs is in itself a valuable influence on the attitudes of people working within the NHS, leading them to be rather more sensitive to local interests and feelings about health policies than might otherwise have been the case.

A final point to add in the context of CHC development is that in late 1976 those in England and Wales decided by a narrow majority to form a national association. The considerable opposition to this move stemmed from a fear that it would undermine the position and local impact of individual CHCs and because of resentment of the manner in which the idea of a national association was apparently steered towards realisation by the government. However, even though the late creation of the national body tends to underline the fact CHCs were originally somewhat of a presentational afterthought within the reorganised NHS structure, its existence may well prove to be valuable in helping CHCs to evaluate national policies and balance the demands of their localities against the overall interests of the country.

Conclusion

The formation of the NHS was intended to establish a comprehensive pattern of health care. Both at the time of its creation and subsequently much political emphasis was laid on the fact that this involved a shifting of medical services away from the market sector of the economy in order to eliminate direct financial barriers to their access. In fact this aspect of the NHS, its availability to everyone regardless of their financial status, has received such attention that it has to a degree obscured the fact that other qualities are essential to a health care system if it is to provide a genuinely comprehensive service. These include the capacity to identify health care needs efficiently and to provide an integrated pattern of primary and secondary services offering the best balance of care possible to all health care groups in the community within the constraints of the available resources.

Although the NHS was successful in removing from the minds of much of the population the stress and anxiety often associated with the costs of health care before the Second World War its record in the latter areas between 1948 and 1974 has been less impressive. This was largely because its tripartite structure retained many of the organisational disadvantages of the system which preceded it. Even in the hospitals, the nationalisation of which was considered to be one of the more radical aspects of the 1946 legislation, change was slower than expected. Regional disparities in service provision persisted as did imbalances between the funding of relatively prestigious acute facilities and that of sectors like the psychiatric hospitals and those for the chronically ill.

Comparison of the structure of the reorganised NHS described in this paper and that which existed prior to 1974 suggests that, on theoretical grounds at least, the new format should help individuals within the service to correct its deficiencies in such areas. The linked systems of planning and administration, with their emphasis on multi-disciplinary agreement and provisions for consultation with outside agencies, were designed to generate a clearer picture of the community's health needs than it was previously possible to form and a management sufficiently strong to ensure that its strategies are adopted and its objectives pursued. They contain many novel characteristics which are recognised by medical planners worldwide to be interesting experiments in health care direction.

But organisational originality or increased administrative capacity are not guarantees that the health service will be able to improve the quality of treatment actually received by its patients. Indeed, many critics of the reorganised NHS have tended to argue the reverse. It may also be pointed out that in some key areas the health service has changed less than it might at first seem. For instance, the independent contractor services under the new FPCs may prove to be as isolated from the rest of the NHS as they were under the old Executive Councils.

Such examples serve to underline the fact that, as in the case of the original formation of the NHS, the arrangements adopted in 1974 were not ideal in any single coherent set of terms. They were a compromise between the interests of the groups involved in health care which appeared to the negotiators involved at the time a workable balance. Little else could be expected in any field where powerful political, economic and professional interests are involved. Perhaps, therefore, the most appropriate way to judge the success or failure of the new NHS is not in absolute terms relating to the desirability of the details of its structure but rather in pragmatic ones relating to the practical experience of its functioning and the opportunities it presents for further improvements. In the light of this understanding the second paper of the study examines the progress and criticisms made of the health service since the reorganisation.

Part 2 – Success or failure?

Introduction

The reorganisation of the National Health Service took place during the aftermath of the three-day week, which was itself associated with the economic crisis brought about by the rise in oil prices in late 1973. Thus the first years following the creation of the new structure were characterised not only by the internal stresses and strains to be expected from such major changes but also by the continuing difficulties and uncertainties resulting from Britain's weak economic position. During late 1974 and early 1975 these were so acute that even short-term predictions of future resource availability could not be made and so it was necessary to postpone the introduction of the new NHS planning system.

Yet the process of participative planning is an essential element within the new administrative format. Without it the intended devolution of delegated responsibility to the Areas and Districts coupled with an improved capacity for the service as a whole to identify its objectives and priorities would be impossible to achieve. The delays in the planning system's initiation therefore helped to fuel doubts about the value of the reorganisation and promoted an apparent loss of commitment to its success amongst some members of NHS staff.

Further, the social and economic climate prevailing in the period immediately after April 1974 was one of unrest. Within much of the health service, management was during the first two years continuously involved in sorting out problems associated with industrial action. This was time consuming and considerably reduced the service's field capacity to consider its future policies. The breakdown of some elements of the traditional pattern of authority within the health care system which coincided with and may to an extent have been exacerbated by the reorganisation acted in a similar manner, tending to concentrate public and professional attention on the ills of the NHS itself rather than those of the people it exists to serve. However, by the beginning of 1976 the situation apparently began to stabilise. Although the outlook was still bleak in that it became clear that the NHS would have virtually no money available for growth over and above that needed to keep pace with the ageing of the population before the start of the 1980s acceptance of this fact opened the way to implementing the planning system with the prime objective of trying to encourage the most effective use of existing funds.

Against this background this paper describes recent progress towards the identification of the NHS's immediate strategies and goals, examines criticisms of the reorganised structure and discusses fields in which development of health care provisions and attitudes in Britain may prove to have long-term significance. It confines its detailed analysis mainly to the NHS in England although most of the issues touched upon are of significance throughout the United Kingdom.

Priorities in the new NHS

It was originally intended that the Department of Health and Social Security would produce a consultative document on health and personal social service priorities in early 1975. However, the government's attempts to control public expenditure led to planning revisions at national level and so publication of the English consultation paper was delayed until the spring of 1976 (DHSS 1976b). Equivalent, although less detailed, documents were issued in the other parts of the United Kingdom at about the same time.

The late publication of the priorities document meant that it was not available to serve as a reference point in the preparation of strategic plans before the first run of operational planning, due to begin in the year 1976–77. But because of the health authorities' desire to initiate the latter as quickly as possible it was decided to go ahead with the two stages simultaneously using the data in the consultative document to guide operational planning whilst at the same time reviewing comments on it in order to prepare a revised priorities paper for spring 1977 and preparing strategic plans at Regional and Area level for use in 1977–78.

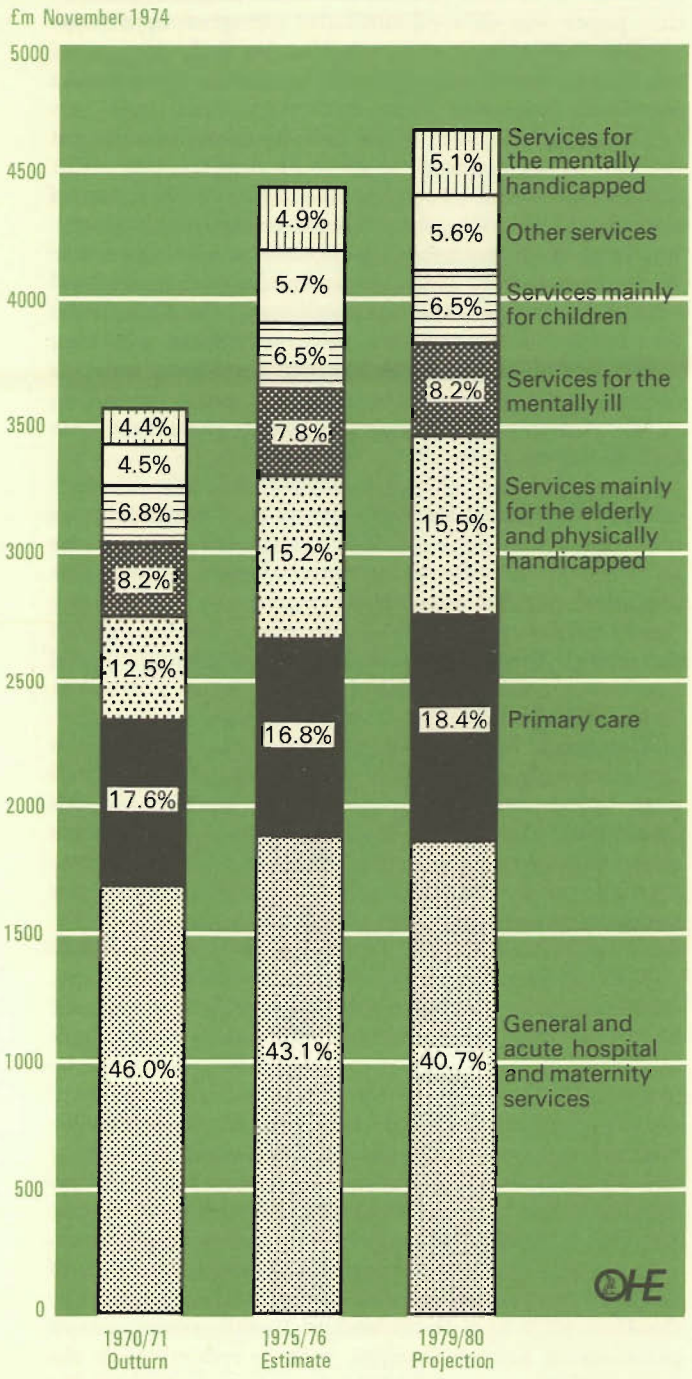
Thus the outline of health and social service development in England given in the spring 1976 document was suggested rather than prescribed, although there can be no doubt that it indicated the general direction of policy over the next few years. The emphasis of its thinking regarding the major divisions of service development is shown in Figures 1, and 2a and 2b, whilst the financial implications of its proposals are shown in more detail in Table 1 (page 22).

The trend of the consultative document was to switch resources, at least in terms of growth, away from hospital based care and acute services in general towards community based care and services for health care groups with longer term problems. It laid special emphasis on improving services for mentally ill and mentally handicapped people in line with the policies suggested in the White Papers *Better Services for the Mentally Handicapped* and *Better Services for the Mentally Ill* (1973, 1975) and on meeting the extra workload likely to be caused by the increasing numbers of very elderly individuals in the population. These priorities are largely shared by planners throughout the United Kingdom although there are some national variations in current service levels. For instance, in Wales services for the mentally handicapped had by 1976 reached a rather higher level of provision than was the case in England and are hence today afforded somewhat less priority.

In view of possible changes in the precise balance of the priorities programme and the influence of factors like the December 1976 'mini-budget' health service cuts or pressures on local authorities, such as reductions in the rate support grant, it would be wrong to regard the estimates quoted in the consultative document as entirely reliable guides to future NHS or personal social services spending. Indeed, in that they tended to understate some service costs (particularly in the PSS sector) they in any case made future rates of growth appear somewhat inflated. But the figures are informative in as much as they indicate trends in spending and may also be used as a base point from which to judge the extent of any shifts in national policies which may be announced in spring 1977 or subsequently.

They show a current expenditure growth of a little

Figure 1 *English health and personal social services expenditure by programme as a percentage of total capital and current costs*



Source Priorities for Health and Personal Social Services in England. DHSS 1976

under 16 per cent by volume[1] between 1975–76 and 1979–80 in Family Practitioner Committee Services, the funding of which is influenced more by consumer demand than is so in other areas of the health service which are now regulated by 'cash limits'. This is matched by a volume increase of 13.6 per cent in the community services administered by the RHAs and AHAs as compared to 5.3 per cent in the hospital based services,[2] although even by 1979–80 hospitals will still be consuming well over twice the revenue resources available to the FPC and other NHS community services combined.

The local authority personal social services will continue to receive a relatively small share of total health and social service expenditure. Comparison of the year 1973–74 with the volume projections for 1979–80 suggests that although the social services share of total HPSS revenue will rise from around 13 per cent to about 15 per cent its proportion of capital spending will drop to around 19 per cent of total, as opposed to nearer 25 per cent in the early 1970s. From these figures it is clear that the consultative document did not propose expansion of the social services at the expense of the NHS although it did allow for the use of a small proportion of NHS resources to fund projects to be managed by and eventually to be supported fully by social services departments. The sum involved will, by 1979–80, be in the order of 0.7 per cent of total NHS spending.

Finally, it is of note that regarding the health and personal social services as a whole the ratio of capital to current expenditure in England was projected as dropping by 36 per cent during the latter years of the 1970s even before the capital spending reductions announced in late 1976. In the local authority personal social services alone the projected fall in the capital to current ratio was almost 50 per cent. To an extent this reflects the claim of the then Secretary of State Barbara Castle who, in the introduction to the consultative document, stated that its policies put 'people before buildings'. However, the increase in current spending relative to capital reflects mainly cuts in the latter, not high growth in the former. Total HPSS capital expenditure in volume terms will, on the basis of spring 1977 figures, have fallen by around a third in the four years 1975–76 to 1979–80 on top of a reduction of about one-fifth between 1973–74 and 1975–76.

Reaction to the priorities document

The reception the document received was mixed. Those interest groups adversely affected by the proposed policies, particularly those in the acute hospital and maternity services, protested vigorously whilst those more favourably treated accepted it, though with some reservations. It is certainly true that some tough measures were proposed, measures which were to an extent forced upon policy makers by the expenditure cuts in the period 1974–76. It is probable that the policies being considered by the DHSS before 1975 were less radical but given the additional reductions in available resources there was a clear choice between abandoning the goal of favouring previously deprived groups or cutting relatively deeply into the funds available for other areas. The latter course was chosen.

This has meant that in the general and acute hospital and maternity sectors in particular severe restrictions are envisaged. Given the economic circumstances the choices made are understandable although it should not be assumed that the NHS has in the past been characterised by an excessive use of 'high technology' medicine.

1 For an explanation of the term volume expenditure see note to Figures 2a and 2b.

2 Most of which will be to areas devoted to the care of older people.

Figure 2a *English health and personal social service expenditure (revenue). Projected changes 1975–76 to 1979–80*

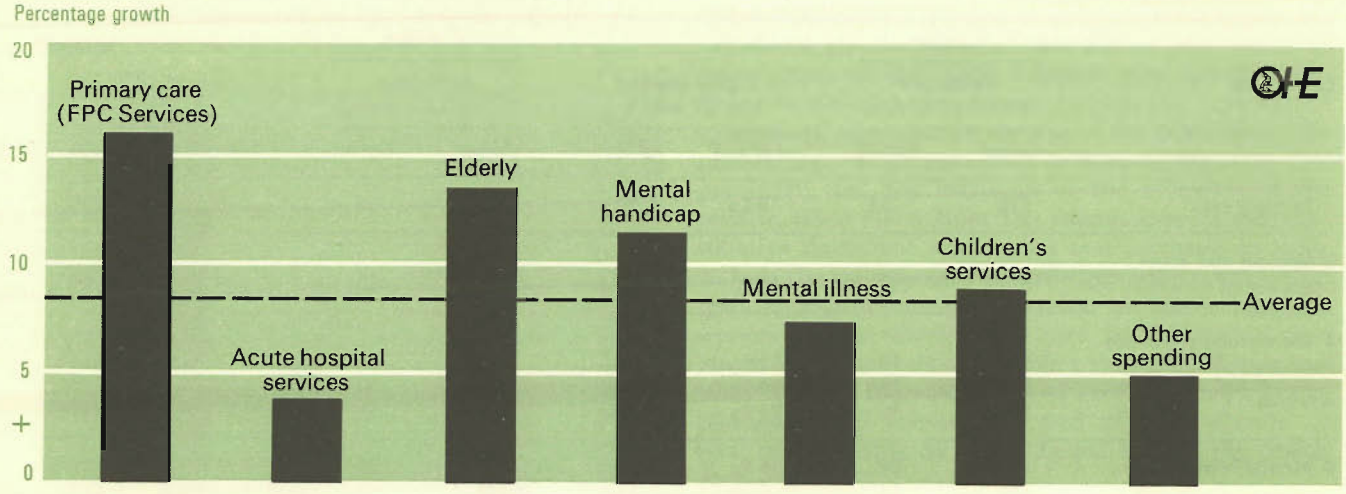
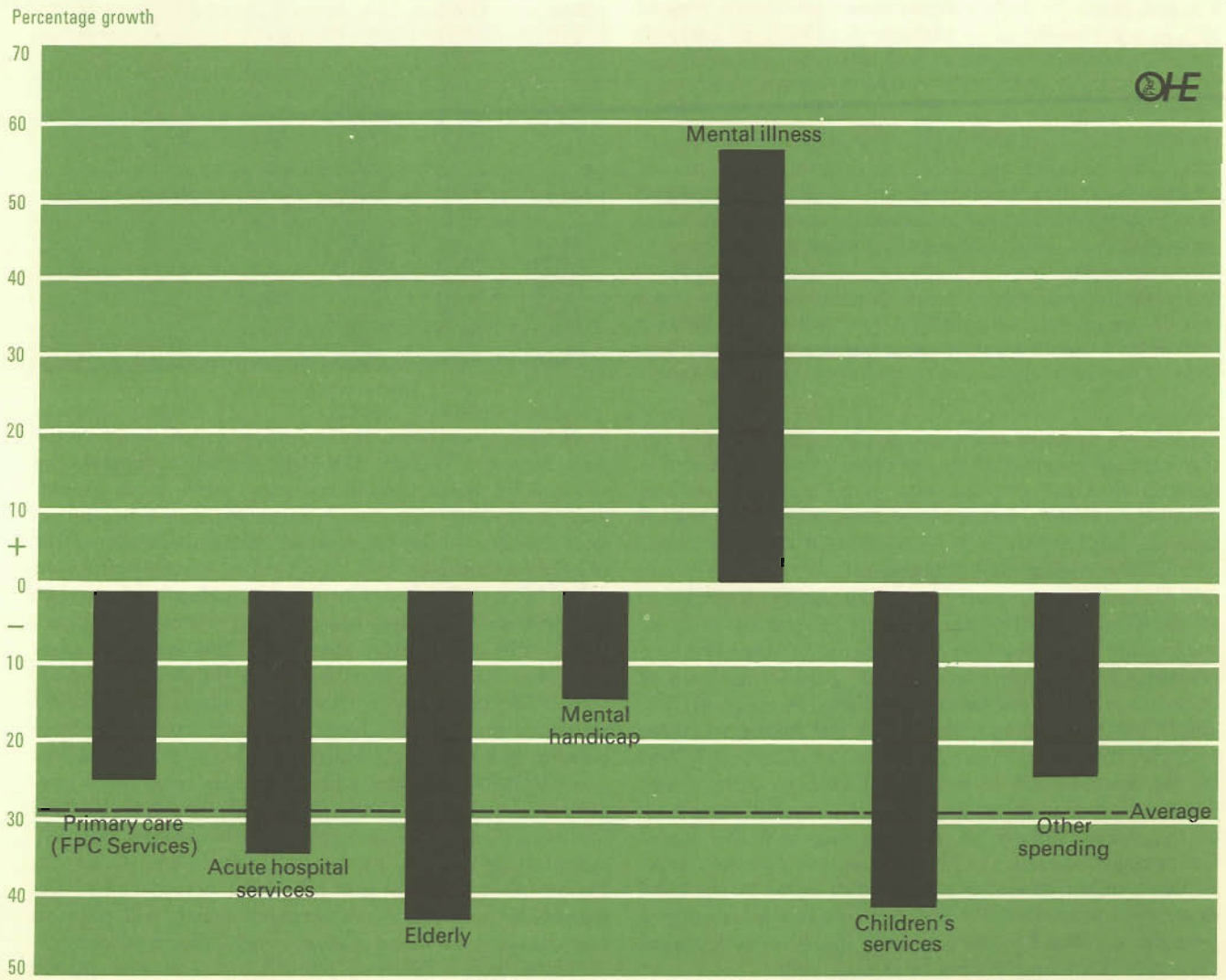


Figure 2b *English health and personal social service expenditure (capital). Projected changes 1975–76 to 1979–80*



Note Figures 2a and 2b show projected changes in spending by volume, that is excluding the relative price effect. This basically means that no allowance is made for alterations in the ratio of costs between labour intensive and capital intensive items within the total NHS bill. The projections were made before the December 1976 cuts, which chiefly affected capital spending. Most of the reductions in the latter shown in Figure 2b will have been achieved by or before the end of 1977–78.

Source (Figures 2a and 2b) Priorities for Health and Personal Social Services in England. DHSS 1976

Table 1 *English health and personal social services expenditure 1975–76 to 1979–80*
(£ November 1974 constant prices)

Client Group	£ million Expenditure 1975/76 (Estimated)		Capital spending per £1 current		£ million Expenditure 1979/80 (Projected)		Growth 1975/76 to 1979/80	
	Current	Capital	1975/76	1979/80	Current	Capital	Current	Capital
1 Primary care	718	24	3·3p	2·2p	833	18	+16%	−25%
2 General and acute hospital and maternity care	1670	233	13·9p	8·9p	1733	155	+3·8%	−33·5%
3 Elderly and physically handicapped	593	76	12·8p	6·5p	673	44	+13·5%	−42·1%
of which { health	317	32	10·1p	7·6p	369	28	+8·6%	−14·3%
of which { soc. serv.	182	44	24·2p	5·3p	304	16	+67%	−63·6%
4 Mental handicap	189	29	15·3p	11·8p	211	25	+11·6%	−13·8%
of which { health	146	12	8·2p	5·8p	156	9	+6·8%	−25%
of which { soc. serv.	43	17	39·5p	28·6p	56	16	+30·2%	−5·9%
5 Mental illness	320	23	7·2p	10·5p	344	36	+7·5%	+56·5%
of which { health	312	19	6·1p	8·7p	332	29	+6·4%	+52·6%
of which { soc. serv.	8	4	50p	58p	12	7	+50%	+75%
6 Children	266	22	8·3p	4·5p	290	13	+9%	−41%
of which { health	122	—	—	—	132	1	+8·2%	—
of which { soc. serv.	144	22	15·3p	6·9p	158	11	+9·7%	−50%
7 Other	236	17	7·2p	5·2p	248	13	+5·1%	−23·5%
All Health	3393	324	9·5p	6·7p	3659	245	+7·8%	−24·4%
All Social Services	599	100	16·7p	8·8p	673	59	+12·4%	−44%
Total	3992	424	10·6p	7p	4332	304	+10%	−28·3%

Source Priorities for Health and Personal Social Services in England. DHSS 1976

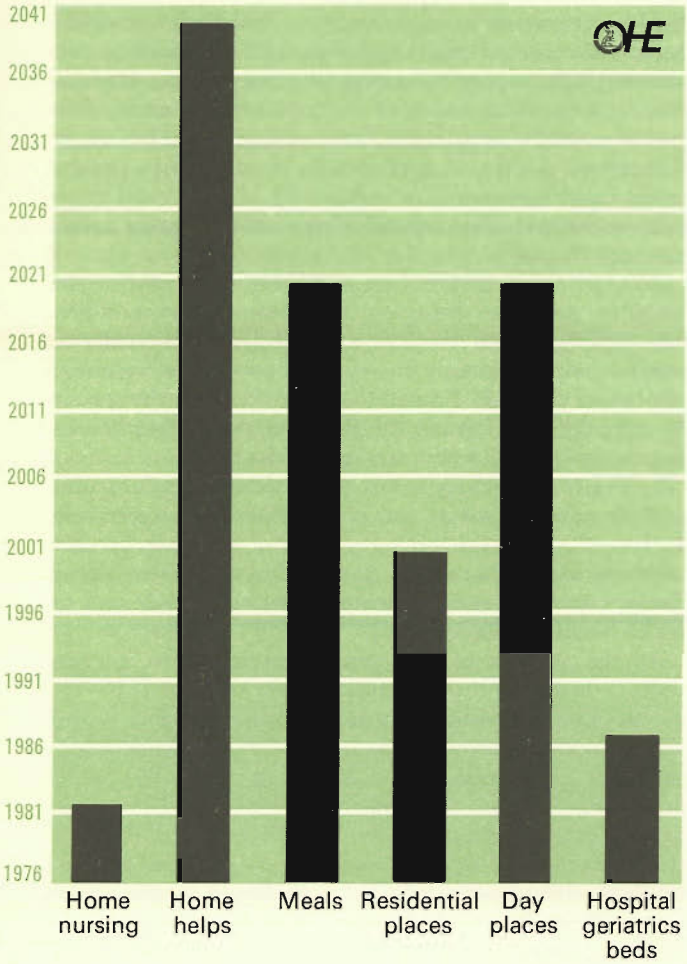
To take an example often thought to typify the latter, in the case of haemodialysis or renal transplantation it appears that in 1975 the rate of patients per million population with a functioning transplant or on maintainence haemodialysis in Great Britain was only about half that in nations like Switzerland, Denmark, France, the United States, and Japan (Executive Committee of the Renal Association 1976). The relative lack of availability of pacemakers as compared to other Western countries is probably even greater. And in the case of obstetric services, resources for which are to be significantly reduced, rising costs despite the falling numbers of live births in recent years may be to an extent explained by the introduction of equipment such as ultra sound devices used to monitor foetal development. Bodies such as the Royal College of Obstetricians and the Royal College of Physicians (1976) have argued that the reason Britain's infant mortality rate has not fallen to the level experience in nations like Sweden and Japan indicates is possible, is related to the relatively low level of financial resources this country devotes to such ends.

However, even in more favoured areas the provisions outlined in the consultative document are by no means prodigal. An instance of this is illustrated in Figure 3, which indicates that many of the nationally recommended levels of services mainly for elderly people will, on current projections, not be achieved until well into the next century. Indeed, the next decade's demand for services for older individuals may prove even greater than is currently expected because of rising expectations and changes in the demographic characteristics of the elderly population.

It is thus difficult to question the balance of resource distribution by main programme sectors proposed within the consultative document and in some cases criticisms may have been made on rather a superficial level. For example, it has been suggested that the proposals on mental illness services do not give them positive priority in as much as the share of total NHS revenue resources they will receive in 1979–80 is projected as being the same as that in 1970–71 (Radical Statistics Health Group 1976). But this ignores the very considerable switch in capital investment shown in Figure 2b and does not take into consideration the manpower training issues involved which will play an important factor in expanding mental illness services.

Similarly the future 5 per cent growth rate in FPC pharmaceutical service costs described in the consultative document (since the publication of which further savings on medicines have been announced) has been taken by some commentators as evidence of an unchecked rise in NHS spending on medicines. But in fact

Figure 3 *Approximate dates at which current guidelines for services for the elderly will be achieved nationally, given the rates of growth suggested in the 1976 priorities paper for England*



Source Williams and Rathwell 1976

such criticisms of the health service are difficult to justify and serve to illustrate how important it is to understand the basis of the calculations on which the economic projections in the priorities paper are based.

The section on pharmaceutical services points out that recent increases in cost have been related to the extension of free family planning and that future costs have been calculated on the basis of the falling real value of prescription charges being counted as a cost increase. Other factors to be considered include the extension of community care and the ageing of the population, the probability of pharmaceutical innovations and the possibility that the exclusion of the influence of the relative price effect from the calculations in the consultative document means that cost increases in areas such as the manufacture of medicines will be artificially made to look greater than increases on labour intensive services such as direct health care. In this context it is interesting to note that, as Table 2 shows, for the UK as a whole the net ingredient cost of medicines used in the pharmaceutical services dropped as a proportion of total NHS spending by about 25 per cent in the period 1970–75.

Yet even though there are considerable problems inherent in criticising the broad allocations of the limited available resources identified or suggested by the DHSS in 1976 it is possible to question some of the more specific elements. For example, it has been noted that within the social service allocations expenditure on residential services was projected as rising faster than that for community care. Some commentators believe this to be inappropriate. Also, the effect of the joint funding arrangements between health and social services could have been miscalculated. But criticism at this level of a document which represents only the first step towards the establishment of what may well prove to be a more sophisticated and sensitive planning process than that which exists in any other health care system in the world could be thought somewhat captious.

NHS finance

In the first quarter of a century of its existence the NHS enjoyed a considerable growth in the economic resources available to it. By 1974 the health service was spending, in volume terms, almost twice as much money as it was at the start of the 1950s. The share of the UK gross

Table 2 *Cost of UK executive council/FPC pharmaceutical services 1968–75*

Year	*(1) Total cost of NHS (£ million)*	*(2) Total cost of pharmaceutical services (£ million)*	*(2) as % of (1)*	*(3) Net ingredient cost of medicines (£ million)*	*(3) as % of (1)*	*(3) as % of (2)*
1968	1739	177·6	10·2	143·4	8·2	80·1
1969	1831	190·2	10·4	156	8·5	82
1970	2083	209·4	10·1	170·9	8·2	81·6
1971	2371	233·5	9·8	177·1	7·5	75·8
1972	2734	263	9·6	200·2	7·3	76·1
1973	3092	291·6	9·4	216·4	7	74·2
1974	3922	341·1	8·7	257·9	6·6	75·6
1975	5280	445·1	8·4	329·2	6·2	73·9

Note Costs quoted exclusive of patient payments for medicines and also, in the case of England and Wales, before subtraction of discounts received from the manufacturers. Hospital medicine costs stayed at around 1.5 per cent of total NHS costs throughout the period.

Source OHE estimates

national product devoted to it rose from a nadir of about 3.5 per cent in the calendar year 1954 to about 5.3 per cent in 1974. This growth, although not as great as that enjoyed by many other public sectors, enabled a considerable expansion of NHS services. For example, overall manpower more than doubled in the first 25 years whilst in areas like administrative and clerical staff and hospital professional and technical staff it increased by between two and a half and three times.

But the reorganisation of the NHS coincided with the ending, or at least the interruption of, this pattern of the extension of the health service through increases in real expenditure. Although the NHS's share of the GNP rose at an unprecedented rate between the financial years 1973–74 and 1975–76, from about 5 per cent to 5.8 per cent, this was a time of near zero national growth and of rapid wage increases relative to other factor costs within the economy.[3] Thus the real rate of increase of NHS service provision was lower than that in the 1960s and early 1970s, particularly within the hospital sector. And it appears that until the end of this decade any further growth of NHS overall funding in the United Kingdom will only be sufficient to cover the increasing workload imposed by the ageing of the population. Thus increased emphasis will have to be placed on the more efficient use of resources if improvements in the standards of health care received by people in Britain are to be achieved. Recent efforts to this end have included not only the attempts to identify health service priorities but also a critical examination of NHS resource distribution on a national basis.

Resource allocation

Large differences in the levels of funding of the NHS in various parts of the country have been taken by some commentators and politicians to indicate that the 1948 creation of the health service led to less radical changes than many people originally expected or subsequently came to believe had occurred. For example, not only does the health service in England today receive a rather lower level of resources per capita than it does in other parts of the United Kingdom but poorer English Regions spent in the mid-1970s around 20 per cent less per capita than richer ones.

The reason for the perpetuation of national variations in the provision of hospital care across England post-1948 lay partly in the system of allocating resources to the Regional Hospital Boards. This was largely based on incremental allowances which were related to the level of existing services and so allowed well provided regions to maintain their relative advantages (West 1973).

In recognition of this problem the DHSS introduced in 1970 a resource allocation formula for the non-teaching hospital services which was intended to produce an equable distribution in a 10-year period. Allocations were calculated by the use of three weighting factors. These were age-adjusted populations, a bed-stock adjustment (positively linked to the number of beds existing in a Region) and a case-load adjustment (positively linked to the number of cases treated). The first factor was given a double weighting, so stressing the significance of the differential use of hospital services by the various age groups within the population.

However, this formula was judged by a number of authorities to be unsatisfactory, mainly because of the bed-stock and case-load elements. They are closely correlated with one another and are now generally seen as indicators of service supply rather than of identifiable health care needs in a community. And their use could have exacerbated some problems. For example, an efficient Region might improve its services for its population by increasing case-load without a rise in costs. This would entitle it to a higher level of funding although in fact people in other Regions might be receiving a poorer service with low case-flow and would become even more relatively deprived as a result of more money going to the efficient Region.

In the light of this dissatisfaction with the 1970 formula and the bringing together of the non-FPC community health services and all hospitals under a unified administration in 1974 a review of resource allocation policy in England was initiated. In the spring of 1975 the DHSS formed the Resource Allocation Working Party (RAWP) which was given the brief:

'To review the arrangements for distributing NHS capital and revenue to RHAs, AHAs and Districts respectively with a view to establishing a method of securing, as soon as practicable, a pattern of distribution responsive objectively, equitably and efficiently to relative needs and to make recommendations.'

In the autumn of that year it produced an interim report containing recommendations for the year 1976–77, its calculations based on a sophisticated version of the 1971 allocation formula which had removed from it bed numbers as an indicator of financing need. The main conclusion of the working party's study of revenue expenditure was that relatively high financed Regions should in the year 1976–77 lose up to 2.5 per cent of their budgets whilst under-provided ones should receive up to 2.5 per cent growth (calculated in both cases exclusive of the revenue consequences of major capital schemes). On the capital side the recommendations of the working party were of limited significance, mainly because the cuts in the programme since December 1973 meant that there was very little uncommitted money to be allocated.

The then Secretary of State responded to these recommendations in February 1976. She ruled that in the Thames and Mersey regions revenue would be frozen rather than reduced in 1976–77 and that in the most under-provided Regions a maximum growth rate of 4 per cent per annum would be permitted as opposed to the 2.5 per cent suggested. To prevent wastage of resources occurring because of Authorities hurrying to take up all their allocations they could in 1976–77 carry over 1 per cent of their total revenue to the next year and also switch a further 1 per cent to the capital budget if

3 However, the Western European/North American average of spending on health care is now in excess of 8 per cent of GNP. Of developed nations outside the communist bloc only Japan spent a lesser proportion of her GNP than Britain in the mid-1970s. And because of that country's higher per capita wealth and low proportion of people aged over 65 its absolute spending levels still compare well with those of this country. To some commentators this indicates that NHS spending should be increased as a percentage of GNP although in economic terms it could equally well be argued that our poor financial performance means that we necessarily cannot spend as great a proportion of our national income on health or welfare services as do countries like Sweden and Germany.

they so desired or up to 10 per cent of capital to the revenue budget. She also decided that 1976–77 would be the last year in which the Department would specifically allocate money to Regions to meet the revenue consequences of capital schemes (RCCSS).

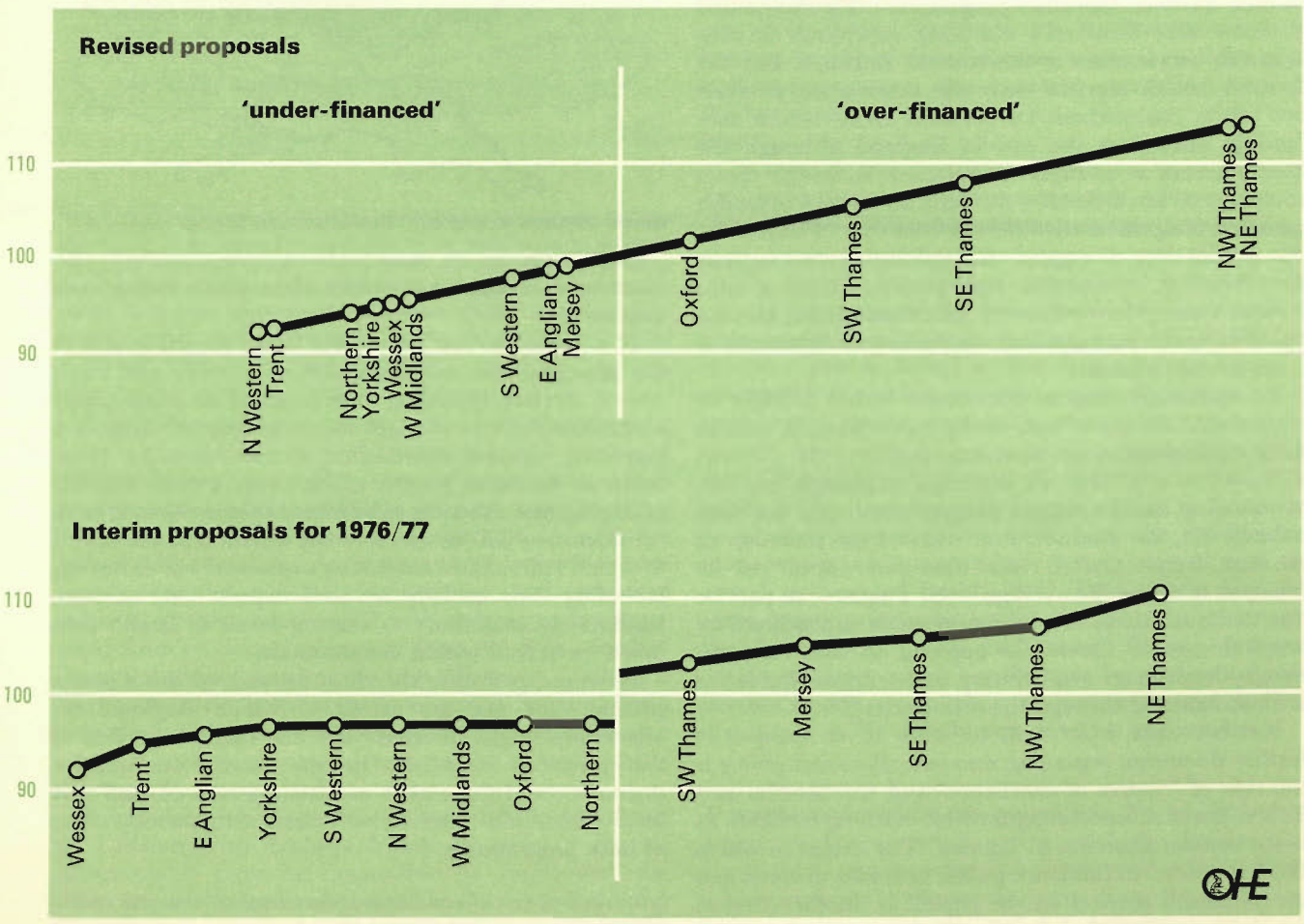
Thus at Regional level no cuts in revenue occurred during 1976–77 although below that tier this was not the case. It has been recently shown that variations of expenditure within Regions are probably greater than those between them (Rickard 1976). Attempts to balance out the former have led to considerable cuts in some Area and District budgets which have also been under pressure because of factors such as the need to finance pay settlements like the recent junior hospital doctors' overtime award out of fixed financial allocations.

The second report of RAWP was published in September 1976. It suggested a very much more sophisticated formula for the establishment of revenue targets which excluded case-load and introduced weightings based on standardised mortality ratios (SMRs) for broad groups of medical conditions in addition to the existing weightings for population structure and geographical patient flow. Fertility was introduced as an indicator of need for maternity services and statistics on the marital status of the Regions' populations were used as a guide to need for mental illness services. It proposed that capital allocations for Regions should be calculated in relation to the value of existing capital stock and the weighted population served.

The working party also recommended that greater flexibility between capital and current spending should be allowed over and above existing arrangements. Compared to the implications of the criteria used in the interim report these proposals substantially alter the extent to which various Regions are considered under or over financed. Figure 4 shows that the North Western, Trent, Northern Mersey, North West Thames and North East Thames RHAs are particularly affected. This is largely because of the use of SMRs as a proxy indicator of morbidity and thus of health care need (an idea promulgated by Cooper and Culyer in 1970) although the North London RHAs are also significantly affected by the service increment for teaching (SIFT) proposals. These allow for only 75 per cent of the national median excess cost[4] for medical teaching (subject to considerations like University Grants Council financing and London Weighting) to be met in Regions' increments.

4 That is the excess cost of teaching as opposed to comparable non-teaching hospitals. Dental students rank as only 25 per cent of the cost of medical students.

Figure 4 *Comparison of the interim and revised proposals for distributing revenue funds to the Regions*



Source Final report of the Resource Allocation Working Party. DHSS 1976

In late 1976 the Secretary of State, David Ennals, accepted the findings of the working party at least as a basis for calculating the 1977–78 allocations. He announced that the higher financed Regions would be restricted to very limited growth on the revenue side (0.25 per cent in 1977 for North West Thames) whilst the less wealthy ones would receive up to 3 per cent additional real resources in 1977–78. But he also stated that a rapid process of resource equalisation was not envisaged.

Unresolved issues

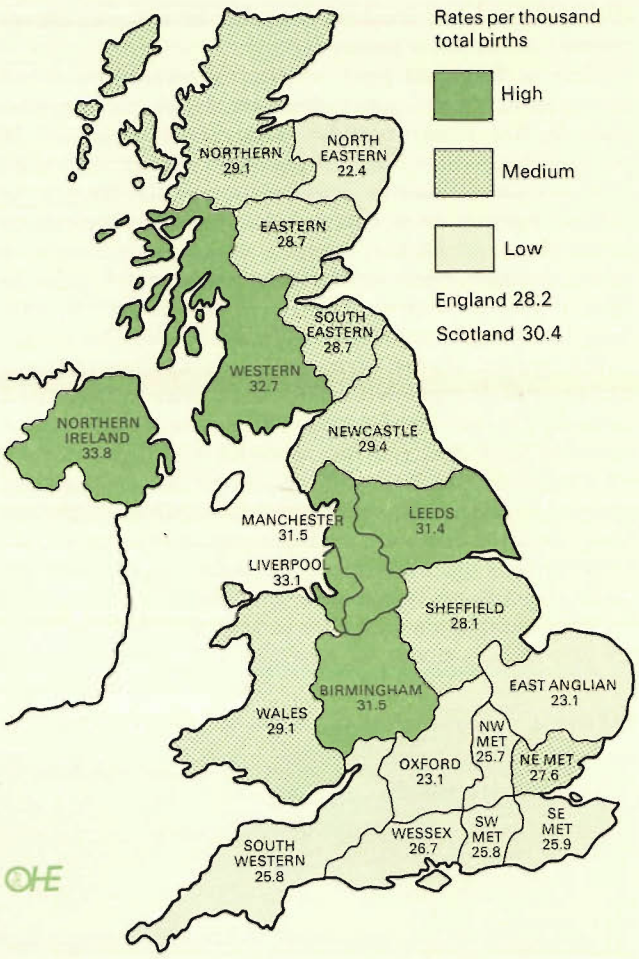
A number of objections have been raised to the criteria adopted in the final RAWP report and the working party itself admitted in its commentary that there were areas which needed more research. It may be questioned, for example, whether SMRs are sufficiently sensitive indicators of health care need. They correlate very closely with the social class make up of given communities and it might be argued that only changes in local social infrastructure are likely to affect the SMRs to any great extent. Thus it is conceivable that reallocation of health care resources could have little positive effect and might only serve to aggravate experienced need or disturb existing structures of care delivery in previously highly financed Regions.

This line of argument is to an extent supported by a comparison of English and Scottish data (Scotland has its own resource allocation programme). Figures 5a and 5b show that Scotland's mortality experience is considerably worse than is the case in England. But the Scottish health services currently receive, on a crude per capita basis, about 10 per cent more health care funding than does the NHS in England although the former serves a 'younger' population. Although direct comparisons are difficult – the Scottish pattern of health spending is significantly different from that of England – this would seem to suggest that cultural factors such as diet, housing, occupation and possibly selective emigration rather than relatively minor variations in provision of health care facilities are the key determinants of a community's health.

An additional point in this context is that it might be argued that the use of SMRs in the RAWP formula may in some circumstances act as a disincentive to the efficient distribution of a Region's resources. Although this line of reasoning may be subject to some question it has been pointed out, for instance, that without the inclusion of the SMR factor Oxford RHA does not appear to be financed to above the average level. This may in part be due to the relatively low level of revenue expenditure on hospital care in Oxford as opposed to that on community health and FPC primary care services (the latter are not financed through the RHA budget).[5]

Another topic which will certainly be the subject of further discussion regarding resource allocation policy is the role of 'centres of excellence' and the benefits and disbenefits of concentrating medical teaching facilities, as is the current situation in London. The extent to which this has tended to influence public attitudes towards and use of health services in the capital is another subject for debate although it is already clear that London's relatively mobile population with its high proportion of immigrants creates a number of atypical health care demands.

Figure 5a *Infant life wastage (still-births and deaths under 1 year) 1973*



Source (Figures 5a and 5b) Prevention and Health. DHSS 1976

It is probable that eventually closer co-ordination in the planning and administration of hospital and community services, including those supplied by independent contractors, will be thought to be necessary to achieve a genuinely equable distribution of NHS resources, in as much as the latter implies efficiency as well as a distributive fairness. Also it is to be hoped that in the long term consideration will be given to the question of the extent to which individuals' subjective experiences of ill health, including their socially induced expectations of care, legitimately contribute to varying levels of health care 'need' perceived within communities.

However, probably the main unresolved issues at the present time are the extent to which Regional reallocations might interfere with the implementation of the priorities described in the recent consultative document and the extent to which perceived staff and local community interests will clash with the objectives of both programmes.

5 In 1974–75 51 per cent of total NHS spending (RHA plus FPC) in Oxford went to hospital revenue costs, as opposed to nearly 64 per cent in North East Thames and 57 per cent in the North Western Region. However, Oxford's capital spending was high in that year.

Figure 5b *Standardised mortality ratios 1972 (males)*

Note The standardised mortality ratio makes adjustment for the differences in the age-sex composition of the population in different regions or countries. It shows the number of deaths that occurred in the region or country expressed as a percentage of the number that would have been expected if the age-sex specific death rates for England and Wales as a whole had applied to the age-sex composition of the population in the region or country.

Regarding the latter point RAWP commented in its interim report that 'rationalisation of the order envisaged will be illusory unless Ministers are prepared to take a resolute stand when politically sensitive cases or those which are otherwise contested, for example, by CHCs, are presented for decision.' And a number of authorities have noted potential political, professional and industrial relations problems associated with redeployments stemming from reallocations and/or from the type of policy change described in the priorities document (such as a switch of acute hospital beds to geriatric use). Until recently health service managers at a senior level and national politicians may have, in public at least, rather ingenuously ignored such considerations.

It has also been suggested (Creese 1976) that in Areas or Districts with budgets frozen or reduced by reallocation it may be impossible to implement the programmes for deprived groups like the mentally ill and handicapped described in the priorities paper. This view appears reasonable to many people within the NHS although even in the London Regions, which in effect under the later RAWP report proposals will be funding real growth in the rest of England through cuts in their existing or planned health facilities, there is considerable sympathy with the long-term objective of reallocation.

Yet despite the fact that there may in the coming few years be conflicts between the goals of even health resource allocation on a national basis and more appropriate distribution on a patient group basis it may be argued that in the longer term the two are compatible. For both are in harmony in the sense that they are fundamentally aimed at achieving an equable provision of health services relative to logically defined and generally agreed need in the community. This was a major objective of many of the people who took part in the establishment of the original NHS structure as well as those responsible for the 1974 reorganisation.

The administration of health care

An organisation of the size of the NHS, which is the tenth largest employer in the world, is always changing and always experiencing internal conflict at one point or another in its structure. The activities of the NHS continually involve compromises between conflicting interests which means that from time to time there is inevitably a feeling of dissatisfaction amongst sections of its staff and consumers. But in recent years dissent within the health service appears to have risen to a disturbing level.

To some degree a crisis in the NHS was to be expected during the first year after reorganisation, when awareness of its disruptive effects would peak and yet little evidence of its value would have had time to emerge (Chester 1976). But the current criticisms of the health service cannot be dismissed as being merely symptomatic of temporarily 'low morale'. Rather, they reflect the fact that the NHS is facing serious long-term problems, a proportion of which may have been needlessly created or exacerbated during the last few years. These range from specific issues such as the 'pay beds' dispute through to more general topics of concern, the most important of which is the fear that the health service is becoming progressively more preoccupied with the processes of management and progressively less concerned with the actual delivery of health care. This section discusses some questions relating to the structure of the NHS and the bureaucratic and professional forces operating within it, forces which are likely to be particularly important in any system where market pressures play little direct role in the distribution of goods and services.

A mechanistic bureaucracy?

A number of writers have argued that the newly formed hierarchical structure of power, with the Secretary of State and his or her senior civil service staff at the summit, is inappropriate to the requirements of the health service. Some, such as Draper and his colleagues at Guy's Hospital (1972, 1973, 1976) have found in the literature

of the sociology of organisations reason to believe that structures of the type introduced become rule-bound, inflexible and insensitive to the needs of and changes in the world around them. There is concern within the NHS, particularly amongst medical staff, to the effect that the changes of 1974 slowed decision making at field level to such an extent that the quality of patient service is seriously threatened whilst at the same time they promoted an accelerating process of 'bureaucratic displacement' (Gammon 1976). This is said to involve a progressive shift of health service resources, human and material, away from medical care as such into administrative activity.

Many critics maintain that the reorganisation was more concerned with management for its own sake rather than management for the sake of better health service. They underline the force of their arguments by pointing to the way the reorganisation was apparently introduced with frequent disregard for NHS employees' sensitivities and with excessive concentration on central direction rather than 'grass roots' participation. It may even now be said that despite numerous calls for more open government in recent years much of the evidence on which decisions about the health service's future were based has never been made available to the public and there is still a widespread feeling that unsatisfactorily explained changes were (and are still being) imposed from 'above'.

Some of the most bitter opponents of the new structure believe that the health service cannot be effectively run until its management becomes more closely linked to that of other welfare state provisions such as housing and the personal social services and is also made more sensitive to local people's needs and feelings by being placed under the control of local authorities.

Counter arguments to these changes may be developed along a number of lines. For instance, under the old NHS structure there were many areas in which poor planning and inadequate control led to obvious waste of resources. Whilst it would be wrong to advocate too rigid a system the improved administration envisaged by the reorganisation's planners may clearly help to reduce such instances. Indeed, there is obviously a need for increasingly sophisticated managerial activity in the NHS merely to handle the raised throughput and workload of its services. In the hospital sector, for example, the volume of inpatients handled every year approximately doubled between the late 1940s and the mid-1970s even though the number of available beds fell by about 10 per cent in the same period.

It might also be thought that a detailed examination of the new NHS reveals a considerably more flexible and humane structure than may be perceived at first glance. The management theory behind the reorganisation rested on the concept that only through a clear pattern of responsibilities and accountability between and within 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 had to defend the health service from such tendencies by defining roles in detail it may have appeared unnecessarily bureaucratic but the system it created need not necessarily become so. In fact it may be argued that some aspects of the new NHS which are now subject to particular criticism, such as the proliferation of committees and the slowness of decision making relating to minor local issues, are mainly the result of attempts to 'democratise' the service by involving as many groups as possible in consultative processes rather than phenomena of the type normally associated with classically defined bureaucracies.

In the context of the advocacy of local authority control of the health services it may be suggested that although many members of the health authorities are still either directly or indirectly appointed by the Secretary of State, who of course is an elected member of parliament, and are thus not themselves subject to electoral selection this does not mean to say that in practice the NHS will be less responsive to local feelings and interests than would otherwise be so. Indeed, there may even be a case for moderating the influence of local politicians on the health service in as much as it is possible, for instance, that local political expediencies may not always coincide with the needs of people like the mentally ill or handicapped.

Planning

The creation of the NHS was predicated on the belief that health care should be separated from the market sector of the economy. The removal of market barriers to life-saving or health-enhancing care would, it was hoped, reduce the 'pool of ill health' in the community and so open the way to maintaining the condition of the population at an optimum health level for relatively little cost. But because the resources available to the NHS were and still are limited and because the value of different types of health care intervention varies widely the formation of the NHS itself created a need for a system of planning. This requires administrators and other professionals to identify the priorities of the health service not necessarily in terms of what its individual clients would be most prepared to pay for but in those of what the health of the community is most likely to benefit from.

Thus the planning system of the new NHS is especially important for two reasons. First, because the desirability of the health service being able to identify its tasks and policies efficiently and direct its efforts accordingly is a key reason for the NHS's initial formation and continued existence. Second, because it is an area which naturally serves as a focus for debate on the advantages and disadvantages of bureaucratic control.

It is argued by some commentators that the 'global' approach to planning adopted in the reorganised structure has a number of potential disadvantages. For example, experience in near parallel situations, such as the Department of the Environment's system of land use planning, appears to justify suggestions that comprehensive planning attempts often degenerate into risk aversion exercises which tend to slow or even freeze organisational development. Also there are many areas of the health service where the number of variable or unknown factors makes it very difficult to identify an ideal pattern of care provision, particularly when resource restrictions mean that the planning horizons being used are several decades distant. In such circumstances

it may sometimes be of little value to build up comprehensive long term strategies, the formation of which itself requires the considerable use of expensive manpower.

Rather it might be preferable to cope with the most obviously urgent problems as well as is possible, which is probably the approach often adopted today in many areas which are nominally under the direction of central government planning departments. Opinion relative to the debate following the publication of the Layfield Committee's report on Local Authority Financing would seem to reflect this attitude in that it appears to be increasingly critical of detailed central interventions in the development of most types of welfare service at a local level.

However, there may still well be a legitimate role for comprehensive planning in areas such as the control of budgets or the identification of groups of consumers who for special reasons have unmet needs. Indeed, the primary driving force behind 1974 reorganisation was the belief that the original NHS had not proved able to divert its resources into providing adequate services for health care groups of increasing relative importance such as the elderly. In as much as the DHSS's publications on priorities have, despite their imperfections, already initiated a shift in programme allocations the new planning approach would already seem to evidence some signs of success. Further, the system's emphasis on local modification of national policies and objectives and on continuous, cyclical revisions of both operational and strategic plans may well enable the health service to avoid the pitfalls described above.

Thus overall it appears that, failing the advocacy of a free market in health care, the creation of the sophisticated planning system embodied in the reorganised NHS structure should be seen as a desirable development. What is open to criticism is not its establishment but the manner of its establishment, which some commentators believe has been characterised by the production of too much complex explanation and a failure to produce a sufficiently brief and clear outline of the nature of the new procedures and their intended purpose. This may account for much of the feeling that they represent an unwieldy and unnecessary intrusion into the working of the health service.

Extrapolating from these points to look at the new pattern of health service administration as a whole it may be suggested that to want to eliminate 'bureaucracy' as such is probably an undesirable and in any case unobtainable goal. Instead the objective should be the creation of a system of management which is as flexible, perceptive, innovative and humane as possible and which is seen to be so by the people working in the NHS. In this light it is probable that critics of the current NHS administration would be best occupied in calling for better bureaucracy rather than less or even no bureaucracy, a point worth considering in the light of recently announced cuts in administrative expenditure.[6]

Further changes in the structure?

Even before the 1974 reorganisation it was argued that the proposed NHS structure was too complex, involved too many tiers and to an extent contradicted the concept of national policy formation and strategic planning at the centre balanced by the maximum possible delegation of operational authority to the periphery of the service. It was for example, widely suggested that the Regional tier in particular would prove superfluous and even today the early model of relatively small number of English AHAs standing in direct relation to the DHSS is regarded as desirable in some quarters although this view appears to be less popular now as it has been in the past. This may in part be because the Regions are seen in retrospect to have played a valuable role during the initial period of reorganisation and in part because experience in parts of the country where there is direct contact between Areas and government departments, such as Scotland, has not proved to be entirely satisfactory.

Instead attention in England has concentrated on the possibilities of modifying the roles of both the DHSS and the Regions and also on the problems which are beginning to be identified at the AHA/District level. The latter are associated with the decision to make the Areas conterminous with the new local authority metropolitan districts and the non-metropolitan counties in order to encourage collaboration between the NHS and the local authorities.

Such an arrangement was first proposed in the second of the Labour Government's green papers on the structure of the NHS (DHSS 1970a). It followed the publication in 1967 of the report of the Royal Commission on Local Government which had argued in favour of district council (local authority) control of the health service or, failing the latter, construction of health and local authority boundaries in such a way that they should not intersect one another. Thus conterminosity of the NHS Areas with local authority units, either singly or in combination, was a compromise intended to promote liaison between the two sides and yet to permit continued health service independence.

In practice it appears (despite the improvements provided by the joint financing system to have been an unsatisfactory approach. For on the one hand allowing the Area boundaries to be determined by those of the 1974 local government reorganisation led to non-optimal results in health care terms whilst on the other the fact that the key local planning units of the NHS, the Districts, were defined on criteria not involving conterminosity tended in some cases to defeat the objective of facilitating liaison.

Certain authorities believe that the imposition of a uniform structure below Area level in England was a 'costly chimera' (Chester and Donald 1976) and point to the relative success of the single District Areas since the reorganisation. Such comments suggest the possibility of dismantling the multiple District Areas and their replacement with units more like single District Areas.

Thus there is considerable future opportunity for revision of the current format at both the DHSS/Regional interface and the AHA/District level. Yet the current Secretary of State, David Ennals, has stated that the government does not intend to introduce a further radical reorganisation in the foreseeable future and thus that any

6 In 1976 about 6 per cent of NHS spending was expressed in direct administrative costs, a low proportion when compared with many other sectors of the economy. Over the three years to 1979–80 this figure is planned to fall by 5.5 per cent.

short-term modifications of the NHS will have to be evolutions within the present structure. It is highly unlikely that in England any major steps towards reshaping the health service will be contemplated until a clear idea of the result of the current political debate about the devolution of power to regional government has emerged although there are many questions about the structure of the NHS which are worthy of detailed debate in the interim period. Amongst the most important of these are those relating to a possible restructuring of the DHSS and its relationship with the Regions and also the suggestion that the circumstances of London make it a suitable case for a local reorganisation on a basis different from that applying in the rest of the country.

The proposal that a national management board for the NHS should be formed is by no means new. The model most commonly cited is the Swedish National Board of Health which manages that country's health services within the politically defined parameters laid down by the Swedish Health Ministry. The advantage of such arrangement would be that it would provide a clear summit for the vertically organised NHS administrative system (which has been described as a triangle with the top cut off) and remove the ambiguity surrounding the DHSS's role as both an arm of central government and the head organisation of the NHS. The Department would, if such a board were created, still be able to exercise control over the health service in areas like finance. But its freedom from the day-to-day running of the NHS would open the way to greater lateral development of the DHSS in relation to the work of other Departments which could prove valuable in the formation of the type of integrated national approach to overall social policy recently advocated by the Central Policy Review Staff (CPRS 1974).[7]

The formation of a national board of management of the NHS is sometimes advocated on the grounds that it would remove or decrease political influences on the health services. Yet although it may be the case that it might seem valuable to moderate the immediate impact of extreme political pressures on the NHS development this would not on the whole be a desirable goal. Many important health care problems have significant political aspects just as their potential solutions have political implications. Thus the strongest arguments in favour of a national board relate to straightforward issues of management simplicity and the need to allow the DHSS to concentrate more on its relations with other arms of government, not to the desire to 'take the NHS out of politics'.

The relationship between the DHSS and the English Regional tier is an area in which changes may occur within the present overall NHS structure. A recent enquiry by Regional chairmen into the working of the DHSS suggested a number of innovations, ranging from a reduction of DHSS involvement in day-to-day detail by the referral of ad hoc queries on the NHS to the field authorities concerned (in 1975 the DHSS answered some 25,000 letters from MPs to Ministers – Hartley-Brewer 1976) to an alteration in the system of parliamentary votes to allow financial accountability to Parliament within the NHS at Regional level.

Although the latter recommendation is of questionable practicability and would require legislation and the former point may not be based on a thorough study of the political purpose of parliamentary questions about the health service some action in this sphere is likely. David Owen, a former Minister of State for Health, has publicly noted a number of possible developments, including changes in the NHS career structures to allow movement of staff 'upwards' from Regional level to the Department. He envisaged strengthening the role of the Regions in the sphere of overall NHS management and planning, balanced by increased devolution of day-to-day power to the Areas and increased DHSS concentration on overall policy making (Owen 1976). This would reduce areas of administrative overlap at the DHSS/RHA interface which might involve a reduction in DHSS staff numbers. As Owen commented, the position shown in Table 3 can hardly be described as a pyramidal administrative structure.

Table 3 *DHSS and RHA staff*

DHSS staff engaged on health and personal social services as at April 1975	
Administrative groups	1931
Common services	910
Health (non-NHS)	212
Professional divisions*	998
Administrative and support service to professional divisions	820
Total	4871

*Professional divisions include doctors, nurses, architects, engineers, pharmacists and other technical grades.

RHA staff as at September 1974†	
Administrative and clerical	4095
Computers	903
Works, scientific and technical	2259
Medical and nursing	115
Total	7372

†Excludes 378 ancillary staff.

Source Owen 1976

Such a change in balance would be similar to that envisaged by the Regional chairmen and would go some way to meeting the objectives of those advocating a national board of management for the NHS, although a dual role for the DHSS would still exist. It would probably also be welcomed by the Areas, whose chairmen were in 1976 invited to examine their links with the Regions in a second stage in the 'interface' exercise, in that it is the view of many people at Area level that increased operational autonomy for them is most likely to result if those at Regions are involved more in national management issues. However, the apparent competition for operational management roles at the AHA/District

7 A variety of policy issues have been identified as suitable for such joint approaches. For example, the CPRS has researched some aspects of policy relating to the care of disabled people whilst Draper *et al* (1976) have noted the failure of the 1976 Green Paper on Transport to look at the health implications of this topic. Similar issues include the possible health significance of fiscal controls relating to drinking and smoking and aspects of penal policy relating to mental health.

interface would be unaffected by such changes even though its intensity may be reduced by an increased AHA involvement in planning activities now that the new system has been initiated.

At a sub-national level the situation in London raises important questions because of the city's role as the traditional focus of medical 'excellence' and its associated current experience of reductions in resource availability and because the relationship between local government services and those of the NHS is exceptionally complicated. Some authorities argue that the current division of London into four Regions is undesirable and that perhaps a structure based on a relatively small number of new Thames Areas could be introduced. In that there is already limited pressure for a redrawing of local authority boundaries in London it is possible that such a restructuring could occur independently of the development of the NHS in other parts of the country and at a fairly early date.

If such a reorganisation were to occur it might be possible to attempt to bring together or at least further co-ordinate the teaching facilities within the capital with a view to establishing more economic arrangements. At the moment London may well be bearing an unfair burden in acting as the national centre for medical teaching.

It is possible, for example, that there is a complex relationship between the historical development of primary and community care in London and the existence of a large number of high status teaching hospitals. Perhaps a reorganisation of London's health services could involve some restructuring of FPC services and their relationship with the rest of the NHS to allow for the special needs and expectations of the capital's population which has a high proportion of transient individuals, of immigrants and of elderly people isolated by the rapid social changes in their community. Such a restructuring could provide useful information when the development of services in other parts of the country is considered.

Professional power in the NHS

During the development of the NHS the medical profession has understandably striven to defend its own interests and to protect its relationship with the public from the intrusions of third parties. However, as a result of this it may be argued that some of Britain's doctors have failed to adjust to a number of new factors bearing on the desirability of their traditional attitudes. For example, the increasingly firm scientific basis to many of the therapies employed in modern practice coupled with 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 authority 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 integrated pattern of social and medical care now generally recognised as ideal in many areas of health service intervention can usually only be achieved if all those contributing to it sacrifice a degree of independence and personal autonomy for the sake of efficient organisation and thus effective patient care.

Yet within the new structure the medical profession retains much of its power (if not its unquestioned authority) and has even extended it in areas like the administration of clinical services. Despite the claims of some doctors that their new involvement in management means a heavy workload it has, partly at least, been achieved through the political pressure applied by the profession itself. It is significant in this context that the administration of the general medical services in England was practically 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 England and Wales in the late 1970s has many of the structural characteristics of that which existed in the 1920s and 1930s.

As a result, some authorities argue, the family practitioner services are too isolated from the rest of the NHS and their administrators take too little part in the overall planning of health care development.[8]

Yet in balance to these points it should be noted that very often medically qualified individuals find themselves in the position of being the most able and informed people attempting to cope with the day-to-day problems of the NHS, many of which are essentially medical. This fact may well justify direct medical involvement in health service administration. Also in the field of general medical practice it is clear that, despite recent criticism (Butler and Knight 1976), the achievement of the Medical Practices Committee in ensuring a fairly even distribution of resources nationally has been considerably greater than that of the rest of the NHS, a point which may qualify some claims regarding the need for better planning.

It is also apparent that the development of other professional groups within the health service has been rapid in recent years and that although this may be seen as in some ways a valuable counter to medical dominance it has probably had a number of undesirable side effects. Whilst the medical profession has surrendered certain aspects of its control of the NHS many other professional groups have, since reorganisation, won new rights of consultation at every level in the service. This may not only have slowed its capacity to react to problems but may also have encouraged a professional 'pressure group' approach to policy making.

Although the medical profession is still widely regarded as the most influential sectional interest group within the health service it may thus be that the power of other groups is now becoming a more significant phenomenon, particularly in that pressure to establish the relatively new professions has frequently led to the formation of hierarchical career structures. The effect of these is often to remove individuals with experience and skill from situations where they are involved in the

8 In Northern Ireland and Scotland the Executive Council structure has been abandoned in favour of the administration of independent contractor services by health authority committees. However, this in itself may not be any more satisfactory than the arrangements in England and Wales.

delivery of care into posts devoid of direct service significance. Nursing standards, for example, may have suffered as a result of the implementation of the Salmon Report. The provisions of the latter are often thought of as stemming from an urge for more administration within the health service although in fact their genesis may also be related to changing professional aspirations. Similarly current patterns of incentives tend to draw the more able young administrators in the health service up the chain of District, Area and Regional command to levels where it is fairly clear that the NHS is if anything 'over managed' and away from the local level where there is an apparent shortage of management skill and initiative.

However, a shift of emphasis away from this type of career structure in the newer professions like health service administration may be difficult to achieve, partly because it would in some ways run contrary to the interests of established staff who during their 'professionalisation' have gained a powerful influence over the training and consequent attitudes and expectations of new personnel.

Conclusions

The National Health Service is undoubtedly facing numerous problems, some of which seriously threaten to undermine the quality of care it offers the British people. Consciousness of this fact has been brought to a head in recent years by the events surrounding the 1974 reorganisation, which many individuals regard as largely responsible for the disturbing situation of today. It is widely blamed for being the cause of 'excessive bureaucracy' in the health service and for the destruction of its traditional patterns of working.

Yet a close examination of the history of health care in Britain suggests that the current difficulties of the NHS cannot be attributed to any one set of factors. Rather they have arisen out of a combination of events like the changes in the health care needs of the population over the past thirty years, the limitations imposed by Britain's poor economic position and the shifting balance of professional authority within the NHS.

In the late 1940s there were considerable benefits still to be gained from extending the acute medical services available with the intent of reducing premature mortality and as far as possible eliminating the burden imposed on the community by infectious disease. The NHS proved to be relatively successful in achieving these goals. Hence today the benefits to be gained from extra investment in such fields appear low as compared to those rewards likely to be generated by an increased emphasis on the primary prevention of ill health and services designed to alleviate conditions like the chronic degenerative disorders of later life or the more serious mental illnesses.

The improvement of these requires a significant economic input. But at a time of near zero growth in national product this cannot be achieved except by reallocation of resources within the health service or by transfer of moneys from other areas of public or private expenditure both of which would have the effect of depriving other sectors of the economy of funds. Given the politically and economically limited scope for the latter, Ministers have laid emphasis on the former approach. This, together with the steps taken towards geographical reallocation, has exacerbated the problems associated with the financial stringencies experienced by the NHS.

Simultaneously there has over the last few years been an increased realisation of the need for NHS services to be more effectively integrated with those of other agencies of the welfare state. The maintenance of health is no longer regarded solely a responsibility of the medical profession. This trend helped to undermine the authority of the latter body (which may also have been affected by broader changes in British society) and demanded a more comprehensive approach to planning and management and the strengthening of other occupational and professional groups within the health service.

The breakdown of the former status of the medical profession, which may in some ways be exemplified by the current dispute over private practice, also created within the health service uncertainty as to how and by whom the discipline necessary for its efficient functioning should be exercised. In an attempt to compensate for this lack of commonly recognised authority emphasis has in recent years been placed on concensus management in the health service although this itself has slowed and complicated the process of administration, so possibly generating a further loss of purpose and direction.

Thus underlying the commonly expressed belief that the NHS is being overwhelmed by a wave of bureaucracy and discontent there is a highly complex process of organisational adaptation to the changing nature of health care which is linked to trends like the emergence of new professional groups and stronger unionisation. Much of the 'crisis' in the NHS exists in the context of its being an employer rather than its being an efficient provider of services to health care consumers. The 1974 reorganisation was an attempt to accommodate some of the stresses which were building up in the health service as well as to enable it to attain more effectively its original objectives. But because the introduction of the new structure itself helped to create awareness of the NHS's problems and in some ways necessarily stimulated fresh ones it is often wrongly used as a scapegoat event to which are attributed all the health service's ills.

This is not to say that there were no faults in the organisational format established in 1974. In England, for example, it may be true that the chain of communication between the Districts is too complicated for information to flow up the chain swiftly and too restrictive for operational autonomy at local level to become a practical reality. There is certainly a glut of time consuming and apparently pointless committees at all levels and there are unsatisfactory aspects of the Community Health Councils, which may in some cases never become anything more than 'talking shops' or platforms for local politicians to pursue their particular interests.

There is also justifiable concern as to the efficacy of the collaborative arrangements between the health and local authorities, although these may have been strengthened by the recent joint financing arrangements and the

increased emphasis on the Area tiers' role in this field. In addition the way in which the planning system was initiated in 1976 may have repeated mistakes made at the time of the reorganisation and so have failed to communicate its provisions and purposes adequately to many NHS staff members.

However, none of these points are of sufficient strength to make an objective observer believe that the reorganised NHS is inevitably doomed to failure. Furthermore some of them, like the concern about too many committees and the consultative process, relate to attempts to solve fundamental problems in health care such as the breakdown of the traditional medical authority. It is highly unlikely that difficulties in this area could have been avoided, whatever the course adopted.

Similarly it is improbable that the obstacles to co-ordinating NHS activities with those of other agencies, such as the personal social service departments, could have been bypassed by a different organisational approach. Some authorities appear to regret the separation of the health and social services and advocate a return to the pre-1971 position in which the latter were under the control of the Medical Officers of Health. Others believe that the transfer of the NHS to local government control could eliminate the barriers to effective collaboration. Yet on examination neither of these views appear realistic.[9] For on one hand it would be undesirable for the work of the social service departments to be under too great a medical influence because much of it has little or no bearing on health care. Previous arrangements probably impeded the development of social work as a profession for little positive gain. Whilst on the other hand the agencies already under local political control often apparently pursue differing policies with little co-ordination. At least the 1974 reorganisation created clear routes of communication between the NHS and the local authorities at the service planning level where none had existed before.

It would thus appear that premature judgements on the success or failure of the 1974 reorganisation should be avoided. It will probably be at least a decade before its advantages and faults can be properly determined. For the moment perhaps one of the more significant contributions the Royal Commission on the National Health Service may be able to make is to encourage both the public not to make unrealistic demands for, and of, health care and also individuals working in the NHS not to have unrealistic expectations regarding the speed and manner in which the service's problems can be resolved. In the immediate future what in many cases is required is personal adjustment to a changed environment rather than a further restructuring of the NHS.

And in the final analysis it is to be remembered that the object of ultimate importance is not the health service as such but the health of the community it seeks to serve. In balance to the anxiety so frequently expressed about the reorganised NHS's structure or about defects in the services it provides it is worthwhile emphasising that the formation of a general understanding of and changed attitudes towards the dangers of smoking, excessive drinking and poor diet has the potential to reduce morbidity and mortality in Britain by a greater degree than any currently foreseeable form of curative or palliative medical intervention. The responsibility for achieving such ends is not exclusively the health service's. It is shared by the entire community.

9 In Northern Ireland the social services are linked to those for health under combined Health and Social Services Boards. However, special circumstances apply in this case. For instance, the political situation and the position of minority groups in that part of the United Kingdom may be thought to make local political control of the social services undesirable.

References

Battistella R M and Chester T E (1972). The Role of Management in Health Services in Britain and the US. *Lancet*, 18 March 1972.

Battistella R M and Chester T E (1973). The Reorganisation of the British National Health Service. *New England Journal of Medicine*, 20 September 1973.

Better Services for the Mentally handicapped. Cmnd 4683, HMSO 1971.

Better Services for the Mentally Ill. Cmnd 6233, HMSO 1975.

Butler J R and Knight R (1976). *Health Trends*, 8, pp 8–12.

Brown R G S (1973). 'The Changing National Health Service'. Routledge and Kegan Paul, London.

Brunel Institute of Organisation and Social Studies (Health Services Organisation Research Unit) 1973. Working Papers on the Reorganisation of the National Health Service.

Chester T E (1973). Health Service Reorganised. *National Westminster Bank Quarterly Review*, November 1973.

Chester T E (1976). Personal communication.

Chester T E and Donald B L (1976). Social Change and the NHS Reorganisation. *Hospital and Health Services Review*, July 1976, p 230–34.

Committee on Nursing Report (Briggs Report). Cmnd 5115, HMSO 1972.

Crease A (1976). *In* 'Labour's Social Priorities'. Ed H Glennerster, Fabian Research Series No 327.

DHSS (1969a). Report of the Working Party on Management Structure in Local Authority Nursing Services (Mayston Report). HMSO.

DHSS (1969b). The Functions of the District General Hospital (CHSC Report). HMSO.

DHSS (1970a). The Future Structure of the NHS (Second Green Paper). HMSO.

DHSS (1970b). Report of the Working Party on the Hospital Pharmaceutical Service (Noel Hall Report). HMSO.

DHSS (1971). NHS Reorganisation (Consultative Document). DHSS.

DHSS (1972a). Second Report of the Joint Working Party on the Organisation of Medical Work in Hospitals (Cogwheel II). HMSO.

DHSS (1972b). Report of the Working Party on Medical Administrators (Hunter Report). HMSO.

DHSS (1972c). Management Arrangements for the Reorganised NHS. (Grey Book). HMSO.

DHSS (1975). First Interim Report of the Resource Allocation Working Party.

DHSS (1976a). A Review of the Mental Health Act 1959.

DHSS (1976b). Priorities for Health and Social Services in England. HMSO.

DHSS (1976c). Sharing Resources for Health in England. Final Report of the Resource Allocation Working Party. HMSO.

DHSS (1976d). Regional Chairmen's Enquiry into the Working of the DHSS in relation to the Regional Health Authorities.

Draper P, Kogan M and Morris J N (1970). The NHS: Three views. Fabian Research Series No 287.

Draper P and Smart T (1972). The Future of our Health Care. Dept of Community Medicine, Guy's Hospital.

Draper P (1976). Personal communication.

Elliot F A and Brown C D (1973). Reorganisation – a perspective from Northern Ireland. *The Hospital and Social Services Review*, January 1973.

Executive Committee of the Renal Association (1976). *BMJ*, 6041, 2, p 903.

Gammon M (1976). Health and Security. The St Michael's Organisation, London.

Galbraith N S (1976). *BMJ*, 6039, 2, p 805.

Hartley-Brewer M (1976). *Guardian*, 17 September 1976.

Heath P J and Parry W H (1976). *Lancet*, 7976, 2, pp 82–83.

Klein R and Lewis J (1976). 'The Politics of Consumer Representation'. Centre for Studies in Social Policy, London.

Levitt R (1976). 'The Reorganised National Health Service'. Croom Helm, London.

Maxwell R J (1976a). Hospital and Health Services Review. March 1976, pp 89–93.

Maxwell R J (1976b). Personal communication.

Ministry of Health (1920). Interim Report of the Future Provision of Medical and Allied Services (The Dawson Report). HMSO.

Ministry of Health and Scottish Home and Health Department (1966). Report of the Committee on Senior Nursing Staff Structure (Salmon Report). HMSO.

Ministry of Health (1967). First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals (Cogwheel I). HMSO.

Ministry of Health (1968). The Administrative Structure of the Medical and Related Services in England and Wales (First Green Paper). HMSO.

National Health Service Reorganisation: England. Cmnd 5055, HMSO, 1972.

National Health Service Reorganisation in Wales. Cmnd 5057, HMSO, 1972.

National Health Services (Scotland) Act. HMSO, 1972.

National Health Service Reorganisation Act. HMSO, 1973.

Owen D (1976). The Organisation and Management of the NHS. *Hospital and Health Services Review*, July 1976, pp 239–44.

Radical Statistics Health Group (1976). 'Whose Priorities?'. Radical Statistics, London.

Report of the Committee on Local Authority and Allied Personal Social Services. Cmnd 3703 (Seebohm Report), HMSO, 1968.

Reorganisation of the Scottish Health Services. Cmnd 4734, HMSO, 1972.

Rickard J H (1976). *BMJ*, 6001, 1, pp 299–300.

Royal College of Physicians of London (1976). *BMJ*, 6046, 2, p 1247.

West P A (1973). *Applied Economics*. 5, pp 153-66.

West P A (1976). *Social and Economic Administration*. 10, 2, pp 83-91.

Williams C J H and Rathwell T A (1976). *BMJ*, 6041, 2, pp 956–58.

The Office of Health Economics

The Office of Health Economics was founded in 1962 by the Association of the British Pharmaceutical Industry. Its terms of reference are:

To undertake research on the economic aspects of medical care.
To investigate other health and social problems.
To collect data from other countries.
To publish results, data and conclusions relevant to the above.

The Office of Health Economics welcomes financial support and discussions on research problems with any persons or bodies interested in its work.

OHE Publications

Studies of Current Health Problems

ISSN 0473 8837

33 The Ophthalmic Service 35p
34 Alcohol Abuse 35p
35 Building for Health 35p
36 Off Sick 35p
37 Prospects in Health 35p
38 Epilepsy in Society 35p
39 Hypertension 35p
40 Family Planning in Britain 35p
41 Migraine 35p
42 Hospital Purchasing 35p
43 Medicine and Society 35p
44 Medical Care in Developing Countries 35p
45 Rheumatism and Arthritis in Britain 35p
46 Skin Disorders 35p
47 Mental Handicap 35p
50 Vaccination 35p
51 Parkinson's Disease 35p
52 Multiple Sclerosis 35p
53 The Health Care Dilemma 35p
54 Medicines which Affect the Mind 35p
55 Anaesthesia 35p
56 Rabies 35p
57 Asthma 35p

Reports on OHE Symposia

Innovation and the Balance of Payments:
the experience in the Pharmaceutical Industry £1.50
Human Relations in General Practice 75p
Economics and Innovation in the Pharmaceutical Industry £1.50
Evaluation in the Health Services 75p
The Pharmaceutical Industry and Society:
its changing environment and economics £1.50
Benefits and Risks in Medical Care £1.50

OHE Briefings

Venereal Diseases 20p
Accidental Deaths 20p
Infant and Child Health 20p
Murder, Manslaughter and Infanticide 20p
Viral Hepatitis 20p

Studies and General Publications

Medicines in the 1990s 75p
The Canberra Hypothesis:
The economics of the pharmaceutical industry £1.50
Brand names in prescribing 50p

About OHE *free*

Details of other OHE publications are available on request.