The National Antibiotic Therapy Test also deserves commendation as a technique of postgraduate education—a subject recently reviewed.[2] Both television and simulation have been used in Britain more extensively than they have been evaluated and reported. Projects developing the ideas used in the NATT may offer an opportunity to combine specialist and generalist education; to reduce the costs of duplicating programmes; and to introduce a mechanism of continuing and private self-assessment which might be acceptable to both the hawks and doves of medical audit. Postgraduate education has been fortunate in being able to recruit many able and imaginative staff; but legitimate concern over its running expenses and "cost-effectiveness" are creating pressures for reducing instead of expanding these interests. Sadly, a British programme of this type might be difficult to finance.

[1] Neu, H C, and Howrey, S P, *New England Journal of Medicine*, 1975, **293**, 1291.
[2] *British Journal of Medical Education*, 1974, **8**, 84.

Devolution and the NHS

If the case for devolution hinged on the experience of the National Health Service it is unlikely that the issue would have become of any political importance. But now that the bandwagon has started rolling—some, indeed, would say that it is out of the control of the political parties at Westminster—decisions about devolution inevitably have implications for the NHS and for the medical profession. For that reason before the publication of the White Paper[1] the *BMJ* decided to organise a conference of individual doctors on devolution as part of its series of meetings concerned with questions crucial to the Service and to the profession. In the event, the conference was held after the White Paper and full comments from the BMA[2] had been published. The discussion papers and the report of the conference appears at p 1127.

In the past the tendency has been to discuss devolution in general political terms rather than in the context of the specific requirements of particular services. Neither the majority[3] nor minority[4] reports of the 1973 Royal Commission on the Constitution, for example, had much to say about the problems of the NHS or any other public service. There is therefore a danger that Mr Michael Foot (who has now inherited ministerial responsibility for devolution and is revising the policy proposals in last November's White Paper) may believe that this relative lack of concern is evidence that he need not take much account of the special interests of the NHS and of the medical profession.

That would be a mistake. As the full reports by the Scottish and Welsh Councils and the conference discussion show, devolution does raise some very important, and contentious, issues. The participants varied in their attitudes towards devolution—some were committed advocates, others were agnostic sceptics—and there was substantial disagreement on many questions. Even so, some clear-cut conclusions emerged. Firstly, it became apparent that the reason devolution had excited so little passion in the specific context of the NHS has been that in Scotland (though not in Wales) administrative devolution already exists and has indeed existed for many years. Many of the much-admired qualities of the Health Service in Scotland reflect the fact that decisions are taken in Edinburgh by a small group of people, doctors and administrators, who can cut through the formalities of the bureaucratic system and short-circuit the kind of long-distance negotiations characteristic of England and Wales. To this extent the Scottish experience suggests that there is a case for allowing more freedom in decision-making to those actually running the health services in Wales and the English regions. Such a change could well yield considerable gains in terms of flexibility, informality, and the ability to improvise.

But, secondly, the Scottish experience also carries a warning. Administrative devolution there has reinforced, not silenced, the demands for political devolution—the transfer of power to a locally elected assembly. And there is, indeed, an element of logic about such demands. Political accountability is the Siamese-twin of administrative responsibility for spending public money; if the responsibility is devolved, so also must be the accountability, since otherwise devolution would lead to a total loss of political control over the taxpayer's money. So it is not surprising that the BMA should have expressed fears lest devolution should lead to an intensification, rather than a diminution, of political influence in Health Service matters.[2] If devolution is about anything it is about the distribution of political power.

A positive case may, of course, be made for increased political influence and interest in NHS matters. For example, it was argued at the conference that one reason for the Service's financial plight is its comparative insulation from politics. If raising more money is to be made politically more attractive then health policy may well have to become more political. But here again the experience in Scotland carries a warning. On a per caput basis more is spent on health in Scotland than in either England or Wales—some English regions now have a greater unmet need for resources than any other parts of Britain.[5] If political devolution were to come to Scotland then the pressure might well be to cut rather than to increase spending on health: one of the Scottish participants at the conference did indeed argue in favour of diverting resources to other social services in Scotland. And, even allowing for social conditions in Scotland, the fact that these services are of low quality is a poor advertisement for devolved political control—in this case local authority control over housing (where Scotland's record has long been notoriously inadequate) and over the personal social services.

These are only some of the specific health issues relevant to the debate about devolution. There are others. Any proposal for less bureaucracy which saves time and money for the NHS must be examined carefully: but a proposal such as the devolution of health might well lead to a fragmented profession working in a segmented Health Service and it ought to be opposed.

[1] *Our Changing Democracy. Devolution to Scotland and Wales.* London, HMSO, 1975.
[2] *British Medical Journal*, 1976, **1**, 724.
[3] *Royal Commission on the Constitution Volume I. Report.* London, HMSO, 1973.
[4] *Royal Commission on the Constitution Volume II. Memorandum of Dissent.* London, HMSO, 1973.
[5] Godber, G, *Change in Medicine*, London, Nuffield Provincial Hospitals Trust, 1975.