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Hospital Staffing Structure (Medical and Dental): Third Progress Report

The third progress report on hospital staffing structure (medical and dental) produced jointly by the Health Departments and the Joint Consultants Committee is printed below. A leading article appears at p. 429.

The following represented the Joint Consultants Committee: Sir John Richardson, Bt. (Chairman, Joint Consultants Committee); Dr. R. M. Mayon-White (Vice-chairman, Joint Consultants Committee); Dr. C. E. Astley; Mr. J. S. Elkington; Dr. J. Campbell Ferguson; Mr. A. H. Grabham; Mr. J. H. Hovell (hospital dental staff); Mr. Walpole Lewin; Sir Thomas Holmes Sellors; and Mr. R. B. Wright.

Introduction

(1) These discussions originated with the submission to the then Minister of Health in January 1967 of the B.M.A.'s "Memorandum on the Current Problems of Hospital Medical Staff."[1]

(2) The present phase of these discussions began in 1969 following a report on the career structure of hospital doctors by a subcommittee of the Joint Consultants Committee,[2] and the *Report on the Responsibilities of the Consultant Grade.*[3]

(3) A progress report on these discussions was published in December 1969,[4] and a second report was published in 1971.[5]

(4) The first progress report set out certain propositions on which it was considered the future career structure should be based. These included the propositions that the postgraduate training of doctors should take only as long as the needs of training require and should lead without undue delay to a permanent post in a specialty, and that a balance should be attained between the number of career vacancies anticipated in each specialty and the number in training for career posts in that specialty, taking into account entrants to the consultant grade from other fields of work such as university posts.

(5) Agreement was subsequently reached on the need for more rapid expansion of the consultant grade, and for control over the number of training posts. It was also agreed that progress towards an improved career structure would require more forward planning of hospital medical and dental staffing and that progress should be monitored and assessed if planning was to be effective. New arrangements for joint central machinery for these purposes were proposed in the second progress report and, for England and Wales, the Central Manpower Committee was subsequently established.

(6) In discussions following publication of the second progress report the Health Departments and the professions' representatives have reached agreement on:

(*a*) Arrangements for senior registrars temporarily unable to obtain consultant posts on completion of training.

(*b*) A final review of the personal status of S.H.M.O.s and S.H.D.O.s with allowances holding consultant posts.

(*c*) The future of the medical assistant grade.

(7) Details of the agreements reached are set out in the rest of this report and will be incorporated in guidance to be sent out by the Health Departments to hospital authorities who will be notified at that stage of the date later this year when they will come into effect.

(8) In addition discussions are proceeding with representatives of hospital doctors and general practitioners for the establishment of a hospital practitioner grade for general practitioners wishing to work part-time in the hospital service. A progress report on the position reached is also given below.

Arrangements for Senior Registrars who Complete Training but do not Immediately Obtain Consultant Posts

(9) It was stated in the first progress report that the training programmes should be flexible enough to allow individuals reasonable freedom to alter their preferences during training and to take account of variations in the rate of progress. It was also stated that if a balance was to be attained between those in training and career vacancies there would have to be limitation of tenure of training posts as well as control over the numbers in training and more rapid expansion of the consultant grade. If there is to be a satisfactory progression through the training grades it is clearly essential that posts in the senior registrar grades should not be blocked for any significant length of time by practitioners who no longer need further training in the grade.

(10) At present the number of senior registrars who have been in the grade for five years or more is very small (at 30 September 1971 the figure for England and Wales was 57 out of a total of 1,831, or 3·1%, and of this number only nine were considered to have completed training). A breakdown of these figures is given in Annex B. So the problem in numerical terms is already quite small, and in the future careful control of numbers in the grade exercised through the Central Manpower Committee will aim to ensure that doctors entering training are able to obtain consultant posts without undue delay. The arrangements set out in H.M.(61)119 (whereby in each region the progress of the senior registrar is reviewed by the Joint Advisory Committee on Senior Registrars after his first year and a decision about his suitability to continue made effective by the end of his second year) should ensure that, as far as possible, those completing training are suitable candidates for consultant posts.

(11) It is proposed that in future the length of tenure of a senior registrar post, or of a programme where training is through a rotation of senior registrar posts, should be clearly defined at the outset of training in that grade. The employing authority should seek the advice of the Joint Advisory Committee on Senior Registrars in its region in determining the length of tenure appropriate in each case. This would be subject to review by the J.A.C.S.R. during the course of training, but when in the view of the J.A.C.S.R. there were no educational grounds for the doctor to continue to hold the post, the Health Departments and the professions' representatives consider that it would be reasonable for the hospital authority to inform the doctor that after a further maximum period of one year he would be given the normal period of notice to vacate the post.

(12) Where a doctor is not making satisfactory progress in the senior registrar grade, he may, *inter alia*, be advised by the J.A.C.S.R. to seek training in another specialty. Where, exceptionally, a doctor

completes training but is unable to obtain a consultant post before he is required to vacate his senior registrar post, it may be that, even at this late stage, the J.A.C.S.R. will advise that he should retrain in another specialty. If not, the employing authority would be expected to use its best endeavours to place the doctor in any temporarily vacant and suitable post: this might be a senior registrar post available on a temporary basis, or a vacant consultant post to which a locum appointment could be made; tenure of such posts would be for determination in the light of individual circumstances. The Health Departments intend to inform employing authorities that where, exceptionally, it is not possible to make suitable temporary placements of this kind within existing establishments, they may, after seeking the advice of the J.A.C.S.R., create special temporary posts remunerated at the point in the senior registrar grade appropriate to the individual concerned. Tenure of such posts would be on a year-to-year basis at the discretion of the employing authority. It is regarded as of great importance that regional manpower committees should have the opportunity to comment on proposals to establish special posts of this kind.

(13) These principles will apply also in Scotland. The arrangements will be for agreement between the Scottish Home and Health Department and the representatives of the professions in Scotland.

Senior Hospital Medical and Dental Officers Holding Allowances and Occupying Consultant Posts

(14) In 1959 employing authorities were authorized to pay an allowance to S.H.M.O.s and S.H.D.O.s where in the view of the authority these officers were undertaking work which would after the existing holder's tenure of the post be performed by a consultant, and were carrying out such work for all or most of the time covered by their contracts. S.H.M.O.s and S.H.D.O.s were able to appeal through the Whitley appeals procedure against a decision by their employing authority not to grade their work as of consultant level.

(15) Under arrangements set out in Ministry of Health circular H.M.(64)94 (which announced the Minister of Health's conclusions on the reviews of medical staffing carried out by hospital boards following recommendations made in the Platt report, 1961) the S.H.M.O. and S.H.D.O. grades were closed, and officers holding allowances and in posts approved as of consultant level were invited to apply for personal regrading as consultants, with the right of appeal against the decisions of the professional committees considering the applications. There was also a subsequent "paper" review of unsuccessful appellants by a joint panel appointed by the Health Departments and the professions.

(16) At 30 September 1971 there were 102 S.H.M.O.s and not more than 17 S.H.D.O.s holding allowances.

(17) Following representations from the professions made on behalf of all S.H.M.O.s the Health Departments have agreed that there should be a final central review of the personal status of S.H.M.O.s and S.H.D.O.s holding allowances and occupying consultant posts. Arrangements for the review will be settled with the professions' representatives in due course.

The Future of the Medical Assistant Grade

(18) The medical assistant grade was introduced as a permanent career grade of limited responsibility in 1964, following a recommendation made in the Platt report (1961).

(19) In June 1968, the British Medical Association's Annual Representative Meeting carried a motion rejecting the grade and the Association subsequently asked the Departments for a moratorium on the creation of further wholetime posts in the grade until such time as the J.C.C. and the Health Departments had been able to consider together the future of the grade in the light of proposals then current for the reform of the hospital staffing structure (including the Todd report[6] and the Panel 1 report.[7]) Following an inquiry by the Health Departments into the use made of the grade since 1964, it was agreed in January 1969 between the J.C.C. and the Departments that the moratorium should remain in force, but that, with the agreement of the Chairman of the J.C.C. and of the Advisory Committee on Consultant Establishments (A.C.C.E.), exceptions might be made

(*a*) where there was a pressing service requirement; and

(*b*) where the holder of a post wished his post to be converted to the medical assistant grade and this was recommended to A.C.C.E. by the Regional Committee for Hospital Medical Services and the Board.

(20) Part-time posts were not included in the moratorium, and applications for such posts continued to be considered by A.C.C.E. without the need for any special approval similar to that for wholetime posts.

(21) Annex A shows the number of new medical assistant posts approved since the moratorium began in August 1968. Between 30 September 1968 and 30 September 1971 the total number of doctors in the permanent non-consultant grades did not increase at all, although hospital medical staff as a whole increased by over 11%. Between July 1968 and January 1972 only 80 wholetime medical assistant posts were approved and 114 part-time posts (most of them created specially for married women). Only 18 posts were approved in general medicine and obstetrics and gynaecology, of which seven were for married women, and only two in general surgery. Of the total of 194 posts, 145 had been proposed on personal grounds at the request of the doctor concerned.

(22) The moratorium also applied to the equivalent dental grade of assistant dental surgeon.

(23) It has been agreed in the present phase of discussions between the professions' representatives and the Health Departments that the normal career progression of hospital doctors and dentists should be through the training grades direct to the consultant grade. This is a fundamental principle and the forward planning of national hospital medical and dental staffing by the Central Manpower Committee is founded on that basis and on the assumption that doctors will not spend any time in a permanent sub-consultant grade (such as medical assistant) in their progress toward consultant appointments. The professions' representatives and the Health Departments consider that employment in the medical assistant grade of doctors who have completed specialist training (either as a senior registrar or in equivalent academic appointments) should occur only in exceptional cases of personal hardship and on the personal application of the doctor concerned. In that sense they concur fully with the intention underlying the proposition in the first progress report that there should in future be no permanent sub-consultant career grade. They believe, however, that there remains a need to provide for those few doctors who are not able for one reason or another satisfactorily to complete specialist training to consultant level but wish to work part-time or full-time in the hospital service. They consider that the most suitable arrangement for these doctors would be to continue to allow them to be employed as medical assistants if they so wished. In addition, they recognize that there are certain narrow areas of hospital medical practice where practitioners may specialize in work which would not justify the appointment of a consultant to carry it out and that medical assistant appointments may be appropriate for these practitioners. Since the moratorium started in August 1968 a small number of M.A. posts have been created, with the agreement of the Chairman of the J.C.C. and of the A.C.C.E., in order to meet urgent service needs. In the period August 1971 to June 1972 six such wholetime posts were authorized. The Health Departments and the representatives of the profession agree that, where there is an urgent service need which cannot appropriately be met by training post apointments, the solution should be to create a consultant post, and they would expect the hospital authority to put forward a proposal accordingly. If after consultation with the professions' regional manpower committee, the hospital authority did not feel able to put forward proposals for a consultant post and asked for a medical assistant post, the Health Departments and the C.M.C. would require a full explanation of the circumstances thought to warrant this. Appointment of medical assistants in these circumstances should therefore be very rare, but the Health Departments and the professions' representatives do not think at present that the possibility should be excluded entirely, and that the arrangements described above should ensure that there is no risk that medical assistant appointments will be made unnecessarily. However, they intend jointly to keep the working of the arrangements under review.

(24) The Health Departments and the professions' representatives are agreed that all existing medical assistant posts (part-time or wholetime) should lapse when vacated by their holders. They consider that the hospital authority should on all such occasions review the staffing structure at the hospital or hospitals concerned in order to see whether a new consultant post could be established, and that the authority should seek the views of the professions' regional manpower committee.

(25) The professions' representatives and the Health Departments have therefore agreed that the continuance of medical assistant appointments shall be strictly limited by the following conditions:

(*a*) Posts will only be established on a personal basis by doctors who apply to a hospital authority for employment as medical assistants; they will not be advertised ex-

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cept in the limited circumstances described in paragraph (*d*) below.

(*b*) New medical assistant posts (whole-time or part-time) will be established only when authorized by the Health Departments following advice from the Central Manpower Committee (C.M.C.) in which its junior members have concurred. It would be expected that any proposals for such posts would not be made unless they were supported by the professions' regional manpower committee.

(*c*) Posts (including existing posts) will lapse on being vacated by the holder, unless renewed under (*b*) above.

(*d*) Wholetime posts will not be advertised except with the approval of the Health Departments following advice from the C.M.C. The circumstances in which it was envisaged such approval might be given would be strictly limited but would ordinarily include posts in refraction, the blood transfusion service, audiology, dental services for long-stay, mental and handicapped patients, or in other specialties which the Health Departments and the Joint Consultants Committee may subsequently agree in which it was recognized that there was work of a specialized nature which could not appropriately be carried out by practitioners in the training or consultant grades.

(*e*) Medical assistants will continue to have the same terms and conditions of service as at present, subject to any improvements which may be negotiated on their behalf.

(26) The above arrangements will apply also to appointments as assistant dental surgeon; applications for posts would be considered centrally by the Dental Subcommittee of the C.M.C.

(27) The principles set out above will apply in Scotland although different administrative arrangements will be necessary (the C.M.C. is concerned with medical and dental staffing in England and Wales only). These will be for agreement between the representatives of the professions in Scotland and the Scottish Home and Health Department.

The Hospital Practitioner Grade

(28) One of the basic propositions put forward in the first progress report was that there should be a special grade (to be called the hospital practitioner grade) in the hospital staffing structure for general practitioners.

(29) In March this year the Central Committee for Hospital Medical Services and the General Medical Services Committee agreed on proposals for the establishment of such a grade which would enable general practitioners wishing to work in hospital to do so as part of a hospital team. Minimal criteria for entry to the grade were proposed.

(30) A copy of the proposals is at Annex C. With some modifications they have been accepted by the Health Departments as a basis for further discussions, which are currently taking place.

1 Memorandum on the Current Problems of Hospital Medical Staff (January 1967). *British Medical Journal Supplement*, 1967, 2, 93.
2 Report of a Subcommittee of the Joint Consultants Committee on Hospital Staffing Structure. *British Medical Journal Supplement*, 1969, 1, 75.
3 Report of the Working Party on the Responsibilities of the Consultant Grade. London. H.M.S.O., 1969.
4 Hospital Staffing Structure (Medical and Dental). Progress Report on Discussions Between Representatives of the Health Departments and the Joint Consultants Committee. *British Medical Journal Supplement*, 1969, 4, 53.
5 Hospital Staffing Structure (Medical and Dental). Second Progress Report on Discussions between Representatives of the Health Departments and the Joint Consultants Committee. *British Medical Journal Supplement*, 1971, 3, 119.
6 Report of the Royal Commission on Medical Education (Cmnd. 3569). H.M.S.O., 1968.
7 Negotiations between Health Departments and Hospital Doctors and Dentists: Joint Final Report. *British Medical Journal Supplement*, 1968, 1, 73.

Annex A

Control of the Medical Assistant Grade During the Moratorium

Since the original agreement to create the moratorium in August 1968 the following new medical assistant posts have been approved:

Period	Total No. of Posts	Whole Time	Part-time*		Reason for Making Post	
			1-4 Sessions	5-9 Sessions	Personal Grounds	Service Needs
Medical						
Total	194†	80	38	76	145	49
August 1968-June 1969	46	32	6	8	17	29
July 1969-June 1970	39	14	9	16	35	4
July 1970-July 1971	75	21	17	37	65	10
August 1971-January 1972	34	13	6	15	28	6
Dental						
Total	16	7	5	4	4	12
August 1968-June 1969	7	3	4	0	3	4
June 1969-July 1970	2	0	0	2	0	2
July 1970-July 1971	2	2	0	0	0	2
August 1971-January 1972	5	2	1	2	1	4

†Of the total of 194 posts, 87 were created specially for married women.

*Part-time medical assistant posts were not included in the moratorium; applications could still be approved by A.C.C.E. without having to meet the special conditions necessary in the case of whole-time posts.

The specialties mainly involved were:

Specialty	Total	Married Women
Psychiatry	45	20
Anaesthetics	31	11
Pathology	16	5
Traumatic and orthopaedic surgery	16	4
Obstetrics and gynaecology	11	4
Geriatrics	10	6
General medicine	7	3
E.N.T.	6	6
Ophthalmology	6	2
Venereal diseases	5	2

Apart from these, there were no more than four posts in any one specialty and there were very few posts in some of the large specialties, for example, only two in general surgery.

There has been little change in the total numbers in the non-consultant career grades since 30 September 1968, as shown in the following table:

Grade	1968	1969	1970	1971
Total	1,354	1,351	1,337	1,355
M.A.	754	820	850	920
S.H.M.O.:				
with allowance	134	120	114	102
without allowance	422	387	349	322
J.H.M.O.	44	24	24	15

Annex B

Hospital Medical Staff

ENGLAND AND WALES, 30 SEPTEMBER 1971

Senior Registrars who have Completed Training

Up to 7 Years in the Grade		7 Years and More	
General surgery	1	Physical medicine and rheumatology	1
T. and O. surgery	1	Venereal diseases	1
E.N.T.	1	Ophthalmology	1
Anaesthetics	1	Total	3
Mental illness	1		
Radiology	1		
Thoracic surgery	1		
General pathology	1		
Total	8		

Senior Registrars in Training for Five Years or Over

Specialty		Specialty	
General medicine	6	Radiology	1
Dermatology	3	Neurosurgery	1
Cardiology	3	Plastic surgery	1
Ophthalmology	6	Thoracic surgery	4
Paediatrics	2	Anaesthetics	1
General surgery	4	Radiotherapy	2
Rheumatology and physical medicine	1	Obstetrics and gynaecology	3
E.N.T.	2	Morbid anatomy	4
T. and O. surgery	1	Mental illness	5
General pathology	2	Mental illness (children)	3
Blood transfusion	1		
Venereal diseases	1	Total	57

Note: The figures are for years since first entry into the grade and do not necessarily show the senior registrar's position in the training plan, as no account is taken of possible breaks in service in the grade.

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Annex C

Hospital Practitioner Grade

(a) The hospital practitioner grade will exist to enable general practitioners wishing to work in hospital to do so as part of a hospital team.

(*b*) Holders of posts in the hospital practitioner grade will not, as such, have independent charge of beds, and the ultimate responsibility for the clinical care of every inpatient will continue to rest on a named consultant as at present (with the exception of designated G.P. beds). However, a general practitioner who holds a hospital practitioner grade appointment will enjoy the same right of access to G.P. beds (whether in the same hospital or elsewhere) as do his colleagues in that area.

(*c*) Appointments in the hospital practitioner grade shall be open to general practitioners and limited for each holder to a maximum of five sessions a week in the hospital service.

(*d*) The following criteria shall apply to entry to the grade:

(i) Two years' post-registration wholetime hospital training in an appropriate specialty;

or

(ii) Possession of one of the following higher qualifications in relation to the appropriate specialty: for example, F.R.C.S., M.R.C.P., M.R.C.O.G., M.R.C.Path, F.F.A., F.F.R., M.R.C.Psych., F.D.S.;

or

(iii) Having been approved for the purpose of providing general ophthalmic services;

or

(iv) Five years' experience as a clinical assistant and possession of appropriate specialist diploma;

or

(v) Such experience as a clinical assistant as is deemed equivalent to two years' post-registration wholetime hospital training.

(*e*) The method of appointment should be modelled on that used for appointing registrars, but shall include general practitioner representation on the appointments committee.

(*f*) The hospital practitioner grade shall have an incremental salary scale and holders of appointments in the grade shall enjoy security of tenure.

(*g*) The clinical assistant grade (or part-time medical officer grade) will continue.

Interim Results of Distinction Award Ballot

The following resolution was passed at the Annual Representative Meeting 1971: "That a new referendum of consultants be held on the Distinction Award system and that the system be renegotiated on the basis of any changes supported by the referendum."

In March and April 1972 a questionnaire was sent to consultants, honorary consultants, and senior registrars by the Association. The response to the survey has been as follows (a small number of questionnaires are still being returned):

	Consultants	Senior Registrars
Number of questionnaires despatched	13,190	2,321
Number of valid replies	6,887	992
Response rate	52·2%	42·7%
Number of invalid replies	554	19

The questionnaires contained the following questions:

(A) Do you support the continuation of distinction awards (either on the present or on some revised system)?

(B) Do you consider that the present system requires any change?

(C) Should names of holders be published?

(D) Would you prefer a system of seniority awards?

(E) What other change or changes do you consider desirable?

Tables I and II give a preliminary analysis of the replies received from consultants, and senior registrars respectively. A comparison with the results of the survey undertaken in 1967 is shown in Table III. The replies to question (E) have not yet been analysed.

TABLE I—*Analysis of Replies Received from Consultants*

	Question	Total Replies Number (= 100%)	Yes %	No %	Don't Know %
All consultants	(A)	6,887	74·3	24·3	1·4
	(B)	5,155	61·7	30·5	7·8
	(C)	6,586	55·7	44·2	—
	(D)	6,698	38·6	61·4	—
Consultants in receipt of Distinction Awards	(A)	2,617	93·6	5·8	0·6
	(B)	2,434	42·3	49·5	8·2
	(C)	2,570	32·3	67·7	—
	(D)	2,550	15·7	84·3	—
Consultants not in receipt of Distinction Awards	(A)	4,261	62·5	35·7	1·8
	(B)	2,721	79·1	13·6	7·4
	(C)	4,016	70·8	29·2	—
	(D)	4,148	52·7	47·3	—

TABLE II—*Analysis of Replies Received from Senior Registrars*

Question	Total Replies Number (= 100%)	Yes %	No %	Don't Know %
(A)	960	69·0	30·1	0·9
(B)	662	79·8	12·5	7·7
(C)	935	84·9	15·1	—
(D)	936	30·2	69·8	—

TABLE III—*Comparison of Results from 1967 and 1972 Surveys*

	Question	Date of Survey	Total Replies Number (= 100%)	Yes %	No %	Don't Know %
Consultants	(A)	1967	5,889	75·5	24·5	—
		1972	6,878	74·3	24·3	1·4
	(B)	1967	5,889	64·9	25·5	7·1
		1972	5,155	61·7	30·5	7·8
Senior Registrars ..	(A)	1967	940	74·5	25·5	—
		1972	960	69·0	30·1	0·9
	(B)	1967	940	70·5	14·4	9·6
		1972	662	79·8	12·5	7·7

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N.H.S. Reorganization

Summary of White Paper

A brief summary of the White Paper "National Health Service Reorganization: England" (Cmnd. 5055) was recently published in the British Medical Journal *(5 August, p. 363) along with a leading article (p. 309). Since then a White Paper on N.H.S. reorganization in Wales has appeared (Cmnd. 5057). A longer summary of the White Paper for England is published below. The proposals for Wales are broadly similar, except for the omission of a regional tier, and a map of England and Wales showing the boundaries of the proposed authorities appears at p. 149.*

In his foreword to the English White Paper Sir Keith Joseph, Secretary of State for Social Security, says that "It is about administration, not about treatment and care. But the purpose behind the changes proposed is a better, more sensitive, service to the public. Administration is not of course an end in itself. But both the patients and those who provide treatment and care will gain if the administration embodies both a clear duty to improve the service and the facilities for doing so." He admits that government must take its share of responsibility for the imbalances and gaps in the N.H.S. "Resources were and still are stretched" he continues. "The acute services had a legitimate priority. But the shortcomings were not national. They did not result from a calculation as to the best way to deploy scarce resources. They just happened." Sir Keith maintains that this was because there was no identified authority to provide for an area "the best health service that the money and skills can provide." It is to enable such an authority to operate in each area, with the best professional advice, he states, that the Government proposed to reorganize the administration of the National Health Service.

The Secretary of State attaches great importance to the establishment of strong community councils and he also sees the health services depending crucially on the humane planning and provision of the personal social services and, therefore, on effective and understanding collaboration with local government. He does not anticipate that the changes will affect the professional relationship between the individual patients and the individual professional worker, and the latter will, he states, "retain their clinical freedom—governed as it is by the bounds of professional knowledge and ethics and by the resources that are available—to do as they think best for their patients. This freedom is cherished by the professions and accepted by the Government. It is a safeguard for patients today and an insurance for future improvements."

Unification

Secton I describes the main features of unification. It refers to unification of the personal social services within the local authorities, claiming that this was not done just to get administrative tidiness but to provide "solid advantages to the individual and family." The hub of the Government's proposals for the reorganized N.H.S. provide for a single administrative body locally which will draw its funds from one source taking "a wide, unbiased and constructive view of the priorities across the whole range of needs served by the general practitioner and other community health services and by the hospitals."

Consultative Document

The Government next gives the historical background to its proposals for reorganization and confirms that legislation is being prepared to be introduced in time for the reorganized Service to start on 1 April 1974, the same date as local government reorganization.

Services Within the N.H.S.

This section defines the services which will be within and outside the N.H.S. The services to be brought together under unified N.H.S. administration are: the hospital and specialist services now administered by the Regional Hospital Boards, Hospital Management Committees and Boards of Governors; the family practitioner services now administered by the Executive Councils; the personal health services now administered by the local authorities through their health committees; and the school health service.

The personal health services which will come within the N.H.S. include: ambulance services; epidemiological work, including general surveillance of the health of the community; family planning; health centres; health visiting; home nursing and midwifery; maternity and child health care; medical, nursing and supplementary arrangements for the prevention of illness, care, and after care; and vaccination and immunization. The registration of nursing homes will also become the responsibility of the N.H.S.

Environmental health and personal social services will continue to be provided by local authorities but health education will become the responsibility of the health authorities. On occupational health the White Paper has the following to say:

"The health authorities will be concerned with preventive health measures of many kinds and will provide treatment and care for people who suffer injury or ill health however caused. But, apart from the authorities' concern with the health of their own staff, responsibility for the health of persons in relation to their employment lies with the Department of Employment. In matters affecting the health and safety of employed persons there must always be close working between those responsible for health and the environment both inside and outside the workplace. It is intended that there should be very close co-operation between the NHS and the Employment Medical Advisory Service in relation to both policy formulation and day to day operations. In addition arrangements are being made for EMAS to use NHS laboratories and other investigatory facilities."

N.H.S. Authorities and Their Functions

N.H.S. authorities and their functions are described in this section (IV). In England the Government has described that there will be two levels of organization, regional and area, in addition to the central Department, and at each of these levels there will be a unified administration covering "the whole span of the N.H.S." The section outlines the statutory responsibility the Secretary of State has for providing the Health Service, with Parliament holding him accountable for the money spent on it—nearly all of which comes from central sources. A great deal of planning and allocation of resources must take place on a basis wider than an area. "This means," states the White Paper, "that the Secretary of State must satisfy himself that the service in England is being efficiently run." It goes on to say:

"In Scotland and in Wales, with their relatively small populations, it will be practicable to do this by means of area health authorities in direct relationship with the central Departments in Edinburgh and Cardiff. Health services in those two countries could therefore be operated without interposing a regional organisation between the central Health Departments and the areas. But in England, a central Department operating from London could not hope to exercise effective and prompt general supervision over area authorities whose numbers will be six times those of their counterparts in Scotland and eleven times those in Wales."

Planning in the N.H.S. will be carried out at area and regional levels as well as by the central Department, each with its own role:

"The regional health authority (RHA) will have a regional planning responsibility which will include settling priorities when there are competing claims between areas. But the fundamental unit in the planning process will be the area. Area health authority plans for the communities within the area—the 'districts'—will strongly influence the way in which local, regional and national priorities are carried into effect in the area, and how they are harmonised with local authority plans."

A.H.A. Functions

Describing the functions of area health authorities in section 5 the White Paper says:

"The area health authority (AHA) will be responsible for achieving national health care objectives through the provision of comprehensive health services designed to meet the needs of the communities within its districts. It will be responsible for planning and developing services in consultation with its matching local authority and with the regional health authority. It will regularly and systematically appraise the quality of existing services in the districts and assess unmet needs, comparing the situation with national standards of care and identifying opportunities for improvement. This approach will encourage comparisons be-

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tween alternative methods of care, in the home and in the hospital. It will also make it possible for the area authority, with guidance from the region, to gear its plans in such a way that, in time, its services match national standards of care."

The A.H.A. will operate the services as well as plan them and it will be the employer of the staff who work at area headquarters and in the districts. One exception to this will be medical and dental consultants and senior registrars (other than those working in teaching areas) who will continue to be appointed and employed at regional level.

On the working of the N.H.S. at district level the Government proposes:

"The day to day running of services will be based on localities ('districts') within which it is possible to satisfy the greater part of the public's health care needs. As such, the district will form the natural community for the planning and delivery of comprehensive health care. It will be small enough for professional representative machinery to be effective within it, it will contain a district general hospital—or several hospitals together carrying out the functions of such a hospital—and will usually have a population of between 200,000 and 500,000. Because the boundaries of the health district will be related to health care needs, they will not necessarily correspond with the boundaries of a local government district, for which different criteria are appropriate. Many AHAs will be responsible for only one or two districts; a few will have up to five.

"The districts will not in any sense form a separate formal tier of authority below the areas. Within them, however, it will be possible for the services of doctors, nurses and others to be organised so as to answer community needs most effectively, and to fulfil the area authority's obligation to ensure unification of health services. The organisation in a district will be designed to achieve integration of all health services available within it, so that the representatives of the medical profession and the professional heads of services in the district can jointly make the important district decisions and in that way be responsible, not merely for running district services but for helping to shape them."

Referring to administrative boundaries the Government does not want these to be barriers to the use of the health services and it emphasizes that collaboration between the areas will be in the provision of services may well be required.

Collaboration with Local Government

With common boundaries for N.H.S. and local government collaboration between the two will be important. Subject to the outcome of the local government Bill there will be 72 A.H.A.s outside London (38 corresponding with non-metropolitan councils and 34 with metropolitan districts [see list on p. 153 and the map on p. 149]).

Collaboration cannot be left to depend merely on common boundaries, the White Paper declares, and it refers to the recommendations of the working party set up by the Secretary of State on collaboration between the N.H.S. and local government. Its recommendations are as follows:

"Collaboration must include planning and investment on the one hand and day to day operations on the other.

"On planning and investment, the requirements of an area need to be jointly identified and, in the light of the resources available, the best ways of fulfilling them agreed between the health and local authorities concerned.

"On day to day operations, the arrangements for collaboration must cover the general sharing of goods and facilities, such as the use of premises; the bulk purchase of supplies; building and associated maintenance services; "hotel" services like catering, domestic work and laundries; and management services such as computers, O and M and work study, and information services. The arrangements must also extend to the provision by one authority to the other, of the advice and services of professional staff. For example, social services staff will need to be made available by the local authority to the health authority. Equally, local authorities must continue to have professional advice—from doctors, dentists and nurses—in order to carry out their statutory functions in the personal social services, education, environmental health and housing. They should look to the health authorities for such help.

"There must be means of making sure that the arrangements for working together are firmly established and comprehensive and that they involve members and senior staff of the authorities concerned. There will therefore be local joint consultative committees of members of the authorities to examine jointly the plans of the authorities and to advise on the planning and operation of services in spheres of common concern. One such joint consultative committee might be established in a metropolitan district to cover all the services of common concern; but in a non-metropolitan county two committees would be needed—one covering personal social services and school health, and representing on the local authority side the county council; and another for environmental health and housing, which would include representatives of all the local authority district councils. Special arrangements would be needed in some areas, e.g., London. Each joint consultative committee would be supported by a group of senior officers from the authorities concerned.

"The joint consultative committee would make its views known to the constituent health and local authorities and these views might be published. It is expected that discussions on the joint committees would generally lead to agreement being reached between the authorities but there will be arrangements under which an authority can seek the help of Central Government on any matter where it has not been possible to reach agreement.

"In addition to the joint consultative committees, each AHA will include in its membership members of the corresponding local authority (see Section X); and local authorities will be strongly recommended to co-opt to their relevant committees members or officers of the AHA. These arrangements for membership of the authorities or committees will be supplemented by close working relationships between the chief officers of the authorities and by the arrangements for sharing the services of professional staff.

STATUTORY PROVISIONS FOR COLLABORATION

"In the last resort, the quality of collaboration will depend on the readiness of those concerned at all levels to communicate and co-operate with each other. But it is desirable to provide an administrative setting for this, as described above. And it is desirable also to provide a sound statutory basis. It is therefore proposed that the NHS Reorganisation Bill should contain a generel obligation on the authorities concerned to collaborate; should give them the fullest powers to provide each other with goods and services; and should make it obligatory to set up joint consultative committees.

FINANCE

"Appropriate financial arrangements between health and local authorities to cover these different forms of collaboration will be recommended in the light of advice from the Working Party on Collaboration."

Family Practitioner Services

Section VII is devoted to the family practitioner service, the whole of which is quoted here:

"Unification of the health services will not change the status of the general medical and dental practitioners, ophthalmic medical practitioners, opticians and pharmacists. They now provide services as independent contractors, and they will continue to do so.

"Unification will however open up new opportunities for family practitioners to develop their services as integral parts of comprehensive, integrated health care.

FAMILY PRACTITIONER COMMITTEE

"To administer the contracts, the A.H.A. will be required by statute to set up a Family Practitioner Committee (F.P.C.). Its work will consist of entering into contracts with the individual practitioners, and administering their terms of service, including remuneration schemes (which will be settled nationally), and the statutory disciplinary arrangements (which will be unchanged). On all of these matters, the Committee will deal direct with the central Department.

"The Committee will be made up in the same way as are Executive Councils at present outside the London area. There will be 30 members, half of them appointed by the professions themselves. The 15 professional members—8 doctors, 3 dentists, 2 pharmacists, one ophthalmic optician and one dispensing optician—will be appointed by the local professional committees for the area, which will perform broadly the same functions as they now do in relation to the family practitioner services. Of the remaining 15 members, 11 will be appointed by the AHA (at least one being an area authority member) and 4 by the local authority (or authorities) entitled to appoint members to the AHA. (See Section X for details of AHA membership). The chairman will be appointed by the Committee from among its own members.

AHA RESPONSIBILITIES

"If there is to be proper integration of health care in the reorganized service, the AHA must itself take responsibility for those issues where the provision of family practitioner services involves other parts of the unified NHS or the personal social services. These include the planning and development of health centres; the approval where necessary of practitioners' own proposals for providing premises; plans for contractor services in new towns and redevelopment areas; and general arrangements for nursing and other skilled staff employed by the AHA or by the local authority to work with family doctors in their own practices, whether in health centres or elsewhere. The AHA will of course want to be sure that plans for developments which affect contractor services are generally acceptable to its family practitioners. It will therefore consult the FPC and the local professional committees, and will take full account of their views before it makes decisions on these matters.

STAFF FOR THE FAMILY PRACTITIONER COMMITTEE

"The staff serving the FPC will, like other staff working within the area, be employed by the AHA, but the Committee will be consulted before senior appointments are made. Some staff may choose to make their career in the service of the Committee, but those who want a wider career will be given opportunities to transfer between the work of the Committee and other parts of the area administration.

"These arrangements will give the Committee a better prospect of getting the services of the best quality staff than would be the case if staff were to be appointed by them because in that event, career prospects would inevitably be limited.

MEDICAL PRACTICES COMMITTEE, DENTAL ESTIMATES BOARD, JOINT PRICING COMMITTEE

"The work of the Medical Practices Committee and the Dental Estimates Board will remain unchanged in the new structure. The Joint Pricing Committee will be replaced by a joint health authority with the same functions."

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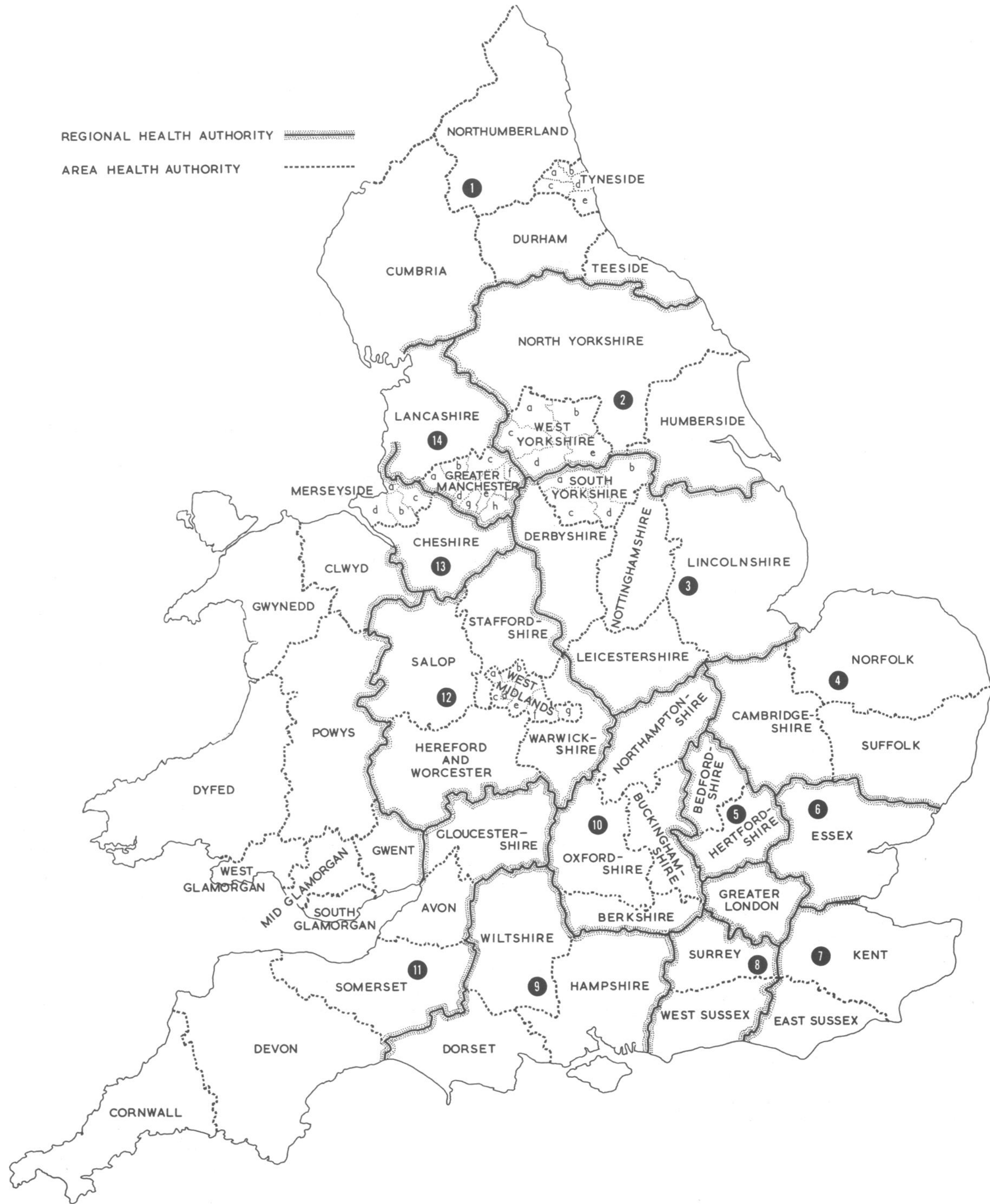
The map, based on information supplied by the Department of Health and the Welsh Office, shows the regional and area health authority boundaries proposed for the reorganized N.H.S. in England. Wales has no regional tier, and the eight area health authorities shown will be directly responsible to the Welsh Office.

Each lettered division (in the areas of high population density) corresponds to a metropolitan district as envisaged by the Local Government Bill. Each local government metropolitan district will be the equivalent of an area health authority. The pattern of area health authorities for Greater London has not yet been decided.



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Regional Health Authorities

Section VIII is devoted to the planning, co-ordination, and executive activities of the regional health authority. The R.H.A. will "develop strategic plans and priorities based on a review of the needs identified by A.H.A.s and on its judgement of the right balance between the individual areas and claims on resources."

It will also see that there is effective co-ordination and collaboration on ambulance services, blood transfusion services, the sponsorship of research projects, and some parts of the overall plan for supplies in the region. The Government has decided that the new health regions will be based on the 14 planning regions now in use for the hospital service. (Boundaries of the regions are shown in the map at p. 149). Details for London have yet to be arranged.

Central Department

Chapter IX, dealing with the Central Department, lists the ways in which the Department must assist the Secretary of State as follows:

(1) Settling, within the framework laid down by the Act, the kind, scale and balance of services to be provided in the regions and areas.

(2) Guiding, supporting and (to the extent that this is desirable) controlling the R.H.A.s.

(3) Obtaining or developing resources which strongly influence the adequacy, efficiency and economy of the services. This will require specialist work on particular resources—personnel; finance; property and building; supply.

(4) Carrying out other functions that are best organized centrally. Examples are some types of research, the standardization and preparation of national statistics, purchase of some equipment or supplies centrally. The N.H.S. superannuation scheme will also continue to be centrally administered. A microbiological service related to communicable disease will continue to be administered centrally by the Public Health Laboratory Service Board on behalf of the Secretary of State.

(5) Supporting the Secretary of State in his Parliamentary and public duties.

The organization and operation of the Department has been reviewed, with the help of management consultants. Proposals have been produced which are designed to enable the Department to carry out effectively the functions it will have after N.H.S. reorganization.

It will be organized on an inter-professional basis to carry out three main groups of tasks in connexion with the N.H.S.: planning the kind, scale and balance of services in association with the field authorities and the professions; working in partnership with the R.H.A.s and providing them with support and guidance; and carrying out central N.H.S. personnel functions.

Membership of Authorities

The membership of authorities is the subject of section X, in which the Government states that the strength of the new administrative structure will largely depend on three factors: "small and capable membership of authorities to approve the monitor policies; effective machinery for getting expert advice to the members from the medical and other health professions, and for gathering, appraising and handling intelligence; and channels by which, in every health district, the users of services can represent their views vigorously to management."

The N.H.S. should be administered by trained staff under the general direction of authorities composed of part-time members who give their services voluntarily. The Government proposes that "Members of the area and regional health authorities will serve in an unpaid capacity though they will be entitled to travelling and other allowances. The chairmen will however have a specially heavy and time-consuming job and . . . . The legislation will include a provision to make it possible for the chairmen of health authorities to be remunerated on a part-time basis."

SCOPE OF THE AUTHORITIES' WORK

The area authorities, which will employ thousands of staff, will be responsible for the health care of up to a million people or even more, and will administer annual budgets running into millions of pounds.

Its members will, according to the White Paper, supervise "the creation and development by their chief officers of policies in response to changing needs; and the overseeing of standards of performance, both in quantity and quality."

The area authority will normally have about 15 members, with regional authorities about the same size. The authority will be free to co-opt to committees. Members will visit the hospitals and other units for the management of which they will be responsible. The Government suggests that in the main members should be chosen for their personal qualities after appropriate consultations, not elected as representatives reflecting the views of particular interests.

The chairmen and members of regional health authorities will be selected and approved by the Secretary of State, who will be required before making his choice to consult with the appropriate interested organizations including the universities, the main local authorities, and the main health professions.

The chairman of an A.H.A. will be appointed by the Secretary of State, after consultation with the chairman of the R.H.A. Four members of the corresponding local authority will be appointed and at least one place will be filled on the nomination of a university.

The remaining members of the A.H.A. will be chosen and appointed by the R.H.A., which will be required to consult with appropriate organizations. The White Paper continues "These organizations will include those representative of the main health professions, as it is intended that A.H.A.s should include in their membership people of authority and experience who themselves are members of the healing professions. This is in addition to the A.H.A.s professional advisory machinery and to its chief professional officers. The proportion of professional members will not be prescribed, and will differ from area to area and change from time to time according to circumstances, but an A.H.A. will always include doctors and at least one nurse or midwife—but not drawn from staff who are accountable to the authority's chief professional officers."

Professional Advisory Machinery

Section XI, on professional advisory machinery, is quoted here in full:

"Strong professional advisory machinery will be built into the new structure. The Act will include provision for this. It will function at each level of management, and will ensure that the RHA and AHA and their staffs make decisions in the full knowledge of expert opinion. It will ensure, too, that at all levels the health professions exercise an effective voice in the planning and operation of the NHS."

PROFESSIONAL ADVICE FOR THE HEALTH AUTHORITIES

"The details will be worked out in consultation with the various professions in readiness for 1974. Though the detailed arrangements will vary according to the circumstances of the individual professions, it is clear that

(*a*) at least the following professions must be covered: doctors, dentists, opticians, pharmacists, and nurses and midwives;

(*b*) the arrangements must include provision for successors to the local medical, dental, optical and pharmaceutical committees, since they will, as now, have important statutory and other functions to perform, e.g., the appointment of members to the Family Practitioner Committees;

(*c*) the arrangements should also carry into the reorganized service the best of the experience already gained in the existing service (e.g., the developing 'Cogwheel' structure, other satisfactory arrangements at Hospital Management Committee and individual hospital level, and the advisory systems on professional matters built up by the Regional Hospital Boards); and should take account of the interests of medical, dental and nursing education."

PROFESSIONAL ADVICE FOR THE DEPARTMENT

"At the national level, the Department of Health and Social Security must have available to it expert opinion on a wide range of matters, many of which are highly technical, relating to the provision of the National Health Service. Advisory bodies will continue to be the main source of this advice. They are either set up as standing bodies or appointed as occasion requires.

"The main standing advisory body is the Central Health Services Council, created in 1948 to advise the Secretary of State on general matters bearing on the service. Standing Advisory Committees have been appointed to advise the Central Health Services Council and the Secretary of State on specific aspects. The constitutions and terms of reference of the Council and of the Advisory Committees will be adjusted as necessary to meet the needs of the reorganized and unified service. In 1946 the elements in the composition of the Central Health Services Council were specified in the Act, but it is now proposed to use subordinate legislation for this purpose—as has always been the case with the Standing Committees—so that the composition can be readily adjusted to meet changing circumstances. As well as members appointed by virtue of their official positions at the heads of certain professional bodies, the list of which is under review, and members with other health service experience, it is intended to include on the new Council some people specifically appointed to advise from the patient's viewpoint.

"There will also be a cross-representation with the Personal Social Services Council, so as to secure representation of social work interests on the Central Health Services Council and of health service interests on the Personal Social Services Council. The new—like the present—advisory bodies will be free to offer advice on their own initiative as well as on request."

ADVICE ON STAFF TRAINING

"Arrangements are also being made for giving expert advice to the Secretary of State on the training of N.H.S. staff: detalis are given in section XV."

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Community Health Councils

In Section XII the Government refers to the community health councils, which will be set up in each district of the A.H.A. to represent the consumer interest. Half of a council's 20 to 30 members will be appointed by the local government district council(s), and the rest by the A.H.A., mainly on the nomination of voluntary bodies concerned locally with the N.H.S. and some after consultation with other organizations. Councils will appoint a chairman from among the members.

The councils will have powers to secure information, the right to visit hospitals and other institutions, and they will have access to the area authority.

"Councils will be well placed" states the White Paper "to bring to the notice of the A.H.A. and its district staff potential causes of local complaint, especially those of a general nature, but their function will be distinct from that of the A.H.A.'s complaints machinery of the Health Service Commissioner." The A.H.A. will meet the council's reasonable expenditure, including expenses incurred by their members, and will provide accommodation for meetings and secretarial staff.

Medical and Dental Teaching

Section XIII on medical and dental teaching says that areas with substantial teaching facilities will be described as "teaching areas" and the A.H.A.s which administer them will be called A.H.A.(T.)s.

The section continues:

INTEGRATION WITHIN THE REGIONS

"Administrative unification is essential if there is to be a properly balanced development of community and hospital facilities to meet the needs of teaching, of research and of services to the public. Teaching hospitals have in recent years gone a long way in providing district hospital services. Unification will help them to take this further, and in so doing, will bring great benefit to the districts concerned. At the same time, facilities for teaching and research are increasingly needed, not only in hospitals but also in the community health services: here too the closer union of teaching hospital and community services will be of benefit. Moreover, administrative unification will enable the staff of the teaching hospitals to play the full part which they and the Health Service as a whole would wish them to take in the development of the new administrative organization that will be set up in 1974.

"For these reasons, the teaching areas will be administered as part of the regions in which they are situated.

SPECIAL PROVISIONS FOR TEACHING HOSPITALS

"But integration of teaching hospitals within the unified NHS must take account of the special character of undergraduate teaching and of University sponsored research, and of the fact that the hospitals where they take place also provide specialised services for many people living outside their area. The hospitals' individual identity and historic traditions are valuable assets which must and will be preserved when the new organization is set up. The rest of this Section describes the arrangements to achieve these important objects.

"The teaching hospital will obviously have a central role in the health services for the district in which it is situated. The administrative arrangements at hospital and district level have still to be worked out in detail in the light of the recommendations of the management study. But it is clear that there will be intimate links between the AHA(T) and those responsible for the administration of the teaching hospital. It is clear also that the management at the district level acting for the AHA(T), will have the main responsibility for all operational matters and will play a leading part in planning the development and improvement of services. It is expected that AHA(T)s will wish to nominate one or more of their members to take a special interest in the services of a district where there is a teaching hospital. They will be free to co-opt people to give them support in this, and to assist in planned programmes of visiting.

"It is important to maintain the present close working relationships between teaching hospitals and their associated medical and dental schools, and to extend those relationships to all the health services in the districts. The responsibility for securing this, day in and day out, must rest at the local level. A joint committee between the AHA(T) and the medical or dental school may also be found useful. Where, in London, statutory arrangements exist for Board of Governors representation on school Councils, similar arrangements will be made for AHA(T) representation.

"The AHA(T) itself will have teaching and research interests prominently in mind in its operational responsibility for the area and in the work it does on planning the improvement and development of the NHS. The AHA(T)'s membership will demonstrate this. The AHA without substantial teaching and research facilities will have one member nominated by the University, but the AHA(T) will have two. The AHA(T) will also have at least two additional members with teaching hospital experience—more if the area includes more than one teaching hospital (or group of hospitals of a kind that has hitherto been designated as a single teaching hospital).

"The AHA(T)s will exert a strong influence at the regional level, where the regional health authority's responsibilities will be much wider than those of the existing Regional Hospital Board and, will include provision of support for teaching and research. The RHA will include a member appointed by the Secretary of State after consultation with the University (more than one member if there is more than one University concerned).

"The Department's review of regional plans and estimates to ensure consistency with national policies and priorities, will pay particular attention to the balance between teaching and non-teaching areas. The RHA will receive its financial allocation a specific identified allowance for teaching and research. It will also be required to set up a committee to advise it on its responsibilities in relation to medical and dental undergraduate education and research; this committee will contain members co-opted from the University (or Universities) and the AHA(T)s.

"Regional health authorities will have important responsibilities for helping to ensure that there are satisfactory arrangements within the new service for postgraduate medical and dental education and training. It is envisaged that they will be advised on the discharge of these responsibilities by regional postgraduate education committees, as are Regional Hospital Boards at present, and that these bodies should be distinct from the committees advising on the provision required for undergraduate teaching.

"These arrangements should make for a fully integrated service in which the teaching hospitals will play as vital a part as they do in the hospital service as at present organized.

SPECIAL INTERIM PROVISIONS

"Teaching hospitals have traditionally been centres of excellence in acute medicine. Increasingly they have widened their interests to include aspects of non-acute conditions. In future, the integrated services of the district and teaching area will be able to benefit from their capacity for general excellence and for high standards. The teaching hospitals' contribution to the reorganized service will undoubtedly be a growing one, but during the early years there is bound to be anxiety about the possible effects of new administrative relationships. There is therefore a need for additional safeguards during these years, as reassurance that full weight will be given to the importance of the teaching and research functions as well as to the essential service role of these distinguished hospitals.

"The scope of the safeguards needed is still being discussed, but two have already been decided upon. On the first appointment of the AHA(T)s, the members appointed for their teaching hospital experience will be appointed by the Secretary of State from among the members of existing Boards of Governors of teaching hospitals and University Hospital Management Committees. Similarly, on its first appointment, the RHA's teaching and research committee will include members drawn from the present Boards of Governors and University Hospital Management Committees."

Management Structure

In section XIV, called "A Sound Management Structure," the White Paper refers to an administrative framework which will be flexible so as to respond to experience and altered circumstances. If planning is good, according to the Government, then "there can be the maximum delegation of authority in the actual conduct of the job, and the need for much more detailed intervention later on can be avoided." It sees monitoring being done in various ways: "by the collection and analysis of regular statistical information, by specially commissioned reports and enquiries, by visiting and contacts between the staff of the Department and field authorities, by systematic visiting, inspection and advice such as are carried out by the Department's auditors or by the Hospital Advisory Service, and by the self-critical observation and analysis of practice by which the professions monitor their own work."

The Department will prepare guidance on national policy objectives annually for A.H.A.s and R.H.A.s who will then draw up plans for the development of their services to meet these objectives together with their own local priorities. Acknowledging that measurement of needs and performance is exceptionally difficult in health care, the White Paper states that better statistical indicators will have to be devised.

On member/officer relationship the Government see R.H.A. and A.H.A. members as there to ask the right questions about the preparation, operation and review of plans; and to ensure a full awareness of health needs as a basis for the design of policy, the settlement of priorities, and the provision of a good standard of service. It maintains that the success of the service will depend not only on the work of clinicians and other professional staff but also on the quality of administrative staff.

After declaring its intention to develop the Cogwheel (medical staff), Salmon (nursing staff), and Noel Hall (pharmaceutical services) proposals, the Government turns to specialists in community medicine stating:

"Unification will bring together into one service medical administrators now working in the public health services and those in the hospital service. Their functions will continue to be carried out after reorganization and doctors from both these spheres will have a central part in the planning and management of the unified service, in the Department, in the regions and in the areas and districts.

"As specialists in what is now recognized within the profession as community medicine, their concern will be with assessing need for health services, evaluating the effectiveness of existing services and planning the best use of health resources. Equally, they will concern themselves with developing preventive health services, with the links between the health and the local authority personal social,

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public health and education services, and with providing the medical advice and help which local authorities will need for the administration of those and other services.

"The Working Party on Medical Administrators, under Dr. R. B. Hunter's chairmanship, has described the work of the specialist in community medicine at all levels of a unified health service. Their report points to the especially important responsibility which these specialists will have within the district management for promoting the functional integration of health care.

"Their skills will complement those of other health service administrators and of the clinicians. These groups will together form a partnership in management of the new service."

N.H.S. Staff

In a section (XV) covering the N.H.S. staff the White Paper states that rates of pay and conditions of service in the new N.H.S. will continue to be settled through national machinery. It refers to the new review body that has been set up to advise the Government on the remuneration of doctors and dentists, going on to say: "Management and staff will need to negotiate changes in the constitution of the present Whitley Councils in order to meet the changes in the service and in particular to provide for the representation of the new management bodies and of staff whose pay was previously settled outside the N.H.S. Whitley system."

Financial Administration

Section XVI on financial administration is reproduced in full here.

"The change in administrative structure will not mean a change in the methods of financing the National Health Service except in the case of services transferred from local authorities. The cost of those services, and of the health authorities' other expenditure, will be financed mainly by taxation and met from moneys voted by Parliament. The general arrangements for charging for certain NHS services will not be affected.

"The Department will make capital and revenue allocations to regional health authorities. From these the RHAs will meet the cost of their own services and will allocate money to AHAs to meet the cost of area services including the cost of the community health councils. Payments made to practitioners under the terms of their contracts will be separately funded by the Department.

"Regional and area health authorities will be required to prepare and maintain a medium term 'roll-forward' plan covering a four-year period together with indications of likely targets for the main capital developments over a longer period. Authorities will be notified of provisional financial ceilings for each of the succeeding four years so that plans may be expressed in the form of financial estimates, covering both revenue and capital expenditure. The allocation of funds by the regional authorities will be closely integrated with the planning processes so that the plans are based realistically on the levels of funds likely to be made available. To encourage the most efficient use of resources and flexibility in the execution of planned developments, authorities will have freedom within limits, to use funds allocated for capital expenditure to meet revenue expenditure and vice versa. Arrangements will also be worked out to enable unspent revenue allocations to be carried over from one year to the next. In addition, authorities will be given a more direct financial interest in land holdings and land transactions.

"Improved accounting and financial systems are being devised. The estimates produced as part of the planning process will be the framework for a budgeting system designed both to give overall control and to provide functional budgets which will help individual managers to exercise detailed control over resources and to assess the cost-effectiveness of departments and services against any recommended standards. Financial monitoring will form an important part of the monitoring of performance so that RHAs and AGAs will be able to compare actual results against estimates and budgets. It will also enable the Department to be satisfied that efficient financial control and management is maintained throughout all authorities, and that funds are used to the best advantage and in conformity with national policies. The Department will continue existing arrangements for carrying out a statutory audit of the authorities' accounts.

"The allocation of available funds to health authorities will be designed progressively to reduce the disparities between the resources available to different regions, and to achieve standards and improvements in services with due regard to national, regional, and area priorities. The new information systems and other methods of assessment and review of services should help to ensure that the bases used for allocating funds meet these objectives with increasing effectiveness.

"The transfer of services will relieve local authorities of expenditure and this will have to be taken into account when assessing the level of grant to be paid by the Central Government to local authorities after April 1974."

Voluntary Services

Voluntary service has always played an important part in the development of health and welfare services in this country the Government says, and voluntary bodies will be encouraged, in close co-operation with the area health and local authorities, to increase and extend their activities. The R.H.A.s and A.H.A.s will be able to make grants in support of voluntary bodies which provide and promote services within the general scope of the authorities' responsibilities. Financial help for national activities will continue to come from the central Department.

The Private Sector

The Government recognizes the contribution made by the private sector of medicine to the sum of health care. It thinks it right for people to have an opportunity to exercise a personal choice to seek treatment privately. The existence of facilities for private treatment, both within and outside the N.H.S., provides this opportunity. The White Paper sees the private sector acting as a stimulus to enterprise, development, and high standards of service. The Government "will continue to make available facilities in N.H.S. hospitals for private patients, without prejudice to the needs of those—the vast majority —who wish to be treated as N.H.S. patients and who are the hospitals' primary concern."

Endowments

Hospital authorities are trustees of substantial sums given to them by the public. Much of this money was given for local and special purposes. In transferring these trusts to the new authorities, the Government believes it "right and necessary to preserve both the local administration and the purposes of these gifts as far as it is possible to do so."

The future administration of funds held by teaching hospitals is still under discussion. The new authorities will be able to accept fresh gifts to help them in any part of their work. According to the White Paper money from voluntary sources has an important part to play in the N.H.S., and every encouragement will be given to locally organized fund-raising by voluntary organizations.

Handling Complaints

The White Paper calls for each health authority to have effective arrangements (which have the public's confidence) for dealing with complaints. Referring to the long-established statutory procedures in executive councils for investigating complaints against contractor practitioners, this section also mentions the independent committee, with Mr. Michael Davies, Q.C., as its Chairman, which is reviewing hospitals' arrangements for handling complaints. It is expected to report later this year.

As previously announced, the Government has decided that a Health Service Commissioner should be established to investigate complaints against N.H.S. authorities. The necessary legislation will form part of the N.H.S. Reorganization Bill, but the Commissioner will be starting work before the unified service comes into operation on 1 April 1974, though he will not deal with health services provided at present by local authorities. The White Paper goes on: "After unification, his terms of reference will cover the whole of the N.H.S., but he will not investigate complaints that in his opinion relate to the exercise of clinical judgement by doctors and other staff, and he will not deal with complaints for which statutory procedures already exist (for example, those about general medical and dental practitioners, pharmacists and opticians, which will continue to be dealt with under the service committee procedure), or which he thinks the complainant could reasonably pursue through the courts or before some tribunal."

"The complainant will have direct access to the Health Service Commissioner. The Commissioner will not however investigate a complaint until he is satisfied that the health authority concerned has had a reasonable opportunity to investigate it and reply to the complainant who, despite this, is still dissatisfied. It is plainly important that the health authority should itself have the opportunity to investigate a complaint about a service for which it is responsible, and in the great majority of cases the internal procedures can be expected to satisfy the complainant. It is only when the complainant remains dissatisfied that there may be scope for an investigation by the Health Service Commissioner.

"Complaints to the Health Service Commissioner will not have to be made by the patient himself, although no doubt most of them will be. There will be cases where the patient is unable to act for himself, and when that happens, the complaint may be made for him. This is an important safeguard for those who, because of the nature of their infirmity, are unable to speak for themselves; it will enable a wrong suffered, for example, by a mentally handicapped person to be brought to light. In such cases, the complaint can be made by a relative or friend of the patient or by a member of the hospital staff."

London

Certain special arrangements will be made in the London area, which will take account of three important aspects of the situation in London:

"(*a*) London borough boundaries must be used in forming area health authorities so that there can be collaboration between the NHS and borough services;

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"(b) these boundaries are in the main unrelated to many of the existing health services, and the natural health districts overlap them;

"(c) some important health services—notably the family practitioner and ambulance services—need units of administration larger than either the borough or the health district."

The special arrangements are:

"(a) There will be four regional health authorities which, like such authorities elsewhere, will include teaching areas. Each regional authority is likely to contain territory inside and outside Greater London, and territory in inner and in outer London;

"(b) an advisory co-ordinating working group will be set up on lines similar to the Joint Working Group which now exists to advise on hospital services in London. The group will secure co-ordinated planning of facilities for medical and dental teaching and research and the location of regional and sub-regional specialities;

"(c) health areas will be formed out of single London boroughs or groups of boroughs. The boundaries have not yet been settled. The local authority places on the AHA (which, in order to give each of the grouped boroughs appropriate representation, may be more than the four mentioned in paragraph 98) will be shared between the boroughs on an equitable basis;

"(d) the health districts, each of which will have a community health council, will have boundaries which will not always follow the borough boundaries within the health area;

"(e) the Greater London Ambulance Service will not be split up between the RHAs or AHAs but will continue to be administered as a single unit;

"(f) it is an accepted aim that each postgraduate teaching hospital should become closely associated with other hospitals and health services in its vicinity. But until this association is close enough to make it desirable for the postgraduate hospital to be administered by the AHA(T), the Secretary of State will, after consultation with London University, continue its Board of Governors in being for an appropriate transitional period. During this transitional period the Board will continue to be appointed as at present, except that the members now nominated by the Regional Hospital Board will be nominated by the regional health authority. The Board will have a direct relationship with and will get its money from the central Department."

The replacement of the five executive councils which cover Greater London and parts of the surrounding areas by a different number of family practitioner committees will give rise to certain practical problems, and the central Department promises help in overcoming them—in consultation with the interests concerned.

Run up to 1974

Joint liaison committees are to be set up to co-ordinate the efforts of existing authorities in planning for the changeover. The new area and regional authorities will be appointed in shadow form as soon as possible after necessary legislation is passed. But preparatory work will be necessary before then. Firstly, states the White Paper, there is work that can be done by the existing authorities such as "the preparation for each new area of statements about existing resources, developments in hand and current forward plans." Secondly, there are matters which can be settled only by the new shadow authorities but on which preliminary assessments can be carried out in advance, for instance, the pattern of health districts, the management structure, and staffing and accommodation requirements. The joint liaison committees, normally one such committee for each new health area (composed of representatives from each existing authority) and one for each new health region (composed of representatives of each area joint liaison committee and of the regional hospital board) will help in this work and will co-operate with similar committees that are being set up for local government reorganization. They will have a special responsibility for ensuring that N.H.S. staff are fully consulted, and are kept fully informed about N.H.S. reorganization by their existing employing authorities.

The White Paper then refers to the integration courses for senior staff and states that "it is proposed soon to arrange a series of short conferences or seminars for the most senior staff in each region, following publication of this White Paper; and local arrangements for training will be made by the joint liaison committees."

The Government reaffirms its intention to set up a National Health Service Staff Commission in England responsible for advising on the procedures to be followed for filling posts and on the arrangements for the transfer of staff, and for safeguarding their interests during the period of reorganization. The Commission would also have the duty of considering arrangements for appeals. Though the Commission cannot be set up formally until legislation has been passed, an advisory committee has already started work.

The Government is also studying "existing arrangements for compensation for loss of office with regard to their implications for the whole of public employment."

Conclusion

In its final section the White Paper comments that "health care depends on the effective delivery at the right time and place of the skills and devotion of those providing the services required." Asking how the public will benefit from reorganization it goes on to claim: "A more informed judgement of priorities will concentrate more of the available resources where they are most needed. There will be better co-ordinated provision for their health and social needs. Professional skills will be grouped into teams to meet the needs of particular categories of patients—the old, the handicapped, the acutely ill, mothers and children, the mentally sick. Strong community health councils will ensure that the public's views are known and that the service is run with full regard to them. Improved arrangements will be made for inquiring into complaints, and an ombudsman for the health service will be appointed."

"This White Paper proposes a framework which will co-ordinate the many and varied skills of all those who work in the National Health Service and will focus them on the needs of the individual citizen of this country. Its purpose is to enable an improved health service for all to be provided."

Appendices

There are three appendices. The first, a table of the new authorities is reproduced below; the second is the Secretary of State's Parliamentary statement (22 February 1972) on the Health Service Commissioner; and the final appendix deals with the management study.

APPENDIX I

National Health Service Reorganization: England

Boundaries for the area and regional health authorities outside London

Regional Health Authority	Area Health Authorities (Corresponding to the local government counties and metropolitan districts shown below)	Number of Area Health Authorities
1	Cumbria, Durham, Northumberland, Teesside and the 5 metropolitan districts in Tyneside	9
2	Humberside, North Yorkshire and the 5 metropolitan districts in West Yorkshire	7
3	Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire and the 4 metropolitan districts in South Yorkshire	8
4	Cambridgeshire, Norfolk and Suffolk	3
5*	Bedfordshire and Hertfordshire	2†
6*	Essex	1†
7*	East Sussex and Kent	2†
8*	Surrey and West Sussex	2†
9	Dorset, Hampshire and Wiltshire	3
10	Berkshire, Buckinghamshire, Northamptonshire and Oxfordshire	4
11	Avon, Cornwall, Devon, Gloucestershire and Somerset	5
12	Hereford and Worcester, Salop, Staffordshire, Warwickshire and the 7 metropolitan districts in West Midlands	11
13	Cheshire and the 4 metropolitan districts in Merseyside	5
14	Lancashire and the 9 metropolitan districts in Greater Manchester	10
		72

*These regions will also include London areas.
†Outside London.

Note: The names and boundaries shown in the second column above and on the map are those published in the Local Government Bill (as amended by Standing Committee D) and are still subject to changes in Parliament.

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British Medical Association

President: Sir THOMAS HOLMES SELLORS, D.M., M.CH., F.R.C.P., F.R.C.S.

Annual Postgraduate Meeting—Inverness 29 and 30 September 1972

Chairman, Local Organizing Committee: GORDON B. FARQUHARSON, M.B., C.H.B.

General Secretary: ROBERT MILLER, M.B., CH.B.

Science Secretary: JOHN KNOX, M.B., CH.B., M.R.C.P.

Executive Officer: B.M.A. House, Tavistock Square, London WC1H 9JP. (Tel. 01-387 4499.)

To assist the organizers to make adequate arrangements members who propose to attend are asked to inform the Executive Officer at B.M.A. House by 15 September, if possible. Attention is drawn to the information about postgraduate training allowance.

Programme

The 1st Annual Postgraduate Meeting of the British Medical Association will be held at Craig Phadrig Hospital, Inverness, on Friday and Saturday, 29 and 30 September 1972.

Friday, 29 September

The Opening Address entitled "The Use and Abuse of Medicines" will be given in the Town House, Inverness, at 11.30 a.m. by Sir Derrick Dunlop, M.D., F.R.C.P., Emeritus Professor of Therapeutic and Clinical Medicine, University of Edinburgh.

In the afternoon two clinico-pathological conferences will be held at Craig Phadrig Hospital, the first chaired by Dr. Macdonald Critchley of London and the second by Dr. Peter W. Brunt of Aberdeen.

In the evening there will be a Civic Reception given by the Inverness Town Council in the Caledonian Hotel.

Saturday, 30 September

There will be a symposium on "Malabsorption Syndrome" from 9.15 to 10.45 a.m., followed by a symposium on "Inherited Disease" from 11.00 a.m. to 1.00 p.m. which will be chaired by Professor C. A. Clarke, P.R.C.P. In the afternoon three seminars will run concurrently: "Emergency Medical Care in Transport," "Alcoholism," and "Surgery in Rheumatoid Disease." After tea there will be three tutorials on "Examination of the Eye," "Modern Casualty Appliances," and "Examination of the Newborn."

There will be a buffet dinner in the Station Hotel in the evening.

Allowances for General Practitioners

The scientific sessions have been approved as three full sessions under Section 63 of the Health Service and Public Health Act, 1968, for the payment of fees and expenses to general practitioners, subject to satisfaction of the usual conditions. As the meeting is of less than one week's duration payment of fees and expenses will be made only to doctors practising in Scotland, but sessions attended will count towards Postgraduate Training Allowance requirements for all doctors.

Congress Fee

There will be a congress fee of £3 for every doctor attending the meeting (no fee for ladies accompanying members). This fee covers coffee, lunch, and tea on September 29 and 30, and transport between the meeting venues in Inverness. Cheques made payable to "British Medical Association" should be sent with advance registration forms obtainable from the Executive Officer (Inverness Meeting) at B.M.A. House.

Registration Fee for Non-Members

A registration fee of £2 is payable by non-members of the B.M.A. in addition to the congress fee.

Hotel Accommodation

A selected list of hotels in Inverness is given below. Members wishing to reserve accommodation are asked to write direct to the hotel, as early as possible, stating that they are attending the B.M.A. meeting. The rates given are subject to variation without notice and applicants should verify tariffs with the hotel when making reservations.

Hotel	Tel. No.	No. of Rooms	Bed and Breakfast: Single Rooms from
Caledonian	35181	120	£4·50 plus 10% service charge
Cummings	32531	40	£3·50 plus 10% service charge
Douglas	34671	86	£2·75 plus 10% service charge
Royal	30665	45	£3·40 plus 10% service charge
Station	31926	70	£5·20 plus 12½% service charge

Car Parking and Transport

There is adequate car parking within the grounds of Craig Phadrig Hospital. Transport will be provided from the Caledonian Hotel to the meetings.

Caravan Site

The Bught Caravan Park is about two miles from the centre of Inverness on the main Fort Augustus Road. Further details from Dr. Robert Miller, 26 Grigor Drive, Inverness.

Travel to Inverness

Members are advised to make their own arrangements for travel to Inverness. The overnight train from London leaves Euston Station at 20.20 and arrives in Inverness at 08.20. There is an overnight train back to London on both Saturday and Sunday. Inverness is 168 miles from Glasgow and 156 from Edinburgh by road.

SPECIAL TRAIN

A special train has been arranged for another medical conference departing London Euston at 19.30 on Wednesday, 27 September, stopping at Birmingham and Crewe, and arriving Aviemore at 08.00 and Inverness at 08.45 on Thursday, 28 September. For the return journey this train leaves Inverness at 20.00 on Saturday, 30 September, arriving London Euston at 10.00 on Sunday, 1 October. The return fares are:

From London

First Class Sleeper £25
Second Class Sleeper £17

From Birmingham and Crewe

First Class Sleeper £22
Second Class Sleeper £15

There is limited accommodation available now on this train and more may become available after 21 August.

Any requests for reservations on this train should be addressed to: McKenzie Travel Ltd., 144 St. Vincent Street, Glasgow C2 5LH, mentioning the B.M.A. Meeting.

AIR TRAVEL

The Airport is at Dalcross, 7 miles from Inverness.

Catering Arrangements

Lunches will be at Craig Dunain Hospital, which is about 500 yards from Craig Phadrig Hospital. Transport will be provided.

Ladies Programme

On Friday afternoon there will be a coach tour via Loch Ness to Urquhart Castle with tea at Glen Urquhart Lodge Hotel. On Saturday there will be an all day tour to Landmark, the Cairngorms Exhibition Centre, at Carr Bridge (28 miles from Inverness) with lunch there. The return route is via Grantown, Dava Moor, Cawdor, and

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Culloden. Advance application for ladies tours should be made on the member's registration form.

Golf

On Sunday morning, 1 October, facilities for golf will be available to members and their wives at Nairn Golf Club (15 miles from Inverness). Those interested should indicate this on the advance registration form or should contact Dr. Gordon Farquharson, 15 Culduthel Road, Inverness.

Fishing

Members interested in fishing during their stay should contact Dr. Robert Miller, 26 Grigor Drive, Inverness.

Detailed Programme

Programme arranged by the Association's Board of Science and Education.

Friday, 29 September

9 a.m.—11.30 a.m. Registration Bureau open in the Town House

OPENING ADDRESS

"The Use and Abuse of Medicines"

11.30 a.m. Town House.

Chairman: SIR RONALD TUNBRIDGE, Chairman, B.M.A. Board of Science and Education.
Speaker: Sir DERRICK DUNLOP, Emeritus Professor of Therapeutic and Clinical Medicine, University of Edinburgh.
Open also to ladies and invited lay audience.

12.45—2.00 p.m. Lunch at Craig Dunain Hospital.

CLINICO-PATHOLOGICAL CONFERENCES

Neurosurgical Clinico-pathological Conference

2.30—3.45 p.m. Craig Phadrig Hospital.

Chairman: Dr. MACDONALD CRITCHLEY, London.
Speakers: Professor J. HUME ADAMS, Glasgow; Professor BRYAN JENNETT, Glasgow.

Gastroenterological Clinico-pathological Conference

4.15—5.30 p.m. Craig Phadrig Hospital.

Chairman: Dr. PETER W. BRUNT, Aberdeen.
Speakers: Dr. J. E. LENNARD-JONES, London; Dr. W. SIRCUS, Edinburgh.

CIVIC RECEPTION

7.45 for 8.00 p.m. Caledonian Hotel.

By invitation of the Provost and Town Council of Inverness. (Informal dress.)

Saturday, 30 September

SYMPOSIA

"Malabsorption Syndrome"

9.15—10.45 a.m. Craig Phadrig Hospital.

Chairman and Opening Speaker: Professor A. E. A. READ, Bristol, "Coeliac Disease—Complications and Treatment."
Speaker: Professor CHARLOTTE ANDERSON, Birmingham, "Malabsorption Syndrome in Childhood."

"Inherited Disease"

11.00 a.m.—1.00 p.m. Craig Phadrig Hospital.

Chairman and Opening Speaker: Professor C. A. CLARKE, Liverpool, "Genetics in Medicine."
Speakers: Dr. ALAN W. JOHNSTON, Aberdeen, "Human Cytogenetics"; Professor A. E. H. EMERY, Edinburgh, "Detection of Genetic Disorders in the Unborn Child."

1.00—2.00 p.m. Lunch at Craig Dunain Hospital.

SEMINARS (to run concurrently)

2.00—3.30 p.m. Craig Phadrig Hospital.

"Emergency Medical Care in Transport"

Chairman: Mr. W. SILLAR, Accident and Orthopaedic Service, Southern General Hospital, Glasgow.
On the Panel: Dr. ALAN BOOTH, Anaesthetist, Inverness.
Contributors: (1) Mr. ALASTAIR MORRISON, Accident and Orthopaedic Surgeon, Raigmore Hospital, Inverness; (2) Dr. EDWARD BUCHANAN, General Practitioner, Fort Augustus; (3) Dr. D. D. JOHNSTONE, General Practitioner, Stromness, Orkney; (4) Dr. PAUL MACKENZIE, General Practitioner, Forgandenny; (5) Dr. J. D. MUIR, Anaesthetist, Royal Northern Infirmary, Inverness.
A short film will be shown of the latest apparatus available to the ambulance service and Mr. Ross, the Regional Ambulance Officer, will demonstrate the latest equipment.

"Alcoholism"

Chairman: Dr. MARTIN M. WHITTET, Physician Superintendent, Craig Dunain Hospital.
A short paper by Dr. M. M. GLATT, University College and St. Bernard's Hospitals, London, on "Loss of Control" will be read by the Chairman.
Panel: Mrs. J. E. DAVENPORT, Research Assistant, Craig Dunain Hospital; Professor A. K. M. MACRAE, Professor of Forensic Medicine, Edinburgh University, and Physician Superintendent, State Hospital, Carstairs.

"Surgery in Rheumatoid Disease"

Chairman: Mr. G. S. WELCH, Orthopaedic Surgeon, Inverness.
Panel: Mr. JOHN M. C. GIBSON, Surgeon, Aberdeen.

TUTORIALS (to run concurrently)

4.00—5.00 p.m. Craig Phadrig Hospital.

"Examination of the Eye"

Speaker: Mr. IAN M. DUGUID, London, with a local ophthalmologist.

"Modern Casualty Appliances"

Speaker: Dr. DAVID M. PROCTOR, Aberdeen.

"Examination of the Newborn"

Speaker: Dr. GEORGE RUSSELL, Aberdeen.

BUFFET DINNER (limited to 120)

7.30 p.m. Station Hotel.

Ticket £3 inclusive of wine and gratuities. (Informal Dress).

Sunday, 1 October

GOLF

10.00 a.m. approx. Nairn Golf Course. Advance reservation required for lunch.

Ladies' Programme

REGISTRATION

Ladies should register at the Ladies' Club, Caledonian Hotel (Tel.: Inverness 35181), on Friday, 29 September from 9.00 to 11.30 a.m. where tour tickets will be available.
Coaches for tours will leave from and return to the Caledonian Hotel.

FRIDAY, 29 SEPTEMBER

11.30 a.m. Ladies are invited to attend the Opening Address on "The Use and Abuse of Medicines" by Sir Derrick Dunlop in the Town House.

2.00—5.30 p.m. Coach Tour via Loch Ness to Urquhart Castle. Tea at Glenurquhart Lodge Hotel. (Ticket 75p)

SATURDAY, 30 SEPTEMBER

10.30 a.m.—5.00 p.m. Coach Tour to Landmark, the Cairngorms exhibition centre. Lunch at Landmark, Carr Bridge (28 miles from Inverness). Return via Grantown, Dava Moor, Cawdor, and Culloden. (Ticket £1.50).

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From the Committees

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Public Health Committee

At a meeting of the Public Health Committee on 4 August, Dr. C. D. L. LYCETT was elected Chairman, and Dr. W. G. HARDING and Dr. J. T. A. GEORGE, Deputy-Chairmen of the Committee for the session 1972-3.

The CHAIRMAN thanked the Committee for re-electing him, and extended a welcome to the new members present, Dr. Margaret Ormiston and Dr. Mary E. Budding.

C.M.O.'s Visit

Having dealt with one or two preliminary matters, the Committee welcomed Sir George Godber, Chief Medical Officer at the Department of Health and Social Security, who attended the meeting in response to the Committee's invitation.

Sir GEORGE GODBER said that he realized that there was every reason why doctors in public health should feel uncertain about their position at the present time—more so than in other sections of the profession. After all, when the Health Service was reorganized, the clinical work of consultants and family doctors would go on just as it had before. But for those in the administrative side of medicine—in what had been known as public health—things were indeed going to be very different, because the jobs and the employing authorities would change.

There would be a transitional period when the new authorities would have been created and set up an organization of their own but not actually taken over responsibility. That would be a period of adjustment. It would, for medical administrators, be a different kind of world that had not been known since the public health service first began. In July 1948 some of the things for which the medical officers of health had become responsible were transferred elsewhere. But the M.O.H. still continued working for the same authorities. In 1948 the leaders of that section of the profession had been gloomy. The prophets of doom in public health were not then talking about what might happen in 20 years' time for they saw doom around the corner. The 20 years of the fifties and and sixties that had elapsed had seen a bigger contribution from the public health side of the profession to the care of the public than perhaps had been made since the first medical officer of health had been appointed.

PARTNERSHIP

After 1 April 1974 those in the public health side of the profession would be placed in a position of partnership with the consultants and the general practitioners, which was more markedly different than any change which had happened in the public health field hitherto. Whereas over many years medical officers of health were developing a hierarchical structure so as to provide services which were often not being provided at all 50 years ago, now they would function mainly as doctors in their own right in a special area of medicine, supporting other doctors in their clinical fields. It would be a more personal contribution to the total medical services of an area than it had been 20 years ago.

Already, Sir George reminded the meeting, some public health officers had had great success in promoting health centres. It had taken 16 years to open 17 health centres at the beginning of the Health Service. In England alone last year some 83 were opened, and the current year saw 307 health centres in England, with a further 140 odd being built. So that really the last five or six years had brought about a transformation in general practice in which the personal contribution of many medical officers of health was quite crucial.

Furthermore, the public health field had been more closely linked with the hospital service, but perhaps not so intimately with general practice. He took the view that the development of Cogwheel within the hospital service presented an opportunity to doctors with a social medicine background to contribute to specialist care, and to the review of the results of specialist care, given support from the kind of discipline that members of the Committee represented.

The second Cogwheel Report (*B.M.J.*, 22 July, p. 191) recorded a remarkable change of heart in the last four years or so among hospital specialists, with the recognition that in future single-handed responsibility in medicine really did not exist. "You cannot provide medical care without the support of a number of other people, and you cannot assess the result of what you have done without people who are expert in helping you to do it," continued the C.M.O.

HUNTER REPORT

Many people thought that the Hunter Working Party should have been set up sooner than it was. Indeed, Sir George said he had been impatient at the time it took to get it under way; but he had been wrong, because the Hunter Working Party had been held up in the early stages by lack of definition about future planning, and as things had turned out, the report had come out as early as it could. The White Paper defined the framework within which work would be carried out centrally, regionally, and at area and district level in the future, and both Hunter and the tailpiece to the White Paper showed clearly the importance of the functions that had to be discharged by people in the public health field and medical administration in the future. Though there must be great uncertainties in the minds of some individuals, there was no doubt that the places in which the work was to be done were there, and his principal doubt would be whether there would be as many doctors available as would be needed within a reasonable time to discharge those functions.

He was referring, he continued, to the work of the community physician. Many of those concerned had needed a degree of re-orientation for that work, and various courses had been organized with remarkable speed during the last year which would help. But it was a long-term problem, and not one which would be handled and completed by the time reorganization had been put into effect. That took care of the senior public health staff and the medical staff of regional boards, but those doctors were a minority of the total public health force. There were a great many doctors doing clinical work within the public health service, and they had been the least certain of their role in the future.

CLINICAL WORK

It was true that as one looked into the future, general practitioners with suitable experience would play a larger part in the clinical work that had been done in the former public health field. But Sir George said he did not believe for one moment that the work being done by doctors in the public health service would promptly be handed over to someone else on 1 April 1974. The doctors doing that work would be those who had been doing it on 31 March—and they would continue. As the new Service developed the work would be shared with general practitioners and hospital paediatricians and some of the child care doctors might move partly into one of those fields, but it would be by choice and not because those now doing the work would have become redundant.

There would be a long transitional period before even a substantial part of the work now done in clinics and in the school health service was done by someone else. Then it would be found, the C.M.O. forecast, that the doctors now doing that kind of work would begin to share it with some of those working, say, in paediatric departments or perhaps in general practice. "I am not offering you the answer that it will be all right on the day. I am merely trying to say to you that in fact an abrupt change and redundancies will not occur, because the work will be there to be done and will have to be organized," continued Sir George.

There would be disturbances but the N.H.S. Staff Commission would look after the interests of those affected, and though it might well happen that the odd person would miss out, Sir George felt that the commission could be relied upon to see if that happened to any extent, those concerned would be safeguarded for what might perhaps be only a short remaining time of their

expected career. "It is my belief that we shall be short of people to do social medicine work at all levels for a long time to come," he concluded. "I do not believe we are facing a period of substantial redundancy. I believe that the community physician can be the key doctor as the supporter of the others in improving the quality of health care."

Questions

Dr. JOAN M. ST. V. DAWKINS asked whether there was to be any age limit for persons holding permanent appointments in the N.H.S. At present there was an age-weighted public health service because of failure to attract and retain younger doctors of suitable calibre during the last decade. During the transitional period of the reorganized N.H.S. it was essential to retain those doctors who had the expertise and skill acquired in the public health service until the new specialty of community medicine could attract the young doctors that would be needed.

Sir GEORGE GODBER replied that the ordinary age limits of employment would probably apply, but those age limits were not rigid. There was nothing to prevent a health authority in the future extending the appointment of someone, as, indeed, the local authority could have done in the past, in the interests of the service. Any general extension would be undesirable. People should not be kept on because they liked to be kept on, but if it was desirable to keep somebody on in the interests of the Service, then there would be nothing to stop the authority from doing so.

Dr. JOAN DAWKINS said that rumours had been circulating that anybody over the age of 55 would be unlikely to obtain an appointment.

Replying, Sir GEORGE said that nothing of the kind was intended. Probably an authority might be inclined to say of two people they would prefer to appoint the younger man if they were otherwise equal to a post involving leadership, but it was up to the authority. Authorities ought not to look first at a doctor's birthday—they should look first at what he or she could do for them.

ASSURANCES

Commenting that she was pleased to hear Sir George say that those doing the work in March 1974 would continue to do it in April 1974, Dr. DAPHNE P. RICHARDS went on to say that many colleagues were extremely concerned because the reassurances they had received in that connexion were few. They feared that community paediatricians would take over the work with hospital colleagues, with those who had been doing it ending up very much as dogsbodies.

Sir GEORGE GODBER said that he did not believe there were enough paediatricians or that hospital paediatricians were sufficiently familiar with the work that needed to be done with children in the community to take over what was now being done by doctors who had spent their lives doing it. The readiness of some paediatricians to take over this or that was evidence, he suggested, of their unawareness of the extent of the work involved.

The CHAIRMAN observed that one of the difficulties about giving reassurances was that they were usually general, and people were inclined to say "Does this mean me?".

Recalling that he had already written two letters for the explicit purpose of giving an assurance, Sir GEORGE said that he would be glad to do anything he could to carry that assurance further. The general frame was such that the local organization which put flesh on the skeleton could provide for the placing of everybody.

Dr. J. T. A. GEORGE asked what were the plans in the Department for meeting the shortage of doctors in community medicine in the future, in view of the poor recruitment of young, good quality entrants to public health.

Sir GEORGE GODBER replied that a good deal of effort had already been put into getting the London School of Hygiene course reconstituted. As time went by future recruitment to the clinical part of the work might be on a different basis, but the people who were to be recruited to the community physician type of post at all levels would have a good clinical grounding before they started. The number of places for training at that level for that kind of person had been considerably increased in the last two or three years, and would be increased further as fast as suitable applicants appeared.

Dr. GEORGE then asked whether there would be a new policy to encourage people to take such posts, and the C.M.O. replied that recruits for clinical work were likely to be drawn from a much wider range. For instance, greater use would be made of general practitioners as recruits and more joint appointments with paediatric departments would be arranged. One might expect to get a larger proportion of the clinical work done by people who were also doing other clinical work. Movement into that field would be on a replacement basis as people retired.

Dr. MAUD P. MENZIES referred to one D.P.H. course which was based on what were expected to be the training requirements for membership of the Faculty. The course had been advertised, and she understood that there had been six or seven applicants, only one of whom had been accepted after interview. The question was whether a D.P.H. course was run for one person, she said.

Sir GEORGE GODBER replied that the difficulty was probably that of uncertainty.

HIERARCHY

Dr. H. GORDON suggested that the hierarchical system might well militate against recruitment to the medical administrator class in the future. While it was recognized that it might be necessary in part of the Service, the Committee hoped that some community physicians would rank as consultants and be independent.

Sir GEORGE GODBER, in reply, said that if there were an administrative organization of an area with a chief medical officer to the authority he would have other specialists working under him. The relationship might well be hierarchical, but that did not mean tyrannical. For the purpose of a managing authority it was necessary to have somebody who was answerable for the organization.

The CHAIRMAN suggested that unless potential recruits to the ranks of community physician thought it was a worthwhile, useful specialty comparable with other specialties, they would not embark upon it. It was urgent to establish the image of community medicine and to start recruitment forthwith.

"I have not the slightest doubt about the standing that the community physician of the right quality would achieve with his colleagues," answered Sir GEORGE. If the impression were to be given by the Public Health Committee that its members did not believe that the function of the community physician was of such importance as to warrant people of equal standing with consultants, then the right people would not be obtained. Such an impression was not going out from the Department of Health. The Secretary of State was imbued with the idea that the individuals holding the post of community physician would be the key people in promoting the overall improvement in the quality of medical care. "It is important that what I have always regarded as our side of the profession makes it clear that it believes in itself, and in its capacity to demonstrate its worth to its clinical colleagues," continued Sir George. "I believe that the opportunity is there, and I believe we shall be short of the numbers we require, but as in other fields of medicine where there is a shortage, I believe our side of the profession contains as many people of outstanding quality as any of the other specialties."

The CHAIRMAN said he felt sure that the Public Health Committee was in no doubt about the potentialities of the community physician.

Sir GEORGE GODBER said that it would be unfortunate if *any* committee took another view.

FUNDS FOR COMMUNITY MEDICINE

Dr. B. G. GRETTON-WATSON recalled that there was a corporate body known as the Institute of Hospital Administrators which recently changed its name to the Institute of Health Service Administrators. He asked Sir George whether there was any reason to doubt that the regional hospital boards would change their name and become regional health authorities with the same members and staff. If so, what confidence could community physicians have in the allocation of funds for community medicine, he asked.

Sir GEORGE GODBER replied that it would be odd if the new authorities did not employ some of the same officers, but it did not follow that they would continue with only the same officers, and he felt certain that there would not be identical membership.

The allocation of funds for community medicine would be the responsibility of the regional and area authorities. The exercise of integrating the administration of the Health Service was really only to be justified as a means of improving the deployment of resources. Some of the things that had been happening on the hospital side had pointed directly towards some sort of redistribution of effort in the future. It was intended that the Department of Health would be much more fully aware of the planning by areas and regions than in the past.

Dr. GEORGE suggested that when the new allocation of funds was made, it would be at a falsely low figure for community health due to a gradual running down of the service by local authorities.

Sir GEORGE GODBER disagreed that the service would be run down, pointing to the

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increased number of health centres being built in 1972 as compared with 1971. He said he had been afraid that the health centre programme which was crucial for future development might lag, but it had not.

Dr. J. R. PRESTON asked Sir George whether he would be prepared to write to the chairmen of Cogwheel committees suggesting that they might invite the medical officer of health and a representative of local general practitioners to join their committees.

Sir GEORGE GODBER said he would consider it, but there was a risk that a letter of that kind might be counter productive.

In reply to Dr. R. GLENN, Sir George said the appointment of officers was the responsibility of authorities and appointments could not be made until the shadow authorities were established.

Dr. J. LEIPER pointed to some difficulty in reconciling what was said by the Hunter Working Party and others in authority with the small and rather insignificant part of the White Paper in relation to specialists in community medicine.

The C.M.O. replied that the White Paper did not deal with the functions of the community physician in any detail because the Hunter report had already been published. The function of the community physician as outlined in the Consultative Document had not changed.

In reply to Dr. GORDON, Sir George said that local authorities would be advised to look to the health authorities for their medical advice.

The Committee then accorded Sir George Godber a vote of thanks.

N.H.S. Reorganization

The Committee spent the afternoon considering the White Paper. Referring to paragraph 25, Dr. JOAN DAWKINS expressed concern at the last sentence which read "Local authorities will be encouraged to seek the advice, and indeed the services, of medical staff employed by the health authorities, though statutory responsibility will rest on the local authorities, not the health authorities."

The Committee agreed that local authorities must be required to seek advice from specialists in community medicine employed by local health authorities or through arrangements made by such specialists.

Further concern was expressed about paragraph 44, which dealt with area operation of services, and the Committee agreed that contracts of specialists in community medicine should be held at the same level of those of colleagues of comparable status in the clinical field.

Under Chapter X "Membership of Authorities," and in particular paragraph 99, the Committee adopted a suggestion by Dr. W. G. HARDING that a definition should be sought of the term "accountable," and it be indicated that it should not be interpreted so as to preclude the community physicians employed by area health authorities from membership of those authorities.

Dr. P. A. TYSER drew attention to—and the Committee welcomed—the statement in paragraph 122 that the regional health authority would receive in its financial allocation a specific identified allowance for teaching and research.

On the handling of complaints, Chapter XX, the Committee took the view that the Health Service Commissioner should not have jurisdiction extending to clinical judgement, whether it was clinical judgement, exercised in respect of a single patient or exercised on behalf of a group (for example, where a decision was taken to advocate the use of a particular antigen in an immunization programme or the dosage or periodicity of actual immunization with that antigen). Actions excluded under clinical judgement should be those taken by the doctor, and also those taken by another person on the instructions of the doctor. There should be no question of the commissioner, or his advisers, concerning themselves with the merits of a particular clinical or other medical judgement defined in these wide terms.

Finally, in Appendix III "Management Study," the Committee adopted a suggestion by Dr. H. GORDON that the community physician should not be excluded from the non-hierarchical system referred to in paragraph 15.2.

G.M.C. Retention Fee

B.M.A. Secretary's Statement

The Association's policy in regard to the General Medical Council's annual retention fee remains as determined by the Annual Representative Meeting in July 1971, that is, doctors are advised to pay the G.M.C. annual retention fee of £5, as and when demanded by the G.M.C. on a year-to-year basis, without prejudice to the future and while negotiations continue.

A report on the G.M.C.'s financial procedures by an independent firm of accountants with experience in management consultancy was published in the *Supplement* (15 July, p. 41).

It is hoped that Parliament will soon take action to reconstitute the G.M.C. along the lines recommended by the Brynmor Jones report (*Supplement*, 6 March 1971, p. 55), which will involve a great increase in the proportion of elected members.

At Southampton in July 1972 the A.R.M. welcomed the news that a joint inquiry on the functions of the G.M.C. was now in progress between the B.M.A. and the G.M.C. and expressed the opinion that if this joint inquiry did not lead to an agreed report within six months the B.M.A. should then ask the Government to initiate an independent inquiry into the composition and functions of the G.M.C.

Association Notices

Special Representative Meeting

Notice is hereby given that on the requisition of the Council a Special Representative Meeting will be held in the Great Hall at B.M.A. House, Tavistock Square, London WC1H 9JP, on Wednesday, 15 November 1972 at 10 a.m. to consider:

(i) Sir Paul Chambers's report on the constitution and organization of the Association, the Council's reports thereon, and any matters relevant thereto.

(ii) The selection of candidates to be sponsored by the Association at an election of members of the General Medical Council under its proposed new constitution.

DEREK STEVENSON,
Secretary.

Diary of Central Meetings

AUGUST

23 Wed. Dispensing Working Group, 2 p.m.
24 Thurs. G.M.S. Committee, 10.30 a.m.
30 Wed. **Council**, 10 a.m.

SEPTEMBER

7 Thurs. C.C.H.M.S. Executive Subcommittee, 10.30 a.m.
7 Thurs. G.M.S. Standing Orders Working Group, 10.30 a.m.
7 Thurs. G.M.S. Working Group on Reporting and Publicity, 2 p.m.
22 Fri. Radiologists Group, 2 p.m.,
25 Mon. Board of Science and Education, 10.30 a.m.
26 Tues. Board of Science and Education, 10.30 a.m.
26 Tues. Working Party on Services for the Elderly (Board of Science and Education), 11.30 a.m.

Branch and Division Meetings to be Held

*Members proposing to attend meetings marked * are asked to notify in advance the honorary secretary concerned.*

Folkestone and Dover Division.—At Burlington Hotel, Folkestone, Tuesday, 22 August, 8.30 p.m., meeting to discuss registration of psychiatrically ill doctors.

Rochdale Division.—At Crimble Hotel, Wednesday, 23 August, 8.30 p.m., meeting to discuss report on registration of psychiatrically ill doctors.

South Middlesex Division.—At Red Lion Hotel, Hounslow, Thursday, 24 August, 8.30 p.m., meeting to discuss report on registration of psychiatrically ill doctors.

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