Conclusions

This paper has tried to describe some of the complex inter-relationships between general and health service planning, all of which will require further study and definition during the next phase of planning for Milton Keynes. It has been possible to establish a number of guide-lines which are helpful in ensuring a joint approach to planning. Early discussion of objectives and possibilities has been invaluable in establishing a common starting-point; support for necessary change and innovation has been readily forthcoming where those who will later be responsible for the provision of services have been involved in a clearly identified way with the planning; and it has also been fruitful to consider simultaneously the design of administrative and physical systems. So far as health services are concerned, the object must continue to be to secure maximum participation, both by the public and by members of the health professions, in discussions which will result in the

evolution of a closely co-ordinated health service for Milton Keynes.

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REFERENCES

- Acheson, E. D. (1967). *Medical Record Linkage*. Oxford University Press, London.
 Duncan, A. H. (1969). *Brit. med. J.*, **1**, 632.
 Llewelyn-Davies, Lord, Weeks, J., Forestier-Walker, G., and Bor, W. (1968). Interim Report to the Milton Keynes Development Corporation.
 Medical Planning Group (1968). *A Health Service for Milton Keynes*. Office of Health Economics (1967). *Provision of General Medical Care in New Towns*. London.
 Royal Commission on Medical Education (1968). *Report 1965-1968*. London, H.M.S.O.
 Smith, R., Curwen, M. P., Chamberlain, J., and Butterfield, W. J. H. (1966). *Lancet*, **1**, 650.

The Livingston Project

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The publication of the English and Scottish Green Papers on the administrative reorganization of the health services makes it timely to consider the experiment in health services organization and provision in Livingston New Town and the surrounding area. At this stage the services being developed are limited to the New Town itself and to the local district hospital. How much wider these arrangements can extend remains to be seen.

Four years ago it was decided that a major experiment in providing health services on an area basis should be started. The intention was partly to develop new ways of planning and deploying services in a new town, but also (in the favourable context of a new town) to test the possibilities of new patterns of integrated services within the existing statute. The new town situation seemed particularly favourable, as no services existed which would require modification and nobody held established positions. The field was therefore wide open. Furthermore, the district hospital in the area—an old E.M.S. hospital—is due for replacement, and a new district hospital should have been built by the late 1970s. The population served by the hospital is now 130,000, and this is expected to rise to 250,000 in the next 25 years.

The first major step in launching the project was to establish in 1966 a Health Services Joint Advisory Committee. This committee was made up of representatives of the board of management for West Lothian (Bangour) hospitals, Livingston Development Corporation, Lothians and Peebles Executive Council, South-Eastern Regional Hospital Board (Scotland), Midlothian County Council, and West Lothian County Council. The committee elected a chairman from among its members, who in fact is chairman of Lothians and Peebles Executive Council. Being a non-statutory group, the committee can function only as an advisory committee to the constituent bodies.

The next step was for the committee to appoint a chief officer and it decided that it would require a medical administrator to fill this role. The title "principal medical adviser" was eventually agreed, and this post, which incorporates that of medical superintendent of the district hospital, was filled in the autumn of 1967. The secretary to the joint advisory committee is clerk to the Lothians and Peebles Executive Council.

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Objectives

There are four main objectives of the project. Firstly, to prepare a prototype of an area health services plan. Basic to the plan is the intention of improving the standards of primary medical care and, in so doing, also that of clinical work and status of the general practitioner. An attempt is being made to devise a new role for the general practitioner if not indeed a new type of doctor altogether, with community and hospital duties.

The second objective is to promote a scheme of preventive medicine based on a population whose basic data are recorded on a computer and consequently readily available and accessible for effective preventive medicine. It is hoped that the scheme will eventually include occupational health—which, of course, is essentially a preventive service with first-aid and diagnostic services incorporated. Thirdly, it is aimed to bring the hospital service out into the community so far as is possible, and, lastly, to exploit the opportunities in health services administration presented by the creation of a new town and a new district hospital.

All these aims might be summarized by saying that we are setting out to create an area health service based on the health centre and backed up by an outward-looking and community-orientated hospital. There will be one main health centre built into the hospital outpatient department as part of the hospital's ambulatory patients' service. This will give all doctors access to the hospital diagnostic services as well as facilities for routine care of the patients living near by. There will also be a number of other health centres, each dealing with populations of about 20,000, sited conveniently to residential areas.

Achieving Long-term Objectives

To achieve our long-term objectives the following steps have to be taken, and progress can be made only by persuasion, argument, and conversion to one point of view of all the statutory bodies involved—a difficult and laborious process. The first step is that the hospital service must concentrate on those procedures that can be provided only in hospital. The hospital must therefore become a place where only intensive highly

specialized care and intensive investigation is carried out. There are demands for long-term care, which have to be met in addition.

Secondly, patients must be kept out of hospital whenever possible, and as many investigations as possible should be done on an outpatient basis.

Thirdly, the concept of the general-practitioner/specialist is being introduced, and in this way it is hoped to reduce the load on the hospital outpatient department. The general-practitioner/specialist will also provide medical care of in-patients, not necessarily from his practice, as a member of the team of the hospital unit. Obviously some medical specialties lend themselves better than others to this arrangement. This will naturally lead to the development that consultants should be able to concentrate on true consultant work. It has been estimated by some that approaching one-half the work of consultants in some specialties at present is not true consultant work in terms of difficulty and complexity of the problems dealt with (Crombie and Cross, 1959; Forsyth and Logan, 1960). Some of this work will be undertaken in the health centres.

The bulk of the medical care sought will be provided by the family doctor and his team outside the hospital, and some of the hospital medical care will also be provided by him. The health workers in the community will work as a team, with the doctor being central to the team. The other members of the team—which is health-centre based—will be nurses, social workers, and a secretariat, all of whom will contribute to the health care provided. It is expected that much of the demand can be met otherwise than by doctors, thus freeing the doctor for the different range of work expected of him.

The "total" medical care of the individual will be provided by the family doctor, including many services previously carried out by clinical public health doctors—such as child health supervision and screening. A community paediatric service in which the consultant and the general-practitioner/paediatricians work as a team is being established at present, and advice on medical aspects of educational problems will come from this source. Paediatrics present an outstanding opportunity for development as a community service.

Finally, a vocational training scheme has been introduced, covering a three-year period, which is intended to attract fully registered doctors who have perhaps had one year of hospital experience beyond full registration. The three-year training period is intended to be one year in hospital at registrar level in the specialty which the general-practitioner/specialist is to profess, one year in general practice as a trainee assistant, and one year during which the options are open and will be dependent on the interests of the individual.

The posts are advertised and doctors are appointed by a joint appointing committee representing the constituent authorities of the Health Services Joint Advisory Committee and the Scottish Medical Practices Committee. These doctors are guaranteed a net minimum remuneration of £4,000 per annum, which is made up of five sessions at medical assistant rates and, initially, a general-practice inducement payment. The inducement payment falls as income from the practice rises, and the inducement payment ceases when income from the practice plus the five sessions at medical assistant rate exceeds £4,000 excluding expenses. The inducement payment then becomes available for the next doctor appointed.

Progress and Experience

Progress, though painfully slow, has been made. Three general-practitioner/specialists have taken up duty and a fourth has been appointed. The specialties concerned are general medicine, obstetrics, geriatrics, and paediatrics. A further two

posts are to be filled straightaway—one in psychiatry and another in a specialty not yet determined, but dependent on the experience and interest of the successful applicant. At present the general-practitioner/specialists have been appointed on the basis of their experience, including higher degrees or diplomas if held. In the long run it is hoped to recruit many of these doctors from our own vocational training scheme.

Three vocational trainees have already been appointed and a fourth will soon be taking up employment. The first health centre was opened in December 1968, and, in addition to the doctors, the staffing of this health centre includes secretarial staff, nursing staff, and a social worker. There is also a dental department in the health centre and the first dentist has taken up duties.

It is perhaps too early to assess the working of the arrangements in detail, since only with the full operation of the health centre as a team enterprise can it be judged and can the doctors contribute a full measure to hospital staffing; nevertheless, we think that the omens are encouraging.

The most striking lesson that has been learnt to date is the confirmation of the early fears that introducing a service of this kind within the existing statute produces endless difficulties and delays. Each of the constituent authorities involved in the joint advisory committee must first accept the principle of any step agreed jointly, and then it must find the money to put the agreements reached into practice. There is good will in all these authorities towards the experiment, and that any progress has been made at all is a substantial tribute to this fact. However, at every step when money has to be spent each individual authority has to find money to contribute its share to the overall scheme. Frequently schemes do not achieve the same priority in the various authorities. Perhaps it is unnecessary to labour the point, but the time taken and the "diplomatic" activity involved in making progress seems to make it clear that no substantial advance can be made in reorganizing health services and making the most economic use of the facilities available in manpower and in other terms until some new statutory provisions are introduced to overcome present administrative difficulties.

There is no suggestion that the arrangements being tried at Livingston are the only way in which health services can be organized. The Livingston project is one method of providing health services in the particular circumstances that exist there. It should be emphasized that no question of a "take-over" by one branch of the Health Service arises. This is an attempt to bring together the functions of all three branches into a single organization. One thing is already abundantly clear—whatever criticisms of detail there may be of the proposals outlined in the two Green Papers the general principles on which they are based have much to commend them. There appears to be a general acceptance of the need for a new look at the National Health Service, and the experience at Livingston clearly shows, firstly, the difficulties of attempting to reorganize the health services within existing statute, and, secondly, the need for some statutory change to permit rational evolution of the National Health Service.

As it develops it is hoped that the Livingston project will demonstrate clearly the advantages to the patient as well as to the services of a united integrated organization in which all the resources are engaged in a logical and sensibly balanced way to preserve good health and to treat the sick when prevention fails. I think there is an urgent need to create a new administrative structure to allow this to be achieved. The obstacles in the existing statute are too great.

REFERENCES

- Crombie, D. L., and Cross, K. W. (1959). *Med. Press*, **242**, 316.
Forsyth, G., and Logan, R. F. L. (1960). *The Demand for Medical Care*. Oxford University Press, London.