Reorganization—1974 or 1984?

Background to Reorganization

British Medical Journal, 1973, 2, 415–417

FROM A SPECIAL CORRESPONDENT

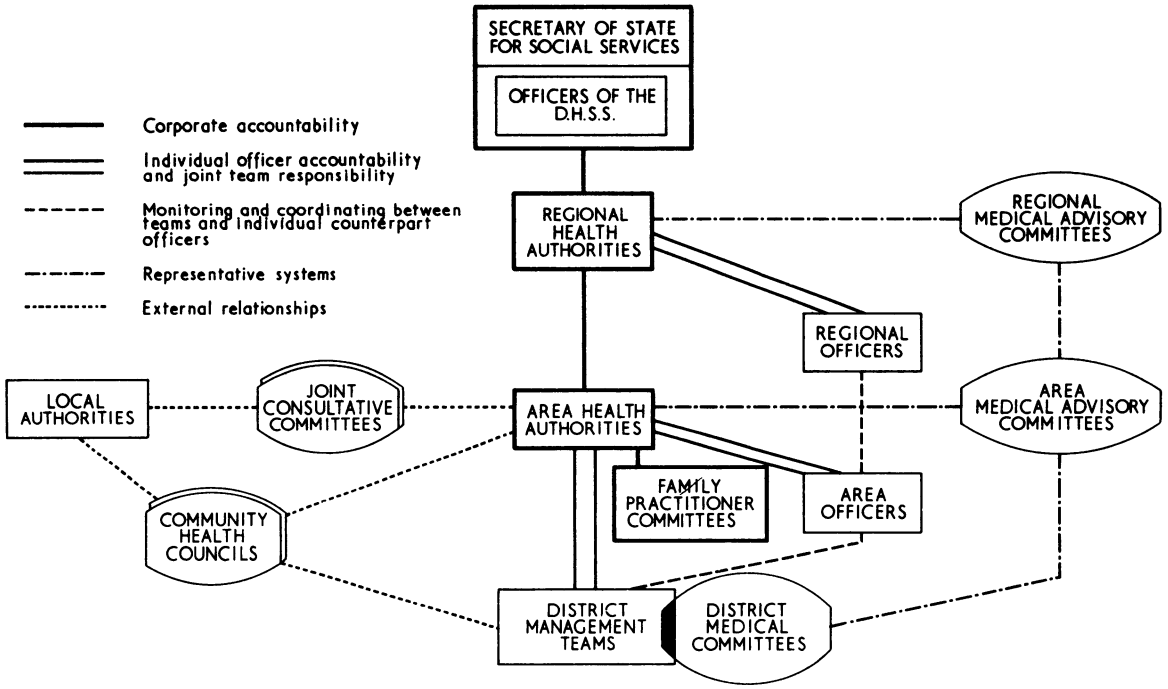
In April 1974 the vast machinery of the National Health Service—with its staff of 900,000 and budget of £2,600 m—will be reorganized. In his introduction to the White Paper Sir Keith Joseph explained the background to this. "Everyone is aware of gaps in our health services," he says, "Even for acute illness, where we provide at least as good a service for our whole population as any country in the world, there are some respects in which we achieve less than we could. On the non-acute side the services for the elderly, for the disabled, and for the mentally ill and the mentally handicapped have failed to attract the attention and indeed the resources which they need—and all the more credit to the staff who have toiled so tirelessly for their patients despite the difficulties."

The National Health Service Reorganization Bill is expected to receive the Royal Assent in the summer. It will remove the present distinction between hospital and specialist services—which are administered for the Secretary of State by regional hospital boards, boards of governors, and hospital management committees—and personal health services—which it is the function of local health authorities to provide. All these services, and the school medical service and (by contract) the family practitioner services, will become the responsibility of the Secretary of State. He will be required to set up regional health authorities and area health authorities, and area health authorities, (teaching). These areas will be coterminous with the new local authorities, which will be established at the same time. The Act allocates functions to the health authorities. It provides for the area health authorities to set up Family Practitioner committees as successors to the executive councils, and professional advisory committees.

Area as the Basis

The detailed workings of the new arrangements are, however, set out in the "Grey Book", *Management Arrangement for the Reorganised National Health Service*. In this it is apparent that the unit of health services management is to be the area. In the new metropolitan counties the area health authorities will generally be about this size and will not be further subdivided. Elsewhere the bigger areas will be subdivided into districts containing about 250,000 people. The new feature at district or area-without-district level will be the district or area management team. This team will be responsible for managing and co-ordinating most of the operational services of the N.H.S.; it will also review the needs for health care and the provision of services locally to recognize and deal with unfulfilled needs. To do this it will set up health care planning teams, which may be either ad hoc or permanent. The idea behind this approach is that it could provide more and more relevant health information on which to base the health service.

FRAMEWORK OF THE ORGANISATION STRUCTURE



Finally, the Act will provide for joint consultative committees whereby the N.H.S. and the local authorities can co-ordinate these services (though these committees will not have statutory powers); for community health councils to represent the public interest; and for Health Service Commissioners (Ombudsmen) for England and for Wales to investigate complaints against N.H.S. authorities.

Preparing the Ground

Meanwhile between now and April 1974 the way is being prepared in each new area by joint liaison committees. Their main task is to prepare an "area profile" for the shadow area health authorities which will be appointed as soon as the Act is law.

Even so, the formidable problem remains of translating plan into practice. For this series I have visited one particular region, Newcastle upon Tyne, and asked people for their views and problems. Firstly, I talked with three doctors, one of whom, Dr. W. B. Shaw, Principal Medical Officer, Health Department, City and County of Newcastle upon Tyne, told me that nobody yet knew officially how many districts there were to be in the nine new areas. He had taken part in courses on N.H.S. management and was familiar not only with the voluminous literature on it but also with the series of N.H.S. Reorganization Circulars which had been sent to joint liaison committees by the Department of Health and Social Security. Two other doctors, Mr. A. Crombie, a consultant ophthalmic surgeon, and Dr. Andrew Smith, a family doctor, were certainly more interested in what was going on than the average doctor but had obviously not had easy access to much of the official literature.

Naturally enough, the thoughts and feelings of all the doctors about reorganization were entwined with many other aspects of their work in the region and with their views of administrators, management, and the whole concept of the Health Service. For example, all agreed that when the N.H.S. had started in 1948 there had been a positive effort to dissuade local people from taking an interest in their hospital—an attitude which explained why, for example, 25 years later land had been bought for the new hospital (against local advice) when there was plenty of land available around the psychiatric hospital. The site of the general hospital could have been sold for a sum which would have financed quite a lot of the new hospital building. But this course was apparently anathema to the N.H.S. New plans from Whitehall were therefore received with some scepticism.

For his part, Mr. Crombie had also experienced the mini-reorganization at the Royal Victoria Infirmary, when the University Hospitals Group had been formed in 1971 under the regional hospital board amid promises of benefits all round. In fact many of these promises had not materialized, and there was a feeling that there had actually been a diminution in the resources allocated to the hospital. The consultants had not known who to go to about specific problems and the administrators had been unable to tell them. Committees had mushroomed but their precise function was often unknown, as was their membership. Mr Crombie felt that up to the present his hospital had not benefitted from the reorganization and that in 1974 another five years of administrative chaos might well ensue.

Exit of the Social Workers

Dr. Shaw had also been involved in the reorganization brought about by the implementation of the Seebohm report, which had also affected the quality of service that Dr. Smith and Mr. Crombie could provide. Mr. Crombie in particular had been deprived of medical social workers altogether, as his had gone to work for a higher salary for the local authority department of social services. None of the three doctors believed in "generic" social workers, but Dr. Shaw pointed out that there was ten times less money for the social services department of the local authorities than in the present Health Service. Moreover, before the Seebohm report had been implemented there had been many bad pits between the good peaks; he was not pessimistic about the social services in the long term if the present climate continued.

Against this background the discussion turned to Dr. Smith's home ground in Whickham, which he expected to become part of the area health authority of Gateshead—a single district area, like the other four areas in the metropolitan part of Newcastle. Mr. Crombie asked who was responsible for such decisions and Dr. Shaw replied that probably they would arise from recommendations made by the area joint liaison committee. The latter included members from the local authorities; the executive councils (which would become the family practitioner committees); and a combined hospitals group—comprising about eight members altogether. This body was already collecting information for the Gateshead "area profile" but no decisions could be made until the shadow area health authorities could be set up—that is, after the Bill was law.

The Gateshead area would have about 250,000 people (the recommended size), one district general hospital, three other general hospitals, and a cottage (or community hospital) staffed by general practitioners. There were about 100 general practitioners; 21 of these were members of the local medical committee, which would nominate general practitioner members to the new district medical committee. At present local authorities overlapped, but after local government reorganization the health area, and local authority county of Gateshead would coincide.

Dr. Smith was excited about these developments—"at last general practitioners will have a voice," he said. By this he meant that he expected them to take part in one of the health care planning teams—which would assess the area's needs for such things as maternity services and primary care and their views would therefore have to be heard by the area management team. This would include a general practitioner representative (chairman or vice-chairman of the district medical committee), who would argue with the rest of the team. If an idea was agreed to be a good one—for example, for a day hospital—it would go to the area health authority. At present no general practitioner could put the case for better home geriatric services, except to the local medical committee—which had no power—while the geriatricians were naturally more concerned with hospital patients than with old people living at home.

Coping with problems

Could the new Gateshead district cope with its problems I asked. The "Grey Book" had said that a district of 250,000 people might contain 19,000 people needing acute hospital care in any year (550 at any one time), 7,000 physically handicapped people, 700 mentally handicapped people (350 in hospital), 35,000 people over 65 (800 in hospital; 800 in old people's homes; 1,000 needing domiciliary care), and 60,000 children (200 mentally handicapped, 500 physically handicapped). Dr. Shaw said that the public health service was more used to thinking about numbers of this size, but neither he nor Dr. Smith could say whether these figures were correct for Gateshead—even after 25 years of the N.H.S. no-one really knew enough. Nor did they know whether the distribution of health care resources was related to the health or

social needs of a particular area. This was precisely what the health care planning teams and area management team had to find out.

Dr. Smith asked whether his patients would still be able to go to any of several hospitals that were outside his area—such as the Royal Victoria Infirmary in Newcastle, and at Hexham (in Northumberland) and Shotley Bridge (in Durham),—Dr. Shaw thought they could, and that there would be protests if they were not allowed to; such a course would be a fundamental interference with clinical freedom.

The figure is reproduced from the steering committee's report by permission of the Controller of H.M.S.O.

(A bibliography will be published at the end of this series.)

Any Questions?

We publish below a selection of questions and answers of general interest

Loss of Eyelashes

A young girl with long thick eyelashes liberally applied some waterproof mascara. When she tried to wash it off by scrubbing the lashes they all came off. After a long time she has grown very fine hairs only 1 mm long along her eyelids. Can any treatment be given?

Broken hairs and even hairs removed from the root would have soon regrown. Most probably the scrubbing removed hairs which were ready to fall because of an underlying disease process such as alopecia areata—the growth of a fine hair is in keeping with this idea. It would be worth looking for the broken off hair stumps which are a feature of the disease and also for patchy hair loss in the scalp. If there has been no further regrowth it would be worth trying a corticosteroid injected locally.

Notes and Comments

Immunization after Convulsions.—Professor R. S. ILLINGWORTH (The Children's Hospital, Sheffield) writes: In the discussion under Notes and Comments (10 March, p. 607) on the answer to this question ("Any Questions?" 23 December, p. 725) there is some confusion as to the difference between a history of convulsions before the immunization and a convulsion occurring as a result of the first immunization. I would like to make my view clear—namely, that if a child has a convulsion after the first or second triple vaccine injection it would be extremely unwise to give a further one. The convulsion might have been a mere febrile convulsion but it might not, and one fears that a further injection might cause something more serious.

Steroids and the Development of Tumours.—Dr. M. H. BRIGGS (Director of Biochemistry, Alfred Hospital, Prahran, Victoria, Australia) and Dr. Maxine Briggs (Kingston Centre, Cheltenham, Victoria, Australia) write: Your Expert states ("Any Questions?" 20 January, p. 168) that he is unaware of any obvious effects of corticosteroid administration on the development of malignant tumours. Such compounds are potent immunosuppressive agents in humans,[1] and the high incidence of malignancies in patients who have received steroidal and non-steroidal immunosuppressive drugs is well documented.[2]

It has been shown[3] that oral doses of dexamethasone acetate or betamethasone acetate induce marked increases in rat hepatic aryl hydrocarbon hydroxylase (AHH), an enzyme thought to catalyse the formation of proximate carcinogens from aromatic hydrocarbons.[4] We have shown that some topical corticosteroid ointments induce this enzyme in mouse skin and that animals pretreated with such preparations show a significantly higher incidence of skin tumours after exposure to dimethylbenzanthracene.[5] In unpublished studies we found a similar increase in AHH induced in human skin after topical corticosteroid administration. Low levels of aromatic hydrocarbons occur in water, air, and foods, but are probably insufficient to induce AHH in human tissues. Possibly patients undergoing corticosteroid therapy have high AHH and may be at increased risk of malignancy from carcinogenic metabolites of hydrocarbons.

OUR EXPERT replies: The reference[2] cited by Drs. Briggs and Briggs documenting the occurrence of malignancies in patients who have received immunosuppressive drugs provides undoubted evidence of the risk to such patients when they are recipients of organ transplants from donors with unsuspected malignant disease. It also states: "Whether immunosuppression encourages the growth of cancer arising from the recipient's own cells is more debatable." And further: "Immunosuppressive agents might facilitate infection by and proliferation of oncogenic virus. One or more immunosuppressive agents may even be carcinogenic. But is there in fact an increased incidence of cancer in recipients given immunosuppressive drugs? . . . Lymphomas have developed in recipients of renal homografts on immunosuppressive regimens. They all received azathioprine (Imuran) and steroids, and three were given antilymphocytic serum . . . and in six of the seven patients tumours developed within one year of transplantation . . . as yet no indication has emerged of increasing frequency in long-surving patients."

This, then, is the total of evidence provided by the reference cited for the increased incidence of malignancies in patients receiving steroids. I do not consider it to be very convincing since it refers only to transplant recipients, all of whom received non-steroidal immunosuppressive drugs. I remain unaware of evidence that corticosteroids alone, given in therapeutic doses, and not to transplant recipients have convincingly been shown to be responsible for malignancies. I am unable to comment on the likelihood or otherwise that humans undergoing corticosteroid therapy may be at increased risk of malignancy from carcinogenic metabolites of hydrocarbons because of increased aryl hydrocarbon hydroxylase in the liver or skin.

1 Larson, D. T., and Tomlinson, L. J., *Journal of Clinical Investigation*, 1951, **30**, 1451.
2 *Lancet*, 1969, **1**, 505.
3 Somogyi, A., Kovacs, K., Solymoss, B., Kuntzman, R., and Conney, A. H., *Life Sciences, Part II*, 1971, **10**, 1261.
4 Gelboin, H. V., Huberman, E., and Sachs, L., *Proceedings of the National Academy of Sciences, U.S.A.*, 1969, **64**, 1188.
5 Briggs, M. H., and Briggs, M., *British Journal of Dermatology*, 1973, **88**, 75.