New NHS structure needs new attitudes

For those familiar with *Patients First*,[1] the latest sheaves of paper on NHS reorganisation (p 394) contain no surprises. The Secretary of State, however, has yet to decide where consultants' contracts should be held or what the professional advisory machinery should be (discussions on both are still in progress), while the Welsh plans are described as preliminary conclusions because of "evident misunderstanding of the full implications of the proposals for Wales." Thus the Principality is to have further time for consultation. Even so, the Welsh Office has kept pace with the DHSS in announcing the retention of family practitioner committees—GPs will be pleased with that—and of community health councils, though a consultative paper on the workings of CHCs is promised for the autumn. In England, as expected, the 90 area health authorities are to be replaced by 180 to 200 district health authorities, with a membership averaging around 16 members and containing one consultant and one GP. Scotland's plans were announced in Parliament as the *BMJ* was going to press (p 399).

The BMA's Annual Representative Meeting at Newcastle welcomed "the general tenor of *Patients First*,"[2] a response in line with the great majority of organisations and individuals who commented. Over 90% of the statutory bodies which replied supported the principal aims in the Government's consultative document: to simplify the NHS structure; to strengthen management below district level; to streamline the professional advisory machinery; and to simplify planning. Mr Jenkin is clearly determined to fulfil his pledge that decisions should be taken as close to the patient as possible, for among other moves he is giving districts considerable freedom "to establish only those posts which will provide the most effective and economical delivery of services in its own circumstances." This greater local autonomy may, however, worry community physicians, barely recovering from the insecurities of the 1974 reorganisation. Nevertheless, given their unique functions and the recruitment difficulties facing this specialty, they are unlikely to face redundancy—a fate that may befall some lay administrators.

Community physicians have been key members of district medical teams, which are to continue, but consensus management generally in the NHS was criticised by the Royal Commission[3] and many doctors have blamed it for much of the management weaknesses in the present Service. Referring to this, the DHSS circular states ". . . authorities and team members must ensure that the personal responsibilities of individual managers are not blurred or qualified by their responsibilities as members of the management team." Certainly, a return to more direct personal responsibility can only benefit a service where decisions too often fail to get taken because of endless consultations and buck-passing. Fewer, better administrators, an objective of the slimming process, should mean quicker, better decisions.

While devolution of power in the NHS will be generally welcomed, those with long memories will recall the wide variation in standards among local authority hospitals in pre-NHS days. How can unwanted variations be prevented without stifling local initiative? Regional health authorities will still retain some responsibilities, which should militate against districts pursuing eccentric policies. They will co-ordinate strategic plans, allocate resources and monitor cash limits, determine certain specialised hospital facilities and co-ordinate specialised services, plan medical manpower and determine the facilities for undergraduate and postgraduate education in liaison with universities, and "generally promote the implementation of national policies." One important factor in ensuring adequately distributed hospital facilities would be for consultant contracts, as now, to be held at regional level. Indeed, the RHAs' proposed responsibilities make this a logical proposition. To relegate the contracts to district level would mean, as a leading CCHMS member, Dr W J Appleyard, warned the ARM, "the national and regional development of consultant services grinding to a halt." General practitioners will be largely unaffected by the changes. With their close and regular contacts with patients, however, they can, along with community physicians (who will be at the heart of local management), make major contributions to maintaining high standards of care throughout the Service. In particular, both groups could improve the priority accorded to preventive medicine, a policy that the Representative Body strongly supported. Then there is the simplified medical advisory machinery, which should mean clinicians having a much greater influence on the course of the Service than has been so since 1974. The complexity of the present machinery has too often resulted in conflicting and disregarded medical advice: the NHS cannot afford to lose such knowledge and experience.

In welcoming the Government's proposals, the Institute of Health Service Administrators calls for quick, efficient changes. Mr Jenkin realises the risks of a protracted transitional period and RHAs, which will be responsible for making the changes, are asked for their plan by the end of February 1981, with DHAs being formally launched before 1 April 1982 and structure changes completed by 1 April 1983. This timetable will need the full co-operation of staff, and procedures for protecting their interests are being negotiated in the Whitley Council's NHS Reorganisation Committee. The attitudes of staff and, indeed, of all associated with the Service will be no less important than the new structure in restoring vitality to the NHS. The BMA, which has welcomed the latest proposals, is concerned, too, about the financing of the NHS, for it sees new sources of funds as essential if the NHS is to emerge from the doldrums.[4]

Finding extra funds will take time; changing attitudes could be effected quickly. Staff who regard the NHS primarily as a vehicle for their employment or who prefer confrontation to co-operation with colleagues, patients whose expectations of cure and care are unrealistically high, and pressure groups who see their special interest as the most urgent priority all undermine the NHS. If the forthcoming changes really succeed in devolving power this could restore a sense of local pride, loyalty, and co-operation among staff; promote greater sensitivity in the Service to local needs; and inform the community of the NHS's capabilities. Such new attitudes could prove an even more valuable asset than the £30m or so that the Secretary of State hopes his reforms will save in administrative costs.

[1] Department of Health and Social Security. *Patients first*. London: HMSO, 1979.
[2] *Br Med J* 1980; **281**:249.
[3] Royal Commission on the National Health Service. *Report*, Cmnd 7615. London: HMSO, 1979.
[4] *Br Med J* 1980;**281**:323-4.