(1) Labour costs—on the basis of a cost per standard minute for the different types of packs. These calculations were based on the standard minutes of the CSSD bonus scheme.

(2) Material costs—the contents of the packs were costed and these were applied to the number of packs issued to wards, theatres, etc.

Conclusion

Throughout our research we have been aware of the danger of looking at a limited number of specialties—for example, the danger of not recognising the relevance of a particular expenditure head. The benefit of our research, however, is that it has illustrated to us that progress may be made in improving the NHS financial and non-financial information systems. Problems will be encountered. One is the regular compilation of certain statistical information—for example, work measurement, arrangement of sessions, numbers and types of tests, drug issues, etc. This is particularly the case where there are multispecialty wards, theatres, etc. Another problem is promotion of the sense of need for the information in the various departments. This is particularly important if accurate information is to be collected.

The reorganised NHS structure offers an ideal opportunity to improve the information systems so that management has information relevant to decisions and in particular so that

clinicians can redirect resources to meet changing circumstances. Undoubtedly it will be argued that there are more pressing operational and organisational problems to be faced in the DHAs but we would counter that this is shortsighted and in any case is there ever a right time for a change?

References

- 1 Anonymous. Your money or your life. *The Economist* 1980 November 22: 12-14.
- 2 Department of Health and Social Security. *Health Service development: structure and management*. HC(80)8. London: DHSS, 1980.
- 3 Joint Working Group on Medical Advisory and Representative Machinery. *Report on district management arrangements*. London: DHSS, 1981.
- 4 Association of Health Service Treasurers. *Financial arrangements in the restructured National Health Service*. Bristol: South Western RHA, 1981.
- 5 Department of Health and Social Security. *Care in action*. London: HMSO, 1981.
- 6 Garner L. *The NHS—your money or your life*. London: Pelican, 1979.
- 7 West Midlands Regional Health Authority. *NHS financial information project—research programme. Preliminary statement by the Centre of Responsibility*. Birmingham: West Midlands RHA, 1979.
- 8 Magee CC, Osmolski RJ. *A comprehensive system of management information for financial planning, decision making and control in the hospital service*. Technical paper, Royal Commission on the National Health Service, 1978.

(Accepted 27 July 1981)

Community physicians and NHS reorganisation in England

D P B MILES

On 1 April 1982 the Health Service in England will be reorganised. Ellis¹ has recently discussed the implications of this for clinicians but not for community physicians, who are once again the only group of the medical profession in career grades whose current jobs will disappear overnight. Naturally, anyone, however able, who has to apply and compete for a new job becomes anxious about it, particularly when as in this case his old post is whisked away from under his feet. Anxieties have not been lessened by the experiences of the many community physicians who went through this traumatic process for the 1974 reorganisation—some had been through it previously with London local government reorganisation—and it is from these experiences that present attitudes to further change have been derived.

In 1974 the rules for competition were tightly controlled nationally and area medical officer (AMO) and regional medical officer (RMO) posts were open to national competition. Thus many able medical officers of health and hospital board medical staff had the difficult choice of where to apply (only five applications were allowed) and where they might stand the best chance of appointment. Inevitably, some doctors failed to achieve the appointment they wanted or even any appointment in the AMO or RMO grades, and so they then joined other aspiring community physicians in a region-by-region competition for specialist in community medicine (SCM) and district community physician (DCP) posts. Many families had to move to other parts of

the country and the appointees had to learn instantly the health profiles of their new authorities. The net results of these changes were a loss of some community physicians by early retirement, the disaffection of others by changes forced on them, and the time lost to new authorities by the need to learn about the new areas. It is not always recognised by those outside the specialty how important continuity is to the practice of community medicine in order to know the history of local services and their potential for change. One benefit of the reorganisation rules in 1974 was the infusion of some younger doctors into career grade posts at an earlier stage than would have occurred in the old services.

Avoiding previous traumas

The aim of community physicians for 1982 has been to avoid the traumas of the past and to try wherever possible to arrange for minimum turbulence with the hope that most doctors in the specialty will be working in the same community before and after 1982. But despite earlier hopes it has not been possible to negotiate separate reorganisation terms for community physicians and they will be bound—as are all other Health Service workers—by the final offers of the management side^{2 3} on protection, staffing, appeals, and compensation. For protection and compensation the terms offered are less satisfactory than in 1974, but the proposals for staffing do go some way to achieving the aims for minimum turbulence in the profession. But the management-side proposals give only a broad outline of rules for change; a lot will depend on how each regional health authority interprets these in its negotiations with regional staff side groups. What is clear is that competition in the initial round of job filling—the district medical officer (DMO) posts—will be

Aylesbury and Milton Keynes Health District, Milton Keynes Hospital, Eaglestone, Milton Keynes, Bucks

D P B MILES, MB, MFCM, district community physician

limited to geographical areas no bigger than that of the regional health authority (RHA), and in some cases it may be possible to limit the competition to individual counties if that is the wish of all community physicians working in the region. Such a decision would allow staff in unchanging single-district areas to be excluded from competition, as are those working at RHA headquarters.

It is also clear that staff eligible to apply for the DMO post will be those whose present appointment was through a career grade advisory appointments committee—that is, those in AMO, DCP, or SCM posts—and will exclude doctors still “latched on” from the last reorganisation and senior registrars, even if fully accredited for specialist posts. This exclusion of senior registrars is the result of a finely balanced argument and has led to some understandable criticism because they think that the proposals, coupled with the current reluctance of the “old” authorities to fill vacant posts before reorganisation, will mean an interval of a year or so before posts become available to them. The opposing argument is that doctors who have previously jumped all the hurdles and reached career grade posts should not now be subjected to competition from other than their peers, if the principle of minimum turbulence is to be maintained. The specialty has a duty to ensure that qualified senior registrars do obtain specialist posts as quickly as possible after reorganisation.

We know that the DMO posts will be the first to be filled; the timetable suggests that this will be during November and December 1981, the health authority chairmen having been appointed in late summer and the other DHA members in the early autumn. Having done this, DHAs could then decide not to have any other community physicians on their staff, the only obligation on new health authorities being to appoint district and unit management team members, while the rest of the staffing structure is up to individual authorities. This was confirmed in a Parliamentary written answer on 28 July in which the Government announced that each DHA would employ a DMO, who would have primary responsibility for community medicine in the district, while individual DHAs would employ SCMs in accordance with their own assessment of local needs and of the most effective way of meeting them.

Ellis¹ has discussed the implications of this on other professional groups—for example, personnel, works—who fear for the future of district level posts in their disciplines. One approach has been for such groups to produce explanatory booklets on the need for their services and staff, these booklets being sent to chairmen and members as they are appointed. The BMA has necessarily had to adopt a similar function and a document has been produced by the Central Committee for Community Medicine on the need for specialists in community medicine to be appointed to work with the district medical officer. This has been circulated nationally and it is to be hoped that copies will reach the medical members of the new health authorities, for it may be essential to have their support in the establishment of SCM posts. The shortage of community medicine manpower will certainly ensure there is no over-staffing; the CCCM suggests that each authority should have a DMO plus one SCM per 100 000 population plus 0.5 plus a further 0.5 SCM in teaching districts.

The timetable for filling the SCM posts is still not clear; indeed, it is absurd that a specialist, not directly concerned in management, should have to reapply for a post at all. It certainly does not happen to a clinician when the health authorities are reorganised. One region has a tentative timetable for recruitment of second-level posts in all disciplines not being filled until August 1982. This seems incredibly late and the local BMA

representatives must ensure that this timetable does not apply to community medicine, where SCM posts are not part of management costs and SCMs are equal with the DMO in status and salary.

No excess manpower

At this stage of reorganisation it is impossible to tell whether the local autonomy given to regions and regional timetables for change will prove beneficial to the profession or not. The total numbers in community medicine are small compared with those in nursing, finance, or administration, and as there will be no excess manpower nationally (unlike nursing and administration) it should be possible to match rapidly staff with posts. Indeed, the reorganisation committee documents³ may be interpreted as allowing the BMA regionally to negotiate independently from other groups and thereby achieve a separate timetable. But whether this is being done in any region, rather than by one BMA representative sitting as part of a regional trade union committee, is uncertain. Separate negotiations would be beneficial if they could prevent delays in completing the appointment processes. Until they are complete in each region it will not easily be possible for staff to seek posts in regions other than their pre-1982 region. For accredited senior registrars the earliest they can apply for posts would seem to be when the remaining unfilled jobs are thrown open to national competition.

The position of community physicians working for regional health authorities is particularly odd. They are currently excluded from competition, reasonably enough as their posts are not threatened this time. But there is likely to be a DHSS review of RHAs once this reorganisation is over, and if their functions are to be diminished then some community physicians may no longer be needed at the RHAs and they may have to look for employment in those posts remaining unfilled after 1982. The regional medical officers have an interesting problem also, for in this reorganisation they are representatives of the management side rather than the staff side, and it must take considerable skill on their part to protect fully the interests of their community medicine colleagues and yet also support management views on the progress and pattern of reorganisation.

Individual community physicians in training and career grades face considerable problems as reorganisation approaches. It is to be hoped that most will come through unscathed, but such an outcome does rely heavily on local negotiations in which many clinicians as members of health authorities and management teams will be concerned. If they are fully briefed by the BMA then all will be well, but lack of support from these clinicians in establishing community medicine posts in the new authorities will be damning to the specialty. Once these SCM posts are established then the eligible senior registrars can apply for them and their success will encourage others to come into the specialty. A disastrous reorganisation could lead to further resignations among the specialists and a loss to the NHS of many able doctors. The specialty hopes to avoid this and to ensure that individuals continue to offer a service to the NHS so that the Health Service meets the community's needs.

References

- 1 Ellis N. Will doctors miss out again? *Br Med J* 1981;283:84-5.
- 2 Sarginson J. NHS reorganisation 1981-2. *Br Med J* 1981;282:1977.
- 3 Anonymous. NHS reorganisation. Proposals on protection, staffing, appeals, and compensation. *Br Med J* 1981;282:1989-91.