surgeon, has been able to spend only a year on the area management team, largely because of the time commitment that this takes and his consequent absence from clinical duties. At present the clinicians on the team are enthusiastic but their successors may be hard to find; nevertheless, all were agreed that "consensus management" was actually working.

Dr. Smith had no doubt that, as he had predicted, reorganization had given the G.P. a voice. At present he was one of nine doctors practising in accommodation built for three, and a long-awaited health centre had been lost on reorganization. But he had gone to the A.M.T. and put his case; in its turn, the A.M.T. had lobbied the local M.P.s, who had taken the problem to the Minister, who had given the health centre top priority. The G.P.s had been fully consulted about the plans, a better design had been worked out, and building was about to start. Dr. Smith would, however, have accepted any adverse decision from the A.M.T. if other practices or problems had been judged to have priority. What he had had was the chance to state his case. He was a member of the A.H.A. and was convinced that it must decide also on priorities between hospital and community. That was what reorganization was about and why it was working in these areas where this principle was being followed.

Too Many Committees

The dean's diary contained about five times as many functions as he could physically attend. And the same subjects, often trivial, were often discussed by the same people at many of them. The 18 committees that now had to consider a new registrar post was an example.[7] The hospital medical executive committee thrashed out hospital problems and then did it again at the area medical committee, where the G.P. members rarely had anything to add. The Regional Medical Committee and its specialist committees, a sort of super-Cogwheel, could not find a role because the regional manpower committee was doing the same thing. And anyway the area was the statutory body: the region could only advise. In addition, the committee structure was now resurrecting matters which had been disposed of years ago.

Other matters had undergone a three-year delay under the shadow of reorganization. For example, building sites—which had been a regional board responsibility—now came under the A.H.A.(T). This was all very frustrating. Before reorganization the dean had known what was going on in the region and in the hospitals and in the university. Now it was impossible to belong to all the levels. Professor Walton sat on the A.H.A., while the clinical sub-dean sat on the R.M.A. as a university nominee. The Faculty of Medicine was being asked to appoint additional deans so that the increasing load of administrative and committee work could be shared. Professor Walton was also on the M.R.C. and G.M.C., while other senior members of the staff were also heavily involved: the professor of anaesthetics, for example, was chairman of the hospital M.E.C. and chaired the A.M.C., spending over half his time on management. This sort of thing affected teaching, clinical duties, and services—for example, the professor of anaesthetic's duties would last for three years.

Though the three areas were single-district ones, the doctors I talked to doubted whether the region would in future have an effective role: it should be replaced by a committee from the A.H.A.s to talk about the distribution of specialized medical care and facilities throughout the region as a whole.

Local Politics

When the A.H.A.s had been set up, the four local authority representatives had started by behaving politically but this stopped very quickly. The A.H.A.s actually had to run the Service, and these members recognized that the major frustration was lack of finance. In fact, they had offered to help in lobbying for the new district general hospitals, since they knew the political ropes, and were free to go and talk directly to the Secretary of State. The Community Health Council (C.H.C.) was proving to be a forum in which 20 people could talk about health matters with greater freedom. Admittedly, one C.H.C. had passed a resolution condemning fluoridation (though their chairman was a world expert on the subject) and had passed it to the A.H.A.—which had voted against it, incidentally. Nevertheless, the C.H.C. possessed much specialized knowledge, such as from Age Concern and the W.R.V.S. and there was a great eagerness to learn. Relationships between the C.H.C.s and A.H.A.s are still in the exploratory stages.

The joint consultative committees (J.C.C.) between the A.H.A.s and the local authorities were "toothless wonders" at the moment, and true co-ordination took place between officers. The J.C.C. was not a decision-making body—decisions in the local authority sphere being made by the big spending committees, such as social services and education—but it might eventually be able to decide on the nature of the problems, for example, that an old people's home was needed rather than a geriatric hospital.

"We Shall Overcome"

Though not expressed, this sentiment seemed to summarize the forward-looking attitude of these varied, but determined representatives of the medical profession in Newcastle and Gateshead in 1975. The A.H.A.(T) is not easy to understand, and in general I found too many committees, too much confusion, too much "rethinking" with too little money, but no illusions, no ivory towers, and no arrogance towards non-medical health workers. Can they possibly be a representative sample—or indeed is there such a thing?

1 *British Medical Journal*, 1973, 2, 415.
2 *British Medical Journal*, 1973, 2, 478.
3 *British Medical Journal*, 1973, 2, 542.
4 *British Medical Journal*, 1973, 2, 603.
5 *British Medical Journal*, 1973, 2, 654.
6 *British Medical Journal*, 1973, 2, 709.
7 *British Medical Journal*, 1975, 1, 675.

King's College Hospital Medical School, London
W. F. WHIMSTER, M.R.C.P., M.R.C.PATH., Senior Lecturer in Pathology

Discussion

CHAIRMAN: Miss Lewis, could we begin by asking you how D.M.T.s work?

MISS JANET LEWIS[1]: The first year has been spent in running the Service, because of the absence of the planning cycle. The district was envisaged as the cornerstone of management, so it's not surprising that they're less frustrated about their job than the equivalent officials at area level. Even so, there were many complaints about control by the area: priorities put forward by those who knew local conditions—the D.M.T.—were rejected by the area and the region. Otherwise, the districts have retained much independence: some have declined to provide the area with all the statistics asked for, some have resisted visits to hospitals by area authorities (particularly the A.T.O.s), some have made area specialists attend health care planning teams by invitation only.

DR. G. COLEMAN[2]: Our D.M.T. recently analysed its perform-

ance in the first year and one thing that came out clearly was the need for a monthly financial report from the D.F.O.—you can't manage without this. There have also been problems of getting information around. Last summer we closed 90 acute hospital beds, without permission from the area—though we told it. But six months later a consultant member of the A.H.A. asked why we had closed the beds: the A.T.O. had not informed the A.H.A. about this and the A.T.O. had forgotten that we'd written about this.

Finally administrators have tried to run area and districts but they have been guided into their own field of administration.

MR. DAVID M. ROBSON[3]: I accept the suspicion of others that the district administrator is potential chief executive, but effective team consensus can eliminate this.

DR. R. G. S. BROWN[4]: One new and encouraging feature is how openly members of area and district bodies have been willing to examine their performance over the last year.

MISS ZENA OXLADE[5]: This reluctance by the D.M.T. members to contact professionals in the area does vary widely: but it is true that everybody is monitoring their own working much more than before reorganization.

DR. J. M. FORSYTHE[6]: There's a danger of separating the D.M.T. from the A.T.O. as tiers, when they're part of the same area health authority, though different; one has line management functions, the other staff functions. Though the different roles of the area and district teams will not become completely clear until the planning cycle starts working properly, I believe that it's the area's task to determine financial policy and the district's job to spend the money, giving its reasons. If this doesn't happen, then the consensus decisions by the district have no force behind them.

Closing Hospital Beds

MR. RUDOLF KLEIN[7]: Can a line be drawn between the district and the area about the type of decision each takes?

DR. COLEMAN: Our decision to close those hospital beds was taken jointly with the appropriate hospital management team.

MISS OXLADE: Were you right to do this, though, without telling the area authority beforehand?

DR. ALEC PATON[8]: Closing beds is nothing new: we were doing this five years ago. We didn't ask people—if there were no nurses to look after the patients, the beds had to be closed. Of course, those concerned have to be told of the decision but to blow this up with a huge management exercise seems to be absolutely crazy. And the D.M.T.s must stop looking at their own navels and take action, even if this is unpopular. Why doesn't the D.M.T. have a leader—or six leaders, each with something to do. Once action has been taken, then it's important to tell everybody about it.

MR. P. F. PLUMLEY[9]: We don't have an H.M.T. or a resource group of the type that Dr. Coleman mentioned yesterday (*B.M.J.*, 28 June, p. 736)—merely a D.M.T. and a D.M.C., which we use to discuss all medical decisions and to make sure that hospital doctors and G.P.s are told about these.

DR. COLEMAN: Whom do the six consultants on the D.M.C. represent?

MR. PLUMLEY: Their own divisions.

DR. W. F. WHIMSTER[10]: Do you have a D.M.C. and not a medical executive committee?

MR. PLUMLEY: Yes, the D.M.C. is entirely responsible for letting people know about decisions. It's the only possible way of doing this.

DR. COLEMAN: This system must be easier with a small number of consultants—only 60 in Mr. Plumley's case. In Birmingham we have 140 consultants, who are organized into 14 divisions.

MR. PLUMLEY: The experience of other D.M.T.s represented at this conference is completely different from mine: we've been bedevilled by not knowing how much money we were going to get.

DR. J. C. HASLER[11]: I know that this is really only one tier, but I believe that the district sees the area as a tier above it. Aren't there too many people doing the basic job of running the N.H.S.?

DR. A. M. B. GOLDING[12]: In talking of an area you must distinguish between the A.T.O. and the A.H.A. The D.M.T. reports to the latter, but is on an equal footing with the A.T.O. Problems arise because the area administrator has two roles: he acts as secretary to the A.H.A. and also as a member of the A.T.O. When the D.M.T. closes beds I suggest it should tell the area administrator in his role as secretary to the A.H.A.—in this way the A.T.O. can be confined to being monitors rather than managers.

DR. J. H. MARKS[13]: All this procedure is laid down in the Grey Book.

DR. COLEMAN: But some A.T.O.s are afraid that the D.M.T.s may become too powerful and take over control.

DR HASLER: Many A.T.O.s feel frustrated because they have this merely monitoring role.

MISS LEWIS: Can you monitor and plan, though, without managing?

DR. HASLER: Doctors prefer to work in the district because this is where the action is. There's a danger of ending up with second rate people at the area holding things up.

MR. ROBSON: This illustrates how the N.H.S. has never taken seriously planning as part of management.

Information

MR. KLEIN: What sort of information does the area collect?

DR. FORSYTHE: At present comparable information on the distribution of resources and various measures of care among the health districts, so that we can develop a health profile.

DR. S. P. LOCK[14]: Can you give us some concrete examples?

DR. FORSYTHE: The number of health visitors allocated to each general practice; the perinatal mortality figures in each new district; the hospital discharge rates for age-specific groups; and so on.

CHAIRMAN: And what are you going to do with all these data?

DR. FORSYTHE: Feed it into the planning cycle eventually. We have two area planning teams—one on health centres, the other on mental handicap, both topics which we think need considering on an area basis. This doesn't preclude, of course, the district setting up their own health care planning teams.

CHAIRMAN: Could we turn to the work of the community physician. To be unkind, Dr. Golding, how far has the training of many M.O.H.s fitted them for their new co-ordinating role?

DR. GOLDING: There were some special courses before reorganization started, and you must remember that the environmental health role of the present D.C.P. is directly related to the sort of work done by the former M.O.H. Different D.C.P.s had different backgrounds—I myself came from a regional hospital board—and the future training courses and examinations run by the Faculty of Community Medicine will ensure that new entrants are given training relevant to the needs of the new service.

To some extent there is already specialization within community medicine, and the background should be much the same—just as the neuroradiologist is basically a radiologist. At district level the community physician is concerned more with short-term projects, while in the area the time scale is longer—say, two to three, and five to 10 years, respectively.

DR. FORSYTHE: I'm worried that so many of our presentday problems concern environmental health—pollution and so on—and that there's nobody to replace the old M.O.H. with his expert knowledge and executive function.

MISS LEWIS: If we hadn't had to find jobs for M.O.H.s, would we now have D.C.P.s on D.M.T.s and A.T.O.s?

DR. MARKS: Yes: a medically qualified co-ordinator in that line is necessary, because doctors would not reveal confidential

information to laymen. The only person available with anything like the skills needed was the M.O.H.

MISS LEWIS: In all the districts I've visited I've never heard anybody say that the D.C.P.'s role is co-ordination.

DR. MARKS: G.P.s are used to working with M.O.H.s; hospital doctors aren't, and regard them as snoopers and gauleiters. But this attitude will change.

DR. S. HORSLEY[15]: There's not enough emphasis on management in the training courses for community physicians.

Fighting Statistics

MR. PLUMLEY: What is a community physician beyond an administrator? What does he do beyond fighting statistics?

DR. WHIMSTER: I think this is a very useful function.

MR. PLUMLEY: But what happens once this organization has finished its first lot of planning?

DR. BROWN: Since 1948 there's been a tremendous gap in the arrangements for co-ordinating medical views. There's an enormous difference between a committee of part-timers with clinical work to do and one serviced by a full-time professional with time to go fully through the documents in between meetings, and get the needed figures.

MR. KLEIN: Who takes the decision on waiting lists, whether to close beds, and so on?

DR. MARKS: the D.C.P. monitors (which is what we proposed in the Grey Book) and the D.M.T. takes the decisions.

DR. HORSLEY: The D.C.P. has the important role of bringing consultants and G.P.s together at an earlier stage, as in considering an early discharge policy. His work also reveals important facts every day: as in Cornwall every day 30 patients in acute beds could go into Part 3 accommodation, but the County Council won't accommodate them. Now Social Security payments could provide a private home for £22 a week, but the local agreement for Social Security is only £19. By blocking acute beds it is costing us £100 a week to keep a patient suitable for Part 3 accommodation in hospital, whereas, if there was more liaison with the social services and social security, the funding of an extra £3 would free these beds for more acute work. It is up to the community physician to go to the director of social services and point this out.

MR. ROBSON: It is not feasible in this way to make more money available.

DR. PATON: You say this, but this is the quickest way of destroying idealism. Dr. Horsley's ideas are marvellous, but this sort of administrative negativism is what made me cynical and sceptical over 10 years ago. It costs us £100 a week for a geriatric patient in one of my acute beds, and yet I could accommodate him in the best hotel at half the price.

MR. PLUMLEY: We are specifically prevented from doing this and are not allowed to use facilities outside the N.H.S. This is where I share Dr. Paton's cynicism: we've both been in the Service for so long, and the people outside examining health care do not understand. We were promised that the Treasury regulations about financial freedom would be removed—and all these promises have been broken.

MR. ROBSON: But if we pay for people in hotels we are carrying out a function which is not part of the N.H.S. and may not help it obtain more resources.

MR. PLUMLEY: The only things I have ever achieved in a bureaucracy have been by cutting through barriers.

DR. GOLDING: Why do you want to clear these beds?

MR. PLUMLEY: To deal with the waiting list, and because the geriatric patients don't need hospital care.

DR. GOLDING: Then the total sum of money spent by the community is larger—on the acute beds and the geriatric accommodation.

DR. G. MACPHERSON[16]: But even if there wasn't a waiting list, why shouldn't doctors be able to transfer patients so that they can be cared for at half the cost?

DR. MARKS: Because the community as tax payers will ultimately not provide the money: therefore these patients are stuck wherever they happen to be. It's the community's responsibility.

Community Health Councils

DR. HASLER: Just conceivably, if the C.H.C. is effective, community attitudes will change.

DR. MACPHERSON: Are the C.H.C.s really established and working?

DR. MARKS: They will have a role that the Government never intended—to expose the scandals of the N.H.S., such as underfinancing and its effects.

MR. KLEIN: They will be yet another pressure group.

DR. MARKS: They're composed largely of the 1% of any community that already serve on a number of committees.

DR. HASLER: We have to see how the new system can be manipulated.

MR. ROBSON: Yes. Some changes are feasible, provided you work within the system. For example, a building belonging to the N.H.S. would probably be converted into a hostel for the mentally handicapped. The argument whether the N.H.S. or the social services are responsible has prevented this. Nevertheless, the Institute of Mental Subnormality could set itself up into a housing association, buy the building from the N.H.S., and use Social Security payments to individual clients to meet the running costs.

DR. HORSLEY: It's just at this time of financial stringency that we must explore projects like this.

CHAIRMAN: The G.P.s have certainly been brought into the management of the reorganized N.H.S., but are they any more controllable than before?

DR. MARKS: No. They are independent contractors, and, as we heard on the steering committee, the public wishes them to remain so as to allow freedom of choice.

DR. HASLER: You can't direct consultants either. The real point is motivating G.P.s to take part in decision-making.

DR. MARKS: And they are involved in management, in allocating resources generally. The ordinary G.P. is going to have to take a much more active interest because otherwise we will find the D.M.T. giving money which would have been spent on community nurses to a hospital operating theatre.

DR. WHIMSTER: As I was told in Newcastle, reorganization has made it much easier for the voice of the average G.P. to be heard in the D.M.T. and at the area level.

DR. COLEMAN: The D.M.C. has taught consultants a lot about general practice. So far as communications are concerned, our D.M.C. sends out bulletins to every G.P. in the district about general practitioner and hospital matters.

DR. MACPHERSON: The Government is providing a lot of capital for health centres at present: does the district or even the area have any control over this, which may land it with excessive revenue expenditure?

DR. GOLDING: The D.M.T. can make an assessment and decide whether they can afford the extra revenue or not.

MR. PLUMLEY: The health centre project is much the same as the abortion scheme: the State provides a capital sum and takes no responsibility for the revenue consequences at all.

Reallocating Resources

CHAIRMAN: Has the reorganized structure shown any potential for reallocating resources from one sector to another?

DR. MARKS: Yes, there are the means, but reallocation depends on the political will of the community.

MR. PLUMLEY: Three years ago—well before reorganization—some more beds were needed in our hospital. So our consensus

group, then the group medical committee, closed half of the private beds and diverted them to the N.H.S. The reason hospital doctors are getting cross is that you, the administrators, are doing things without any evidence of value whatsoever—for example, you don't know whether health centres are cost effective or not, yet the State is spending millions and millions of pounds on them, for largely political reasons. If a logical case can be made out for health centres, I'm perfectly confident that I can go back from my D.M.T. to my hospital colleagues and tell them why we've decided in their favour.

DR. PATON: I should like to see the hospital returning to the community and consultants doing more work there.

MR. KLEIN: To go back to the question of reallocating resources, even before the reorganization the Minister of Health had virtually absolute power to do this, by cutting budgets and reallocating money to local authorities—why was so little done?

MISS OXLADE: I don't know, but I'm sure the reason reallocation has gone on so slowly after reorganization is the time needed to collect accurate information on which to base any decisions. It's no good moving money around without knowing whether it's going to be effective, but in small ways it's already been done: we reallocated money, for instance, to a night-sitting service for old people, after research had shown that this was what was needed.

MR. FORSYTHE: Central government must take a lot of blame for not reallocating resources. Time and again the Minister has failed to confirm a decision which is locally unpopular, such as to close a hospital.

DR. BROWN: I should have thought that the new requirement to consult with C.H.C.s should stop any firm local decisions being reversed higher up—that's provided the C.H.C. has agreed to a closure.

CHAIRMAN: How much central direction would be acceptable to the regions, areas, and districts—about allocating resources preferentially to geriatrics or mental subnormality, for instance?

DR. BROWN: If an authority doesn't want to take up earmarked money—such as its share of the money allocated specifically to reduce waiting lists—it needn't.

DR. HASLER: But is this good enough? I understand a few years ago my region had spent a lot on mental subnormality and was about to spend more on some of the acute services when it received some money earmarked for mental subnormality, which was already providing a reasonable service. Decisions need to be taken locally. The region's hands were tied on this occasion, and are said to be more so after reorganization.

Attributed Money

MR. ROBSON: But that's not true: the attributed money is a fraction of the total allocation.

DR. COLEMAN: When our D.M.T. met the A.T.O. about revenue and capital allocations, we were presented with a document from the R.H.A. laying down guidelines for this money.

DR. GOLDING: But if the D.M.T. goes totally outside these guidelines it's unlikely to get its proper share of any funds.

MR. ROBSON: It's a game, guidelines are rules, you offer priorities within the rules.

MISS LEWIS: But with reorganization the rules have changed.

MR. PLUMLEY: It's not a game that amuses me. It wastes an enormous amount of professional time.

CHAIRMAN: There are a large number of advisory committees. To what extent do items have to be referred to them or are they consulted only when an authority wants to?

MR. PLUMLEY: Most of the time a committee is there to see that there is not a technological error—for instance, that the wrong type of machine isn't being bought.

DR. MARKS: "It is the duty of the authority to consult"—that's in the Act, and it certainly applies to the reallocation of resources.

MR. KLEIN: It is important to stress that political interference does partly aim at seeing that decent human standards are maintained in the Health Service—that a mentally ill patient should have his own locker and own clothes. After 25 years of the N.H.S. and central direction there are still hospitals where this doesn't happen, and I think this is a justification for increased central control.

MR. PLUMLEY: What about decent technological standards? Some problems could be solved by the injection of more money. Others, such as the appalling casualty service in this country, need quite a different approach.

DR. MARKS: Perhaps it's more important that a mentally ill patient should have his own locker than a young man should have his nose put straight because he doesn't like its shape.

APPOINTMENTS OF SPEAKERS

[1] Miss Janet Lewis, Fellow, Centre for Studies in Social Policy, London WC1N 2LS.
[2] Dr. G. Coleman, L.R.C.P.I., L.R.C.S.I., General Practitioner, Birmingham.
[3] Mr. David M. Robson, District Administrator, Worcester.
[4] Dr. R. G. S. Brown, M.A., Ph.D., Director, Institute for Health Studies, University of Hull.
[5] Miss Zena Oxlade, S.R.N., District Nursing Officer, Bury St. Edmonds.
[6] Dr. J. M. Forsythe, M.B., M.F.C.M., Area Medical Officer, Maidstone, Kent.
[7] Mr. Rudolf Klein, M.A., Senior Fellow, Centre for Studies in Social Policy, London WC1N 2LS.
[8] Dr. A. Paton, M.D., F.R.C.P., Consultant Physician, Birmingham.
[9] Mr. P. F. Plumley, M.B., F.R.C.S., Consultant Surgeon, Bexhill-on-Sea, Sussex.
[10] Dr. W. F. Whimster, M.R.C.P., M.R.C.Path., Senior Lecturer in Pathology, King's College Hospital Medical School, London.
[11] Dr. J. C. Hasler, M.B., M.R.C.G.P., General Practitioner, Sonning Common, Berkshire.
[12] Dr. A. M. B. Golding, M.B., M.F.C.M., District Community Physician, King's Heath District(T), London
[13] Dr. J. H. Marks, M.D., M.R.C.G.P., General Practitioner, Boreham Wood, Herts WD6 4PU.
[14] Dr. S. P. Lock, M.B., F.R.C.P., Deputy Editor, *British Medical Journal*.
[15] Dr. S. Horsley, M.B., Ch.B., Medical Registrar, Truro, Cornwall.
[16] Dr. G. Macpherson, M.B., B.S., Assistant Editor, *British Medical Journal*.