3. Health centres should form a base for main and not just branch practice and for all the field workers (including social workers) operating in the local community.

4. Modifications to training curricula so that: (a) The medical undergraduate is given more teaching in the social, preventive, and psychological aspects of medicine; the community services he can use for his patient. He should also know something of the training followed by his team mates and the kind of problems in which they can help. (b) Instead of a separate health visitor and home nurse in towns there should be a "community nurse" with a new kind of training course. These community nurses should be able to deploy less skilled staff to meet the simpler needs of patients. These suggestions are not impracticable. They involve expenditure, but at a fraction of the cost of the hospital services; they might give a shift in the emphasis of medicine towards prevention, and the existing health and social personnel would be used to better purpose. To give the proposals effect will mean above all a change of attitudes—of the general practitioner against his traditional isolation and towards team-work; of the medical officer of health against the preservation of his empire; of those responsible for training a wider view which will take into account twentieth-century needs of co-operation and co-ordination; of local government councillors that health centres are not for subsidizing general medical practice, but to give a better service to the people; and, crucially, of the central government, that if the National Health Service is to work really effectively they should give every incentive to the rapid development of a nation-wide health centre programme.

Summary

Health centres to facilitate the integration of local health services were suggested almost half a century ago, but until recently demand for health-centre practice has been small. Interest is now quickening, but the provision of a well-equipped building is only the first step towards co-ordination. There is a concomitant need for rationalization of practice areas and the redeployment of health visitors, home nurses, midwives, and social workers on a functional, instead of geographical, basis. Changes in the training of medical and nursing staff are suggested in order to meet present and future community health problems. Health centre experience and future plans for Bristol are described.

REFERENCE


IS THERE AN ALTERNATIVE?

The possibility of decentralizing the administration of the Health Service has often been raised. In this article Professor Colin Clark deals with the general question of decentralizing organizations and some of the criteria for deciding when an administrative machine has become over-large.

Decentralizing Administration

COLIN CLARK,* M.A.

Of all the free-market economists—that is, those who contend that all transactions should be settled by free bargaining between buyers and sellers, without Government intervention—the most drastic and dogmatic is probably Professor F. A. Hayek, from Vienna. It is of particular interest, therefore, to note those transactions in which he thinks Government intervention is necessary—namely, those involving children, certain types of town-planning regulation, the control of the monetary system, and finally that which concerns us here, of meeting the full cost of treatment of serious illness or accident. The latter is likely to be beyond the resources of a great many families, however prudent and thrifty, so that some form of organized insurance is necessary. So, of course, is insurance for third-party risks in driving cars. Nevertheless, like car insurance, medical insurance can be abused. Common sense tells us that the most efficient type of insurance and least open to abuse is that encountered in America—which requires the patient to meet the first 50 dollars or 100 dollars (in some schemes as much as the first 500 dollars) of the costs of any illness or accident himself, before he has recourse to insurance. The insurance should then be able to meet the costs of really serious or chronic illness—a liability from which American insurance has often run away.

The above expresses my own idea of how medical service should be provided. Many well acquainted with the problem, however, may contend that insurance—however well organized—will not suffice, and that substantial provision of medical service by public authorities is necessary. They may well be right; and in any case I do not wish to debate this point further. What I do want to say, as emphatically as possible, is that if there have to be public authorities providing medical service they should be local or regional, not national. There are strong objections to unduly large-scale organizations, in this as in other fields.

First, however, it may be necessary to dispel the illusion, if any readers of the B.M.J. still cherish it, that it is possible to have a national organization whose control will be "divorced from politics." If you expect Parliament to provide the money, of course Parliament will control the organization. Members of Parliament will point out, quite rightly, that they are failing in their duty to their constituents and taxpayers if they provide public funds without supervising the manner in which they are spent. For some years people have been quoting the universities as an example of organizations which can receive Government funds without being subject to Government control. Those who believe this had better come and take another look at the steely but inexorable process by which Government control over universities in this country is steadily being tightened.

Regional Authorities

By similar reasoning we must also conclude that a genuine decentralization of responsibility for running hospital and medical services will be possible only if we have regional authorities spending their own funds, obtained from taxes or fees collected from the inhabitants of the region. If we expect them to live on grants from the central Government this will

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soon bring back central control again, probably in an even more cumbrous form than before. A decentralized regional organization is likely to be much more efficient, for a number of reasons. But it must be run by regional politicians; there is no escape from the necessity of political control over organizations spending public funds.

If we approach the question of decentralization in the abstract, we ask ourselves what sort of organizations are unduly large, and what are the criteria for deciding into how many units authority should be decentralized. In his book, *The Logic of Industrial Organisation,* Professor P. S. Florence advised industrialists to follow the Army principle—that no man ought to be required to be responsible for supervising in the direct line of command more than five subordinates—subject, of course, to the provision that important responsibilities of a general nature fell on the staff, who stood outside the line of command and were directly responsible to the commanding officer. But, though this is a useful initial principle, we must remember that an army has a single, clearly defined object—namely, to win a war. When the objects of an organization become more widespread, the organization needs to be decentralized further. Something like an army type of organization may be possible for a few large industrial concerns producing and selling single simple products. This is certainly not the case with organizations producing a great diversity of products, such as Imperial Chemicals or Unilever, which in fact have an extremely decentralized organization—even too decentralized in the opinion of some economists.

By why cannot we have a national health organization similarly decentralized? Here we are back again at the same difficulty—it is spending public money. The Board of Directors of a large industrial concern will be content to leave the running of their subsidiaries decentralized, so long as they follow certain broad lines of policy and return a satisfactory profit. But a public authority cannot afford to do this, when it knows that every action even by its most subordinate staff may at some time—perhaps months or years after the event—be the subject of a Parliamentary Question. In order to protect themselves, the administrators have to adopt rigid rules and red-tape procedure, which cannot be altered to meet differing circumstances. This is the essential reason for the inefficiency of nearly all large public enterprises.

**How Large is Too Large?**

How large is too large for an organization to be? Professor Austin Robinson of Cambridge wrote in his book for first-year students, *The Structure of Competitive Industry,* that a good working criterion for judging whether an organization was too large was when its principal officials found that they had to spend more time on committees than on getting on with their own proper tasks. It is the nature of unduly large organizations to require an inordinate amount of effort to co-ordinate their activities, and each further increase in size requires a much more than proportionate increase in the number and activity of co-ordinating committees.

The most trenchant attack on over-large organizations that I know—and which seems to me essentially true at every point—was delivered 25 years ago by Sir Alexander Cairncross. Sir Alexander is now head of the Economic Division of the Treasury, and cannot be engaged in controversial debate. But what he wrote in 1942 may be quoted, and is even more true now than it was then.

"The bigger an organization grows, the more readily it falls a victim to the diseases of bigness—indecision, apathy, routine and red tape, personal intrigue, confusion of counsel and responsibility. It is difficult to delimit functions; there is therefore duplication of effort, waste of time in establishing responsibility, elaborate consultation, petty sabotage. It is necessary to preserve uniformity, partly as an economy in bureaucratic intelligence, partly to forestall charges of discrimination; there is therefore restricted discretion, insome adherence to regulations, disregard of personal circumstances. This is just as true in a large business as in a government department."

Municipal and regional organizations have their vices, too, especially when the regions delimited are unduly large. But on the whole they are on a lesser scale. And further it is to be hoped that doctors and administrators, even if not convinced of the need for regional decentralization in the light of their own knowledge, will nevertheless look on the question as citizens as well as professional men. The restoration and preservation of regional autonomy may be a necessary condition for the very survival of our civilization. After all, it has happened before.

"In the century following the reign of Constantine the centralization of government and the multiplication of imperial functionaries had extinguished the free civic life, which was in an earlier period the greatest glory of Roman administration. The local councils became less concerned with the local interests of the municipalities and more and more burdened with duties to the Imperial Government. Eventually the popular assemblies lost their right of electing to the provincial magistracies." 

**References**


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**SELF-HELP IN THE HOSPITALS**

**Tenovus**

[FROM A SPECIAL CORRESPONDENT]

When Tenovus was born just over 20 years ago it had a limited aim. Some Cardiff business men wanted to show their appreciation to their local hospital—the Cardiff Royal Infirmary, then a voluntary hospital—for the nursing care and medical attention given to one of them when a patient there. The 10 men who subsequently met to decide how best to show their appreciation called themselves "Tenovus." Tenovus decided to launch a local appeal to raise money for a gift to the hospital—this was its only intention when it was formed, and it was implicitly assumed that after the appeal Tenovus would disband when its purpose was accomplished. But it did not disband, and has grown larger and wider in scope ever since, having raised and put to charitable use well over £1m. since it was founded. Of this, £1m. has gone to cancer research, upon which Tenovus decided in 1960 to concentrate most of its efforts.

**The First Appeal**

The original 10 members of Tenovus decided in 1945 to provide headphone wireless throughout the Cardiff Royal Infirmary in recognition of the nursing care received by one of them after an accident. With the success of this appeal many charities in South Wales asked the members of Tenovus if they would organize appeals on their behalf. Among these was the Royal National Institute for the Blind, who wanted...