acknowledged failure and we are uneasily back to a sort of administration.

There have been other unfortunate consequences. Senior staff whose length of service had given them some pride and loyalty to the institution either left or became disillusioned. Few of the new managers stayed long either, regarding their jobs as stepping stones to something better. Moreover, they were so busy with paper work and discussions that they were never seen about the place. A few trouble-shooters, who would walk round their hospital, inviting complaints and criticisms and pointing out improvements that could be made, might help to restore morale. I am reactionary enough to believe that we might even benefit from an old-style medical administrator.

No one asks people who do the work for their views. Instead, unrealistic committees—in the sense that members know little of the day-to-day work—run mostly by grey men of second-rate ability whose natural reaction is to say “No” have proliferated. In spite of promises of streamlining it now takes longer (by more devious routes) to get a decision than it did before the reorganization. This inhibits self-evident improvements, which would not only lead to a more human hospital but would also save money. The waste of electricity, heating, paper, disposable equipment, etc., is a matter of common knowledge, but it is impossible to do anything about it. On the clinical side we have been talking for years about admission wards; five-day wards for cold surgery and investigation, and specialized units—and yet we still have extra beds in all the wards in spite of a diminishing catchment area. Clinicians spend more rather than less time on committees, most of which are acknowledged round the luncheon table to be useless. If committees were abolished tomorrow none of us would be fully employed: there is over-manning in hospitals as well as in factories. My request for a new endoscope costing a few thousand pounds stays on a waiting list for several years when I know that money saved by a properly run hospital would pay for dozens of new instruments. I look at the decaying fabric of our Victorian pile and think of the thousands of pounds spent on accommodating the A.H.A. in prestige offices in the city centre.

Are We Really Short of Doctors?

No wonder I question the current dogma that the country is short of doctors (at least in the hospital sphere) and that the N.H.S. is short of money. To justify itself in my eyes, reorganization will have to show that it can free doctors, nurses, and other professional staff by efficient administration (not management, which is something different) to look after patients. It should give hospitals their own budget to spend as staff, not managers, think fit. Above all it will have to decide on the proper role of the acute general hospital, since many of the current problems (the front door of the casualty and emergency department; social as opposed to medical geriatrics; unnecessarily prolonged care of acute medical and surgical conditions) are the concern of the community. Not only would such hospitals be smaller and cheaper, but they would be properly staffed, with a high morale born of pride in the institution, and they would take their place once more as an integral part of the community.

Run-up to Reorganization

J. H. MARKS

Though the Messer (1950) and Guillebaud (1956) Committees rejected the concept of unification in the Health Service, the Porritt Committee (1962) concluded that the tripartite division was harmful to its development and suggested that unified administrative units (area health boards) should be established, with regional planning committees between them and the
Ministry of Health. Subsequently the B.M.A., suggested that a pilot scheme should be established in Wales. In 1968 the first Green Paper described area boards, headed by a chief executive officer who would be accountable directly to the Minister of Health. Richard Crossman's second Green Paper, in 1969, proposed area health authorities, one-third of whose members would be appointed by the health professions, linked with the (reorganized) local authorities. In addition, there would be regional and district committees.

The Conservative Government's consultative document (1971) introduced the concept of "management" in the N.H.S., with delegation downwards and accountability upwards. Regional and area health authorities, consisting of appointed members, would consult elected professional advisory committees. Area health authority boundaries would be coterminous with local authorities and each A.H.A. would appoint a family practitioner committee for independent contractors. I served on a steering committee, which worked within these political guidelines (reiterated later in the White Paper) and examined detailed management arrangements at each level of the Health Service. In addition a study group was set up to study problems and work alternative solutions.

Steering Committee

Sir Philip Rogers chaired the meetings of the steering committee. Since legislation had to be introduced so that reorganization could take place on 1 April 1974 there was pressure on us to observe a "flow chart" devised by the civil service and McKinsey & Co., but we took great care assessing documents, and the committee's comments were informed and brief. Some documents were of crucial importance—particularly that written by Professor Elliot Jacques of Brunel University which showed that consultants and general practitioners were their own managers.

The committee guided the study group firmly, making its decision on the next step and expecting the group to act on it. Whether this was the intention of the originators of the Steering Committee or whether they hoped it would rubber stamp preconceived ideas I do not know, but the fact is that it worked. The study group learned a lot about the N.H.S. from informal discussions with the practising members of the professions. They consulted widely and the field trials involving almost 2000 N.H.S. workers produced many new ideas. At an early stage they became disillusioned with some of their theoretical ideas about how the Service worked.

The Grey Book

Recognizing that the objective of reorganization was to improve health care, the steering committee decided that this depended primarily on the people in the professions and that management played a subsidiary, but important, part. Because the N.H.S. was to be fully integrated and care was to be provided locally, the committee accepted that the areas were too large for effective management, and so the district—defined as "a population served by community health services supported by the specialized services of a district general hospital"—was adopted as the basic operational unit. It was also the largest unit in which general practitioners, consultants, and others could participate actively in management through effective representative systems, an essential factor in a "patient-centred" approach.

Hence in the plan it was laid down that responsibilities would be clearly defined and allocated for members of the authorities and their officers, multidisciplinary management teams of equals being formed at each administrative level. Decentralization of decision making would be balanced against the need for national and regional strategic direction by planning systems. All arrangements were to be flexible and adaptable.

District Management Team

The D.M.T. would be a consensus group of equals: the district community physician, district nursing officer, district finance officer, and the district administrator—all employees of the A.H.A.—together with a consultant and a general practitioner elected by their colleagues on the district medical committee. Nevertheless, the officers were not to be subordinates of the Area Team of Officers (A.T.O.) both groups being directly accountable to the A.H.A., to whom all unresolved issues would be referred. The D.M.T. would be reasonably free to manage and co-ordinate its services within an agreed plan and would identify opportunities for improvement and respond to local innovations. It was expected to meet no more frequently than weekly and no less frequently than monthly. It should identify gaps in its service and establish multidisciplinary health care planning teams to concentrate on planning services to remedy the defects and monitor their effectiveness.

The exact distribution of function among the levels would not be fixed. The Regional Health Authorities (R.H.A.s) would act as a link between the A.H.A.s and the Secretary of State, while being directly responsible for certain functions such as blood transfusion. Members' limited time would be focused on critical policy planning and decisions about allocating resources. The Regional Team of Officers (R.T.O.) would not manage their equivalents at area level but monitor their performance.

Family practitioner committees (F.P.C.s) would carry out certain prescribed functions in relation to the contractor services, but other functions—for example, the development of health centres, would be based on the A.H.A., acting in consultation with the F.P.C.

There were a few specific subjects on which management were required to seek the approval of the next highest level—the most important being revenue expenditure, capital expenditure, and new building, and "certain aspects of authorities' and districts' organization and management processes." This applied particularly to the definition of districts, and was essential because of the difficulties of "overlap," where the "natural" health districts and the area boundaries did not coincide.

Achievements

I have no doubt that the greatest achievement of the study group and the steering committee was the development of the health districts—which had been given little prominence in any previous documents. They insisted that the district should become the keystone of the management structure, while the introduction of the "consensus team"—comprising employees and elected medical representatives—made management by persuasive authority a reality. The potential influence of the district management team (D.M.T.) was rapidly recognized even by the conservative medical profession.

Nevertheless, there have been some disappointments. While everybody accepted that reorganization would lead to some dislocation, this was exacerbated by the speed of implementation and further complicated by coincidental changes in the political and economic climate. Personally I regret the apparent increase in the influence of the regional health authorities, which, to some extent has come about because they were established before the other tiers. It is also alleged that too large an allocation of resources has been "squeezed" on administrative personnel and their premises. This was certainly not the intention of the steering committee and if it is true it is deplorable.

4 Supplement, B.M.J., 1968, 2, 213.
The Community Physician

A. M. B. GOLDING

The area team of officers (A.T.O.) consists of the area medical officer, the area nursing officer, the area treasurer, and the area administrator. They advise the area health authority on all matters which affect the authority, but the district management teams also have direct access to the authority, so that the A.T.O. is not responsible for managing the day-to-day work of the district management teams—though it has a duty to monitor their work. The area medical officer has two or more specialists in community medicine working for him. For most of their duties they are subordinate to him, though they are of consultant rank. I shall concentrate on the area medical officer and describe what he does on his own, as a member of the A.T.O., and through specialists in community medicine. These functions are described in the Grey Book,

Area Medical Officer

"The Area Medical Officer will stand in relation to the area health authority as the regional medical officer stands in relation to the regional health authority. He will advise the area health authority both as a member of the area team of officers and as the authority's senior community physician. He will himself be directly accountable to the authority, and will share the joint responsibilities of the area team of officers."

"The area medical officer will lead the team comprising all specialists in community medicine on the staff of the area health authority which will include those with responsibility for specific functions carried out for the local authorities in relation to education, personal social services, environmental health (where applicable) and the various functions referred to below; (the district community physician is not a member of this team, but as a member of the district management team is directly accountable to the authority). Members of the team of specialists in community medicine will be accountable to the area health authority through the area medical officer, except for those of their functions for which they are directly responsible to the local authority. The area medical officer will co-ordinate and monitor the medical aspects of the work of the area chief ambulance officer, and will co-ordinate the work of the district community physicians within the area, and that of the area pharmaceutical officer with the activities of the relevant disciplines." (Hospital Circular—H.S.C. (I.S.) paras. 12 and 13).

Specialist in Community Medicine (Child Health)

The area medical officer is also responsible for co-ordinating child health services, including the school health services. Through him, the specialist in community medicine (child health) is accountable, to the area health authority for the N.H.S. responsibilities, but directly accountable to the local education authority for school health. Where some of the duties have been allocated to the district community physician, the latter must accept accountability for these functions to the specialist in community medicine (child health) at area health authority headquarters.

The pattern varies according to circumstances, and I propose to concentrate on the problems in a large area, with several districts. This is partly because I work in such an area and because the distinction between the area officers and the district officers is greatest here. In smaller areas—notably where there is only one district but also where, for example, there are two districts which bear little relation to the flow of patients within the area—the area medical officer needs to have more managerial responsibilities.

Role of District Community Physician

In a larger area the district community physicians have much greater independence and the district management team has to manage all the local medical services. The D.C.P. is responsible for ensuring that there is close co-operation between the paediatric department of the hospital and those community doctors who are concerned with child care in the clinics, and the school health service. In my district all the doctors working whole time in the child health service have sessions in the hospital. This is one way of ensuring integration of the community and hospital services. In a large area the details of each post need to be sorted out at district level. The responsibilities of the area medical officer are quite different from the former medical officer of health. He has to co-ordinate the service, and must ensure that all the districts maintain adequate standards, encouraging the laggards and ensuring that the money available is distributed fairly.

The area medical officer's most difficult role is to co-ordinate the former hospital services. This is especially important with services which are poorly represented in one or all of the districts. A common example would be the services for the mentally handicapped, but there is a similar need to develop the acute services—especially those which are very expensive and which involve newer technologies. Thus not every district needs its own cardiac surgical unit, nor necessarily haemodialysis. My area has three undergraduate teaching hospitals and the problems are particularly noticeable here as their high technology makes them the natural place for the regional and national centres for special investigation and treatment. A start has been made in the paediatric service, where one teaching hospital concentrates in the special areas of paediatric hepatology and fetal resuscitation while another specializes on the particular problems of renal dialysis in children and in paediatric cardiac surgery. The Todd report pointed out the disadvantages of the single specialty hospital and the advantages of a large general or teaching hospital as a base from which the highly specialized unit can develop, sharing many basic services. Thus it is no coincidence that the paediatric hepatologist works closely with the regional (and national) liver centre.

This co-ordinating function is difficult. It means persuading hospitals that they must concentrate in some fields and leave others to their neighbours. This sort of approach should be cost-effective in that each centre will have a substantial base with sufficient patients to justify adequate staffing. It will also mean more joint appointments between one hospital and the rest. Thus the paediatric hepatologist must be welcomed in the other hospitals where his expertise is needed.

Constraints

The main constraints are financial but it is easier to think in terms of concrete resources such as the availability of nurses. The total number that can be recruited is limited. A decision...