Discussion

CHAIRMAN: Some of the questions we might answer in this session are why reorganization was thought to be necessary, was it worth the quoted expenditure so far of £8 million, and what were the differences between the consultative documents and the eventual Bill?

DR. J. H. MARKS: In my view reorganization was essential. The move for some sort of integration came from the profession because the tripartite system wasn’t working. Then the politicians took a hand: Kenneth Robinson with his first Green Paper—which produced an outcry—and subsequently Richard Crossman’s second Green Paper—thought to be a great advance. Then there was a general election: the whole thing went out of the window, and in came management.

Both doctors and the community tend to forget that the N.H.S. is the largest employer of labour in Britain—900,000 people, three times the size of G.E.C., our largest private employer—and such an organization cannot be allowed to shamble on. Now Dr. Paton’s working paper describes our Grey Book as “gobbledygook.” This is true of the first document—the tentative hypothesis—but not of the final version. Anybody coming new to a subject doesn’t understand it and thinks that a textbook is written in gobbledygook, and inevitably we had to learn the definition of “aims,” “targets,” and “strategies.” The Grey Book is a simple textbook about management, and it’s understandable by any intelligent human being.

DR. A. PATON: The N.H.S. isn’t an industry, and I don’t think it is really capable of being managed in the same way as industries are. I was really describing the hypothesis document as gobbledygook, but articles are still appearing in incomprehensible language—there was one in the Lancet yesterday. I still think that it should be possible to put management ideas into terms which any ordinary intelligent person can understand.

CHAIRMAN: Dr. Brown, are management and administration the same thing?

DR. R. G. S. BROWN: We mustn’t spend time on semantics. In terms of what the N.H.S. needs, management—or administration—is about avoiding waste, deciding on priorities, and making good use of resources. Not all of these are medical resources: there are many “hotel” services, such as catering, which don’t involve problems of clinical freedom and which need to be managed in the conventional industrial sense.

Flabby Management

CHAIRMAN: Are you implying that up to reorganization management was poor, or even absent?

DR. BROWN: It was flabby. Hospital management was centred on hospital management committees, some of which (though they obviously varied enormously in quality) did very little because they weren’t very clear what their jobs were—to keep the doctors happy, to protect the patient, or to get better uses of resources. I like aspects of the Grey Book because it did attempt to define, for instance, what an area health authority ought to be doing.

MR. P. F. PLUMLEY: What statistical evidence do you have, on a pound for patient basis, that the N.H.S. was poorly managed before reorganization? The supply of medical services here has been far cheaper than in any other country. But I’m chiefly worried that the management formulae in the Grey Book were American ones using ideas which were out of date when they were originally put into effect. They have been applied in a similar way in many services connected with the State (such as education, local government, and the police) and the effects on people working in these have been very similar: an increase in the number of staff and the amount of paper—a form which was previously four inches by six inches is now 10 by 12 inches and has got numerous pockets in it.

So there was no brave new plan about this reorganization, and, what’s more, we started off with a tripartite structure with three tiers and we now have a tripartite structure with five tiers. This is retrogression, not advance.

MR. RUDOLF KLEIN: In itself the Grey Book isn’t very important—it was a top dressing—but the significant aspects of reorganization were the structural decisions, such as aligning Health Service boundaries with local authority boundaries. The other subject we should discuss is the suspicion that a lot of the desire for reorganization came from a desire to increase the power of central government: over 25 years the Minister of Health has been nominally in charge of the N.H.S. and setting policies for it, but finding that in practice what he said wasn’t being carried out. It was Richard Crossman who once described the N.H.S. as a mediæval system run by the “great baronies”—meaning the consultants. He set out deliberately to break their power.

DR. A. M. B. GOLDFING: I’m not sure I agree, but certainly there was a general feeling among non-professionals that the hospital service had been insensitive to other needs, though its technical expertise was undoubtedly very high.

MR. PLUMLEY: Would reorganization have taken place if Britain had been a rich country and not facing economic disaster?

DR. J. M. FORSYTHE: At the time of all the plans the economic position was good and the N.H.S. was getting more money every year.

MR. PLUMLEY: No; more pound notes every year.

DR. FORSYTHE: No; except for 1972-3 in real terms the N.H.S. has done better every year. So there was never any encouragement to management to see how resources were being used and how they could be used better.

MR. PLUMLEY: One thing we do not know about the N.H.S. is how much money it spends because all we have are revenue accounts.

DR. FORSYTHE: As regards the Grey Book, it’s never been fully implemented.

W. F. WHIMSTER: Which bits?

MR. D. ROBSON: Largely chapter 7 relating to paramedical work. This has always been a poor relation to the medical and nursing services.

MR. KLEIN: I’m surprised at Mr. Plumley saying that we don’t know how much has been spent—because we do. The national income and expenditure blue book sets this out.

MR. PLUMLEY: How much capital does the Health Service own?

MR. KLEIN: I agree, we don’t know, but you’d find the same lack in education, roads...
DR. MARKS: The profession asked for reorganization in 1962, but the Grey Book was geared to local authority changes.

DR. G. MACPHERSON: And the first Green Paper was published in 1968.

DR. BROWN: Dr. Paton's question is impossible to answer: in the late 1960s there was general political enthusiasm for changing society's institutions. For the N.H.S. much of the impetus for reorganization came from the relative neglect of geriatrics, psychiatry, and community services.

CHAIRMAN: But did it need reorganization to make these changes . . .

DR. PATON: And did it need management?

DR. MARKS: 'The Royal Commission on Local Government' suggested that local authorities should take over health care, and the Government rejected this.

DR. S. HORSLEY: Because it was unacceptable to the doctors?

DR. MARKS: That's right.

MR. KLEIN: The whole reorganization was implicit in the initial debates about setting up the N.H.S. The interesting thing is that reorganization was merely righting many agreed nonsense. For example, non-coincident Health Service and local authority boundaries were obviously silly, but they had to wait to be righted until local government was altered.

MR. PLUMLEY: Does any human organization work with a rational structure? At present reorganization seems to have come about merely because the authorities said "we really must do something."

DR. BROWN: Most of us here will agree that the present split between the Health Service and the social services is wrong, and looking 25 years ahead (when resistance may well be less) I can see another reorganization to bring the relevant part of the social services into the N.H.S.

DR. COLEMAN: To come back to reorganization, the purpose of the N.H.S. is to treat the patients. My limited experience suggests that reorganization is going to take us back to pre-N.H.S. days, where general practitioners worked in hospitals and had a bigger say in them.

DR. MACPHERSON: So should consultants have a bigger say in general practice?

DR. COLEMAN: They do already in D.M.C.s with an equal number of general practitioners and consultants: we talk as much about hospital matters, say, as health centre planning.

Insular Attitudes

MISS ZENA OXLADE: The medical staff is looking at this in rather an insular way: each group is trying to protect its own interests. How much do consultants want to know about what happens to their patients when they've been discharged? Really comprehensive care can come from true co-operation.

A. J. SMITH: And reorganization was necessary to achieve this?

MISS OXLADE: Yes. Previously the system worked well in some areas, but this depended on the generosity of certain local authorities.

MR. ROBSON: Changes can happen only as fast as people will accept them. That is why a year after the beginning of reorganization we are seeing more problems than successes. Integration was already practised in some areas before 1974. But those areas where integration wasn't happening must find it difficult to forget the barriers just because reorganization says they aren't there.

DR. BROWN: That functional integration didn't achieve before reorganization was a better look at priorities or a voice for the general practitioner in hospital matters. It was also impossible to see whether resources were being wasted or not and whether they could be better deployed by bringing resources under the control of one person (such as a nursing officer in the case of nurses).

DR. PATON: I welcome reorganization for its co-operation aspects. What I'm concerned about is that management has wrecked our hospital system.

DR. WHIMSTER: Management has got blown up disproportionately. All it means is that we identify problems and correct them.

MISS JANET LEWIS: There's a difference between talking about reorganization generally and what actually happened as a result of this particular reorganization. When doctors talk about too much management it really means that they don't appreciate the management structure which has been set up.

DR. HORSLEY: I believe in management more than most hospital doctors, but the leadership from the Department of Health has been absolutely appalling: it isn't explaining to workers in the N.H.S. just what reorganization is setting out to achieve. They should tell the area that there's so much money for health and that the area authorities should decide what to spend it on. Even so, the system can't work until the managers know how to manage: many of the M.O.H.s and area administrators who enjoyed a quiet life at the regional board pre-1974 just aren't capable of managing or communicating. It's also being said that the new committee structure doesn't work—but the old structure didn't work either, and there was even less contact between general practitioners and consultants.

DR. PATON: Why have committees at all?

DR. MARKS: Because "no man is an island."

MR. PLUMLEY: The one thing that seems impossible in this management structure is for the politicians to say to the public: "you can't have it; it's too expensive." This is where leadership is failing: over the last 15 years the pressure groups have been conspicuously successful and hospitals have often been forced to start services which are incompletely financed—abortion was the worst example of this.

Right Reorganization?

DR. M. WARE: Is the present reorganization of the right type to achieve integration of the tripartite system, and has the continued separation of general practice made progress more difficult?

DR. MARKS: Your first question is answered by the first words in the Grey Book "the objective in reorganizing the National Health Service is to enable health care to be improved. Management plays only a subsidiary part." Secondly, the tripartite system worked well only in a few areas, but general practitioners as independent contractors believe in functional integration and have a great fear of becoming salaried servants. Interestingly, when this was discussed in the steering committee the laymen couldn't conceive that their general practitioner would become a salaried employee of the State: that was why the family practitioner committees were preserved, but general practitioners are included in the D.M.T.s.

MR. KLEIN: Another main reason for reorganization was that no one before reorganization was asking about the quality of medical care in any particular district in the country.

MR. PLUMLEY: It's not being done now.

MR. KLEIN: But the new structure will make it easier.

DR. COLEMAN: Will consultants and general practitioners be willing to be monitored in this way?

DR. HASLER: Yes, in the next few years, on a voluntary basis.

DR. GOLDSING: Some monitoring is acceptable if it's done in the right way. Monitoring is coming, but it must be done by the doctors treating the patients, or possibly by an outsider with their agreement.

MR. PLUMLEY: I disagree. If somebody is going to do something you don't want, you don't do it yourself. As American experience has shown monitoring must be done by an outside agency: otherwise it becomes a "whitewash procedure."

DR. FORSYTHE: The best form of monitoring in Britain so far has been the Confidential Inquiry into Maternal Mortality—entirely a professional evaluation.
DR. BROWN: We're wandering into clinical audit, which if it's done anywhere is done in the cogwheel division. The exciting thing is monitoring services where the right balance of resources is important—the care of the elderly or the mentally handicapped. Reorganization has allowed the setting up of health care planning teams, which will evaluate this sort of question.

MISS LEWIS: Though over the whole country there are many health care planning teams, many areas still have only one or two.

MR. ROBSON: These teams will be ineffective without adequate administrative support, and this brings us back to the cost of management.

MR. PLUMLEY: What exactly does adequate administrative support mean?

MR. ROBSON: One extra person per two or three health care planning teams at a middle management level, within a section devoted to service planning. This is something which the N.H.S. has not been willing to do before at district level.

DR. MARKS: Experiment will show.

DR. GOLDSMITH: One of the district community physician's main functions is to set up health care planning teams. So far we ourselves have only working parties and not formal planning teams: for example, the one on family planning receives ideas produced by the consultant in this specialty which are discussed by a wide spectrum of other team members, including general practitioners, nurses, and representatives of the social services. The working party's proposals then go to the district management team who add to it.

DR. COLEMAN: Aren't the A.M.O.s and the D.C.P.s going to be the monitoring mechanism under reorganization?

DR. GOLDSMITH: Not on their own: they will involve the people being monitored. But suppose a D.C.P. finds that a consultant isn't seeing enough patients: discussion with him will probably reveal a reason for this—the doctor may be ill, for example, and something's got to be done about it. But I don't see the D.C.P. being able to take action by himself: it will have to be done with the agreement of the D.M.T.

DR. MARKS: Monitoring has two functions: ask questions and try to persuade. Suppose a general practitioner isn't doing enough immunizations, the D.C.P. explains their importance and asks him why he isn't doing more, and he says "because I don't want to"—that's the end of the discussion.

MR. KLING: But the other equally important aspect of monitoring is to look at a population and see who is getting what and who isn't.

DR. HORSEBY: The next thing a D.C.P. should do is to cost various forms of treatment, and then clinical decisions can be made more logically.

Unknown Figures

MR. PUMLEY: It's physically impossible to get proper figures. All the accounts in the N.H.S. are by attribution: the administrator says "I think Dr. X was in the hospital for about six hours—that's two sessions." Also articles on comparative costs of various treatments ignore social expenses—bus fares for out-patient treatment, for example. You just can't measure things to this degree of accuracy.

DR. HORSEBY: You can in terms of beds and resources.

DR. FORSYTHE: Even with the most accurate costs, there remains the decision about priorities—allocating resources to one or another service.

MR. ROBSON: I also wonder whether sophisticated figures (which would be highly expensive to obtain) would lead to better decisions, and an improved selection of priorities.

DR. COLEMAN: Dr. Paton should know that our district has set up a resource group for the acute area of the district general hospital, comprising the users of the hospital service. They have been given a budget for their plans, so that they can decide on priorities—the distribution of surgical and medical bed numbers, the creation of a five-day ward, and so on. This should have been done years ago.

DR. PATON: But it was—15 years ago, when, for instance, we told the regional hospital board of our difficulties with geriatrics. This is why I'm so against many aspects of the reorganization. The various medical administrators should spend their time going round talking to people. I've never yet seen a representative of the D.H.S.S. in my hospital.

Perhaps also I should explain my disillusionment with planning. As a new consultant, I served enthusiastically on committees, planning a new district hospital with advanced departments and features such as a helicopter pad. It wasn't until 10 years later, when nothing had happened, that I suddenly realized that we were still talking about the same plans. That's why I resigned from committees and no longer read their documents.

MR. PLUMLEY: Planning in the N.H.S. is so often for ideals and for yesterday's diseases.

DR. MARKS: We don't know tomorrow's diseases.

MISS LEWIS: I don't see why there couldn't have been health care planning teams (which are based on the districts) in the old-style N.H.S. After all, district boundaries do not usually coincide with the local authority boundaries.

DR. FORSYTHE: But we had some teams: the old maternity liaison committees had a similar composition, and there were also geriatric and other working parties on groups.

MISS OXLADE: The difficulty, though, was in getting adequate information, and this brings us back to really adequate support. Reasonable planning is impossible without first-class information.

CHAIRMAN: Dr. Paton knew about his geriatric problems 15 years ago.

MISS OXLADE: He knew his views about it.

DR. PATON: We had actual figures.

DR. MARKS: You were concerned only with the hospital—not the position of the patients in the community—or the allocation of the resources to the hospital or to badly needed general-practitioner premises. Now somebody has to decide on priorities.

MR. PLUMLEY: Whose decision will it be, and will it be based on anything other than personal opinion dependent on the personality of the pressure group pushing it? So what's different?

DR. MARKS: In the Service we envisaged there will be an allocation to an area and somebody through the D.M.T., the A.H.A., and the A.T.O. will have to decide on priorities.

Too Much Central Control

MR. PLUMLEY: This solution is being prevented both centrally and locally by regulation and by shortage of money. The ideal will never come to pass because central authority can never allow that sort of decision to pass to the periphery.

DR. HASLER: I also get the impression from people in the periphery that I've talked to that they can't take the decisions they'd like to because their hands are tied.

DR. FORSYTHE: This is absolutely right. Historically the Department has been offering more and more guidance and the gap between putting this guidance into practice and the amount of money available was getting wider and wider. The N.H.S. reorganization has given us the framework; now we've got to get changes in decision-making—the Department and the politicians have to make decisions down to district level.

DR. MARKS: Is there any evidence they're going to do this and have the money?

DR. FORSYTHE: If the district is convinced that its revenue/ capital has been allocated fairly—which does not go on at present—then I think you would get proper decision making.

MR. ROBSON: I think D.M.T.s have already got authority to make these decisions; the present financial stringency means local choice for essential activities. There is no money to meet the ideals laid down in central guide lines.

MR. PLUMLEY: How do you reallocate resources in practice? You can't sack people.
DR. GOLDING: We've temporarily closed an orthopaedic ward in my own district and are going to open a five-day ward for urology.

MR. PLOXLADE: How did you do it?

DR. GOLDING: Three wards were closed by political pressure because of our using agency nurses: in reopening them we have borne in mind what the D.M.T. consensus considers are the priorities.

DR. SMITH: Consensus decisions are often those that ought to be over-ruled—for instance, we'd rarely get one in favour of mental subnormality. If resources are reallocated in the way you describe, little is going to be done for areas of social deprivation.

MR. KLEIN: Earlier, the word political has been used pejoratively: as a layman I would argue that the reason for reorganization was to get more political decisions and to denote professional decisions.

MR. PLUMLEY: Most of the decisions in any technology must be taken by the technologists. If they're alienated then their quality will fall and persistence with a patient-oriented approach will eventually finish with patient-determined treatment.

DR. MARKS: Mr. Klein is wrong: the principal feature of the D.M.T. is that practising doctors are involved in decision-making, which did not occur before 1974.

Participation

CHAIRMAN: In his introduction to the White Paper on N.H.S. reorganization Sir Keith Joseph said that "the professional worker . . . will have the opportunity of organizing his or her own work better and of playing a much greater part than hitherto in the management decisions that are taken in each area." Was the proposed framework of the reorganized N.H.S. right for this?

MISS OXLADE: It's not completely right, yet, but the plan was correct.

DR. MARKS: The consensus plan is the only way of getting the employed and the contractors together, people who are managed and people who are their own managers.

DR. HORSEY: There is now a forum into which suggestions from the junior staff can come. The A.M.T. is also very willing to listen to any ideas.

DR. SMITH: Isn't it terribly demanding, in terms of time, for a busy clinician?

DR. PATON: So many doctors I know spend so much time on committees that I don't know when they do their clinical work at all. But if they stopped all committee going they wouldn't have enough clinical work. Shouldn't we discuss whether there's a proliferation of committees, contrary to the Grey Book's intentions?

DR. HASLER: I understood that there were fewer committees.

MISS LEWIS: Surely all the area committees didn't exist before.

MR. PLUMLEY: I will enumerate them: all the old cogwheel committees, which feed up through the D.M.C., to the D.M.T.—which has five basic health care teams. There is the A.H.A. with its own health care planning teams, the family practitioner committee, the community health care committee, the area medical advisory committee—and we're trying to prevent the last proliferating into subcommittees. Then there is the R.H.A. with an R.T.O. with about 20 subcommittees.

DR. COLEMAN: You've missed out the local medical committee and the area hospital medical committees.

DR. MARKS: Not to mention dental and pharmaceutical committees, and so on.

DR. WHIMSTER: What does this involve you in, Mr. Plumley?

MR. PLUMLEY: I go to one committee a week (the D.M.T.) and the D.M.C. once a month; the rest is paper work at home. If I let committee work interfere with my clinical interests I should go mad. The weight of paper coming from the D.H.S.S. is fantastic—between one and one and a half inches thick of paper every week. Some of this is relevant, and there's a great danger of missing vital information—such as the hazard warnings, which have a legal implication. Part of the reason for this is because we are in a transitional period, part because the Department is scrutinizing things more closely, and part because of inflation—new pay scales for example.

DR. HASLER: Surely what you're saying is that at present the cost-effectiveness of medical participation is very low? If processes could be streamlined, should clinicians take a full part?

MR. PLUMLEY: It's Catch 22: the less money you have to spend, the more you have to talk about it, and the more committees are needed.

DR. PATON: Nobody ever talks about saving money. I don't believe the N.H.S. is really short of money. In just the same way as personally I'm always short of money, and would like more, so would the Health Service.

DR. COLEMAN: There are no incentives to save money, and the D.F.O.s and the D.A.s do not agree with the principle that any saving should benefit the department that makes it.

MR. ROBSON: District priorities should be seen as a whole and a department which makes a saving shouldn't necessarily receive it.

DR. COLEMAN: This removes the incentives to saving.

DR. FORSYTHE: How are you going to get money into deprived areas at a time of no economic growth if one department is allowed to keep any savings it makes?

DR. COLEMAN: A D.M.T. can do this, for instance, by selling a surplus hospital or building and reallocating the money—since reorganization the D.M.T. is allowed to keep a fair percentage of the sale price for local use.

DR. MARKS: Reorganization has meant less rigidity—for example, there's now a carry-over budget. Some of the present difficulty stems from our present economic plight.

Cost of Reorganization

CHAIRMAN: While we're talking about money, what about the cost of reorganization?

DR. MARKS: The Department told our committee that the exercise of reorganization would be £4 million. If you have a £3000 house and you spend £14 on keeping it in good repair for the next 20 years, then that's nothing.

DR. PATON: Has the cost gone up?

DR. MARKS: I assume so, like everything else. But, as I say in my working paper, I'm told that vast sums have been squandered on things such as administrative blocks and carpets.

DR. HORSEY: Reorganization cost about £150 000 in Cornwall. This is cheaper than most areas as much of it is non-recurring—for example, the A.H.A. did not rent costly new office accommodation as, I believe, some areas have done. New operating theatres at the city hospital would have cost £110 000.

DR. FORSYTHE: We have to be very careful about quoting figures: even the one quoted in Hansard refers only to central costs—not those down to district level, or those of new services—for example, occupational health nurses.

DR. SMITH: Does administration now take up a larger proportion of the costs of the N.H.S.?

MR. KLEIN: Yes. In one area the administrative costs have risen from 2·9% of the total budget before reorganization to 3·7% afterwards.

DR. FORSYTHE: In the U.S.A. Blue Cross/Blue Shield spend up to 14% of premiums on administrative costs.

CHAIRMAN: Turning to the way reorganization was introduced, I wonder whether there should have been a pilot trial in one region.

DR. MARKS: Years ago the B.M.A. suggested this should have been done in Wales—an ideal place—but the politicians were against it.

DR. BROWN: There was pressure to introduce reorganization
quickly because of the reform of local government due to start in April 1974. And what would the results of a pilot trial have meant?

**DR. GOLDSING:** The problems of evaluating any pilot study would have been enormous.

**MR. PLUMLEY:** Once the Seebohm recommendations had been put into effect, the shambles of reorganization was inevitable.

**DR. MARKS:** Yes, the social service changes were the greatest disaster for health this century.

**MR. PLUMLEY:** Seebohm set the tone for management, financial structure, and wage levels.

**MR. ROBSON:** After the green paper N.H.S. staff squandered away time before facing up to the realities of change.

**MR. KLEIN:** And the plans for changing local government themselves kept changing. But should diversity have been encouraged a lot more—14 grey books for the 14 regions, for example?

**DR. MACPHERSON:** But one of the objectives was to produce maximum flexibility at area and district level.

**DR. MARKS:** This was one of our key features, but the D.H.S.S. hasn’t followed its own plans.

**DR. PATON:** “Flexible arrangements” is classical gobbledygook. Just what does it mean, with all those committees?

**MR. ROBSON:** Many of the committees that have been formed or retained are not in the formal structure.

**DR. GOLDSING:** Some rigidity is necessary, as in the composition of the D.M.T., which is laid down: this oversees unfair competition of conflicting medical interests. If the structure is found to be wrong, then it should be modified.

**Spread of Non-doctor Power**

**DR. WHIMSTER:** In our area we’ve a conference of staff organizations, an area body made up of 10 unions, including N.A.L.G.O., C.O.H.S.E.—and the B.M.A. They discuss topics such as the use of agency nurses and the closing of hospital beds. The representatives are nominated directly by national negotiating bodies and they won’t have anybody else—which raises the centralization question even more acutely. These mostly non-doctor bodies are very powerful, and it’s going to spread to the regional and the district levels.

**MR. ROBSON:** All this has happened at the same time as reorganization, or even afterwards, and is not really linked with it.

**MR. KLEIN:** You’ve had medical syndicalism in the N.H.S. for 25 years. Why should you be surprised that other workers in it want a voice?

**DR. BROWN:** Much of the centralization is because the professional groups such as doctors and nurses didn’t want flexibility at local level.

**DR. MARKS:** Yes, consultants insisted that they should be appointed by the region; everybody else’s appointments are made by the area.

**MISS LEWIS:** But these arrangements have become institutionalized. I still don’t see why many more decisions could not be made locally rather than fixed uniformly on a national basis.

**MR. PLUMLEY:** I agree: things won’t get better until the local authorities take over the Health Service entirely.

**DR. MARKS:** You can’t arrange all health locally because it’s paid for out of taxes.

**MR. PLUMLEY:** Rubbish: you can run the N.H.S. in any way you like. The water rate is a splendid example of central money being used with virtually no local control whatsoever.

**DR. FORSYTHE:** Everybody realizes what an extravagant disaster the reorganization of the water authorities has been.

**DR. HASLER:** And the D.H.S.S. wants to increase central control, not slacken it.

**DR. MARKS:** When some health care was more under local authorities before the war, the standards were so variable that the State had to step in and raise them.

**DR. FORSYTHE:** There is some flexibility: at present some D.M.C.s are meeting fortnightly, others only quarterly. Nobody this afternoon has produced any evidence that there are any more committees than before. What has happened is that some clinicians are grossly overcommitted in the new N.H.S. structure.

**MISS OXLADE:** Yes; where there are a massive number of committees it’s because the professionals have demanded them. Everybody is trying to protect their own interests, and I hope this is because it’s the early stage of reorganization and we don’t yet trust one another.

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**Glossary of N.H.S. Terms**

- **A.H.A.** Area Health Authority
- **A.H.A.(T)** Area Health Authority (Teaching)
- **A.M.C.** Area Medical Committee
- **A.M.O.** Area Medical Officer
- **A.M.T.** Area Medical Team
- **A.T.O.** Area Team of Officers
- **C.H.C.** Community Health Council
- **D.A.** District Administrator
- **D.C.P.** District Community Physician
- **D.F.O.** District Finance Officer
- **D.H.S.S.** Department of Health and Social Security
- **D.M.C.** District Medical Committee
- **D.M.T.** District Management Team
- **F.P.C.** Family Practitioner Committee
- **H.C.P.T.** Health Care Planning Team
- **J.C.C.** Joint Consultative Committee
- **M.E.C.** Medical Executive Committee
- **R.HA.** Regional Health Authority
- **R.T.O.** Regional Team of Officers

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**References**

1. Hansard, House of Commons, 6 May 1975, col. 360.