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FOREWORD

The first Green Paper on the National Health Service in England and Wales was published by my predecessor in July, 1968 while the Royal Commission on Local Government in England was still at work. It contained " tentative proposals . . . as a basis for wide public discussion and consultation with representative bodies ". It sparked off a vigorous discussion inside and outside the service. Over 400 sets of written comments have been received and I have discussed these proposals with representatives of nearly fifty organisations.

The Royal Commission has now reported and the Government has announced its decisions on the future structure of local government in England in the White Paper which has just been published. The Government has now also reached three firm decisions concerning the health services. First, it has decided, for reasons given later, that the National Health Service will not be administered by local government but by area health authorities directly responsible to me and closely associated with local authorities. Secondly, it has decided on the administrative boundary which must as a consequence be drawn between the National Health Service and the public health and personal social services which will continue to be administered by local authorities. Thirdly, it has decided that in general the number and areas of the new health authorities must match those of the new local authorities—the unitary areas and the metropolitan districts outside London. On other questions, this paper contains revised proposals for England on which there is now a further opportunity for comment before final decisions are taken.

The paper does not cover Wales or Scotland. The Secretary of State for Wales will shortly be publishing a separate Green Paper. The Secretary of State for Scotland is reviewing the proposals in his Green Paper of December, 1968 in the light of the comments received and the consideration being given to the report of the Royal Commission on Local Government in Scotland.

Most of those who commented on the Green Paper of July, 1968 endorsed its central theme—the need to weld together the three parts of the health service at every level to form an integrated service. Differing views were expressed about the precise point at which the line should be drawn for administrative purposes between the health service and other social services, but all wanted to see close co-ordination between them. There were, however, three strong criticisms of the proposals which were expressed from many quarters. First, the proposal to place the responsibility for providing health services on 40 to 50 area boards with no participation of local people below this level would have made the day-to-day running of the health service too remote from the people it serves and would have made it necessary to devolve excessive powers on the officers of the boards. Secondly, many feared that the boards might be dominated by the hospital service. Thirdly, there was concern that no provision had been made for regional planning. On the other hand, many of those who condemned the size and remoteness of the proposed boards wanted to see integrated health authorities large enough to take extensive responsibility for the control of local health services.

I accept the argument that in a reorganised health service there must be more, not less, local participation. This does not, however, make it necessary to establish further statutory authorities below the area level. The need for local participation can best be met by district committees of the area health authority on which people drawn from the local community and people working in the local health service can contribute to the work of running the district's services. The need to secure close co-ordination between the health and other social services underlies the Government's decision that the number and boundaries of the area health authorities will, in general, be the same as for the new unitary and metropolitan district authorities. Instead of 40 to 50 area boards, there will be about 90, including those in London. Finally, I accept the need for planning on a regional basis, particularly on the hospital front. I therefore propose to set up 14 or more regional health councils. Their main task, and one of major importance, will be to advise me and the area health authorities on the hospital and specialist plans for the regions. They will also carry special responsibility for the organisation of postgraduate medical education and exercise other functions appropriate to a body of this kind. But the maximum authority, consistent with my own responsibility and accountability to Parliament, will be concentrated at the area level where, through the inclusion of elected local councillors and members of the health professions in the area authorities, representatives of the local community will be able to play a full part in the running of the National Health Service. These are the main differences between my proposals and those published in the earlier Green Paper.

This, too, is a Green Paper and—apart from the three matters already mentioned upon which firm decisions have been taken—the Government is not yet finally committed to the proposals made in it. Some of the arrangements have yet to be worked out in detail: for example, the functions and constitution of regional health councils; the relationship between the area health authorities and the local authorities in regard to arrangements for sharing or exchanging services; and the functions of the district committees. Meanwhile, I shall welcome comments and suggestions both from organisations and individuals. I shall, of course, be discussing the proposals fully with the representatives of the staff who would be affected by them.

The future of the National Health Service is of vital concern to all who pay for it as well as to all who use it. My main aim in making these proposals is to secure that the total health needs of each individual patient and each family will be met by one integrated health service. The removal of the present administrative barriers between the different parts of the service will enable everyone working at every level of the health service to plan, administer and provide for the comprehensive health needs of every citizen.

RICHARD CROSSMAN

Secretary of State for Social Services

CHAPTER 1

THE PRINCIPLES OF THE NEW HEALTH SERVICE

1. The National Health Service was built on four fundamental principles. Though the service has not yet achieved all its objectives, these principles have stood the test of time:—

(i) The health service should be financed by taxes and contributions paid when people are well rather than by charges levied on them when they are sick; the financial burden of sickness should be spread over the whole community. In practice, the cost of the service has increased so rapidly that it has not always been possible to maintain this principle. But a " free " service in this sense is still right in principle. It encourages preventive medicine and early treatment, relieves the sick of financial anxiety, and collects the money when people can afford to pay it.

(ii) The service should be national in the sense that the same high quality of service, but not a standardised service, should be provided in every part of the country. In the twenty-one years since the National Health Service was created there has been some (though not sufficient) levelling up of areas which were medically impoverished before 1948. Doctors—particularly consultants—are now more evenly distributed over the country. Although there is still more to be done, specialist services are within reach of all. Hospitals outside the main centres of population have been upgraded within the limits set by antiquated buildings. But considerable differences in standards still remain. Further levelling up of resources, particularly of trained staff, is needed—especially in the Midlands and the North—to provide the same high quality of service all over England. There are also unjustifiable differences between the average standards of care provided for long stay hospital patients—the elderly, the mentally ill and handicapped—and the standards of care provided for short stay hospital patients. In the services paid for partly from local rates, standards of services also differ because of the differing demands made on local authorities and the differing priorities they give to their health services.

(iii) The service should provide full clinical freedom to the doctors working in it.

(iv) The service should be centred on the family doctor team. The general practitioner provides the essential continuity to the health care of each individual and each family and mobilises the services needed. His ability to do so can, however, be limited by the administrative barriers between the different parts of the service. Originally it was intended that the different parts of the service would be coordinated in health centres. Until recently these have been slow in developing. There has, however, been a rapid growth of group practice and of attachment of health visitors, midwives and domiciliary nurses to family doctors.

2. There have been striking improvements in standards of health during the twenty-one years since the National Health Service was established. The main infectious diseases which were once the major cause of death of people of

working age have been virtually eliminated as health problems. As a result of the dental services provided under the Act the standard of dental health throughout the country has greatly improved. The death of mothers in child birth is so rare that each is made the subject of a special investigation. The proportion of British children who die in the first year of life is among the lowest of all countries in the world. People in Britain live longer than in most other countries. Subject only to the heavy toll of accidents, most people now live on into old age. Not all this progress is due to the establishment of the National Health Service, but much of it must be due to the virtual removal of financial and geographical barriers to the use of health services, and to the increase in resources which have been devoted to the health service.

3. But more could be achieved if the service were not still divided into three parts. The hospital and specialist services are provided through Regional Hospital Boards, Boards of Governors and Hospital Management Committees. The family doctor, general dental, ophthalmic and pharmaceutical services are provided through Executive Councils. The local health authorities provide maternity and child care, midwifery, home nursing, health visitors, health centres, home helps, ambulances, mental health social work services, after-care, chiropody, vaccination and immunisation, health education and other preventive health services. Outside the National Health Service is the school health service provided by local education authorities.

4. Local health and education authorities are controlled by elected local authority members. Hospital authorities are controlled by members many of whom are suggested by the professions, local government, the universities, trade unions, voluntary organisations and other bodies. But the final selection of people to serve on hospital authorities is made by the Secretary of State in the case of Regional Hospital Boards and by Regional Hospital Boards in the case of Hospital Management Committees. The Boards of Governors of teaching hospitals are nominated one fifth by the university, one fifth by the doctors and dentists undertaking clinical teaching, and one fifth by the Regional Hospital Board in whose region the hospital lies, with the remainder appointed directly by the Secretary of State. About half the members of Executive Councils are appointed by the professions, a quarter are appointed by the Secretary of State and a quarter by the local health authority.

5. The money which pays for the hospital and Executive Council services is, apart from relatively minor sums paid by patients, raised in taxes and National Health Service constributions. It is distributed by the Secretary of State to Regional Hospital Boards, Boards of Governors and Executive Councils. The money which pays for the local authority health services and the school health service comes (again apart from minor sums paid by patients) from the rates and the rate support grant.

6. The proposed reorganisation of the National Health Service must aim to strengthen, develop and reinforce the original principles upon which it is based. The proposals in this Green Paper have four main objectives:—

(i) To unite the National Health Service. Not only must the different branches be controlled by the same authority but the separate services must be integrated at the local level.

(ii) To establish close links between the National Health Service and the public health and social services provided by local government.

(iii) To place the maximum responsibility for administering the National Health Service, consistent with national plans and priorities, on area health authorities in which there must be strong local and professional participation, and to involve each community in the running of the services of its district.

(iv) To provide effective central control over the money spent on the service and to ensure that the maximum value is obtained for it.

7. These four aims—unification, co-ordination, local participation and effective central control—must be achieved if the weaknesses of the present service are to be countered. The reorganised National Health Service should also provide an administrative structure in which ill-health prevention and health promotion can be given a fresh and stronger emphasis.

CHAPTER 2

THE CASE FOR UNIFICATION

8. The case for unification is now widely accepted. Full co-ordination of the National Health Service cannot be achieved in a service run by no fewer than 168 bodies which are either agents of or regulated by the Secretary of State (119 Executive Councils, 35 Boards of Governors and 14 Regional Hospital Boards), by 299 agents of the 14 Regional Hospital Boards (Hospital Management Committees), and finally by 158 local health authorities which have only a limited responsibility to the Secretary of State.

9. Joint planning is obstructed by the sheer number of administrative authorities of varying size serving different populations. The areas from which Hospital Management Committees or Boards of Governors draw most of their patients often cross the frontiers of several local authorities. Few local health authorities need to deal with fewer than three different hospital authorities; some in London have to deal with considerably more. In the case of patients with mental illness or handicap some hospitals may be located many miles from the local authority area from which their patients are drawn. If a Regional Hospital Board tries to act as co-ordinator for its region it can find itself negotiating with as many as 20 different authorities, including Boards of Governors of teaching hospitals which are not under its jurisdiction. There is one Regional Hospital Board which has as many as 13 teaching hospitals in its region.

10. The problems of co-ordination have been eased by a variety of liaison and other committees established for different purposes in different areas. Such committees, however, cannot resolve the problems but can only ease them. If all the co-ordinating committees were established which needed to be established, some officers and members would be left with little time for the essential work of running the particular service for which each authority is responsible.

11. Two practical consequences result from this multiplicity of authorities. First, they impede the ultimate aim of meeting the needs of individual patients and their families comprehensively. Secondly, the limited resources provided for the National Health Service are at risk of being wasted or used to less than full advantage. For example, at heavy cost the hospital service cares for patients who could well be treated at home if the right local services were available on a large enough scale. Many patients are in hospital who could live outside, would prefer to live outside and would fare better outside. In many such cases care at home with the support of the community health services would be the better and the cheaper solution. At the same time other patients who really need care in hospital make demands on the local authority services while they wait to be admitted.

12. Often the barrier to discharge from hospital is the lack of adequate services for people who would prefer to stay in their own homes. When deciding what priority to give to their health services as against the competing needs of their other services, it is clearly difficult for local authorities to take full account of the advantages which would accrue to the health service as a whole. It is not surprising that local authorities, faced as they are by many competing needs,

Hospitals cannot refuse to admit LHA can to their extended type care.

may often not be able or ready to spend money from the rates on caring for patients who are being looked after by the hospital service but could be discharged. At present neither the hospitals' resources nor those of local health authorities are used to maximum advantage.

13. The administrative divisions of the service make it difficult to secure the flexible use of staff or continuity of relationships for users of the health service. For example, the staff of the maternity unit of a hospital in which a baby has been delivered does not necessarily continue the care of the mother after she is discharged from hospital. One social worker employed by a local authority may be helping a patient at home while another with a different employer may help the same patient in hospital. Each has to establish a relationship with the patient; each has to identify the problem of the patient and his family; each has a different loyalty.

14. The tripartite division of the National Health Service gave administrative reinforcement to the evolving trend of separation between general practice and hospital practice. The cleavage between the hospital service and the Executive Council services does not help communication between family doctors and hospital doctors. In the hospitals, the doctor and the nurse are employed by the same branch of the health service, but outside, the family doctor under contract with the Executive Council leads a domiciliary team of health visitor, midwife and district nurse, some or all of whom owe ultimate allegiance to a local health authority; he may also practice from premises provided by the authority.

15. The Royal Commission on Medical Education has recently emphasised the important role for general practice in the future but this role cannot be fulfilled unless there is the closest link between medicine practised in and out of hospital. Moreover the family doctor must be provided with the tools to do his job and this means full access to pathological, radiological and other diagnostic facilities which are provided at the hospital but should be regarded as services for the district. Greater mutual confidence and closer co-operation between consultants and family doctors can prevent the unnecessary use of out-patient departments. A unified health service will give a new priority to developing the services provided by family doctors. Neither consultants nor general practitioners can be self-sufficient: they can only do their work effectively if they do it together.

16. Unification is needed to secure the co-ordinated planning of the services of each district and the more effective deployment of local resources. But it is also needed to improve team work and ease the problem of communication. If all local health personnel worked within one local service there would be a better foundation for the provision of integrated health care. In this service the focus must be not on the particular institutions in which or from which health services are delivered, but on the needs of each patient for which these institutions were created.

17. It is the need to remedy these deficiencies and to meet those needs which are not at present fully met that dictates the kind of unified service required. The existing division of the service into three parts must be abolished in fact as well as in name. All decisions on staffing, planning and the deployment of resources must be governed by the total health needs of each area. One authority

must be responsible for the National Health Service in each area and it must administer the services of each district as a whole. Only if there is a total merger of hospital and community health services in the administration of both district and area services will resources be efficiently deployed to meet the needs of each patient.

CHAPTER 3

AREA HEALTH AUTHORITIES

Administration by local government?

18. The Royal Commission on Local Government in England suggested that consideration should be given to the possibility of unifying responsibility for the National Health Service within the new system of local government. They emphasised two main advantages of this proposal. First, they believed that there was no doubt that democratic control of the health services would be much more effectively secured by putting them under the control of local authorities directly answerable to the electorate and to the citizens at large. Secondly, local authority control would give a better chance of establishing close relationships between the health services and the personal social services.

19. The Government accepts the force of these arguments but has nevertheless decided that the course recommended is unacceptable for two main reasons. First, the professions believe that only a service administered by special bodies on which the professions are represented can provide a proper assurance of clinical freedom. Secondly, the independent financial resources available to local authorities are not sufficient to enable them to take over responsibility for the whole health service. The scale of the problem can be illustrated thus: central Government expenditure on the National Health Service (about £1,400 million a year) is nearly as great as the present yield of rates, and about three-quarters of the total of present government grants to local authorities. The transfer of financial responsibility would seriously complicate the problem, now being considered by the Government following the Royal Commission's Report, of how to give the new local authorities a degree of financial independence corresponding to their responsibilities.

20. The Government has carefully considered the suggestion of the Royal Commission that, as a possible alternative to direct local government control of the National Health Service, the relationship between elected representatives and the passenger transport executives responsible for the day-to-day running of services under the Transport Act 1968 should be examined for its relevance to the administration of a unified health service. This would not, however, resolve the problem of clinical freedom. Nor would it offer a relevant financial model: transport services are largely self-financing. For the health services, the main potential advantages of local government control would not be realised. The less direct the control of health services exercised by local authorities, the greater the loss of community participation; if health services are to be made responsive to local and indeed individual needs, there must be closer involvement of members of health authorities in the running of health services than is customary in the case of public transport services. Secondly, the co-ordination between the health and personal social services would be harder to achieve if the health services were run by semi-autonomous bodies. Moreover, such bodies would not be accountable in detail for the money they spent either to the local authorities or to the Secretary of State.

The establishment of area health authorities

21. For these reasons, the Government has concluded that the unified National Health Service cannot be directly or indirectly controlled by local authorities, and that special area health authorities must be established to administer it.

Common areas of administration

22. Because of the importance of close collaboration and co-ordination of services, the Government has arrived at the firm view that the new area health authorities must serve the same areas for which the new local authorities will be providing personal social services—the unitary areas and the metropolitan districts outside London. In Greater London, where the local government pattern has already been reorganised, some boroughs are small geographically or have special characteristics which make them unsuitable for the separate planning and operation of health services. The concentration of teaching hospitals in Inner London further complicates the situation. In most cases, therefore, the areas of two or three London boroughs will be grouped to form a single area health authority. But even in London, the areas of the health authorities will comprise whole boroughs: no borough will be divided for health purposes. Proposals for London are set out in Appendix I.

23. Though area health authorities will have responsibilities for defined areas, this will not prevent patients from using services outside the boundary of their area authority: they will, for example, be able to receive treatment from a family doctor, dentist, or hospital in an area outside that in which they live. Nor will it mean that an area health authority cannot administer an institution, such as a hospital annex, which is situated in the area of another authority. Joint arrangements may also need to be made between area health authorities when the needs of an individual cannot be met within his own area.

Membership

24. At present the hospital service is controlled by over 5,000 appointed " volunteers " who give considerable time to this work without payment for it; the ultimate selection of all members of Regional Hospital Boards and Boards of Governors is made by the Secretary of State and the ultimate selection of all members of Hospital Management Committees is made by Regional Hospital Boards. The substantial development of the hospital service during the last twenty-one years is to a considerable extent due to the devoted and largely unacknowledged work of the members of these Boards and Committees. Nevertheless, the system under which they are appointed has been criticised as " undemocratic ". It is said that many hospital authorities are in practice controlled by self-perpetuating oligarchies. Members of Hospital Management Committees, as agents of agents of the Secretary of State, have a particularly slender democratic basis.

25. The new area health authorities must be more clearly representative of their areas and of the professions working in the area's services. The Government therefore proposes that area health authorities should consist of one third of members appointed by the health professions, one third appointed by the local authorities and one third plus the chairman appointed by the Secretary of State. This will introduce a powerful element of local participation and at the

same time help to promote co-ordination with the other services of the area. The Government hopes that local authorities will include among their representatives members of their personal social services committees, and others with a special interest in services which have a health aspect. The inclusion of members of education committees in Inner London and the proposed metropolitan districts where education will be a responsibility of the Inner London Education Authority or the metropolitan area authority will need special consideration.

26. At present the medical profession holds about a quarter of the places on hospital authorities and half the members of Executive Councils are drawn from the professions. It has also increasingly been the practice to appoint at least one nurse to each hospital authority. But only in the case of Boards of Governors of teaching hospitals have the professions been free to select their own representatives on hospital authorities. The Government proposes that the main health professions, and this includes the dental and nursing professions, should have the right to select their representatives for their third of the places on the new area health authorities. The local professions must shoulder their share of responsibility for the management of the health services in their area which they so largely provide.

27. The chairman and the remaining third of the members would be appointed by the Secretary of State. The intention would be to choose these members for their relevant experience, interest and readiness to devote their energies to the administration and development of the health service. Where a health authority covers an area which includes a medical school, representatives of the appropriate university will also be included in the membership to ensure that the interests of medical and dental education and research are safeguarded and that related scientific expertise is available. An area health authority might consist of 20-25 members.

28. In view of the heavy responsibilities which will fall on the chairmen of area health authorities, the Government proposes to pay them part-time salaries, on a basis to be settled later. The members of the area health authorities would receive travelling expenses, and subsistence and related allowances.

The boundary of the National Health Service

29. An administrative division has to be made between the National Health Service and the services which are to remain with local government—particularly the personal social services. Health needs and social needs overlap and shade into one another; as a result any dividing line cannot fail to create problems of definition at the border. Many opposing views have been expressed on the principles which should determine the frontier. Should provision be made within an integrated health service for social needs which are ancillary to or arise out of medical needs? When the social need is predominant, should the medical need be met as part of a social welfare service? Should services be organised according to the label of the user—the mentally ill, the mentally handicapped, the convalescent, the aged, or women needing maternity services? Or should they be organised according to the skill of the provider?

30. Many of those who commented on the first Green Paper argued that unless a wide range of services for social support were brought under the control

of the health authority there would be a damaging split between preventive and curative medicine, and an insufficient guarantee that personal social services would be provided when they were needed to support the medical services. For example, if the residential and home care services for the mentally ill and mentally handicapped formed part of the personal social services, the process of medical assessment might be neglected. If home help services were provided as part of these social services, they might not be available to prevent admission to hospital or support a policy of early discharge from hospital. Thus needs might go unrecognised, the care given to individuals and their families would be fragmented and the limited resources available for health and personal social services would not be deployed to the best advantage.

31. After carefully considering the contrasting views expressed on these questions, the Government has decided that the services should be organised according to the main skills required to provide them rather than by any categorisation of primary user. Any alternative would involve the establishment of more than one local service deploying the same skill. Broadly speaking, the decision is that the health authorities will be responsible for services where the primary skill needed is that of the health professions, while the local authorities will be responsible for services where the primary skill is social care or support. The scarce skills of professional people will be used to greatest advantage if those of each profession are marshalled and husbanded by one agency in each area. Moreover it will more often be possible to provide for users the advantages of continuity of care by one professional worker of any one discipline. Classification of services by skill will also help to enhance professional standards.

32. The application of this principle means that the various services making up the school health service will be brought within the integrated National Health Service. The services will be provided by doctors, especially paediatricians and general practitioners, dentists, nurses, and others in the employment of, or in contract with, the area health authority. Their close contact with the schools will be maintained. At the same time, the new arrangements will help to secure continuity in the medical and dental care of children from birth through their school days. This continuity will be beneficial whether a child is in good health or has a physical or mental handicap that calls for constant medical supervision and perhaps special educational arrangements. There will be other benefits too, notably a closer association between what is provided as part of the school health service and what is provided for the child and his family by general practitioners, other community health workers and hospitals. The risk of duplication of services will also be avoided and there will be opportunities for improved efficiency in the use of medical, dental and nursing staff.

33. The service will continue to be provided in a manner acceptable to the local education authority and its staff. Medical examinations will as now be fitted in with educational requirements. Similarly, there is no reason why the present good working relationships between the teachers and the doctors, dentists and nurses should not continue.

34. These links need to be supported by suitable administrative arrangements of the kinds described later in this Paper.

35. The home help service, on the other hand, will be part of the local authority social services. Even though home helps may often be needed by patients of the health service, the overall assessment of need for a home help is essentially a social rather than a health assessment. In the case of the services for the mentally ill and mentally handicapped, the essential medical diagnosis, treatment, assessment and reassessment will be undertaken by the staff of the health authorities in the same way as the assessment and medical management of associated physical disabilities. Local authority social services will be responsible for providing the adult training centres, though medical assessments may be undertaken in them and also for social work with the mentally disordered. The area health authorities will be responsible for hospital and hostel services for the mentally ill or handicapped who need continuing psychiatric supervision—including those who are being considered for discharge and need a trial period in a hostel where the practicability of discharge can be further assessed. Residential care for those who are able to manage without continuing psychiatric supervision will be provided by local authorities.

36. The area health authorities will thus administer the following services:

the existing hospital and specialist services;

the existing family practitioner services;

the following services at present provided by local health authorities:

ambulances,

epidemiological work (general surveillance of the health of the community),

family planning,

health centres,

health visiting,

home nursing and midwifery,

maternity and child health care,

prevention of illness, care and after care, through medical, nursing and allied services (including chiropody, health education—other than its place in the school curriculum—and screening),

residential accommodation for those needing continuing medical supervision and not ready to live in the community,

vaccination and immunisation;

the school health service.

37. The Government will consider further where responsibility for the child guidance service should lie.

38. Though the area health authorities would provide services for people who suffer injury or ill-health however caused and would be responsible for preventive health measures of many kinds, they would not have a specific responsibility for occupational health. The general arrangements for occupational health

(which are the responsibility of the Department of Employment and Productivity as the Department most closely concerned with conditions of employment) are set out in Appendix II.

39. This list of responsibilities should be read alongside those which the Government has decided should be exercised by the local authority social services. In addition to the social services at present provided for the elderly, the handicapped and the homeless, and the children's services, local authorities will be responsible for the following services which are at present provided under health powers:—

family case work and social work with the sick and the mentally disordered;

day centres, clubs, adult training centres and workshops for the above;

the day care of children under five, day nurseries and child-minding;

the care of unsupported mothers, including residential care;

residential accommodation for those who cannot live at home but do not need continuing medical supervision;

home helps.

40. Local authorities will retain their responsibilities for public health matters. The following public health services will continue to be administered by them:—

the prevention of the spread of communicable diseases other than by specific prophylaxis or treatment;

food safety and hygiene;

port health;

the public health aspects of environmental services;

diseases of animals in so far as they affect human health;

enforcement responsibilities relating to environmental conditions at work places;

health education (a power concurrent with that of the health authorities).

41. This allocation of responsibilities means that, for a time, Medical Officers of Health will be in charge of departments with more limited responsibilities than they now exercise. These responsibilities will, however, continue to be considerable and in addition they will be closely involved in preparations for the new health service structure.

CHAPTER 4

COLLABORATION WITH LOCAL GOVERNMENT

Exchange of services

42. Any line drawn between the health services and the personal social services can scarcely avoid creating difficulties at particular points. There will need to be close consultation between the area health authorities and the local authorities about their respective development plans and about individual difficulties. This will be promoted by the arrangements proposed for local authority representation on area health authorities; it would be further helped if health authority members were co-opted on to the social services and other relevant committees of local authorities. Moreover, each authority would look to the other for advice on subjects on which it has no adviser on its own staff and their officers would regularly consult on matters of common interest and would exploit opportunities for joint action where this would be mutually advantageous—hence the built-in interdependence of these proposals.

43. Each type of authority will be able to undertake work for the other. There may, for example, be advantages in extending the scope of bulk supply arrangements made by the area health authorities or by the local authorities to cover both health service and local government needs. Joint arrangements might also be made for vehicle maintenance and for the use of computers. Where local authorities are sponsoring major developments, for instance new towns, the requirements of the health service might be included as part of such projects.

44. These are only a few examples of where partnership might be of benefit. The advantages and practicability of such arrangements would depend on local circumstances and on the needs and resources of the authorities directly concerned. These suggestions, and those relating to staff that are made in the following paragraphs, will be discussed with the professional and local authority associations and other bodies concerned, as part of the consultations on the Green Paper. The exact arrangements for the reimbursement of expenditure will also need to be worked out.

45. The medical, dental, nursing and midwifery staff and some of the other staff in the health departments of the local authorities would transfer to the service of the area health authorities. Similarly, the social work staff of the hospital authorities might transfer to the local authorities. The new local authorities will, however, have a continuing need for medical advice and services and the new health authorities will have a continuing need for social advice and services. It is intended that each of the two parallel authorities will provide advice and services to the other.

46. Social workers would be made available by the local authority to serve the hospitals or the community health services centred on the general practitioner. There would be advantages in efficiency, flexibility, career structure and continuity if social workers who gave a substantial proportion of their time to work in the health service were seconded to the area health authority. At the same time local authorities will need medical officers, full-time or part-time, for such work as the examination of people arriving at sea ports and airports. Such staff might similarly be seconded to the local authority. Medical attendance on people in

the care of the local authority, for example, children and old people in hostels and homes, can continue to be provided by the patient's own general practitioner who would call in specialist help where necessary.

47. More generally, local authorities will need health advice in the planning and running of their personal social services, housing and general environmental services and in exercising their statutory responsibilities for public health. The senior officers of the area health authority will be available to give this advice. For example, in addition to medical advice and services, the local education authority may need advice and services from the dental and nursing staff of the area health authority and may need health visitors to help generally with the education services and with health education in schools. There will also be a continuing need for close collaboration between the medical staff of the area health authorities and the local authorities' public health inspectors. This will be particularly necessary for the control of outbreaks of communicable disease or food poisoning where the Public Health Laboratory Service will also continue to have an important role. Some outbreaks demand immediate and concerted action by all concerned to prevent the spread of the disease and to treat those already infected. The chief administrative medical officer of the area health authority should be able both to call for information needed for health purposes and to act with the help of family doctors, health visitors and hospital staff and of public health inspectors.

48. One possible way for local authorities to meet their statutory requirements and administrative needs would be for them to appoint for their purposes on an honorary basis medical officers who are in the employment of the area health authority. This would ensure that the staff engaged on local authority health work were in the main stream of the health service and at the same time would provide the local authority with a share in the responsibility for selecting the staff who would serve them.

The work of the community physician

49. If the proposals in this Paper are adopted, there will be one corps of administrative medical staff serving both the area health authority and the local authority. Most of the present work of the Medical Officer of Health will be included in the wider functions of the chief administrative medical officer. The chief administrative medical officer, in his capacity as chief " community physician ", will also work with the local authority on public health and other services where medical advice is needed. As adviser both to the area health authority and to the local authority, the community physician will be able to survey the general pattern of health care, both in the hospitals and in the community, and take a comprehensive view of health needs and health problems. He will be uniquely placed to help his clinical colleagues in the continuous monitoring of the need for and the outcome of clinical services. This process of medical audit has already been developed to a considerable extent by, for example, obstetricians and paediatricians and by the use of such new developments as the hospital in-patient enquiry and hospital activity analysis. But there have not been the local resources or organisation to pursue it more widely. The system recommended in the First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals (the " Cogwheel " report) gives

new opportunities for collaboration with the community physician and the community services. In addition, the community physician will continue to exercise the responsibilities of present Medical Officers of Health in promoting the development of the local authority services which are incorporated in the unified health services.

50. The community physician will have much greater opportunities for acquiring closer knowledge of health hazards as they arise through continuing study of the pattern of illness presenting itself to the health services. This will enable him to make a more effective contribution as the main adviser to the local authority on the health aspects of all its services.

51. Thus there will be four main tasks. First, to develop the quantity and quality of information about health needs and the working of area health services. Second, to act as adviser on the health services to the area health authority. Third, to advise the local authority on the health aspects of all its services and particularly to give a lead in health education. Fourth, to perform the public health duties of the present Medical Officer of Health.

52. This description of the role of the community physician is necessarily brief and tentative. It is intended to make a detailed study of the scope and nature of his work in a reorganised National Health Service.

CHAPTER 5

LOCAL PARTICIPATION

District committees

53. The areas of health authorities will vary from about 200,000 population to about 1,300,000 population. It is essential to ensure that the residents in each community and the professional staff working in each district can participate in the running of their district health services. The full implications of an integrated service can only be worked out on the ground, on a scale such that all concerned can participate in decisions affecting their profession or their community. It is therefore proposed that most of the area health authorities should establish district committees. The area served by a district hospital or the hospitals which are jointly its present equivalent will normally be the the smallest organisational unit for an integrated health service. Closely associated with this hospital will be a varying number of domiciliary health teams led by groups of general practitioners. The district served by a single district hospital will in many cases be an appropriate unit for a district committee. The precise number of these district committees—perhaps 200 or so—will therefore be determined by the pattern of the district health services, but where possible they will serve the same districts as the proposed district committees of the new unitary local authorities. Where the area of the health authority is small, it will be able to administer its services satisfactorily without any district committees.

54. It is proposed that a district committee should consist of a chairman and half the membership appointed by and drawn from the area health authority, and the other half drawn from people living or working in the district who are not on the area health authority itself. The general balance of its composition would reflect that of the area health authority. The district committees will be served by the officers of the area health authority. There will be no need for them to have their own separate budgets. No powers will be delegated to them by statute. Their functions require study but it is intended that the area health authority which establishes these committees will use them to supervise the running of services at the district level, while maintaining its own general responsibility for establishing priorities and securing the efficiency of the health services throughout its area. The district committee will also serve as one of the channels through which local people can keep the area health authority informed of any problems they encounter with the local health services. The exercise of these functions will ensure that the area health authority is exposed to the full vigour of local opinion in the professions and of local users of the health service.

Voluntary organisations and voluntary work

55. The involvement of people from the local community in the running of their services should help to maintain their quality and the public's understanding and acceptance of them. But these aims will not be fully achieved if the participation of the community consists only of representation at the committee level. There is undoubtedly a much greater potential for the participation of voluntary workers in the health service than has been realised in the past and a

much wider role for the work of voluntary organisations. There are many needs of the sick and handicapped which are better met by voluntary workers than by paid staff.

56. Voluntary organisations have always made an important contribution to the working of the National Health Service. The unification of the health service will enable their work to be extended. Those organisations which have aimed to help particular types of patient have found the administrative barriers within the present service an obstacle to the full achievement of these aims. Voluntary service which supports patients both in hospital and in the community will strengthen the sense of continuity throughout the health service and constitute a further force helping to knit its elements together. The discussions following the publication of the first Green Paper have shown that the voluntary organistions are ready to take a fresh look at their activities and to see how far they need to be adapted to work alongside an integrated service.

57. Voluntary activity by organisations and by groups, and volunteer projects of many kinds, will receive encouragement and support from the new area health authorities, but the main working links will be with the district committees. Paid organisers of voluntary effort will be employed, for example, to co-ordinate support for a particular hospital; some might be jointly employed by an area health authority and a local authority to co-ordinate voluntary help for the elderly or mentally ill or handicapped both in hospital and in the community. Grants and subsidies paid by the area health authority—either from its approved allocation of finance or, where appropriate, from trust and endowment funds—will be available to support voluntary bodies which provide and promote services within the general scope of the authority's responsibilities.

58. A special and continuing effort needs to be made to foster voluntary work with long stay patients. Many elderly, mentally ill, mentally handicapped and younger chronic sick patients risk losing touch with their local community. Some have lost contact with friends and relatives. There is a special need for volunteers to visit and befriend such patients. Voluntary effort may also be needed to enable relatives and friends to visit when distance or disability makes this impossible without special help. The greater the participation of the local community in its local health services, the greater the response of the service to the community's needs and of the community to the service's needs. Voluntary work can be an important source for the recruitment of paid staff.

59. A number of voluntary bodies provide services on an agency basis for the present local health authorities. The hospital car service, for example, is provided by voluntary organisations to supplement the main ambulance service and in some areas, voluntary nursing associations provide agency services. Area health authorities will be empowered to enter into agency agreements and to continue and develop regular arrangements of this kind.

CHAPTER 6

THE ADMINISTRATION OF AREA HEALTH AUTHORITIES

The role of the central Department

60. The Secretary of State will be fully responsible for all aspects of the administration of the health services. Just as he is answerable for the actions of the present hospital authorities, so he must be for those of the new authorities. This is inherent in the fact that the great bulk of the finance required, amounting at present to some £1,500 million a year, will be provided from central sources and voted by Parliament. It is the Secretary of State who will allocate the available funds to the new area health authorities both on capital and revenue account; and he must be satisfied that the money is spent to the best advantage. The central Department will need to concern itself more closely than in the past with the expenditure and efficiency of the administration at the local level. This applies, for example, to the standards of provision to be aimed at and the priorities to be adopted between competing demands. The Department must also ensure a reasonable balance between the main areas and divisions of expenditure, and maintain oversight of the value for money secured from the allocations made to the area health authorities. There will be available to the Secretary of State the full range of powers of guidance, and if necessary direction, that is required for this purpose.

61. The intention will however be, in accordance with the objective in paragraph 6 (iii), to place on area health authorities the responsibility for administering the health services to the maximum extent consistent with the objective in paragraph 6 (iv) of providing effective central control. To reconcile these objectives means that there must be closer understanding and shorter communications between the central Department and the area health authorities. It is for these reasons, among others, that it is proposed that the central Department should deal direct with the area health authorities, without an intervening tier of authority such as now exists in the hospital service. The Department will also give greater attention, with the advice of those concerned, to improving the allocation of resources, and to encouraging their most effective use, bearing in mind especially the possibilities of a more rational deployment which will be offered by the integration of the health services.

Integrated services under area health authorities

62. Provided national priorities are observed and standards of efficiency are attained, effective power will rest with the area health authority to develop and plan its own services within the budget allocated and to link them with those of the local authority. All responsibilities for an integrated health service which can be economically and efficiently devolved on the area health authorities will be conferred on them. This will include some of the responsibilities at present exercised by Regional Hospital Boards. Each area health authority will settle the boundaries of its constituent districts and determine what resources should be deployed in each district, and in so doing would seek to secure a desirable balance between services outside and inside hospitals.

63. Area health authorities and their district committees will act as catalysts in developing new patterns of health services. There can be no standard form

which integration should take at the local level. The aim must be to bring together the out-of-hospital services which serve each community while at the same time creating much stronger links with the district hospital. Where health centres are provided, they will be provided by a health authority upon which the professions have strong representation. Under these new arrangements, more general practitioners may wish to accept this form of practice. But a health centre is no more than a building. It is the basic ideas which underlie it which are important, and these can be realised or largely realised in other ways. The aim is to co-ordinate local preventive and curative services so as to provide integrated health care to a community. What is important is not the ownership of buildings but the siting and deployment of services, provided that the various buildings in which people work are suited for their purpose.

64. There will no doubt be experiments with larger practices which give greater opportunities for individual practitioners to develop their special interest and for the economical use of a wider range of technical supporting services. If operational units of local authority social services were sited alongside group practices or in or near health centres there would be obvious advantages both to the authorities concerned and to the communities they serve.

Statutory committee for the family practitioner services

65. The reorganisation of the health services will not detract in any way from the present status of family practitioners as independent contractors. Instead of entering into contracts with Executive Councils as they now do, doctors, dentists, pharmacists, ophthalmic medical practitioners and opticians will enter into contracts with a special committee, which each area health authority will be required by statute to establish. This statutory committee will be directly responsible for securing the provision of the family practitioner services in accordance with national regulations. It will in general stand in the same relationship to the independent contractors and the local professional committees as Executive Councils do now. The local professional committees would need to be reconstituted to correspond with area boundaries.

66. The composition of the statutory committee will be laid down in legislation or in statutory regulations. It is proposed that it should resemble the composition of Executive Councils and include members appointed by the local professional committees. There will be some common membership of the area health authority and of the statutory committee, and in addition these two bodies will be served by a common staff.

67. The area health authority will be responsible for co-ordinating the family practitioner service with the other services and for planning supporting services and health centres, although day to day co-ordination might be at district level. The closer linking of general practitioners and hospitals depends on this overall responsibility of the area health authority.

68. Under these arrangements, the family practitioners as independent contractors will not be under the direct control of the area health authority. But there will in practice be substantial integration in the organisation and planning of the services.

Internal organisation

69. The main principles which the area health authority would be expected to adopt in organising its committees and appointing its chief officers and laying down their departmental duties would be:

(i) that the administration of all the health services for which it is responsible is to be unified;

(ii) that most of the services provided will depend upon the close collaboration of the many professions within the service working together in various groups and teams.

It follows that the pattern of the organisation should no longer follow the tripartite division into hospital, general practitioner and local authority services. Nor should it be based upon the separate professions within the service. The organisation of a unified service should be based primarily upon the various functions which comprise the service. Apart from the statutory committee for the family practitioner services, any headquarter standing committees should cover all parts of the service. They should be few and should be kept small in the interests of efficiency. The main one would no doubt be a finance and general policy committee covering all the various aspects of the service.

70. The organisation of the area health authority's headquarters staff should also be such as would ensure the comprehensive planning and management of services. One of the main functions will be to formulate requirements for health services and to plan their organisation and use. A department would be required to specialise in this work and the skills of both community and hospital services should be represented in it. There are other main functions that would require specialised departments. The administrative departments would include a secretariat and a department with personnel as one of its main functions. There would be a financial department. The weight of work on supplies, building and engineering functions would probably call for a separate department or departments for these purposes.

71. Most functions will require close teamwork between several professions and disciplines. This will be particularly the case in the planning of the organisation and use of services. The core of the team advising the authority on this function must necessarily be its chief administrative medical officer, chief nursing officer and chief administrative officer, together with the chief financial officer who will have a special responsibility for giving advice on the financial implications of policies and the efficient and economical use of resources. Other professional staff and senior officers will need to form part of the team when matters covering their responsibilities or departments are discussed.

72. General co-ordination of the function of planning the organisation and use of services throughout the authority's area would be a major responsibility for the chief administrative medical officer and he would also have immediate oversight of the department specialising in this work. The chief administrative medical officer would also need to work closely with the chairman of the Local Medical Committee for the area; and with the chairman (or chairmen) of the Medical Executive Committee (or Committees) established in his area as a result of the " Cogwheel " report.

73. Co-ordination of most of the activities that do not fall wholly within the scope of this specialised department would be a major responsibility for the chief administrative officer who would also have immediate oversight of the department or departments dealing with administrative matters.

74. Some important questions are likely to concern separate professions or groups of professional staff as such and the principal officer for each would be recognised as having a special position for this purpose. These principal officers would be brought into consultation on any matters that closely concerned their profession or professional group as such, and they would also have the right of direct access to the area health authority on such matters.

75. The suggestions made about patterns of administration in the preceding paragraphs are necessarily tentative. They will need further study and elaboration in the light of the comments on this paper. Any administrative framework which is established should be sufficiently flexible for changes to be made in the light of experience.

76. The actual working of local arrangements will depend to a considerable extent on the managerial capacity, energy and enthusiasm of the authority's team of chief officers—the lay manager or administrator and the chief nursing officer as well as the chief medical administrator. The reorganised National Health Service will be fortunate in inheriting—from Regional Hospital Boards, Boards of Governors, Hospital Management Committees, Executive Councils and local health authorities—a considerable body of lay administrators and professional staff with long experience and training in management.

77. The most important principle which must govern the administration and organisation of the area health authority is the removal of the present barriers between the three parts of the service. Both the members and the officers must view the service which they are administering as an integrated service and base their plans upon the total health needs of the patients for whom the services are provided and of the communities in which they are providing them.

Finance

78. It is estimated that in 1970/71, the total cost of the health services in England (including the school health service) which it is proposed to include in the new unified National Health Service will amount to about £1,500 million. This includes current expenditure of about £100 million on the services to be transferred from local authorities, of which rather more than half will be provided by central Government through the rate support grant and rather less than half will be due to be met from the rates. Finance for the new service will continue to be provided very largely from central funds. It has been suggested, however, that the identification of local authority members with the interests of the health service would be strengthened if there were some continuing contribution from local authority sources. This suggestion, and the appropriate financial adjustments between the central Government and local authorities, will need to be further considered in the light of the arrangements for the future of local government finance generally, on which the Government intends to publish a Green Paper.

79. The area health authorities will prepare programmes of capital and revenue expenditure for approval by the central Department. In approving programmes, the Department will ensure that a proper balance is maintained between the development of the hospital services and the development of other services, and that proper account is taken of the needs of medical and dental teaching and research, in view of the obligations of the new authorities towards hospitals administered by Boards of Governors or University Hospital Management Committees. Finance for payments to those in contract to provide the family practitioner services will be provided separately by the central Department. In the long run, it is intended that the basic determinant of area health authority budgets will be the population served by the area, modified to take account of relevant demographic variables, underlying differences in morbidity, the characteristics of the capital plant inherited by each authority and any special responsibilities undertaken for a wider area and particularly for the special needs of teaching and research.

Trust funds

80. The present hospital authorities are trustees of substantial sums which have over the years been given by members of the public for hospital purposes. It will be important to continue to respect the local character of these gifts. It is therefore proposed to transfer these trusts to the new area health authorities and thus ensure that the funds are still available for use by the authority on purposes which supplement the centrally financed health services provided for the people of the area. The area health authorities will be able to accept and to seek fresh gifts in aid of any part of their work, as happens at present. It is hoped that the public of each locality will continue to give generous support to their local health services.

81. It will be necessary to consider the question of maintaining any present limitation on the purposes for which trust funds may be used. In addition, where funds are held in trust for the support of a particular hospital, the district committees might be associated with their management.

82. Representatives of the present Boards of Governors and of other hospital authorities will be invited to take part in discussions on these questions.

CHAPTER 7

REGIONAL HEALTH COUNCILS AND CENTRAL GOVERNMENT

Regional health councils

83. While the area health authorities are large enough for most health purposes, they are too small for the performance of a number of important functions, particularly those related to the overall planning of the hospital and specialist services—including the rarer specialties (such as neurology, radiotherapy, neurosurgery, nephrology and specialised laboratory facilities); the organisation of facilities for postgraduate medical and dental education; the deployment of senior hospital medical, dental and scientific staff; the regional organisation of staff training; blood transfusion services; and the planning of ambulance services. To undertake these important tasks, fourteen or more regional health councils will be established. The regions will cover areas similar to those of the present Regional Hospital Boards. They will be constructed by grouping the areas of several area health authorities—probably between three and nine.

84. The membership of the regional health councils will reflect that of the area health authorities grouped in the region. Each of the area health authorities will appoint at least one member. There will be several members appointed by the professions, some or all of whom might also be members of area health authorities. The university concerned will also be represented and there will be a chairman and some members appointed by the Secretary of State. The size and composition of each regional health council have been left open at this stage. They will depend, amongst other things, on the number of area health authorities in the region. The council will have a small but highly expert staff with experience of hospital planning and other skills needed for its work.

85. Similarly, their functions have not been defined precisely. But one of the most important functions will be planning the hospital and specialist services in the region and assessing priorities between competing developments. Of special importance will be the planning of the development and location of the rarer specialties. In this work their role will be advisory, both to the central Department and to the area health authorities. But in view of their membership, their recommendations will carry great weight.

86. To maintain continuity in planning the specialised services in London and South-East England, and to maintain the important links between the facilities in central London and the rest of the South-East, there will be four " metropolitan " regional health councils, covering roughly the same areas as the present four metropolitan Regional Hospital Boards but keeping to the area health authorities' boundaries. In the central part of these four regions, co-ordination of hospital services is at present achieved through a Joint Working Group which includes representatives of the four metropolitan Regional Hospital Boards, the London Boards of Governors, the University of London, the London Boroughs' Association, the Inner London Executive Council, and the Inner London Local Medical Committee. It has an independent chairman appointed by the Secretary of State. Under the new administrative structure, a similar co-ordinating body will no doubt be needed, with representatives of the four regional health councils, the area health authorities, and probably also the local authorities and the university, and a chairman appointed by the Secretary of State.

87. The organisation of the ambulance service in Greater London (and in the metropolitan areas elsewhere) will need special study.

88. Regional health councils will also be responsible to the Secretary of State for a number of executive functions now discharged by Regional Hospital Boards. These might include the running of the blood transfusion service and the deployment of senior hospital medical, dental and scientific staff. In addition the councils will carry special responsibility for the organisation of post-graduate medical education which will need to be extensively developed in the future. Finally, the regional health councils will have a critical role to play in promoting and sponsoring research into the clinical and operational problems of the health services throughout the region. In recent years there has been a rapid increase in decentralised clinical research supported mainly through Regional Hospital Boards and Boards of Governors, partly from voluntary and partly from Exchequer funds. This is a particularly desirable development which will need to be fostered by regional health councils with their close links with the scientific resources of the universities and hospitals, including the teaching hospitals. University departments of social medicine, statistics and the like also provide valuable support for operational studies in the deployment of health services which commonly need investigation on a wider than area basis. With their responsibilities for planning, and strong representation of area health authorities, the regional health councils will be in a special position to identify the problems which need investigation and to find, with the help of the university, investigators who are equipped to undertake each assignment.

89. While they will exercise some executive functions of their own the regional health councils will not supervise or control the area health authorities, which will have a direct relationship to the central Department. Area health authorities will also be free to establish consortia with one another or to make joint arrangements with local authorities where these seem to offer the best methods of dealing with matters of common concern.

The central Department

90. In order to maintain an effective direct relationship with about 90 area health authorities, the central Department will need considerable reorganisation. There will need to be strengthened regional offices and much more interchange of staff between the area health authorities and the central Department. This interchange will be of benefit to both parties. The central Department will be constantly refreshing itself with doctors, dentists, nurses, administrators and others with recent knowledge and experience of running health services at the local level. Area health authorities will have officers with recent knowledge of the priorities established at the centre, of on-going research and of the major policy issues being debated at the centre.

91. Certain functions which are at present performed by Regional Hospital Boards will in future be performed by the central Department—particularly the programming, planning and execution of major building schemes. In compiling the programme of these schemes and in considering the capital programmes of the area health authorities, the Department will take into account the advice given by the regional health councils. Centrally, and in its

regional offices, the Department will employ the professional and other staff needed for planning and designing and carrying out, in consultation with the future users, the major schemes included in the national programme. Their services will also be available for the smaller schemes such as health centres for which the area health authorities will be responsible. The central Department will also play a more active role in manpower planning and training in conjunction with representatives of health service staff.

Central Advisory Council

92. To assist him in exercising these enlarged functions, the Secretary of State will establish a new Central Advisory Council with a widely drawn membership from within and outside the professions. The Secretary of State will consult the Council on all matters of importance to the health service including the deployment of available resources.

The National Health Service Hospital Advisory Service

93. The Secretary of State will maintain contact with the day-to-day problems of the health service through his Department and its regional offices, through the Central Advisory Council, through discussions with chairmen of area health authorities and through the Hospital Advisory Service which is already at work. The latter has two functions specified in its terms of reference:

(i) by constructive criticism and by propagating good practices and new ideas, to help to improve the management of patient care in individual hospitals (excluding matters of individual clinical judgment) and in the hospital service as a whole;

(ii) to advise the Secretary of State for Social Services about conditions in hospitals in England (and the Secretary of State for Wales about conditions in hospitals in Wales.)

94. The Hospital Advisory Service will provide a further channel by which the difficulties facing hospitals can be brought to the attention of the central Department and the Secretary of State. It is in a position to draw together on a national basis the lessons learnt in each hospital, and to convey this information to other hospitals. Every hospital has something it can teach others; every hospital has something it can learn from others. The Advisory Service should facilitate the communication of ideas between the central Department, the area health authorities and the hospital wards. Similarly it should encourage communication between hospitals, and between hospitals and the community services, including those provided by local authorities, general practitioners and voluntary societies. At present it is concentrating its attention on long-stay hospitals. Its services will eventually be provided for all hospitals in the National Health Service.

Complaints and a health commissioner

95. The vast majority of complaints are at present conscientiously investigated by health service authorities to an extent which is not always appreciated by members of the public. Some complainants, however, doubt whether the health service authority, which must itself take responsibility for any mistakes which

have been made, can be expected to undertake impartial investigations. Steps are now being taken to introduce more uniform and better publicised procedures for the handling of complaints by hospital authorities.

96. In July, 1968, the first Green Paper made a number of tentative suggestions for dealing with complaints, including the possible appointment of a health commissioner, or commissioners, to consider complaints not dealt with by the health authority to the satisfaction of the complainant. This suggestion attracted a good deal of comment, mostly favourable but some of it critical.

97. In July, 1969, the Prime Minister, when announcing that an ombudsman system would be established for investigating complaints of maladministration in local government, said in regard to the health service that it would be necessary to consider, in consultation with the professional and other interests, the relationship of any health commissioner to the new National Health Service Hospital Advisory Service, and also other problems of definition, for example where complaints involve clinical matters.

98. These consultations will now be undertaken in the light of the general proposals made in this Green Paper for the future structure of the National Health Service.

CHAPTER 8

STAFFING THE SERVICE

99. The National Health Service is already one of our largest " industries ". It employs nearly three-quarters of a million people. The quality of the service it provides depends above all else on the calibre of the men and women working in it.

100. It will be necessary to ensure that the skill and experience of existing staff are used to full advantage in the new structure. The reorganisation described in this Paper will involve considerable redeployment of staff now working for the hospital authorities, the Executive Councils and the local health authorities. This must be effected as smoothly as possible, with full consideration of the interests and circumstances of staff who may be called upon to move. A national staff commission or similar machinery will need to be established at an early stage in consultation with representatives of the staff to undertake this work. The commission will be expected to work in conjunction with any similar machinery set up in connection with local government reorganisation.

101. More generally, skilled control of manpower policy, based on an informed understanding of the needs of the service and of the individual, will be essential, especially during the period of transition. A major effort will be needed to introduce new training programmes, or adapt existing ones, to prepare staff for work in the new service. Because of the time needed for sufficient staff to complete training on so large a scale, training courses may have to be started before many staff know for certain what posts they will obtain in the new service. The timetable for such training will need close co-ordination with the staff commission's plans and timetable for the filling of the groups of posts concerned.

102. If the proposals in this Paper are adopted, some of the staff of the Regional Hospital Boards will be invited to work for the new regional health councils, some in the regional offices of the central Department, and some for the area health authorities. Those employed by the Hospital Management Committees, Boards of Governors and Executive Councils and the staff transferred from local health and local education authorities will in general be required by the area health authorities.

103. The rights of transferred staff will be maintained. There will be full consultation with all the staff interests concerning the effects of the changes on the staff themselves including, for example, any superannuation questions that arise. Rates of pay and conditions of service in the new administrative structure will continue to be settled through national machinery.

104. Early discussions will take place between representatives of staff and of the Department and the employing authorities in order to review and define as soon as practicable the effect on staff, and the principles of personnel movement to be followed and the actions needed if the proposals are finally adopted. Well before any actual movement takes place, these matters will come within the scope of the proposed staff commission.

105. For an integrated service, the training of staff assumes an added importance. The need for developing postgraduate medical education has already been

mentioned. Of no less importance is the need to extend the education and training facilities available to all other staff throughout the health service. This will ensure that everyone is able to work to his full potential, and will conserve the scarce resources upon which the service depends. The new area health authorities, with the help of the central Department and others with experience and responsibilities in this field, will need to make extensive use of existing facilities for training and education and develop new facilities where they are required.

106. The tripartite division of the health services is reflected in the arrangements which are now made for training staff. The tripartite service has its origins in the history of Britain's health services extending far beyond the creation of the National Health Service. Earlier patterns of services were developed to meet particular needs or to establish particular priorities not all of which are still relevant today. These patterns have had a major influence on training programmes. The establishment of an integrated health service will make it necessary to consider how far particular specialised training programmes are still appriate, whether existing personnel can with further training undertake wider functions and whether new forms of generic training need to be developed. An integrated health service gives opportunities for greater continuity of care of individual patients and a much more flexible deployment of staff. The wide power which will be devolved on area health authorities will give them opportunities to experiment in new patterns of care and to respond to new needs.

107. The proposed organisational changes will create new responsibilities for many people. For example, the responsibilities of the chief medical administrator will extend to all branches of the unified health service. The area health authority's chief nursing officer will be concerned with both hospital and community nursing and midwifery services. The supplies officer will become responsible for supplies required in all area health authority activities. There is likely to be an increasing number of posts with duties in both hospital and community. Moreover, the unification of all the personal health services in an area under one employing authority will make it easier than now for members of staff to widen their experience; there will be greater opportunities for movement between different fields within the service or for working part-time in different branches of it.

108. These new opportunities and responsibilities will pose new challenges to the personnel and training branches within the area health authorities. Some forms of training will have to be organised on a scale wider than that of a single area health authority. Special arrangements for this will be required. At the national level, machinery will be needed to organise the training and development of health service staff, as well as to carry out on a wider basis functions similar to those now undertaken by the National Staff Committee for hospital administrative and clerical staff and by the National Nursing Staff Committee for nurses and midwives. The proportion of the service's total resources of manpower and money which is invested annually in training has been rising sharply; still higher rates of investment will be needed in many areas. And the larger the investment which authorities make in their employees, the greater the need to husband these valuable assets by personnel policies which keep wastage to a minimum.

CHAPTER 9

CONCLUSION

109. There is every reason to believe that both the need for particular health services and the capacity to meet health needs will change rapidly during the next few decades. No one can predict what precise technological advances in medicine will come in the future. It is, however, essential that any new structure of the National Health Service should be capable of rapid change and that the system of organisation should encourage experiment of every kind. The Government's proposals for integrated and decentralised services are designed to provide the flexibility for each local area to respond to change and adapt its services to meet it.

NOTE:

In his Foreword to this Green Paper, the Secretary of State for Social Services invites comments and suggestions on the proposals made in it. These should be sent to the Department of Health and Social Security, Alexander Fleming House, London, S.E.1, not later than the end of May, 1970.

APPENDIX I

ARRANGEMENTS FOR LONDON

1. The concentration of population, the location of the major hospitals, the complexity of communications and the smaller geographical size of some of the London boroughs as compared with unitary and metropolitan district authorities in other parts of England, make it desirable to group the areas of the London boroughs into a smaller number of health areas. An appropriate arrangement might be to establish 5 health areas in Inner London (excluding Greenwich) and 10 to 12 in the rest of London. Each of these would comprise the areas of one, two or three London boroughs.

2. The areas provisionally suggested for the new health authorities in Inner London, which would contain all the present London undergraduate teaching hospitals, are as follows:—

A Hackney
Tower Hamlets
City of London

B Camden
Islington

C Westminster
Kensington & Chelsea
Hammersmith

D Wandsworth
Lambeth

E Southwark
Lewisham

3. The remaining London boroughs might be grouped in 11 areas, as follows:—

F Greenwich
Bexley

G Bromley

H Croydon

I Sutton
Merton

J Hounslow
Richmond upon Thames
Kingston upon Thames

K Ealing
Hillingdon

L Harrow
Brent

M Barnet

N Enfield
Haringey

O Waltham Forest
Newham

P Redbridge
Barking
Havering

4. Whether the area health authorities in London should have district committees, each covering an area corresponding with that of a single borough, will need to be considered in consultation with the interests concerned.

5. Consultations on the recommendations of the Royal Commission on Medical Education are not yet concluded and it is not intended to reach any final decision on the administration of the postgraduate hospitals until the future pattern of postgraduate education in London has been more fully discussed.

APPENDIX II

OCCUPATIONAL HEALTH

1. At present, apart from works medical officers, various categories of doctor are engaged on work connected with employment. Medical Inspectors of Factories are concerned with the medical aspects of hazards arising in industry; Appointed Factory Doctors carry out the statutory medical examinations, which are required under the Factories Act and Regulations, of young persons and of persons engaged in hazardous trades; doctors are concerned with the medical supervision of persons attending Government Training Centres and Industrial Rehabilitation Units; and the Regional Medical Service of the Department of Health and Social Security carries out medical examinations of disabled persons with a view to advising on their fitness for employment. The establishment of the Employment Medical Advisory Service by the Department of Employment and Productivity will, however, bring together most of these at present unco-ordinated duties into a single organisation. The responsibilities of the new Service will include the work now done by Medical Inspectors of Factories and Appointed Factory Doctors together with that carried out in Government Training Centres and Industrial Rehabilitation Units. It will also be concerned with any medical problems which arise in connection with employment and as an expert service will be available to give advice and help to anyone needing it.

2. So far as the medical examination of young persons is concerned, the present routine examinations under the Factories Act will be replaced by a more selective system concentrating on those young persons in need of medical advice and based on the area health authority's programmes of medical supervision of school children. From this, the Employment Medical Advisory Service will develop procedures for looking after the health of young persons in employment and giving advice to the Youth Employment Service.

3. It is intended that there should be close links between the local authority, the area health authority and the Employment Medical Advisory Service. Local authorities have certain enforcement duties under the Factories Act and the Offices, Shops and Railway Premises Act and it is clearly essential that both they and the area health authority should maintain close links with the services provided by the Employment Medical Advisory Service. Equally, that Service must work in close liaison with the personal health services to ensure that occupational factors are not lost sight of in treatment. The needs of the Employment Medical Advisory Service will be taken into account in the development of hospital laboratory and other specialist facilities.

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