

# Reorganization of the National Health Service: Background and Issues in England's Quest for a Comprehensive-Integrated Planning and Delivery System

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*The first major reorganization of the National Health Service since its founding in 1948 will take place on April 1, 1974. Three major objectives are involved: the consolidation of the tripartite structure into a single unified system, the strengthening of management processes, and the expansion of machinery for making health services more responsive to local needs. While generally supportive of the reorganization, this assessment of the changes in policy and structure identifies a number of constraints in the form of political realities and organizational-administrative capabilities which may limit the attainment of objectives. In particular, the bias in modern medicine for hospital-based specialization, the uneven power relationships among competing professional interests, and the continued separation of health from social services are seen as restricting policy aimed at altering the balance between primary, secondary, and tertiary levels of care and between curative and "carative" services.*

Since the pressures underlying the reorganization of the National Health Service (NHS) reflect the broad changes accompanying social and economic development, such as the aging of the population, the shift from acute to chronic patterns of illness, and the decline in the marginal social benefit of capital-intensive medical technology, England's experience may be relevant to other highly developed countries, both as a field laboratory for the elucidation of alternatives and as a case study of the complexities inherent in any attempt to carry out large-scale organizational change. With the possible exception of Sweden's, the reorganization represents the most ambitious attempt to institute comprehensive health services planning and integrated delivery among Western capitalist countries.

The main thrust of the reorganization, as this paper will explain, is the transformation of the NHS from a conglomerate of services, which although publicly financed are organizationally and

administratively separate, into a unified and comprehensive whole for purposes of more rationalized planning and delivery. Though less clearly and less consistently articulated in the discussions leading up to the reorganization, there are at least two other important objectives: to make the bureaucratic apparatus more responsive to centralized policy guidelines through the means of monitoring and evaluation; and to increase the responsiveness of health services to local needs through the means of decentralized planning and consumer-advisory and complaint machinery.

In point of fact, there will be four separate and slightly different health services—in England, Wales, Scotland, and Northern Ireland. The Welsh have succeeded as their non-English colleagues had done previously in obtaining a measure of home rule. The changes described herein pertain to health services in England, although the general pattern followed in each instance is much the same. A notable difference is that because the territorial-population dimensions are considerably smaller, none of the others will have a regional tier as in England. Another difference is that, in Northern Ireland, health and social services will be combined into a single entity rather than coordinated on the basis of separate but coterminous service areas.

The purpose of this paper is threefold: (1) to identify some of the larger social, economic, and political pressures underlying the reorganization; (2) to describe the salient features of the new structure; and (3) to discuss selected unresolved problems and issues which may have a bearing on future developments.

## Background to Reorganization

Since its inception, the NHS has provided the patient with access to health care irrespective of ability to pay at the point of consumption which is still outside the range of most other Western countries. This was made possible by a system of public finance which obtains its funds overwhelmingly from general taxation which still provides about 85 percent of the total cost, with approximately 10 percent supplementation from social insurance payments (a relic of the more limited 1911 national health insurance scheme for blue-collar workers which was retained with a true British sense of pragmatism and tradition), and the remaining 5 percent

supplied from a number of user charges, of which those on non-essential drugs are most important. The comprehensive feature of the service as viewed from the patient was, however, not reflected in a unified structure.

In the main, the original NHS structure was a "hospital-based specialists' service." Indeed, the cardinal feature of the NHS as originally conceived was the predominant role accorded to both hospitals and specialists—as evidenced by the substantial freedom granted to the specialists and the large share of resources made available to hospitals. Along with the compromises necessitated by the political exigencies of the situation, this decision was a manifestation of the deep faith then prevalent in the power of medical science and the superior efficacy of technologically intensive treatment methods. For the most part, the hospital was perceived as the hub of the modern medical care world and public policy was fixed on the diffusion of methods emanating from the medical schools and teaching hospitals, which were looked upon as the exemplars of high-quality care and the fountainheads of valued innovation. A clear expression of this sentiment is found in the special status given under the original legislation to the teaching hospitals which, governed by their own thirty-six boards of governors, had direct access to the Ministry of Health, and in addition were (unlike other hospitals where such matters were controlled by regional hospital bodies) free to appoint their senior medical staff and to retain undisputed rights over their endowments.

It is true that general-practitioner services were also included in the NHS and considerably expanded in relation to what existed under the national health insurance scheme passed in 1911 by the bringing in of dental care, ophthalmic services, and, in particular, pharmaceuticals. Otherwise, however, the NHS left the organization of general-practitioner service pretty much undisturbed under the aegis of 140 executive councils. The councils (a carry-over of the fiscal intermediary agencies which functioned in the pre-1948 national health insurance program) formed a protective buffer between the practitioners and the government in carrying out their assigned role as agents for the administration of the contracts of individual practitioners, whose self-employment status was kept intact along with traditionally preferred modes of capitation reimbursement and organization of practice in single-handed

and small-sized partnership settings. One must recall that in the context of the prevailing conventional wisdom, general practice was reaching its nadir in that, to paraphrase a common expression circulating in Britain in the 1950s: "a general practitioner is nothing more than a failed specialist!"

Insofar as those services are concerned which have since become known as community care (i.e., preventive services, domiciliary care, and personal social services), they were at the time fairly underdeveloped, sporadic, and subject to considerable variation in availability and quality. They had been historically in the hands of local government and voluntary organizations, and the NHS left them as it found them, apart from providing a sounder financial base through means of special grants which led central government to eventually pay for 50 percent or more of the costs. The public health and ambulance services were left with local government as compensation for the loss of municipal hospitals which were joined with voluntary hospitals to form a nationalized system, with hospitals reorganized into groups within regions in terms of a division of labor based on level and intensity of technical services provided. (For an unusually lucid account of the issues and events surrounding the development of the NHS, see Forsyth, 1966.)

The patchwork arrangements resulting from the separation of hospital, general-practitioner, and community services, soon became known as the tripartite system of administration. Although widely hailed as testimony to the political pragmatism which made possible the attainment of the then controversial egalitarian principle that people should receive health services according to need rather than their ability to pay, the tripartite structure impeded effective planning and coordination of services and contributed to serious imbalances in priority setting and resource allocation.

### *Limitations of the Tripartite Structure*

Unlike the regionalized hospital service which was in principle subject to central control, there was little the Minister of Health could do to directly affect either general practitioners who retained the status of independent contractors or community services which were the responsibility of roughly 150 units of local government, each jealously protective of its home-rule prerogatives. Because

the process of influence in these areas could only be established indirectly through use of financial incentives it was slow-moving in pace and uneven in results.

In practice, the powers of the Minister were also quite limited in the hospital service because of the weight of orthodox thinking and interlocking dependencies which favored technologically intensive hospital-based services for acute illness over the development of low-technology community-based primary services and the care, as distinct from cure, of the long-term chronically ill. Some measure of the bias inherent in the hospital services may be derived from the fact that although two-thirds of NHS activity is concerned with the care of the elderly, the mentally ill, and the mentally retarded, these services get only one-third of the resources. It has become a vicious circle, with bright young graduates refusing to enter specialities dealing with chronic illness because of their low status and undercapitalization. The poor working conditions and manpower shortages swell normal workloads, making it even more difficult to recruit staff. Even the introduction of special units in general hospitals has not always helped. Oftentimes these have only served to "cream off" the better and more easily treated patients, leaving the old mental hospitals to treat the most helpless cases. Another indication of the bias toward acute services may be found in the distribution of merit awards, a system of payments introduced at the start of the NHS to keep the medical specialists in the service. Amounting to about one-fifth of total payments to specialists, these awards are highly prized by recipients as a sign of their competence and as an important income supplement which permit top specialists to double their salaries. But whereas four out of five chest surgeons obtain merit payments, only one out of four geriatric or mental health specialists are so recognized.

The organization of hospital and general-practitioner services outside of the framework of local government compounded the weaknesses in the tripartite structure. By fragmenting authority among separate layers of government it exacerbated problems of coordination and further retarded the development of systemic planning whereby the interactions and spillover effects which actions taken in one sector create in other sectors of the health service might be taken into account, such as, for example, the consequences of running down general practice and community services

for hospital admissions and lengths of stay. The interconnectedness of the three sectors was driven home by several well-known studies (Ferguson and MacPhail, 1954; Forsyth and Logan, 1960) which showed that anywhere from 25 percent to 40 percent of hospital utilization was clinically unnecessary and that failure to coordinate the post-hospital care of discharged patients resulted in high re-admission rates and an undoing of the benefits of hospitalization.

One of the biggest fears on the part of voluntary hospitals and general practitioners at the time was that they might be placed under the control of local government, since the reasons for coordination and integration were well known to policy makers, even though the size of the statistical relationships remained to be pinned down. The resistance to local government was due mainly to the stigma of its Poor Law association and its reputation for impecuniosity, together with the fear of health professionals that democracy at the grass roots was too unpredictable and stifling to decision making by experts. What spokesman for the health interests, such as the B.M.A., wanted and succeeded in getting, was independence for hospitals and general practitioners from municipal authorities.

In addition to the obstacles it placed in the way of any attempt to cope with the problem of "unnecessary" hospital utilization, the decision to organize hospital and general-practitioner services outside of the framework of local government effectively isolated the health services from local influences and needs. Most of the planning which took place was centered in remote regional hospital boards removed from normal political checks—recently criticized by a former Minister of Health, Richard Crossman (*Manchester Guardian*, 1973a), as "the most autocratic, self-perpetuating oligarchies since the Persian Empire." Not only were the regional boards non-accountable to the communities on whose behalf they were planning, but they were independent in practice from the control of the Minister of Health, whose instructions they were prone to ignore in cases of disagreement, as illustrated by the unsuccessful attempts to redirect resources from acute hospitals to long-stay hospitals for the mentally ill, the mentally retarded, and for geriatric patients, despite repeated ministerial directives and mass-media disclosures calling public attention to outdated treatment methods and widespread neglect of patients. (For a synopsis of the problem see, for example, the *London Sunday Times*, 1973a.)

*Pressures for Change*

The planning and management difficulties arising from the tripartite structure soon became visible in the wake of three major developments once the NHS became operational: (1) the unexpected and very substantial rise in demand for health services; (2) the enormous increase in gross expenditure (from 455 million pounds to approximately 2,500 million pounds in twenty-five years' time); and (3) the gaps in continuous care and the smooth flow of patients from hospital to community as a result of the fragmented structure. Britain, with nearly 15 percent of her population elderly, was at the end of World War II quite unprepared, as were all other Western countries, for the impact which a changed population structure would make on health services. When applied to an aging population, the scientific and technological advances of modern medicine resulted in an unexpected rise in utilization and expenditures because of the increased prevalence and complexity of morbidity accompanying old age and the survival of the seriously ill for longer periods of time. Moreover, it was not generally conceded that the chronic-degenerative diseases accompanying economic development required the coordination of multiple specialists and the full panoply of facility and community-based care encompassing health and social services. Also, in concentrating on the development and dissemination of more sophisticated technologies, medical research and education remained indifferent, for the most part, to the spillover effects for the organization of services which had been established earlier in the century to accommodate acute-infectious diseases and simpler, inexpensive treatment methods which were more readily provided by a single practitioner and which did not require an elaborate planning and management structure. Finally, it was hard to acknowledge in the luster of advanced medical specialization and technology that many of the more common forms of disability today are largely unpreventable and often incurable by medical methods and hospitalization. The best hope for attacking leading health problems like heart disease, cancer, stroke, accidents, and mental-emotional disorders lies not so much in improved surgical techniques as in more mundane health education for altering behavior and in early detection activities among "at risk" individuals and population groups. The imperviousness of contemporary disease problems to

acute treatment methods and the approaching of natural limits in the biological life span reduces the potential of technology at a point in time in which it is becoming increasingly more expensive, as indicated by the escalation of hospital costs in all highly developed countries.

The British government has become increasingly troubled by the cost and efficiency of the NHS. It does happen that the proportion of GNP going to health and the average annual rate of increase in health spending are lower in Britain than in other developed Western countries, but there is nevertheless the same general concern over rising costs and, in particular, that too high a proportion of total health expenditure may be going to expensive hospital services unnecessarily. Much of this concern is no doubt due to the amount of the total government budget going to support health services which at 16 percent is higher than that of such other welfare states as Sweden and Holland, where the figure is about 12 percent (Simansis, 1973). Because of the heavier dependence on centralized government finance health spending takes on a bigger importance in the management of the national economy in Britain than in other countries.

The steep rise in the cost of hospital care, which now absorbs 60 percent of health expenditures in Britain, led the government to look for less costly alternatives. This soon brought to the forefront the idea that home care, or at least care in less expensive settings, could provide care equally good as that provided in higher-cost acute general hospitals, which so far have been the keystone of the NHS. Similar considerations were sparked off by the needs of the mentally ill for whom Britain still supplies about 40 percent of its hospital beds, and the failure of treating the mentally retarded properly in the old-fashioned colonies now renamed hospitals. In an attempt to galvanize health professionals to rechannel their efforts and to underscore its own commitment to reallocating resource support the government recently has labeled these services the "Cinderella Services." It also established in 1970 a special investigatory body (the Hospital Advisory Service) staffed by multidisciplinary teams of health professionals to carry out random checks to spotlight problems in long-stay hospitals and to review the progress of individual institutions in correcting deficiencies.

The cumulative effect of economic pressures and gaps in patient care associated with the priority given to high-technology



medicine engendered gradually a re-evaluation of the role of the hospital and acute treatment services which made policy makers more aware of the problems arising from a grossly uneven allocation of resources. It was concluded that a wholesale reform of the NHS structure was necessary for bringing together the tripartite-fragmented services into a single organization which would permit a rectification of the present imbalances in favor of the acute services to the "underdeveloped" parts of health care—the elderly, the chronic sick, the mentally ill, and the mentally retarded. Only in a unified structure, it is generally believed, would it be possible to carry out balanced planning and to reallocate resources in a way to transform the NHS from a narrow-focused illness-treatment service to one with a broader focus on health maintenance and the management of chronic-degenerative disease conditions predominant in the population.

It must, of course, be realized that attempts were made to deal with these shortcomings within the existing framework. The British are well known for their ability to surmount administrative hurdles by commonsense action! Thus, for example, in spite of the formal split between general practitioners and home care, more and more public health nurses (in Britain called district nurses) began to work closely with general practitioners so that hospital surgical patients could be quickly discharged. (Nurses and social workers employed by local government are assigned to work with general practitioners requesting such assistance, free of charge.) It has become fairly common practice for such nurses, looking after discharged patients in the home, to carry out procedures like removal of sutures, especially in the case of varicose veins and hernia operations. Of far greater importance is the movement of general practitioners from single-handed to group practices and the increased use of the health center as the operational unit for primary health care (a central-government-subsidized local-government facility coordinating the services of independent general practitioners' tenants with those of attached public health nurses and social workers as described above). In 1971, there were 3,200 group practices covering 11,000 out of a national total of 20,000 general practitioners. In the last twenty years the number of general practitioners in solo practice has been reduced by 50 percent; and in 1972, about 80 percent of general practitioners were practicing in groups with an average membership of three

(Great Britain, Department of Health and Social Security, 1972b). Though initially off to a slow start, the number of health centers has increased dramatically from 28 in 1965 to 350 in 1972, with another 100 in the pipeline scheduled for completion by the end of 1974. The growth is due to bigger grants to local government for new construction and incentives to general practitioners to locate in the facilities (e.g., reimbursement of rent and repayment of 70 percent of salaries for administrative and clerical help). It's estimated that about 10 to 15 percent of general practitioners are now working out of health centers (Great Britain, Department of Health and Social Security, 1972a). These developments, supported by a financial improvement in the average income of the general practitioner based on the so-called General Practitioner Charter of 1967, have revived interest in general practice among patients and medical students. Impressive as these developments have been in relation to the formidable barriers to centralized direction, planning remained piecemeal and fragmentary. The tripartite structure mitigated against comprehensive approaches capable of dealing more satisfactorily with the interdependencies among hospital, general-practitioner, and community services.

### *The Timing of Change*

Although the limitations in the tripartite structure were apparent to policy makers from the start, reorganization was not thought to be politically feasible previously because of (1) the resistance within the health field to changing concepts of delivery of patient care; (2) the underdeveloped state of essential support services like the personal social services, which in addition to suffering from low status were widely scattered in a number of authorities and administrative jurisdictions; and (3) the non-viability of small-sized units of local government which possessed too limited an economic base to support essential services and whose boundaries failed to match those of health services for purposes of planning, administration, and accountability. The general attitude among the policy makers and politicians was that there was no point in undertaking any large-scale change foredoomed to failure because the timing was not right.

The first sign that events had evolved to the point where change might be practicable came, interestingly enough, from the British Medical Association in 1962, when it released an unofficial

report which stated that the only way to assure comprehensive-integrated patient care was to bring all the health services together at the community level (Poritt Report, 1962). Another sign that the time for reorganization was approaching came from the decision to streamline and modernize local government. Following completion of a four-year study begun in 1966, the decision was taken to consolidate local government from over a thousand units into fewer than one hundred major bodies (Great Britain, 1971b). Beginning in 1974, when the change is scheduled to take effect, local government will have exclusive responsibility for personal social services. To strengthen local government's ability to follow through, previously dispersed social services have already been brought together in 1971 into a single department of social services. The responsibilities of the newly created departments of social services include medical social work services formerly provided by the NHS (Great Britain, 1970).

The first official proposal for the unification of the NHS came in 1968 with the publication of the first of two Green Papers (parliamentary parlance for a discussion document outlining tentative plans) by the Labour government (Great Britain, Ministry of Health, 1968; Great Britain, Department of Health and Social Security, 1970). Following its election to office in 1970, the Conservative government carried forward the deliberations with the publication of a consultative document in 1971, outlining its own tentative plans, closely paralleling those of the Labour government (Great Britain, Department of Health and Social Security, 1971). These documents, together with a White Paper (a paper laying out the government's final legislative plans) and a so-called Grey Book published in September, 1972, detailing the management arrangements, constitute the terms of reference for the reorganization (Great Britain, Department of Health and Social Security, 1971; Great Britain, Department of Health and Social Security, 1972b). The final bill was submitted to Parliament in November, 1972, and signed into law on July 5, 1973—the very day on which the NHS had been founded twenty-five years earlier (England, House of Lords, 1972). Thus the reorganization has been in the making anywhere from five to ten years, depending on where one chooses to fix the starting time—an ample period for assuring its acceptance, if not active support, by the public and the health professions.

## Reorganization Highlights

The management dictum of maximum delegation downward and maximum accountability upward is the guidepost of the reorganization. Approved plans originating at the bottommost level and proceeding upward in the organizational hierarchy are the chief instrument for accountability enabling the Secretary of State for Health and Social Security to comply with his constitutional responsibilities to Parliament. (Unlike the U.S. system, where cabinet appointees are not required to be members of Congress, the appointment of ministers is restricted to active members of Parliament.) In the last resort, the Secretary's will must prevail and he has the right to give direction to the lower tiers. In general, however, it is assumed, in keeping with British precedents and practice, that these will remain "reserved powers" to be used in the last resort and sparingly. In fact, similar powers already exist but only on the hospital side, and no use has been made of them as suggested previously.

Health services will not be merged with local government, to the disappointment of advocates of democratic participation and more generic approaches to social planning, who felt the time was ripe to do so in the wake of the consolidation of local government which rendered invalid such previous arguments against integration as the noncomparability of administrative boundaries. Both major political parties have decided against bringing health within the fold of local government for several reasons. First, opposition to the idea remains strong among hospitals and organized medicine whose support and cooperation is vital to the smooth functioning of the health service. And second, local government will not have the fiscal capability to support health services despite consolidation (the budget for health services exceeds the total costs of local government operations). The Labour and Conservative parties each maintain that unless local government is prepared to share substantially in paying the costs it cannot be expected to maintain responsibility for what is spent. The absence of fiscal responsibility would only diffuse accountability and complicate management. Instead, a compromise has been worked out in which the day-to-day delivery and planning machinery of the NHS will be coterminous with but separate from local government.

### *Rationalized Bureaucracy*

The reorganization will do away with all of the features of the old structure in preference for a more simplified bureaucracy. Many familiar features such as regional hospital boards, boards of governors, hospital management committees, and local executive councils will be terminated and local government will give up their NHS public health and school health responsibilities. The new structure will consist of four tiers: the Department of Health and Social Security, regional health authorities, area health authorities, and districts. There will be close to a three-fourths reduction in the number of organizational units which should contribute materially to more effective administration and help make the NHS bureaucracy more accountable to central authority.

In 1968 the Ministry of Health was combined with the Ministry of National Insurance to form a superdepartment, the Department of Health and Social Security (DHSS), permitting more effective coordination of finance and service delivery. The DHSS will be responsible mainly for the determination of national objectives, priorities standards, and allocation of resources to regional authorities.

The regional tier will consist of fourteen regional bodies ranging in size from one to five million population. Their chief responsibilities will be planning, monitoring, and evaluation of services provided at lower levels. Regional health authorities (RHAs) will also be in charge of allocating centrally determined funds to area health authorities and monitoring their performance (including the effectiveness of their links with the matching local-government authorities). The RHAs will themselves provide services which require economies of scale such as blood banks, computers, operations-research capabilities, and the servicing of medical education and research. They will also carry out all major construction projects for hospitals and related facilities.

The area health authorities (AHAs) comprise the lowest statutory authority with full planning and operational responsibilities. The number of AHAs within each region will vary from one to eleven (all but four regions will have three or more AHAs). There will be a total of ninety AHAs ranging in size from one-quarter million to one and one-half million inhabitants. Their

boundaries will be coterminous with those of local government which as described will itself be reorganized simultaneously with the NHS. To assure coordination with social services and such other relevant local government bodies as housing and education, each AHA is required to establish a joint consultative committee, staffed by officers from health and local government authorities. The primary responsibilities of the AHAs center on the detailed planning and administration of comprehensive health services to meet the needs of the population in their jurisdictions.

The larger AHAs will be divided into districts. In complying with the primary aim of reorganization to achieve integration at the point where services and people meet, the district comprises the fundamental work unit for planning and delivery for the full scope of primary and secondary services (i.e., hospital, general-practitioner, and community-care services). The integration of services at this level are the building blocks on which higher levels of organization are based. In total there will be about 200 districts. Though the details remain to be worked out, it appears that of the 90 AHAs, 34 (more than one-third) will have 3 districts and 15 will have more than 3 districts. The population serviced by each district will be based on the service area of the district general hospital—approximately 250,000.

A typical district will spend about 8 million pounds a year (approximately 20 million U.S. dollars). It will have a district general hospital of from 600 to 1,000 beds, depending on the size of the service area, and will be staffed to provide a full range of primary and secondary services including the active treatment of the mentally ill and geriatrics. (Low-volume high-cost tertiary services like neurology and organ transplantation will not be staffed in each district but organized on a larger scale to assure full employment of resources and low unit cost.) There may also be three to four 100-bed community hospitals, each of which will provide a mixture of extended-care and minimal-care units. The plans are for general-practitioner and community care services to be delivered out of 500 health centers (an increase of about 100 in the number of centers currently available or under construction), staffed by up to 12 doctors working on a group practice arrangement, and supported by nursing and social work professionals. A typical district will employ between 2,500 and 3,000 health personnel of all grades (e.g., perhaps about 100 hospital

doctors, 100 general practitioners, 1,000 hospital nurses, 150 community nurses, 1,000 ancillary staff, etc.).

### *Operational Policy Responsibility*

The historical practice in the voluntary health services of placing corporate power and responsibility in the hands of unpaid, part-time, voluntary lay boards, which was preserved by the NHS in the hospital service, will be continued and extended to all statutory regional and local authorities in the reorganization. The number of lay persons involved, however, will be cut back sharply by about two-thirds. In keeping with a straight line of command, the Secretary of State will appoint the members of the RHAs and the chairmen of the AHAs. In the selection of appointees, generalists will be favored who are managerially oriented and strong enough in status and experience to stand up to health professionals. They will take the policy decisions at their respective levels but leave the details of administration to teams of officers whom they can appoint and dismiss. There are, however, some exceptions to this general rule. First, the government gave way to those who complained that the new structure would be dominated by managerialists with little responsiveness to or awareness of local needs and consumer values. Provision has been made therefore for the appointment of four members to the area health authorities on the nomination of local governments, who, while not officially representing local government, will nevertheless have a local-government point of view. Second, as was the situation at the time of the founding of the NHS, the health professions expressed considerable dismay at the prospect of being dominated by lay persons unfamiliar with the specialized needs of medicine and health care. Consequently, it was agreed that of the fifteen members of the area health authority, there must always be at least one doctor of medicine and at least one nurse or midwife. The likelihood is that further compromises will have to be made to accommodate the desires of other health-occupational groups for representation.

### *Management and Planning Responsibility*

Possibly the most innovative feature of the reorganization is the accommodation of conventional hierarchical-authoritarian principles of management to (1) the emerging team concept of decision making, and (2) the growing recognition of the need to involve

clinicians in management if objectives of cost containment and program effectiveness are to be achieved. How one accomplishes these innovations in a field as pluralistic and divided as health, with its rigidly stratified occupational systems, intense service rivalries, public-private sector partitions, and strong traditional sentiment for solo entrepreneurial medical practice, surely must rank among the most complex problems in the subject of organizational theory today. The unusually large proportion of high-status professionals in the health labor force who are accustomed to a great deal of freedom in their work, because of manpower shortages, prolonged training and certification requirements, and the attachment of primary individual loyalty to powerful, self-regulating, external professional associations, presents another unusual complication. Given the complexities, the single hierarchy controlled by a chief executive favored by industry and business seems inappropriate. The reorganization plan employs a more promising alternative based (1) on unified management within the hierarchically organized professions like nursing, public health, and administration; (2) on representative systems within the non-hierarchically organized medical and dental professions; and (3) on coordination between professions. The solution advanced for coordinating the activities of separate professional groups within each level of authority is the multidisciplinary team (an extension of the practice followed in the regional hospital boards in the old structure) with members organized as equals and decisions arrived at by consensus, with decisions passing upward in event of conflict. To optimize orderly decision making, the size of teams will be limited to a half-dozen or fewer individuals whose unanimous agreement is essential to the making and effective implementation of decisions for the totality of health care. In addition to being collectively responsible to their respective level of authority, each management team member will be accountable individually for the performance of specific functions in his professional area.

At the regional and area levels the composition of the managerial team is the same (a medical officer, a nursing officer, a treasurer, and an administrator), except that the regional team will also include a works officer because of its responsibility for capital construction and improvements. Within the districts, where the actual integration of delivery and planning is to occur, day-to-day coordination will be provided by a multiprofessional team made up of a community physician, a district nurse, a chief



administrator, a finance officer, and two clinicians (a general practitioner and a hospital-based specialist) elected by their peers. Each district management team will also be responsible for the appointment of permanent and/or ad hoc multidisciplinary teams to concentrate on planning services to meet the needs of special population groups (e.g., the elderly, mentally ill, mentally retarded, physically disabled, and children, etc.), or to carry out special studies for improving the efficiency and quality of existing patterns of care whether in the community or in hospital (e.g., review of primary-care services, introduction of halfway houses, reorganization of outpatients' departments, and review of services for alcoholics and drug addicts). The composition of the health care planning teams will need to be adjusted to fit the situation, but there will probably have to be representation of general practitioners, hospital and community nurses, home visitors, and representatives of local government services, especially social-service departments.

The reorganization plan acknowledges that the first duty of a clinician is to practice clinical medicine, but it also recognizes that doctors are responsible for up to 80 percent of all the expenditures for health care; in addition to the services provided directly, they control hospital and pharmaceutical utilization. Clinicians not only consume scarce resources but are important innovators whose ideas must be picked up by management if they are to have an impact in the organization. If health organizations cannot survive without the expertise of the clinician, neither can the clinician survive without the supportive structure of the organization—the two must be brought together in a symbiosis. The agency designated to carry out the symbiosis is expected to be the district medical committee (DMC), a group of one dozen general practitioners and hospital specialists, who, in addition to electing two clinicians to the district management team, will use their prestige to persuade colleagues in hospitals and general practice to support priorities determined by the district management. In order to encourage the formation of DMCs, details have deliberately been left vague by the government so as to allow maximum flexibility at the grass roots.

### *The Teaching Hospital*

In the wake of mounting criticism that teaching hospitals have become overly isolated islands committed to the pursuit of esoteric research and treatment, to the neglect of more common but wide-

spread day-to-day problems of community health, the government has acted to incorporate them into the delivery system at area and district levels. Teaching hospitals will no longer have a direct line to the Secretary of State. After having been on top for so long, the teaching hospitals are very worried that they might wind up being downgraded in budgetary matters by the renaissance of community health and primary care. Another worry is the prospect of having their beds filled with a large number of geriatric and other chronic cases which offer uninteresting research and teaching material. To allay some of these fears and to assure that standards of excellence carefully built up in the past will not be compromised, the government has granted the teaching hospitals a number of special privileges. First, area health authorities containing a teaching hospital will bear a special designation, AHA(T), and their membership will be modified to provide for an extra medical school representative and an additional member with teaching hospital experience. Second, unlike non-teaching hospitals where senior medical appointments are made by the regional health authorities, AHA(Ts) will have the power to appoint their own specialists along with junior hospital medical staff. Finally, although their budgets will flow through the regional authorities like everybody else's, the Secretary of State has agreed for the first five years to earmark funds for teaching hospitals' use to assure that teaching and research interests are not overlooked. These concessions notwithstanding, the direction and the magnitude of the changes appear structured to assure that teaching hospitals will, to a greater extent than previously, consider the impact of their decisions for health services delivery as a whole and take on greater responsibility for the care and treatment of the chronically ill.

### *The Role of the Public Health Officer*

The vast changes in medicine and health problems which have outdated most communicable disease and environmental control functions—in company with the transfer of many traditional public health department responsibilities to social service departments—have raised questions about the future of the public health officer role. The reorganization suggests a new mission for the public health officer and the job has been renamed the community physician. There is still some confusion over what the term implies but

the community physician has been identified as the principal agent for the planning, monitoring, and evaluation of the effectiveness of health programs (Great Britain, Department of Health and Social Security, 1972d).<sup>1</sup> It is also suggested that the community physician might be especially suited for administration in the new structure because of a medical background which could aid in enlisting the cooperation and respect of other medical and health professionals. The scope proclaimed is quite broad and the role forecast for the community physician may be too diffuse to be performed successfully. Apart from the problem of retraining personnel who because of age and lengthy experience may be resistant or slow to pick up new ideas, the curricula of training programs in schools of hygiene and medicine are possibly too isolated from the technical content found in schools of management and other academic departments (planning, sociology, etc.) to disseminate the essential skills.

### *Consumer Participation*

Despite heavy criticism for stressing management efficiency at the expense of democratic process, the government has taken the position that it recognizes the value of consumer input but believes in the need to separate participation and management if confusion and paralysis in decision making are to be avoided.

The consumer's voice will be expressed by community health councils (CHCs) which will be established within each district. They will consist of from twenty to thirty members, with half of them appointed by local government and the remainder on the nomination of voluntary community agencies. The councils will elect their own chairman and have powers of access to information and reports, visits to hospitals and other facilities, and consultation with senior AHA officers. AHA officers will be required to be in constant touch with CHCs and to convene at least one full meeting a year of all the councils in their area. The councils will be provided staff by the area authority for the preparation of reports

<sup>1</sup> A similar shift in orientation and function in the United States may have been foreshadowed by the strong role which the Association of State and Territorial Health Officers played in getting the Comprehensive Health Planning Program started, and more recently by the decision in Washington to terminate federal support for schools of public health on the grounds that they have outlived their usefulness.

which the AHAs are required to publish along with a statement of action taken on all issues and complaints raised. In a closely related move, the government has introduced an ombudsman into the service, known as the health services commissioner. His job will be to deal with complaints of individuals involving non-clinical matters, such as excessive waiting times for hospital appointments, bad food, and failure of ambulances to arrive to time. The advantages claimed for the ombudsman are impartial review of claimed injustices and the facilitation of inexpensive remedial action.

## Problems and Issues

Reorganization is not generally thought to be a cure-all. Indeed some critics have attacked the reorganization for ignoring a number of long-standing issues such as the existence of private practice in the NHS and lengthy waiting lines for hospital admission for non-urgent care. Especially upsetting is the growth in commercial firms specializing in supplying for a fee nurses and doctors to fill in the staffing cracks in the NHS. Rental-agency nurses are commonly used to staff vacancies in hospitals, and doctors (mostly junior hospital doctors seeking to supplement modest incomes) are used to step in during evenings and weekends for general practitioners under contract with the NHS to provide twenty-four-hour service. What the general practitioners pay to the agencies is often less than the out-of-hours payment they themselves receive from the NHS. The low cost of the service together with the attraction of having evenings and weekends off reportedly had led up to 70 percent of urban general practitioners to subcontract at least part of their work this way (London Sunday Times, 1973b). The problem with this arrangement is that the controls over the qualifications of part-time nurses are poor and the part-time doctors are not only frequently exhausted by holding down two jobs but unfamiliar with vital details concerning patients' medical histories. Related criticisms deal with the continuation of private-practice privileges for NHS hospital specialists and the retention of patient charges for pharmaceuticals and other services, including family-planning supplies, which will be added soon to the NHS benefit structure. (In April, 1973, the Labour Party acted to end its

lengthy policy of ambivalent toleration and declared its intention to separate all forms of private practice from the NHS once elected to office.)

While pointing to real and important problems, the appropriateness of the above line of criticism appears questionable since the thrust of the reorganization does not extend to finance and benefit structure but concentrates on matters of management and planning. There are, however, a number of other issues which clearly are consistent with the aims of the reorganization and which deal with the suitability of the means established for their attainment.

### *Completeness of Unification*

Taken in the context of the policy declarations for a unified health service, the decision to separate occupational health from other personal health services seems inconsistent. However, both major political parties agreed that occupational health should be retained by the Department of Employment on the grounds that the job and work-safety aspects are more important than the health aspects—a decision opposite to that in the case of school health services, which were transferred to health authorities from local government. Potentially far more disturbing to many critics is the preservation of the status quo in the organization of the general medical services—a situation widely interpreted as reflecting the residual political strength of the general practitioners and desire on the government's part to avoid a confrontation. The old executive council functions will be taken over by newly created family-practitioner committees (FPCs). Family-practitioner committees will be established in each area health authority. They will consist of thirty members, with half appointed by the professions. Amid outcries that the preservation of the independent-contractor status of general practitioners and establishment of the FPCs represents nothing more than the transformation of the NHS from a tripartite to a bipartite structure, the government did change things somewhat in that responsibility for the planning of the location of doctors' practices and health centers was transferred from the old executive councils to the area health authorities rather than to the newly formed family-practitioner committees. Otherwise, things will remain pretty much the same. Incentives in the form of rent subsidies, partial reimbursement of salaries for clerical help, and

the attachment of freely provided community nurses and social workers will remain the chief devices for getting doctors to move into groups and health centers. (Though free community nurses and social workers are available for patient visits in other types of practice, only in health centers are they assigned to work in the same office as general practitioners, thereby contributing to more efficient organization.)

The continuation of independent-contractor status may, however, be a less serious impediment to integration than it appears. In practice it may affect only the way in which practitioners are paid and not interfere with the planning of general practitioners' and related services, whether in terms of the output of professional school graduates going into primary care or the supply and distribution of health centers. With a stepped-up program of incentives most knowledgeable observers expect that the 10 to 15 percent of general practitioners who have already opted to locate their practices in health centers can be doubled or better by the end of the decade.

### *Feasibility of Integrated Planning*

The integration of planning across hospital, general-practitioner, and community sectors is, as mentioned earlier, the chief element in the government's strategy for making health services more responsive to the comprehensive needs of patients and for the reallocation of resources from hospitals to less costly community-care alternatives. And the decentralization of responsibility for planning to service areas coterminous with local government is the pragmatic solution put forward for making centrally determined policies and programs more adaptable to local needs and preferences, while assuring stronger and more effective accountability upward. Decentralization is also viewed as a mechanism for enabling professional and community interests to participate in planning and to be consulted about key decisions, thereby helping to offset the impersonalization due to growth of scale in organization and increased concentration of powers in the office of the Secretary of State for Health and Social Security.

Even though there do not appear to be any insurmountable obstacles in the way, it may require a decade or longer before the comprehensive-integrated planning machinery can be implemented

fully. Independent of the lead time required to establish information and reporting systems which have to be developed pretty much from scratch, there are a number of thorny cost and technical problems involving the choice of morbidity measures (utilization records, household interviews, and medical examinations) which will require time to resolve. Further difficulties arise from the lack of uniformity between health and social-service administrative units at the interface between services and people. The failure to match the boundaries of health and social services at the district level is bound to make coordination troublesome, as will the division of responsibility within local government for education, housing, and social services. While education and social services will become a function of the counties which will emerge as the main unit in the reorganization of local government, housing will remain in the hands of county subdivisions (local government districts), which have a smaller and separate tax base.

Once the system is in operation, plans will be prepared in accordance with an annual planning cycle which will result in the production and approval annually of comprehensive plans for health services at, successively, district, area, and regional levels. The plans are expected to look ten years ahead in outline and up to four years in greater detail; and to incorporate separate but compatible plans for all services and important resource requirements—notably capital and current expenditure and manpower. In the interim, multidisciplinary planning teams will be encouraged to reconsider priorities and resource-allocation patterns within districts by guidelines, issued by the Department of Health and Social Security, which will contain a statistical profile of relevant socioeconomic and demographic data along with comparisons of service and utilization characteristics for comparable localities. The planning teams will be instructed to set targets and to state how they expect objectives will improve the overall effectiveness of programs and alter the health status of populations. They will also be asked to indicate the implications of their proposals for other services along with the changes in resources needed to implement the proposals. These interim measures will be introduced gradually over a three- to four-year period, and will undoubtedly contribute a great deal to setting the stage for more sophisticated planning, monitoring, and program evaluation in future years. The

planning arrangements are described in detail in a circular (Great Britain, Department of Health and Social Security, 1973), "Planning Systems for the Reorganized National Health Service."

### *Barriers to Integrated Delivery*

Unlike planning which is a more abstract and hence less directly threatening activity, the future of integrated delivery appears less optimistic because of the potential for conflict arising from any attempt to alter relationships at the level of day-to-day practice. The deeply ingrained habit of doctors for independent action will most certainly create problems. Along with the general practitioners whose private-contract status remains unchanged, it will not be easy to get the support of hospital specialists who, because of their high status and traditional freedom for unilateral action in hospital affairs, are pretty much used to having things their own way. In the light of the long-standing rivalries between hospital and non-hospital practitioners, getting the two groups to work together harmoniously will not be easy either.

While it has become commonplace to advocate bringing general practitioners' and specialists' services closer together, the advisability of such a policy is questionable. Contrary to the teachings of management and planning theory which support the complete integration of all services within a single comprehensive system, separation of primary and hospital services may in reality be more of an asset than a liability.

Given the opportunity, it is possible that general practitioners may abandon many of their present functions, which are necessary for meeting the day-to-day health care needs of individuals and families but adjudged marginal on the prestige scale of scientific and technological medicine, thereby compounding current problems in the adequacy of primary-care services and the escalation of health services inflation and spending.

The transformation of general practice from a low-technology, emotional-supportive, diagnostic-referral service to a more scientific and technologically intensive treatment orientation might be welcomed, if not encouraged, by hospitals which are distressed about the implications of the new emphasis on community health for their future financing. Indeed, one can discern some undercurrent fear among non-hospital interests that integration may provide hospitals and specialists in the treatment of acute illness



with an opportunity to expand and solidify their hegemony over the rest of the health field. A take-over by technologically intensive medicine would be relatively easy given the long-standing inferiority complex of general practitioners which could cause them to jump at any opportunity to work in hospitals and expensively equipped diagnostic centers on a par with more prestigious medical specialists. In addition to the problem of low status, one detects that more and more general practitioners are beginning to feel that the price for maintaining their independent-contractor status and preferred mode of capitation payment may have been too high. In contrast to the longer hours and more demanding patient loads characterizing their workday which have made general practitioners the workhorses of the NHS (the average practitioner cares for 2,500 patients), salaried hospital-based specialists appear to be getting far more for less work. The proliferation of this attitude could lessen opposition toward corporate modes of practice and result in a blurring of the distinction between general practice and the medical specialties, especially in access to costly, status-conferring technology. Conceivably, it could also lower general-practitioner productivity if salary was substituted for capitation payment. The strong desire on the part of general practitioners to emulate their hospital colleagues is manifest in the recent emergence of general practice as a separate specialty and the nascent trend among medical schools to establish full professional chairs of general practice, first begun at the University of Manchester in 1970 following a precedent established in Scotland.

General practice is surely the pivot in any attempt to redistribute resources from hospitals and must stand committed to low-technology out-of-hospital services if reorganization is to succeed in its objectives. It may, however, require a period of special treatment and reassurance if it is to succeed in this role, because of the mixture of idealism and self-interest behind the reassessment of general practice now going on in the medical community. The decision to exclude general practitioners from hospitals at the time the NHS was first established, though previously lauded as an important contribution to raising the quality of care, is now widely seen in retrospect as a mistake. There is considerable interest in medical circles in restoring hospital privileges to general practitioners, together with upgrading the technology at their disposal for diagnostic purposes. The idea is to move the general practitioner

further into the mainstream of scientific and clinical medicine and to de-emphasize emotional-supportive and counseling services for sick individuals and their families as well as distasteful responsibility for the certification of illness and control of access to hospitals through the exercise of powers of referral.

While developments such as the above can do a great deal to raise confidence in general practice, the danger is, of course, that in the absence of appropriate safeguards, general practice might cease to provide countervailance useful for keeping high-technology medicine in check and become more hospital-oriented, contrary to the thrust of public policy. Since from one-half to two-thirds of all the cases seen by general practitioners are of minor severity and only 5 to 10 percent are estimated to require referral, it has been suggested (Fry, 1970:79) that a major task of general practice is to protect hospitals and specialists from conditions which can be treated equally if not more effectively in less expensive alternative settings. In addition to the economic consequences, the quality-of-care implications need to be kept in mind in terms of (1) the emotional-supportive and other technologically non-intensive medical needs intrinsic to primary care and the care of the chronically ill; (2) the further fragmentation of medical care as a result of increased specialization; and (3) the questionable efficacy and even safety of uncontrolled diffusion of high-powered medical techniques, as spelled out by A. L. Cochrane (1972).

The dangers to any attempted renaissance of primary and community care are exacerbated by a leadership structure in medical education and practice which is geared primarily to an expansion of sophisticated research and specialization. Strategies for minimizing the risk of general practice being captured by high-technology medicine might well include the possibility of creating a new generation of medical schools funded and staffed to deal with primary care exclusively. It is well known in administration that one of the more effective ways to kill off a new or threatening program is to house it in a hostile or unsympathetic environment. Though it is true that the job of the medical schools is to prepare students to move into any branch of medicine and that specialty training is under the control of the teaching hospitals, the career aspirations of students in large part mirror the expectations of faculty members which typically assign a greater value to medical

specialization and research than to general practice and community medicine. Frustration over inability to qualify for or otherwise obtain prestigious specialist's status is widely recognized as a major factor in the emigration of doctors and the poor morale and sense of failure prevalent among general practitioners (Mechanic, 1972:193). The Royal Commission on Medical Education (Great Britain, 1968:32-35, 59-69) recognized that medical schools do not encourage favorable attitudes toward general practice and recommended changes in curriculums which it hopes will provide a more positive atmosphere for students and a more generous system of rewards and continuing education for practitioners. It is symptomatic of the problem, however, that the most potent remedy prescribed was lengthier and more specialized training in medical technology, and more elaborate organization of practitioners in groups of at least one dozen members. Together with improving the prospects for retaining the integrity of general practice, separation of general practice from more technologically oriented medical education and practice might have the effect of assuring that capabilities in research and specialty training which require large sums of money and years of painful striving to build up are not themselves jeopardized needlessly by enervating professional power struggles and rivalries. Thus there could be practical advantages all around from preserving the clear dividing line between general practice and hospital-based medical care. In place of the single all-embracing model, a multiple systems approach might be a more appropriate way to organize health services.

Taking into account the many dilemmas for primary as well as higher levels of care, the time may have arrived to revise the ideal model propagated throughout much of this century, in which the teaching hospital is positioned at the center of a planetary system of revolving secondary and primary services arranged hierarchically to reflect differences in technological intensity. Rather than spinning off benefits throughout the system to the periphery as hypothesized, the huge resource requirements of contemporary supertechnology, teaching, and research are more likely, as suggested by the experience in nearly all developed countries, to exercise a centripetal motion culminating in the depletion of capital and manpower in lower levels and remote areas. Though less tidy conceptually, the restructuring of primary and secondary services

to make them less vulnerable to the reach of tertiary interests offers a way for minimizing diseconomies of scale and dysfunctional patterns of domination inherent in large, complex systems with numerous varied objectives. Moreover, as indicated earlier, too close a union between primary and secondary services may also prove dysfunctional. The exigencies of hospital services for economies of scale and centralized coordination and planning are quite different from those characterizing community-based services. Effective primary care depends on a highly personalized and continuous relationship between doctor and patient in a non-bureaucratic setting located convenient to where persons live.

It would be ironic if unswerving adherence to the assertions of a concept which has been the companion of health service reformers for well over half a century were, when combined with competition for status among medical professionals, to reshape general practice to make it resemble the stronger hospital orientation found in the United States. In studying the causes of the near-total collapse of primary care and the economic cost of relying too heavily on the hospital, many Americans are beginning to look with envy to England as a country which has enjoyed more success in protecting the viability of general practice. In comparison with the United States, the proportion of all doctors who are general practitioners is twice as high in England—20 percent and 40 percent respectively—and the English are reportedly much more satisfied with the primary health services they receive than is true of the American public, for whom the undersupply and maldistribution of general practitioners is a more serious problem and doctors are less readily available during off hours and emergencies. It may be a manifestation of the countervailing effect which a strong and independent scheme of general-practitioner services can have that in England the hospital-admission rates are much lower than in the United States, where access is not dependent on referral by general practitioners. It may also be a manifestation of the disadvantages of pushing specialization too far that the amount of surgery performed in England is roughly half that done in the United States where there are twice as many surgeons in relation to population (Mechanic, 1972: 187–189). The fact that surgeons in the United States are more likely than their English counterparts to carry out such questionable procedures as tonsillectomy, hysterectomy, hemorrhoidectomy, and cholecystectomy may be due less

to differences in economic incentives than to factors of self-esteem and professional pride in esoteric skills acquired from prolonged training and demanding examination which motivate professionals to want to be kept fully employed.

### *Interface with Social Services*

Consolidation and coordination of the various health components of primary and secondary care are only half of the job to be done before the objective of integration can be met. Once harmonized successfully the health services must be linked with the social services. Although the establishment of coterminous area health authority and local government boundaries in union with the provision of machinery for joint planning and sharing of resources at the area and district levels represent progress over what existed previously, a number of troublesome problems remain.

In nationalizing the municipal health services it was not always easy to decide which activities properly belonged to health and which should be left with local government and social service departments. Questions arose as to where one should draw the line and how to deal with overlap areas, especially as local government and the NHS are separate financial and administrative entities. Thus while preventive health services and public health physicians were transferred into the new NHS structure, environmental health and sanitarians were left with local government. The question of where medical social workers belong was resolved by placing them in local government social service departments. The school health services were assigned to the new health authorities rather than being allowed to remain with the educational authorities. As the result of these actions, physicians employed by the NHS will be assigned to local government and educational authorities, to carry out health advisory and service functions so as to avoid the need to duplicate personnel. While on attachment, personnel will be held accountable to assigned authorities. The reverse situation prevails for medical social workers, who, while employed by social service departments, will be on attachment to hospitals. Apart from confused loyalties and reporting, such assignments may prove unattractive to competent personnel and compound problems of coordination because they are off the center path of normal career structures. There are already complaints by the British Medical Association (Manchester Guardian, 1973b)

that doctors are encountering difficulty in arranging adequate liaison with social workers for the care of patients, because of a tendency for them to eschew identification with specialty areas like medical and psychiatric social work in favor of the "generic" social worker label more prized for the career flexibility it provides and its symbolization of professional autonomy and non-subservience to medical authority. In justifying the policy of coordination in place of consolidation, both major political parties believe that the social services need a period of independence and special support to acquire strength and confidence; otherwise, they will be swallowed up by the more powerful and prestigious health sector. Tension among evenly matched competitors is thought to be the way to keep a balance between hospital and community care. The strategy strikes one as being highly practical. However, in the absence of a close union between general practice and social services, the imbalance between hospital and community care might grow worse instead of better; for the social services are still associated in the public mind with low-status and unpopular public assistance functions.

Another serious problem involves the financial disincentives to cooperation between health authorities and local government. For example, local government, which depends for one-third or more of its revenues on voter-sensitive property taxes (the rest is provided by central government grants) is not likely to cooperate extensively in providing the residential-custodial and social services which are needed to bring down hospital lengths of stay for psycho-geriatrics, the mentally retarded, and other classifications of patients in between the categories of medicine and social services. Chances are that the health services and local government will try to push costly services off on to one another with the result that the incurably chronic ill and the aged will continue to experience neglect and isolation. The seriousness of this problem leads many observers, including parliamentarians, to conclude that another major reorganization is inevitable within twenty-five years' time to complete the integration of health and social services which has just begun.

### *Consensus Decision Making*

The difficulties of changing long-established patterns of doing things which must be overcome if integrated care is to become a

reality are compounded when one considers that the same people who were running things under the old setup will be in charge after the reorganization. It will require years of patient effort by the government before health personnel and vested interest groups can be expected to change their habits even after the initial anxieties and confusion raised by the reorganization die down. In this strained psychological climate, consensus management may in the short run be used by the various professional groups competing for dominance in the new structure as a device for keeping the status quo. Even when it works, consensus decision making, as anyone who has had experience with collegial bodies in universities can attest, is very ponderous and slow-moving. The system works best when there is considerable agreement on basic values and objectives, or in an expansionary climate where everyone has a chance to get a fair share of resources. In such bodies change cannot be forced but must be allowed to proceed organically if it is to be accepted. In times of stress the best precept for avoiding internecine conflict is that "to get along one must go along," with the result that efficiency and change most often possess a lower priority than harmony and stability. Considering the realities, it is problematic whether any substantial changes in the presently fragmented pattern of delivery can be expected in the short to medium run. The prospects are pretty good that productivity and efficiency may actually decline for a time after reorganization because of the anxieties and aggravation of conflicts from the awakening of dormant differences. The short-term losses in economic terms may, however, be more than compensated by long-run improvements in standards resulting from better management of services. Often-repeated rhetoric to the contrary, experience indicates that reorganization can seldom be justified for saving money—the primary contribution is improved management. By substituting multidisciplinary team methods for the arbitrary exercise of hierarchical and bureaucratic power, consensus decision making may in time create a far stronger environment in support of comprehensive patient care ideals. In the context of collective responsibility founded on close association and mutual respect, consensus need not mean difficult-to-attain unanimity but a more practical sense of the meeting and the accommodation of views, with rare instances of conflict intense enough to invite the exercise of veto powers.

It is unlikely that more money will be forthcoming from the

reorganization, thereby smoothing the way for change by fixing everyone's attention on growth and expansion. The government has made it quite clear that financing will not be much affected. What is hoped is that the reorganization will allow, under cost-benefit analysis, a more rational allocation among competing needs, which, as has already been explained, was found difficult under the old tripartite structure. Some of the money for the development of the community services might result from the removal from hospitals of the large numbers of patients not requiring hospital care (25 percent or more of all hospitalization is thought to be clinically unnecessary and as many as 50 percent of the 60,000 adults in hospitals for the retarded and at least 10 percent of the 100,000 in hospitals for the mentally ill could, it is believed, probably do better outside). The thinking among government planners is that the number of hospital beds could be reduced by one-third and that most of the special hospitals for the chronically ill can be phased out by transferring patients to acute hospital and community facilities. It may also be possible to redeploy resources more equitably throughout the country to reduce regional disparities in the supply and distribution of personnel and facilities.<sup>2</sup>

Under the recently reformed system of planning public expenditures, the allocations reserved for health care are in fact fixed already five years in advance, and the annual increases will be very small in real terms. The only noticeable change is in the rates of growth assigned to the major service areas. For the period 1971-72 to 1975-76, total expenditure for personal social services and family practitioner services is projected to grow at 4.6 percent annually as compared to a 3.6 percent growth rate for hospital services. During this same period the proportion of total health expenditures going to hospitals is expected to drop from 59.4 percent to 58.7 percent while that for the community services is scheduled to increase from 37.3 percent to 38.1 percent (Great Britain, 1971a).

### *Synthesis of Clinical Practice and Management*

The idea of having clinicians elected by their colleagues participate fully in management at the district level, where all the day-to-day

<sup>2</sup> Although the NHS has since its inception in 1948 reduced by more than half the number of persons living in designated underdoctored areas, there has been little change in regional disparities in hospital beds and per capita hospital spending.



resource allocation questions will be decided and the basic data for planning will begin its upward journey, is the linchpin in the government's strategy for containing costs and improving program effectiveness. Some sources (*Hospital and Health Services Review*, 1971) doubt this can be done. "True, there are precedents in public health and the running of mental institutions; but clinicians as distinct from medical administrators, willing to involve themselves in planning and management may be atypical of their colleagues and will almost certainly find it difficult to carry their colleagues with them in all difficult decisions. Hospital specialists notoriously do not like being committed by one of their numbers and general practitioners, who do not even have the common interests which arise from working together in an institution, are even more individualistic." The independence long enjoyed by general practitioners and hospital specialists underscores their historic preference for relationships founded on collegial rather than on hierarchical corporate principles.

The government seems determined to push ahead against these obstacles, convinced that the solution to cost-control and program-coordination problems is dependent on getting clinicians to take part in management. Some experience has been acquired on the hospital side where since publication of the Cogwheel Report (Great Britain, Ministry of Health, 1967) the government has been trying, through use of various incentives, to organize the specialists into clinical divisions responsible to a medical executive committee. Unlike the prevailing practice where senior members of the medical staff negotiate for resources directly with hospital management, Cogwheel seeks to get them to justify their requests within the framework of medical departments organized along functional and specialty lines. The purpose is to foster greater recognition of the effects of individual decisions on others and willingness to work cooperatively with colleagues so as to be able to get the best use out of scarce resources. Toward this end, the formation of medical executive committees is encouraged and these are then given responsibility for coordinating departmental budgets and plans for presentation to hospital management. The results to date, as disclosed by a recent study (McLachlan, 1971) are that it is working out only moderately well. From a political realities standpoint it is surprising, however, that the effort managed to get off the ground, let alone survive. Three years after the appearance of the Cogwheel Report, 25 percent of

all hospital groups in England had adopted a divisional structure, of which over half had also set up medical executive committees. The attractiveness of the Cogwheel structure as a convenient means for the selection of the hospital clinician to serve on the district management teams in the reorganized structure will probably hasten its acceptance among non-participating hospital groups. Similar changes were introduced simultaneously for hospital nurses following the publication of the Salmon Report (Great Britain, Ministry of Health and Scottish Home and Health Departments, 1966). Briefly stated, the objective is to expand the nursing management superstructure to carry planning and coordinating responsibilities for an entire group of hospitals as opposed to single hospitals, and thereby make nursing a more attractive career for talented women and men.

A few of the larger teaching hospital groups have carried Cogwheel and Salmon further and experimented in the past several years with replacing the single "man at the top" pattern of management with a management team consisting of the chairman of the medical executive committee, the chief nursing officer, the finance officer, and the hospital administrator.

The attempt to involve clinicians and nurses in top management may be the single most important development in the NHS and one which bears close watching in all countries where the autonomy and independence of health professionals is regarded as the key to the control of costs and coordination of services.

### *Responsiveness of Bureaucracy to Central Authority*

Unification has been advanced as the means for assuring clearer lines of authority, responsibility, and accountability within a single chain of command. While the various ministers of health associated with the reorganization since 1948 were frustrated by the limitations of the old structure (such as the seeming inability of regional hospital boards to correct various acts of maladministration occurring in facilities for the aged, the chronic sick, and the mentally ill), and clearly intended to strengthen the role of central authority, it remains to be seen whether the new structure in practice will lead to more centralization or whether, as some hope, it may not bring about greater powers at the periphery, in particular by giving the basic work unit at district level greater powers in planning.

Whether reorganization will appreciably strengthen the hand of central government over the periphery, will certainly be affected by the character of the voluntary members appointed to the health authorities. If past experience is any guide the appointment of unpaid volunteers will assure a certain independence of mind and advocacy of local over centralized interests. Unlike the U.S., where population mobility has had a greater unifying effect, regional and local differences continue to inspire loyalty and pride. Members drawn from the ranks of the "establishment" who are senior in years and financially well off have the time and influence to serve as an effective buffer to protect management from unreasonable demands from remote upper tiers and to promote local interest in political councils.

There is some concern that the new structure will stifle productivity and innovation through too much bureaucray. It is generally agreed that three levels of authority are necessary: (1) operational; (2) planning, monitoring, evaluation, and provision of economy-of-scale services; and (3) national policy. The government is faced with a dilemma. While there is merit in the arguments of those who say that because of the overlap and duplication of function, either the regional or area authority is redundant, the government feels that both need to be preserved for larger political reasons. The local health authority, because of having coterminous boundaries with local government, symbolizes the commitment to coordinate health services with personal social services, education, and housing, which play an equally if not more important part in affecting health status and hospital use than does medical care. The government is unwilling to abandon the regional tier because it recognizes that, if health services are to be fully integrated with local government in the future, a larger tax base than now exists will be required before local government can finance the running of costly hospital and ambulatory services. As stated earlier, inability to bear financial responsibility is the most common reason cited by both political parties for not turning over the health services to local government at this time. It is generally felt that such an action would be premature until the pressures have built up sufficiently to transfer local government into larger and more economically viable regional units. In the meantime it does appear that the superstructure is top-heavy. The elaborate hierarchy for monitoring and coordination may be counterproductive in that the ratio of "gaffers to doers"

(or support to delivery personnel) strikes one as being unnecessarily burdensome.

*Public Accountability  
and Consumer Participation*

In reviewing the parliamentary debates in the House of Commons, one is struck by the absence of any serious differences among the major political parties (Great Britain, House of Commons, 1973a; Great Britain, House of Commons, 1973b). Similar to the political climate attending the establishment of the NHS in 1948, there is considerable bipartisan agreement on substance. Whatever differences exist are marginal and cross party lines—except for consumer participation, which in the view of the Labour Party has been made too subordinate to managerial values.

Questions of whether and how to strengthen public accountability and the influence of consumers constituted one of the liveliest and more significant topics of debate in the parliamentary hearings on reorganization. In opposition to those critical of the remoteness and high degree of centralization of the new structure, defenders of the reorganization looked to the parliamentary checks and balances of representative government as being sufficient for the assurance of accountability which might otherwise be blurred by decentralization and the sharing of authority with too many different groups. Rather than increasing democracy it was feared that the introduction of alternative sources of power within the system would make it much harder to fix responsibility. The chief argument on behalf of the new unified structure was that the NHS was a *national* service for which the Secretary of State was clearly accountable. The public can get to the Secretary of State through Parliament, limits of time and machinery notwithstanding. While readily conceding that the health authorities are not fully accountable except upward, the government maintains that the public can approach the area health authority, and to a lesser extent the regional health authority, through the newly established health councils and health ombudsman, in addition to the allowance made for local government to appoint four of the fourteen area health authority members.

Opinion on the adequacy of the consumer complaint and advisory machinery varies. Some persons see the community health councils evolving in time into powerful platforms for con-

sumer advocacy, whereas others, more skeptical, have a tendency to dismiss them as toothless lap poodles of management. If the experience with similar bodies in the nationalized industries is any indication, the pessimism appears justifiable. Lacking their own budgets, the CHCs will be completely dependent for support on the very groups they are supposed to be keeping an eye on. Furthermore, the districts containing as many as 200,000 or more people will be too large for consumers to be able to establish any personal or community identification with the CHCs, whose visibility will be lost in the large numbers. It is doubtful whether there can be a meaningful sense of community participation in areas larger than 40,000 to 60,000 population. To get community identification with and participation in the health service, it may be necessary to subdivide districts into smaller units for purposes of administering primary-care services organized around health centers. This will be especially important should it be attempted in the future to transform CHCs from their present role as reactive bodies to active participants in the drawing up of community health plans. Hospital-based secondary and tertiary services, which require a larger scale and which play a less important part in the daily lives of people, might be more suitably held to account by the normal checks of representative general-purpose government or handled by special management authorities along present lines.

There is also skepticism over how well the ombudsman innovation will work out in practice since he will be hobbled by proscriptions forbidding the investigation of complaints involving clinical actions (by far the more important topic of concern to consumers) or from looking into any other complaint until the health authority involved has first had a chance to respond.

Few issues are more complex than the relationship between management and public accountability. In all developed societies rising public expectations and the imperatives of capital-intensive technology create simultaneously contradictory pressures for centralization and decentralization, which can produce confusion and polarization in public policy. Policy makers are pressured to respond on the one hand to the belief that the restoration of effective local sovereignty to solve social problems is essential for dealing with the growing alienation resulting from the depersonalization of large-scale organization and with the breakdown in

credibility between the public and the government resulting from the remoteness of centralized authority. On the other hand, they must contend with the belief popular in management circles that democracy is incompatible with the efficiency requirements of modern management. Moreover, the beauty at the heart of the dream of local democracy is often unmatched by harsh reality. More often than not, grass-roots democracy has proven in practice to be highly undemocratic. The evidence on voter behavior in England and the U.S. suggests a general state of apathy which gets worse instead of better as one moves from national to local elections and the number of special elections, e.g., education, transportation, town and regional planning, etc., increases (Taylor and Hudson, 1972:104; McKie, 1973).<sup>3</sup> Programs tailor-made to increase participation and political power among disadvantaged groups have been a particular source of disappointment. For example, many of the so-called representatives of the poor in the highly publicized recent anti-poverty program in the U.S. were elected by as little as 1 percent of those eligible to vote. In this instance the truth of the matter was that consumer participation was used as an instrument for transferring power from officials who had at least some political responsibility to the community at large to small self-perpetuating local cliques and to the bureaucracies of central government. The justification for doing so, paradoxically enough, was that local government was too reactionary to respond to the needs of the poor. Historically, the poor and other disadvantaged groups such as the aged and the disabled have always fared better when their fate was in the hands of central government rather than local government. The reason for this in all likelihood goes beyond technical problems of fiscal boundaries which are too small to support social services and forms of taxation, such as the property tax, which tend to pit the "haves" against the "have nots," and make political reactionaries of the working and lower-middle classes when it comes to paying for services for the poor. From a purely sociological standpoint, local

<sup>3</sup> In a ranking of 104 countries by the percent of turnout among eligible voters, the U.S. was placed 92nd and the U.K. 61st (Taylor and Hudson, 1972). An article in *The Lancet* disclosed that in local elections conducted in England in 1973 fewer than one-third of those eligible to vote in major metropolitan areas like London, Birmingham, Liverpool, and Manchester bothered to do so (McKie, 1973).

communities are inherently conservative because of the high degree of internal cohesiveness and homogeneity which causes them to resist change and to be less tolerant of deviations from normative standards of acceptable thought and behavior. The shared values and common interests born of stable relationships which constitute the taproot of local community life are threatened by the extirpative effects of rapid change as represented by the massive shifts of populations from rural to urban areas going on in all developed countries, and which in some cases are aggravated by the importation of unskilled foreign laborers to take on jobs no longer acceptable to the domestic work force. Finally, there is the question of just how much intragovernmental and regional variation in access and standards of service a modern industrial society can tolerate when mobility rates are high and workers must be persuaded to relocate in accordance with shifts in employment patterns and the location of firms.

The complex and frequently contradictory principles involved indicate that the resolution of the relationship between democracy and management will not be easy. Ultimately, however, a way may have to be found to make possible a stronger and more efficient management to handle today's complex systems of health care while transferring a greater measure of authority to citizens in a manner which will enable them to effectively influence and evaluate the uses to which health care resources are put—i.e., a relationship based on mutual trust and partnership rather than the suspicion and antagonism too often found in the hierarchical and stratified relationships of the past.

## Summary and Conclusions

The reorganization of the NHS represents a bold strategy for re-directing health resources from technologically intensive hospital-centered care toward a more balanced delivery system involving the revitalization of primary health care and the coordination of health services with social services at the community level. The reorganization underscores a movement occurring in all developed countries in which many of the policy assumptions of the past half century responsible for the emergence of the hospital as the apotheosis of the faith in the unlimited power of biomedical re-

search and technology are being re-examined in the light of changes in population structure, disease patterns, and increased knowledge about the cost and effectiveness of alternative treatment methods. Hospitals, particularly teaching hospitals, will find it necessary in the new NHS structure to become more responsive to previously shunned low-status medical responsibilities in the areas of chronic illness and community medicine.

The reorganization also represents an important step for closing the gap between policy and execution by strengthening the capabilities of central government for over-all direction and evaluation while decentralizing responsibility for management and planning. The indications are promising, furthermore, that the new unified structure will succeed in making health services responsive to contemporary population needs while permitting more comprehensive planning and better-integrated services than was possible under the old tripartite structure, despite a continuation of problems of coordination between health and social services which suggests that another reorganization may be inevitable within twenty-five years' time.

As a field laboratory for possible developments elsewhere, the reorganization deserves the careful study and close attention of all persons interested in what effect social and economic pressures in highly developed countries will have in reshaping health services priorities and structure.

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