Reorganizing the British National Health Service

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Received for publication 7 November 1972

I propose to discuss certain developments in health care arrangements which are planned in the United Kingdom. I will discuss these in terms of Scotland which has a separate health service and a separate health department for which the Secretary of State for Scotland with one of his junior Ministers is responsible to Parliament in Westminster. When the National Health Service was established, Scotland had its own National Health Service Act, and in preparation for the reorganization of our Scottish National Health Service in April, 1974, Parliament has just passed another National Health Service Act for Scotland. The specifications and arrangements of the National Health Service in Scotland and in England and Wales are very similar. Similar changes are proposed in our programs of reorganization, although in Scotland we are slightly ahead in terms of our timetable.

I will try to present aspects of our experience which may be of interest to you, but let me state at the outset that there are no blueprints for health services. Each country's health services are a product of its culture and political traditions, and there is no place for chauvinism in discussing international differences in health services. At the same time, there are broad similarities between us; our problems have the same common base in developing medical science and technology on the one hand and public expectations on the other. In fact I suspect that the essential problems of health service development facing us today in Western countries are becoming steadily more similar, although the structure and administrative arrangement may be very different. I believe too that we each may see ourselves more clearly in the mirror of a foreign experience. It is with this hope in mind that I will tell you something about our plans in Scotland.

We look back now almost a generation to 1948 when our National Health Service was introduced. The National Health Service was brought into existence in a mood of wartime and postwar idealism. It was a central part of a much larger program of change in social services framed to achieve a better society and a more equal and purposeful distribution of resources. The National Health Service took over the preexisting health services and made them available to all as a right of citizenship and without payment. Responsibility was given to Health Ministers and central government departments to promote health, prevent disease, and to provide

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caring services available to all. Everybody was given the right to a personal doctor or general practitioner and, through him, access to a regionally and locally organized hospital and specialist service. The service also incorporated public health departments, as part of local government responsibility, which are responsible for environmental and epidemiological health control and certain health promotive services, for example, for children.

In retrospect after this generation span, what are the outstanding impressions about our National Health Service? It was certainly one of our boldest and most successful social reforms and certainly, too, it has been the least controversial of these reforms. The agreement between political parties in our recent Parliamentary debates on our new Bill has been striking. It is impossible to assess the net gains to the public's health from our National Health Service because we do not know what would have been achieved under alternative arrangements, but it is clear that the National Health Service has come to stay; it is widely accepted as an important part of the matrix of our society. In terms of its major intentions, the service has been successful. It has provided easy access to medical care and also has made available in all parts of the country the wide range of services needed in a modern health care system. We can note, however, in passing that there remain some obstinate regional and institutional differences in the quality of service, although there are no major quantitative gaps.

Some of you will know our interest in the United Kingdom—perhaps an excessive preoccupation—with the structure of health service organization and I want to discuss this structure with you now. The shape of the organization which was created in 1948 to run the National Health Service was traditional and conservative, although the purpose behind the service was new and revolutionary. In fact in 1948 we took over a traditional tripartite set of arrangements for running our service, and, by imposing statutory definitions on previously fuzzy traditional boundaries, the National Health Service increased the separateness of the three parts of our service. Every schoolboy knows that all Gaul is divided into three parts; so too is our National Health Service. We have separate administrations, sovereignties, and financial responsibilities for running our hospitals, our general practice arrangements, and our public health service. These boundaries, these separate administrations and budgets have imparted a considerable inflexibility to our arrangements. It is largely because of these boundaries that there has been comparatively little real experiment within the National Health Service in new methods of delivering care. Almost any such experiment today will be an attempt to create a mix of hospital and primary care and preventive and curative medicine. In our circumstances it is very difficult to create the necessary joint decisions and trade-offs to achieve such a mixture. At the earlier stages of the service these boundaries and barriers were not so troublesome because each component part of the service was busily engaged in organizing its own bailiwick. Much the biggest effort in organization, and in many ways the most notable achievement in the National Health Service, was in the hospital sector. Regional Boards and Boards of Management were created which took over all hospitals in their areas and, from 1948 onwards, set to work to make a hospital service out of a series of separate institutions of different sizes and strengths. We can say that the biggest change since 1948 in our health services scene has been the progressive integration of hospital services into a hospital system. This process of integrating hospital services has now reached a point where the tripartite boundaries of our present structure have become visibly
obstructive to further progress. This is one reason why we are now preoccupied
with a further major structural change in our health service arrangements. Our
proposal is to integrate the total health service by uniting the administrative and
financial responsibilities for all three parts of the service in the hands of a single
Health Board in each area. There are some differences in the methods proposed
for doing this in England and Wales and in Scotland, but I do not believe these
differences need concern you for the moment. In Scotland we propose to have
15 Health Boards; these will be of very varying size but each one will have the
total responsibility to meet the health needs of the population in its area, and each
will have the total responsibility for allocating resources to meet the needs.

We have to note that these administrative and structural changes, although very
important as a prerequisite to change and progress, are only an enabling procedure.
What matters now is the extent to which we use the opportunity which these
changes provide. The opportunity will be seized only if those concerned with pro-
viding the services, and particularly those in the medical profession, change their
thinking radically about the nature of their responsibilities and their methods of
work. They must develop concern for the population for which they are responsible
as well as for individual patients. We must all learn to see the health service as
a total system of care with related subsystems rather than a series of separate insti-
tutions and remits and individuals.

What I propose to discuss now is how the various components of our service
at area and district level may come to be related more closely to each other and
work in a more system-related fashion.

**Hospitals**

Let me start first of all with the hospitals and figuratively place them in the center
of the circle of my system. I do this because of the importance of the hospital
in providing leadership, scientific and technical support, skills, and education. In
figurative terms the hospital is the powerhouse which drives the system and the
motherhouse of its health professionals. As I said earlier, much has already been
accomplished within the hospital service in integrating separate institutions. The
concept of the district general hospital has created an organization bringing to-
gether all the resources of acute hospital medicine for populations of 150–250,000,
and more recently there has been a move to link the acute hospital service with
the longer-term hospital caring institutions for the elderly and the mentally ill. The
logical next stage of this process of integration, which has now successfully married
separate institutions into a hospital service, involves us in going outside the hospi-
tal; it involves us in a closer integration of hospital and primary care. Why is this
essential? We see more clearly than ever before that the hospital cannot go it alone
in terms of providing a caring service. The job is just too big. Not only that, hospi-
tal care alone is inadequate care; the contemporary problems of degenerative dis-
ease require continuity of care as the name of the game, and most of this should
take place outside the hospital. We have to recognize this and link together the
hospital and the other community components. If they are not linked and planned
purposefully together, caring is desultory and disjointed. Excessive preoccupation
with building up a hospital service as the solution to all problems also leads to
misuse of resources. The hospital becomes stifled by relatively simple problems
which others can look after at least as well, and the hospital is then less able to
apply its energies to those problems which only it can solve. There is a further
danger from an overdevelopment of the hospital system. It leads to wrong gearing which is destructive to the other elements of the health system. If the hospital takes on too much, then it erodes the responsibilities of primary care and damages the strength of that basic component of our service.

We have to think how to link hospital and primary care (Fig. 1). We are thinking of this in two ways: The first is by linking the hospital to the health center, where primary care will be provided, by the hospital specialist moving to the health center for part of his work. This should not be seen as a simple displacement of the hospital outpatient department, but rather as a means whereby the hospital specialist can influence his general practitioner colleagues and their standards of care and in turn learn from them about community care. Even more important is bringing the general practitioner from the health center into the hospital. This seems obvious to you in North America but in the United Kingdom, particularly in urban areas, the general practitioner has long been separated from the hospital with unfortunate consequences to the interest and incentives of his professional life. We see it as important to give the general practitioner the option of looking after his own patients in hospital beds and also working for part of his time in specialist units appropriate to his interests. Most important of all, hospital doctors and general practitioners should have a means of combined professional planning so that they can deploy their work to serve the population for which they are jointly responsible. (I shall return to this point.)

**Primary Care**

It would be difficult to exaggerate the importance of general practice in our health service. It provides the visible, acceptable, and informal point of contact for the citizen with the National Health Service. We are fortunate that National Health Service arrangements have ensured the survival of general practice in strength. What we now must do is to take steps to ensure that this great inheritance is preserved in good shape. There have been some recent signs which have caused
anxiety and hinted at falling professional morale in general practice; of these, the so-called "brain drain" of some of our younger doctors to other countries has been perhaps the most important signal. There has been some impoverishment of the professional interest and responsibility of general practice, and we now have to reverse this process by purposeful measures to achieve job enrichment and to increase the opportunities for problem solving by the general practitioner. I have indicated our hopes in relation to the provision of hospital beds for the general practitioner and opportunities for membership of the specialist teams, but the biggest part of our program relates to health centers. We have at last under way a major program of health center building and development in Scotland. By 1975 about 1 in 5 of our citizens will be looked after from health centers; by the end of this decade the majority will be looked after from health centers. These health centers are of varying sizes, but in the urban area an average health center would relate to a population of patients of about 30,000. This larger size seems desirable because, then, economics and logistics allow us to put in more resources, more diagnostic machinery and so on. In such a center there will be perhaps 15 practitioners working; there will be visiting specialists, community nurses, and social workers, and also a community medicine specialist to assist the planning and pursuit of the health center team's intentions. We are only at the beginning of studying the dynamics of primary care from health centers; we are only at the beginning of realizing the potential of this health center team.

The Population Approach

The most important component of a health service system is its population of patients, and an appropriate population medicine approach seems an essential requirement without losing in any way our sense of the importance of the individual patient or the individual doctor/patient relationship. We have to ask ourselves how we get beyond a situation where health service activities are dictated only by the perceived requirements of individuals as manifested by their visits to a doctor. We have to learn how to study the needs of populations at risk and to plan to meet their requirements. The simplest expression of this approach is our definition of the responsibility of the Health Boards for delivering the health service in terms of defined geographical areas and populations. Within these boundaries these Boards are obliged to study the needs and demands of their population and the resources available to meet these.

How are we going to sophisticate this arrangement from a broad political mandate to a cogent policy of population medicine (Fig. 2), for example, in terms of:

(a) epidemiological analysis of the problems and evaluation of effort expended;
(b) better definition of objectives priorities, and resource allocation;
(c) coordinated professional (and especially medical professional) decisions and policies directed to the needs of groups as well as individuals; and
(d) a more effective consumer contribution to the working of the service and a more cogent consumer criticism of its efforts.

a. Community medicine specialist. I have depicted the community medicine specialist as the leading point of my arrow of population medicine attack and epidemiological skills. Community medicine is a new name for an old responsibility of medicine. This is the old public health writ large. Public health, as the responsi-
b. Administration. I cannot go into much detail about the proposed arrangements of our health board administration. The health boards themselves will consist of representative citizens who have been nominated by our Secretary of State after wide consultation with the many interests concerned in their community. It will be the responsibility of these members to review and decide on the major policies of their board. They will be funded from central government, most of the money coming from central government taxation, and, according to their population size and needs, they will get their share of the National Health Service budget which
in Scotland, with its five million population, is presently of the order of £200 million. The board will have an executive group of chief officers, whose job it will be to plan the service on behalf of the board, and the chief administrative medical officer as a member of this executive group is also the leader of the team of specialists of community medicine.

c. Medical organization. It may be of interest to you to learn something of our hopes of translating individual professional viewpoints into coordinated suggestions for policy. There will be opportunities provided for the main health professions, and most importantly for the medical profession to advise management. We hope through this medical advisory system to enlarge the input of medical advice from its present tendencies to be concerned mainly with individual patients or specialty groups to a broader concern with the total needs of each area and each district. In passing, it is worth noting that medical clinicians within our National Health Service have a very marked degree of freedom in their professional work and in the deployment of their time. Paradoxically it can be said that within our state provided Health Service the clinician is often left in greater freedom to do his own thing on his own patch than he would be within a well-run teaching hospital in the USA. Inevitably, there is a great deal of preoccupation with the next patient and with the immediate requirements of the particular specialty which the clinician practices. There is also a feeling on the part of the clinician that he is outside the organization of the service. There is a we/they viewpoint separating the clinician from the administrator. We are studying ways and means to marry vital clinical freedom in patient care with consideration of population needs and common purpose with management. Our new National Health Service Act requires that medical advisory committees be established by the profession at national level and at area level, and I am sure they will also be established at district level. These medical advisory committees are to provide a means whereby the profession may channel its views on policy needs to the administration and join with the administration in an appropriate dialogue. Behind the medical advisory committee, there will be a divisional organization providing a constituency for every practitioner where, with appropriate colleagues, he considers the needs of his part of the service and is able to express his viewpoints to the medical advisory committee. At the moment, members of the profession are considering in detail how they will set up such an organization which will advise management on requirements, policy and on the use of resources, will also lead to more purposeful efforts in patient care evaluation, and will relate the doctors with other professional groups such as nurses in the discussion of common needs and purposes. It is highly desirable that this medical organization at area and district level should link vertically to a national medical advisory committee. It is also hoped that the community medicine specialist will work with the divisions and the main medical advisory committee and that this will be one of the means of translating the potential of a population medicine approach into effect throughout all the clinical disciplines.

d. Local health councils. Consumer and citizen representation in health services is a matter for vigorous discussion in your country and we too are thinking about how to do a better job in this regard. At present, the consumer and the citizen are heavily represented on a wide array of management bodies. This will continue, although the management bodies will be less numerous in future, but in this way the citizen becomes identified as a manager. He becomes identified with the policies of the health service and its establishment. How can we bring in the consumer
and citizen as a constructive critic and direct contributor? We can note that citizen criticism of our National Health Service since its inception has been surprisingly muted and sporadic. Indeed, a common and surprised American observation of the British scene is our low-key discussion on health service matters which is far less passionate than your debates in the United States. Along with our new health service structure, we are bringing in a health service Ombudsman who will be a focus for certain kinds of criticism and complaint. He will perform valuable functions but these will be limited in their effect. We are also establishing what we call Local Health Councils at the grass-roots level. They will be made up of citizens, many of whom will be nominated by democratically elected local authorities. It is hoped that they will be the means of vivid expression of citizen interests and concerns. It is for us now to think out how to make them work most effectively. They will only come to a full impact if they are assisted in some way to be well informed about the service in their districts and neighborhoods and to have some understanding about how they can make an appropriate citizen contribution.

**Social Work**

Any structural definition of health service administration inevitably has artificially firm boundaries round it, with arbitrary definitions of what lies within the bailiwick of the health authority and what belongs outside to other agencies. There are a number of authorities outside the National Health Service which are concerned with services which will be of the greatest importance in achieving optimum delivery of health care. The education authorities, for example, are concerned with arrangements for a school health system to be provided by the National Health Service. Democratically elected local government authorities will be responsible for the safety of the environment, and they must receive their medical advice from the health board. I particularly want to call attention to the fact that the responsibility for an integrated social work service lies outside the remit of our National Health Service Boards. It belongs to the Social Work departments of our local government authorities. It is increasingly perceived by us all that in critical areas of service, for example for the elderly and for the mentally ill, medical care and social work responsibilities merge into each other. How then are we going to keep these two services in step so that they provide appropriate support for each other? Good will alone is not enough; we will have to discuss appropriate administrative crosslinkages so that mutual responsibilities can be defined and discharged.

**Programs of Care**

I want to call attention to the potential which integration will provide for program planning. This is certainly one of the most interesting new possibilities which will emerge out of integration. For the first time, all the resources for particular aspects of care will be in the hands of a single health authority: all the resources, for example, for providing an obstetric service, a child health service, a mental health service, and a care of the aged service; whereas, now these resources are divided. Take, for example, child health. At the moment the responsibility is divided between the hospital pediatrician, the general practitioner, and the child health officer of the local authority, each belonging to and paid by a separate authority. In future these people and the other professionals concerned will be able to come together in program committees at area and national level to plan for the needs of the children in their area, and they will be able to mesh their efforts together into a new
pattern of teamwork. Indeed, in certain circumstances, we can envisage that there will be substantial changes in the way in which professional work is done as a result of the new perceptions and possibilities which will develop. Community medicine specialists and administrators will work with these program committees to derive with the professionals a clearer definition of objectives, priorities, and the use of resources.

National Level

I have kept my discussion at area and district level near to the point of delivery, but reorganization and integration also provides opportunities and challenges at the national level. At the national level, also, for the first time we will be looking at plans and priorities across the board without the inhibitions of a separate tripartite organization. To give expression to these new possibilities, we are creating a Planning Council which will bring together the health boards and other interests to join with us in national planning. Thus, we can have a sharing of views, and also decisions, which are seen to be taken by and on behalf of the health boards which will put the policies into practice on the ground. Planning staff from the Scottish Home and Health department will function alongside the Planning Council and the national professional advisory bodies, for example, the national medical advisory committees. We will also be forming, at the national level, program committees which will bring together professionals and planners to delineate objectives and priorities for the guidance of area programs.

Information for Planning

These principles which I have outlined to you are easier to describe than to exploit. Every day that passes highlights our relative ignorance and the primitiveness of our information and planning technologies. Slowly we are sophisticating our information system. We have ambitious plans to create national and area patient-based files in which, through record linkage, we tie together the data of our health service, but we have a long way to go (1). There is urgent necessity for research, experiment and education, not only for the benefit of planners, administrators, and community medicine specialists, but to provide an informed background to the decisions of all the health professionals in the service.

REFERENCE

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