CABINET

REORGANISATION OF THE NATIONAL HEALTH SERVICE

Memorandum by the Secretary of State for Social Services

A second Green Paper on the administrative reorganisation of the National Health Service has been promised for early this year. I would like to publish it as soon as possible after the publication of the White Paper on the reorganisation of local government, to the contents of which it will be closely related.

2. The lines on which the reorganisation of the National Health Service should take place have been discussed on a number of occasions by the Ministerial Committee on Social Services and I have also had confidential consultations with representatives of the local authority associations, some of the health service authorities and some of the professional and other workers in the Service, including the British Medical Association. In the light of these discussions and consultations I propose that the reorganisation should be on the lines set out in the following paragraphs.

Local government

3. The main decision to be reached is whether the reorganised National Health Service should be put under local government control. On this, the general view in the Social Services Committee is that it must be placed outside local government. This will be a controversial decision because control by local government would dispose of the criticisms of the present system of wholly appointed hospital boards and committees and would make much easier the necessary co-ordination of the health services with the personal social services that are to remain within local government. Moreover, the Royal Commission on Local Government in England went out of its way to say that the new local authorities would be suitable for controlling the National Health Service.

4. There are, however, two insoluble difficulties, at any rate in the foreseeable future - finance and the doctors. Formidable additional expenditure would come under local authority control, and even if one could see a way through this difficulty, one is left with the implacable hostility which the doctors have expressed to local authority control.
5. My confidential discussions have, moreover, shown that the local authority associations themselves do not expect to be given control. What they really want - and I agree with these points and develop them later in this memorandum - is that local authorities should appoint a reasonable proportion of the members of the health authorities; that there should be the closest possible collaboration between the local and health authorities; and that the dividing line between the services for which the two sets of authorities are responsible should be an acceptable one.

On this footing I take the view that, at least in the foreseeable future, the reorganised National Health Service should not form part of local government.

Division of functions between National Health Service and social service departments of local authorities

7. The decision not to give administrative responsibility for the National Health Service to local authorities means that a boundary must be drawn for purposes of administration between those services now provided by local health authorities which as personal health services would fall to be transferred to the new authorities, and those which as personal social services would appropriately pass to the new social service departments of local authorities under the Seebohm Bill. The Social Services Committee agreed the division listed at Annex 1 for the purposes of outside consultations.

8. The British Medical Association expressed strong views on two points. They were most anxious that the Medical Officer of Health and his staff should become part of the integrated health services; and that he should also have a statutory responsibility for advising the new local authority on all health matters. Secondly they pressed for the new health authorities to have administrative responsibility for a number of the services which it was proposed to allocate to the social service departments. They had particularly in mind all services for the mentally disordered (with the exception of the junior training centres which are becoming the responsibility of the education departments).

9. There is no difficulty about the first point, as I propose that the Medical Officer of Health and certain members of his staff should be transferred to the new health authority and that he should advise the local authority on health matters. The real area of dispute relates to certain of the present functions of local health authorities, notably the mental health services. This genuine concern on the doctors' part is matched by an equal concern on the part of the social work profession for the unity of the personal social services. Moreover if the unified health service is not to be local authority run we shall want to leave as many services as we appropriately can in local authority hands. In fact both professions have to work together and there is certainly scope for agency services on a mutual basis between health authorities and local government. It seems clear that the line of responsibility should appropriately be drawn in the Bill between those
services where the skills required are predominantly medical and those which require predominantly social work skills including residential and day care in the community. In terms of the client the distinction lies between those who are able to live in the community and those who either need continuous medical care or are not yet ready for life in the community and need residential nursing care under medical supervision. It would follow, therefore, that the health authorities should be given powers to provide the "halfway house" type of residential accommodation for the mentally ill and handicapped who are not yet ready for life in the community; and since the borderline here is bound to be somewhat blurred there will, in practice, be some concurrency of powers to provide residential accommodation. Full consultation will be involved between the two authorities in each area on the diagnosis of the needs of individual cases.

10. I accordingly now propose that the division of responsibilities should be that set out in Annex 2.

Main aims

11. Once firm decisions are reached that the reorganised National Health Service should not form part of local government and on where the dividing line should be placed, a framework exists for considering what form the reorganisation itself of the National Health Service should take. While the second Green Paper must make it clear that the firm decisions are not open to reconsideration, the proposals for reorganising the National Health Service in the context of those decisions would be put forward on the basis that they are open to public discussion and debate.

12. The proposals which in the rest of this paper I suggest should be put forward on this basis seek to secure the following main aims:

(a) to create an integrated structure for the National Health Service, running parallel to, and, co-ordinated with the reformed structure of local government;

(b) to provide for much more local sharing of responsibility; and to place day-to-day operational control of the Service as near as possible to the consumer;

(c) in deciding the composition of the authorities, to give the local authorities and the health professions a due share in the management of the Service; and

(d) to provide much more effective central control than at present over the money spent on the Service and to ensure that maximum value is received.
13. At present the Service is administered by a very large number of authorities. In England alone the hospitals are run by 14 Regional Hospital Boards (under whom there are 299 Hospital Management Committees) and 35 Boards of Governors of Teaching Hospitals; the family practitioner services by 119 Executive Councils; and the local health authority services by 187 local authorities - the County Councils (with some delegation to large district councils) the County Borough Councils, and the London Borough Councils. The boundaries for the three groups of Services do not correspond.

14. The first Green Paper of July, 1968 proposed an integration of these services, and suggested that they might be administered by about 40 or 50 Area Boards (for England and Wales). These Area Boards were however strongly criticised as covering too large an area and being too remote from local feeling. To meet this criticism I first considered a two tier structure with areas smaller than the areas suggested in the first Green Paper, but with a regional tier above them. My confidential consultations have however shown that such a structure would still be criticised as being too remote, and would also be open to the criticism of being top-heavy. Moreover, it would suffer from the disadvantages that caused the Redcliffe-Maud Commission to abandon the two tier system of County government. I propose, therefore, a simpler structure designed to complement the new unitary authorities.

Area health authorities

15. My principal proposal is to establish some 90 area health authorities to administer the integrated service, whose boundaries would correspond with those of the unitary areas and metropolitan districts proposed for local government. My confidential consultations have emphasised the need for the closest possible collaboration between the new health authorities and the new local authorities; this is particularly so in relation to the personal social services, but it is also the case in all other fields that involve the public health. Medical advice should be provided to the local authority by the staff of the health authority, and social advice to the health authority by the staff of the local authority. There is a great deal of room, too, for collaboration between the health and local authorities in other respects; the bulk supply of goods required by both, and the use of computers are examples.

16. This close collaboration can be ensured only if the local authority is matched by a single health authority. There will therefore be one such health authority for each unitary area and metropolitan district. The only departures I expect from this rule will be in Greater London, where it will be necessary to group the areas of two or three London Boroughs in order to form satisfactory health areas,
17. The scale of the services administered by most area health authorities would make it necessary to provide for administrative devolution to district management sub-committees. The local district is where the day-to-day management must take place, and where a district management body is needed to guide the paid officers and reach decisions that these officers cannot be expected to take on their own responsibility. These district committees would need to come into existence on the appointed day for the reorganisation of the National Health Service, and their number and areas would be determined by the needs of the health service. I would, however, expect that there might prove to be a substantial identity of pattern (though not of boundaries) with the proposed district committees of the new unitary local authorities.

18. The aim will be to place a great deal of the day-to-day work of running the service at district level. The districts will not, however, constitute a separate administrative tier; all administrative responsibility will rest in the area authority. It will settle the areas of its constituent districts; it will determine how much can be spent in the various districts (and in so doing will seek to secure a reasonable balance of services); it will submit to the Central Department annually its hospital capital programmes and enter into contracts for the schemes included therein; it will itself plan and see to the execution of smaller capital works such as health centres; it will be the legal employer of all staff including that at district level; and it will have a general responsibility for the efficiency of the health services throughout its area, even though their day-to-day administration is carried out by its district committees on its behalf.

19. The area health authority will also be the body that establishes a statutory committee to enter into contracts for the provision of services by general medical and dental practitioners, pharmacists and opticians.

Regional health councils

20. The size of the new area health authorities - which will be determined by the local government pattern and not by the needs of the health service - will make them too small for certain health planning purposes. I have in mind such matters as the overall planning of hospital and specialist services (including the development and location of highly specialised medical services); the organisation of the provision of post graduate medical education and of the deployment of hospital medical, dental and scientific staff; the organisation of staff training where this cannot be effectively organised within the compass of a single area health authority; and other functions such as the planning of the ambulance service.

21. This points to the need for some 14 to 18 Regional health councils whose areas would be similar to those of the present Regional Hospital Boards. These Regional Councils would continue some of the work (particularly the planning work) of the Regional Hospital Boards. But they would be entirely advisory and would not be placed in authority over the
new area health authorities, which would have a direct relationship with
the Central Department. Nor would they stand in the way of the
establishment by the area health authorities of consortia where this seems
to offer the most satisfactory method of dealing with matters of common
concern to several authorities.

22. The relationship of the Regional Health Councils with the
provincial machinery ultimately established in the light of the recommenda­
tions of the Redcliffe-Maud Report and the Crowther Commission on the
Constitution will need to be considered in due course.

Central department

23. Under my new proposals, the control of the area authorities will be
exercised directly by the Central Department. The Central Department
will itself allocate money to each authority and approve its budget. It will
control the capital building programme. It will exercise any necessary
manpower controls. It will take direct responsibility for supervising
the efficiency of the services the area authority administers and securing
that value is received for the resources allocated to the authority. That
these central controls should be real and effective is a matter to which I
attach the utmost importance.

24. This direct relationship, while it will be strongly opposed in some
quarters, particularly by the Regional Hospital Boards, will be welcomed
by some parts of the Service, in particular the teaching hospitals and the
local health authority and family practitioner services where (unlike most
of the hospital service) there is no tradition of a regional tier.

25. In order to maintain an effective direct relationship with the new
health authorities, the Central Department will need considerable
reorganisation. In particular there must be greatly strengthened
Regional Offices in the main centres of population to maintain close touch
with the area health authorities. Centrally and through these Regional
Offices, the Department would employ the professional staff needed for
planning and designing, in consultation with the potential users, the
hospitals included in the national hospital building plan. This will involve
no net increase in the number of staff employed in the public sector;
indeed the introduction of a one tier system into the hospital service should
produce a net saving. It will however involve a substantial increase in
the number of staff employed by the Central Department.

26. There must also be an influential Central Council with a widely
drawn membership by no means wholly professional, which I would consult
on all matters of importance to the National Health Service, including the
deployment of the available resources. There will be a need for new
national machinery to organise training for health service staff. There
will also be more importation into the Central Department of staff from
the Health Service.
Composition of authorities

27. These arrangements for strong control by the central Government make it, in my view, unnecessary to insist on having a majority of centrally appointed members on the health authorities; indeed the arrangements offer a much greater certainty of compliance with Government policy than would be the case if one relied on working through appointed members. Authorities with a majority of centrally appointed members cannot in my opinion be regarded as offering a realistic alternative to local government controls; it has become clear that to attempt to restrict the representational element of the local authorities, professions and Universities to less than a half of the membership of the area authorities would be completely unacceptable.

Local authorities

28. This viewpoint has been argued with particular cogency on behalf of the local authority associations on the following grounds:

(a) that the social services, including the health services, are completely interdependent, and the local authorities already play a major role in their provision within policies laid down by the Government;

(b) that the changes introduced as a result of the Royal Commission's report will strengthen local government and equip it to play such a role even more effectively in the future;

(c) that the unification, separately, of the administration of the health services, on the one hand and that of the Seeborn social services on the other will necessarily create difficult operational problems at points along the lines of demarcation; but that these will be less serious the greater the participation in the health service of the local authorities who will be running the social services; and

(d) that the local authority, being composed of elected members, would reflect the views of the users of the services, as well as present an overall local authority view.

29. I propose to concede to the local authorities one-third of the seats on the new area health authorities. To those who suggest that this extent of local authority membership is dangerously large, I would point out that in the scheme that I have outlined I would retain full control over total expenditure on the health service and would have available all the present administrative controls of advice and guidance, the setting of standards and the indication of national priorities and, in the last resort, the power of direction. The area within which the local authority members could effectively exert an influence would be in the choice of priorities within the provision the Government makes available. I believe this is a role which elected representatives are particularly well-fitted to fulfil.
30. Finance for the National Health Service will continue to be provided in the main from central funds. The local authority associations believe that the identification of the local government members with the interests of the health service would be greatly aided if there were a contribution, even a small one, from local authority sources. This suggestion seems to be worth further consideration, but it might best be pursued in the context of local government finance generally rather than in that of the Green Paper on the administrative organisation of the National Health Service.

**Professions**

31. I would wish to offer broadly the same representation to the health professions. The third of the membership allocated to them would be so composed as to give the medical profession as near as possible to the 25 per cent share of the total seats which they have traditionally had on some National Health Service authorities and for which they are pressing. The remaining professional seats would be filled by members of other health occupations, particularly dentists, nurses and midwives.

**Proposal on composition**

32. My proposal on the composition of the area health authorities is therefore that the membership should be divided into three roughly equal groups. One third, and the Chairman, would be appointed by me; a third by the local authorities, and a third by the health professions and Universities.

33. In view of the importance of obtaining Chairmen of the necessary managerial calibre who can devote sufficient time to the work, I propose that the Chairman (who would be appointed by me) should receive a part-time salary, at a rate to be settled later. Unless salaries are introduced in local government (in which case I would want to reopen the matter), all the remaining members would receive only travelling expenses, subsistence allowances and any attendance allowances paid in local government.

34. The application of these principles to the area health authority would produce a composition on the lines of that given in Annex 3.

35. The role assigned to the regional health councils in paragraphs 20 and 21 has considerable implications for the composition. A substantial number of the members would be appointed by me; the rest would be drawn from the area authorities. Thus each area authority would appoint a member to the regional council (who might well be the Chairman of the area authority) and the professions would be requested or even required to appoint people who are on the area authorities. The planning role of the regional council would make the professional and University membership particularly important. The exact size and composition of each regional council would depend on the number of area authorities in its region.
35. I seek the Cabinet's agreement that firm decisions should be taken on the following matters:

(a) that the reorganised National Health Service, while closely linked with local government, should not form part of it (paragraphs 3 to 6); and

(b) that the dividing line between the National Health Service and the social service departments of local authorities should be as set out in paragraphs 7 to 10.

37. I also ask the Cabinet to agree that the reorganisation of the National Health Service should be based on the principles set out in paragraph 12; and that the second Green Paper, while making it clear that the decisions in paragraph 35 are firm and not open to debate, should set out the remaining proposals outlined in this paper - without the Government being finally committed to them at this stage - as a basis for further public consultation and debate against the background of the decisions that will then have been announced about local government reorganisation and the Seebohm Bill.

R. H. S. C.
BASIS OF CONSULTATIONS ON DIVISION OF SERVICES NOW ADMINISTERED BY LOCAL AUTHORITY HEALTH DEPARTMENTS

a. Allocated to new health authorities

Ambulances
Chiropody
Family Planning
Health Centres
Health Education (other than in schools)
Health Visiting
Home Nursing and Midwifery
Maternity and Child Health Care
School Health Service (subject to the confidential discussions the Secretary of State for Education and Science is having with the education interests)
Vaccination, Immunisation and Screening

b. Allocated to local authority social service committees

Family case work and social work with the mentally disordered, elderly, handicapped and chronic sick

Day centres, clubs, hostels, adult training centres and workshops for these groups

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

Care of unmarried mothers, including residential care

Home helps
REVISED DIVISION OF SERVICES NOW ADMINISTERED
BY LOCAL AUTHORITY HEALTH DEPARTMENTS

a. Allocated to new area health authorities
(1) Medical services and advice to the local authority in respect of services for which the local authority is responsible. These would be provided by the Medical Officer of Health (and his staff) who would be transferred to the area health authority and by the staff who would be transferred with him.

(2) The following health services:

- Ambulances
- Chiropody
- Family Planning
- Health Centres
- Health Education (other than in schools)
- Health Visiting
- Home Nursing and Midwifery
- Maternity and Child Health Care
- School Health Service (subject to the confidential discussions the Secretary of State for Education and Science is having with the education interests)
- Vaccination, Immunisation and Screening

b. Allocated to local authority social service committees
(1) Social work services and advice to the area health authority in respect of services for which the area health authority is responsible. These would be provided by social work staff employed by the local authority.

(2) The following personal social services:

- Family case work and social work with the mentally disordered, elderly, handicapped and chronic sick in the community.
- Day centres, clubs, adult training centres and workshops for these groups in the community.
- Day care of children under five, day nurseries and child-minding.
- Care of unmarried mothers, including residential care.
- Home Helps

II.
c. **Hostel Accommodation**

To be provided by the area health authority for people who are not yet ready for life in the community and need residential nursing care under medical supervision; and by the local authority social service department for those who are able to live in the community but require residential care.
Composition of Area Health Authority
(with medical training school)

Chairman (appointed by Secretary of State) 1)
Other members appointed by Secretary of State 7)

Appointed by local authority 7
Appointed by professions (probably one hospital doctor, one general practitioner, one dentist and one nurse or midwife) 4
Appointed by University (probably at least one doctor) 2
Appointed by Statutory Committee 1

Total 22

Note: The total would be reduced to 20 if there were no medical training school in the area and therefore no University representatives.