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AN INTEGRATED APPROACH TO HEALTH SERVICES AND MANPOWER DEVELOPMENT: THE EXPERIENCE OF THE UNITED KINGDOM

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Having been asked to prepare a paper from the particular point of view of the United Kingdom I should explain that, although I have for a short time been Chief Medical Officer in Scotland, I have spent most of my professional life in England. The legal and administrative systems of the four component countries of the UK vary, and this is reflected in the National Health Service (NHS) as it applies to England, Scotland, Wales and Northern Ireland, each of which has its own ministry with responsibility for health services, which are commonly referred to collectively as the "Health Departments". The differences, however, are essentially in detail rather than principle, and I have prepared my paper primarily from the English point of view, indicating where I am referring to features applicable particularly to Scotland.

The subject is a vast one, which could be tackled in many different ways. I do not want to lose the reader in a welter of details and figures, so I will keep these to a minimum and try to stick to some of the principal issues involved. I will similarly concentrate on the National Health Service, as it is universally available to the people of the UK, and the private sector of health care is very small in relation to it.

Background

The pattern of health service and educational development in the United Kingdom has been one of gradual evolution, involving in both cases a multiplicity of agencies. The general subject of health services and manpower development involves three main elements, these being the National Health Service, a range of educational bodies, and a series of professional regulatory bodies. The precise relationships between these vary in detail between the different health service professions, but once again I will try not to confuse and will, as far as possible, stick to broad principles, although exemplifying my remarks by reference to particular arrangements applicable to individual professions, or to particular aspects of the health service.

National Health Service

As in other countries, the progressive evolution of a system of health care for the population extends back over a long period of history, but the main developments in the United Kingdom have been concentrated in the present century, and more particularly in the period since 1948. In that year, the National Health Service came into being, and it was at that time tripartite in nature, being comprised of the hospital services, the family practitioner services (including the general medical, dental, pharmaceutical and optical services) and the public health services (See Figure 1). Each was provided by a different authority; each had its own staff; and, in the early years of the National Health Service, a substantial degree of separatism was maintained, no doubt partly due to insecurities stemming from what, at the time in question, was a radical change in the provision of health care.

An outstanding feature, particularly of the period after about 1960, however, was the functional drawing together of the three branches of the original National Health Service; and examples of what is meant by this are relevant to the theme of my paper.

Thus in individual parts of the country the public health and general practitioner services began to come together in order to enhance the provision of primary health care. Traditionally, the general practitioner (who is a key figure in the British NHS, and about whom more will be said later) was a doctor accepting responsibility for the primary care of a list of patients, and working separately from the public health nursing staff, the members of which covered geographical areas rather than individual lists. Initial experiments showed that, by combining a group of general practitioners with a team of nursing staff, including a wide range of skills from the highly trained health visitor, district midwife and State Registered Nurse, to the State Enrolled Nurse (whose skills are largely of a practical nature),

it was possible simultaneously to provide a better service to patients, to give greater job satisfaction to the nurses, and to make the best use of skilled human resources.

Similarly, the provision of health centres from which such teams could operate has played an important role in providing an adequate focus for local health care. Another development in pulling the former separate public health and general practitioner services together lay in arrangements whereby family doctors undertook the immunization of children in their own practices instead of this commonly being carried out at public health clinics; some public health authorities assuming a complementary role by providing computer systems for calling forward children for immunization at appropriate ages.

At the same time links were being forged between the public health service on the one hand and the hospital service on the other as, for example, in a series of joint hospital and community care and after-care schemes for particular groups of patients such as those suffering from mental illness, from diabetes, or from the ailments of old age. Progress was mainly in the more community-oriented specialties, including paediatrics, mental illness and mental handicap; and impetus was commonly given to such developments as a result of increasing interest in prevention, in its broadest sense. On the other hand, less progress was made in relating the general practitioner to the hospital medical team, this being the result of various historical factors going back to 1948, when the general practitioner and hospital medical staff became separate from one another instead of, as had previously been the case, quite commonly holding joint appointments.

The object of all these endeavours was to make the best use of resources, whilst at the same time supplying as high as possible a degree of continuity of care for patients. As might be expected, there was sometimes initial resistance to such changes from particular professional groups, but the general pattern was one of local experimentation which, if successful, soon spread to other localities.

The next logical step in the evolution of the National Health Service took place in 1974 when increasing functional integration was followed by administrative unification; and responsibility for all types of health services passed to Area Health Authorities which, in turn, were largely coterminous with the local government authorities, which had likewise undergone reorganization (see Figure 2). The important point here is that these local authorities are responsible for services complementary to health services including educational, environmental and personal social services, such as domiciliary assistance or residential care for the elderly or handicapped who do not require care in hospitals. Depending upon their size and geographical constitution some Area Health Authorities were broken down functionally into two or more districts, the district being the basic comprehensive unit of health care, involving a series of primary care units backed by the facilities of a district general hospital or by a group of hospitals which together fulfilled a similar function.

The object of the 1974 reorganization was, simply, to enable each Area Health Authority to look at local health needs across the board; to consider the available local resources; and from there to move on to a system of arriving at priorities in the use of its financial and human resources. At the same time, the consumer input to the National Health Service was strengthened by the creation of district Community Health Councils, with the duty of public representation and of helping to keep the health authorities fully in touch with "consumer" opinion. Thus, since reorganization, responsibility both for prevention and for cure, as well as for hospital and for community care, are the collective responsibility of each health authority. In the case of England, on account of population size, there is an intervening tier of regions, but in all countries of the United Kingdom overall responsibility for the health service lies in the hand of the appropriate Secretary of State (Senior Minister), with the health authorities as his local agents.

As far as management of services at Regional, area and district level is concerned, this is basically by teams comprising representatives from medicine, nursing, administration and finance. A system of health care planning has gradually evolved with the National Health Service. At first it was concerned primarily with hospital planning, then medium-term planning of public health services followed; and since the 1974 reorganization a national cyclical arrangement for planning has been evolved, with on the one hand, national guidelines on policy matters from the central Government Health Department (Ministry), but with all detailed responsibility delegated to the individual health service authorities. This, in turn, is supplemented by a feedback from the periphery which is, of course, where care and cure take place, and where experimentation in the provision of health services, together with its evaluation, must similarly occur.

The health service authorities are responsible for all types of personnel, whose salaries account for over 70% of health service non-capital expenditure, and about whom more will be said later in my paper. It might however, be appropriate at this stage to include a particular word about the three main sub-divisions of the medical profession. There is, I assume, no need to explain the function of hospital doctors. In the United Kingdom, however, the role of the general practitioner is central to the functioning of the National Health Service. He is the sole portal of entry to care, and every member of the public is guaranteed the services of an individual family doctor. The general practitioner in effect controls access to hospital specialist services; and his responsibility is for the totality of the patient's needs and for his continuing care in the community. From being in many ways neglected in the early years of the health service the status of general practitioners has steadily risen, not least as a result of their own efforts much of which was channelled through the Royal College of General Practitioners; and specific vocational training of general practice (for which these are special joint NHS and educational arrangements) is now widespread, and will shortly become mandatory. The general practitioner and the primary care team within which he increasingly operates are in fact the key to much of the effective working of the National Health Service.

A word should also be said about the third branch of the medical profession which practices what is now known as "community medicine". To avoid semantic confusion I should explain that, as defined in the 1968 Report of the Royal Commission on Medical Education, community medicine is "the specialty practised by epidemiologists and by administrators of medical services ... and by the staff of the corresponding academic departments". Its membership was initially drawn from staff with a professional background of public health or hospital medical administration, and they are now deployed at national, Regional, area and district level throughout the National Health Service. Their epidemiological, interpretative, innovative and administrative skills are vital to the entire health care planning process, including medical manpower planning; and the evolution of community medicine is I believe one of the most important developments of the past decade. It has been Government policy to support the medical profession in the development of this new specialty; and this was initially done by the provision of reorientation courses prior to the reorganization of the National Health Service in 1974, as well as by subsequent financial backing for training courses for new recruits to the specialty. This development is a good example of co-operation between governmental, educational and professional interests in the development of a medical specialty of substantial importance to the National Health Service.

Education

Here there is a complex pattern, varying with the different professional groups within the health service. To take the medical profession as an example, the training is carried out in universities, which receive their funds not from health service sources but from the Government Department (Ministry) of Education and Sciences, through the medium of the University Grants Committee. This administrative separation of education from service is considered important, in United Kingdom philosophy, in

ensuring that universities maintain a clear role not merely in training but also in the "search for knowledge". It calls, however, for effective liaison machinery between the academic and applied aspects of medicine.

There is great competition for places for students in the medical faculties, but the numbers at each university are limited within a national pattern determined by the Government. Historically, the United Kingdom has provided extensive facilities for the post-graduate training of overseas doctors but, for a substantial number of years, the British National Health Service has also been heavily dependent on such doctors for the provision of services, particularly in the more junior hospital posts, and increasingly in general practice. Indeed, currently, approximately a quarter of National Health Service posts are held by doctors from overseas. This is clearly undesirable in terms of the brain drain which it imposes, frequently on developing countries, and largely for that reason the Government agreed, following the report of the Royal Commission on Medical Education (1968), that there should be a planned increase in the number of university places for medical students from 2 600 until a target figure of some 4 000 is achieved by the early 1980s. This, allowing for wastage, should provide an output of about 3 700 doctors per annum. The difficulties in predicting future patterns of work and of immigration and emigration are notorious but, despite recent suggestions from sections of the profession that this may be an excessive number in relation to need, it remains current Government policy.

The medical curriculum is determined by the individual universities, working within guidelines produced by the General Medical Council, to which reference will shortly be made. In providing undergraduate training, National Health Service facilities are extensively utilized and NHS staff take part in university teaching just as university staff in the clinical subjects virtually all have honorary contracts in the National Health Service. To help to co-ordinate arrangements, Regional University Liaison Committees have been established on the nature and extent of present and developing needs of the universities to utilize NHS facilities and staff in connection with the teaching of medical and dental students, and associated research; the adequacy of regional plans to meet these needs, having regard to the total allocation of resources to the region, the specific identified financial allowance for teaching and research and the general needs of the health service; and possible new areas of collaboration of potential mutual benefit, together with the resource implications. In addition, it is important to mention the indirect help given by the National Health Service to universities. Thus, where new professorial Chairs have been established in subjects which it has been considered important to develop as part of national policy, the National Health Service has been able to provide help in terms of supporting NHS staff and facilities.

Whilst the precise content of medical education is a matter for the Universities, working along the guidelines put forward by the General Medical Council, the dialogue between academic and service interests is continuous; and there is no doubt that it has gradually influenced the medical curriculum. For example, the formal involvement of medical undergraduates in instruction in the principles of general practice is now almost universal; teaching in the basic components of community medicine is vastly more widespread than a decade ago; professorial departments of psychiatry are almost universal; and there is a small but growing number of professorial Chairs in geriatric medicine. Such developments represent responses to changing demographic and epidemiological patterns and service needs in order to meet the requirements of the community through the NHS.

In the United Kingdom dentistry is a separate profession from medicine, but the arrangements which apply are broadly analogous to those relevant to medicine. In addition to dental surgeons there are two registered types of ancillary dental staff, namely the dental auxiliary, whose work is restricted to children and involves extractions, simple fillings and similar uncomplicated procedures; and the dental hygienist, who is concerned with oral hygiene, preventive treatments, scaling, treatment of gums,

and dental health education. The training of such dental ancillary staff, together with dental technicians and dental surgery assistants, is of much shorter duration than that of a graduate dental surgeon and it is directly related to the work which they will be expected to undertake once they have been trained. Nationally there is an overall shortage of dentists, dental technicians, dental auxiliaries and dental hygienists, but no fundamental consideration of dental manpower has been undertaken for some twenty years, that being before the introduction of dental auxiliaries.

In contrast with doctors and dentists, the great majority of nurse training is carried out within the National Health Service at training schools associated with hospitals; and nurses in training provide a substantial practical input to the National Health Service, although the trend is clearly towards an increasingly educational emphasis. There is also a limited involvement of universities and other centres of higher education in relation to nurse-teacher courses and to the relatively small numbers of the profession who are preparing themselves for degrees in nursing. The relationship between the National Health Service and the training of midwives is broadly similar to that appertaining to nurses; and in the case of health visitors (public health nurses) there is a mixed pattern of further education, involving universities, polytechnics or colleges of further education.

On the manpower side there has been a steady rise in the number of nurses employed in the National Health Service, representing an overall increase of 135% in the period from 1949 to 1975, and with a notable growth in the number of nursing auxiliaries (284%) within that period. These figures, however, take no account of nationally agreed reductions in the working week; which have had the practical effect of reducing these figures by about one-third in terms of real increase. The period has also been notable for the growing use of part-time staff and for the fact that more of the less skilled tasks have passed from pupil nurses to nursing auxiliaries, although the former still account for more than a quarter of all NHS nursing manpower.

Payment both for student nurses and for qualified staff is met out of the service budgets of individual Area Health Authorities, and there is no overall national manpower policy of the kind applicable to doctors. It thus falls to each health authority to set its own staffing levels, taking into account its particular local requirements; but the central Government has suggested guidelines, for example, in the target ratios relating health visitors and district nurses to population; together with minimum ratios for nursing staff caring for the mentally ill, the mentally handicapped and the elderly - in other words the services most liable to be neglected. However, research is in hand to try to establish a means of setting standards for nurse establishment, for example, by studies of patient requirements in different types of wards. Having said that, however, it must be admitted that nursing establishments in the United Kingdom still relate more to historical patterns than to scientific predictions of need.

I do not propose to discuss the other health professions involved in the UK National Health Service, including such groups as physiotherapists, dietitians, opticians, occupational therapists, etc., as that would further complicate this paper; similarly I will mention the training of health service administrators only in passing, although they are a large and important group, and one for which there is a national training scheme. Here it should be mentioned that, as with community medicine staff, administrators in the past were concerned either with hospitals, with public health services or with family practitioner services, whereas training is now geared towards overall health service management rather than towards particular sectors of it.

Before leaving the subject of basic training it might be appropriate to say something about the gradual change which has taken place in the role of hospitals which teach undergraduate medical students. In England, until the reorganization of the National Health Service in 1974, such teaching hospitals were separately administered and were in direct relationship with the central Government Department (Ministry) of

Health and Social Security. This clearly gave them advantages, but at the price of emphasizing their difference from the other hospitals serving the needs of local populations. In Scotland on the other hand, teaching hospitals were, right from 1948, an integral part of the overall health service structure, and they have steadily spread their teaching facilities to involve hospitals other than the original teaching hospitals of the four Scottish universities with medical schools.

In England, since 1974, teaching hospitals have become the responsibility of designated Area Health Authorities instead of having separate Boards of Governors. It must be admitted that this has in some cases not been universally welcomed by academic medical staff, but I personally believe that it is a move in the right direction, as teaching and service cannot be separated one from the other; and the exposure of medical students to the full range of problems seen in district general hospitals presents them with a wider spectrum of knowledge than can be achieved amongst the more selective types of patients who inevitably use the specialized facilities of the main teaching hospitals. However, if district hospitals are to be increasingly used for undergraduate teaching purposes, this will inevitably involve some degree of additional expenditure in terms of accommodation, other facilities and, in some degree, of staff; and allowance is made for this in financial estimates to cover the overall responsibilities of the NHS Regional and Area Health Authorities.

In the United Kingdom it is now accepted that, for all types of health service professional staff, initial qualification is no more than a landmark in a process of continuing education which, irrespective of their fields of practice, is essential if they are to remain abreast of developments; and a word should be said about this in relation to post-graduate medical education. Here, once again, the United Kingdom pattern is complex, with a leading role being played by the various specialty Colleges rather than by the universities. Co-ordination in this field is undertaken by the three national Councils for Post-graduate Medical Education, and the National Health Service is very substantially involved, both as the employers of those undergoing further training and as the providers for such training.

The Council for Post-graduate Medical Education for England and Wales was formally set up in 1970, having been preceded for some three years by an unofficial Central Committee, and much of the impetus for such post-graduate training in fact stemmed from a conference held in Oxford in 1961 by a voluntary organization in the form of the Nuffield Provincial Hospital Trust. The Council has the broad tasks of maintaining close contact with professional and educational bodies at national level; advising the representative regional bodies active in the same field; providing a national forum for discussion; and acting as an authoritative source of advice to the central Government Health Departments (Ministries) in England and Wales. It is much concerned with the provision of constructive careers-advice for young doctors and with the running of an information service for doctors from overseas; and its membership is wide and encompasses both University and post-graduate College interests; the profession at large (through the British Medical Association); Regional and Area community medicine staff; post-graduate deans and tutors; and the central Government Health Departments in England and Wales (which also make substantial annual grants towards its running expenses). The process is thus a joint venture, involving service as well as academic and professional interests.

University appointments as post-graduate deans exist in every region and, at district level, there is a post-graduate tutor, commonly working from a post-graduate centre situated in association with the district general hospital. The development of such centres, usually on the initiative of the local medical profession, and with day to day running costs met by the Area Health Authority has been one of the most significant developments in the National Health Service, as they provide foci for the continuing education of all types of medical staff, bringing together those from different disciplines both in the hospital and in the community, and also facilitating

joint approaches to further training in association with other health service professional staff. The health service has the duty of fostering the participation of staff in such post-graduate training.

Regulatory Bodies

Having referred to the National Health Service and to professional training it is necessary to say a word about the regulatory bodies which are concerned with the maintenance of standards of training and of conduct in the various health professions and with the protection of the public. A range of these bodies exists, and brief reference will be made to two of them.

The body concerned with the regulation of the medical profession is the General Medical Council. No doctor can practise within the National Health Service or privately unless registered by that Council. As far as those trained in the United Kingdom are concerned, it has a supervisory role in relation to medical education, and it is also concerned with the approval and registration of doctors coming from overseas medical schools. It publishes recommendations on educational matters; carries out periodic inspections of medical schools and of their examinations; as well as maintaining close liaison with new medical schools in the establishment of their training patterns and subsequently in the recognition of their degrees. It also regularly organizes conferences on topics relevant to medical education. The Council is composed of 22 members nominated by the universities and specialty Colleges, together with 11 elected representatives of the medical profession and eight Government nominees; but it is likely that future legislation proposed by the present Government will lead to a reconstitution so that the elected representative of the medical profession will have a small overall majority on the Council. Thus, once again, this regulatory machinery involves cooperation between professional, academic and government interests.

To take another example, the General Nursing Council for England and Wales is a similar statutory body concerned with the control of the nursing profession. It has disciplinary and educational functions related to the State Registration and Enrolment of nurses and its membership is partly elected by the profession and partly appointed by Health Ministers after appropriate consultations. The Council inspects and approves NHS establishments as training schools for nurses and it has the power to refuse or withdraw such approval where necessary; it offers advice to National Health Service authorities on matters relating to nurse training; and consults with the Department of Education and Sciences on courses taking place in the general education system, such as those for nurse teachers. It similarly relates to the University Grants Committee on relevant matters.

Distribution of Medical Manpower Resources

As the utilization of the expensive facilities of the health service is in large measure determined by doctors, it might be appropriate at this stage to say something about the mechanisms used to try to ensure an appropriate national distribution of the various types of medical practitioner. As has already been explained, the overall output of medical schools in the United Kingdom is determined as a matter of Government policy, but different distribution mechanisms apply for the three main branches of the profession.

In the case of general practitioners, control is at national level, through the Medical Practices Committee. The country is divided geographically into localities, each of which comes into one of four categories, ranging from those where there is a positive need to attract doctors, to others which are already adequately or oversupplied with general practitioners. A general practitioner cannot establish himself in the National Health Service in one of these so-called "closed" localities whereas, at the other end of the scale, various incentives exist to attract general practitioners

to designated areas such as, for example, rapidly growing centres of population, as in the case of new towns. The classification of localities is kept under review by a national committee, and the system which has been described has gradually steered the national position towards a more equitable distribution of general practitioners without in any way involving their compulsory direction towards particular parts of the country.

The specialty of community medicine is in a substantially different position, as the establishment of posts took place in relation to the reorganization of the National Health Service in 1974 in which community medicine specialists had specific roles to carry out at Regional, area and district levels. Partly because of the age structure of those in the former public health and hospital medical administrative services and because of the advantageous voluntary retirement arrangements made for those who wished to leave the service, and partly because of inadequate recruitment, there is an overall shortage of community medicine specialists. In consequence, manpower advisory machinery for the specialty has been established by central Government, in cooperation with representatives of the specialty, to try to ensure the best possible distribution of available resources. Again, this is done not by means of compulsory transfers but rather by the consideration of posts which either are vacant or fall vacant as a result of retirement or other circumstance.

Manpower distribution arrangements in the case of hospital staff are more complex, as a result of a series of inter-related factors. There is, for example, the obvious fact that certain parts of the country are more popular to work in than others; there has been an understandable historical tendency towards preferring to work in university teaching hospitals rather than in peripheral ones; in addition to which certain specialties such as general surgery are more popular with trainee specialists than are others, such as geriatric medicine. Furthermore, there is a need to try to balance the number of trainees entering a particular specialty against the likely vacancies which will arise for them as consultants on completion of their training; and representatives of the profession have agreed with the Government Health Departments that such a balance is important and should, as far as possible, be maintained.

To deal with these difficult problems there is, in England and Wales, a Central Manpower Committee, set up in 1972, with widely based representation from the medical profession and from educational interests on the one hand, and from the Health Departments (Ministries) on the other. This body offers advice on such matters as the distribution of hospital medical manpower in the consultant and training grades and on the balance between these various grades, as well as ensuring through the specialist Colleges, that manpower approval is not given to individual training posts unless they are educationally satisfactory. The Committee seeks to carry out its work by means of mutual agreement, but it obviously has difficulties in such sensitive issues as the redistribution of hospital medical manpower, although once again this is not effected by the compulsory transfer of staff but rather by closing posts as they fall vacant where that is desirable, if necessary relocating them in other parts of the country.

A major problem still remains in the United Kingdom in the form of the present hospital career structure, which is pyramidal in shape with a wide base of trainees and a relatively small apex of consultants; and which substantially depends upon junior medical staff from overseas, who commonly leave the country after three or four years as trainees. There is clearly need to broaden the top of the pyramid in order that there may be a better balance between those in training and those in permanent career posts, but this is a complex medico-political matter on which the medical profession itself is not yet able to come to an agreed overall conclusion. For the present, the profession accepts that training should take only as long as is essential, without undue delay in appointment to permanent posts in the candidates' chosen specialties; and that there should be a balance between the numbers in training and the anticipated career vacancies.

These three examples of health service and manpower development mechanisms are all the outcome of discussion and agreement between the Government Departments (Ministries) and the medical profession. They have been progressively evolved to meet both professional and service needs, and this process of evolution will continue into the future - not least, it is to be hoped, in relation to the career structure for hospital medical staff.

Coordinating Mechanisms

From what has been said it will be seen that, in the United Kingdom, the National Health Service, the various educational bodies concerned with the training of professional personnel, and the professional regulatory bodies have all evolved their structures and their roles over a substantial period of time. Similarly, the liaison between all these organizations has largely been established on an ad hoc basis rather than by creating a single structure for the purpose. Liaison however, exists at all levels of the health service. (See Figure 3).

Centrally there is, of course, close co-ordination between the various Government Departments (Ministries) concerned, and the Health Departments of the UK countries have particularly close linkage both with the University Grants Committee and with the Vice Chancellors (i.e. the heads or "presidents") of universities containing medical schools. There are, similarly, observers from the Health Departments (Ministries) on the Medical Sub-Committee of the University Grants Committee. As far as medical post-graduate training is concerned, the Health Departments (Ministries) are represented on the national Councils for Post-graduate Medical Education, and close contact is also maintained with the various sub-committees of these Councils, with Regional Post-graduate Deans, with Chairmen of Regional Post-graduate Committees, and with the Deans of individual medical schools.

The General Medical Council is an independent statutory body, but it contains representatives appointed on the recommendation of the Secretary of State for Social Services and analogous Ministers in Scotland and Northern Ireland, and amongst these representatives are the Chief Medical Officers of the countries concerned. Similarly, in relation to the General Nursing Council and other regulatory bodies, there is a Health Department input.

Liaison is also maintained with the specialty Colleges, and observers from the Health Departments (Ministries) are customarily present at the meetings of their committees concerned with higher specialist training, in addition to which the Presidents of the various Colleges are members of the statutory central National Health Service advisory machinery, and there is also a large amount of informal contact between the Health Departments and individual Colleges.

At Regional level there are Regional Liaison Committees involving the National Health Service on the one hand and the universities providing medical education on the other, in addition to which there are regional committees concerned with post-graduate medical education. At area level there is close liaison between the health authorities and universities with medical faculties, with funding arrangements which recognize the increased load put upon the authorities in consequence of their being involved in the teaching of undergraduate students. Health authorities also have direct responsibilities towards the facilitation of post-graduate training for medical staff and towards the initial and further training of nursing and other health service personnel.

Of great importance is the fact that the vast majority of University clinical staff holding honorary appointments in the National Health Service while, on the other hand, many NHS medical staff similarly have honorary academic appointments. Academic staff are involved in the management of the NHS at all levels; and particular mention might be made of the young specialty of community medicine, within which most

academic teachers now also hold honorary NHS appointments, thus providing their expertise to assist with the epidemiological and other aspects of health service management; and healing the split which occurred between academic social medicine and applied public health some 30 years ago. The result of the arrangements outlined in this paragraph is that such NHS medical staff are enabled to bring their practical experience to bear on academic matters; whilst academic staff make a substantial contribution not merely to their university duties but also to the management and development of the National Health Service.

Continuing Developments

Whilst a substantial degree of integration of health service and manpower development already exists in the United Kingdom, no such system can ever be static; and it might be helpful to conclude with a few remarks on current problems and possible future developments.

There is no simple or final solution to the question of the number of health service personnel of varying types who are required in a National Health Service. The answer must relate to the expectations both of society and of the professions concerned.

In the United Kingdom, the increasing involvement of the public in National Health Service matters will help to ensure that the first of these factors is kept under review; whilst the professions, on the other hand, can be expected to continue to suggest developments, without which medicine would fossilize instead of advancing.

Ultimately the resolution of the demand made on resources by these various pressures must be a political one, taken not least in the light of the economic circumstances of the country.

It is important to ensure, however, that flexibility in the employment of personnel is maintained, as the work of each profession involved in the British National Health Service must continue to evolve in detail, although certain tasks will clearly remain the prerogatives of particular groups. Thus, the doctor will ultimately be involved in the diagnostic process and in the prescription of most forms of therapy; whilst with their steadily advancing roles and interests it is important that nursing staff should maintain their unique task of providing care for individual patients. At the same time, nurses and other health service professional personnel must maintain and develop their input into the planning of services.

It is important to try to ensure that there are adequate career prospects for each type of health service staff and that rewards both in terms of finance and of job satisfaction should be as justly balanced as possible. It is, for example, desirable that, in the medical profession, those who undertake work in the less popular specialties should not be penalized for doing so; and in a team situation it is important to look at the rewards given to those with complementary skills. At the same time, it is essential to keep under continuing scrutiny the way in which various services are provided. For example, in the case of such shortage medical specialties as anaesthesia and geriatrics, the question must be asked as to whether the contribution of the doctor might be supplemented by augmenting the skills and responsibilities of other groups.

Research is also necessary, and one of the major developments in the United Kingdom during the past 15 years has been the increasing development of Health Service (as distinct from Biomedical Research), this having been funded largely by the central Government Departments (Ministries) of Health. Such research should be the basis for future development in the health service and there is need for much more attention to the comparatively neglected field of manpower research. This is

a difficult area within which to operate, as it is liable to give rise to insecurities amongst staff, in addition to which objective measurements of need and of the input of individual members of particular professions are difficult to achieve.

There is also need in the United Kingdom to move towards a more comprehensive overall manpower monitoring system, as such mechanisms as at present exist are confined to individual professions. The difficulty here lies in the complexity of such a structure and, once again, in the possible insecurities which might result if individual groups of staff felt themselves to be threatened by others of a different background of training.

A Royal Commission is currently studying the National Health Service with the following terms of reference "To consider, in the interests both of the patients and of those who work in the National Health Service, the best use and management of the financial and manpower resources of the National Health Service". It may confidently be predicted that the Commission will comment upon the next steps which should be taken in the evolution of comprehensive manpower planning mechanisms within the broad framework of the planning and administration of the British form of National Health Service.

Conclusions

To conclude in terms of the questions being asked in the course of this consultation, the United Kingdom has gradually built up a co-ordinating mechanism for health service and manpower development. The various mechanisms involved were arrived at in general agreement with the professions concerned and would, in fact, be impossible to operate without the co-operation of these professions. The mechanisms are multiple rather than single, but all are brought together locally, regionally or nationally, and sometimes at more than one of these levels. It may be alleged that the mechanisms are weak insofar as they are essentially ad hoc, but this is in keeping with the traditional British approach to such matters; and it has the merit of achieving acceptance by the professions involved, whereas a more monolithic and compulsory type of mechanism would probably be self-defeating as a result of the resistance which it would create.

Comprehensive health service planning involves the balancing of needs for medical and other professional staff against one another and against the allocation of resources for support staff, buildings and equipment. This is becoming an increasingly effective process at Area Health Authority level in the reorganized NHS - stimulated by the unified administrative structure and also, it must be said, by current financial restraints!

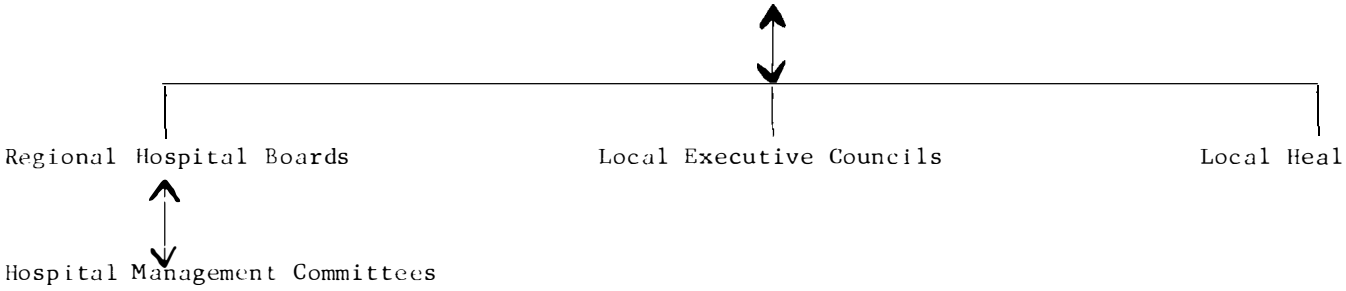
All aspects of any health service must, however, be in a state of constant evolution and, just as major changes resulted from the advent of the National Health Service in 1948, and from its administrative reorganization in 1974, it is probable that the Royal Commission will suggest the next steps which should be taken towards the further progress of effective health service and manpower development. When its Report is published, it will be widely discussed, both by the health service professions and other staff involved on the one hand and by the public on the other, after which Government decisions will be required in preparation for the next step forward.

FIGURE 1

ENGLAND - STRUCTURE OF NHS 1948-74

Minister of Health/Secretary of State for Social Services

Ministry of Health/Department of Health and Social Security



(All hospital and out-patient services)

(All family practitioner services)

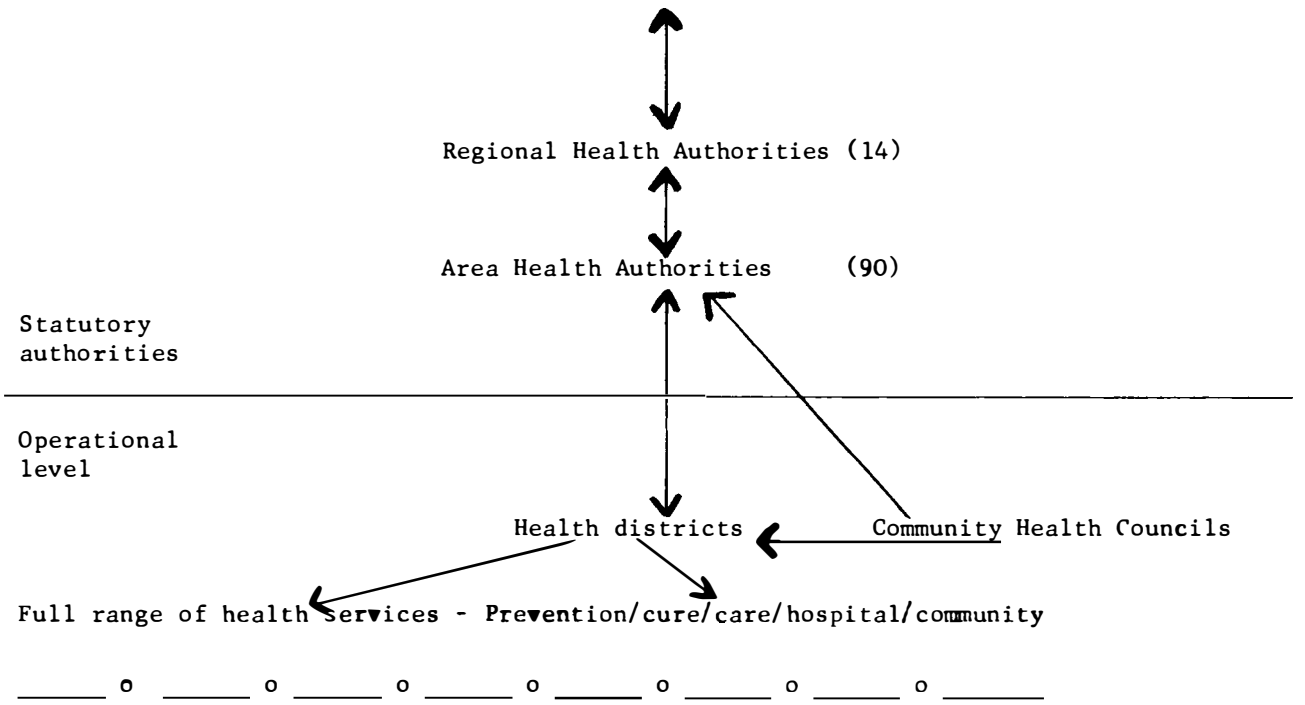
(All public health plus certain domiciliary services)

Financed by Central Government

Financed partly by Central and partly by Local Government

FIGURE 2

ENGLAND - STRUCTURE OF NHS SINCE 1974



Note:

1. In Scotland there is no Regional tier.

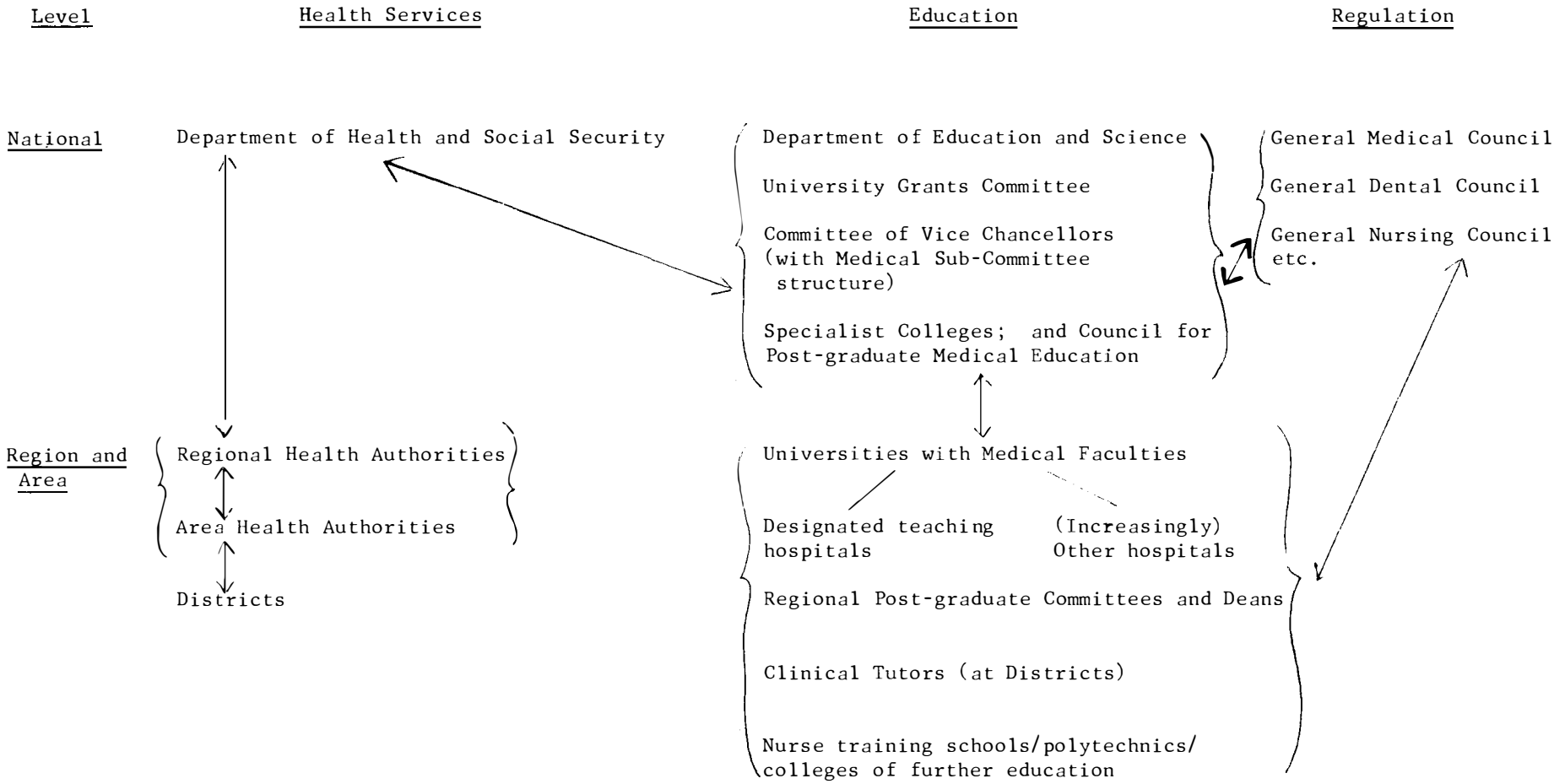
2. There is at least one University with a medical faculty in each Region.

3. Area Health Authorities are related to local government structure (which has responsibility, inter alia, for environmental and personal social services).

4. District populations vary, but are commonly around 250 000.

5. All services (other than environmental) are financed by central Government.

FIGURE 3


Level
Health Services
Education
Regulation
National
Department of Health and Social Security
Department of Education and Science
University Grants Committee
Committee of Vice Chancellors (with Medical Sub-Committee structure)
Specialist Colleges; and Council for Post-graduate Medical Education
General Medical Council
General Dental Council
General Nursing Council
etc.
Region and Area
Regional Health Authorities
Area Health Authorities
Districts
Universities with Medical Faculties
Designated teaching hospitals
(Increasingly) Other hospitals
Regional Post-graduate Committees and Deans
Clinical Tutors (at Districts)
Nurse training schools/polytechnics/ colleges of further education