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ABSTRACT

Begun in 1948, The National Health Service was organized in a "functional" pattern of three main groups: hospital service, primary health care, and community health services and personal social services. Dissatisfaction led to a reorganization in 1974 along geographical divisions for region, area, and district levels, necessitating a managing staff. New organizational problems presented themselves: (1) the need for training management personnel and community physicians and (2) decision-making based on consensus rather than authoritative hierarchical status. The Department of Health entered into agreement with eight educational centers in various parts of England to sponsor four types of training: multiprofessional integration courses for all types of senior staff, courses for voluntary members of the new health authorities, programs for clinicians to prepare them for management roles, and courses for Medical Officers of Health and their medically qualified staffs in preparation for their role as community physicians. The costs of the residential courses were to be borne by the Department of Health. (The program at the University of Manchester is described in detail.) An evaluation of the program arrived at a positive assessment. (Outcomes of the program are viewed from three perspectives: the National Health Service, the universities, and the government.) (AG)

Centre for Educational Research and Innovation (CERI)

ORGANISATION FOR CHANGE:

THE BRITISH NATIONAL HEALTH SERVICE

by

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ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT
1975

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- *to contribute to sound economic expansion in Member as well as non-member countries in the process of economic development;*
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The main objectives of the Centre are as follows:

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PREFACE

Just as with so many facets of modern society, health care poses major developmental problems. Access to complete health care has come to be regarded as a right, and the last 20 years have seen an explosive growth in national systems of health care. At the present time they constitute major elements in our society, involving 4 to 6 per cent of the labour force and from 4 to 8 per cent of annual expenditure in most OECD Member countries.

Behind these signs of size and growth lie many riddles. Health care has achieved remarkable advances in terms of falling infant death rates, new treatments, and surgical wonders - yet there remain large pockets of society without adequate access to health care, and there is growing dissatisfaction with health care in its individual and human aspects. A lengthening life span and the complexities of modern society have created the need for new approaches to escalating socio-medical conditions such as ageing, chronic illness, mental illness, drug abuse, and alcoholism. To sustain the excellence of the present while grappling with these new problems, and to do so within reasonable limits of human and financial resources, is the challenge now facing the health professions.

New answers to new problems in whatever field inevitably call for personnel with different kinds of knowledge and skill. It was with this fact in mind that CERI in 1972 undertook a study of education of the health professions in the context of evolving health care systems, with the financial support of the Josiah Macy, Jr. Foundation.

The study was directed by a Group of Experts appointed by the Secretary-General of the OECD, Mr. Emile van Lennep. From the first, the Group addressed itself to certain basic questions: where are health care systems going, and why? Do these directions put new calls to our patterns for educating the health professions and occupations? Are there models of innovation that deserve to be followed up at national or international level?

The far-ranging results of the Group's study have been published under the title "New Directions in Education for Changing Health Care Systems" (OECD, Paris, 1975). Future health care, in the Group's view, will have a much stronger orientation to individualised, community-based primary health care. This reorientation will require professional

personnel with new understanding and skills in social, psychological and management areas. The effectiveness of the reorientations and the speed with which it will come hinge on new partnerships between education and health care - partnerships forged at the regional level, and fostered by national and international policy clarification.

In the course of their study, the Group commissioned a number of special investigations dealing with important aspects of the health care/education interaction. The present document was prepared by Professor T.E. Chester, University of Manchester, Manchester, England.

J.R. Gass
Director,
Centre for Educational
Research and Innovation

I. BACKGROUND

1. The National Health Service 1948-1974

Structure and administration

When the National Health Service was introduced in 1948 it brought with it three major reforms of the previously prevailing health care situation:

- a fundamental reform of the system of finance
- a complete reorganisation of the hospital service
- an expansion of primary care and provisions for community care and personal social services.

These characteristic features of the National Health Service remained in force up to the present reorganisation. Their implications for its structure and administration can be briefly described and analysed as follows:

Financial organisation: The traditional practice of paying directly for health care services by the patients to the providers at the time of consumption (supported by religious or humanitarian philanthropy where patients were poor or unable to afford the costs of expensive treatment), was replaced with a system of payment from general taxation. The British Government took a conscious decision that finance by this method was the most equitable and practical solution under the circumstances prevailing in the 1940s: there was very little private health insurance in existence and social insurance was only in force for protection in the area of primary care, i.e. general practitioner services (where it had been introduced in 1911 but only for the lower income groups). In practice this decision had the result that since 1948 the overwhelming part of the costs of the National Health Service (approximately 85 per cent) came from general taxation, with about 10 per cent contributed by social insurance under the 1911 Act, and the remaining 5 per cent coming from payments by patients, in particular for prescription charges and part payments for dental treatment and eye services.

This method of finance from general taxation had of course the consequence that the finances of the National Health Service were part of the national financial budget. This in turn necessitated that a Government department, i.e. the then Ministry of Health, had to have

the financial responsibility in that it was to this department that the British Treasury, responsible for financial management, allocated resources derived from public taxation. As the British are strong adherents of the principle "no taxation without representation" it also followed that the Minister of Health incurred the responsibility for the financial control of the National Health Service, with full accountability to parliament. If he had to be accountable and responsible, he had of course to have the authority and power to control the spending of this money. In short, the National Health Service Act laid it down that in the last resort the Minister of Health had legally unrestricted authority to give directions to the subordinate health authorities, and thus his Ministry became in fact the headquarters organisation of the National Health Service.

It needs to be stressed that the method of finance and the economics of the National Health Service are not affected by the present reorganisation.

Hospital reorganisation: In the field of hospitals, the 1948 National Health Service Act provided for three main reforms:

- It created for the first time a national hospital system.
- It created a system of regional planning.
- It organised the individual hospitals into major groups, so-called Hospital Management Committees.

Before 1948 the situation in Britain was very similar to the one prevailing in most other European nations. Hospitals had grown up individually and mostly without plan, either as voluntary institutions donated by rich individuals or groups or - and this was a much later development - they were organised by the local authorities. The latter, however, were mainly restricted to the treatment of infectious diseases, the care of the chronic sick and aged, and the long-term care of the mentally ill and defective. The 1948 Act transferred the ownership of the about 3,000 hospitals in the country to the State, and thus created for the first time a unified national system.

The individual hospital, however, ceased to be a separate administrative unit in that all hospitals in a given locality were brought together for administrative purposes under unified management, so as to permit the benefits of "the economies of scale", in particular for joint purchasing arrangements, etc. In all about 350 such hospital groups were set up.

Finally, since 1948 the country was divided into 14 regions, comprising approximately 3-4 million population, which were to be the key planning units. It was the newly established Regional Hospital Boards which were entrusted with the decision of the need for new hospitals, their actual design and building, and the control of their use. One major exception from regional control was the status of the about 150 University Teaching Hospitals. These were given a privileged position,

working directly to the Ministry of Health and were in charge of their own finance and planning.

Apart from these major reforms, the National Health Service Act in 1948 attempted to retain as much as possible of the traditional organisation of the health services. In spite of the fact that the Service became now a public and national responsibility, the Government decided to retain the old-established tradition of involving voluntary unpaid part-time people in the running of it. Thus voluntary membership was established at the Regional Boards, Hospital Management Committees and also for the individual hospital in the form of so-called House Committees. A Regional Hospital Board, for example, comprises about 30 voluntary members, a Hospital Management Committee approximately 20, and a House Committee on average perhaps 12. This does not take into account the 140 Executive Councils where approximately 50 per cent of the members were volunteers, and those who were elected to the local authorities in control of the local health services. It will, therefore, be seen that in the National Health Service a strong voluntary element was established which comprises more than 20,000 members.

Primary care and community services: Since 1911, as was earlier indicated, a system of social insurance for the low income groups existed which gave protection for the costs of primary care through general practitioners. The latter were being paid a so-called "capitation fee" for each patient who registered with an individual practitioner. The organisation of this limited service in each locality was in the hands of so-called "Insurance Committees" on which the physicians themselves were strongly represented.

This system was expanded in several directions in 1948:

a) The restriction for low-income groups was dropped and general practitioner care became available to everyone and all dependants.

b) In addition to access to general practitioners, the National Health Service opened up access to general dental practitioners, the provision of medicines and the provision of eye care (spectacles, etc.) through opticians and opthalmologists.

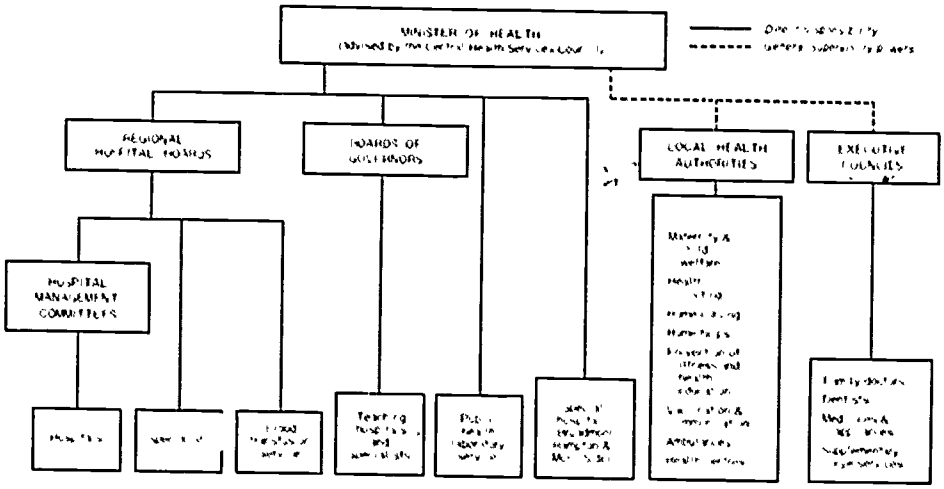
Whereas general practitioners continued to be paid on a capitation fee basis, dentists and opticians were paid a fee for service, and as to drugs - patients themselves had to pay a fixed contribution (which was changed over the years), and the rest of the costs were refunded from State funds.

The basic organisation or primary care, however, remained the same. The only change made was in the redesignation of Insurance Committees into "Executive Councils". There were about 140 such Councils set up for the whole country.

In addition to the primary care services on the lines briefly described, the National Health Service Act made provision for certain community care services which remained in the hands of the major local authorities, cities and countries which had developed them for the preceding one hundred years. Thus, Medical Officers of Health remained responsible for preventive and after-care services; they had the control of maternity services and they employed the community nurses. Finally, certain rudimentary social services began to be developed with the local authorities, of which the main groups were: services for the aged, the care of the disabled, help for the mentally ill and handicapped not confined to hospitals, and also - a much more recent creation - services for the care of children.

The Organisation Chart in existence from 1948-74 presented the following picture:

ORGANISATION OF THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES*



* The administration of the National Health Service is shared differently by organisations in Scotland and Northern Ireland.

Manpower summary

The following summary of the present manpower situation by main categories will provide a helpful background for an understanding of the human problems and the training questions involved. The data will be given in round figures (thousands) and relate to the situation in 1972, the latest year for which official figures are available. The data apply to the National Health Service in England:

a) HOSPITAL SERVICE			
Medical staffs	24,000		
Dental staffs	1,000		
Nursing	286,000		
Midwifery	16,000		
Professional and technical	37,000		
Ancillary staffs	228,000		
Administrative and clerical	48,000		
Regional Hospital Boards Headquarters staff and regional services	11,000		
		651,000	
b) EXECUTIVE COUNCIL SERVICES			
General Medical Practitioners	21,000		
General Dental Practitioners	11,000		
Opthalmic services	6,000		
Pharmaceutical services	11,000		
Executive Councils and allied staffs	9,000		
		58,000	
c) LOCAL AUTHORITY STAFFS			
- Health Service			
Doctors and dentists	2,000		
Community nurses and midwives	27,000		
Ambulance staff	17,000		
Miscellaneous categories	12,000		
- Social Services			
Social workers	15,000		
Home helps	37,000		
Residential homes for the physically and mentally disabled	55,000		
		165,000	
TOTAL HEALTH SERVICES STAFFS			874,000

Source: Health and Personal Social Services statistics for England, 1973, published by the Department of Health and Social Security. Table 3.2.

2. Plans for the Reorganisation in April 1974

The new structure and administration - the reasons for the change

As has been described in the preceding part of this paper, the organisational structure chosen for the National Health Service was one which in organisational theory is usually described as "functional

organisation". This implies
is first of all divided
respond to the hospital
munity care services.

This tripartite
soon began to attract
ed in 1953 to review
Guillebaud Committee
report, published in
however, more voices
functional tripartite
various stages
obsolete and
ical Association,
functional organisation
tion integrating all
ive structure for
This demand for a
National Health Service
the changing population

The functional
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operate quite
treat patients irrespective
services. This became
creasing number of
a continuous and comprehensive
the Service. The number
mously over the last
than 15 per cent of
It became quite clear
number of hospital beds
bility of the other
even more so on the
in their residential
sary numbers, very expensive
were the only means of
did not really need
a modern acute General

More and more
the National Health Service
acute care in hospitals,
were admitted annually
2½ per cent of the total
and community care which

budget. (These calculations are derived from an estimate that a population of 50 million seeks health care, on average, about four times per year, that is it presents 200 million cases for treatment).

For all these reasons the government in power in 1968 presented for discussion an organisational structure whereby the multiplicity of existing authorities would be replaced by 40 Area Health Boards, which within themselves would co-ordinate and control all branches of the National Health Service on a geographically integrated basis. This proposal provoked considerable criticism and in 1970 was replaced by another scheme which increased the number of Area Health Authorities to 90. This was explained by the fact that a simultaneous reorganisation of local authorities provided for 90 new local government bodies, which would be responsible for the social services, and it was by now obvious that there had to be a close administrative link between the new health service organisation and any administration responsible for the social services. Moreover, the division of a country of about 50 million people into 90 Area Health Boards made these rather unwieldy bodies from the health care point of view. In collaboration with industrial consultants it was therefore decided to reduce the optimum size of the projected operational units by dividing each Area into a 'District' organisation. A District was therefore defined as a geographical entity with a population not greater than 250,000, corresponding to the catchment area of a modern acute District General Hospital. The country as a whole would be divided into slightly more than 200 such health districts, which within themselves would control the operation of all parts of the Health Service.

Later in 1970, the Party in charge of the Government changed, and the new Government proposed in 1971 that the existing regional organisation for hospitals should be retained and expanded to cover also the other parts of the National Health Service. From all these considerations the following organisational structure emerged, which was finally incorporated into the new Health Service Reorganisation Act.

New functions for individuals and groups

The previous section analysed briefly the main objectives of the projected reorganisation, i.e.:

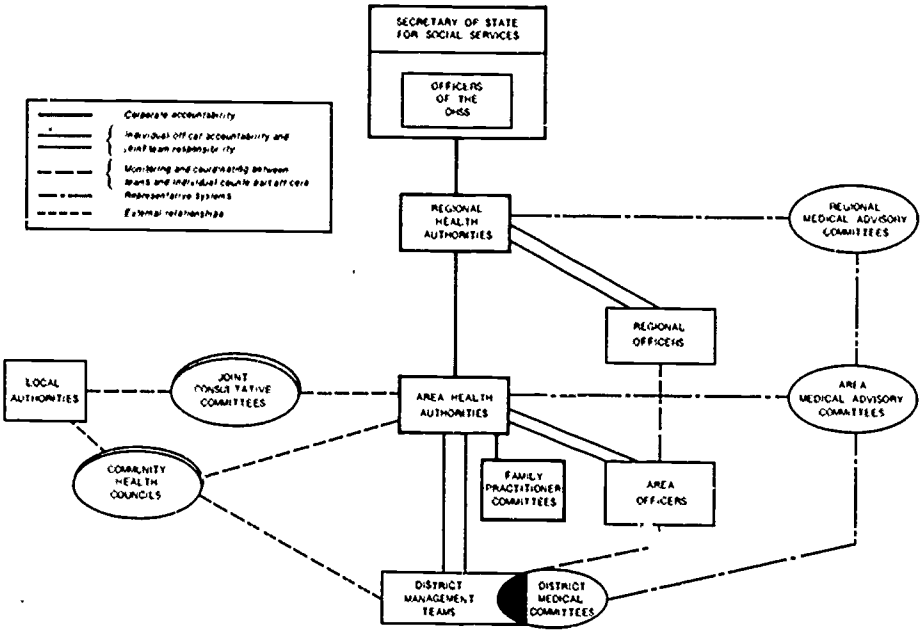
a) Integration of the tripartite functional organisation into a new unified geographical organisation.

b) Reallocation of the existing budgetary resources through the construction of a new comprehensive health care planning system.

c) Collaboration of the new health service authorities with their corresponding new local government authorities, with respect to social services.

To these three main goals must be added two subsidiary objectives which, nevertheless, have a considerable impact on the functions and management problems of the new organisation. These could be summarised

FRAMEWORK OF THE ORGANISATION STRUCTURE FOR 1974



under the heading of Professional Participation and Democratic Representation:

d) Not surprisingly, it has been right from early beginnings the medical profession who demanded a substantial participation in the decision-making management processes of the Health Service. Every government since 1948, however, refrained from accepting this demand by insisting that the National Health Service was a publicly financed body which had to be publicly accountable. On the other hand, every government recognised that the medical profession was clearly one of the key bodies in any Health Service and that from the scientific and technical point of view, its opinion had to be taken into account. In the new structure, provision was therefore incorporated for increasing the effective participation of the medical profession at all levels. Thus, a District Medical Committee would comprise all clinicians within the district, i.e. consultants and general practitioners, who would form a collective opinion which could then be voiced at the District Management Team through two representatives, i.e. a consultant and a general practitioner. Equally, they obtained the right to organise themselves at Area and Regional level, whereas a National Central Committee would bring their opinion to bear at the level of the Ministry.

Similar participatory machinery was eventually agreed for other professional bodies, i.e. the dentist, the nurses, the pharmacist and the optician. The Act foresees the possibility that a Minister may recognise even more bodies as long as they are representative of particular groups of health workers, and their recognition would be in the interests of the Service.

e) Perhaps an even more interesting innovation has been provided in the so-called Community Health Councils which are laid down in the Act. Here too, a solution has been attempted for a long-standing problem. In the original National Health Service (1948-1974) popular participation existed but one of the major criticisms was that these committees of voluntary unpaid part-time members represented a mixture attempting to combine the managerial role with that of representing the interests of the public, which was not always successful and often led to a conflict of roles. The Government decided finally on a separation of these roles by making the new Regional and Area Health Authorities purely managerial bodies, small in numbers and filled by people with executive and administrative experience. This policy meant of course that the number of places available to non-Health Service groups, which was already curtailed considerably in relation to the past by the enormous reduction of health authorities, was even further reduced, so that the number of voluntary members is now only a few thousand. To make room for substantive representation of the public and potential patients, the new concept of Community Health Councils was introduced. These were conceived as bodies of approximately 30 lay personnel which in each of the 200 Districts would have the right to make representations to the responsible managerial health authorities about the existing Service, its adequacies and short-comings. The authority, however, to make final decisions was left unequivocally with the new District, Area and Regional Health Authorities.

f) Finally, the National Health Service reorganisation led to the creation of a new function within the medical profession, i.e. the concept of the Community Physician. For the last 100 years or so the role of the Medical Officer of Health as the chief organiser and executive director of all Community Health Services under the control of the local authorities was well recognised. Within the last few decades, however, this role became less and less attractive to the younger generation of physicians in particular, with the decline of infectious diseases which were previously their main activity and success. On the other hand, the development of modern epidemiology and health care planning demanded increasing attention. It was therefore recommended by various Government committees that there was scope for a new medical specialism, which was designated "Community Physician". This new role became fully incorporated into the new organisational

structure at all levels and it is estimated that approximately 800 Community Physicians may be required.

New management problems foreseen

In the official document issued by the Department of Health and Social Security, "Management arrangements for the reorganised National Health Service", the general aim of the reorganisation was clearly defined as: "There should be a fully integrated Health Service in which every aspect of health care can be provided". This goal required for its achievement that instead of the separate management of the three sectors of the National Health Service previously described, there should from then onwards exist only one management organisation which would plan and control all of them. This in itself was bound to create very difficult problems because the individuals comprising the new management were the same people who had previously been in charge of individual sectors. In addition, moreover, it was suggested that the management should be put on a fundamentally different basis, i.e. instead of being hierarchy, it would from now onwards be based on multi-disciplinary management teams. To quote from the above-mentioned document:

> "A characteristic of the Health Service is that the provision of health care is often a team activity. Different skills have to be combined in various ways to meet the needs of individual patients; different professions must come together to plan and co-ordinate their activities to meet complex objectives; and the work of the various skill groups has to be co-ordinated within institutions."
>
> "Because of this complexity, organisation in a single hierarchy controlled by a chief executive is not appropriate. The appropriate structure is based on unified management within the hierarchically-organised professions, on representative systems within the non-hierarchically organised medical and dental professions, and on co-ordination between professions. Co-ordination between professions at all levels will be achieved by multi-disciplinary teams through which the managers and representatives of the relevant professions can jointly make decisions."
>
> "The teams will be consensus bodies, that is, decisions will need the agreement of each of the team members. They will share joint responsibility to the Authority for preparing plans, making delegated planning and operational decisions, and monitoring performance against plans. The teams must be small, and will therefore consist only of those whose unanimous agreement is essential to the making and effective implementation of decisions for the totality of health care."
>
> (Sections 1.22. 1.24 and 1.25)

II. PLANNING FOR TRANSITION

1. Department of Health and Social Security: Analysis of Need for Preparation

Already in the first preliminary document issued by the Department in 1968 ("The Administrative Structure of the Medical and Related Services in England and Wales",) it was clearly recognised that the setting out of new patterns for the organisational machinery would not be sufficient:

> "Steps would also have to be taken well in advance of making any final change to a new administrative structure to prepare staff for their prospective roles. In particular, training for management in a unified Service should be an early priority."
> (Section 87).

These considerations were upheld and expanded in the second official document published in 1970, "The Future Structure of the National Health Service". It underlined equally the need for a major effort so as to prepare staff for work in the new Service, and added:

> "...because of the time needed for sufficient staff to complete training on so large a scale, training courses may have to be started before many staff know for certain what posts they will obtain in the new Service."
> (Section 101)

and

> "The establishment of an integrated Health Service will make it necessary to consider how far particular specialised training programmes are still appropriate, whether existing personnel can with further training undertake wider functions, and whether new forms of generic training need to be developed."
> (Section 106)

It is very important to stress that the change of government which occurred after the elections in 1970 did not lead to any change in this policy. The Consultative Document published by the new government reiterated the policy of its predecessors completely:

> "It will be our aim to improve the training arrangements for senior staff so that we may develop managers trained to consider and...to serve the total needs of their Areas."

When finally the policy of the government was officially formulated in a White Paper published in the summer of 1972, it specifically stated under the heading, "Management training" (Section 149):

> "Professional and occupational training will be complemented by management training, that is training to equip all the decision-makers with an understanding of the needs of the Service as a whole and of its staff, and with the skills enabling them to make the best use of the available resources. Most management training will need to be multi-professional."

These quotations indicate that the government department responsible for the administrative reorganisation fully realised the importance of the human factor in its success. As a previous government Report - the Gillebaud Committee published in 1956, Section 149 - had forcefully pointed out: "..those who have spent the greater part of their working lives under quite different conditions...have not always found it easy to adapt themselves to the new order of things".

> "Some of the strains and stresses of the National Health Service are attributable to the difficulty experienced by many who have grown up under the old system, when called upon to operate a Service administered on different lines."

2. Decisions and Negotiations Regarding Training

In deciding on the immediate training needs for the preparation of the reorganisation, the Department had to keep in mind the following major fundamental changes previously outlined:

a) To retrain officers used to managing individual sectors of health care, i.e. hospitals, primary care or community services, so that they would be capable of "serving the total health care needs of the Areas".

b) To transform officers used to executive and hierarchial management into managers forming a team with co-equal partners making decisions on a consensus basis.

c) In addition to these retraining needs of officers, the Department had to take into consideration also that the voluntary members were in a similar position. From 1948-74 they were either responsible as hospital authorities or they were elected members of local government, or belonged to Executive Councils responsible only for primary care. From now onwards they were at regional or Area level responsible for total health care in all its aspects. It was fairly obvious that similar considerations as appropriate to officers were necessary if this conversion should be successfully accomplished.

d) There was, moreover, a specific training need in giving the former Medical Officers of Health traditionally in charge of local government health services a chance of being converted into the new

role of "Community Physician", and indeed a special government committee, the "Hunter Report", made urgent recommendations in this respect.

To summarise the immediate training needs for the preparation of the change results in the following main training pattern:

- Integration courses for senior officers from the three levels.
- A training programme to prepare officers for team management on a consensus basis.
- Courses for voluntary members of the newly constituted Health Authorities.
- Conversion courses for Medical Officers of Health to Community Physicians.

To these decisions was equally added another vital area of retraining. It had long been recognised in the National Health Service, as in many other countries, that the effective control over the immediate use of resources (money and manpower), rests in the hands of individual clinicians who decide who, how long, and the methods of treatment of patients. Within the framework of the reorganisation, the fundamental decision was taken that this authority should be matched by an equal responsibility of physicians. To achieve this, clinicians were to be given responsible posts in the new organisation, particularly at the basic operational level, i.e. the Districts. From now onwards, a District would be managed by a "District Management Team" on which a consultant and a general practitioner elected by their colleagues in the locality would be full members. The Department of Health decided that it would be necessary to prepare, through special training programmes, a sufficient number of clinicians in all parts of the country for this new management role. As a consequence, courses were to be offered to general practitioners and consultants so that they would be familiar with this task.

Traditionally, the Department of Health and Social Security had never operated training services of its own. For a number of years it had collaborated with existing educational centres to do this job for the Department, and provided the necessary funds. The same pattern of training through these educational centres was decided upon also for the programme of "Reorganisation Training", as will be described more fully in the next section.

III. COMPREHENSIVE RETRAINING PROGRAMMES

1. General Picture

Total population to be served: As far as the "Multi-disciplinary Integration Courses" were concerned, it was estimated that - taking account of the manning of senior management positions of the new health authorities concerned (14 Regions, 90 Areas and 205 Districts) - there would be a need for approximately 2,000 well-trained officers. To achieve a pool from which this number could be selected, it would probably be necessary to provide training for approximately 3/4,000 officers as a first priority. The programmes for "Community Physicians" had to cater for an estimated need at all levels in the new organisation of about 800. The 14 Regions and 90 Area Health Authorities would each need about 20 voluntary members for whom it was necessary to provide induction training, that is in total about 2,200. As far as clinicians were concerned - bearing in mind the need for two at each of the 200 Districts, and the manning of the advisory machinery at Area and Regional level - courses had to be provided for about 2,500/3,000. The total population to be served was therefore estimated not far short of 10,000.

Number of educational centres: In total, therefore, the most urgent needs of the training programme in preparation for the change offered in sheer numbers a logistically formidable challenge, which the Department could only hope to cope with by enrolling in its support a substantial number of training centres. At the peak of the reorganisation programme the Department sponsored such courses at the following centres (see Annual Report of the Department for 1972, Section 7.75): the Universities of Bath, Birmingham, Leeds, Manchester, Nottingham and York; the Polytechnic at Leicester and the Management College of the King's Fund in London - a voluntary organisation.

National Health Service Fellows: A number of these centres were comparatively new to the National Health Service and even those who had a longer connection as training institutions with the Department of Health were short of experienced training staff to cope with these numbers. The Department announced, therefore, early in 1972, arrangements to finance centrally a number of Fellowships to enable senior officers of the existing Service to assist the educational centres

providing courses. These Fellows were intended to assist in the planning and development of courses and take an active part in leading syndicate discussions, holding tutorials, etc., as well as performing a bridging role between the academic staff and the course members. (Annual Report 1972, Section 7.78).

General educational objectives: The aims of the Multi-professional Integration Courses which the Department planned were stated in broad terms as follows:

a) "to extend and deepen senior staffs' knowledge of the National Health Service as a whole."
b) "to increase their understanding of the implications of integration."
c) "to consider some aspects of management which will have increased relevance in an integrated Service," and
d) "course members will study how integration will change the ways in which National Health Service resources can be deployed in the service of the public."

Administrative and financial arrangement:

In the same document, "Staff training memorandum 1 - 72", it was laid down that these courses will be open to staff of all professions carrying senior administrative responsibilities in the existing health centres: medical administrators, chief nursing officers of hospital authorities and the local authorities, hospital group secretaries and treasurers, chief administrative officers of local authorities' health departments and clerks of executive councils; and those of equivalent seniority and responsibility in their professional groups...

All courses would be residential, and the cost of the courses, including the cost of residence, would be met by the Department of Health. Any other expenses incurred by course members, such as travelling costs, would be refunded by their employing health authorities in the normal way. It was understood that the salaries of staffs attending courses would be paid, and that general practitioners would receive compensation for the costs of any locums to cover their absence.

Applications for places on these courses were invited by the Department from the officer groups defined. Every officer could state his preference for a particular educational centre and a specific course, and the Department was responsible for allocations to centres and to courses. The training centres themselves would not be involved in any selection.

In the financial memorandum accompanying the National Health Service Reorganisation Bill it was estimated that the total financial costs of the reorganisation might amount to £17 million. This figure would also include the cost of special training for senior staff. The 'supply estimates" of the official budget for the financial years

1972-73, 1973-74 and 1974-75 (Class VII (4)) show under the heading "National Health Service Reorganisation: F2 Staff Training", the following figures:

1972/73	£272,000
1973/74	£574,000
1974/75	£440,000

2. Pattern of Action at the University of Manchester

Authority and administrative arrangements

The Department of Social Administration at the University of Manchester had collaborated with the Department of Health since 1956 in the organisation of training programmes for junior and middle managers. It was in this context that the University was approached to take part also in the training programme planned for preparation of the integration. At the same university the Department of Social Medicine was also selected as one of the three university centres in England to provide 'conversion courses' for medical administrators into Community Physicians.

The Department of Social Administration is part of the Faculty of Economic and Social Studies at the University of Manchester, and Professor Chester was Head of the Department, and its Chairman since 1955. Up to 1971 the staff of the department exclusively concerned with training in the health field was one senior tutor and one junior tutor. It had been customary to call on lecturers and teachers from other departments and faculties as and when required. This had the two-fold result that this specific health budget was comparatively small and that, moreover, teaching could be easily adapted to any changing need without creating an upheaval or even redundancies among the teaching staff. The costs of these staff members, who were legally employees of the University, were included in the annual budget which the University authorities submitted to the Ministry, and refunded by the latter, including all other costs of the training such as secretarial staff, teaching material, etc.

It was made clear by the University to the Department of Health that the massive retraining programme would need at least one senior new staff member for its planning and direction. This was fully approved by the Department, otherwise the same policy would be followed, i.e. by drawing on outside lecturers and speakers and paying them for their individual services. In addition, the Department of Social Administration requested and was granted the services of two "National Health Service Fellows" to function as tutors for individual courses. In general, the Department of Social Administration submitted the names of outstanding participants from previous courses and received the services of a substantial number of doctors, nurses and administrators in the course of the last two years. These in turn profited

from these assignments in the widening of their experiences and acquisition of new skills in teaching.

Planning mechanisms

As previously described, the Department of Health entered into contracts with eight institutions, ranging from universities to voluntary foundations and even embracing within each university a diversity of departments of experiences. It also had promulgated in its circulars the broad goals and objectives of the training schemes. As a national effort was required it was clearly necessary for the Department to provide for some basic uniformity of the programmes to be organised by these diverse institutions. This aim was achieved by arranging a number of conferences at the National Headquarters of the Department in London, to which representatives of the training institutions were invited. This gave them an opporunity to get to know each other's ideas, approaches and plans, and to attain a broad co-ordination. Otherwise the Department refrained consciously from imposing at this stage a centrally conceived scheme. Each training institute was left free to design its own programme and experiment with ideas as long as the broad objectives were incorporated.

Implementation

Numbers and types of attendance: Within the last two academic sessions (1972-73 and 1973-74), the Department of Social Administration held the following courses:

a) Sixteen "Multi-Disciplinary Integration Courses" - each course attended by 25 members, that is a total of about 400 participants. The first seven courses extended over four weeks, the remaining nine were shortened to two weeks to increase the 'through-put'.

b) Eleven courses for newly appointed Health Authority Voluntary Members - 15 members per course, that is a total of about 170 participants. These courses lasted two days as this was considered to be the maximum period which voluntary unpaid lay people people could give up.

c) Ten programmes for Clinicians, each attended by 20 participants, a total of 200 people, equally shared by consultants and general practitioners. The length of these courses was three days, normally from Wednesday evening to Saturday lunch-time - a pattern which was considered convenient particularly for general practitioners who thereby only lost two days of busy surgery (office work).

d) In addition, the Department of Social Administration co-operated with the Dental School of its University in organising four programmes for dentists, which were attended by about 200 dental surgeons, each programme lasting about nine days.

Groups served: In accordance with the wishes of the Department of Health, the representation of course members was extremely diverse. In the first place the choice was made so that the three main sectors of the existing Health Service were represented by Chief Officers, i.e. about one-third from the hospital sector, one-third from primary care and one-third from community service. The second criteria of choice was a representation of the various professional groups involved in health care, i.e. physicians, nurses and administrators from all three sectors; thus physicians comprised hospital consultants, general practitioners and Medical Officers of Health (some of those also attended the conversion courses to Community Physicians) and there were nurses from hospitals (both acute and psychiatric) as well as nursing officers working in the community. Good care was taken to include male as well as female nurses. The administrative group again included finance officers, engineers, supplies officers, ambulance officers, etc. Course membership for the Multi-Disciplinary Course was drawn from all parts of the country, as at this stage it was by no means determined where senior officers would finally work. The other two programmes - for members and clinicians - were in the main drawn from the North-Western region, where they would work after reorganisation. This dual system worked fairly smoothly and no complaints were made.

General course format: All courses were fully residential and were held in the new residential block at the Manchester Business School, with whom the Department of Health made a contract for board and lodging of each attendee. The sleeping accommodation including private bath with each room was very modern, the standards of feeding on the premises excellent and there was purpose-built accommodation for lectures and seminars. In addition there was plenty of room for informal gatherings of the participants and, in particular, a bar for their use in the building.

Great care was taken in designing each course for the needs of a mature audience. This meant that the time given to formal representation and lectures had to be brief, with the greatest possible scope given to participation by the course members. In practice this meant that each day of the course was divided into three parts, a morning session, an afternoon session and an evening session, with only one presenter at each session. Moreover, each session in itself was divided into three parts, again, i.e. a presentation of information, discussion by the participants in small syndicate groups of about six under the guidance of a tutor to discuss the lecture and prepare questions for discussion, and finally a plenary session with general discussion, with a break for refreshments in between.

To increase the direct participation by the course members, periods were also set aside for project work in groups. These projects resulted in joint reports which were finally submitted by the groups to the whole course and led to a general discussion of the issues involved. (To increase the interest of the course members, copies of their reports were regularly sent to a senior officer of the Department of Health so that they knew that their ideas might influence national policy).

Course content for different groups

a) Multi-Disciplinary Integration Courses: The primary objective of this programme, as previously indicated, was "to extend and deepen the participants' knowledge of the National Health Service as a whole". This had the clear implication of providing them with information on the various parts of the existing Service, i.e. the organisation and management of hospitals, the work of the local authority health departments, the organisation of primary care with particular emphasis on health centres, the problems of psychiatric health services, the role of rehabilitation, etc.:

In pursuance of the second aim, i.e. to extend the implications of the integration, a series of lectures were mounted explaining the background to the reorganisation, the emerging new pattern, a comparison with trends in the health care systems of other countries and finally a critical review of the proposed reorganisation under the heading "The reorganisation in perspective". The third goal of the course was to consider these aspects of management with increased relevance in an integrated Service. This was done through a three-fold programme by concentrating on the future planning of health care including information systems, the increased emphasis on personnel management and industrial relations, and finally by stressing the need to understand the financial machinery, including the costing and accounting system. Finally, an attempt was made to present to course members the scope of the present resources devoted to the National Health Service, and possible changes in their deployment. This was done by providing some basic lectures on health economics and the British system of public expenditure control.

b) Courses for voluntary health authority members: The course content was of necessity circumscribed by the short duration of this programme. What was attempted was to give the voluntary members some understanding of the reasons for the reorganisation and the main objectives to be attained. This was followed by a presentation normally given by a senior official from London explaining how the government saw the role of the new Authorities and the functions of the individual members. Equally a representative of the Regional Authority concerned was given the opportunity to set out the Authority's views about the relationship with the Area Health Authorities under its jurisdiction.

The remainder of the short programme was devoted to analysing briefly the relationships of the Health Authorities with outside bodies with which it had to establish close relations in the future reorganised Service, i.e. the social services under local government, the Community Health Councils to be established and finally, the professional advisory machinery to be organised by the major staff groups.

c) Courses for clinicians (consultants and general practitioners): Here again the course started with a presentation of the Genesis and purpose of the reorganisation. The major part was devoted to showing each individual participant the role of physicians 'in the round' in the new Health Service. One session each was given up to the role of consultants in the new system, the scope for participation by general practitioners and finally, explaining to the clinicians the new concept of the specialist in community medicine. The rest of the programme was allocated to a discussion of service planning in the new system and in particular to the unaccustomed principle of consensus management. Most clinicians learned by this method how difficult it is for members of such an individualistic profession to arrive at a consensus view.

3. Evaluation of Overall Programme and Programme at Manchester

Formal evaluation

Use of questionnaires: An attempt was made to design formal questionnaires to obtain a feed-back from the participants about a course programme. These were administered in two ways, experimentally, i.e. immediately at the end of each course, or after a period of several months had elapsed. On the whole this method of evaluation did not prove particularly helpful. Criticisms were comparatively negligible and generally dealt with minor problems of administration during the longer courses, i.e. the availability of hot drinks during the night - a subject very dear to the hearts of most English people!

Informal evaluation

Much more informative were the general review sessions provided at the end of each course, when each individual participant could make his views known on every aspect of the programme. Again one has to be forewarned by the fact that immediately at the end of a course there is the danger of euphoria created by the general course atmosphere and congenial environment. On the other hand, there is an equal danger that if it is suggested to the participants that they should be critical, they will in fact produce comments which taken out of context may be too hypercritical and unbalanced.

Experience with management education, and particularly with programmes designed to change traditional attitudes, indicates that a proper evaluation is a complex and long-term process because the most

successful courses have often a subconscious impact which the individual course member in most cases can neither analyse nor express. It demands the observation by an outsider of his behaviour before and after the course to attain a true picture of the course success. The only possible substitute to such observation are detailed interviews with the course participants, their superiors and their subordinates. Such an objective and critical evaluation has not as yet taken place. It nevertheless seems possible to make the following general observations from the point of view of one who has organised, directed and participated in most of the courses described above:

a) There is no doubt that the total environment in which the learning processes, particularly of adults, takes place is of fundamental importance. This applies particularly to programme objectives where senior course members from different sectors meet with the aim of learning about the total Service: in this particular case they would be learning from each other probably more than from a formal session. Sitting in the evening in a bar and having a friendly drink, they feel much more at ease in interrupting and cross-examining each other about their mutual jobs. It became clear over the course of the programme that the impact of the informal residential character of the courses in agreeable modern surroundings was very important. Senior officers from a variety of jobs who rarely had a chance to meet each other came across for the first time. They expressed their pleasant surprise about the previously unknown colleagues. Any number of personal friendships across the normal boundaries of professions were established during a course and subsequent information indicated that these lasted during the ensuing years and led to a closer co-operation where course participants worked in the same geographical area.

As the course objectives were primarily to extend and deepen the knowledge of the whole of the National Health Service there can be no doubt that these were in most cases achieved.

b) Probably a similar level of success was achieved by laying the emphasis of the course on participation particularly through group work and far less on formal presentations. Many participants had held before arriving the traditional view of a university as an 'ivory tower' where professors lectured 'ex cathedra' without waiting for or even being interested in the views of the students. They enjoyed, therefore, the opportunity to work in groups and to raise questions, formally and informally, with the speakers who in all cases had sessions lasting several hours to put themselves across.

c) The syndicate discussions were particularly valuable in that they enabled the members to work out their problems in a group without an individual dominating the discussion. They had a chance to fill the role of chairman and group secretary, trying to direct a discussion group and experience the difficulties of recording the proceedings and

reporting the result. This group work also meant that the questions which its members wanted to put before the speakers were much more carefully considered and presented. The National Health Service tutors who assisted each syndicate group performed an extremely valuable role.

d) At a different level of evaluation, it must be stated - not unexpectedly - that even in a Service where the overall goal seems so obvious to help suffering humanity - specialisation of roles and functions is going very far indeed. The ignorance which individual course members revealed about the other parts of the Service was very often enormous. There can really be no doubt that from this point of view, courses made a lasting impact.

e) Clinicians: It is a well-known fact that owing to the historical development in the practice of medicine, general practitioners and consultants do not see eye to eye. In the United Kingdom general practitioners could not forget for a long time in the National Health Service that they in former days were the masters in charge of patients who brought in the specialist as and when they thought necessary. Under the National Health Service, the consultants became the heroes of medicine who considered a general practitioner as a "failed specialist". This personal antagonism between these two sectional groups probably created more difficulties in the National Health Service than their separate former organisation. Since 1965 the situation considerably improved with the so-called Charter for General Practitioners which enhanced the economic status of the general practitioner. The development of post-graduate education and the spread of such centres also helped in bridging the existing gap. Bearing this situation in mind, the courses for clinicians must be considered a success, as they brought together the two branches of the profession in amiable surroundings conducive to friendly conversation and interaction. One can only hope that this persisted beyond the confines of the School!

f) Voluntary Members: The conspicuous impression from the course arranged for voluntary members was their keeness and, in most cases, intelligence. They were very anxious to learn and, in particular, to identify their personal contribution to the National Health Service. Indeed, one observed as an outsider how quickly they absorbed their prerogatives and were prepared to defend their territory of action against any 'intruder' from higher authority or from an outside body. It is, of course, difficult to judge whether the programme will have a lasting impact on their attitudes. Probably the Department is right in considering that the impetus given by the current seminars needs to be sustained.

IV. DISCUSSION AND CONCLUSIONS

1. Prospects for the Future

Having, so to speak, laid the basic foundations for the preparation of the projected reorganisation through the three programmes described and evaluated, the Department is now contemplating the filling in of the other major outstanding problems, in particular in five directions:

i) Community Health Councils.
ii) Joint Consultative Committees for the collaboration between health and local authorities.
iii) The Professional Advisory Machinery.
iv) The new Planning Machinery.
v) Promoting the effectiveness of consensus management by multi-professional teams.

re i): As was explained earlier in this paper, the new law provides for the establishment of Community Health Councils as a new means of representing the local communities' interest in health services to those responsible for managing them. These councils will normally comprise 30 voluntary members from diverse backgrounds nominated by local government or other voluntary organisations. The regulations setting up these new councils are fully aware of the fact that the effective functioning of such councils demands satisfactory information about the National Health Service for its members, and states specifically:

> "Although it is likely that some members of Community Health Councils will have considerable previous knowledge and experience of the health services, a number may not and Regional Health Authorities should consider, in consultation with the Councils and their relevant Area Authorities, the need to offer seminars or other arrangements by which new members can be informed about the National Health Service and its management arrangements. It might be convenient to arrange a series of half-day sessions and visits. The object should be to cover such subjects as the organisation and functions of the new health authorities, financing the health service, planning systems, manpower problems, and studies of particular services."
> (Section 28: Circular HRC(74)4.)

re ii): One of the crucial problems of the National Health Service in the future is the close collaboration between health and social services and their respective management bodies. The Act lays down specific machinery for such collaboration in the form of Joint Consultative Councils made up by members of each authority, supported by their respective Chief Officers. Again, the Department of Health is quite realistic about this problem that such collaboration will vitally depend on the mutual understanding of the groups involved, of each other's problems and points of view. What will probably happen from the training point of view will be the organisation of "bridging seminars" to bring together members and officers from both sides.

re iii): As earlier described, a beginning has already been made by organising seminars for clinicians. Many other groups are, however, involved in this advisory machinery and the education centres are encouraged to give this problem more thought. Not only will there be a quantitative expansion of programmes for physicians but it is more than likely that future courses will be opened to junior trainee-specialists, in this country designated as Registrars and Senior Registrars. Experience has shown that the timing of such training is very important if its major objective is the changing of deep-seated professional attitudes traditionally held by professional practitioners. Clearly an effective system of management in the health care service demands that the professional staff understand the inherent constraints of the Service i.e. in finance, manpower, etc.: so that they learn how to extend practical advice and not 'demand the moon'.

re iv): One key factor of the Service is the extension of the concept of planning. Under the existing organisation, planning in the main meant the conception of the need for a major facility, (hospital, health centre, etc.), its design and building. In the new Service, planning will not just cover physical planning but be concerned with total service planning. Moreover, planning will also be extended in the time dimension in that it may cover such service replanning for a number of years, perhaps up to ten. This new planning machinery is still being worked out at headquarters. Its practical implementation will obviously need qualified practitioners. It is, therefore, envisaged that the educational centres will be asked to organise courses on a sufficient scale to provide for this training.

re v): But more complex and challenging will be the organisation for "team building". As has been stressed in this document, the present reorganisation of the National Health Service is based on a double goal - a new organisation and a new style of management. The first is being achieved by integrating the former functional sectors on a geographical basis, whereas the second one replaces the traditional executive hierarchy by multi-professional consensus management.

In future, management decisions at all levels of the new organisation will be taken by multi-professional teams comprising physicians, nurses, administrators and finance officers.

Whilst the integration courses previously described catered for the first need - reorganisation by integration - the second issue creates a host of new problems. It was clear to the planners of the reorganisation that managers used to traditional methods would, without preparation and help, experience great difficulty in getting used to the new syle. One major problem in helping them to overcome these difficulties was that contrary to the Integration Courses these Team Building Courses could not be organised before the new teams were actually in office. All posts have now been filled but the first few months of the reorganisation will be completely taken up with urgent tasks to get the new organisation going, so that the start of the Team Building Courses will have to be postponed. The University of Manchester expects to run a pilot programme during the summer and perhaps a dozen courses during the next academic year. The Department has attempted to set out the objectives of these programmes more clearly. They are not seen as a means of conveying further information or advice, nor are they intended to be used as instruments of 'experiential learning', i.e. an analysis of inter-personal relationship within the actual group. They are on the contrary envisaged as providing a platform for the pooling of experience and cross-fertilisation of ideas. The members of the multi-professional teams will have an opportunity to discuss with others in the same situation, and with the help of academic people used to looking at management problems conceptually and objectively, the difficulties which face them particularly in managing the change process itself.

In practice it could be expected that two types of courses may be developed. Horizontal programmes consisting of management teams from the same level in different parts of the country, or vertical ones which would be offered to an Area Management Team, together with the District Teams of its own territory. It seems clear that teaching centres will be faced here with a new and challenging task where probably they could profit from the experience of the behavioural sciences, in particular from the new discipline of Organisational Development.

2. Some Lessons Learned

The lessons learned from the current experiment in preparing for organisational change can perhaps best be analysed from the point of view of the three major participants involved: the National Health Service, the universities and, finally, the government in particular the Department of Health.

The National Health Service

The case for retraining - 'ts reasons and rationales: The case described in this paper reveals clearly that any reorganisation is not just an exercise in logical thinking, the drawing of neat organisation charts and careful job descriptions. It is in fact a major social upheaval demanding a careful preparation of individuals and groups for the change demanded from them by the new system. Failing such preparation, any reorganisation is in danger of becoming a dead letter without any substantive achievements in reality. The case for retraining in this situation seems irresistible and - with hindsight - it is difficult to understand why this has not been done in all cases. One would hope that the lesson of the British experiment will be heeded.

Need for continued retraining mechanisms on a broad basis: Any organisation is at all times a living organism. Staffs are continually changing and the methods of operation are equally varying. Especially at a period of a rapid technological change, retraining demands a continuous effort. Moreover, to be effective it has to be very broadly based. It has been estimated for example that the number of officers in the National Health Service who have some managerial responsibility is about 100,000, i.e. about 10 per cent of the total staff when first-line supervisors to Chief Officers in all occupational groups are taken account of. It is therefore to be welcomed that very substantial efforts are being made in the Health Service to create a permanent body for retraining in the form of a National Health Service Training Council.

The role of management vis-à-vis professional retraining: In recent years an understanding has grown up in most organisations that their effectiveness depends on two factors: the technical efficiency of their professional staffs in their particular discipline, i.e. engineers, accountants, etc. and the corporate efficiency of the organisation derived from the ability of its management, i.e. the effectiveness with which the varied professional tasks are planned, organised, co-ordinated and controlled. There is no doubt that training has to satisfy both needs. One must, however, realise that professional training is a long recognised and established need with well tried content and methods. Management training on the other hand is a fairly new discipline where both content and methods are still undergoing trial and error. The National Health Service is no exception. The training of professional staffs is well established, whereas management training was introduced less than 20 years ago. Again, it is very noteworthy that management education and training for and in a reorganised National Health Service has been given so much attention. A major effort is under way to particularly improve personnel management which is of vital importance in such a highly labour

intensive service, where nearly 70 per cent of costs are being incurred on salaries and wages.

Perhaps it is worth adding that management education and training in administration may even be given scope also within the training programmes of the older professions, thus for example, the report of the Committee on Nursing (Briggs Committee) published in 1972, strongly recommended the setting-up of a number of Colleges of Health for a considerable degree of inter-professional training. (Section 362-369).

The universities

Post-graduate and post-experience education: Post-graduate education is currently out of favour in British education policy. All resources are being concentrated on creating more places for undergraduates. In this situation where universities feel the dearth of resources for their post-graduate programmes, they welcomed in principle the new task offered to them by the National Health Service as it seemed to fill a gap between their expectations and the present reality. The universities, however, may hope to see that these short management programmes may be supplemented by longer traditional post-graduate courses leading to a Master's degree or even to a doctorate. The National Health Service on the other hand finds it difficult to establish acceptable criteria for identifying those of its staff members who would benefit from such longer courses. It must be pointed out that the situation in Britain is fundamentally different from that long prevailing in the United States of America where Masters' and doctoral programmes have proliferated during the last decades.

Relevance and vocational training: The universities are still accused by their students that the courses offered are not relevant to the needs of the modern world. Equally, they are under strong pressure from traditional academics not to get involved in vocational training which should be left to the lower levels of further education. Current experience with Health Service management training seems to indicate that this is a false dichotomy. The difference between higher learning and vocational training lies not so much in the topic at issue but in the method and depth of the approach. It is not the subject matter but the way it is being taught; "relevance" is not necessarily opposed to this.

Experiments in educational methods: Perhaps the greatest benefit which education centres derived from their participation in the present programme consisted in the great scope for experience from experiments with different teaching methods. Foremost there was the need to design programmes for the multiple educational needs of very mixed audiences with great variations in previous education, intelligence and experience. There were highly trained clinicians, including some Professors of Medical Schools, and at the other extreme simple

house-wives who had left school at fourteen. Equally, there was an enormous age range from 30 to 60 years with vastly different individual capacities to listen and to learn.

There was also the challenge to develop the most appropriate educational technology and visual aids. Thus use was made of closed-circuit T.V. for filming groups in session and replaying the tapes for self-observation.

Finally, the participation in these programmes opened for most universities fresh possibilities for research, which it is hoped may lead not only to an increase in factual knowledge about National Health Service problems but enhance their teaching capacity.

The availability of resources: There can be no doubt that expertise in management training in the universities is very scarce in general, and the number of those who can effectively teach for the National Health Service is very small indeed. There is no question that the development of the required training base needs urgent arangements to develop more and better qualified teachers. A beginning has been made in that a few suitable officers have been offered posts at the education centres which combine service as trainers with the opportunity to read part-time for relevant higher degrees.

The Government and the Department of Health

Recognising the need: Comparing the reorganisation of the National Health Service with similar changes introduced in other spheres, and in particular in industry, one must recognise that the government and the Department of Health appreciated right from the beginning the need for training. This is the more remarkable when it is realised that training for reorganisation by definition implies training in advance of reality for an as yet not existing position. Unless other examples can be pointed out, it looks currently as if the Department of Health holds a leading position in creating this precedent in preparation for change.

The advantages of central control: The Department of Health has - as has been described earlier in this paper - the full ultimate control over the National Health Service. In particular, it disposes of all its finances. The one million staff of the National Health Service are not civil servants nor are they employed by the government. Their legal employers are the different Health Authorities who have the right to hire and fire. Nevertheless, the powers of the Department are such that it can generally "get things done" in the National Health Service if it decides to sponsor an issue such as training schemes from the centre and nationally. It could be doubted whether the retraining programme for the reorganisation could have been carried out at the present scope if it had not benefited from this national sponsorship. Although the costs of this retraining scheme are very substantial, seen in the context of the total national expenditure for health of

nearly £3,000 million, it was a very small amount and probably more easily accepted within the framework of national accounts. The lower authorities such as Regions and Areas would have encountered more difficulties in getting such expenditure through.

The advantages of decentralised training: Whilst the Department sponsored nationally the training scheme, it delegated its execution to eight institutions of higher learning, each with different resources and ideas. It did not attempt to impose a national solution but was content with broad co-ordination of policy whilst permitting a number of experiments which in turn allowed comparisons between different methods to attain the same national goal. Looking at the total situation from the vantage point of an independent observer, one becomes conscious that an advantageous balance between national sponsorship and finance, with decentralised pluralism in the execution, was a very good solution to the issues involved.

V. SUMMARY

i) From its beginning in 1948 to its reorganisation in 1974, the National Health Service was organised on a "functional" pattern. Its administration was divided under the Ministry of Health (later the Department of Health and Social Security) into three main groups:

1. The hospital services.
2. Primary health care.
3. Community health services and personal social services.

Management training and experience was accordingly restricted to one of these three groups for permanent officers and the voluntary members concerned.

ii) The main purpose of the reorganisation in 1974 was to integrate this functional tripartite structure into a geographical organisation at the Region, Area and District, with authority and responsibility for all health sectors concentrated into one management body. It created thereby for the first time the need for senior staff and voluntary members to acquire experience, so that they would be enabled to manage the integrated National Health Service. The Department of Health decided therefore -well in advance of the reorganisation - to organise preparatory training schemes.

iii) Moreover, a new problem was created by the concept of basing management in the reorganised Service on "Multi-professional Teams" which would take decisions by consensus and not derive their authority from executive hierarchical status. This need was seen as particularly urgent for clinicians (consultants and general practitioners) who were being drawn into such managerial teams, especially at the District level, for the first time.

iv) The community care services had been traditionally in the hands of the local government, where they were controlled by public health officials with the title, "Medical Officers of Health". When these functions were transferred from local government to the integrated new health authorities, the role of the Medical Officer of Health became obsolete. On the other hand the requirement for well-trained medical planners and administrators was clearly seen. The Department of Health was therefore advised by a committee of specialists to provide training also for converting the former Medical Officers of Health into the new role of Community Physicians.

v) The total need for training in preparing for the change through the reorganisation was estimated at about 10,000 staffs. The Department of Health, which has the ultimate responsibility for the National Health Service in general and for its training needs in particular, decided to enter into agreement with eight educational centres in various parts of the country to sponsor four types of training:

a) Multi-Professional Integration Courses for all types of senior staffs.
b) Courses for Voluntary Members of the new health authorities.
c) Programmes for Clinicians, preparing them for their new management roles.
d) Courses for Medical Officers of Health and their medically qualified staffs in preparation of their new function as Community Physicians.

All courses were to be residential, with the total costs borne by the Department of Health. Individual staff members applied centrally to the Department of Health for admission to the programme concerned and were allocated to individual training centres and, wherever possible, to a particular course according to the preferences expressed. The Department of Health laid down general objectives of the courses without prescribing in detail course content or method.

The costs of the training during the last two years can be estimated at approximately one million pounds.

vi) The paper describes then in some detail the pattern of action at one of the educational centres chosen by the Department of Health, the University of Manchester. There the Department of Social Administration has organised during the last two years more than 30 courses for nearly 1,000 participants.

vii) The document discusses the evaluation of the training programmes in general and at the University of Manchester in particular, and stresses the difficulties of formal evaluation. It nevertheless arrives at a positive assessment of the total training programme, emphasizing the need for a congenial environment, participation of the course members, group and project work. It reaches the conclusion that the integration training certainly succeeded in widening the knowledge of the participants beyond their past sectional roles, to encompass the total needs of the integrated Service. It finds that the clinicians' courses helped to bridge the traditional gap between specialists and general practitioners, and suggests that voluntary members acquired a better concept of the roles assigned to them.

viii) The final section summarises first the prospects for the future before analysing the main lessons learned. Under the first heading it describes briefly five new programmes which are now being planned, of which particularly the concept of "team building" is a challenging innovation. It is suggested that each of the three main

participants, i.e. the National Health Service, the universities and the central government, derived lessons from the current experience. As far as the National Health Service is concerned, retraining is acknowledged as an essential part of formal reorganisation. It is seen that it must be broadly based and on a continuous mechanism to be effective. Whilst professional training is well recognised and developed, equally essential management training is still in an experimental stage. For the universities, reorganisation training helped to fill a gap between the wishes of the universities to expand advanced teaching and the present policy of the government to concentrate on undergraduate education. Valuable lessons were learned in educational methods and the designing of relevant programme content. The government deserves praise for recognising the need for training and providing the means for its implementation. Equally, a successful balance between central control and decentralised execution was struck to the advantage of all concerned.

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