inflation and this must be the prime aim of Government policy.

I invite the profession to discuss these problems with me fully and constructively. I have today repeated my assurance that it is not the Government's intention to abolish private practice, merely to separate it from the NHS. Nothing I am proposing will prevent patients from seeking private medical treatment nor remove the freedom of doctors to practise privately. I have pointed out that the legislation I propose will specifically provide that no change threatening the right to practise privately can be made except by a change in the law.

And I have expressed my willingness to discuss with the profession the best way, consistent with the interests of patients and of the profession itself, of dealing with the situation which will arise when private practice is phased out of NHS hospitals.

Among the matters I shall be happy to discuss with the profession are the extent and causes of the emigration now taking place. Accurate information for any year is not available until about two years afterwards owing to the need to check up whether the anticipated emigration has actually taken place.

Because I was anxious to find out as fully as possible what was happening I asked the health authorities' regional medical officers to conduct a special study of the number of senior staff in the NHS who have emigrated. Their preliminary findings, which I have just received, show that in the year ending 30 September 1975, 64 consultants and 42 senior registrars in

England resigned from the NHS with the stated intention of emigrating. It is not possible, of course, to be sure that these figures are complete but equally not all those resigning would be UK born. Nor was there any similar ad hoc study in previous years with which to make a comparison. I am anxious to examine these figures, and any others, jointly with the profession so that we could agree at least on the extent to which emigration is taking place.

As to the causes, it is I believe significant that the major specialties from which these resignations took place were mental illness, anaesthetics, pathology, and radiology. With the exception of anaesthetics these are not specialties in which private practice plays a significant role.

One of the causes of emigration is that there is a world market for anaesthetics and radiology which makes them particularly vulnerable. In recent years NHS demand for these services has increased considerably and the number of consultant posts in these specialties has increased at about 5% per year. Naturally any loss from these specialties must cause anxiety and I would like to discuss with the profession how we might make them more attractive. I would hope, in particular, that the profession would be willing to discuss our proposal to review the present system of merit awards and to institute career supplements so as to ensure that consultants in important but less glamorous specialties get proper financial recognition.

TALKING POINT

Modifying the reorganisation of the NHS

Several people have suggested the abolition of the regional health authorities (RHAs) and some the abolition of the area health authorities (AHAs). An editorial in the *British Medical Journal*¹ suggested that perhaps the British compromise was a cross between the two. But the regional level does not exist in Scotland, Wales, and Northern Ireland. This paper sets out a compromise solution and discusses how some of the ensuing problems might be ameliorated. If a mistake has been made it should be corrected as soon as possible, if the present structure is on balance preferable to any alternatives or at least preferable to the trauma of further change, then to continue to talk of the abolition of one tier can only be damaging.

The case against the present structure is that the three tiers dissipate authority and leadership, and generate needs for additional management and clerical staff and for additional consultative committees. The substantial differences in the responsibilities and resources between authorities in the same tier raise doubts about their abilities to perform similar functions. The size of population served by each

RHA varies considerably: the smallest (1.67 million) is that served by the East Anglia RHA and the largest (5.11 million) is that served by the West Midlands RHA. The number of AHAs per region varies from three to 11 and the number of districts from seven to 22 (table 1). The diversity in size of population and number of districts between area health authorities is even greater than between regional health authorities. Five AHAs serve populations of less than 200 000 and six AHAs populations of over 1 000 000; the majority (50) serve populations of between 200 000 and 500 000. One area (Kent) serves almost the same population as one region (East Anglia). Six of the AHAs are divided into five or six districts, 27 into three or four districts, 23 into two districts and 34 are single-district AHAs. There are wide variations between regions and even wider variations between areas in current revenue and in the allocation of beds in different specialties to such an extent that it is improbable that all the AHAs can offer a comprehensive service.^{2,3}

New area health boards

The compromise structure could be achieved by dividing most of the present regions into two or three area health boards along the boundaries of present area authorities, thus maintaining the conterminous boundaries with local government authorities. The present district structure including the community health councils could be left unchanged, although the opportunity could be taken to realign the few unnatural districts that have emerged.⁴ Each of the new area health boards would take on the functions of both the regional and area health authorities and have between 20 and 30 members, including the representatives from local government.

The tenets taken into account in deciding the number and composition of the proposed area health boards were the need to minimise the changes and those tenets set out in the first Green Paper.⁵ "Each board should have full scope for the efficient and imaginative development of comprehensive services. Each must be able to employ the expert skills necessary for their planning and operation. Each should be sufficiently removed from day-to-day operations to take a wide view of their efficiency and requirements and to allow the professional staff and officers who manage units of the service to get on with their jobs. An area should also group together a number of localities . . . and attention should be paid to the boundaries of the new local government areas."

Two further considerations were taken into account. Firstly, in seeking the conterminous boundaries with local government units, importance should be attached to conterminous boundaries between the proposed area health boards and the greater metropolitan areas. Thus the population of the Greater

TABLE 1—Present regional health authorities*

RHA	Population in thousands	Number of areas	Number of districts
Northern	3141	9	16
Yorkshire	3528	7	17
Trent	4451	8	18
East Anglia	1677	3	7
NW Thames	3526	7	18
NE Thames	3809	6	17
SE Thames	3652	5	16
SW Thames	2968	5	14
Wessex	2571	4	10
Oxford	2074	4	7
South Western	2858	5	13
West Midlands	5112	11	22
Mersey	2519	5	12
North Western	4095	11	18
Total	45981	90	205

*Based on figures given in DHSS Circular HRC/74/23.

London area is divided between four area health boards each of which is only concerned with a sector of the Greater London conurbation. Secondly, each new area health board should be related to at least one medical school and where this could not be achieved it should be related to a university which had already in one way or another developed links with postgraduate medical education and health service studies.

Allocating the present area health authorities to the proposed area health boards (table II) shows that some diversity of size persists and reveals possible weaknesses. Two of the proposed area health boards have no obvious university to link with, and one of the proposed boards (Cheshire) has a population substantially smaller than the others. No doubt local knowledge and circumstances will make apparent other difficulties to balance against the possible advantages of the proposals.

TABLE II—Population, number of districts, and related university for the proposed 28 area health boards

New area health board	Component AHAs	1971 Population in thousands	Number of districts	Related university
1	Durham, Cleveland	1174	7	Durham
2	Tyne and Wear, Cumbria, Northumberland	1967	9	Newcastle
3	Humberside, N Yorks	1419	8	Hull/York
4	All in West Yorkshire	2109	9	Leeds
5	Nottinghamshire, Derbyshire	1831	7	Nottingham
6	Leicestershire, Lincolnshire	1300	5	Leicester
7	All in South Yorkshire	1320	6	Sheffield
8	All in East Anglia RHA	1677	7	Cambridge
9	Bedfordshire, Hertfordshire	1288	6	?
10	All in NW London	2238	12	London
11	Essex	1358	5	Essex
12	All in NE London	2451	12	London
13	Kent, E Sussex	2084	9	Kent Sussex
14	All in SE London	1568	7	London
15	Surrey, West Sussex	1702	9	Surrey
16	All in SW London	1266	5	London
17	Hampshire, Isle of Wight	1341	5	Southampton
18	Dorset, Wiltshire	1230	5	Bath
19	Oxford, Bucks, Berks, Northants	2074	7	Oxford
20	Devon, Cornwall	1274	5	Exeter
21	Avon, Somerset, Glos	1584	8	Bristol
22	Shropshire, Staffs	1300	4	Keele
23	Hereford, Worcs, Warws	1021	7	Warwick*
24	All in West Midlands	2791	11	Birmingham
25	Cheshire	848	5	?
26	All in Merseyside	1671	7	Liverpool
27	Lancashire	1342	6	Lancaster
28	All in Greater Manchester	2753	12	Manchester

*Although not geographically within the proposed AHB, the centre is very near.

ADVANTAGES

The proposals are put forward to correct certain identified defects in the present administrative structure at levels above that of the district. Complaints of the remoteness of the district staff from region and DHSS with consequential delay in decisions, complaints of the lack of clarity about the respective roles of the committees and officers at district, area, and region,¹ and the feeling that areas are "fenced in by some regions much as the districts feel fenced in by the areas"⁶ should all be ameliorated by the removal of one administrative tier together with its related officers and committees.

The effectiveness of the members of the authorities should be increased. Some members of AHAs find little room for constructive contribution constrained as they are by the proposals coming up from the districts and the guidance (and money) coming down from the region. This can be true particularly of local government members who are also members of area health authorities. Such members are accustomed to a more direct control of their budgets. More effective power would be operated locally by the amalgamation of the major functions of the regional and area authorities.

Many posts at area level have not yet been filled and the criticism has been made that already the filling of area posts has taken away experienced staff from the management of big hospitals and district services to the detriment of district administration.⁷ There are probably insufficient skilled administrators and practitioners to staff the 14 regions and 90 areas and at the same time to have first-class staff at district level, where the patients are treated.

EFFECTS ON FAMILY PRACTITIONER AND LOCAL AUTHORITY SERVICES

No advantage or disadvantage is seen in these proposals for the administration of the family practitioner services. Each of the proposed area health boards could have one or more family practitioner committees—probably, in order to avoid further disturbance, the present family practitioner committees should continue.

The present joint consultative committees between area health authorities and local government authorities must be continued so that the planning and functioning of the social services, education services, and environmental health services can be integrated where necessary with the health services. The position of these joint committees would be unchanged so that most of the new boards would have two or more joint consultative committees, like some of the present AHAs in metropolitan areas.

DISADVANTAGES

A possible disadvantage would be that 12 of the 28 proposed area health boards would not have a medical school within their boundaries. Some of the difficulties could be overcome by the appointment of a postgraduate dean in each board area jointly by the board, the local university, and the related university with a medical school. Such action could be extended by the development of institutes of medical and health services studies at those universities without medical faculties. Such institutes could have a governing body containing representatives from the university, from the medical faculty of the university associated with the appointment of the postgraduate dean, from the local postgraduate medical centre, and from the area health board. Innovations along these lines might enhance the energetic developments already taking place in postgraduate medical education.

An unpleasant feature of the reorganisation of the 1973-4 was the distress and anxiety produced in many members of staff of the previous authorities. Regrettably, the proposals for the 28 area health boards would cause some further disturbance. The main problem would be the appointment of the chief officers of each board. If the new boards were instructed that they must select one from the chief officers of the merging authorities and that all staff would be retained on personal contracts ensuring no detriment in their conditions of service, only few difficulties should arise. Of the present 104 authorities, the administrative, finance, medical, and nursing chief officers are represented at region and area, others are either only or mainly at region or at area. The conversion of the 34 single district area health authorities into districts does not remove the need for the district functions of the present officers. There are at present a number of vacancies at district, area, and regional levels, so there is unlikely to be any redundancy, except among some supporting staff.

Conclusion

A convincing argument against modification would be that the present structure is more or less right; however, very few people make that claim. If people are settling down into the wrong structure, then further trouble and difficulty must be building up. If the districts are really to be concerned with their own services and enjoy delegated authority and the excitements of innovation, then to have two tiers of authority between them and the DHSS is one tier too many.

¹ *British Medical Journal*, 1975, 3, 64.

² Buxton, M J, and Klein, R E, *British Medical Journal*, 1975, 1, 345.

³ Noyce, J, Snaith, A H, and Trickey, A J, *Lancet*, 1974, 1, 554.

⁴ Brown, R G S, *British Medical Journal*, 1975, 3, 81.

⁵ *The Administrative Structure of the Medical and Related Services in England and Wales*. London, HMSO, 1968.

⁶ Lewis, Janet, and Weiner, S. *British Medical Journal*, 1975, 3, 22.

⁷ Chester, T E, *The Hospital and Health Services Review*, 1975, 71, 117.

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