A Manual of
Public Health and Community Medicine

Third edition

A J ESSEX-CATER

A Manual of

Public Health and Community Medicine

A J ESSEX-CATER MRCS LRCP FFCM PH DCH DIH FRAI
Medical Officer of Health and Principal School Medical Officer
States of Jersey, Channel Islands

with a Foreword by
Sir JOHN BUTTERFIELD OBE MD DM FRCP Hon LLD FACP
Regius Professor of Physic, University of Cambridge
Consulting Professor Emeritus, Guy's Hospital Medical School and previously
Visiting Professor to Australia, Cairo, Harvard, Helsinki, Louvain and Yale

Third edition

Bristol: John Wright and Sons Ltd

First edition: 1960
Second edition: 1967
Third edition: 1979

CIP Data
Essex-Cater, Antony John
A manual of public health and community medicine.—3rd ed.
1. Public health—Great Britain
2. Community health services—Great Britain
I. Title II. Synopsis of public health and social medicine
362.1'0941 RA485

ISBN 0 7236 0477 0

Text set in 10/11 pt Photon Times, printed and bound in Great Britain at The Pitman Press, Bath

PREFACE TO THE THIRD EDITION

The second edition was published in 1967 and so radical have been developments in the fields of public health and community medicine since then that a change of title, extensive re-writing and re-arrangement of the volume have been inevitable. The publishers advised the use of the word 'Manual' rather than 'Synopsis' feeling the content was rather greater than should be contained under the latter word. However the style of presentation remains generally synoptic in form and the overall character of the book is unchanged.

As noted in previous editions the book is not intended to replace standard textbooks and the reader is recommended to refer to original sources, medical administrative or legislative, to confirm the accuracy of the condensed material. While the general field is currently poorly represented by textbooks there are numerous specific works of high standard which cover major sections of the study, to which reference should be made by interested readers.

I wish to acknowledge the help of many individuals, some were named in earlier editions, who have willingly given assistance. It is with regret that I must record the death last year, of Dr Dermot Mahon, who assisted with the second edition. Many sources are noted in the text but many more are not so marked and I hope individuals will accept this acknowledgement of my indebtedness. I append a short list of works, in addition to those noted in the text, which I have found indispensable and which are commended to readers.

My wife has continued her unenviable task of proof reader with some assistance from my daughter, Dr Alison Essex-Cater, and I am deeply appreciative of their help. As usual the publisher's personnel, especially Mr A. H. B. Symons, have been most helpful.

As noted in the previous editions a wide-ranging work such as the Manual must profit from thoughtful readers who offer constructive criticism or comment and previous guidance of this nature is gratefully acknowledged.

January, 1979 **AJE-C**

PREFACE TO THE FIRST EDITION

This volume in the *Synopsis Series* is designed to meet the requirements of a variety of readers, including undergraduate medical and social science students, postgraduate students preparing for the Diploma examinations in Child Health, Public Health and Industrial Health, nurses and other workers in ancillary interests.

Like other synoptic volumes this work cannot replace standard textbooks; it is intended to be used in conjunction with them, as a means of quick revision and as an outline for persons not required to make a detailed study of the whole field of Public Health and Social Medicine. Much legislation is summarized, and the reader should always refer to the requisite statute or statutory instrument to verify the validity of my condensation. The new Mental Health Act is unlikely to become fully operative for many months. In view of the changes which will follow its functioning a detailed description of its innovations has not been included in this edition.

In a work such as this the interpretation and selection of the author must invariably fail to satisfy a number of his readers—their forbearance is sought. Constructive criticism will be most gratefully received in the hope that faults can be corrected in any subsequent edition which may be called for.

Certain standard textbooks have provided material for this volume or have indicated the subjects which demanded consideration in a synoptic work. I would especially wish to express my indebtedness to the following authors and their books: Donald Hunter (*The Diseases of Occupations*), whose arrangement of specific occupational diseases I have purposely followed; Professor Bradford-Hill (*Principles of Medical Statistics*, 6th ed.); Llywelyn Roberts (*A Synopsis of Hygiene*, 11th ed.); The American Public Health Association (*Control of Communicable Diseases in Man*); I. G. Davies (*Modern Public Health*); Professor Fraser Brockington (*The Health of the Community*); W. M. Frazer (*History of Public Health*). Numerous Annual Reports and other publications of HMSO have been consulted, and I am indebted also to many other writers of textbooks and articles in specialist journals. Where permission has not been directly sought from individuals the author trusts that they will accept this as sufficient acknowledgement of his gratitude.

I am greatly indebted for the help of a number of individuals, especially Dr Douglas Fleck (Public Health Laboratory Service); Dr Trevor Lewis (Welsh Regional Hospital Board); Dr Dermot Mahon and Dr M. C. O'Brien (Public Health Department, Birmingham); Dr Alan Harries (general practitioner, Swansea); Mr Wyndham Lewis (Headmaster, Iver Heath); Mr A. B. Neale (Central Statistical Office, Birmingham); and Miss Isobel Edwards.

The teaching of certain authorities has undoubtedly coloured my approach to some chapters in this volume, and I should like to express my thanks to Dr J. M. Mackintosh, lately Professor of Public Health in the University of London, and my indebtedness to the late Professor J. C. Cruickshank, Bacteriologist at the London School of Hygiene.

My wife has been of inestimable assistance at all times during the preparation of this book, and I wish to record the stimulus provided by my father before his death early in 1958. Messrs John Wright & Sons Ltd, and in particular Mr L. G. Owens, have always been patient, sympathetic, and helpful.

March, 1960

AJE-C

FOREWORD

I have known Dr. Essex-Cater since our school days together and am delighted to write the foreword to this compendium of information about Public Health and Community Medicine, now revised and produced as a third edition. I say 'compendium', rather than the word in the title, manual, because the volume is in fact a most impressive work bringing together information covering a remarkably wide range of topics, all of which impinge to some degree or other on almost everybody working in the NHS.

Seen as a compendium, I believe this third volume will be an invaluable bookshelf companion to innumerable professional people, and not just those with a basic medical training. It provides, for example, quick reference to answer such questions as, causes of mortality and morbidity or the proportions of workers of different sorts in NHS hospitals, definitions of occupational diseases, regulations about those infectious diseases which are notifiable, the committee structure of the NHS, regulations arising from the legislation covering environmental health, food, the social services and so on.

Throughout it all Dr. Essex-Cater has produced from his own mind and pen succinct and accurate synopses. In my view he has certainly achieved his purpose with honours—a manual which is not intended to replace standard textbooks, but which provides in outline form the main spectrum of topics which medical administrators should know about. I have no doubt it will meet the needs of undergraduate and postgraduate medical students, social scientists, nurses and doctors wishing to specialize in child health, public health, industrial health and those interested in community medical matters. Of course I would go much further. I believe it should be at the desk or bedside of all those who have a responsibility in any of the statutory bodies in the NHS from the Top of the Office to Community Health Councils. All those operating in any of the non-clinical aspects of the NHS should educate themselves and keep themselves up to date about all the other sides of this extraordinary all-purpose organization. This might achieve just that stability which so many NHS workers yearn for so much. I believe such lateral knowledge would permit them to proceed with their responsibilities without looking over their shoulders for the challenges which threaten the very peace of mind which is essential for a curing and caring Service. Careful perusal of this volume would at least help enthusiasts for this or that development to realize how broad and complex the NHS is, and how difficult it is suddenly to accommodate major demands from any single pressure group into what has been growing up slowly over the centuries and very quickly over the last three decades.

So I commend Dr. Essex-Cater's manual to you and make way immediately for his preface and the subsequent chapters he has produced and brought up to date in this the third edition.

Cambridge,
July, 1979

John Butterfield

CONTENTS

THE HEALTH SERVICES

INTRODUCTION

The National Health Service was introduced in 1948 in the face of approbation, doubt and derision. It matured over a quarter of a century, becoming the model for many international offspring, increasingly accepted yet also persistently criticized. Inevitably so bold a sociomedical revolution was bound to stimulate waves of reaction which, whipped up by political, social, medical and economic change, would ultimately crash on to the shores of the NHS beach as large, angry breakers.

By 1974 a reorganized NHS emerged from this onslaught, strengthened in some respects but weakened in others. The events which ultimately yielded reorganization proceeded in an irregular and somewhat confused manner so that a short chronological explanation is necessary to set the scene for the chapter ahead which does not delineate the material in strict historical progression.

It is impossible to separate the catharsis in the health services from other events on a broad sociomedical front. The desire for reorganization in local government resulted in a Royal Commission report in 1966, earlier examinations of the NHS by Guillebaud (Report of Committee of Inquiry into Cost of NHS) 1956 and Porritt (Medical Services Review Committee) 1962; unrest in the nursing services spawning the far-reaching Salmon Report (Committee on Senior Nursing Structure) published in 1966, the First Cogwheel Report (Joint Working Party on the Organization of Medical Work in Hospitals) 1967, the Royal Commission on Medical Education (Todd Report) which reported in 1968, and finally the impelling Seebohm Report (Committee on the Local Authority and Allied Personal Social Services) 1968, which cast its influence before its ultimate publication.

Such a national outpouring of serious investigative and introspective surveillance in medicine and social welfare associated with changing economic pressures, the increasing awareness of inequalities in service provision and new administrative and managerial concepts, demanded and promptly achieved political response with the publication of Green Papers by the Government in 1968 proposing reorganization of the NHS in Scotland and in England and Wales.

The process continued with a 'Salmon-like' look at the then LA nursing services in the Mayston Report (Working Party on Management Structure in LA Nursing Services) 1969.

The concept and functions of District General Hospitals (DGH) were described in the Bonham-Carter Report in 1969 (Functions of the DGH, a Central Health Services Council Committee Report). In 1969 a Royal Commission also reported on Local Government in Scotland.

While the Seebohm proposals ratified in the Social Services Act made wide and basic changes in the structure and function of local authority health departments and beyond, the reorganization of the health services became ensnared in a period of relative political instability. The Second Green Papers were published in 1970 followed by Consultative Documents for England and for Wales in 1971, and a White Paper for Scotland in the same year. Also in 1971 the masterly Brotherston Report appeared (Integration of Medical Work in the NHS—Scotland).

At this time those members of the medical and allied professions working in administrative medicine and public health were formulating ideas for the new structure and methods of working in the light of seemingly inevitable NHS changes. Particularly notable was the Faculty of Community Medicine establishing itself under careful guidance from Royal Colleges of Physicians of London, Edinburgh and Glasgow.

White Papers detailing guidelines for NHS reorganization in England and Wales were published in 1972 and 'Steering Committees', rich in varied professional and lay membership,

were appointed for England and for Wales. Their recommendations for the management of the reorganized NHS were contained in a 'Grey Book' (England) and a 'Red Book' (Wales), both published in 1972. These recommendations were made in the face of forceful direction from Central Government inspired by the advice of management experts (McKinsey & Co.) and assisted by local working parties who provided detailed surveys and information.

The year 1972 also saw publication of the Second Cogwheel Report (Joint Working Party on the Organization of Medical Work in Hospitals), the Hunter Report (Working Party on Medical Administration), and the Briggs Report (Committee on a Nursing Report) which detailed development in the nursing services for many years ahead. Under Government stimulation a range of re-training courses were provided by University Departments of Social and Preventive Medicine to prepare medical, nursing and administrative personnel for reorganization. Similar courses strove to ensure the continuity of cooperation and coordination between health and local government services, including social and education services, which would become separated from direct administrative links with any of the health service by the enactment of the Local Government Act 1972, to become operative for England and Wales on 1 April, 1974, the operative date proposed for the National Health Service Reorganization Act 1973. A Third Cogwheel Report was published in 1974.

A number of Collaboration Working Parties were set up to ensure good working relations between the new local authorities and the reorganized NHS.

Local Government Reform in Scotland was delayed for a year after NHS reorganization in England and Wales, but in Ireland (North) reorganization of the NHS took place a year earlier in April, 1973, and personal social services were integrated with health services.

Outside England the structure of the reorganized health services does not include a regional tier so there is sufficient variation in health services structure in UK to anticipate valuable comparative developments providing the hand of central government, in the form of economic influence, does not rest too heavy.

One remaining feature which should be mentioned in this introductory section is the appointment of an 'ombudsman' for the health services, a Commissioner, in late 1973, with the task of investigating complaints of maladministration in the NHS.

Details of the National Health Service Act 1946, will be found in Chapter 2 along with notes on earlier examinations of NHS structure and adequacy, e.g. Guillebaud and Porritt, while this chapter will take events from the later 1960s onwards.

NATIONAL HEALTH SERVICE. THE ADMINISTRATIVE STRUCTURE OF THE MEDICAL AND RELATED SERVICES IN ENGLAND AND WALES 1968 (First Green Paper) (Labour Government)

First outline of proposals for reorganization of NHS and intended to provoke wide public discussion.

Suggested coordination of arms of NHS in single Area Boards established to plan and operate services comprehensively, to coordinate policy, and to balance care between hospital and community services. Liaison and cooperation would exist between Area Boards and local authority services such as environmental health and social care in geographically-matching areas.

MOHs would extend their role as community physicians.

About 50 Area Health Boards were suggested, directly responsible to Ministry—a single-tier organization. Membership of Boards would be small and they would be advised by an executive under a chief officer and including directors of five major departments (planning and operational; staff; logistics; finance and secretarial), with administrative and professional staff as required.

A Chief Medical Officer (CMO) would be director of the planning and operational department with access to the Board to advise on medical matters.

Report visualized considerable power being delegated to Boards by Minister who would only

interfere in exceptional circumstances beyond coordinating services of Boards.

Boards would be financed by central government and their expenditure regulated. Consortia of Boards envisaged for certain provisions, e.g. capital building projects or supplies arrangements.

A Scottish Green Paper, 1968, suggested a similar service for Scotland.

FUTURE STRUCTURE OF NATIONAL HEALTH SERVICE IN ENGLAND 1970 (Second Green Paper) (Labour Government)

Developed outline proposals for reorganization of NHS but stressing: (*a*) service would not be administered by local government but by area health authorities (AHAs) (90) directly responsible to Secretary of State, matching geographically and organizationally with local authority (LA) services, and (*b*) personal social services and certain public health services would continue to be administered by LAs.

The need for unification of different branches of NHS was reiterated with integration at local level. Clinical freedom of doctors to be preserved with service centred on family doctor team.

Another fundamental principle reaffirmed was financing from taxes, not payments by individual when sick.

Proposed structure showed Regional Health Councils, with members appointed by AHAs, responsible for overall planning of hospital and specialist services, deployment of senior staff, postgraduate professional education and planning of ambulance service. Guided by small specialist staff, Regional Councils would not control or supervise Area Authorities.

AHAs were to be established, matching local authority personal social services areas, with at least one-third of their members appointed by such LAs, one-third by profession and remainder by Secretary of State. They would administer all local services in which primary skill came from health professions, i.e. hospital and specialist service, family practitioner service and much LHA function. They would not provide an occupational health service. LAs would provide social service in certain hitherto medically-run services, e.g. social work, sick elderly, mentally disordered, day nurseries, home help, etc. also environmental and public health services and health education (jointly with AHAs).

Close collaboration between health and local authorities foreseen in respect of supplies; provision of professional and technical services, etc.

District Committee to be established by AHA to ensure participation of local residents and professional staff in running district health service. Half membership would come from AHA, half from other local interests. Committee would be serviced by AHA officers.

Secretary of State would be responsible for Health Service and allocate funds to AHA—on capital and revenue accounts. Power would be gradually delegated to AHAs to develop and plan services within national priorities and funding.

Independent contractor basis of family practitioner protected but otherwise AHA practice would confirm single nature of health service. Team work recognized as fundamental in reorganized service with central team of chief officers—medical, nursing, financial and administrative, to advise AHA in planning and use of service.

A special role accepted for CAMO working closely with chairman of LMC and cogwheel medical executive.

A separate Welsh Green Paper showed no regional tier.

NATIONAL HEALTH SERVICE REORGANIZATION—CONSULTATIVE DOCUMENT 1971 (Conservative Government)

Set out firm intention of government for integration of NHS and invited consultation on a narrow range of issues on which further discussion thought to be of value.

Effective management stressed as a feature of reorganized service. Proposals enacted with only minor variation.

Regional tier confirmed and AHA made responsible for management of their Districts served by separate district general hospitals (DGHs) integrated with associated community health services. Detailed management arrangements were to be subject of a working party study.

Important role of Department of Health and Social Security (DHSS) confirmed in setting national objectives, indicating priorities, setting standards and allocating resources; also responsible for effectiveness of NHS and for monitoring performance. Value of role played by Hospital Advisory Service in relating hospital and community services noted. Reorganization of DHSS necessary to meet new functions under NHS changes.

AHA required to set up Community Health Council (CHC) for each of its districts to reflect local attitudes but distinct from management structure.

Contractual independence of general practitioner protected in Family Practitioner Committee (FPC) but planning and development of family practitioner service to be concern of AHA.

No decision on alignment of school health service.

Exceptional position of districts containing teaching hospitals noted in special arrangements applied to AHA(T)s.

A separate consultative document on NHS Reorganization in Wales issued a month later in 1971 (June); indicated seven areas and confirmed absence of a regional tier. A Welsh Health Council was proposed to advise Secretary of State on major issues; also a common service agency, to deal, e.g. with major capital works, etc.

REORGANIZATION OF SCOTTISH HEALTH SERVICE 1971

White paper on proposals for a new administrative structure for health services in Scotland left responsibility for NHS financing in central government hands. Fourteen health boards to act as single-tier agents for operation of NHS.

Secretary of State advised by Health Services Planning Council, including Chairman of each health board. Common Service Agency to provide major building projects, etc. and to take over number of functions previously responsibility of central government or *ad hoc* bodies, e.g. research and intelligence unit, and dental estimates, etc.

Health boards, conterminous with local government areas, to have small membership including one university nominee.

WORKING PARTY ON COLLABORATION BETWEEN NATIONAL HEALTH SERVICE AND LOCAL GOVERNMENT 1971–1974

Consultative Document 1971 reported the setting-up of a study on collaboration between health authorities and local authorities on matters of common concern essential in view of reorganization and separation of services inevitable in the years ahead.

First Report covered activities until end of 1972; Second and Third Reports appeared in 1973 and 1974 (HMSO).

Working Party proposed statutory Joint Consultative Committee (JCC), meeting quarterly, and composing of members of AHA and matching local government areas and advised by their relevant senior officers who would themselves meet more frequently as working group(s). JCC concerned with policy and broad planning; detail was left with officers.

The main fields of common concern were noted as education, social services and environmental health but many other points of contract between NHS and local government services were confirmed.

The aim of collaboration to close any possible gaps in services while avoiding duplication currently and in the future by joint planning. At a personnel level cooperation varied from the advisory role of senior officers to the delivery of service by field staff working closely together.

NATIONAL HEALTH SERVICE REORGANIZATION—ENGLAND (Conservative Government)

White paper published in 1972 (August) indicated firm intentions on new structure of NHS to be enacted and operative from 1 April, 1974, along with reorganized local government.

Amongst features clarified in white paper:

1. Two-tier system—region and area.
2. Geographical organization not intended to impose barrier on health service users.
3. Special link to exist between AHA(T) and administration of teaching hospitals.
4. NHS Training College to be established.
5. Health education an obligation of AHAs but Local Education Authority responsible for health education in schools.
6. Voluntary services to be encouraged and extended.
7. Special hospitals to remain under direct control of DHSS.

A similar white paper dealt with arrangements for Wales. Number of AHAs increased to 8—earlier proposals had suggested 7. Implications of reorganization on Welsh Office noted; idea of Welsh Health Council abandoned and Secretary of State to be advised instead by relevant panel of Welsh Council. Common service agency retitled as Welsh Health Technical Services Organization (WHTSO).

Steering Committee. Within framework of Consultative Documents for England and Wales. Secretary of State for Social Services and Secretary of State for Wales, respectively, appointed Steering Committees, with supporting Study Groups, to report on management arrangements for reorganized health service in England and Wales, to make recommendations on functions of, and relationships between, authorities in unified health service, on management systems for services for which they would be responsible and on internal organization of those authorities.

Steering Committees appointed in Autumn of 1971 used White Paper as framework for their recommendations and reported in 1972. Steering Committees were representative of professional workers in health service, members of existing health authorities, staff associations and of voluntary bodies or individuals with special interest in and knowledge of health service. Secretariat supplied by central government. Committees were assisted in their review by small Study Group of professional experts, by central government representatives and by staff of McKinsey & Co., an American firm of management consultants retained as expert advisers. Various academic departments, notably Brunel University, also provided general or specific assistance.

Time limit set for Steering Committees prevented review of quality merited and their reports appeared in 1972 as: Management Arrangements for the Reorganized NHS, published by DHSS (the 'Grey Book'), and Management Arrangements for the reorganized NHS in Wales published by Welsh Office (the 'Red Book').

Reports are detailed consideration of management arrangements, i.e. overall structure, professional organization, management processes, and role specification for senior personnel, etc. intended to be used as basis for consultation with management, professional and staff interests prior to adoption in reorganized NHS.

Pre-reorganization. The NHS Reorganization Bill was published in late 1972 and DHSS launched into a spate of publications which have continued unabated to date and which indicate a closer and more detailed control over NHS by the central administration than had existed hitherto.

A series of reorganization circulars (HRC series) was issued from mid-1972 until 1974. In early 1974 another interim series (HSC(IS)) was issued preparatory to a new series replacing the circulars long regularly distributed to health authorities.

A very large number of statutory instruments issued from the inauguration of NHS until 1973 are still operative as are many advisory memoranda.

The undue haste which characterized the terminal stages of the pre-reorganization scheme were not eased by a change of political power when a Labour administration took over government from Conservatives in early 1974.

Situation in which a major item of social legislation representing one political ideal is unavoidably enacted by a succeeding and conversely motivated administration does not provide the most stable basis to develop a complex, costly and essential service. Further early change is anticipated and promotes uncertainty and vacillation at exact time when continuity and certainty is desirable.

The NHS involves every person in the country as a current or potential consumer and is additionally a major employing authority. It appeared, however, that many employees had only a limited appreciation of the changes taking place in the service and patients an even slighter understanding of the situation.

Royal Commission on NHS. It is extraordinary that so soon after a major reorganization of the NHS concern about certain aspects of its functioning should require the detailed examination inherent in a Royal Commission. The Government at first resisted demands for such an independent investigation but in October 1975 the Royal Commission was appointed—'To consider in the interests both of the patients and of those who work in the NHS the best use and management of the financial and manpower resources of the NHS'.

The reference might appear somewhat limited but the Commission has seen its examination as wide-embracing. A large number of organizations and individuals have submitted evidence much of it comprehensive. The amount and variety of evidence—many bodies have published their evidence—is indicative of the national concern for the state of health of the NHS but generally appears to favour rehabilitation rather than demolition.

National Health Service Act 1946. An outline of National Health Service Act 1946 appears at the end of Chapter 2. While structure and organization of NHS was radically altered by National Health Service Reorganization Act 1973, the 1946 Acts' concept of a comprehensive, essentially free medical service, is perpetuated in the National Health Service Act 1977.

National Health Service Reorganization Act 1973. Legislative implementation of the planned reorganization of the NHS. Repealed much of the National Health Service Act 1946 and provided for appointment of Health Services Commissioner. Largely repealed in turn by National Health Service Act 1977.

NATIONAL HEALTH SERVICE ACT 1977

Part I. Services and Administration

Section 1. (1) Duty of Secretary of State to continue the promotion of a comprehensive health service in England and Wales designed to secure improvement: (*a*) In the physical and mental health of the people; and (*b*) In the prevention, diagnosis and treatment of illness. (2) Services to be generally free of charge.

Section 3. (1) Duty of Secretary of State to provide to such extent as he considers necessary to meet all reasonable requirements: (*a*) Hospital accommodation; (*b*) Other accommodation; (*c*) Medical, dental, nursing and ambulance services; (*d*) Other facilities for care of expectant and nursing mothers and young children; (*e*) Facilities for the prevention of illness, care of persons suffering from illness and the after-care of persons who have suffered from illness; (*f*) Other services required for diagnosis and treatment of illness.

Section 4. Provision and maintenance of special hospitals for persons detained under Mental Health Act 1959 who require treatment under conditions of special security due to their dangerous, violent or criminal propensities.

Section 5. (1) Duty of Secretary of State: (*a*) To provide for medical and dental inspection at appropriate intervals for pupils at maintained schools and for medical and dental treatment; (*b*) To arrange for advice on contraception, the medical examination of persons

seeking such advice, the treatment of such persons and the supply of contraceptive substances and appliances. (2) Secretary of State may: (*a*) Provide invalid carriages, or other vehicles, for persons suffering from severe physical defect or disability; (*b*) Provide accommodation and treatment outside Great Britain for persons suffering from respiratory tuberculosis; (*c*) Provide a microbiological service, including laboratories for the control of the spread of infectious diseases; (*d*) Conduct or assist research into any matter relating to the causation, prevention, diagnosis or treatment of illness. (4) Public Health Laboratory Service Board continues to exercise administrative functions with respect to (2)(*c*).

Section 6. (1) Central Health Services Council have duty to advise Secretary of State on general matters relating to services provided under this Act as they think fit and upon questions referred to them. (2) Council constituted in accordance with Schedule 4. (3) Standing advisory committees may be constituted to advise Secretary of State and Council. (6) Central Council to make an annual report to Secretary of State on their proceedings and those of advisory committees.

Section 7. Medical Practices Committee constitution defined.

Local Administration

Section 8. (1)(*a*) Establishing RHAs in England; and (*b*) AHAs for areas in Wales and regions in England including AHA(T)s; (2) Secretary of State may vary a Region or an Area. (3) Duty of Secretary of State to secure: (*b*) That regional health service is associated with a university which has a school of medicine.

Section 9. AHA(T) must provide substantial university facilities for undergraduate or postgraduate clinical teaching.

Section 10. Duty of each AHA to establish a Family Practitioner Committee in accordance with Schedule 5 of Act.

Section 11. Secretary of State may establish a special health authority to perform any function on his behalf or on behalf of an AHA or FPC.

Section 13. Secretary of State may direct an RHA or a Welsh AHA to exercise such health service functions as he directs.

Section 14. An RHA may so direct any AHA in its region.

Section 15. Duty of each FPC in accordance with regulations (*a*) To administer arrangements, under Act, for the provision of general medical, general dental, general ophthalmic and pharmaceutical services in the area of the AHA.

Section 18. Directions given by Secretary of State shall be either by regulations or by an instrument in writing. Similarly directions given by an Authority shall be by an instrument in writing.

Local Advisory Committees and Community Health Councils

Section 19. Secretary of State has duty to recognize any Regional or Area committee of: (*a*) Medical practitioners, or (*b*) Dental practitioners, or (*c*) Nurses and midwives, or (*d*) Registered pharmacists, or (*e*) Ophthalmic and dispensing opticians—which he is satisfied is representative of local persons and called the Welsh or Regional or Area Medical Committee or Dental Committee, etc.

Section 20. Duty of Secretary of State to establish a Community Health Council for the area of each AHA or for separate parts of the area as he thinks fit.

Cooperation and Assistance

Section 21. Local social services authorities to exercise functions, subject to Section 3 (1), (*d*) and (*e*) in relation to: (*a*) Care of mothers and young children, (*b*) Prevention, care and after-care, (*c*) Home help and laundry facilities.

Section 22. (1) Health and local authorities to cooperate in exercising their respective functions to secure and advance the health and welfare of the people. (2) Joint consultative committee to advise AHA and associated local authorities.

Section 23. Secretary of State may arrange with voluntary organization or other body to provide, or assist in providing, any service under the Act.

Part II. General Medical, General Dental, General Ophthalmic, and Pharmaceutical Services.

General Medical Service

Section 29. (1) Duty of every AHA, in accordance with regulations, to arrange personal medical services for all persons in area who wish to take advantage of the arrangements. (2) Regulations may define services to be provided and secure arrangements so that all persons will receive adequate personal care and attendance and regulations shall include provision: (*a*) For lists of medical practitioners undertaking to provide general medical service; (*b*) Conferring right of choice by persons and consent by practitioner and limiting number of patients to be accepted by any practitioner; (*c*) For distribution of patients who have indicated no particular choice or who have been refused by a practitioner; (*d*) For issue of certificates to patient where prescribed; (*e*) For removal of medical practitioner from list as determined.

Section 30. Application to provide general medical service in an Area referred to the medical Practices Committee.

Section 33. Medical Practices Committee may refuse an application if number of practising doctors is adequate for the area.

Section 35. Arrangements for general dental services.

Section 38. Arrangements for general ophthalmic services.

Section 41. Arrangements for pharmaceutical services.

Local Representative Committee

Section 44. Secretary of State may recognize a committee formed for the area of any AHA if satisfied it is representative, as Local Medical Committee, Local Optical Committee, etc.

Section 45. Family Practitioner Committee for an AHA shall consult with such committees as prescribed.

Provision as to Disqualification of Practitioners

Section 46. (1) There shall be a 'Tribunal' constituted in accordance with Schedule 9 of Act to inquire into cases referred by AHA when continued inclusion of person's name in, e.g. medical list, would be prejudicial to the efficiency of the service. (2) Tribunal shall inquire into the case and may direct name to be removed from the list. (3) An appeal lies to the Secretary of State against such a decision.

Other Provisions Supplementary to Part II

Section 56. Power to deal with inadequate services.

Part III. Other Powers of the Secretary of State as to the Health Service

Section 67. Withdrawal of facilities available for private patients.

Regulations as to Certain Charges

Sections 77–83

Inquiries, and Default and Emergency Powers

Section 85. Default powers.

Part IV. Property and Finance

Part V. Health Service Commissioner for England, and for Wales.

Section 106. Appointment of Health Service Commissioners for England and for Wales.

Part VI. Miscellaneous and Supplementary

Section 124. Special notices of births and deaths.

Schedules 15 including: *I.* Additional Provisions as to the medical and dental inspection and treatment of pupils. *III.* Public Health Laboratory Service Board. Constitution and Additional Provisions. *IV.* Central Health Services Council and Advisory Committees. *V.* Regional and Area Health Authorities, Family Practitioner Committee, and Special Health Authorities. Membership and supplementary provisions. *VI.* Additional Provisions as to

Local Advisory Committees. *VII.* Additional Provisions as to Community Health Councils. *VIII.* Local Social Service Authorities. *IX.* Tribunal for purposes of Section 46. Constitution. *XIII.* Additional Provisions as to the Health Service Commissioner for England and for Wales. Procedural and other provisions.

REORGANIZED NATIONAL HEALTH SERVICE IN SCOTLAND

NHS (Scotland) Act 1972 provided for reorganization of NHS in Scotland on lines generally similar to those applying in England and Wales.

Fifteen Health Boards matching reorganized local government regions and districts. In absence of a regional tier Boards exercise functions of both Regions and Areas in England and are directly responsible to Scottish Home and Health Department. Certain services normally undertaken by Regions in England stand referred to a Common Services Agency which provides Boards with, e.g. computer and certain management services, etc.

Each Health Board is required to set up a local health council—*vide* community health councils in England and Wales—at district level.

Larger Health Boards have several Districts, e.g. Fife (2), Greater Glasgow (5) and Lothian (3), but eight have no district organization. Board's team of officers is made up of Secretary, Treasurer, Chief Administrative Medical Officer (CAMO) and Chief Area Nursing Officer (CANO) known as Area Executive Group (AEO).

Secretary of State has established a University Liaison Committee to advise Health Boards on teaching and research matters.

A Scottish Health Service Planning Council is advised by National consultative committee, in turn linked to local consultative committees who advise their Area Boards.

REORGANIZED NATIONAL HEALTH SERVICE IN WALES

There is no regional tier in Wales and accordingly the eight AHAs have greater responsibility than AHAs in England.

AHAs are directly responsible to DHSS through Welsh Office which has an augmented Health Section to absorb some functions which would be Region's responsibility in England.

There is a Welsh Health Technical Service Organization (WHTSO) to supply facilities best provided on an all-Wales basis, e.g. design and building of major capital projects, computer and certain other specialized management services and central supply functions. It services Welsh Office as well as AHAs.

Areas include 3 single districts, 3 two-district and 2 four-district authorities with populations varying from 530 000 (Mid-Glamorgan) to 100 000 (Powys). The Areas are conterminous with reorganized local authority County Councils, but districts not exactly matched with local authority districts.

South Glamorgan is only AHA(T).

REORGANIZED NATIONAL HEALTH SERVICE IN NORTHERN IRELAND

Reorganized Service in N. Ireland started one year in advance of rest of UK, on 1 April, 1973, under Health and Personal Social Services (N. Ireland) Order 1972. Associated with reorganization in local government.

System in N. Ireland is unique in that previous tripartite system was replaced by unified pattern applying in other parts of UK, but new structure also incorporated personal social services.

Four area health boards act as agents of DHSS, three of the areas, North-Eastern (based on Antrim/Ballymena), Western (based on Londonderry) and South (based on Craigavon) having populations of about 250 000—but the other area, Belfast and S.E. Area, has a population of about 750 000 and includes a teaching hospital in Belfast.

Each board has a health services committee and a personal social services committee with some cross representation. Chief officers responsible to boards for coordinated service are a chief

administrative medical officer, a director of social services and a secretary, supported by division heads, e.g. chief nursing officer.

A Central Services Agency, a consortium, provides essential services to all four boards.

Twenty-six local government districts are distributed in conterminous areas of boards and consult with district committees set up by boards served by district executive teams who are responsible to boards.

General practitioners have contracts with the board. Medical advisory machinery is established at every level.

A Central Council for Personal Health and Personal Social Services advises DHSS.

HEALTH SERVICE COMMISSIONER

NHS Reorganization Act 1973, provided for appointment of Health Service Commissioner with security of tenure only disturbed by Parliament and responsibility extending to Wales and Scotland with offices and representation in these countries as well as in London.

His function is to investigate complaints essentially resulting from administrative failure or fault, and not those involving clinical error or family practitioner, for which there is already an established system to deal with complaints.

First year of Commission, 1974–5, yielded nearly 500 new complaints of which two-thirds were outside its jurisdiction.

Of cases investigated and reported on, most involved waiting list errors, inadequate information given to parents or relatives of cases and inadequate records. Many complaints resulted from administrative faults which were easily remediable—most commonly a failure of communication which could have been avoided. Often a more adequate response by health authority concerned could have satisfactorily answered complaint well before it reached Commissioner.

In period 1975–6, of 610 complaints 320 considered outside Commissioner's jurisdiction.

Professional anxiety concerns possible extension of Commissioner's interests into clinical field.

OUTLINE OF ORGANIZATION OF HEALTH SERVICES—ENGLAND

Reorganizing legislation, operative from 1 April, 1974, has established a new pattern for organization of health services which is considered here briefly to provide outline on which details of service noted in subsequent pages provides flesh.

Organization is in three statutory tiers:

1. DHSS
2. RHAs
3. AHAs

Secretary of State for Social Services is responsible to Parliament for health services and exercises his responsibility through DHSS.

Chain of organizational responsibility extends from DHSS through RHAs and AHAs to basic, non-statutory, level at which a service is delivered to persons who seek care and attention because of impaired health.

Type of personal service which patient may seek at base level may be specialist and/or hospital care, primary health care from a family doctor or pharmacist, attention from a home nurse or advice from a health visitor, or help from a child welfare clinic or routine examination of a child by the school health service. All health services of a personal nature in which individual patient has face-to-face contact with persons directly or contractually responsible for providing advice, investigation, treatment and care, singly or collectively as necessary.

Accountability for these services passes back through the organizational levels to DHSS.

To safeguard individuals a special body appears in organizational framework—the CHC—to