UNIFIED SERVICES—PROGRESS OR NOT?

ON 1 April 1974 the National Health Service was reorganised and a new chapter opened in the British method of arranging health care. The legislation of 1973–74 at first appears much less significant than the historic Acts of 1910–11 and 1946–48. History may show, however, that the long-term impact on patient-care may be as great.

The need for some kind of reshaping has long been recognised and the medical profession can take the credit for the concept of unifying the health services of an area. Porritt was a professional, not a governmental, committee. Doctors have done much to show the disadvantages of dividing the Health Service into three parts and have highlighted difficulties in communication, in the allocation of resources, and in simply understanding a colleague's problems.

Nevertheless, there were other possible models for a unified Health Service. Is management really such an important ingredient? Are the three tiers all essential? Do results simply depend on how much government money there is for health?

Two principles are clear. First, the new structure, rightly or wrongly, gives more power to the centre. Delegation downwards and accountability upwards sounds superb —but at the end of the day it means that more power lies in London. This may do much good in helping to counter regional and area inequalities. But could it also inhibit local initiative and the development of local excellence?

Secondly, we have already commented (January *Journal*) on the reduction of the power of the profession.

Specialty services

The new health care planning teams are important and will be formed in many specialties. At first sight planning teams for paediatrics, geriatrics and the mentally ill are attractive. Obviously they will bring together many people involved in the problems of care. Obviously they will break down some rigid barriers and throw up new ideas. Obviously they will be especially valuable in those branches of medicine which have been underprivileged in the past.

But, by definition, each of these teams corresponds to a hospital specialty. Most specialists believe in specialisation. The danger of planning by specialty is that the patient will be seen not as a person, but as the recipient of a service. The danger of specialty services is the fragmentation of care. How can families be considered as whole if the children are under a child care service and one of the adults under a mental illness service. Could a nurse from a paediatric service meet a nurse from a mental-health service and another from a geriatric service all in one home? Who will integrate care? How is the idea of holistic care—of dealing with physical and psychological problems simultaneously—to be preserved?

Already most of the senior regional administrators are hospital trained. The danger is that medical care in the future could become not only more fragmented, but more hospital orientated, and even hospital controlled.

Certainly, some consultants now openly regard themselves as the natural leaders, and the hospital as the natural centre for unified services. Consultants and general

practitioners can work in harmony with mutual respect, but a few consultants seem to regard general practitioners as housemen in the field.

The issue is simple—are the new primary health care teams to be strengthened or weakened?

Representatives

General practitioners all over the country have now chosen their representatives for the new district management teams. Strong personalities have emerged in many areas, often with medicopolitical experience.

It has not, however, been fully realised how much the health care planning teams will influence the district management teams. The general-practitioner representatives for these teams will have to be chosen soon. And these choices will matter. The whole basis of locally integrated care is now at stake.

The Acts of 1910–11 gave general practice its first statutory base. The 1946–48 Acts extended general practice and established it as the basis of the British health system.

It would be ironic if the 1973–74 Acts, reorganising the NHS, passed with the intention of increasing general-practitioner participation in the Health Service, nevertheless seriously weakened personal doctoring and patient-centred care.

NURSING COMES OF AGE

One of the most interesting and important changes occurring with the new National Health Service is the position of the nursing profession. April 1974 marks a subtle but significant change in the relationship between nursing and medicine.

Throughout the history of nursing it has been, albeit decreasingly of late, a secondary profession. The nurse assisted the doctor inside and outside hospital. At best this relationship grew to partnership, at worst the nurse was seen as the handmaiden of the doctor.

During recent years nurses have sharpened their role, improved their education and taken on new managerial responsibilities. They have at last begun to discover the value of training in the community. Academic parity was achieved with the first Chair of Nursing Studies (like the first Chair of General Practice, at Edinburgh University). The financial gap is closing and senior nurses (who are still underpaid) earn more than many doctors.

The new system means that nurses are now responsible to nurses and are no longer ultimately accountable to doctors. In the new Health Service nurses are members of the regional and area team of officers. Other nurses are members—as equal partners—in the new district management teams.

Nursing has come of age. Two of the great caring professions have come to terms. We welcome this development. Nurses have earned their emancipation. Let us hope that we can now all work together for the benefit of the patient.