Health Authorities Bill [Bill 2 of 1994/95]

Research Paper 94/124

29 November 1994

This paper examines the background to and the provisions of the Health Authorities Bill, which received its first reading on 22 November 1994. The Bill introduces changes to the managerial structure of the NHS, with the abolition of the Regional Health Authorities and the merging of District Health Authorities and Family Health Services Authorities.

Katharine Wright
Education and Social Services Section

House of Commons Library

CONTENTS

I Introduction

In the Queen's Speech on 16 November 1994, the Government announced its intention to "bring forward legislation to make further improvements to the management of the National Health Service". The proposed legislation will reshape the management structure of the NHS by abolishing the Regional Health Authorities and merging District Health Authorities and Family Health Services Authorities. The intention to reshape the NHS management structure in this way was announced in October 1993, and since then, the Department of Health has produced a number of documents giving details of the proposed changes. Part II of this paper looks at the background to the legislation, including the announcements made by the Department, comments on the proposals from political parties, professional organisations and the press, and the changes which have already taken place as a result of the October announcement. Part III considers the clauses of the Bill.

II The Functions and Manpower Review

A The proposals for change

In May 1993, Virginia Bottomley, the Secretary of State for Health, announced that she had ordered a review to consider what changes were necessary in NHS management structures as a result of the NHS reforms. The review team, headed by Kate Jenkins, a member of the NHS policy board, was requested to consider "what management processes and organisational structures will best deliver measurable improvements in health and effective and efficient services, through the operation of the NHS internal market, while minimising management costs and ensuring proper public accountability."[1] The review body was asked to complete its work by July.

As a result of this "functions and manpower" review, Mrs Bottomley announced to Parliament on 21 October 1993 that, subject to Parliamentary approval, fundamental changes in the structure of NHS management would take place[2]. These changes would include the following:

- A clearer identity would be created for the NHS Management Executive, as the "headquarters of the NHS" within the Department of Health. The relationship between the NHS Management Executive and the wider Department of Health would be reviewed.

- The 14 Regional Health Authorities [RHAs] would be abolished and the NHS Management Executive would be reorganised to include eight regional offices, each headed by a Regional Director. These offices would replace both the RHAs and the existing "outposts" of the NHS Management Executive. Limits would be set for the number of staff to be employed both in the regional offices and in the headquarters.

- Eight non-executive members, one for each region, would be appointed to the NHS Policy Board, in order to provide a link between Ministers and the Chairs of District Health Authorities [DHAs], Family Health Services Authorities [FHSAs] and NHS Trusts. These members would be "respected local figures".

- DHAs, who are responsible for purchasing hospital and community services ("secondary services"), and FHSAs, whose duties include overseeing the services provided by GPs and other practitioners such as dentists and opticians ("primary

---

[1]HC Deb, 12 May 1993, cc 483-4W

[2]HC Deb, 21 Oct 1993, cc 398-400

services"), would be enabled to merge. This would allow for a greater degree of co-ordination when planning primary and secondary services. Such mergers would be actively encouraged by the Department of Health.

As some of these changes, such as the abolition of the RHAs, would require primary legislation, and hence could not realistically be effected before April 1996, Mrs. Bottomley also announced that, as an interim measure, the number of RHAs would be reduced from 14 to eight from 1 April 1994.

B The reasons for change

The NHS and Community Care Act 1990 has established the principle of the "purchaser/provider split" in the NHS. District Health Authorities have become the purchasers of care, responsible for commissioning services to meet the needs of their resident populations; hospitals are able to "opt-out" of DHA control to become NHS Trusts; and GPs are able to apply to become fundholders, responsible for purchasing certain services for their patients out of their own budgets. In the three years since the reforms were implemented, the vast majority of hospital and community services have become NHS Trusts, with only a few still directly managed by DHAs. District Health Authorities have tended to merge, with the aim of purchasing care more efficiently: their number has dropped from 190 in 1991 to 111 in 1994, and they therefore tend to cover a much larger geographical area than before. There is also an increasing awareness of the need to co-operate between DHAs and FHSAs so that primary and secondary services are properly coordinated. However, despite these major changes in role at local level, the NHS management structure above the districts has remained much the same. It was felt that this represented "unfinished business" in the reforms.

In her statement to the Commons, Mrs Bottomley said that the result of the reforms had been "a fundamental shift of power to the patient" and that the priority should now be "to support better patient care through the continued drive towards decentralisation in the NHS." The Regional Health Authorities had served the NHS well for almost 20 years, but their "hands-on style" was no longer appropriate.[3] The aims of the changes were:

- to streamline management, making savings on administrative costs which could then be reinvested in patient care

- to support the purchasing function, by making it easier for DHAs and FHSAs to work together and plan coherent primary and secondary services

---

[3]HC Deb, 21 Oct 1994, c.398-9

- to develop a "lighter approach" to strategic management which would respect the freedom to purchase and provide services appropriate to the local area, while still remaining nationally accountable

C Responses to the announcement

1 Opposition parties

In his response to Mrs Bottomley's statement, David Blunkett, then shadow Health Secretary, criticised the proposals from a number of angles[4]. He expressed concern about the accountability of the proposed new system, and in particular over the "respected local figures" who, as members of the NHS Policy Board, would provide a link between Ministers and local Chairs of DHAs, FHSAs and Trusts. He suggested that these members would "account for themselves only to the new expanded NHS Policy Board" and that they would be "gauleiters on an NHS politburo." He went on to ask "why should non-elected, non-accountable, non-democratic individuals picked out by the Secretary of State be responsible for running our service? is that not nepotism and bureaucracy gone rampant, with administrative regions replacing the present appointed regions, and individuals replacing those who sit on executive boards?" Similarly, he expressed doubt over the use of the term "light touch", suggesting that this could mean that Ministers were abandoning their responsibility for running the service. Referring to the aim of streamlining management, he said that it was the fault of Government policy that so many managerial positions had been created in the first place, leading to the need for "streamlining". He also criticised the cost of the NHS changes to date and asked how much more would be spent in the proposed reorganisation. Labour's policy document *Health 2000*[5], published a few months later, makes it clear that although DHA/FHSA mergers would be welcomed by the party, the abolition of the RHAs would be opposed.

Liz Lynne for the Liberal Democrats suggested that the plan to abolish RHAs would "lead to more centralisation rather than less" and would "take away any little accountability there may be in the health service"[6]. She also urged that when DHAs and FHSAs were merged, they should be co-terminous with local authority boundaries, in order to make co-operation with local authorities easier. The Liberal Democrat consultation paper "Health"[7], published in August 1994, suggests that regional health authorities should be retained, in order to allow for regional commissioning of specialist services. The paper also takes the idea of merging

---

[4]HC Deb, 21 Oct 1994, c.400-1

[5]Labour Party, *Health 2000: the health and wealth of the nation in the 21st century*, 1994

[6]HC Deb, 21 Oct 1994, c.404

[7]Liberal Democrats, *Health: consultation paper No. 15*, August 1994

FHSAs and DHAs further by proposing they should also merge with local authority social services departments and be democratically elected.

2 Professional bodies

The proposals were broadly welcomed by health services management bodies, such as the Institute for Health Services Management [IHSM] and the National Association of Health Authorities and Trusts [NAHAT], who were keen to see as much freedom as possible at local level. The IHSM stated that "any measures that reduce identifiable waste and streamline services for patients, providing appropriate, cost-effective and quality services, are welcome" and, referring to DHA/FHSA mergers, that "a unified approach to meeting the health needs of the population has got to be good for patients".[8] However, although devolving power as far down the hierarchy as possible has many advantages, "this needs to be monitored with the necessary checks and balances".

Philip Hunt of NAHAT praised the role of the regions in the past, but accepted that the NHS could be no exception to the general trend in large organisations to cut down on the numbers of management tiers. He suggested that "the sweeping away of outdated and bureaucratic controls offers a unique opportunity to secure much greater cohesion", but had a word of warning for the new regional offices: "If they act simply as post-boxes for the centre or become too involved in the minutiae of day-to-day management, they will surely fail."[9] Instead, they need to find a fine balance between "light touch" regulation and encouraging change.

Organisations representing clinical staff were more ambivalent. Christine Hancock of the Royal College of Nursing [RCN] welcomed the possibility of DHA/FHSA mergers, and accepted that abolishing the regions would streamline management, but expressed concern over accountability. Her particular concern was the need for monitoring and a general overview of the NHS: "the RCN's concern is not who reports to whom within the line management but how a national picture of what is happening in the service is established."[10] She also raised the issue of the future of the nursing function at regional level, stressing the important contribution nurses had to make both to purchasing and to management.

The British Medical Association welcomed the principle of the Functions and Manpower review and expressed their support for "an efficient and effective policy making and

---

[8]IHSM press release, 21 Oct 1994

[9]"Shedding a tier: how regions will be restructured", *Health Service Journal*, 28 Oct 1994, pp 11-14

[10]ibid

management structure". However, they emphasised the need for clear lines of accountability and suggested that there was a need for stronger links between the new regional offices of the NHS Management Executive and the communities they would be serving. Like the RCN, they raised the issue of professional input, suggesting that medical representation on the NHS Policy Board should be increased, that a new medical advisory body should feed into the regional offices and that there should be GPs and other professions represented on the new authorities replacing DHAs/FHSAs. They expressed reservations about the way "health commissions" (informal DHA and FHSA joint working arrangements) were operating, suggesting that they were putting FHSA staff at a disadvantage. Proposals to remove the number of administrative and managerial staff at regional level were welcomed, as long as the reduction did not lead to the regional offices becoming too remote from DHAs/FHSAs and Trusts.[11]

The union UNISON described the proposals as "bad news for staff, bad news for accountability and, in the long term, probably bad news for the service".[12] Its head of health, Bob Abberley, claimed that the NHS would come to regret the loss of expertise at regional level in areas such as human resources and IT, suggesting that this would lead either to duplication of effort at Trust level, or the buying in of expensive private sector services. He claimed that if the Government wished to retain a comprehensive, equitable and national health service, then strong regulation and monitoring from the regions would be necessary, but seemed doubtful whether such monitoring would in fact would take place.

3 Press and academic comment

Comment in the health press varied from enthusiasm that "the heavyweight bureaucracy of the NHS is at last to be put on a diet"[13] to fears that the changes would actually lead to the centralisation of control, rather than devolution to local level. Eric Caines (Centre for Health Services Management at the University of Nottingham) welcomed the abolition of the RHAs and the mergers of DHAs/FHSAs with great enthusiasm, but expressed concerns over some of the practical aspects of implementation: would the posts of regional director be open to genuine competition, or would they remain within the "managerial closed shop" at the top of the NHS? Would the DHA/FHSA "mergers" really be mergers, or would they be takeovers by DHAs who might fail to give proper weight to the importance of primary care?[14]

---

[11]British Medical Association, *Managing the new NHS: proposal to determine new NHS regions and establish new regional health authorities: BMA response*, January 1994

[12]"Shedding a tier: how regions will be restructured", *Health Service Journal*, 28 Oct 1993, pp 11-14

[13]"The new look NHS", *The Health Summary*, October 1993, p.1

[14]"More, please", *The Health Summary*, October 1993, p.2

Both Chris Ham (Health Services Management Centre at the University of Birmingham) and David Hunter (Nuffield Institute for Health at the University of Leeds) expressed more fundamental doubts in the *Health Service Journal*. Both suggested that the abolition of RHAs would in fact lead to a centralisation of control: the regional offices would be staffed by civil servants directly responsible to the centre thus strengthening the management capacity at the top of the NHS. Chris Ham raised the issue of public accountability at regional level: "the concern here is about lack of local representation and the greater secrecy that will surround the work of regional offices"[15] David Hunter highlighted some of the functions which he feared would be lost when RHAs had been abolished: work such as "arbitrating in local disputes; providing a challenge to local myopia in service development and commissioning; encouraging innovation and new ways of doing things; and promoting health strategy development, community care and priority services, R&D, and health alliances. In theory, purchasers and providers ought to be able to inherit such an agenda. In practice some will but many more won't."[16]

Similar issues were raised in the national press. The *Independent* claimed that the abolition of the regional health authorities would be "a huge act of centralisation" and "a further loss of accountability at regional level"[17]. The *Guardian* described the proposals as picking "a fine line between giving hospital trusts their head and retaining a firm grip at the centre" suggesting that the plans aim to appease the "pro-market purists", while "keeping trusts on a not-too-long leash"[18]. With regard to the merging of DHAs and FHSAs, it suggested that in practice such mergers were already taking place. The *Times* suggested that the changes would "loosen the reins on the NHS market" and might lead to increased competition between Trusts with subsequent hospital closures.[19] The *Telegraph* concentrated on the potential for staff savings once the RHAs have been abolished.[20]

---

[15]"Shedding a tier: how regions will be restructured", *Health Service Journal*, 28 Oct 1993, p.12

[16]"Protect and survive", *Health Service Journal*, 18 November 1993, p.21

[17]"A spreading sickness of secrecy", *The Independent*, 21 Oct 1994, p.21

[18]"New market plans allow trusts limited freedom", *The Guardian*, 22 Oct 1993

[19]"Competition may close hospitals", *The Times*, 22 Oct 1993

[20]"2,000 jobs to go in health regions overhaul", *The Daily Telegraph*, 22 Oct 1993

D Progress to date

As not all of the measures announced by Mrs. Bottomley in October 1993 required primary legislation, some have already been implemented. In November, the Department of Health issued a consultation document on the boundaries of the new regions[21]: the aim was to align the eight transitional Regional Health Authorities with the eight new offices of the NHS Management Executive, in order to ease the transition in 1996. In January the new regions were announced: Anglia and Oxford, Northern and Yorkshire, Trent, North Thames, North West, South Thames, South and West and West Midlands. The RHA mergers formally took place on 1 April 1994, at the same time as the establishment of the new regional offices. Close working between the transitional RHAs and the restructured NHS Management Executive was further encouraged by the appointment of the new Regional Directors who also act as Regional General Managers of the RHAs. Similarly, the eight non-executive directors, one from each region, appointed to the NHS policy board from April 1994, also act as Chairs of the transitional RHAs. The restructured NHS Management Executive is now known simply as the NHS Executive and regional offices have been set a staff limit of 135 per office.

Although DHAs and FHSAs are not able formally to merge before legislation has gone through Parliament, increasing numbers have formed close working relationships by setting up "health commissions" whose joint Chief Executive oversees both DHA and FHSA statutory functions.

E Functions and responsibilities in the new NHS

1 The functions groups and the review of the wider Department of Health

The critical question in the restructuring of NHS management is undoubtedly the issue of which bodies will be responsible for which functions in the future. The new regional offices of the NHS executive are not statutory bodies like the old RHAs; they are designed to have a "lighter touch" than the RHAs, only getting involved in local matters when this is essential. There are therefore a great many functions presently carried out at regional level which in future will be performed elsewhere. 12 "functions groups" were set up in December 1993 in order to consider this issue. The decisions made on these functions are clearly highly significant for the future management shape of the NHS, as they have the capacity to transform relationships between the various NHS bodies and hence the power each can exert.

---

[21]Dept of Health, *Managing the new NHS: proposal to determine the new NHS regions and establish new Regional Health Authorities*, 1993

The four key principles which these groups were asked to follow in making their recommendations were:

- meeting the requirements of Parliamentary and public accountability

- devolving responsibility to local level and decentralising, with functions being carried out centrally only where there is necessary to ensure that they are discharged satisfactorily

- developing a single corporate structure for central management, integrating regional offices with headquarters

- simplifying and streamlining management arrangements to reduce the burden on local purchasers and providers.[22]

The setting up of these groups was strongly criticised by the BMA who felt that doctors should have had a greater chance to contribute to the debate. Dr Sandy Macara, the Chair of the BMA Council complained that:

"Key elements of the re-organisation, being driven by the NHS Management Executive, are being considered by small groups of carefully selected individuals in a way that implies that the Government has already made up its mind and is merely going through the motions. This has made doctors profoundly unhappy with the process."[23]

While responsibilities within the NHS were being considered by the 12 functions groups, a review of the functions of the wider Department of Health and its relationship with the NHS Executive was also undertaken, as promised in Mrs. Bottomley's original announcement. As a result of this review, it was agreed that in future the Department's structure would reflect its three main areas of responsibility, public health (including health promotion and communicable diseases), social care (local authority and voluntary social services) and health care (the NHS). The NHS Executive would take full responsibility for the NHS, including the policy development work which was formerly carried out in the wider Department. Both the reports on functions and responsibilities in the NHS[22] and the review of the wider Department

---

[22]Dept of Health, *Managing the new NHS: functions and responsibilities in the new NHS,* 1994

[23]BMA, *Parliamentary Briefing: Managing the NHS,* January 1994

of Health[24] were published on 28 July 1994, together with a third report on the public health function in England.[25]

2 Who will be accountable to whom?

The lines of accountability between the NHS Executive, the new health authorities (ie the merged DHAs and FHSAs), GP fundholders and NHS Trusts were set out in *Managing the new NHS: functions and responsibilities in the new NHS* and are as follows:

- "the new health authorities will be responsible for implementation of national health policy, integrating purchasing across primary and secondary care boundaries and for regulation and management of primary care services. They will be accountable to the purchaser arm of regional offices;

- GP Fundholders will be accountable to the purchaser arm of regional offices for the use of their funds but will also have a strong relationship with the new health authorities;

- Trusts will remain primarily accountable to purchasers for the delivery of care through NHS contracts and will have increased responsibilities in human resources management. The provider arm of regional offices will monitor performance in meeting statutory financial duties and implementation of certain national policy initiatives;

- the NHS Executive as a whole will support Ministers in meeting the requirements of Parliamentary and public accountability at national level, and provide an effective headquarters for the NHS. NHS Executive Headquarters will be responsible for supporting Ministers at national level and for determining the overall strategic direction for the NHS; regional offices will have a central role in performance management and important developmental responsibilities in the areas of education and training, research and development and public health."[26]

---

[24]Dept of Health, *Review of the wider Department of Health*, 1994

[25]Dept of Health, *Public health in England*, 1994

[26]Dept of Health, *Managing change: the NHS and the Department of Health* [summary of the three reports issued on 28 July 1994]

3 Who will do what in the new NHS?

Changes in the functions of the NHS Executive, DHAs/FHSAs and Trusts are listed as follows:

- "the NHS Executive will develop a strategic framework for the NHS to ensure that decisions and policies at national level are consistent with Ministerial objectives;

- regional offices will set the local research agenda within a national R&D strategy developed by Headquarters, and manage R&D projects;

- revenue allocations will be made direct to health authorities, subject to further work on methods of allocating resources;[27]

- movement towards local determination of pay will continue, with the NHS Executive retaining a role in liaising with the Treasury and supporting the national pay machinery for as long as it exists;

- health authorities and Trusts will have greater involvement in workforce planning and commissioning of education and training, with phased devolution of responsibility for non-medical education and training;

- responsibility for public health functions will be devolved to local health authorities, with regional offices ensuring that effective arrangements have been put in place;

- the focus for professional advisory machinery will in future be at local or multi-district level, but current district and regional specialty sub-committees will continue;

- regional offices will be responsible for performance management of health authorities and for monitoring Trusts;

- the NHS Executive will ensure that the internal market works as efficiently as possible for the benefit of patients, setting the ground rules which determine the structure of the market and ensuring compliance."[28]

---

[27]Since the framework document was published, an announcement has been made on resource allocation in the Department of Health circular FDL(F94)68. The principle of "weighted capitation" will remain, so that authorities are funded on the size of their population, taking into account their relative health status. However, the formula used to determine health status has been refined and 76% of the allocations will be weighted to reflect health and socio-economic variables such as long-standing illness, age and employment status. 24% of the allocation will be unweighted.

[28]Dept of Health, *Managing change: the NHS and the Department of Health*, 1994

III The Health Authorities Bill

A The Bill

The Health Authorities Bill [Bill 2 of 1994/95] was presented to the House on 22 November 1994. Its long title is "a bill to abolish Regional Health Authorities, District Health Authorities and Family Health Services Authorities, require the establishment of Health Authorities and make provision in relation to Health Authorities and Special Health Authorities and for connected purposes".

Clause 1 of the Bill abolishes Regional Health Authorities, District Health Authories and Family Health Services Authorities and establishes the new Health Authorities. It is the duty of the Secretary of State to ensure that all areas of England and Wales are covered by a Health Authority [HA]; s/he also has the power to issue orders varying the area covered by a HA, to abolish a HA or to establish a new one. As well as the title "Health Authority", these new authorities will be given a name appropriate to their geographical area. This clause will not come into force until 1 April 1996, except for where this is necessary in order to make regulations, directions, appointments and so on in preparation for the new authorities.

Clause 2 introduces **Schedule 1** to the Bill, which details amendments to other Acts resulting from the abolition of RHAs, DHAs and FHSAs, and other amendments relating to Health Authorities and Special Health Authorities (see below). Like Clause 1, Schedule 1 will not come into force until 1 April 1996, except for where this is necessary to prepare for the new authorities.

Clause 3 provides for RHAs, DHAs and FHSAs to work together towards the reorganisation by carrying out each other's functions. The Secretary of State is empowered to make regulations so that FHSA functions may be carried out by a DHA, by two or more DHAs, or by a committee (including a sub-committee) of DHA(s) and FHSA(s). Similiarly, FHSAs will be able to carry out DHA functions, either on behalf of the DHA or jointly with them. Section 125 of the *National Health Service Act 1977* [cap 49], which protects officers of health authorities from personal liability as long as they have acted in good faith, applies to functions in this clause. As clause 3 provides only for interim measures, it will cease to have effect on 1 April 1996.

Clause 4 introduces Schedule 2 to the Bill which makes transitional provisions and savings (see below).

Clause 5 introduces Schedule 3 which lists repeals and revocations of earlier Acts, including those of spent provisions.

Clause 6 requires orders under this Act to be exercisable by statutory instrument, subject to the negative procedure. There are exceptions for certain clauses in Schedule 2 (see below).

Clause 7 makes the financial provisions

Clause 8 allows for certain functions to be exercisable as soon as the Act is passed, in order to prepare for reorganisation.

Clause 9 sets out the extent. As Regional Health Authorities exist only in England and Family Health Services Authorities only in England and Wales, most of the Act extends only to England and Wales. However, there are minor consequential amendments in Scottish and Northern Ireland legislation, set out in the Schedules.

Clause 10 gives the short title.

Schedule 1 makes amendments to the *National Health Service Act 1977* (cap 49), the *National Health Service and Community Care Act 1990* (cap 19) and a number of other statutes. The vast majority of these simply require the terms "Family Health Service Authority" and "District Health Authority" to be replaced with "Health Authority", so that the new HAs can take over the functions of the former DHAs and FHSAs. Statutory functions formerly exercised by RHAs are assigned either "down" to the Health Authorities, or "up" to the Secretary of State. These include responsibility for GP fundholders: the responsibility for deciding applications for fundholding status and determining the size of the fundholder's budget passes from the RHA to the Secretary of State, but the actual resources will be passed to the fundholder via the Health Authority (Sch. 1, paras 73-74). Where regulations transfer functions relating to GP fundholders from the Secretary of State to Health Authorities, GP fundholders will have a right of appeal to the Secretary of State against HA decisions (Sch. 1, para 76). Health Authorities acquire the duty to supervise midwifery practice (Sch. 1, para 105) and the duty to provide information on hospitals in their area when required to do so by a court considering making a "hospital order" under the *Mental Health Act 1983* (Sch. 1, para 108).

The schedule also includes a number of other amendments. The duty to recognise "local advisory committees" of clinicians (established under section 19 of the NHS Act 1977) is abolished for England at both district and regional level, but remains for Wales (Sch. 1, para 10). Paragraph 59 of the Schedule sets out the requirements for the membership of the new HAs: these are very similar to those governing the old RHAs, with the Secretary of State appointing the Chair and the non-executive members, but without the requirement in primary legislation for one of the non-executives to hold a post in a university with a dental or medical school. (There is, however, a provision allowing regulations to stipulate that a non-

executive must hold a prescribed position). Similarly, the statutory requirement under section 6 of the *NHS and Community Care Act 1990*, that community health councils should be consulted on proposed Trust status, has been dropped; instead, the Secretary of State is empowered to prescribe what consultation should take place (Sch. 1, para 69). Paragraph 108 allows the Secretary of State to define "regions" for the purpose of Mental Health Review Tribunals, so that the present structure of one Tribunal in each RHA can continue after the regions have been abolished.

Schedule 2 makes transitional provisions. Property held by RHAs, together with any rights and liabilities to which the RHA was entitled or subject, will be transferred to the Secretary of State on 1 April 1996 (Sch.2, para 1). The Secretary of State is empowered to order that such property, rights and liabilities be transferred to a specified Health Authority or Special Health Authority (para 2). Similarly, property, rights and liabilities can be transferred from a DHA or FHSA to any specified Health Authority (para 4).

Where, as a result of the reorganisation, NHS staff transfer from one employer to another, their contract with their new employer will be treated as a direct continuation of their earlier employment. Occupational pension rights, however, will not be carried over, in line with the the Government's interpretation of the EC Acquired Rights Directive in the "Transfer of Undertakings (Protection of Employment)" Regulations 1981 (though there have been challenges to this interpretation). The new employer will also inherit all the rights, powers, duties and liabilities of the former employer. However, where employees object to the transfer, their employment will terminate immediately before the transfer, without this counting as dismissal (para 9).

Paragraph 17 allows for complaints and appeals, the cause for which had arisen before the reorganisation, to be carried over into the new structure. Paragraph 18 ensures that decisions taken by the bodies to be abolished may continue to have force after 1 April 1996. Finally, the Secretary of State is given the power to make any other transitional provisions "which appear appropriate in connection with any provision of this Act" (para 20).

Schedule 3 lists repeals and revocations.

Financial and manpower effects of the Bill: the Bill is expected to result in savings in NHS management costs of around £150 million in England and £3 million in Wales. It should also reduce public sector manpower.

B Comments on the Bill

There is little in the Bill which had not previously been announced by the Department of Health and there has been correspondingly little coverage in the press. The one significant change since the announcement in October 1993 relates to the mergers of DHAs and FHSAs: while the earlier announcements suggested that they would be "enabled" and "encouraged" to merge, in fact the legislation obliges them to do so.

The press release announcing the publication of the Bill[29] quoted Mrs. Bottomley as saying:

"This Bill would complete the NHS reforms begun in 1990. The reforms have led to dramatic improvements in the quality of patient care. Record numbers of patients are being treated by the NHS. They are being treated faster, at greater convenience and to an ever higher quality of care. However, we need to streamline and give greater clarity to parts of the NHS management structure to deliver further benefits for patients.

The Regional Health Authorities have remained unchanged since before the reforms. However their role has changed enormously as more responsibility has been given to Trusts and local health authorities.

The new purchasing role has encouraged DHAs and FHSAs to work far more closely across the primary and secondary care boundaries. Legislation is need to recognise these changes. The new single Health Authorities would be better placed to take an all round view of the health needs of the populations they serve.

This Bill would offer a valuable opportunity to make further savings in management costs which could be ploughed back into direct patient care. We have already savied over £30 million by reducing the number of authorities. If the Bill is fully implemented, these savings would approach £150 million to be spent on patients. We expect there to be around 100 single Health Authorities compared with 203 DHAs and FHSAs as present."

Mrs. Beckett expressed the Opposition view in the debate on the Queen's Speech:[30]

"We have no great quarrel with the strategy to bring together the work of family and district health authorities. We view with a degree of mild cynicism the trumpeting of claims that abolishing regional health authorities will be a triumph for the reduction of bureaucracy, coming as they do from a Government who have presided over an unprecedented explosion

---

[29]"Publication of Health Authorities Bill", Dept of Health press notice 94/532, 23 November 1994

[30]HC Deb, 22 Nov 1994, cc 479-480

of bureaucracy and costs in recent years, most of which will be left completely untouched by their proposals. We shall, however, want to explore the practical effects of those proposals.

As the Secretary of State must know, there is concern about the consequences for medical education and training. We shall be seeking assurances that some of the specialised patient services that are provided at regional level will not be disbanded if they cannot be provided at district level: there is real anxiety about services such as cancer registries, NHS screening programmes, surveillance and control of communicable diseases, health promotion and environmental health.

There is also anxiety about the implications for the wider community of the alternative means of consultation and representation that will be created. Medical, nursing and other staff wonder if and when their voice and experience will find an outlet.

All who noticed the Secretary of State's first stab at a replacement for existing sources of advice about such matters as appointments - the idea that a respected local figure should be the main and perhaps even the sole source - will have been strongly reminded of the Home Secretary's attempt to draft Lord Lieutenants into service to nominate the chairs of police authorities, one of the more ludicrous examples of the Government's striving to escape from the consequences of the richly deserved electoral hammering that they took at local level when the lies that they had told to win the general election had been exposed.

In the light of that great deceit, and of the lesser, almost daily examples of the Government's economy with the truth, we shall look in the legislation not only for clear, categorical assurances but for practical measures to ensure that there is no loss of hard information enabling the public to test their own experience and the wealth of anecdotal information available against published evidence."

Alex Carlile, speaking for the Liberal Democrats in the debate on the Queen's Speech, concentrated mainly on the proposed Bill to amend the powers of the General Medical Council. However, he raised the specific issue of the future of the medical schools and medical education under the new management structures, expressing the view that it was vital for the universities to continue to have input at the appropriate management levels.[31]

---

[31]HC Deb, 22 Nov 1994, c.500

List of sources

Department of Health documents

Dept of Health, *Managing the new NHS: a background document,* October 1993
Dept of Health, *Managing the new NHS: proposals to determine the new NHS regions and establish new Regional Health Authorities,* Novemebr 1993
Dept of Health, *Managing the new NHS: functions and responsibilities in the new NHS,* July 1994
Dept of Health, *Review of the wider Department of Health,* July 1994
Dept of Health, *Public health in England,* July 1994
Dept of Health, *Managing change: the NHS and the Department of Health,* 1994 [summary of previous 3 reports]

Comment

"A spreading sickness of secrecy", *The Independent,* 21 Oct 1994, p.21
"2,000 jobs to go in health regions overhaul", *The Daily Telegraph,* 22 Oct 1993
"New market plans allow trusts limited freedom", *The Guardian,* 22 Oct 1993
"Competition may close hospitals", *The Times,* 22 Oct 1993
"Shedding a tier: how regions will be restructured", *Health Service Journal,* 28 October 1993, pp 11-14
"The new look NHS", *The Health Summary,* October 1993, p.1
"More, please", *The Health Summary,* October 1993, p.2
"Protect and survive", *Health Service Journal,* 18 November 1993, p.21
British Medical Association, *Managing the new NHS: proposal to determine new NHS regions and establish new regional health authorities: BMA response,* January 1994
Labour Party, *Health 2000: the health and wealth of the nation in the 21st century,* 1994
Liberal Democrats, *Health: consultation paper No. 15,* 1994