The Local Health Services

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The Local Health Services

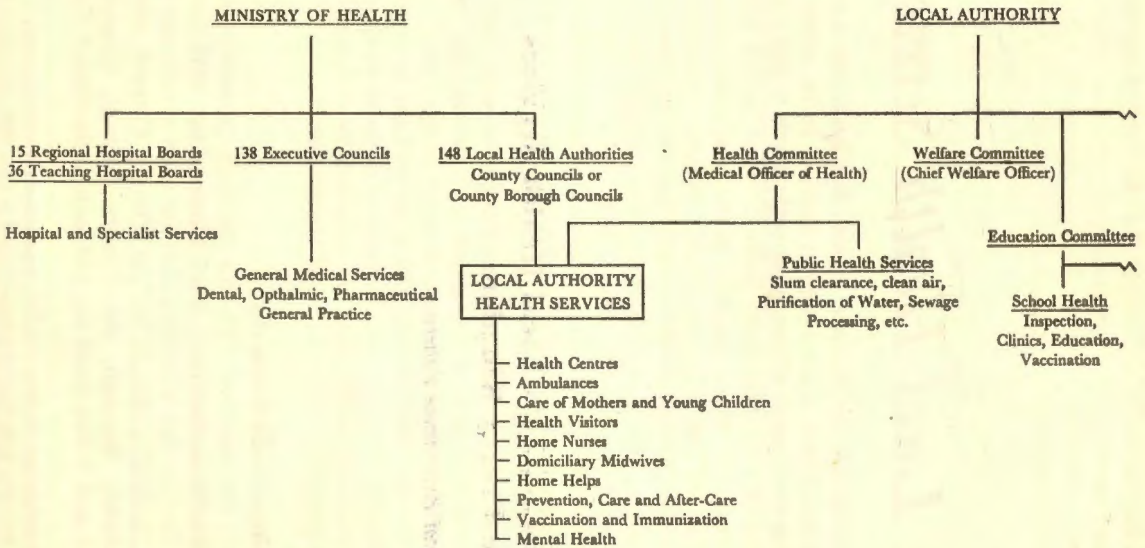
The structure of the National Health Service today is tripartite in form. There is the Hospital Services sector accounting for about two thirds of the total cost; there is the General Medical and Pharmaceutical Services sector, which between them account for about one fifth of the total cost.* The third major part of the National Health Service consists of the services provided by county councils and county boroughs in their role of Local Health Authorities which account for about one tenth of the total cost.† *Figure* 1 depicts this organisation giving particular emphasis to the Local Authority sector. Distinctions between Local Authority duties as Health, Welfare, and Public Health Authority can vary according to the context, and are therefore often difficult to make. However, the general intention of this paper is to discuss that area of Local Authority responsibility delineated in the 1946 National Health Service Act, and by doing so perhaps to credit the Local Health Services with something more than the back-room status with which they are occasionally endowed in the public estimation of the National Health Service.

The National Health Service Act

Under the heading "Health Services provided by the Local Health Authorities", Part Three of the 1946 National Health Service Act stipulates that for each county the Local Health Authority should be the County Council, and, for each County Borough, the County Borough Council. In England and Wales there are 148 such authorities.† The Act

*These two sectors were discussed in O.H.E. Reports numbers three and seven.

†Since the formation of the Greater London Council in April 1965, the London Boroughs have had responsibility to provide their own local health services, bringing the total number of Authorities up to 174.



Organization Chart—England and Wales

Figure 1

required these bodies to submit plans for executing their duties as defined in its subsequent sections. These were: to provide health centres with facilities for a variety of health and welfare services: to arrange for the care of nursing and expectant mothers and children under five: to ensure that sufficient midwives for domiciliary confinements were available to the community, either by employing midwives directly or by making suitable arrangements with hospitals: to ensure, either by direct employment or by arrangement with voluntary organisations, the availability of health visitors, home nurses, and an ambulance service: and to arrange with general practitioners for the vaccination and immunization of the local population against smallpox and diphtheria and, with Ministerial approval or if directed by the Minister, against any other disease. The Authorities were also given the option, subject to Ministerial approval or direction, of providing for prevention of illness, for the care and after-care of the sick and infirm and for provision of domestic help in suitable cases. They were permitted to make a charge appropriate to the means of the patient for provision of mother or child care services, of services in the nature of prevention, care and after-care, or of domestic help service.

Expenditure on Local Health Services in the United Kingdom

The Total Expenditure Pattern

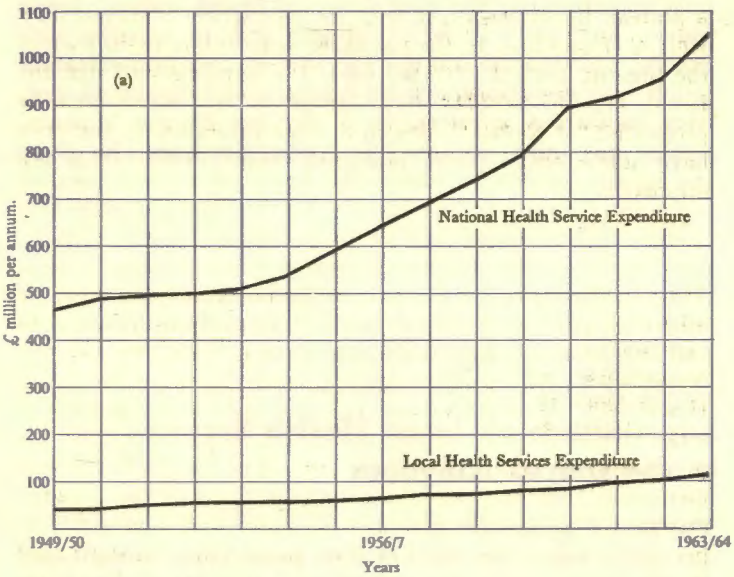
Except for one static year, 1953/4, expenditure by the Local Health Authorities in the United Kingdom has risen in each full year since the inception of the National Health Service. From a 1949/50 total of £34·1 million it had reached £106·7 million in 1963/4 (*Fig.* 2a). This represents an average increase per annum of 8·5 per cent, but such an average conceals important fluctuations. In particular, the increase per annum over the last five years has averaged more than ten per cent because the relaxation of the expenditure restrictions of the mid-fifties, especially in the capital sector, allowed spending to increase more swiftly.

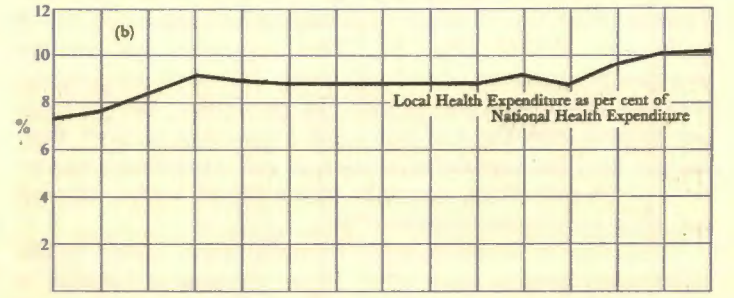
These figures, however, suffer from distortion caused by the inflationary process since 1949. If the element of inflation is extracted from the annual expenditure figures and they are scaled to 1949 prices, the "real" cost of the Local Health

Figure 2

Local Health Authority and National Health Service Expenditure. (Net of patient payments.) United Kingdom, 1949/50–1963/4.

Source: Annual Abstract of Statistics 1964





Authority Services has risen by 84 per cent between 1949 and 1963. In terms of constant prices the nation is expending nearly twice as much now as in 1949 on Local Health Services. This is an average rate of increase of 4·4 per cent per annum over the fifteen years and, more particularly, in view of the increased rate of expansion recently, an average of about eight per cent over the last five years.* The proportion of total Health Service expenditure devoted to the Local Health Authorities rose steadily over the first four years, then reached a plateau in the region of 8·9 per cent where it stayed until 1961/2 (*Figure* 2b). In the last three years it has again risen to the present level of 10·2 per cent. It cannot be said that the Local Health Services have absorbed an ever-increasing proportion of National Health Service expenditure, but they have undoubtedly been becoming more rather than less important.

Expenditure and National Income

The National Health Service expenditure is equivalent to about 4·4 per cent of national income. Local Health Authority expenditure is less than half of one per cent of national income. Nonetheless, just as constant-price expenditure on the Local Health Services is increasing, and just as their proportion of total Health Service expenditure is growing, so too is the proportion of national income absorbed by these services increasing. The proportion was 0·33 per cent of the national income in 1949, while for 1963 the figure had reached 0·44 per cent. Again, the rise has been particularly concentrated in the last five years. In national accounting terms the figures are indeed very small, but the upward trend is significant.

Per Capita Expenditure

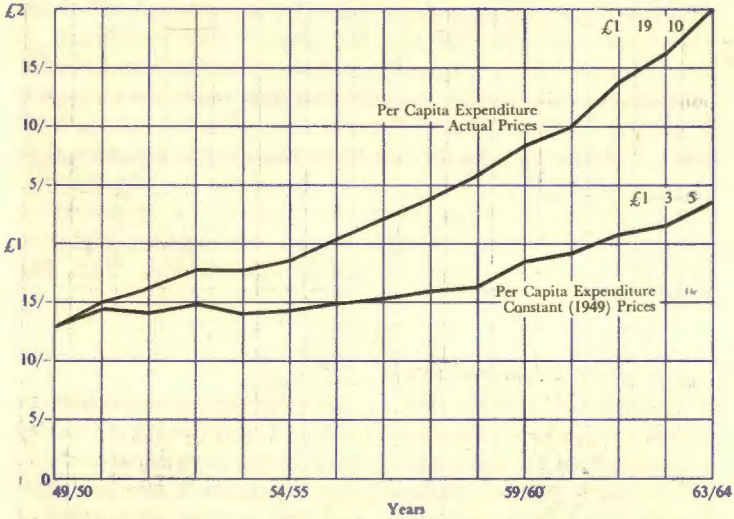
Gross expenditure per capita on Local Health Services shows a steady rise. In 1963/4 almost two pounds were being spent for every man, woman and child in the United Kingdom. This compares with 13s. 7d. in 1949. At constant 1949 prices, the expenditure per head in 1963/4 was equivalent to £1.3.5d. The trends in per capita expenditure are shown in *Figure* 3. It

*These expenditures have been adjusted using a retail price index, which does not necessarily reflect exactly how prices and salaries paid by the Local Health Authorities have risen. The increases stated in "real" terms should, therefore, be treated with this reservation in mind.

Figure 3

Per Capita Expenditure on Local Health Services: United Kingdom 1949/50–1963/4.

Sources: Annual Abstract of Statistics 1964, Index of Retail Prices derived from the London and Cambridge Economic Bulletin.



will be seen that at constant prices expenditure was relatively stable until 1955. The growth in outlay has occurred mainly in the last five years.*

Capital Investment

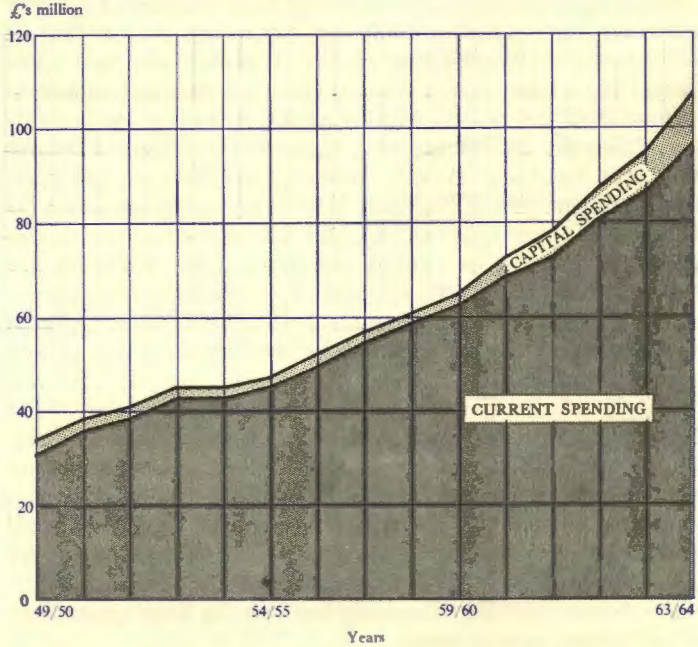
A further appreciation of the pattern of Local Health Authority expenditure can be gained by extracting capital expenditure from the totals discussed above. In the first ten years after 1948 the Local Health Services suffered, first from a shortage of building materials and then from a shortage of capital. Old buildings were often converted despite earlier optimistic plans for purpose-built premises. Capital expenditure in 1950/51 was £2·3 million, and with small fluctuations it stayed at this level until 1958 (*Figure* 4). Thus, allowing for inflation, the level of capital investment was falling in real terms. As a proportion of total National Health Service capital expenditure, Local Health Authority capital spending dropped

*Some of the per capita increase, of course, is due to a disproportionate expansion of those age groups most likely to need the services. For example, while the population as a whole increased by six per cent between 1951 and 1963, those over the age of 70 increased by 17·5 per cent.

Figure 4

Local Health Authority Spending: United Kingdom 1949/50–1963/4.

Source: Annual Abstract of Statistics 1964.



from a 1950 figure of 10·2 per cent to the 1957 low of 7·5 per cent. The estimates of capital investment entered in 1954 by the Authorities had been pruned by the Minister who found them to be beyond the means of the Health Service. In late 1955 it was requested that planned spending for 1956 should be no higher than for the current year, and the need for economy throughout Local Authority capital investment was announced by the Chancellor of the Exchequer. Local Health Authorities were notified that only the most urgent needs would be approved. In 1956 and 1957 Local Authority capital spending was cut back to below the 1949 level. Under these conditions priority developments were accommodation for nurses and midwives and occupational centres for mental defectives.

During 1958/9 the squeeze was gradually relaxed and for the first time a real upswing in capital investment began. Late

in 1958 with investment running some 17 per cent up on 1949, the Minister announced that plans could be brought forward in time and much needed clinics and ambulance stations were commenced. Loan sanctions approved by the Minister in 1959 totalled more than the previous three years together. Expenditure of £5·3 million in 1960 was more than double that of 1958 and the 1963/4 figure of £10·4 million was four times that of 1949. Moreover, the Local Health Authority proportion of total National Health Service capital spending was increasing. From the 1957 figure of 7·5 per cent it became 13·6 per cent in 1963. Local Health Authority expenditure had risen from 8·9 per cent of National Health Service expenditure in 1958, to 10·2 per cent in 1963, and half of this rise was due to the large increase in capital spending. This expansion has meant, among other things, additional ambulance stations and staff accommodation, more maternity and child welfare clinics, and more facilities for occupational and therapeutic training of the mentally ill.

It is interesting to note that generally over the period of the National Health Service, Local Health Service capital expenditure has tended to represent a higher proportion of all Health Service capital expenditure than total Local Health spending of total National Health spending. The Local Authority services have fared better in the area of capital spending than have the other sectors of the Health Service. Nonetheless capital development has been far from spectacular when judged against needs.

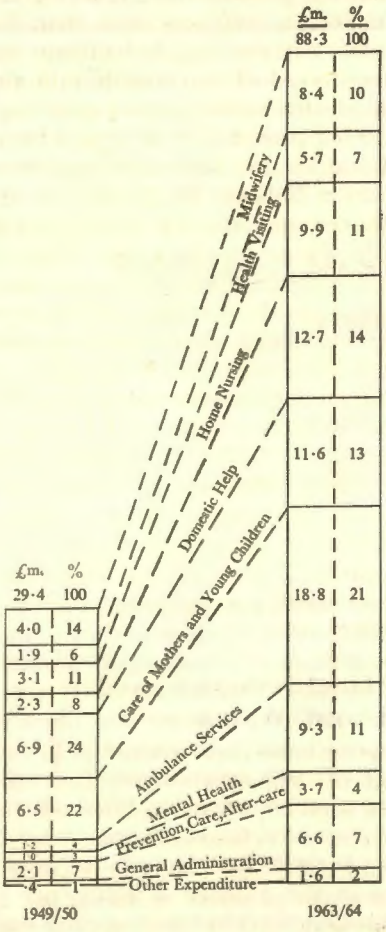
The Local Health Services in England and Wales

Analysis of net revenue expenditure* of Local Health Services in England and Wales for 1949/50 and 1963/4 is shown in chart form in *Figure* 5. "Vaccination and Immunization" and "Health Centres" expenditures have been included in "Other Expenditure" because outlay on these services has been spasmodic. In the case of health centres it has not been on a sufficiently large scale and in the case of vaccination and immunization not sufficiently regular to be subject to meaningful comparison over 15 years.

*Revenue expenditure is expenditure met from revenue income. This includes a small part of capital spending financed from revenue sources as opposed to central Government loan sanctions. It also includes loan charges currently in the region of £2·5m. Net revenue expenditure is obtained by deducting from this the amount of patient payments made for the various services. In 1963–4 such charges totalled £5m.

Local Health Authorities – England and Wales. Net Revenue Expenditure 1949/50, 1963/4.

Sources: Ministry of Health Annual Reports



1949/50: Other Expenditure

	£s
Vacc. and Imm.	300,000
Health Centres	— 5,000
Other Enactments	73,000
	368,000

1963/4: Other Expenditure

	£s
Vacc. and Imm.	1,260,000
Health Centres	123,000
Other Enactments	170,000
	1,553,000

Table I

Increases in constant-price expenditure on various services: 1963/4 as a per cent of 1949/50.

	per cent
Midwifery	113
Health Visiting	166
Home Nursing	172
Domestic Help	305
Care of Mothers and Young Children	92
Ambulance Services	158
Mental Health	423
Prevention, Care and After-Care	203

Source: derived from Ministry of Health Reports.

Figure 5 shows how proportional allocation of resources among the major services has changed during the life of the National Health Service. It does not show the change that has occurred over those years in real, or constant-price, outlay on the various services. This is most easily seen from *Table* I which translates 1963 expenditure into terms of 1949 prices[1] (using a retail-price index; see footnote p. [redacted]) and expresses it as a percentage of 1949 expenditure. This table emphasises that there have been considerable differences in the rates of expansion of the services. Constant-price expenditure on care of mothers and young children actually fell despite an increase of 17 per cent in the number of births per year over the period. On midwifery services constant-price expenditure rose by 13 per cent. The greatest expansion has occurred in the mental health and domestic help services – this being particularly interesting as in the case of the former service the nature of its provision was unspecified in the National Health Service Act, and for the latter service provision was left at the option of the Authorities.

Health Centres

The intention to institute and develop co-ordination among the medical services was an integral part of the National Health Service Act. The health centre was seen as one way of achieving this. It was intended to be a focal point of the National Health Service, and was envisaged as fostering co-operation between the three branches of the Service at a local level. In the 1946 Act its function was defined as the provision of facilities for all or any of: general medical and dental services, pharmaceutical services and services for hospital out-patients, information, and any other services provision of which was made a function of the Authorities. Despite an initial enthusiasm on the part of the Local Authorities progress was soon checked by doubts on the part of general practitioners, the very real problem of assessing potential demands, a severe shortage of capital, and building difficulties. Planning was tempered by the 1950 report of a Sub-Committee of the Central Health Services Committee, which recommended progress by conversion rather than new building. It was thought that only the circumstances of a new community could provide a strong enough case for the building of a health centre.

Not until 1952 did the first specifically designed centres open. These were at Bristol, Stoke Newington and Nottingham – all on new housing estates. Programmes elsewhere were held up not only by the national need for economy but also by the difficulty of thrashing out a fair apportionment of the centre's time and facilities among the various services. The Minister commented in his report that the three completed centres were more likely to be the starting point for a wide range of experiments than to be models for those of the future. During the 1950s, health centres opened at a rate of one or two a year. The Nuffield Provincial Hospital Trust and the Rockefeller Foundation sponsored the building of experimental centres. Such private developments provided an opportunity for experiment along lines other than those suggested in the Health Service Act. Apart from these, however, and a few establishments which had operated pre-1948 and were approved as health centres under the Health Service, there were by the end of 1964 only 21 centres.

There were many reasons for this slow development. The Guillebaud Committee in 1956 had noted that health centres were still only experimental, and acknowledged that equivalent benefits might be achieved in other ways, for instance by co-ordinating group practices with Local Health Authority clinics.[3] Indeed, at that time a growing number of general practitioners were providing their services at clinics and some midwives and health visitors were attending general practitioners' surgeries or serving a particular practice. Health centres were no longer seen as an essential step towards achieving intra-service co-operation. The growth of group practices and the reduction in numbers of single handed practices have been reducing the isolation of the general practitioner, which was another effect that centres were in part designed to achieve. And in his report for 1961 the Minister noted that, even when established, health centres were not always successful in furthering a working measure of integration. The growth of the other forms of co-operation was continuing and often by-passing the need for centres.

According to the Local Authority plans in 1974 there will be 68 health centres, but these will be distributed among less than half that number of authorities. Clearly, the nature and purpose of health centres is still very much an open question, and the general feeling of the Local Health Authorities and medical workers concerned is one of uncertainty over the best way to interpret the health centre concept. As the pattern of medical needs have changed, ideas developed 15 years ago have been modified. The first task is still to investigate the proper function of health centres, and alternative ways of providing community medical care; but even such experiments are restricted by lack of finance and opportunity. However, in particular, new towns do provide a chance to evaluate new ways of organising the local health services. For example, there is an interesting experiment proposed at Woolwich and Erith, and it is certainly important that the opportunities for planning community health services offered by new towns or major redevelopments in city centres should not be missed.

Maternity and Child Welfare Services

Local Health Authorities are required by the 1946 Act to provide a full maternity service. The Act specifies that they shall ensure that sufficient midwives are available to cope with

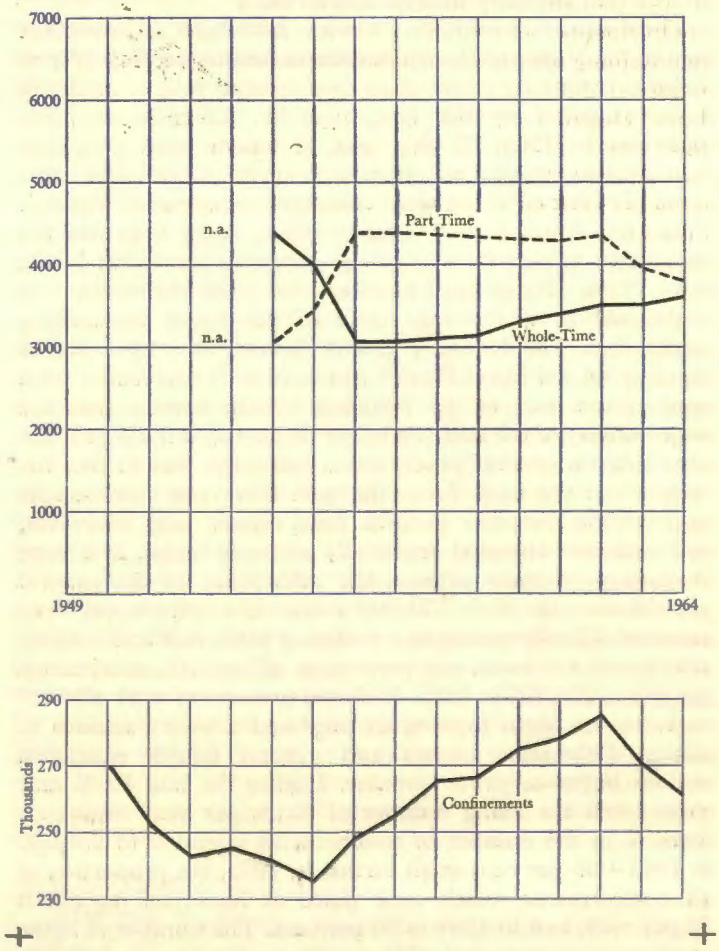
domiciliary confinements and the home care of mothers in the lying-in period and that they should make arrangements for the care, especially dental care, of nursing and expectant mothers and children under five not at school. This has allowed development in many areas of a comprehensive maternity service consisting of ante-natal clinics, domiciliary midwifery, post-natal and child-welfare clinics, dental services for mothers and young children, nursery care during the day, and various ancillary information services.

The domiciliary midwifery services have been an important part of the National Health Service maternity services (*Figure* 6). At present 30 per cent of all confinements take place in the home attended by the local midwife. There were 7,633 midwives in 1964, 53 per cent of whom were part-time (usually also engaged on other local health duties), and some seven per cent of whom were voluntary organisation workers. This total figure has been fairly steady since 1949 but the proportion of part-time midwives increased somewhat in the early 1950s. Under the Midwives' Act 1936 the service was established as a statutory duty of the Local Supervising Authorities. The National Health Service Act 1946 placed the duty on the Local Health Authorities. It was feared for a time at the start of the National Health Service that the responsibility of the midwife might be curtailed if the practice of calling on general practitioners increased. But in fact the reverse was the case. From the start there was considerable co-operation between general practitioners and midwives, and midwives attended practically all home births, in a large proportion of cases without the attendance of the general practitioner. In 1949, 271,000 domestic confinements were attended. Chiefly owing to a declining birth-rate and secondarily to a slowly increasing percentage of hospital confinements this fell to 236,000 in 1955. Reduced pressure of work allowed midwives to begin to conduct pre-natal advisory sessions in clinics. Relaxation classes and general health education sessions began to prove popular. During the late 1950s and early 1960s the rising number of births per year meant an increase in the number of confinements attended to 285,000 in 1962 – 36 per cent of all births. In 1963, the proportion of all confinements which took place at home fell to about 32 per cent, and in 1964 to 30 per cent. The number of home confinements attended fell correspondingly to 262,000. Co-operation between midwives and general practitioners has

Figure 6

Numbers of Domiciliary Midwives, and confinements attended: England and Wales 1949–1964.

Sources: Ministry of Health Annual Reports.



by now reached a very high level. In 1961 the general practitioners were called in during pregnancy to give ante-natal advice in 91 per cent of all cases, compared with 69 per cent in 1955.

The maternity services have often been suggested as suitable for unification under one branch of the Health Service. The Cranbrook Committee, which examined this question, reported in 1959. The main conclusions relevant to this paper were that it was thought unjustifiable to provide hospital beds for all confinements and that administrative unification while maintaining the hospital/domiciliary alternatives would be rendered difficult by a prominent feature of the staffing of Local Health Authority domiciliary services. This is the fact that many whole-time employees divide their time among two or more duties. The Cranbrook Report noted that about 60 per cent of the domiciliary midwives in 1957 had combined duties.[4] Nine hundred of them had as many as four separate functions; midwifery, home nursing, health visiting and school nursing.

Extracting the maternity duty for separate administration would probably, the Committee thought, result in a net disadvantage. Provision of hospital beds for all confinements would result in cases which really had no need for hospitalisation using beds for which non-maternity cases might have considerable need. Provision of beds for women with abnormal conditions or with risk of abnormality, for women already having four or more children, for those requiring admission on social grounds, for first confinement cases, and for emergencies was thought the maximum necessary. The Committee estimated that this would cover at most 70 per cent of all births. This implied that the proportion of domestic confinements should not fall below 30 per cent, the level which on average it has since reached.

Attendances at Local Authority clinics were expected to fall with the introduction of the National Health Service, as the family doctor became freely available for consultation. During the early 1950s this seemed to be occurring. Between 1949 and 1955 attendances fell in ante-natal clinics from 1·7 million to 1·4 million per annum, in post-natal clinics from 88,000 to 56,000 and in child-welfare clinics from 10·1 million to 9·0 million. This was due to the falling birth rate, the increase in hospital confinements, and the greater part played by the general practitioners especially on the post-natal

check. Since 1955, particularly for this last reason the trend has continued for post-natal clinics, at which by 1962 attendances had fallen to 42,000. For the other two services, however, the rising birth rate of the late 1950s helped to reverse the trend. The provision of group sessions, often conducted by midwives, has helped the popularity of antenatal clinics where attendances had risen again to 1·6 million by 1962. One prospective mother in three attended. There have, however, been recent signs of a downturn and the level in 1964 was in the region of 1·4 million. Child Welfare Clinics have since the mid-1950s received constantly increasing attendances, reaching a record level of about 12·5 million in 1964. Nearly 50 per cent of children under five attended at least once compared with 27 per cent in 1950. Introduction of mobile clinics has enabled a wider public to avail itself of the service. Clinics have also been used as outlets for other information on child care, home accident prevention campaigns, and, in some areas, as centres for the welfare of the unmarried mother. The Health Service Act provided specifically for a dental service for expectant and nursing mothers and children under five. This service has however been hampered constantly by recruitment difficulties.

The number of day nurseries run by Local Authorities has fallen from 910 in 1949 to 455 in 1964. They were found expensive to run and in 1952 the Authorities were empowered to levy charges to offset the cost, though it was realised that this might further reduce the demand for them. Throughout the period of the National Health Service the number of registered private nurseries and daily child minders has increased, and the number of children cared for daily by all these methods has risen. In 1964 it was within the region of 50,000 but of this total non-government concerns looked after more than did the Authorities. Local Authority day nurseries have an average daily attendance of 17,000 children and there is evidence to suggest that they are becoming less popular. Local Authority child care is increasingly catering for children from broken homes and the handicapped rather than the normal child, while non-specialised day care is more often being provided by private bodies.

(a) Health Visitors

Prior to the National Health Service the health visitor had been chiefly an advisor on mother and child care problems, but the Act had expanded her scope of work to include giving advice on the care of any persons suffering from illness and on the prevention of the spread of infection. However in the first four or five years of the Health Service the health visitor service remained little more than an extension of the maternity services. In 1949 there were 5,852 health visitors, 302 of which were voluntary workers (*Figure* 7). Of the total, 4,197 were part-time, although most worked full-time within the health service, acting also as school nurses, etc. Ninety per cent of their ten million visits were to advise on care of infants, and for some years the percentage of visits to mothers with infants remained in the upper eighties. Many areas were unable to provide the wider aspects of the service envisaged in the Act simply because of the shortage of staff.

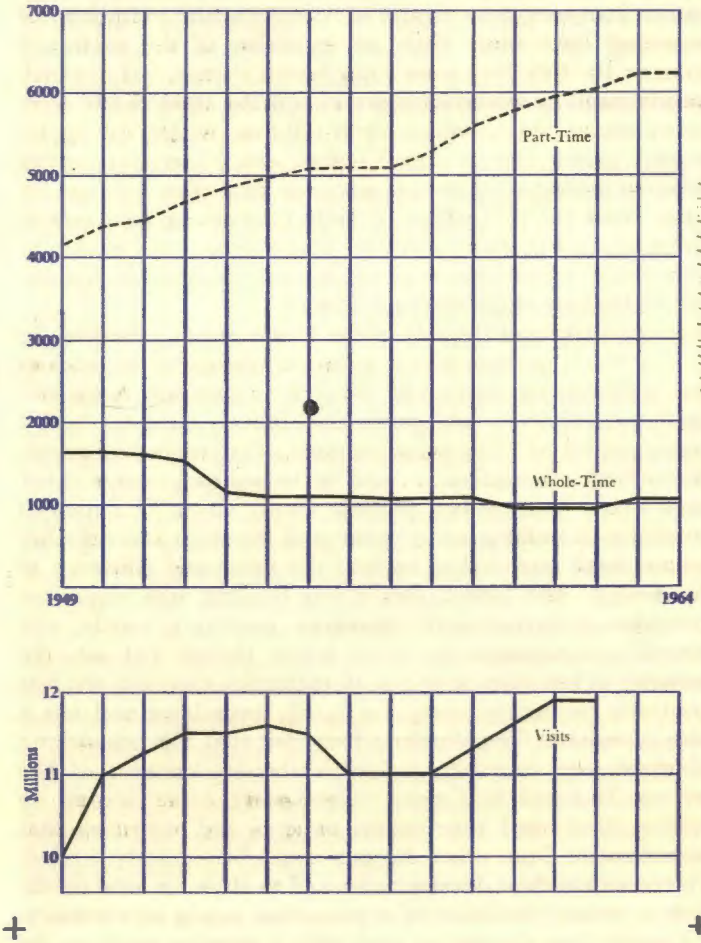
The widening of the role of the health visitor was slow. In 1956 a Working Party on the nature and scope of the work of the health visitor chaired by Sir Wilson Jameson remarked, partly prescriptively and partly descriptively, that the health visitor should be "The common point of reference and source of standard information . . . and in the ordinary course of her work would be a general purpose family visitor".[5] Financial assistance in training and regular staff meetings and refresher courses were intended to expand the scope and efficiency of the service. The health visitor was brought into closer co-operation with hospitals, especially maternity wards, and general practitioners. In most areas, though not all, the majority of her visits were still to maternity cases but she was gradually becoming more of a family consultant and less a case consultant. The Working Party felt that this broadening of scope was necessary to accelerate development of the service. It noted that some visitors were concentrating on visiting discharged tuberculosis patients and suggested that convalescents from other diseases could be similarly tended. To encourage these developments and to allow for local conditions a greater flexibility of organisation would be necessary.

Greater time devoted to each visit, a growing tendency for patients to consult health visitors at clinics or in doctor's

Figure 7

Numbers of Health Visitors, and visits made: England and Wales 1949–1964.

Sources: Ministry of Health Annual Reports.



surgeries, and a more careful exclusion of non-access* visits from the total number of visits recorded accounted for a slight falling off in number of visits in the mid-1950s. Throughout the second half of the decade shortage of fully qualified staff was a recurrent problem. As late as July 1964 the Minister was still having to use his power to dispense with the requirement of full qualifications in order to increase the strength of the service. From 1959 the number of visits was beginning to rise again and the 1962 total of 11·9 million from 7,376 visitors was higher than ever before. By then it was rare for a visitor to be concerned only with young families. Almost all were including visits for the elderly, for purposes of health education, for such specific tasks as screening for diabetes and child deafness, or for collecting data for social and individual research. In recent years the work of health visitors has involved closer contact with other social workers. Increasingly the emphasis is on family advice and on the underlying social and personal aspects of illness.

(b) District Nurses

Before the National Health Service many Local Authorities provided a home nursing service in cases of infectious diseases and in some maternity cases. The Health Service Act stipulated that Local Authorities should provide domiciliary nursing for all those requiring it, usually on the recommendation of the general practitioner. Therefore much of the district nurse's work is done in conjunction with the general practitioner. Such co-ordination can be particularly useful in cases needing regular routine care, such as the giving of prescribed injections. The home nurse's duties cover a broad range of pre- and post-natal care and general nursing particularly of the old and chronic sick. The service has the merit of reducing pressure on hospital beds, and facilitating early discharge from hospital. In 1953, 44 per cent of all visits were to the over 65's. This rose to 64 per cent in 1961, and is apparently continuing to rise. Many of these elderly cases find that regular care from the district nurse enables them to stay in their own homes, rather than having to accept institutional care.

The service has known staffing difficulties. But from the 1949 total of 8,325 nurses (4,865 part-time) the service strength

*A non-access visit was one where the health visitor was unable to see the patient or the visit was for some other reason fruitless. Once a standard method of recording such visits was implemented the isolation of non-access visits from total visits became uniform.

Figure 8

Numbers of Home Nurses, and Cases attended: England and Wales 1949–1964.

Sources: Ministry of Health Annual Reports.

expanded to a 1964 total of 10,478 (again about 50 per cent part-time) (*Fig. 8*). The number of cases attended was 860,000 in 1949. It rose to a 1953 peak of 1,180,000, and has since declined to 837,000. The smaller number of patients have had more visits each from the home nurses, and on average each patient received 26 visits in 1961 (the last available figure), compared with 20 in 1949. Total visits rose from 17·3 million in 1949 to 25·0 million in 1953, but fell again to 22·7 million in 1961. These trends reflect the changing work pattern of district nurses. For example, the availability of oral medications mean that they now less often need to visit patients simply to give an injection, but they will instead have to spend more time on the elderly chronic sick who may need extensive nursing. There have been criticisms that expansion of the home nursing service has failed to keep pace with the rising numbers of elderly in the population. However the changing pattern of the nurses' work makes it difficult to quantify the extent to which these are justified.

(c) Home Helps

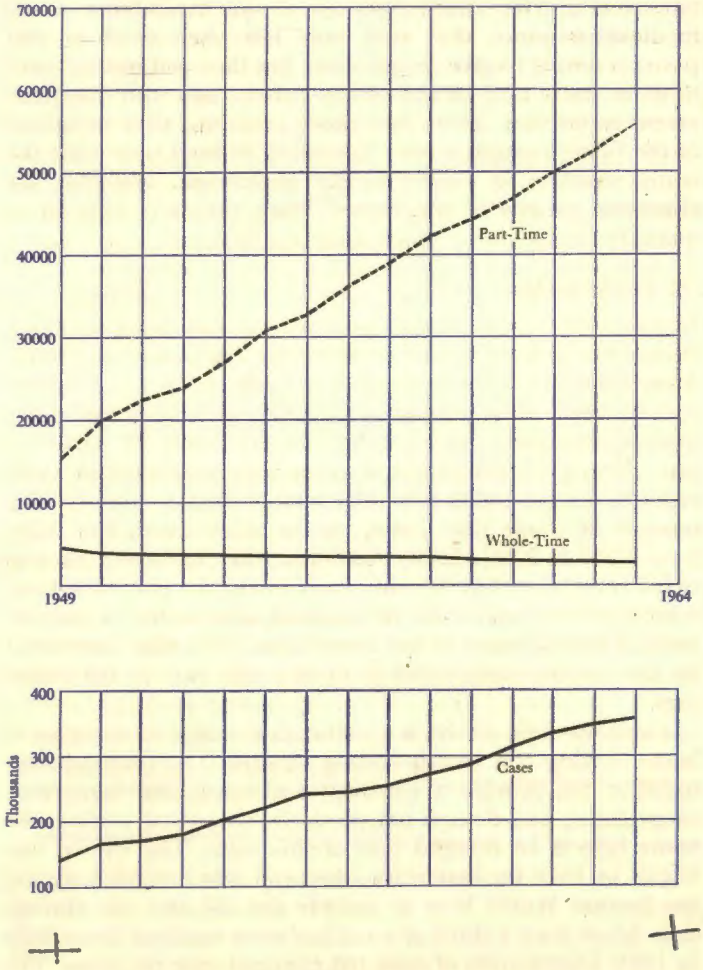
Expenditure on the home help service has increased to a greater extent than on any other service except mental health. More than five times as much was spent in 1963 in England and Wales on the service as in 1949. The great majority of this increase has been incurred by the expansion of part-time staff. Nearly 15,000 part-time helps were employed in 1949, and this has expanded to a 1964 total of 58,083. (*Fig.* 9). The number of whole time helps, on the other hand, has fallen from 3,967 to 2,821. Many Authorities like to have a nucleus of full time helps, but in many ways work on a part-time basis is more convenient for the help herself, who is often a married woman with a home of her own to run. It is also convenient for the patients since many of them prefer help in the mornings.

The home help service is a well-nigh essential counterpart of home nursing and health visiting services. The three services together can provide a thorough and specialised home care programme, and though not primarily a medical worker, the home help is an integral part of this team. The service was begun in 1918 for maternity cases and was extended during the Second World War to include the old and the chronic sick. More than a third of a million cases received home help in 1964. Distribution of cases has changed over the years. The

Figure 9

Numbers of Home Helps, and Cases attended: England and Wales 1949–1964.

Sources: Ministry of Health Annual Reports.



number of maternity cases receiving home help has fallen as a percentage of total cases from 19 per cent in 1952 to nine per cent in 1964. The main cause of the increase in total cases has been the greater number of old people and chronic sick assisted, who in 1964 constituted 83 per cent of the total. A third category where home helps are providing valuable assistance is in the case of problem families, where the mother has died or deserted or lacks the mental or physical ability to cope with her home, with the result that the family unit is in danger of fragmenting. Here the home help's contribution is unique. In some cases she can help to put the mother on her feet by giving advice and assistance on home management or child care or domestic economy.* In other cases, for instance, where the mother has gone to hospital, the home help concentrates on looking after the children and the home until the mother returns. Although the growth of the home help service under the National Health Service has been spectacular, there is evidence that it is still quite inadequate to meet the needs of all those in an ageing population who could benefit from it. The recent study by Townsend and Wedderburn suggested that for every elderly person assisted by a home help, at least two others had difficulty with their housework, but received no help.[6]

Ambulance Services

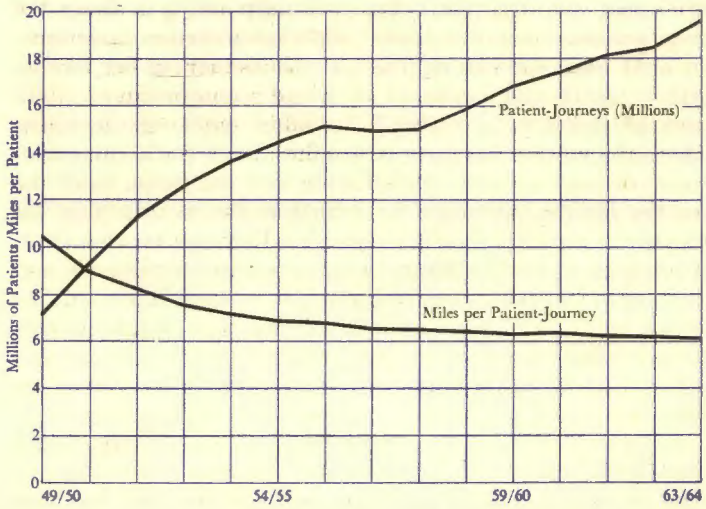
The development of the ambulance service since 1949 has been characterised by a steadily increasing number of patients carried each year and a steadily declining number of miles travelled for each patient (*Figure* 10). The number of patient journeys rose rapidly from 7·0 million in 1949 to 11·3 million in 1951, and has since risen steadily to 19·7 million in 1963. The rise has largely been caused by the increasing number of out-patients who use the service. In 1949 out-patient attendances at hospital numbered 26 million; by 1963 this had risen to 31 million. The vast majority of patients carried by the ambulances are out-patients – approximately 80 per cent in 1961. (Accidents, by contrast, only accounted for five per cent of cases carried in 1961.) Not only has there been a greater number of out-patients who could be carried by the ambulance service, but the proportion of out-patients' journeys between their home and hospital made in an ambu-

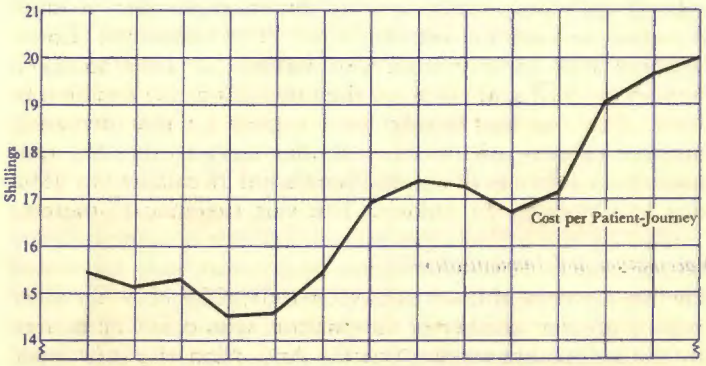
*An experiment conducted by the Kent County Council, in 1957, involving intensive home help for problem-families, produced on average a 30 per cent improvement on a points basis in performance classified under ten headings such as "cooking", "budgeting", etc.

Figure 10

The Ambulance Services in England and Wales 1949/50–1963/4.

Sources: Ministry of Health Annual Reports.





lance has risen from about one tenth in 1949 to about one quarter in 1963. Despite very active measures to discourage and prevent the unnecessary use of ambulances, a much greater proportion of patients attending hospital have been arriving or leaving by ambulance. The total number of patient journeys has risen nearly three times. But the cost of the service per patient journey has risen by only 30 per cent, from 15s. 5d. in 1950 to 20s. in 1963. In fact, in constant price terms this cost has fallen. This has been brought about by more efficient operation of the ambulance service under the Local Health Authorities. Tighter organisation, closer liaison with hospitals, the introduction of radio control and ambulance-buses have succeeded in steadily reducing the miles travelled for each patient. When the Local Authorities first took over control from the mainly voluntary organisations who ran the service before 1948, ambulances were travelling on average 11 miles per patient journey. This had fallen to 6·1 miles by 1963. Despite the trebling of work load the total cost of the service at constant-prices has risen by only 58 per cent, as shown in *Table* I, and total mileage travelled by the ambulances has increased only 63 per cent.

There seems little reason to expect the demand on the service to stop increasing. As long as an increasing variety of treatment for more and more major and minor ailments is available to hospital out-patients, and while the numbers of elderly in the population increases, the demand for the ambulance service will continue to climb steadily.

It is hard to say whether greater efficiency and the provision of more appropriate vehicles have encouraged the Local Health Authorities to provide transport for a larger proportion of out-patients, or whether, on the other hand, the service has been forced to adapt to cater for the greater public demand. No doubt, as in other sectors of the Local Health Services which have seen equally great changes, the real cause has been an interplay between changing needs and technical progress.

Vaccination and Immunisation

The National Health Service Act required Local Authorities to provide, free of charge, vaccination against smallpox and immunisation against diphtheria. Any Authority can with Ministerial approval arrange for protection against any other disease, and if directed by the Minister must make such arrangements. This second clause has allowed for extension

of the service to offer protection against many diseases other than the two originally specified. By 1962 all Authorities offered free protection against smallpox, diphtheria, poliomyelitis, whooping-cough, tuberculosis and tetanus. Vaccination against measles and influenza are possible future extensions of the service. The cost of the service rose gradually from £325,000 in 1949 to £654,000 in 1956. Before that date most protection was against smallpox and diphtheria. Tetanus was classified as an immunisable disease in 1955 and whooping-cough in 1957. Polio vaccine was introduced in 1956 and its availability spread steadily. The number of Authorities offering such protection grew, and demand for these three vaccines, particularly the last, caused a sharp rise in expenditure to the 1961 total of £2·8 million.

It is often suggested that the availability of free medical care encourages excessive demands, but certainly in the field of preventive medicine this is not so. Left to their own initiative it seems that only a small proportion of the public seek immunisation against disease. In the early 1950s, most people were left unmoved by the Ministry publicity campaign for diphtheria and smallpox protection. Personal representations by the general practitioner or health visitor were thought to be the most effective way of getting their patients to take action. The mass X-Ray campaign has shown that a high response rate can also be obtained by taking the service to the person, making it almost easier to accept it than avoid it. The problem is accentuated as the public gradually forget the dangers of diseases. Only 48 per cent of young babies were vaccinated in 1958. Diphtheria immunisations were given to little more than 50 per cent of infants and it took a small outbreak in 1958 to add point to the claim that immunisation was worth while. Ironically, a dramatic manifestation of disease is the only thing that prompts widespread public interest in protection. One of the greatest success stories of the Local Health Authorities vaccination services was their control of poliomyelitis. In this case the demand seemed to result largely from the publicity surrounding the death from polio of a popular footballer in 1959. The abnormally high expenditure on the service in the late 1950s and early 1960s was due to the high acceptance of poliomyelitis protection. By 1963 the incidence of poliomyelitis was the lowest ever recorded but here again there is a real risk of complacency. The outbreak at Blackburn in 1965 highlighted the danger.

Although the official recommendation is that polio vaccination should start at the age of six months, for England and Wales as a whole only 66 per cent of infants born in 1961 had been immunised by the end of 1964. The dangers of infectious diseases have diminished to an extent probably undreamed of 30 years ago; but there can be one disadvantage of a successful vaccination campaign. This is the comfortable but false assumption by the general public that it has been a once-for-all battle which has eliminated the threat for ever.

Prevention, Care and After-Care

Before 1948 it was feared that the Local Health Authorities might lose much of their responsibility with the transfer of hospitals to the control of hospital boards. However in the event it gave the Local Authorities the opportunity to concentrate on a preventive service. Historically an important element of their responsibility, it now became primary. Section 28 of the 1946 Act provided that with Ministerial approval or as directed by the Minister, the Local Authorities might develop services for the prevention of illness, care of ill people (including the mentally ill), or after-care of such persons. The specific services provided under other sections of the Act as it relates to Local Health Authorities are also by nature to a large degree prevention and care services. To this extent the purpose of this Section is to provide a latitude for them to expand their stipulated services and introduce a wider range of non-specified services, allowing the Local Health Services to develop their logical position within the National Health Service as the mainstay of preventive medicine and care in the community.

The concepts of prevention and care frequently overlap. For example, one feature of prevention and care which is of increasing importance is the assistance of problem families. Many workers have a part to play here. The health visitor, the home help, and the social worker all offer a different type of assistance. This care is preventive in intention for it is designed to avoid the break-up of the family, and all that that would entail. The development of prevention and care perhaps more than any other area of Local Health Authority responsibility depends on development of co-operation. Successful care of problem families, for instance, needs co-operation between branches of the services provided by the Local Authorities. The after-care of convalescent patients discharged from hospi-

tal requires co-operation between the personnel of the Local Health Services and the Hospital Services. Co-operation is necessary between the health committees and housing committees in cases where re-housing is a pre-requisite for setting a patient or family on their feet again. Co-operation with the National Assistance Board and the whole range of voluntary organisations is also important.

The direct economic benefit of prevention and care in the community is a saving in institutional costs. In the majority of cases, especially when whole families are affected, it is probable that the cost of community care is less than institutional care. A further unquantifiable benefit is the future stability of the patient. The psychological difference between institutionalisation and care at home is immense, and, again with particular reference to problem families, the difference may be that between permanent break-up and temporary difficulties.

Health Education

One important and under-used method of health improvement and disease prevention is health education. For a few years after the beginning of the Health Service the Ministry of Health was able to use the mass media systems – cinema, television, and press – to a considerable degree for public service films and advertisements. But as the war-time sense of national unity dispersed the media proprietors were prepared to give less time to these projects, and concurrently a normal peace time state of suspicion as to the motives of government propaganda revived among the populace. Partly for these reasons, and partly due to the lack of specialist knowledge of propaganda techniques, health education campaigns have often had a rather forlorn appearance. Some main projects have been: mass X-Ray, diphtheria and polio protection, venereal disease publicity, home accidents, the "Coughs and Sneezes" campaign, and recently the smoking and lung cancer campaign. The Local Authorities are empowered to undertake health education in their areas. In the Central Council for Health Education, they have an organisation which can advise them on methods, materials and techniques.* Health education today takes two main forms, which should not be confused. Health publicity or propaganda is conveyed by means of public service TV films, posters, stickers and leaflets on public noticeboards and in public buildings such as libraries and clinics. However, perhaps more important than

these is the health education provided in schools and elsewhere by lectures from health workers and teachers, and indirectly by lectures, seminars and conferences organised by the Council for the health workers. It is understandable that health education is most effective on a personal level, as instruction from the teacher, the general practitioner, health visitor or pharmacist; but this is of limited availability and in any case needs backing up with the appropriate information and material.

The British Medical Association, in 1956, had deplored the failure of the Ministry of Health in the area of health education, and called for a health education budget. And the Chief Medical Officer of Health, in his report for 1958, said that the development and expansion of health education on a firmer and sounder basis would be one of the most valuable contributions possible to the promotion of public health and prevention of disease. In 1960 a Committee was set up under Lord Cohen to determine the area and extent of health education and assess its future role. The report of the Committee, published in Spring 1964, recommended increased activity in health education on many subjects, and more field studies to evaluate methods and results.[7] It proposed new strong central boards for England and Wales and for Scotland, among the duties of which would be the development of "blanket" campaigns, and the securing of support from commercial and voluntary interests, as well as assisting the Local Authorities. It estimated that its proposals would raise expenditure on health education by about £500,000 a year – something like a tenfold increase over present levels. The Cohen Committee recommendations provide a good framework for intensification and rationalisation of the health education effort. What remains is for them to be implemented. The financial recommendation did not immediately provoke a substantial increase in government finance. Following the report the Council agreed with the Local Authority Associations that the need to increase the resources of the Council necessitated an increase in the minimum contribution by Local Authorities of 50 per cent

*The Council was first established in 1927 and reconstituted in 1950. It is controlled by a Council of Management consisting of representatives appointed on behalf of Local Authorities by the Local Authority Associations, representatives of the medical, dental, teaching and nursing professions, and meetings are attended by observers from various Ministries including the Ministry of Health. Its annual income consists largely of voluntary contributions from Local Authorities. Other income derives from the Council's summer school, lecture fees, conferences, etc. The Council's annual net income is approximately £30,000. The Government undertakes some health propaganda but generally over-lapping of effort is minimised by constant contact between the Council and the Government departments concerned.

over the next three years. Response so far has been good, but this is an uncertain way to gain income as there is no compulsion for Authorities to contribute at all.

Mental Health Services

The National Health Service Act transferred responsibility for mental hospitals from the Local Authorities to the Regional Hospital Boards. Before the Act, provision for the care of the mentally disordered outside hospital had been restricted to the mentally sub-normal, but under it the Local Health Authorities were given responsibility for care of the mentally ill and sub-normal in the community. Generally, care in the home was provided for such cases by the various domiciliary services, and, under Section 28 of the Act, and Sections 21 and 29 of the National Assistance Act, authorities provided centres for occupational training and general rehabilitation. Quicker and easier movement in and out of hospital, increasing social enlightenment on the nature of mental illness, and a growing recognition that mental illness should be accepted and catered for by society in the same way as physical illness, led to increasing emphasis on the mental health services. The Local Authority mental health services have grown consistently since 1948. Expenditure on them has increased more than on any other service. Even during the capital shortage of the mid-1950s capital expenditure on centres and hostels for the mentally disordered was increased, in contrast to reductions in other fields. The number of persons using the local mental health services was nearly 156,000 in 1964. In 1961, the earliest year for which a figure is available, the total was 122,000. Experimental centres such as social clubs, and improvements in co-operation between the Local Health Authorities, the hospitals and the relatives of the mentally disordered – particularly important in these cases – have helped improve the quality of assistance available. Many Authorities have taken the opportunity to widen the scope of the service. As with physical diseases, mental disorder involves preventive as well as curative medicine. Surveillance and care of people at risk of mental disorder is preventive in purpose and in result as much as are vaccination and immunisation.

The Mental Health Act 1959 clarified the scope of Local Authorities' powers under the National Health Act, 1946, Section 28, and indicated that among the services to be provided should be residential accommodation, training

centres, the appointment of officers to act as Mental Welfare Officers, the exercise of functions of guardianship, and home visiting. Backing this up, the Minister issued a directive to the Local Health Authorities making mandatory the provision of domiciliary care, training and rehabilitational care specifically for the mentally ill and sub-normal.

Regional Expenditure Variations

In England and Wales in 1963/4 the Local Health Authorities net expenditure (i.e. after allowing for receipts from patients) was on average £1 17s. 4d. per head of population.[8] Actual amounts ranged from Northampton County Borough's £1 3s. 0d. to Cardigan County Council's £3 1s. 2d. In terms of staff per 1,000 population, this meant twice as many health visitors, and three times as many home helps, nurses and midwives in Cardigan County as in Northampton Borough. In this case, geographical factors are undoubtedly important; but in general it is not easy to say whether variations between the level of provision in different areas are due to differences in need, differences in financial resources, or differences in the appreciation of the value of the services is not easily established. County Boroughs in general were fractionally higher spenders than County Councils (excluding London) – £1 16s. 9d. compared with £1 16s. 3d. The London County Council average was £2 10s. 8d.

On the domiciliary services alone it is the County Councils that spend more. Cost per visit or case, for midwifery, home nursing, ambulances and domestic help services are all higher for County Councils than for County Boroughs, possibly due to the greater distances involved. Health visitors are the only exception to this. Where the County Boroughs incur the expenditure that puts them just ahead of the County Councils is in the amount of capital spending they undertake. New centres are of more value if they can serve a large population nearby, and are more likely to be established in these circumstances. They will also tend to be more expensive to build in urban areas.

This pattern of expenditure is not expected to change greatly, according to the Local Authorities' forward plans for the next ten years. Generally the low (i.e. below national average) spenders of today will be the low spenders of 1974, if the plans are fulfilled; and similarly the high and medium spenders will tend to maintain those positions.

Plans for the future

In early 1962, as a concomitant to the hospital ten year plan published that year, all Authorities were requested to review the Local Health Services and make plans for developments to 1972/3. The results of this were published in *Health and Welfare: The Development of Community Care.*[9] The Minister of Health told Authorities that regular revisions would be required so that in general a moving ten year plan would exist. The first revision was published in 1964, extending the forecast to 1973/4.[10] Providing the background to the plan are the observations that the preservation of health and the prevention of illness are historically among the functions of local government, and that where illness or disability cannot be forestalled by preventive measures, care at home and in the community rather than in hospital should be the aim. Within this framework there are several trends apparent in the projected development of the service.

On balance, the Report concludes, requirements for *midwives* should remain fairly static. Longer holidays and additional responsibility should offset time saved by better transport and organisation. In fact, the Authorities plan an increase in the number of midwives from 0·11 whole-time equivalent* per 1,000 population in 1963, to 0·13 whole-time equivalent per 1,000 population in 1973. As relaxation and mother craft classes become more popular, they are changing the character of the ante-natal clinic. Child welfare *clinics* are increasingly popular. This trend is expected to continue, and nearly one half of the Local Authorities plan further clinics. In contrast only five Authorities see a need for additional day nurseries.

Amongst the other domiciliary workers, it is planned that *home helps* will continue to show the greatest expansion in absolute numbers, increasing from 0·54 whole-time equivalents per 1,000 in 1961 to 0·79 in 1973. For *home nurses*, on the other hand, little expansion is envisaged by the Authorities. Their work will continue to change so that they are expected to have time to assume new responsibilities, especially amongst the elderly. The increase in their numbers will be only from 0·17 whole-time equivalents per 1,000 in 1961 to 0·19 in 1973. *Health visitors* also are expected to continue to widen their

*Whole-time equivalent expresses the number of full-time workers which would be necessary to do the amount of work covered by the actual staff of full and part-time workers.

scope of activities, and in their case numbers are planned to rise from 0·11 whole-time equivalents per 1,000 in 1961 to 0·16 in 1973. The Minister considered this increase to be too small, and he regarded a figure of 0·17 whole-time equivalents per 1,000 as the minimum able to cope with the work. There will continue to be substantial variations between different Authorities. With home helps, for example, the predictions range from 0·6 to 1·53 whole-time equivalents per 1,000.

Earlier detection of mental disorder and better treatment has led to more cases being admitted to mental hospitals and to quicker discharges. At the end of 1961, 2·64 per 1,000 population were receiving some Local Health Authority care for *mental illness or sub-normality*. The Report on the plan comments that increasing knowledge of mental disorders, skill, and treatment, together with identification of those cases as yet undergoing no treatment, suggests that some five per 1,000 population will need these services by 1972. Home care is provided by the domiciliary services, but however successful this is there will always be the need for some accommodation, specialised according to the class catered for, e.g. the mentally ill, mentally sub-normal, children, or adults, residential or non-residential. It was thought by the Minister that the plans for all these things would prove too modest.

Continuing expansion of demand for the *ambulance service* is foreseen. Despite preventive efforts, the numbers of accident cases must be expected to increase. Out-patient use of the service is thought likely to grow due to earlier discharge of in-patients with return for out-patient treatment, and an increasing range of services available in out-patient departments. Although these features imply maintenance of recent growth rates, some Authorities plan little or no expansion. The Report commented that this might prove unrealistic.

Voluntary organisations pioneered many local health and welfare services as we know them today. Voluntary workers still play an important part, on the local level, for instance visiting patients for nursing or domestic assistance or companionship, or provision of meals and home comforts, voluntary ambulance services, and voluntary midwifery. Their proportional effort has been declining partly due to the expansion of the Local Authorities' service as a whole, and partly due to the increasing expense of running the voluntary service. Nonetheless their assistance was taken into consideration in constructing the ten year plan and the Local Health

Authorities for the most part consulted with the local voluntary organisations. The Minister commented that "the development of community care and the rate at which it can go forward will be greatly influenced by the relationship which is established and maintained between statutory and voluntary effort." Many local voluntary bodies are branches of national charities and trusts of a specific nature. The work that is done by such charities as the Spastics Society, and the Society for Mentally Handicapped Children is of continuing value to the development of community care.

Expenditure Planned

From the 1964 revision of the plan to cover years to 1973/4, estimated capital expenditure is shown in *Table* II. Compared

Table II

Anticipated Local Health Authorities Capital Expenditure: constant 1963 prices

	Years beginning April		
	1964/68	*1969/73*	*1964/73*
	£m.	£m.	£m.
Total	62·0	18·4	80·4
Average per year	12·4	3·7	8·0

Source: Reference ten.

Table III

Anticipated Local Health Authority Net Revenue Expenditure: constant 1963 prices

	£m.	*per cent increase over previous year*
1964/5	97	
1965/6	103	6
1966/7	108	5
1967/8	113	5
1968/9	117	4
1973/4	126	1·5 (average per annum)

Source: Reference ten.

with the present level of about £10 million per annum, the first five years' levels are not particularly high. The lowness of the estimates for the second five year period suggests that it is less a genuine measure of the Authorities' intentions than a reflection of the difficulty of forecasting capital expenditure at a distance of ten years.

The total net expenditure on the Local Health Services in England and Wales is planned to expand as shown in *Table* III. The pattern is again one of a slackening expansion rate. Taking constant prices the average percentage expansion rate per annum in net expenditure for four phases of the total period under consideration are given in *Table* IV. For the decade 1954/5 – 1963/4 there was a 63 per cent increase in constant price expenditure: for the decade 1964/5 – 1973/4 there is planned a 30 per cent increase in constant price spending. These planned increases in expenditure are reflected in growths of the service as shown in *Table* V.

Table IV

Rate of increase of Local Health Authority Net Revenue Expenditure:

	per cent increase per annum (constant prices)
1949/50 – 1958/59	2·7
1958/59 – 1963/64	6·8
1963/64 – 1968/69 (planned)	5·8
1968/69 – 1973/74 (planned)	1·5

Source: derived from References one and ten.

The Development of Community Care

The trend towards community care and the consequent necessity for close co-operation between the various sections of the tripartite Health Service have provided an opportunity for the Local Health Authorities to play a more prominent part. They have adapted to changing circumstances, so that their function is now very different from that in 1948. At the same time they have slowly but steadily gained in relative importance in the Health Service as a whole, and it is clear that this trend will continue. However, two anomalies emerge from any examination of present and proposed expenditures

Table V

Anticipated Growth of Local Health Authority Services

	per cent increase in provision 1973/4 over 1964/5	
Adult Mentally Subnormal Training Centres	95	Places per 1,000 population
Junior Mentally Subnormal Training Centres	26	
Hostels for Mentally Subnormal	500	
Health Visitors	33	Staff Whole-time equivalent per 1,000 population
Home Helps	27	
Home Nurses	12	
Midwives	8	
Ambulances	17	Numbers
Ambulances Staff	14	

Source: Reference ten.

by the Local Health Authorities. First, there are remarkable variations between different parts of the country. Second, the ten year forecasts imply a slackening rate of expansion in their Local Health Services which becomes very marked after the end of this decade. It seems likely that both of these have as their underlying cause a third feature of the Local Health Services. That is their rapidly changing role, and the consequent trend away from the provision of stereotyped services and towards an interdependent and co-ordinated range of specialised services, conditioned by the locality, the implementation of which is flexible and, as far as possible, geared to the specific needs of the individual patient. In this situation, it is inevitable that there must still be great uncertainty about what it is right to provide now, and about what will be required in the future.

Thus the falling off in expansion of the services planned by the Authorities must be taken primarily as a reflection of the difficulty of forecasting for a situation in which there are still so many unknowns. The changing responsibilities of the general practitioner, the increasing skill in early diagnosis and the development of day hospitals are but a few of the external factors which must effect the function of the Local Health Authority. What is important is to maintain flexibility, and above all to avoid recrimination if the present rate of expansion of the Local Health Services in fact continues far into the 1970s. Those who framed the National Health Service made a "miscalculation of sublime proportions" in assuming that its costs would not rise as the Service developed, and much criticism of actual expenditure resulted. The ten year Local Health Authorities plans inevitably appear to contain a similar fallacy, and it would be unfortunate if it were eventually to result in similar misunderstandings.

In this connection it is encouraging to note that the new National Plan[11] takes a more expansive view of the Local Health Services in the future. Although it describes its five year forecasts of expenditure on Local Health Services as consistent with the ten year plans prepared by the Local Authorities, it does not in fact seem to foresee the same slowing down of growth. Whilst the Local Authorities forecast an increase in current expenditures of only four per cent in 1968/9, with an annual average of 1·5 per cent in the following five years, the National Plan refers to the annual rate of increase having risen to 6·5 per cent by 1969/70. Whereas the Local Authorities forecast an increase in net revenue expenditure of 30 per cent in the decade from 1964/65, the National Plan forecasts an increase of 34 per cent within the first five years.*

On the question of local variations in expenditure it is easy to indulge in comparative statistical studies to produce implications of either under- or over-provision by individual Authorities. However, apart from the obvious variations in local requirements, the fact is that there is very little indication of what is the right level of expenditure for any part of the Local Health Services, or for the Local Health Authorities'

*The ten year plan forecasts are in terms of net revenue expenditure for England and Wales, while the National Plan forecasts are in terms of current expenditure for Great Britain. The actual figures in each are, therefore, not directly comparable, but the different bases would not account for the differences in the percentage increases.

provisions in totality. Much attention has been focused on the un-met needs, especially among the elderly in the community; but these must be judged against the needs which also exist in other parts of the Health Service. What is badly needed is scientific evaluation of benefits in relation to expenditure, especially for the various services provided by the Local Authorities. The amount of money being spent by them, and the variations between them, are sufficient to justify a very substantial operational research programme. This could take the form of evaluating in depth the services actually provided by typical high spending and low spending areas. These evaluations could be linked with community studies to determine the extent to which needs – whether recognised by the individuals or not – were being met by the services. If such a programme were initiated it would not interfere with local autonomy, but would introduce an element of central appraisal of the benefits of different types of organisation. This is perhaps an ideal formula for any part of the social services, provided that the central judgments do not themselves in turn rely on meaningless averages.

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