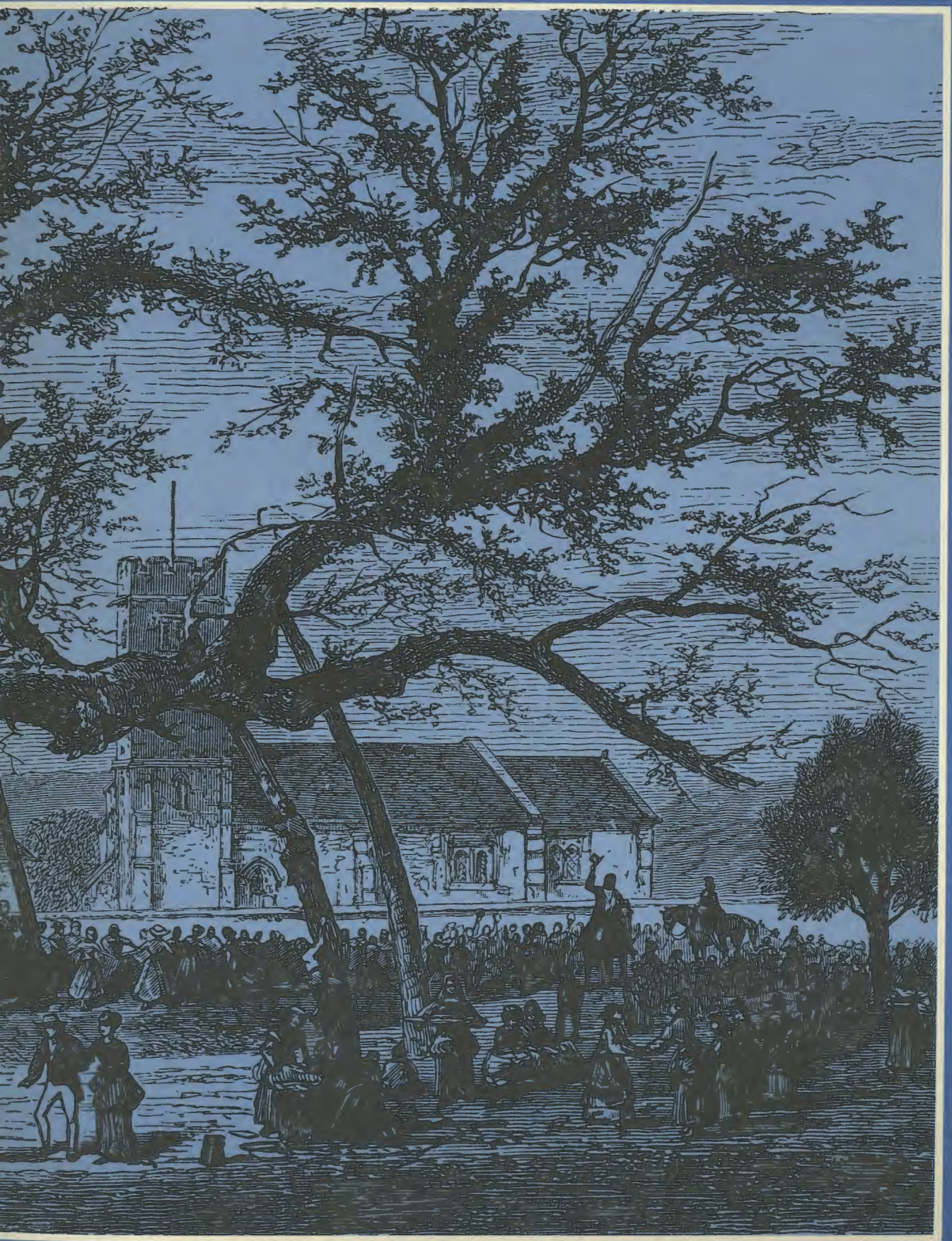
Understanding the NHS

in the 1980's



Understanding the NHS in the 1980's

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Cover illustration, 'the oldest oak in England: the Cowthorpe oak near Wetherby', by courtesy of the Mary Evans Picture Library

This paper was researched and written by **David Taylor**

Introduction

The National Health Service will spend around £17,000 million in the UK in 1984: it employs more than 1.2 million full-time and part-time staff. Thus as well as being very probably the nation's most popular major institution (Iglehart 1983, 1984), it is also its largest. The NHS today utilises around 6 per cent of the country's gross national product and a similar proportion of its manpower resources. This is not far short of double the share enjoyed by the health sector in the years immediately after 1948.

Yet alongside growth and frequent acclaim the last three to four decades have brought the service many new challenges. For example, the ageing of the population has required more of its energies to be focussed on the difficult health problems associated with the chronic, disabling diseases of later life. Whilst the gradual emergence of a less controlled, more individualistic social environment has meant that British health care consumers have become less tolerant of inconvenient or inadequate patterns of service than they were in the 1950s.

Such trends, together with the tensions like those associated with the NHS industrial disputes of the 1970s and early 1980s and the 1974 and 1982 structural reorganisations, have led a number of commentators to believe that the NHS has reached a crisis point. Some even suggest that it is near to collapse.

The analysis on which this paper is based offers little to support such views. Nevertheless, this is not to say that the efficiency or quality of current provisions could not be improved, or to deny the existence of a relatively high level of critical debate on the NHS. The widespread desire for better 'customer care', particularly in contexts such as waiting for hospital appointments; certain unacceptable failures to match service levels offered elsewhere, as in the case of renal dialysis for older patients; and talk of 'gross NHS overmanning' on the one hand (see, for instance, Howell 1983) and of 'life threatening' financial cuts on the other. All are examples of the type of issue about which there is genuine concern.

Against this background the primary goal of this paper is, in addition to updating previous Office of Health Economics guides to the organisational structure of the NHS in England[1] (OHE 1974, 1977), to provide a balanced picture of the continuing evolution of the health care system and of the possibilities for its future progress. The paper does not seek to question the fundamental principle that the NHS exists to provide comprehensive health care for everyone in the population, regardless of their wealth or social status. Rather, it attempts to identify the ways in which a health care system based on the ideal of universal welfare can most efficiently achieve its aims, given both the environment in which the NHS operates in the 1980s and the fresh difficulties it will have to face in the 1990s.

To this end particular attention is paid to the problems of health service management and the issues raised by the 1983 NHS Management Inquiry – the 'Griffiths' report. Also, the implications of recent decisions regarding the administration of the family practitioner services (FPS) are examined.

These last, which include the general medical and the community pharmaceutical services, are run independently of the hospital services (HCHS) and arguably embody some of the most distinctive and desirable facets of the British system. Indeed, despite criticisms from some quarters, the concepts underlying the FPS may one day come to serve as a general model for the future development of the entire health service. For potentially they may permit a more pragmatic combination of national planning and, where appropriate, economic competition between providers than can the current structure of the NHS hospital service.

1 Scotland, Northern Ireland and Wales have rather different NHS arrangements. Although these are referred to at various points in the text the primary focus is on developments in England. Many of the general points made can, however, be related to the overall UK situation.

Health care before the NHS

The origins of institutionally based health care in this country lie in provisions for the sick and destitute offered by the medieval monasteries and the first of the charitable hospitals. The oldest of the latter is St Bartholomews, which was founded in London in 1123. State involvement cannot be said to have begun until the seventeenth century, when the Elizabethan Poor Laws gave the then non elected local authorities the power to raise rates to finance the support of lame, blind or otherwise disadvantaged individuals who were unable to work (Pater 1981). Following further legislation in the 1720s and the 1780s the workhouse system was established, and soon became the main form of residential support for the impoverished sick.

Between 1750 and 1800 the charitable, or voluntary, hospital sector also went through a notable period of growth as Britain increased her wealth through foreign trade and enhanced domestic productivity. Yet hospital inpatient and outpatient care was still, and was to remain for a century or more to come, primarily a resource used by the urban poor. Many of the physicians and surgeons who worked in the voluntary hospitals gained clinical experience rather than income; their earnings largely came from more affluent patients who were treated at home. The majority of ordinary members of the ambulant population sought medical help from community based practitioners, including herbalists, apothecaries/pharmacists and general surgeons.[2]

In the nineteenth century tax funded hospital facilities were extended as a result of two main initiatives, both of which stemmed from the government's attempts to respond to the social problems generated by urbanisation and industrialisation. First, the 1808 County Asylums Act enabled local authorities to build and run facilities for the 'insane'. Gradually a nationwide network of 'lunatic' asylums was established. Second, an amendment to the Poor Laws in the 1830s formally required the provision of wards for the poor sick. This subsequently led to a considerable expansion of Poor Law hospital care. By 1861 there were around 50,000 sick paupers in such institutions, as opposed to 11,000 patients in voluntary hospitals (Abel-Smith 1964).

As the chronology presented in Table 1 notes, a short lived body known as the General Board of Health was set up in the mid 1800s. Its intended role was in part to co-ordinate the efforts of the state and charitable hospitals. In this it had relatively little success. But the Local Government Board which ultimately followed it did have a significant influence in the sphere of public health. In 1875 the Disraeli government sponsored Public Health Act supplied a firm basis for the local provision of services like clean water and adequate drainage and sanitation. It also established an organisational kernel around which other local authority health functions, like mother and child care, would later group.

Another significant measure of around that time was the Metropolitan Poor Act of 1867. This created a common fund for the formation and support of fever and mental hospitals (asylums) in London, administered via a new Metropolitan Asylums Board. This Act, which was partly stimulated by the growing recognition of the infectious of origins of most fevers and the advantages of isolating affected individuals from the rest of the population, represented an important stepping stone on the way to the eventual creation of the NHS.

As a result of medical entrepreneurialism there was a significant expansion in the number of private hospitals towards the end of the nineteenth century, particularly in London. Between 1891 and 1901 the number of 'voluntary' beds in England and Wales rose from 29,000 to 43,000, or by a little over a third. In the public sector even more dramatic increases took place. The total beds in workhouse institutions and public infectious disease hospitals climbed from 83,000 in 1891 to 154,000 in 1911, a rise of some 85 per cent. This shift was generated both by the increasing volume of health problems in the still rapidly expanding population and by improving standards in the somewhat more democratically administered Poor Law facilities.

Just as importantly, perhaps, there became established at around that time a clear distinction between medical specialists and general practitioners. The latters' incomes were then entirely dependent on either fees earned directly from patients, or on payments made via the several thousand Friendly Societies which provided insurance cover for GP services and the costs of the medicines prescribed. The general practitioners were anxious that access to hospital based services should only be obtained by way of referral by them. Otherwise, they feared, they would be destroyed by competition from out-patient departments, most of which offered free care. The substance of the community based doctors concerns is reflected in areas like inner London even today, in that the presence of numerous large hospitals may have harmed the development of primary services.

From 1911 to 1948

During the first half of the twentieth century British medical care development was substantially influenced by the occurrence, or threat, of international conflict. Where previous social reformers argued simply that better health care would enhance national wealth creation, those of the early 1900s also pointed to the growing strength of Germany and the disturbingly poor physical condition of many of the would-be recruits to the army at the time of the Boer War.

The School Medical Service, created in 1907, and Lloyd George's 1911 National Insurance Act, which required lower paid workers (but not their dependents) to be insured for basic general practitioner and pharmaceutical care, both partly stemmed from such pressures. The compulsory system then established, which was administered via county or county-borough wide Insurance Committees, was the forerunner of today's FPS administrative structure.

Following the First World War the work of the Ministry of Reconstruction led to the formation in 1919 of the Ministry of Health, which replaced the old Local Government Board. Its role in the health sphere was co-ordinative and advisory, rather than executive. But its very presence may have suggested the ultimate possibility of a nationally organised, 'integrated' system of health care.

2 The term general practitioner stems from the early 1800s. It referred first and foremost to general surgeons, but came to apply to individuals from a number of backgrounds (Loudon 1979). Family doctors' premises are still termed 'surgeries'.

Table 1 **A chronology of the main nineteenth and twentieth century events in the creation and development of the English NHS**

1808 County Asylums Act enabled local authorities to construct and finance institutions for the 'insane'.
1832 The Provincial Medical and Surgical Association (later to develop into the British Medical Association) founded in Worcester.
1834 Poor Law Amendment Act required the provision of wards for the impoverished sick.
1848 General Board of Health established.
1858 The Medical Act created the General Medical Council and established the medical profession as a mature, self-regulating institution.
1867 The Metropolitan Poor Act created a common fund and obliged the (still non-elected) London local authorities to provide separate institutional care for tuberculosis, smallpox and 'fever' sufferers, as well as the 'insane'. In the next year the Poor Law Amendment Act established a similar provision in the rest of the country, although satisfactory financial arrangements were lacking.
1871 Local Government Board formed.
1875 The Public Health Act provided a firm statutory basis for the development of adequate environmental health services.
1894 The Local Government Act improved, in certain respects, the administration of Poor Law infirmaries by changing the conditions upon which Guardians were appointed.
1907 School Medical Service established.
1911 Following a Royal Commission on national insurance the 1911 National Insurance Act was passed, laying down a basic structure of general practitioner and pharmaceutical care for the working population.
1919 Ministry of Health formed in the aftermath of the First World War.
1920 The 'Dawson' report advocates an integrated health service based on health centres.
1926 A Royal Commission on national health insurance argued that the health services should be financed directly from public funds.
1929 The Local Government Act ended the Poor Law system, transferring responsibility for health care to the local authorities. They thus became the main providers of hospital support, as well as some forms of community care.
1930 The BMA publishes a plan for the general medical services, calling for extended national insurance provision.
1938 BMA document is updated to include a section on unified public policy for health matters.
1939 Emergency Medical Scheme established.
1942 'Beveridge' report. The BMA's Medical Planning Commission argues for a centrally planned, comprehensive health service.
1944 First White Paper on a National Health Service.
1946 Bevan's National Health Service Act passed.
1948 NHS established.
1956 'Guillebaud' report defends the structure and costs of the NHS.
1962 Enoch Powell's 'Hospital Plan for England and Wales' is published. The 'Porritt' report suggests NHS reorganisation.
1965 The 'Doctors Charter' is drawn up. Its implementation is a watershed in the history of family practitioner care.
1968 Kenneth Robinson's Green Paper on restructuring of the NHS.
1970 Richard Crossman's second Green Paper on the NHS.
1972 Sir Keith Joseph's White Paper on National Health Service reorganisation in England.
1974 The first NHS reorganisation. Local authority involvement in health care provision is restricted to environmental services. Family practitioner care remains distinct from the hospital and related structure.
1975 The 'pay-beds' dispute between the medical profession and the Labour government. Harold Wilson asks Lord Goodman to mediate.
1976 The reorganised NHS begins to function effectively. The DHSS publishes a planning paper on health service priorities and several other initiatives are taken with regard to matters like resource allocation, NHS/LA co-operation, and prevention.
A Royal Commission is established.
1979 The Royal Commission reports and the Conservative government publishes its own plans for further health service reorganisation. New contracts negotiated with the consultants give the latter greater freedom to practice privately. They remain in contact with the Regions rather than the Areas/Districts.
1982 The 1982 reorganisation eliminates the Area tier of the NHS in England. Districts become the main operational Authorities.
1983 The 'Griffiths' Management Inquiry is established and conducted.
1984 Conflict between the general practitioners and the government over the use of deputising services leads to a compromise acceptable to most family doctors. The government is set to honour its past pledges on greater FPC independence, but some uncertainty surrounds its intentions on the future of primary care. Authorities deliberate over the ways in which the Management Inquiry recommendations may be locally applied, although the Secretary of State presses ahead with changes to the DHSS.

This revolutionary concept, which would have been unthinkable before the Kaiser's war, was given a significant boost in 1920 by the publication of the report of a committee associated with the Ministry. Known as the Dawson report after the chairman, Sir Bernard Dawson,[3] it urged the formation of a tiered system, based on primary and secondary health centres and administered by a single authority in each locality.

The next major piece of legislation to affect the health sphere was the 1929 Local Government Act. It transferred to the by then elected local authorities the responsibilities of the Poor Law Guardians, and permitted them to provide a full range of hospital services. Thus state sector institutional support for the sick (which by the mid 1930s constituted about 80 per cent of the nation's total bed capacity) was linked, through local government control, with the expanding community services already under the Medical Officers of Health.

Standards were highly variable across the country during the short period between 1929 and 1939 when national government had no direct command over the development of health services. But in some localities at least the positive potential of a publicly financed, electorally accountable, system was demonstrated. Meanwhile, the independent sector had come under increasing financial pressure. In the interwar period the inefficiency of the myriad private health care insurance systems then operating in Britain began to be very apparent. Also 'middle class' patients found it more difficult to meet medical expenses directly, whilst viewing the prospect of having to use the existing public hospitals with some horror.

It is therefore possible that had not World War II begun some form of government intervention designed to support further the voluntary sector, including the teaching institutions, would have taken place. Even at the start of the 1930s the BMA expressed its support for the concept of national health insurance for general medical care, although its views on state support for the hospital sector were rather different. In 1938 a revised version of the BMA's plan for health care improvements envisaged public hospital services being provided by groups of local authorities covering Regional populations of 100,000 or so people.

It appears that one set of factors which helped to frame the latter proposals, which went close to providing a

3 Sir Bernard (later Lord Dawson) had wartime experience as a doctor and a Major-General. Although his committee's report became widely seen as a radical document, reflecting in part the Labour Party's earlier advocacy of health centres, Dawson's personal ideas on issues like medical authority were not 'progressive'. In the 1940s he sat on the BMA's Medical Planning Commission.

'green light' for the creation of the NHS a decade later, related to the interests of the powerful teaching hospitals. Although they were happy to accept support from the public purse, they wanted to retain freedom to select particular case mixes for teaching. A universal, automatic right of admission stemming from an insurance based ability to pay might have undermined their position in this respect. And more broadly the principles underlying the entire interwar public debate on the most desirable way of funding the British hospital services were contrary to the concepts on which the European insurance based health systems were founded. This may in part have been due to the traditions of thought established during the long history of (essentially nationally directed) Poor Law care.

But in any case, with the advent of fresh international conflict attitudes shifted. One important development was the introduction of the Emergency Medical Scheme in 1939. Formed in part in expectation of enormous casualties from enemy bombing (Titmus 1950) this made use of both the public and private hospital services. The advantages of co-ordination and rationalisation were made obvious to the public and to many professionals; hence the EMS paved the way for the formation of the NHS. Government failure to have taken note of its success might have created serious social discontent in post war Britain.

Following the Beveridge report in 1942 (a year which also saw the publication of a BMA report urging the creation of a centrally planned, comprehensive public health service – BMJ 1942) the wartime administration produced in 1944 a White Paper proposing the formation of a National Health Service. The pattern of organisation then suggested involved control of the public hospital sector by a system of joint local authority boards, backed by the Ministry as a planning body. The latter was also to supply financial assistance to the voluntary hospitals, so hopefully acquiring their co-operation in the new arrangements. General practitioner and the related community services stemming from the 1911 Insurance Act were to be controlled by a central board. Family doctors were to be encouraged to group together into health centres, perhaps to become salaried.

These proposals met opposition, not least from the general practitioners' representative body, the Insurance Acts Committee of the British Medical Association, now known as the General Medical Services Committee. When, after the war, Aneurin Bevan became Minister of Health he redrew the plans for the NHS substantially.[4] The objections of the most powerful medical and other interest groups were accommodated and the tripartite NHS structure shown in Figure 1 emerged. Perhaps the most radical element embodied in the 1946 legislation was that it involved the nationalisation of most of the hospitals, although the teaching hospitals were given a special position within the new format.

The administration of the family doctor and allied services was achieved via bodies known as Executive Councils, which performed functions similar to those of the old Insurance Committees. The entire population became entitled to family practitioner care. A nine member statutory body known as the Medical Practices Committee was established to influence the distribution of GP manpower. Local authorities retained school and public health, together with community provisions such as health visiting and domicillary nursing and mother and child care. They also ran the ambulance service, and were empowered to develop comprehensive health centre facilities.

In general, therefore, the NHS as formed in 1948 was by no means a complete break with past arrangements. Bevan compromised with and adapted existing structures in a public and political atmosphere strongly influenced by the disciplines and expectations engendered by Hitler's war. In some respects the result could be said to be victory for the 'values of equity, rationality and efficiency' (Klein 1983). But it might also be argued that the main driving force in British health care evolution was actually the pressure generated by technical and related changes in the sphere of medicine rather than any coherently or humanely based planning process.

The development of anaesthesia, antiseptic practice and more sophisticated surgical techniques in the nineteenth century and early twentieth century; realisation of the need for the epidemiological/environmental control of infections in Victorian England; and the growing understanding of the potential of pharmaceutical treatments in the interwar period. Phenomena like these created forces which stimulated in a somewhat haphazard manner reactions in the overall social system and incremental changes in the established health care structures, as in one way or another they did in all the other richer nations.

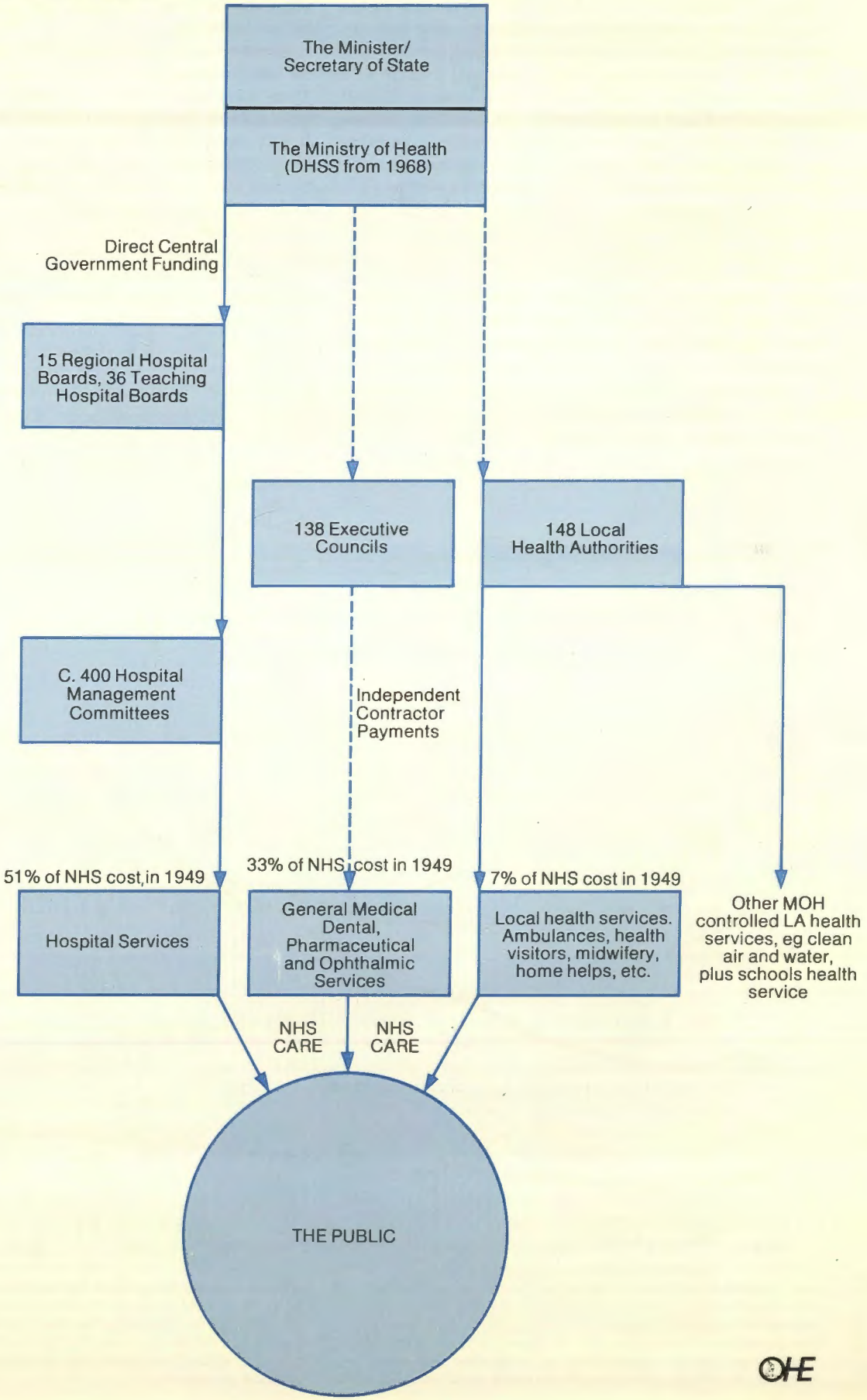
Seen in this light it is understandable that the NHS should have inherited certain constitutional weaknesses from its forebears, as well as some peculiarly British strengths. For example, the problems surrounding the role of local authorities in what was intended as a national health service can in a sense be linked back to the difficulties seen in the interactions between local government and the Poor Law system almost a century before. The unsatisfactory linkage between the FPS and other community services and the hospital sector in the 1948 arrangements was also obviously related to previous structures. And so was the limited ability of the 'top' of the NHS to identify overall goals and priorities and lead the rest of the service towards their achievement.

Finally, it should in addition be acknowledge that the initial format of the NHS was built on assumptions about the nature of medical authority which, however benignly intended, were likely to become less acceptable to the population in times of sustained peace and increasing prosperity. Indeed, cynics might argue that, despite the great popularity of the NHS, the concepts on which it first rested implied that the mass of the British people would never have the skills or intelligence[5] necessary for the exercise of rational choice in the health sphere. Recent demands for more private services, for more local control over NHS decision making and for more emphasis on the role of self-care and consumer involvement in medical interventions can all be seen as reactions to such a paternalistic philosophy.

4 Medical opposition is often cited as the major factor in Bevan's shift away from the idea of local authority control of the hospitals. This is quite probably correct, but the Labour Party's own thinking on nationalisation may also have guided policy formation in the health sphere.

5 The 1944 Education Act has received rather more overt criticism in this context.

Figure 1 **The NHS in England and Wales in 1948**



Continuing evolution

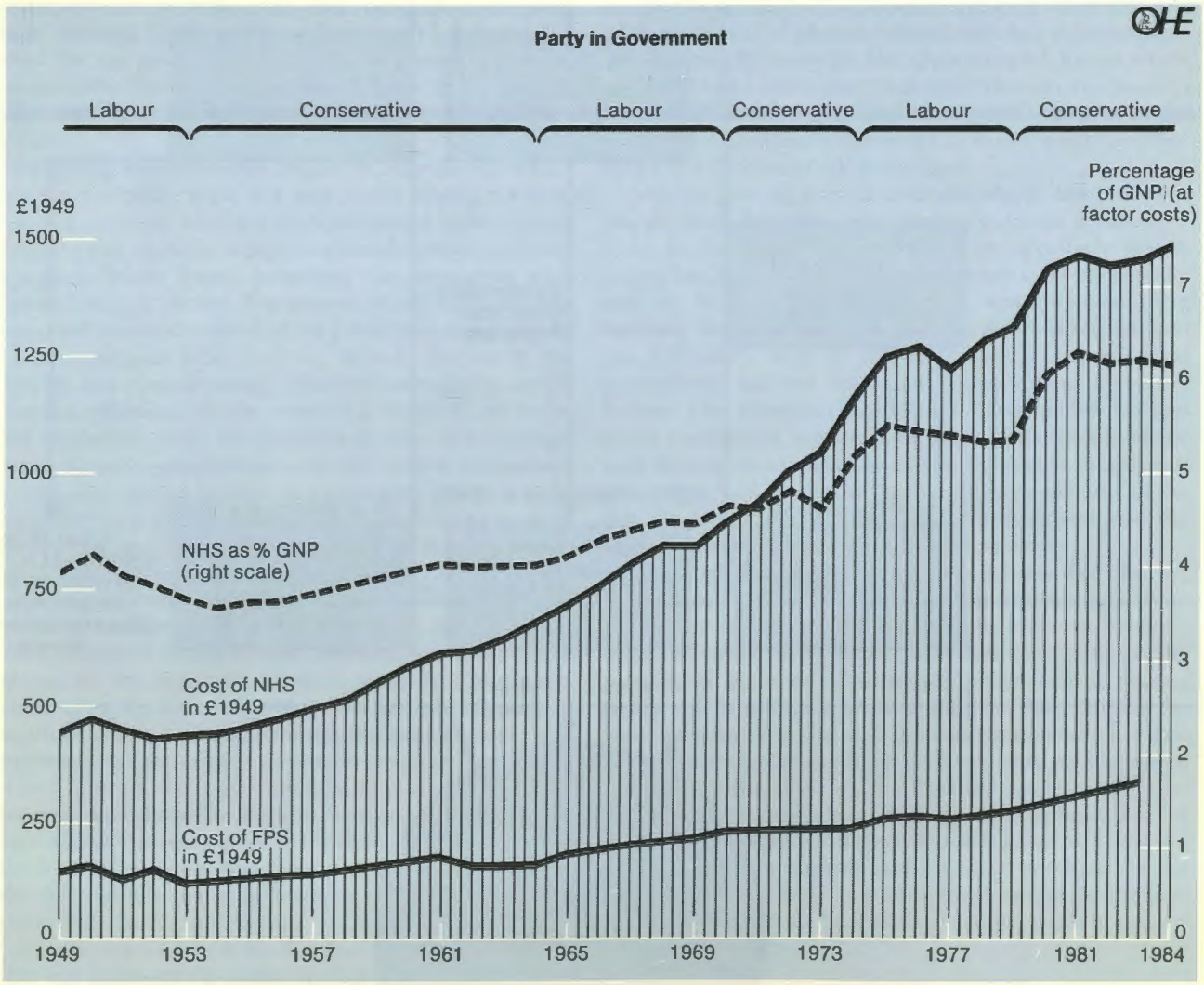
The development of the NHS can be illustrated via a wide variety of indicators. For instance, on a relatively simple level, Figure 2 shows that between the late 1940s and 1974 the gross 'real' (that is, retail price index adjusted) cost of the UK NHS rose to some 2.7 times its original level. Despite the subsequent 'oil crisis' related reductions in growth rates, the NHS had by 1983 around 3.3 times the funding available to it in 1949. Even allowing for the faster than average cost rises with the service its economic resources have more than doubled in the last three decades or so.

Such an expansion is impressive, although other Western economies, which have enjoyed faster overall growth and thus have had more 'new money', have increased spending on their health care systems even more dramatically. The average West European/North American health care outlay is now 8 per cent or more of GNP, compared with Britain's 6 per cent. And British investment in capital facilities has been particularly low. It reached a nadir equivalent to 6 per cent of HCHS revenue costs in the second-half of the 1970s, after Barbara Castle (then the Secretary of State) had decided to put 'people before buildings'.

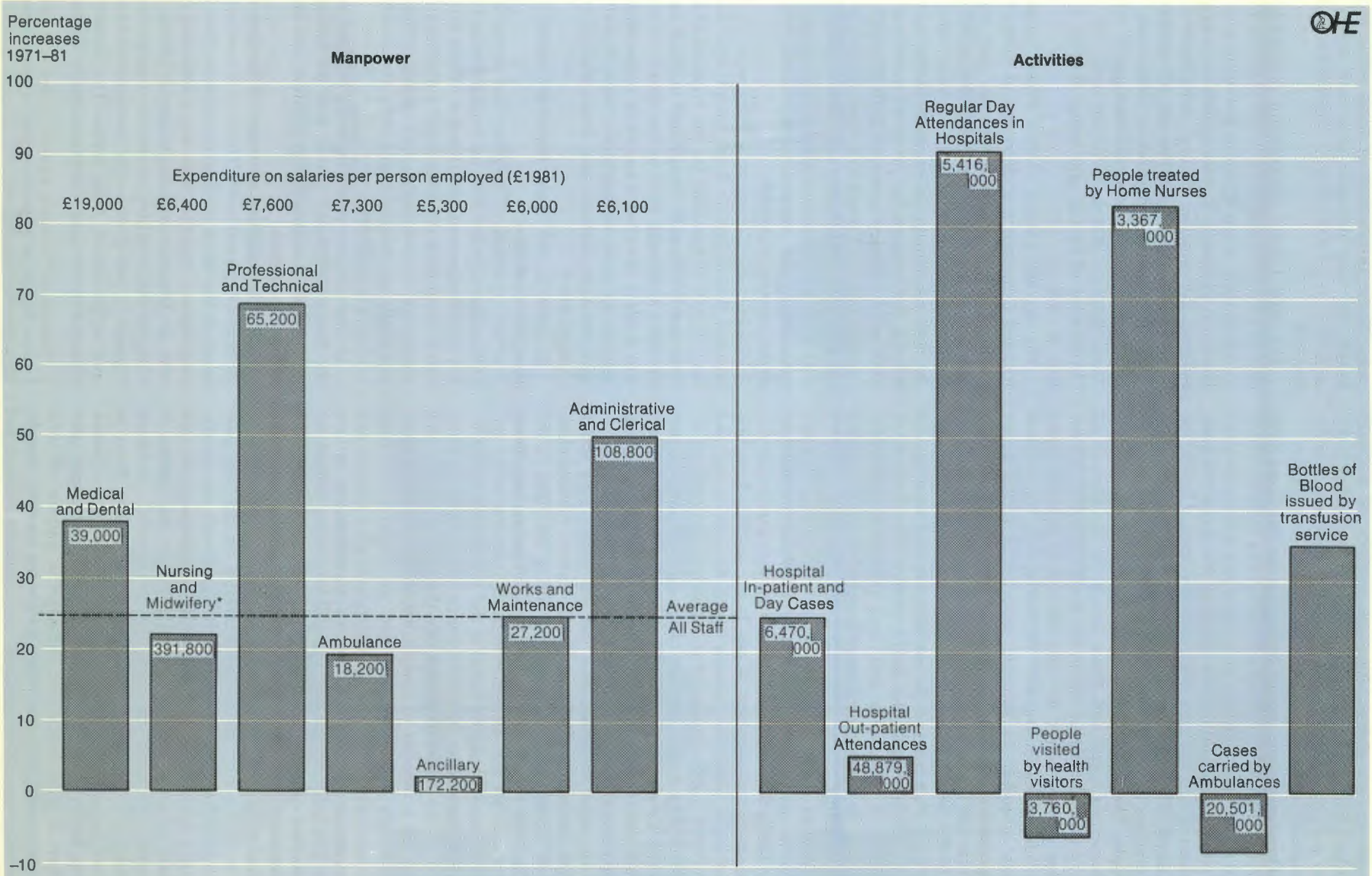
Another set of basic data which casts a revealing light on the evolving NHS is that relating to staff numbers. These have rather more than doubled since the late 1940s, with growth heavily concentrated in the hospital sector. In fact, using statistics for England, it can be shown that in gross (unadjusted whole time equivalent) terms hospital nursing staff increased by over 100 per cent between 1960 and 1982.[6] Growth for hospital doctors and dentists was in excess of 130 per cent. Figure 3, based on information given in a government publication entitled *Health Care and its Costs* (DHSS 1983) compares hospital and health authority community service manpower figures and patient care activity rates for the decade 1971–1981. Amongst the key

6 If adjustment is made for changes in working conditions the volume of nursing labour available in the NHS grew by about 60 per cent, and hospital medical manpower rose by 90 per cent.

Figure 2 **The cost of the NHS, UK 1949–84**



Note Considerable debate has taken place to the amount of extra money needed by the NHS each year to 'stand still'. The ageing of the population is currently estimated to require a growth of about 0.9 per cent in NHS funds if services are to be maintained, a figure acccepted by both the DHSS and the Treasury. However, in the short term the marginal costs of coping with the growing elderly population may not be so great, especially as significant falls have been taking place in the size of the 65–75 year old age group. Whether or not the introduction of costly new technologies or better staff working conditions should be considered to be an expansion of services or 'standing still' is perhaps debatable, although the former description would certainly apply in most sectors of the economy.



*Total nursing and midwifery manpower grew by 37 per cent in unadjusted whole-time equivalents in the period, allowing for changes in NHS functions in 1974.

†Manpower adjusted for changes in NHS functions in 1974 and reductions in the length of the working week.

Note Figures in bars relate to total manpower and activity volumes in 1981.

Source DHSS 1983.

Figure 3 **Trends in Hospital and Community Health Service manpower† and activities, England 1971–81.**

points to note is the fact that around a half of all HCHS employees are nurses. Also the number of ancillary workers (porters, cleaners etc) stayed stable during a ten year period when the overall NHS staff total (adjusted for reductions in working hours) rose by close on a quarter.

Turning to more specific changes in the NHS, there have been a number of professional and service reforms which had a profound influence on its structure and on patterns of patient care, both before and after the major reorganisations of 1974 and 1982. With regard to mental health, for example, the 1959 Mental Health Act involved important alterations in services for mentally ill and handicapped people. The White Papers *Better Services for the Mentally Handicapped* (1971) and *Better Services for the Mentally Ill* (1975) were also landmarks in the development of care for these groups, whilst the 1983 Mental Health Act again introduced significant new provisions and encouraged fresh attitudes. Its valuable innovations included the appointment of some 85 Mental Health Commissioners whose role is to defend the individual rights of patients.

In the hospital sector as a whole Enoch Powell's 1962 Hospital Plan marked the introduction of a new type of rational planning in the health service. The 'Cogwheel' reports of 1967, 1972 and 1974 promoted significant changes in the organisation of hospital doctors' working relationships.

Perhaps even more importantly the 1965 'Doctors Charter' proved to be a critical intervention in relation to the family doctor services. It reversed previous declines in the status and numbers of GPs. In the worlds of nursing and social work the Salmon (1966), Mayston (1969) and Seebohm (1968) reports led to important professional restructurings. And at the start of the 1970s the introduction of the Crossman formula for resource allocation foreshadowed the advent of the Resource Allocation Working Party (RAWP) later in the decade.

Any idea, therefore, that the NHS before 1974 was a rigid, unchanging, bureaucracy is untrue. Nevertheless, quite strong criticisms emerged during the 1960s to the effect that the NHS lacked the management arrangements necessary for the fast and effective adaptation of the service to meet changing needs in the community. The control of much acute, infectious illness and a growing awareness of the plight of groups like the elderly chronic sick also led a number of commentators to complain more vigorously than previously that the tripartite division between the then local authority, executive council and hospital services inhibited proper co-ordination. In fact, the first authoritative post 1946 call for a more unified NHS structure came in the 1962 Porritt report, the work of a committee representing medical institutions such as the Royal Colleges and the BMA.

In retrospect, many commentaries on the NHS published in the 1960s (and indeed the 1970s) were not particularly valuable. This is because they emphasised the possible virtues of a more unified structure, but tended to neglect to think through the managerial problems inherent in directing such a complex system. Even so there was some logic behind the early calls for reorganisation, which were given an added urgency in the mid 1960s when it was decided to reform the pattern of local government. The time seemed right for creating complementary formats for NHS and local authority services and thus preparing the way for a better dovetailing of provisions. Some proponents of local authority control of health care may also have seen such moves as the first step towards a 'reintegration' of health with other welfare services.

The then Labour government produced two Green Papers on the restructuring of the NHS. The first was published in 1968, when Kenneth Robinson was Minister of Health. It proposed, in anticipation of local government reforms, the creation of 40–50 Area Boards in England. They were to be responsible for all services, including those provided by independent contractors. The accent was heavily on the need for managerial expertise. The Areas were to interface directly with the Ministry or Department of Health and Social Security as it became later in 1968.

The second Labour Green Paper, produced when Richard Crossman was Secretary of State, substantially modified these original proposals. Not only was the number of suggested Areas doubled to fit with the by then revised concepts of desirable local authority size, but the clear-cut managerial emphasis of Robinson's plan was diluted. For instance, the proposed membership of health authorities included both local authority and professional representatives. Crossman's Green Paper reintroduced the idea of Regional planning bodies[7] and also suggested that local committees might be formed to involve both members of 'the community' and health service workers in the running of the NHS.

However, the Conservative Party won the 1970 general election. It was thus Sir Keith Joseph who was the Secretary of State responsible for the creation of the new NHS structure functionally established in April 1974. Figure 4 provides an overall view of the system then introduced, and Table 2 describes some of its major elements. Box I sets out the basic arrangements made in Scotland, Wales and Northern Ireland, and looks also at more recent changes there.

In general, the most important facets of the 1974 reorganisation were:

a) The creation of Regions and Areas as executive authorities, together with the establishment of a sub-Area tier of management, the Districts. Whilst the Areas coincided geographically with local authorities, in order to encourage co-ordination, the smaller Districts (based essentially on hospital catchment areas) overlapped the LA/Area boundaries.

b) The effective preservation in England and Wales of the Executive Council system, with the boundaries of the new Family Practitioner Committees redrawn to match those of the Areas.

c) The introduction of teams of managers at District, Area and Regional levels. These were comprised of individuals at the head of functional hierarchies like nursing and finance, together with representatives of local doctors in Districts and single-District Areas. They were charged with reaching consensus management decisions. Figures 5a and 5b show the composition of the Regional and single-district Area teams. The former stayed unchanged in the 1982 reorganisation of the NHS; the latter

7 Subsequently Crossman appeared to favour a closer interaction between Regions and Departmental staff, a concept further developed by David Owen in the mid 1970s.

Figure 4 **The NHS in England in 1974**

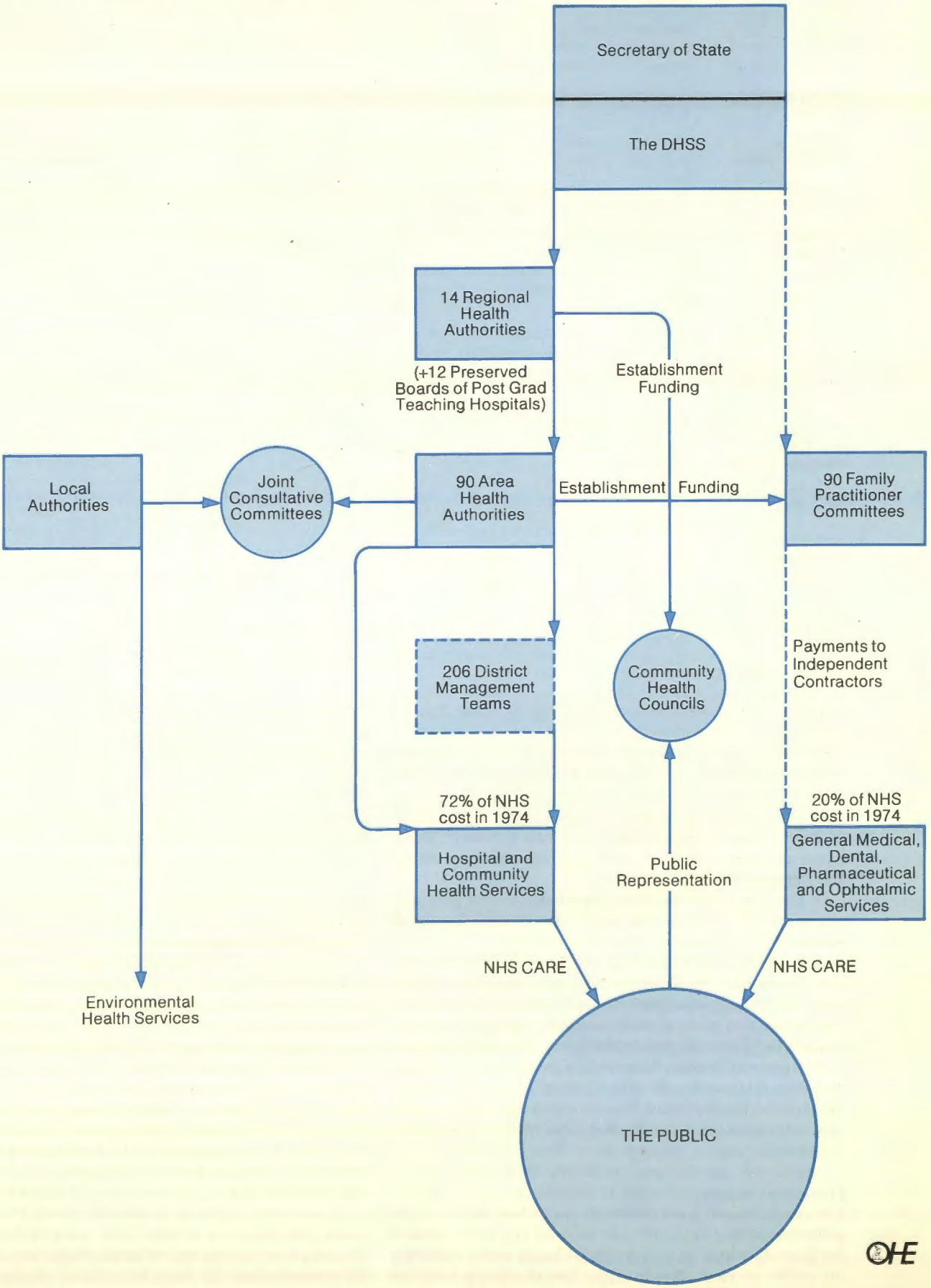


Table 2 **Key elements in the English NHS structure 1974–82**

District Management Teams	These comprised the chairman and the vice-chairman of each District Medical Committee, the District Community Physician, the District Nursing Officer, the District Finance Officer and the District Administrator. The team was jointly responsible to the local Area Health Authority, as were the four non-elected members individually as the heads of their respective professional hierarchies.
District Medical Committees	The 10 member DMCs combined many of the functions of the former hospital medical executive committees with a system of general practitioner representation. Their members on the DMT received special payments for their additional duties.
Health Care Planning Teams	Established by the DMT, these had/have a special role in planning care for priority groups. Each District had several teams in the post 1974 structure, some standing and some ad hoc.
Community Health Councils	The CHCs originally had 18–30 members; half were local authority appointees, and a third represented local charities. The remainder were selected by the RHAs, which fund the CHCs. Their role is to represent consumer interests in the NHS.
Area Health Authorities	The AHAs were the lowest level of statutory authority in the 1974 NHS, with full operational and considerable planning powers. Under the original arrangements each had 15 members, although in 1975 there was an increase of local authority membership from 4 to 6, plus other changes. Others on the AHAs were selected by the Regions, except for the chairmen who were paid and chosen by the Secretary of State. Teaching Authorities had 2 extra teaching hospital representatives on them, as well as a requirement for 2 other members to have had experience relevant to teaching interests.
Area Management Teams	The AMTs comprised the Area Medical Officer, the Area Nursing Officer, the Area Treasurer and the Area Administrator. Single District Areas also included the Medical Committee chairman and vice-chairman.
Joint Consultative Committees	These provided a point of contact between local government and the Health Authorities at area level. Comprised of authority members on both sides, there was one JCC in each metropolitan district. In the counties there were two, one covering personal social services and school health and the other environmental health and housing.
Joint Care Planning Teams	JCPTs operated at Area/LA level under the general direction of the JCCs, with a planning function analogous to that of HCPTs.
Family Practitioner Committees	It was the responsibility of each AHA to establish and staff its local Family Practitioner Committee, even though the FPCs have always had their own independent functions and powers. Of the 30 FPC members half represent(ed) the local professions, 4 the local authority and 11 the AHA.
Regional Health Authorities	After 1975 RHA membership, like that of the AHA, averaged between 18 and 24 members. One third of the membership was made up of local authority nominees, the remainder by appointees of the Secretary of State. Just as the AHAs were corporately responsible to the RHAs, so were/are the latter to the Secretary of State.
Regional Management Teams	Each Regional team of officers was established along similar lines to those of the multi-District Areas, with the exception that the Works Officer was/is also a member.

served as a model for the formation of the new District teams.

d) The integration of the Teaching Hospitals into the unified structure. Postgraduate teaching hospitals retained 'preserved' Boards of Governors.

e) The formation of Community Health Councils to represent consumer interests in the NHS at District level. Local authority members were also appointed to Areas and Regional Health Authorities.

f) The establishment of a comprehensive new planning system, better to equip the NHS to identify and pursue its priorities.

g) A heavy emphasis on the need to balance 'accountability upwards' by 'delegation downwards'. The upper tiers of the organisation were to monitor the performance of lower ones, in order to ensure that agreed plans were being followed. But at the same time the members of the teams at District, Area and Regional levels were not in a line relationship to one another. District and Area officers were jointly and (in some contexts) individually accountable to the AHAs, the Regional officers likewise to the RHAs.

From 1974 to 1979

The early 1970s were difficult years for Britain. The government began the decade with an aggressive search for growth, which in part involved heavy extra spending on public services. But in 1973 the oil crisis struck the Western economies, and Britain was particularly hard hit. The workforce, through the trade unions, resisted government attempts to limit state expenditure and cut back the rising rate of inflation and a miners strike led to the three day week and the eventual demise of the Heath administration. It thus fell on Barbara Castle to supervise the final moments of the NHS's 1974 rebirth.

This would have been a difficult task for even the most well disposed of midwives. As it was, Mrs Castle clearly had reservations regarding the new arrangements. This fact was reflected by her rapid introduction of reforms outlined in a consultative document published in May 1974, *Democracy in the National Health Service*. This amongst other things resulted in the inclusion of local government representatives on the RHAs and an increase in their numbers on the AHAs. The CHCs were given powers regarding the approval of hospital closures.

Later in 1974 the Secretary of State established the Devolution Working Party. Perhaps at that stage individuals in government were interested in eliminating the Regional tier, ultimately with a view to merging the Area level NHS arrangements with the conterminous local authorities. If so, however, this approach was short lived. The Working Party's report remained unpublished, and in 1975 the then Minister of Health, David Owen, invited three RHA chairmen to review the work of the DHSS. Their important report, produced in May 1976, argued in favour of strengthening the Regions' roles in relation to that of

Box 1 **The NHS in Scotland, Wales and Northern Ireland**

The NHS reorganisation of the early 1970s established in the Celtic countries health service structures with one administrative tier less than was the case in England. In Scotland (population 5.2 million) the 1974 changes involved the creation of 15 Area Health Boards immediately below the Home and Health Department there. Ultimate authority lies with the Secretary of State, who is advised by the Scottish Health Service Planning Council. The Common Services Agency has special responsibilities in areas requiring central planning and administration. It executes, for example, the works programme.

At a sub Area level the Scottish Boards were free to determine how many, if any, Districts they wished to establish, and they retained more authority over the latter than did the English AHAs. Thus the Greater Glasgow Health Board (servicing 1.1 million people) set up 5 Districts whilst smaller authorities like the Borders and the Dumfries and Galloway Boards saw no reason to make similar arrangements. Local Health Councils serve the same role as the English CHCs, although the territories they serve do not usually correspond to those of entire Areas or Districts. FPS administration is achieved via standing committees of the Boards.

In Northern Ireland (population 1.5 million) NHS reorganisation took place in October 1973. There four new Health and Social Service Boards were set up, under the Ministry of Health and Social Services. There is an advisory Central Council, and the Northern Ireland Central Services Agency handles the administration of issues of common interest. Each Board had Districts with their own District Executive Teams, working in a line relationship with those above. The populations served by the latter ranged from 50,000 to 100,000, except in the case of the bigger Eastern Board, where the Districts were roughly twice as large. District Committees correspond to the English CHCs. As in Scotland the Northern Irish family practitioners' contracts are administered via the Boards, although there is another important difference from the rest of the UK system in that the social services are controlled via the Boards rather than through local government.

In Wales (population 2.5 million) the 1974 reorganisation followed the English pattern more closely. Eight AHAs were created, together with a Welsh Health Technical Services Organisation similar to the Scottish Common Services Agency. The Secretary of State at the Welsh Office has ultimate authority in the Welsh NHS.

In all three countries the reorganised system appeared to function relatively well during the latter half of the 1970s. One important factor in this was that the resource pressures affecting their health care providers have been rather less acute than was the case in England. Scotland, for example, has around twenty per cent more health money per head of population than the overall UK average figure. Northern Ireland is similarly well funded.

Nevertheless, the Celtic countries followed England in moving to restructure their health care systems at the start of the 1980s. In Wales the original Districts were abolished and the AHAs converted into DHAs, except in the case of Dyfed which was split into two. Below the District tier unit organisation has been introduced.

Likewise in Northern Ireland the government decided to retain the four Health Boards but to eliminate the Districts and to delegate more powers to the unit management level. Reviews of the roles of the Department of Health and Social Services were also conducted, and attempts made to involve GPs more closely in unit level management.

In Scotland the process of reorganisation has been rather more confused. At first, the 15 Health Boards were asked to make plans to eliminate their Districts. Then there was to be local discretion as to whether they would remain. And finally it appears that from April/October of 1984 they are to go, even in the large Greater Glasgow area. Again unit level management is being introduced and strengthened.

Some critics may see the 1980s NHS reforms in Wales, Scotland and Northern Ireland as an unnecessary mimicking of changes in England. This in fact would seem an unduly negative view, but even so it should be clearly borne in mind that the challenges and opportunities for health care development in each of the Celtic countries are unique. English 'solutions' to managerial and other problems cannot be simply transposed to their situations.

the Department. But whatever the proposed pattern of devolution in the health service, such investigations evidenced the Labour administration's early concern to change the 1974 structure.

The NHS was also troubled by the social and economic pressures which had brought Labour into office. Its growth money was curbed just as the new structure, essentially intended to govern an expanding system, came into being. And more seriously industrial conflicts (which began with the ancillary workers in 1973) created a chain reaction which resulted in a bitter clash between Mrs Castle and the doctors' representatives over the question of private medical practice and the existence of pay beds in NHS hospitals. This ideological battle was finally resolved by the 'Goodman compromise' of 1975–76, which recognised NHS doctors' rights to practice privately and established a body known as the Health Services Board[8] to control the numbers of private beds. Yet it left a heritage of division and discord which crucially affected the morale of the reorganised NHS throughout the remainder of the 1970s.

This does not mean to say, however, that the second half of the 1970s was a barren period for the NHS. In addition to events noted earlier the year 1976 alone saw the (somewhat delayed) publication of *Priorities for Health and Personal Social Services in England*, and the commencement of the first health authority planning runs (see Box II); the publication of the main report of the Resource Allocation Working Party (Box III); the introduction of joint financing arrangements by which AHAs could provide 'seed' money for projects with the local authorities; the establishment of the 'Black' working party on inequalities and the publication of *Prevention and Health: Everybodies' Business*; a pioneer exercise designed to cut NHS administration costs; the setting up of the National Development Team for the

(Main text continues on page 18)

8 The Health Services Board was terminated by the Conservatives shortly after their return to power in 1979.

Figure 5a **Framework of a single-District Area, 1974–82, England**

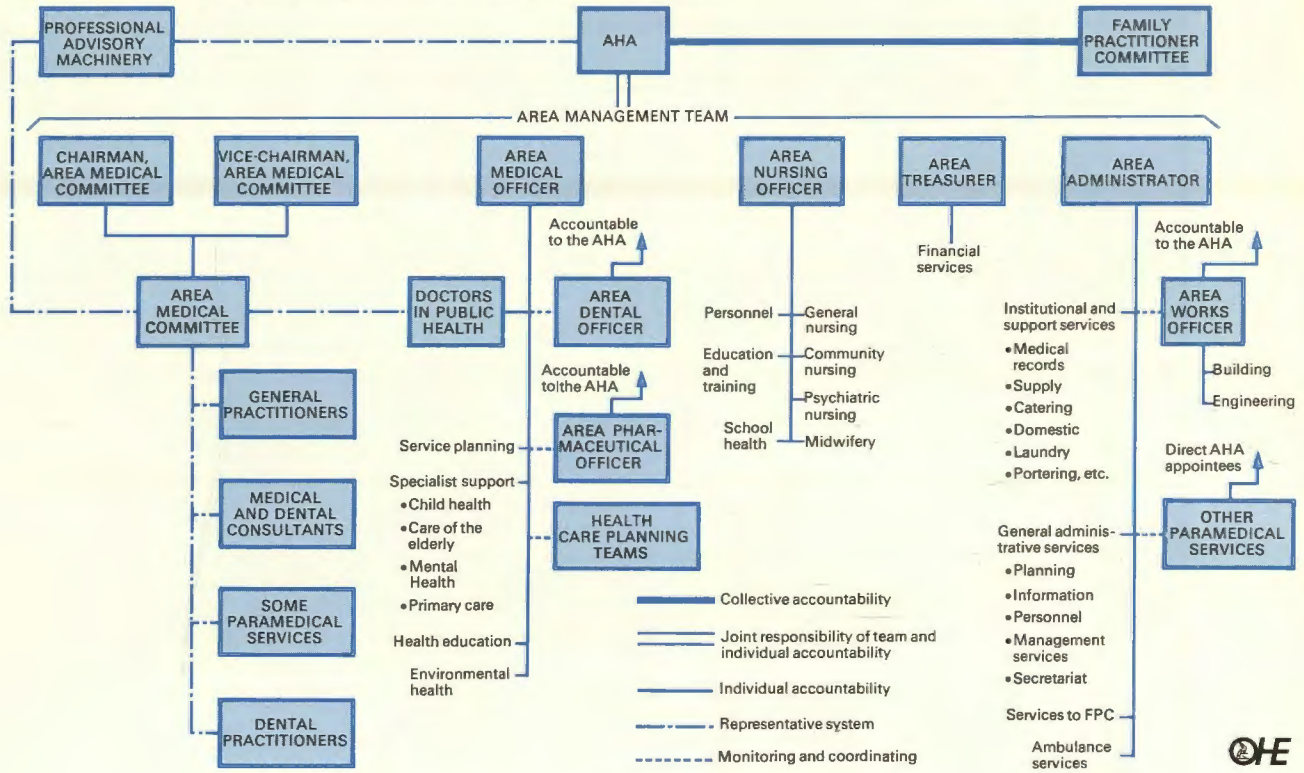
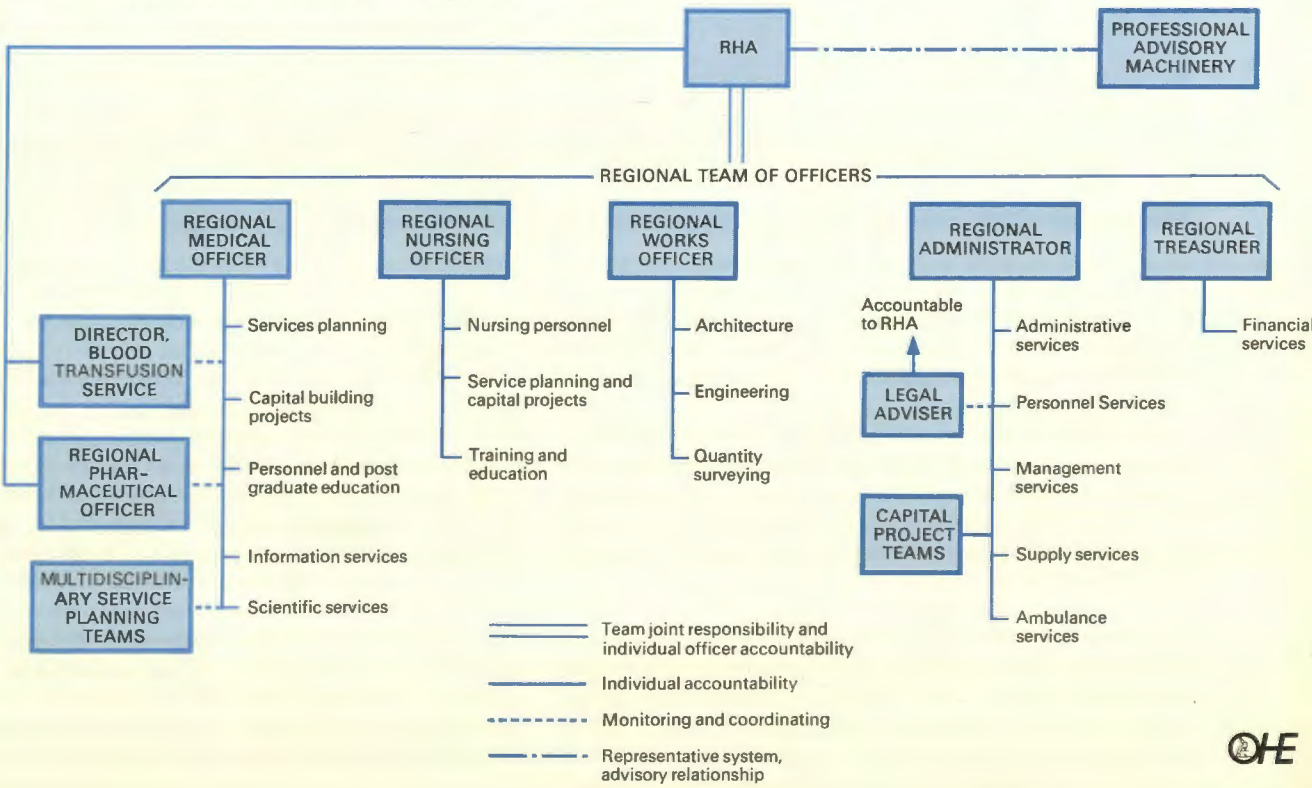


Figure 5b **Framework of an English Regional Health Authority, 1974–**



Box II **Planning in the NHS**

An important phase in the development of large scale, comprehensive planning systems in British government took place during the 1960s and early 1970s. It was in that period that approaches like cost-benefit analysis and PPBS (planning, programming, budgeting systems) were introduced into this country's administrative procedures. For example, the original Public Expenditure Survey Committee system first came into being in 1961.

In the NHS the first moves towards more 'rational' planning took place in 1962, with Enoch Powell's Hospital Plan. But it was not until the 1974 reorganisation that really major changes took place. The latter introduced an elaborate system, which in England took the form of linked cycles of both strategic and operational planning involving the District, Area, Regional and Departmental levels. The strategic element (in which the Districts did not participate directly) was intended to provide a long term, ten year plus, view of the objectives of the service, against which detailed, shorter term, goals could be determined. The operational plans were drawn up on a three year rolling basis, with revisions being made each year in relation to variations in resource availability or priority shifts.

It is arguable that the new planning system was the most significant single element in the reorganised NHS structure. It provided the means by which the service was to define its goals and translate them into being. It was also intended to make the concept of monitoring performance in the health service a workable reality.

Table 2.1 indicates that to an extent the English NHS was successful in shifting resources into priority areas in the years following reorganisation. However, the introduction of the planning system was delayed in its early stages because of the economic crisis of the mid 1970s. Subsequently, its working was criticised because of its relative complexity and the limited contributions made by bodies like the standing District level Health Care Planning Teams (HCPTs). Also, it became apparent that the monitoring process was not functioning as intended.

Thus in the 1982 reorganisation several significant changes were made. First, the new DHAs became the basic planning bodies. Second, operational planning was switched from the original three year sequence to an annual programme based on (a) the operational programme for the year ahead and (b) a forward programme for the subsequent year. Third, a series of annual planning reviews were instituted at Regional and, subsequently, District level. These, conducted with the help of measures like recently developed performance indicators designed to highlight differences in patterns of NHS activity between localities, should facilitate monitoring and cast new light on variations in service efficiency. Fourth, the amount of consultation taking place with regard to operational activities has been reduced. And standing HCPTs have been discouraged in favour of the formation of ad hoc groups tailored to investigate specific issues as and when they arise.

In general these alterations reflect a shift away from the pursuit of fully comprehensive planning in favour of a rather more incremental 'mixed scanning' approach. The latter demands detailed analysis of just the most immediate and pressing problem areas, difficulties in which could be capable of resolution regardless of other factors in the overall health system.

In the related field of local authority planning Bovaird (1982) has remarked that initial attempts at corporate planning in the 1960s/early 1970s often proved grossly over optimistic, and that piecemeal efforts are in practice more likely to be successful (see also Laing 1983). Anderson (1981) has condemned the type of comprehensive planning which led to the construction of tower blocks and similar local authority housing projects, suggesting that well meant but ill-informed social interventions may sometimes damage the welfare of the community more significantly than the unplanned workings of the market-place.

Table II.1 **Hospital and Community Health gross current expenditure, England 1975–76 to 1981–82**

£ Million, average 1981–82 prices

	1975–76	*1981–82*	*% Change 1975–76 to 1981–82*
Non-Psychiatric DP	24.4	44.8	84
Psychiatric DP	30.3	46.2	52
M Handicap IP	365.7	388.6	6
Obstetrics IP	334.5	342.5	2
Geriatric IP	580.7	663.2	14
Acute IP	2,586.5	2,713.3	5
M Illness IP	733.3	764.7	4
M Handicap OP	0.3	0.5	67
Obstetric OP	42.7	49.7	16
Acute OP	704.7	790.9	12
M Illness OP	35.0	46.7	33
Geriatric & YD OP	3.4	5.1	50
Other Hospital	325.2	455.7	40
Units for YD	10.1	15.2	50
Health Visiting	90.5	104.6	16
District Nursing	156.4	212.4	36
Community Midwifery	52.1	55.2	6
Prevention	25.5	33.0	29
Chiropody	25.2	22.6	–10
Family Planning	23.9	24.2	1
School Health	104.8	119.9	14
Other CHS	109.5	93.4	–15
Ambulances	206.0	212.9	3
HQ Admin	394.5	377.0	–4
Joint Finance	0.0	49.2	
Total Hospital and Community Health (ex. Joint Finance)	6,965.0	7,582.0	8.8
Total Personal Social Services (including Joint Finance)	1,852.0	2,147.9	16

DP = Day Patient
IP = In-patient
OP = Out-patient
YD = Younger Disabled

Source Social Services Committee 1983.

Box III **Resource Allocation**

In 1948 the NHS inherited a highly uneven pattern of hospital facilities, the quality of which varied widely from locality to locality. Although the service was able significantly to improve standards across the board during the first twenty years or so of its existence, differences in funding levels between the English Regions remained considerable. This was because extra resources were allocated largely in relation to existing local commitments.

Following the 1962 Hospital Plan, awareness of the need for better mechanisms of health service resource distribution gradually developed. In 1970 the 'Crossman formula' was introduced, which gave much stronger emphasis to the size and structure of the populations being served by Regions. Then following the reorganisation a working party (known as RAWP) was set up to look further at resource allocation. Its final report was produced in 1976, although further work from an advisory group on resource allocation was published in 1980 and the DHSS is continuing to its own internal programme in this area.

Briefly, the RAWP process calculates 'target' shares of NHS resources for each Region, based on their populations weighted for age, sex and mortality/morbidity differences. Adjustments for bed utilisation rates were built in to the scheme in the late 1970s, whilst a special London cost weighting factor was adopted in 1980/81. Teaching costs are also allowed for, although some authorities still argue that the system tends to penalise London, with its unusually high concentration of teaching hospitals.

Figures 3.1 and 3.2 indicate that significant progress has been made towards achieving greater national equity in resource distribution, as measured by the RAWP criteria. However, there is still a high level of debate as to the desirability or otherwise of this process. Points raised include:

1) The RAWP calculations in part involve reliance on measures such as standardised mortality ratios as proxy indicators of sickness in the community. Not only does this involve certain questionable assumptions; even if the use of such data is accepted it might be argued that varying levels of ill-health between or within Regions are not necessarily caused by macro-level differences in NHS provision.

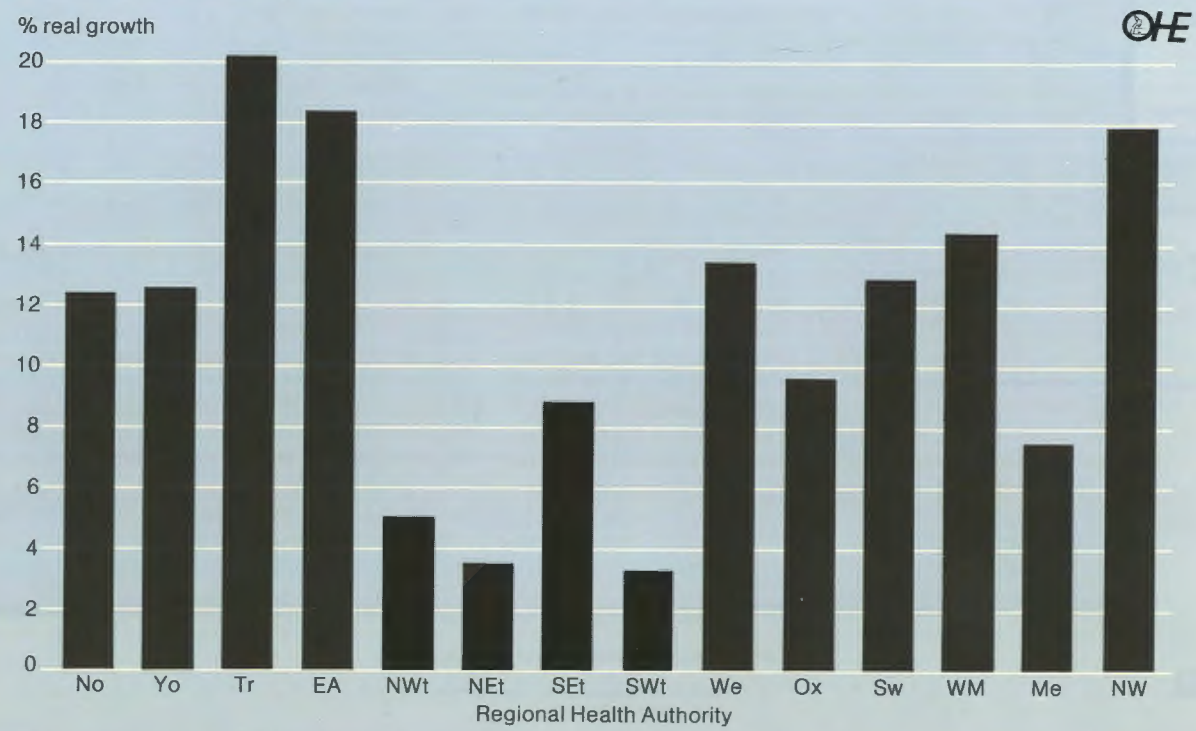
2) With the above point in mind, it could be suggested that in times of relatively static NHS resource levels the disruption and distress caused to RAWP resource losing localities has outweighed the advantages accruing to the resource gaining localities. This point applies to both national and Regional RAWP schemes, although it is the latter which have been seen as affecting some Districts particularly adversely.

3) RAWP did not look at the availability of FPS and social service support at any level. This failing could have led to some unwarranted NHS resource shifts away from certain poorer inner city areas in particular. More integrated approaches may be needed in the future.

4) Given the increased mobility of the population it is possible that more attention should have been paid to exploiting resource concentrations more effectively, rather than redeploying them. One failure of the London teaching hospitals, it could be said, was that they did not sufficiently research and advocate this possibility in the middle 1970s.

5) The other parts of the UK have also embarked on schemes similar to RAWP. Scotland has SHARE and Northern Ireland PARR, for example. But these two countries both enjoy levels of NHS funding twenty per cent or so above the England and Wales mean figure. The justice of this situation has never really been established, a fact made all the more disturbing by the observation that, if anything, the divergence is increasing rather than decreasing.

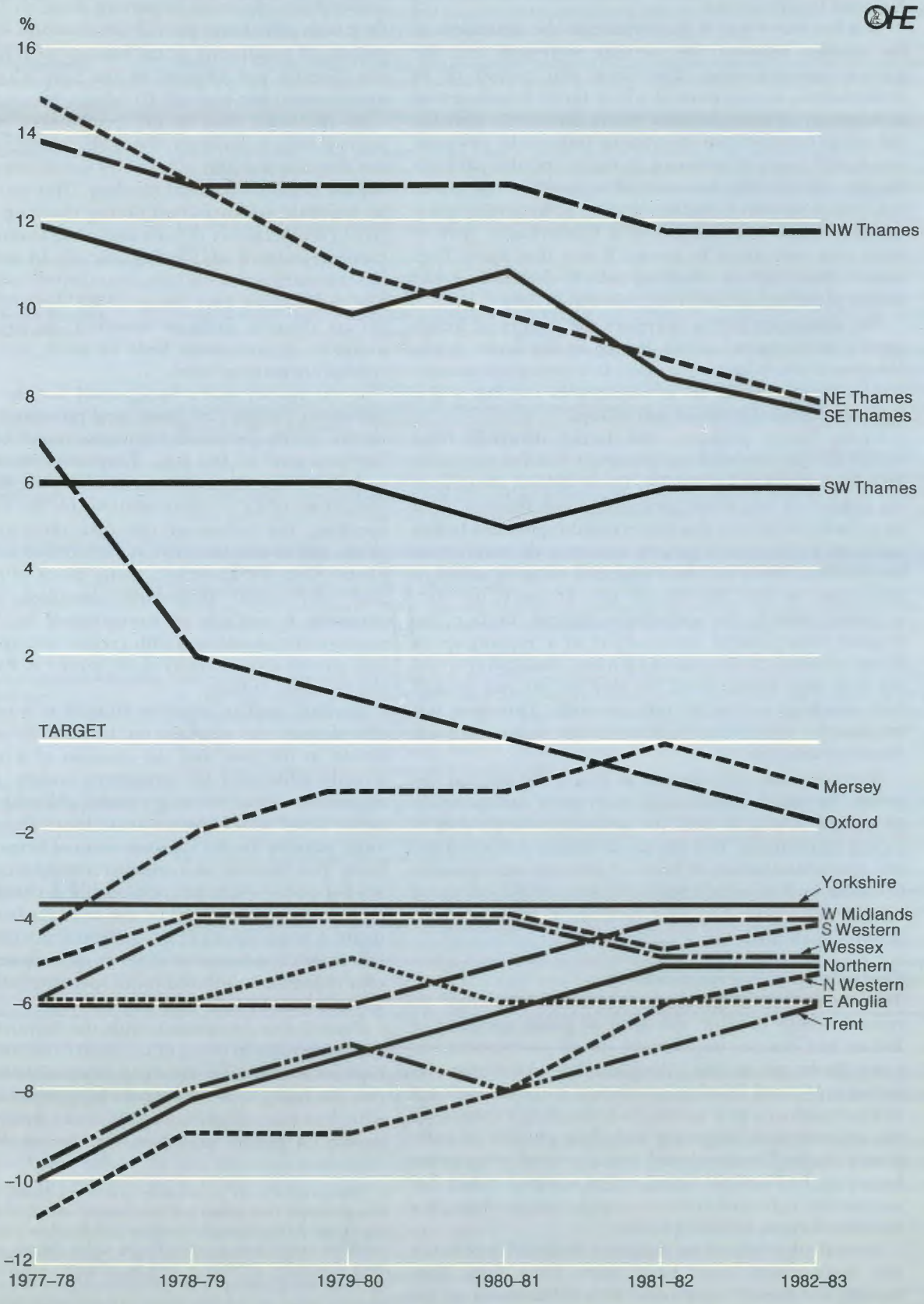
Figure III.1 **Hospital and Community Health Services 'real'* growth in revenue expenditure between 1975–76 and 1981–82 (England)**



*After corrections for pay and price increases in NHS.

Source Hansard 1983.

Figure III.2 **Regions' distances* from Resource Allocation targets 1977–78 to 1982–83**



*Distances from current expenditure targets expressed as percentages of regions' allocations.

Source DHSS 1983.

Mentally Handicapped and the restructuring of the Hospital Advisory Service into the Health Advisory Service; and the establishment of a Royal Commission on the National Health Service.

This last move was in part related to the settlement of the conflict between the medical profession and the Labour administration. The three year period of its deliberations, during most of which David Ennals served as Secretary of State, to some extent provided a time for the NHS to recover from the traumas inflicted by reorganisation, the onset of resource cutbacks and the pay-beds dispute. But by the Summer of 1979, when the study (which cost around £1 million yet was of somewhat questionable value) was completed, a Conservative government was once again in power. It was thus again Tory rather than Labour thinking which determined the nature of the second NHS reorganisation in 1982.

The subsection below examines the pattern of health service development which led up to the latter event. However, before turning to this, it is important to note one more significant set of changes in the NHS which again date from the crucial year of 1976.

Under heavy pressure, and facing demands from bodies like the International Monetary Fund to cut public spending, the then Chancellor, Denis Healey, introduced the concept of cash limits into government financial planning. As far as the NHS was concerned this provided health authorities with much greater incentive to ensure that they did not overspend their allocated budgets, although somewhat to the distress of the Treasury the FPCs remained outside the cash limits system. In fact, the original arrangements were subject to a 'topping-up' of excess spending at the start of each new financial year: yet the 1976 cash limits paved the way for the less flexible cash planning system of 1981 onwards. This does not (necessarily) compensate authorities for factors like unexpected inflation.

Alongside this 1976 also saw an end to the original NHS system by which health authorities were automatically given new money to meet the revenue consequences of capital investments. This key move further pressured the NHS administration on all levels to face the consequences of choice by if necessary having to balance extensions of care or the opening of new facilities in one area with closures in another.

Towards the 1982 reorganisation

The Conservative government's election pledge to reduce, where possible, the level of public spending in Britain had obvious implications for all government services. Early on in the administration's existence, for instance, Michael Heseltine pioneered in the Department of Environment a new system for controlling expenditure via departmental budgeting and close analysis of manpower usage. This developed into a general programme known as the Financial Management Initiative, which has successfully tightened command of civil service costs in a number of areas, including health.

Several other important initiatives designed to enhance NHS management have been taken since 1979. They include the Rayner scrutinies; the establishment of the Körner working party on health service information; the introduction of accountability reviews; and the development of performance indicators and 'value for money' audit. Details of these and a number of other, related, measures are given in Table 3. But for the purposes of this commentary the most important thing to stress is that they may collectively provide mechanisms by which the process of monitoring in the NHS can be translated from the theories put forward in the 1972 'Grey Book' on management into a practical reality.

At the same time as this programme of significant internal reform, however, the public atmosphere in which the NHS acts was also affected by a shift towards a more market oriented political ideology. This was underlined by a debate which started during the time that Patrick Jenkin was Secretary of State regarding alternatives to the current system of NHS funding, and also by moves towards the contracting out, or 'privatisation', of certain services. The possibilities here range from the employment of private cleaning firms or laundries[9] to, say, the use of available private sector beds by some NHS patients, at specially negotiated rates.

It was against such a background that the consultative document *Patients First* (DHSS 1979) presented the government's outline proposals for a new round of changes in the structure of the NHS. They were made partly in response to the Royal Commission's report, and coincided with many of its recommendations for the HCHS. Broadly speaking, the theme of the 1982 reorganisation was, firstly, one of simplification, as exemplified in the removal of the Area tier and the pruning down of the planning and professional procedures described in Box IV. Secondly, it was one of strengthened local (unit) level management, combined with greater managerial efficacy and greater accountability of the service to Parliament via the Secretary of State.

Gerard Vaughan, the then Minister of State for Health, placed particular emphasis on the need for devolution of power in the NHS, and the creation of a system more directly influenced by consumer's wishes. At times he appeared to be advocating a model of health care organisation based on semi-autonomous hospitals and allied services, possibly funded via some form of item of service fee basis. The Minister also stressed the need to cut administrative costs – perhaps questionably in view of the simultaneous emphasis placed on the need for better management. A target saving of £30 million was widely quoted in this context, and objectives set in 1981 envisaged a 10 per cent reduction in administrative spending relative to overall HCHS costs by 1984–85.

Patients First recognised, with the Royal Commission, the heavy price in terms of personal stress and service disruption imposed by the 1974 reorganisation. It argued that the changes of 1982 should be more of an evolution, with less central guidance and more local freedom to decide on precise arrangements. Yet in the event the

9 Even in these areas 'privatisation' exists on extremely low levels, 2 per cent or less in cost terms, and has actually tended to decrease in the recent past. Its significance, it could be said, lies more in its existence as a possibility rather than a reality. Forces within the NHS are less likely to block reasonable attempts to increase efficiency and patient welfare if the result would ultimately be the contracting out of services to private agencies. However, this does not mean that it should be used as a tool to drive down the earnings of already relatively low paid groups within the NHS.

Table 3 **Management initiatives in the NHS: selected examples**

The Health Advisory Service	The English Hospital Advisory Service was established by Richard Crossman in 1969 following the Ely mental hospital scandal. Similar bodies were set up in Wales and Scotland. In 1976 the English body was retitled the Health Advisory Service. In essence it is an independent inspectorate concerned with evaluating the services provided by the NHS and local authorities for the mentally ill, the elderly and children in long term care.
The National Development Team for the Mentally handicapped	Set up in 1976, the NDTMH plays a role comparable to that of HAS in relation to mental handicap services. But it lacks the authority to make compulsory visits. Intended to promote national policies and to catalyse change in this sphere, the team is responsible directly to the Secretary of State.
Rayner Scrutinies	Since 1979 special 90 day scrutinies of many aspects of the work of government departments have been conducted under the auspices of Lord Rayner, whose work received the personal support of the Prime Minister. In the NHS scrutinies have been done in the Regions by officials reporting to Regional Chairmen. Areas covered include the collection of payments to health authorities resulting from road accidents, supplies storage, catering costs and transport usage. To date little action has resulted from these studies, although positive moves now seem to be emerging in areas like the last of those listed above.
The 'Körner' Steering Group on Health Services Information	The 1976 Three Chairmen's Enquiry into the DHSS raised a number of concerns related to health service information systems. In (somewhat delayed) response the Secretary of State set up the NHS/DHSS Steering Group in this area in 1980. It had a unique remit to agree and implement the principles and procedures appropriate to guiding the development of NHS information gathering, as well as to review existing arrangements and change them if necessary. The early work was conducted in a spirit of some optimism. It attempted to identify minimum sets of data necessary for running the Districts, and considerable enthusiasm built up regarding the potential of patient based systems. However, more recently doubts have emerged as to the costs of implementing Körner's ideas. The desirability of imposing from any central body theoretical concepts of information requirement on those responsible for the day to day task of management has also been questioned.
Regional Reviews and Performance Indicators	In 1981 the Public Accounts Committee argued that the accountability to Parliament of the English health authorities should be strengthened. In January 1982 the Secretary of State announced that annual review meetings between Ministers, RHA chairmen and Regional Officers would be organised to help ensure the efficient use of NHS resources within government's priorities. This system has since been extended down to Districts, and may also be applied at unit level. In the context of the review process the DHSS and the Northern RHA in 1982 pioneered the use of a number of performance indicators relating to clinical activity, manpower, finance and estate management. Although subject to further development, they should help to improve efforts to compare NHS localities one with another and to identify topics requiring closer investigation. Taken together the Regional reviews and the use of performance indicators (which may also be applied in the FPS context) offer the prospect of improving considerably planning/monitoring functions within the health service.
Management Advisory Service	Following a suggestion originally made in the 1979 consultative document *Patients First*, the first MAS experiments began in 1982. The original proposals for these came from North Western Region, the Oxford and South Western Regions acting together and the Wessex Region; but only the latter two have been taken forward. The North Western plan envisaged more or less a management inspectorate, whereas the Wessex MAS has been described as a 'do-it-yourself' audit kit for local management. The Oxford/South Western version attempts to combine elements of monitoring and self-help assistance in its efforts to promote managerial change within the NHS.
Optional Appraisal	In 1982 changes to the first stage of the Capricode scheme for evaluating and sanctioning NHS capital spending introduced the technique of option appraisal. This important step means that NHS investment suggestions are now subjected to at least a form of cost-benefit analysis, so that the overall balance of opportunities lost and gained by the implementation of alternative policies can better be appreciated.
Audit	The extension of internal and external audits of NHS activities, including value for money studies, may further help to improve efficiency. In 1983 (when the Salmon report on this topic was published) an experimental scheme involving the use of private firms to examine the accounts of eight DHAs was initiated. This has been extended in 1984.
Competitive Tendering	In September of 1983 the DHSS issued guidance to health service managers on competitive tendering in the provision of domestic, catering and laundering services. A significant measure taken at that time was the effective removal of VAT from such services when purchased by the NHS, which ended the built-in price advantage of in-house labour.

establishment of the structure outlined in Figure 6 was seemingly as traumatic as in the previous case, despite the efforts of the Regional Health Authorities[10] to direct the numerous staff and other changes involved at District level and 'below'. In fact, the term confusion rather than local flexibility seems to be the most appropriate one with which to describe the events surrounding the formation of a substantial part of the new unit level structure over the following 18 months to two years.

However, before events occurring after the 1982 reorganisation are examined one last prior happening is worthy of note. That was the transfer away from his position as a junior Minister of Health of Sir George Young in 1981. Sir George, whose consultative document *Care in the Community* led to important developments in the funding structures designed to enhance local authority/NHS cooperation (Box V) had been regarded by many commentators as a source of vigorous resistance to the harm caused by tobacco and, in this context perhaps even more significantly, alcohol.

10 In the early 1970s special Joint Liaison Committees existed to aid reorganisation at Area and Regional levels. A special NHS staff Commission was formed to allow the new posts to be filled. All new roles were, of course, tightly defined in the 1972 'Grey Book'.

Box IV **Professional advisory machinery in the NHS**

Strong professional advisory machinery at all levels was a characteristic of the 1948 NHS structure which was perpetuated, and if anything strengthened, in the 1974 format. The White Paper issued by Keith Joseph in 1972 emphasised that 'the health professions (should) exercise an effective voice in the planning and operation of the (health service)'.

However, desirable though such a goal may have been, the proliferation of consultative committees which took place in the early/mid 1970s led to much time consuming and unproductive activity. For example, by 1978 around 95 per cent of hospital consultants were members of at least one such body, and 15 per cent or so sat on five or more.

Following an enquiry set up in 1980 a Departmental circular was issued in 1982. This stressed that professionals should have an *absolute* right to give advice on, and be consulted on, matters involving them directly; but it also suggested that the numbers of committees should be cut.

It advocated flexible local arrangements, and noted that District Medical Committees (representing both GPs and hospital physicians) were no longer a statutory requirement. Thus hospital and family doctors may now separately elect medical members of the DHAs and kindred bodies. It also encouraged the replacement of other (non-statutory) advisory committees with, where appropriate, less formal channels of communication between the professions and the health authorities.

Box V **Local authority/NHS collaboration**

Collaboration between the health service and local authority funded provisions was promoted in 1974 by the creation of statutory bodies known in England as Joint Consultative Committees (JCCs). Between 1974 and 1982 there was one JCC in each metropolitan district and two in the non-metropolitan districts, where responsibility for social services and education (county councils) is split from housing and environmental health (district councils). The JCCs (the members of which are usually health or local authority members) established joint planning teams to advise the NHS and local government authorities on the planning and delivery of services of common concern, like the elderly and the mentally ill and handicapped.

In the 1982 reorganisation the latter were retained although the DHSS advised that new, single JCCs should be formed to serve groups of DHAs corresponding to the social service authorities. In general it would appear that the JCC system has significantly helped to improve liaison and mutual awareness between the local authorities and the NHS, even though the effectiveness of the arrangements described above clearly varies from district to district. As the JCCs have only an advisory status they may not always be able to promote desirable co-operation, particularly in areas when clashes of economic interest exist.

In this last context the joint finance arrangements between the NHS and local authority social services first set up in 1976 permit limited NHS funds to be made available for collaborative projects for client groups like the elderly and mentally handicapped. The original provisions, intended particularly to aid the transfer of care from NHS institutions to community settings, required LAs and the NHS to share capital outlays and the former to assume full responsibility for revenue costs after a maximum of seven years.

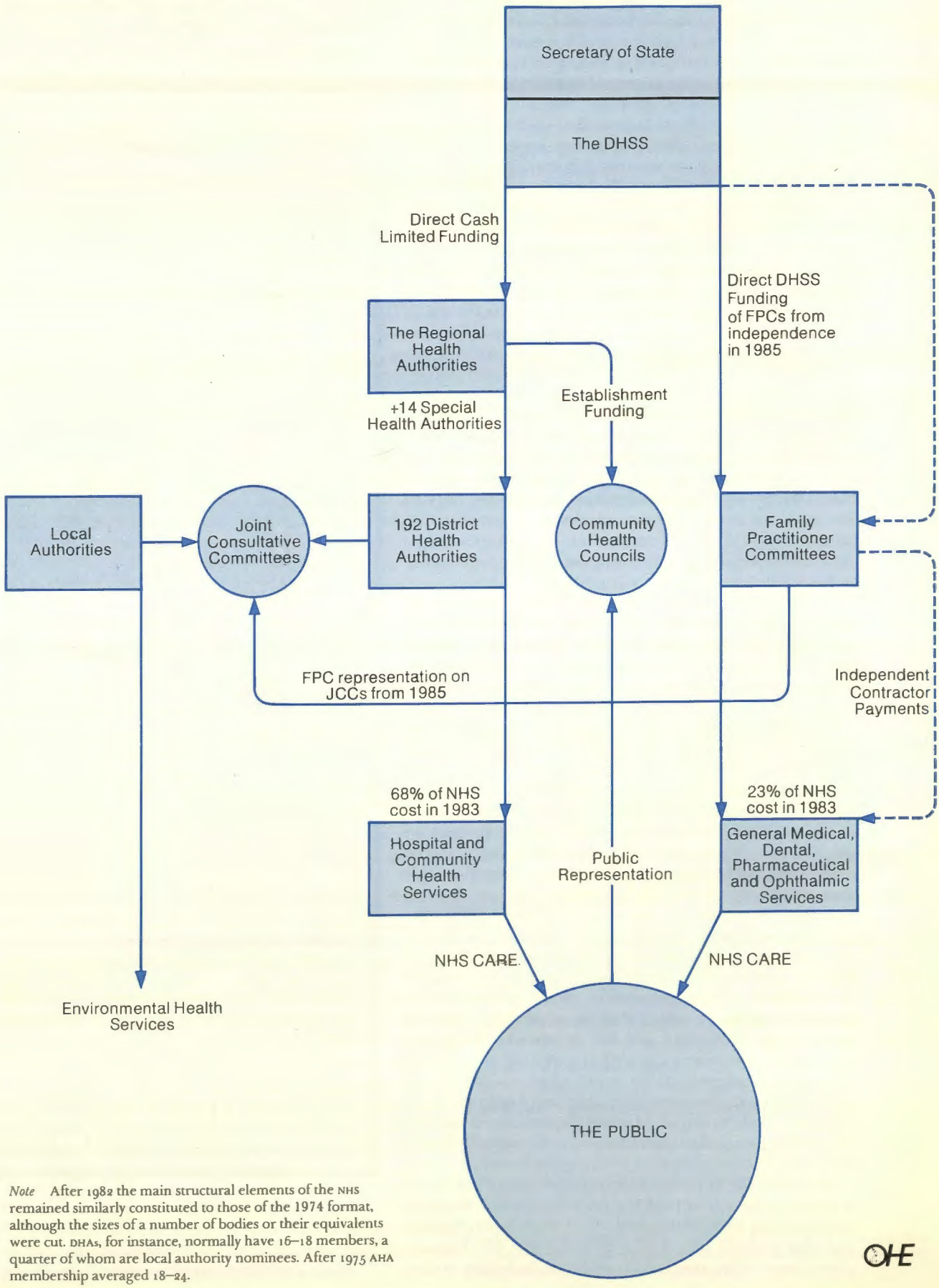
Subsequently the NHS was permitted to meet the full capital cost of joint finance schemes, and in 1981 the report *Care in the Community* suggested a number of further reforms. In 1982 the government proposed that DHAs should be able to offer continuing annual payments in respect of patients moving into the community; that joint finance should be available for up to thirteen years, instead of seven; and that over the coming five years £15 million of joint finance money should be centrally employed to permit the development and assessment of pilot collaborative projects.

The joint finance scheme, which currently (1984) involves about £100 million's worth of resources annually, has enhanced considerably the process of NHS/LA collaboration. However, the House of Commons Public Accounts Committee has drawn attention to the fact that it is difficult to quantify precisely the impact that joint financing has had on social service development. And some commentators have expressed fears regarding the effects of the 1982 restructuring on the system, in that the removal of the geographically conterminous AHA/LA tier might create some new practical problems.

It may thus be that further initiatives designed to promote the effective care of the priority groups mentioned above will be required. Acheson (1982) has argued that a clearer cross departmental policy on care for the elderly is needed.

He and his colleagues wished to widen the scope of the financial benefits available and to simplify the provision of housing support, particularly sheltered accommodation. Glennerster (1982) has suggested that in order to minimise the risk of individuals in need of care and support falling between the two halves of the health care/social care system a 'main-provider' approach might be adopted. For example, financial responsibility for all mental handicap services could be placed on local authorities, whilst all mental illness support could be made chargeable to the NHS. Given the managerial and accountancy capability needed to achieve this type of system, it would help to clarify each side's responsibilities and stimulate mutual LA/NHS monitoring of standards and efficiency.

Figure 6 **The NHS in England in 1984**



Note After 1982 the main structural elements of the NHS remained similarly constituted to those of the 1974 format, although the sizes of a number of bodies or their equivalents were cut. DHAs, for instance, normally have 16–18 members, a quarter of whom are local authority nominees. After 1975 AHA membership averaged 18–24.

The search for better management

The appointment in 1982 of Norman Fowler as Secretary of State for Health and Social Services and Kenneth Clarke as Minister of Health heralded an alteration in the government's approach to the health service. Previously, for instance, the Conservatives had appeared strongly in favour of, and primarily concerned to achieve, a rapid and extensive devolution of effective NHS decision taking down to District level or below. But since the 1982 reorganisation, the emphasis of policy appears to have moved somewhat more towards the need to ensure the NHS' upward accountability to Parliament. Also the power of the 'professional monopolies' in the health service, which in earlier years was supposedly 'immune' to questioning, has been challenged in a number of ways. The debate in early 1984 over general practitioners' use of deputising services is an example of this second shift, which may have influenced negatively morale in the FPS.

However, regarding the NHS as a whole, the latter was more seriously affected by four other events. First, there was industrial action between the Spring and Autumn of 1982 involving several groups, including nurses and ancillary workers. It drove NHS waiting lists up to unprecedented levels. Second, in the Summer of 1983 there were government expenditure adjustments which resulted in a loss to the hospital services equivalent to £140 million. Third, shortly afterwards, there was considerable dispute over Norman Fowler's direct attempts to reduce the NHS manpower levels. And fourth, there was the establishment and report of the 1983 NHS Management Inquiry, led by Roy Griffiths.

All these occurrences raise interesting questions as to the nature of government's efforts to control NHS resource use whilst simultaneously, perhaps, raising its productivity. In the case of the HCHS spending reductions, for instance, it was said at the time that the cash limit cut was in part due to a projected £100 million 'overspend' in the 'open ended' FPS sector, as compared to the provisions made in the relevant expenditure White Paper (Cmnd. 8789). Yet careful examination of these last data may create some doubt as to their realism (Ball 1983), whilst a subsequent government publication (Cmnd. 9143) has shown that FPS outlays rose faster than expected in 1982–83, not 1983–84 as was suggested when the cuts were made. The public debate on this matter was thus in a sense distorted.

In the case of the imposition of manpower reductions on the HCHS, some authorities argued that this was in conflict with the philosophy of delegating power down to Regions and Districts, where local prime objectives may be identified within parameters set by resource constraints. It might be added that the combined effects of sudden cash reductions and the manpower limitations (which after negotiation aimed at reducing the English hospital and allied staff by some 5,000, mainly in the London Regions, between April 1983 and April 1984) were obviously likely to impair planned expansions of services for priority groups like the elderly and the mentally handicapped.

However, the departmental response to this argument is that the concept of health service devolution should in no way imply an abandonment of central responsibilities, and that without DHSS action of some sort on the manpower issue other areas of expenditure, including capital,

Box VI **The independent NHS Management Inquiry**

In February 1983 Norman Fowler announced the establishment of an inquiry into NHS management practices in England. The team responsible for the conduct of this exercise was led by Roy Griffiths, the managing director of J. Sainsbury PLC, who was suggested for the task by the Prime Minister. Other members included Michael Bett, who as board member for personnel at British Telecom has wide experience in matters relating to the work of the Whitley Councils as well as personnel generally; Jim Blyth, group finance director of United Biscuits; and Sir Brian Bailey, who participated in the 1976 'Three Chairmens' review of the DHSS.

The Griffiths inquiry team decided to focus on matters relating primarily to hospital management, and also to recommend reforms which could be achieved within existing legislation. The team's decisions in this context were made on practical grounds, not because of any restraints imposed by the government. Roy Griffiths rejected previous suggestions that NHS manpower numbers should be seen as a central problem, and instead chose to focus on the need to create a new managerial culture.

Working against the background of all the previous work done in this field during the 1970s the team was able to produce its findings by October of 1983. Its brief report, which may be said to represent the first comprehensive exercise in its field since the 1954 Central Health Services Council's Committee on the Internal Administration of Hospitals (the Bradbeer Report), contained proposals covering a wide range of areas. They include:

1) That at the centre a Health Services Supervisory Board and an NHS Management Board should be established (see text). The Chairman of the latter is to sit on the former, which will be chaired by the Secretary of State.

2) That Regional and District Chairmen should extend the accountability review process right through to unit level; identify individual general managers at authority and unit levels; review functional and other management structures and introduce any changes deemed necessary to meet local needs in as flexible manner as possible; and initiate 'major cost improvement' programmes.

3) That at unit level heavy emphasis should be laid on the need to involve clinicians more closely in the management process. The introduction of management budgeting and associated systems was seen by the Griffiths team as a key element in this context.

Much of the controversy over the team's work has concentrated on issues relating to the selection of general managers at Regional and District levels. However, its proposals for the head (DHSS) and 'grass roots' (units) of the NHS are at least as, if not more, significant. Also, it calls for change in the personnel and property/works functions of the service have equally important implications for the future.

The practical impact of the Griffiths report will not be fully apparent until at least April 1985 in England, and probably not till rather later in the rest of the UK. A Welsh consultation document was issued in January 1984, but to date the Scottish and Northern Irish authorities have only noted the publication of the English management inquiry.

would have been neglected. In the short term it could also be considered relevant that the purchase of contract labour by authorities with sufficient funds was not prohibited by Norman Fowler's action. New arrangements for the year 1984/85 onwards should go some way to resolving difficulties in this field, in that planning approvals and funding allocations for new developments will depend on, and be positively stimulated by, satisfactory provisions for the efficient use of manpower.

This introduction of an incentive based approach into the NHS to a degree illustrates the type of 'business-like' thinking embodied in the last of the four events listed above, the establishment and report of the 'Griffiths' NHS Management Inquiry. The main recommendations of the latter, described in Box VI, raise many fundamental issues. Although some commentators and professional bodies have been critical of the Griffiths teams' endeavours (see the House of Commons Social Services Committee 1984) they do not represent merely 'another' management review. Although the Inquiry was not intended to produce a 'major report' it did take account of all the various approaches to management which have been tried in the health service, and of all the various analyses of NHS problems made in the last two decades or so. And its policy suggestions, which range over many areas, could bring about extremely positive changes in the health service. The remainder of this section seeks to indicate the nature of the possibilities open, beginning with a look at the key proposals made for developing the top of the NHS/DHSS hierarchy.

Leadership from the centre

Two fundamental sets of criticism are currently directed at the constitution of the NHS and its relationship with the DHSS, which is manned by civil servants rather than health service employees. The first is that the NHS is in governmental terms an unusual, hybrid, structure. It differs, for example, from the classical ministerial model of administration, where a Minister directly heads what is more or less a line command system down to local level, in that there are intervening authorities like the RHAs and DHAs. Yet the latter cannot be compared with local government bodies, in that their position is not based on a mandate from a local electorate.

Neither can the NHS currently be seen to fit with the model established in the nationalised industries. For there the boards, which have delegated powers, are accountable to Ministers for achieving fairly precise financial and allied targets. Members' roles are relatively clearly defined in terms of professional and technical function, unlike the case with the 'lay' NHS authorities.

The result, it may be argued, is a confusion regarding the possession and legitimacy of authority within the NHS (Regan and Stewart 1982). On the one hand the advantages of the type of nationally planned service originally advocated by Bevan can on occasions be lost, whilst on the other the position of the local health authorities as independent actors is a relatively feeble one. Indeed, given the fact that CHCs already exist to represent and give voice to consumer interests in the health service it could be seriously asked whether the RHAs and DHAs (as opposed to the individuals who chair the authorities and the teams of officers who serve them) are needed at all.

Following on from the above, a second criticism of the current arrangements regarding the DHSS and the NHS is that the latter has 'its head cut off'. Whilst NHS staff loyalties must be to the service itself, civil servants' actions are normally primarily aimed at the support of their political heads. This division may on occasions promote inefficiences in the NHS, not the least of which stem from a lack of proper leadership from the 'top' of the structure.

Figure 7 indicates the possible impact of the Griffiths recommendations, already accepted by the Secretary of State and due for implementation in 1984, that there should be a Health Services Supervisory Board and an NHS Management Board. The latter, to be chaired by a relatively independent individual (but who will nevertheless become a civil servant) is to provide a professional input like that of a nationalised industry board and to give managerial direction to the NHS.[11] The former would decide on broad stategies and resource allocations, and be the major vehicle for the Secretary of State to discharge his or her wider health services responsibilities.

Obviously a great deal depends on the detailed arrangements finally agreed on. But eventually the combination of a strong NHS Management Board head, largely served by his or her own NHS/DHSS staff, and a significant delegation of existing DHSS powers into the NHS could resolve many problems. The upper echelons of the organisation would be freed of any excessive involvement in the day to day working of the health service, and instead able to concentrate on making fundamental decisions about health policy. The NHS might be both led more effectively, and better represented in the overall government process.[12] Should the role of the new Management Board's Chairman develop appropriately, that is become seen as compatible with both managerial efficiency and Ministerial and Parliamentary rights, the creation of a statutory, more independent, Board like that of a nationalised industry might one day be possible. This last idea was, however, strongly opposed by the recent Social Services Committee report on the Management Inquiry.

Another important implication of the current changes is that the size of the DHSS might be significantly reduced (Fowler 1984). In fact the Department claims to have already roughly halved its health service relevant staff in the last few years, from about 5,000 to around 2,500. This has been achieved by internal redefinitions of staff categories, together with some real manpower cuts and moves like the transfer of certain functions, such as those relating to supply and training, to the new Special Health Authorities noted in Box VII. Future additional manpower savings could possibly take place in relation to areas like the DHSS works and personnel functions.

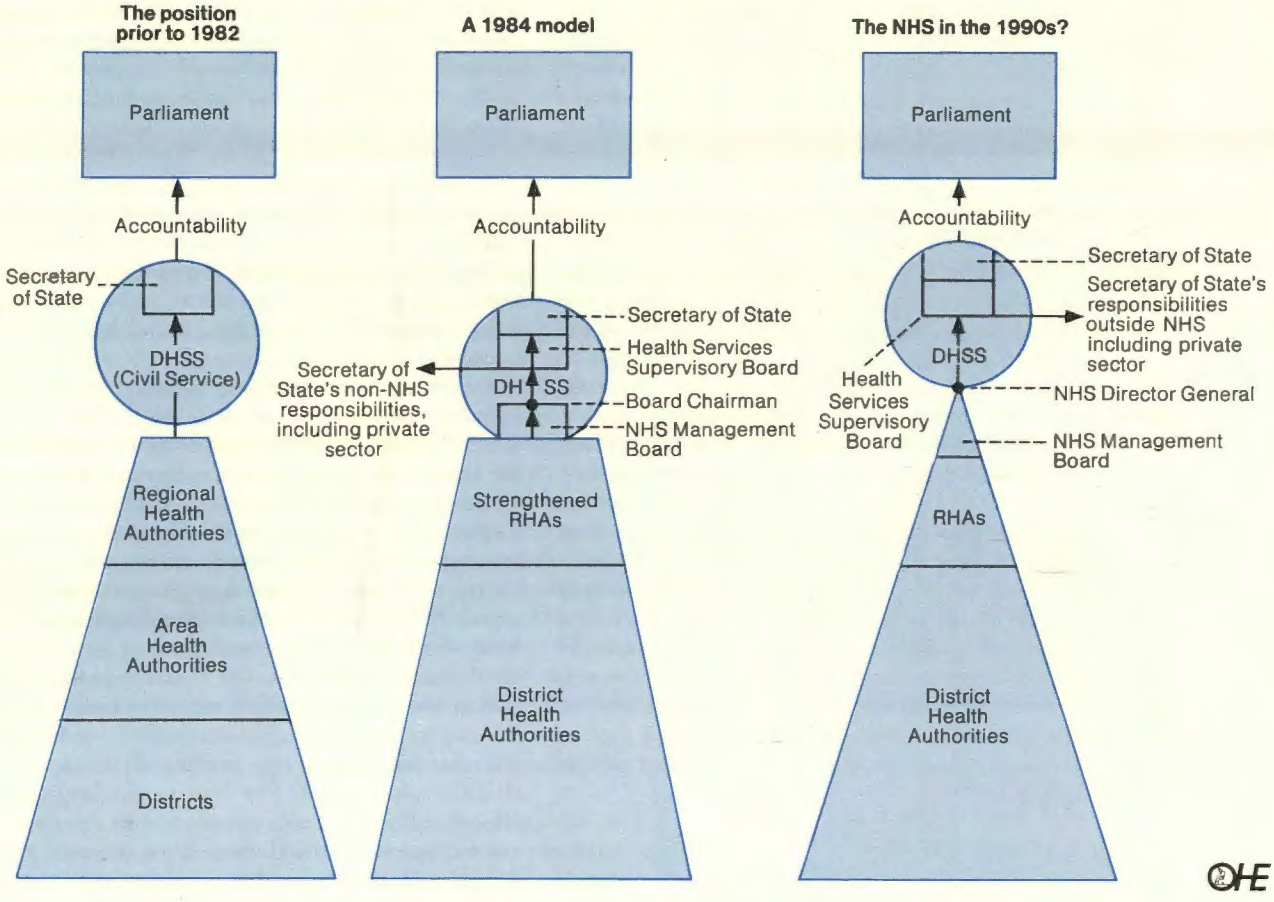
Authority at the periphery

In recommending a stronger role for the fourteen Regional Authorities in England the Griffiths team echoes

11 However, assurances have been given to Regional Chairmen that they will still have direct access to the Secretary of State. The question of managerial responsibility may thus be regarded as a confused one at this level.

12 The chronic weakness of arrangements for interdepartmental co-ordination in the British 'welfare' state and the need for a 'joint approach to social policy' in government is still a matter of major concern despite long standing calls for reforms (CPRS 1974).

Figure 7 **The 1983 NHS Management Inquiry's proposals: the possible impact at DHSS level**



Note In practice the effects of the Griffiths proposals on the DHSS/NHS could prove more modest than this diagram suggests. But it serves to highlight the nature of the choices to be made regarding the central government institutions at the head of the health care system.

views expressed in both the 1976 'Three Chairmen's' review and the 1979 report of the Royal Commission on the NHS. With the DHSS and the NHS Board focussed clearly on strategic issues and overall performance monitoring, the Regions would become the highest level concerned with NHS operational affairs. In pragmatic terms alone, a slimmed down (or even a 'beefed' up) DHSS could not hope to take a sustained, detailed interest in the day to day affairs of all 192 English Districts. And a significant degree of 'delegation downwards' is a necessary precondition for the introduction of the more flexible and positive local NHS direction envisaged by the Management Inquiry.

But some commentators seek more radical changes than may seem to be being proposed at present. Most notably the ex-Labour Health Minister David Owen has advocated a further devolution of power to the Districts, with DHAs becoming locally elected bodies. By contrast others, including representatives of professional and related interest groups (see, for instance, Ellis 1981, Nairne 1981) appear concerned at this prospect, and may wish to retain a relatively strong direct role for the Department. Klein (1983) has argued that the conflict between proponents of central and local power in the NHS has been, and will continue to be, a fundamental feature of its organisational dynamics.

In practice this may be so, especially if a stronger lobby in favour of local government control of health care were to build up.[13] However, it is worth noting that if the arguments of individuals like Bevan in favour of a national health service are accepted then it may be possible to reconcile the centralising/decentralising forces within the NHS to a far greater extent than is commonly supposed. This task is recognised by many industrial managers as one of vital importance.

All major organisations face problems in developing and pursuing integrated global policies whilst also permitting sufficient local freedom for their efficient implementation. The NHS, contrary to what is sometimes alleged, does not face unique problems even though it offers a particularly wide and disparate range of complex services, and employs an enormous workforce, segmented by myriad economic, professional and functional divisions. The experience of the business world indicates that, with sufficient attention to role definitions and linkages, it is by no means impossible to combine advantages like national standard setting and goal identification with strong, semi-autonomous, local managerial pursuit of the latter.

13 It may clearly be in the interests of local and some national politicians for this to happen. But it is less obvious that the public would welcome or benefit from such a move. In areas like housing and education local government control has often led to significant failures in service quality, and has not in fact resolved the centralist/devolutionist debate.

Box VII **The Special Health Authorities**

The NHS Act 1977 (which served largely to draw together previous NHS legislation into a more comprehensive Act) enabled the government to set up Special Health Authorities to administer certain NHS services. These now number the 14 bodies listed in Table VII.1, including the Boards of the London Postgraduate Teaching Hospitals preserved in 1974 plus the Hammersmith Hospital, which no longer has a DGH role.

Few commentators would dispute that it appears sensible to have established the Prescription Pricing Authority, or the recently created Rural Dispensing Committee, as SHAs. Similarly, the Central Blood Laboratory Authority, which, has a major manufacturing capability, can logically be seen as an entity discrete from the main DHA/RHA/DHSS structure.

However, the position with SHAs like the NHS Training Authority and the Health Service Supply Council is less clearcut. The position of the former is as yet ill-defined, whilst the entire concept of the Supply Council is questionable. To place responsibility for policy formation in an area involving some 15–20 per cent of health authority costs upon such a body might in some respects appear to conflict with both the ideal of devolving managerial responsibility down to NHS Regions, Districts and below and the countervailing principle that the NHS needs strong central leadership. The conflicts between the Supply Council and certain RHAs over the implementation of its suggestions indicate the sensitivity of this area.

Table VII.1 **Special Health Authorities created under Section II of the NHS Act 1977**

The Prescription Pricing Authority
The Health Service Supply Council
The Rampton Hospital Review Board
The Board of Governors of the Hospitals for Sick Children
The Board of Governors of the National Hospitals for Nervous Diseases
The Board of Governors of Moorfields Eye Hospital
The Bethlem Royal Hospital and the Maudsley Hospital
The Board of Governors of the National Heart and Chest Hospitals
The Board of Governors of the Royal Marsden Hospital
The Hammersmith Special Health Authority
The Welsh Health Technical Services Organisation
The Central Blood Laboratory Authority
The NHS Training Authority
The Rural Dispensing Committee

An important element of the Griffiths report is, in this context, the idea of introducing general managers 'down' through every tier of the service. Such a move, together with the introduction of appropriate incentive systems for all staff, could be seen as the cornerstone of an organisational policy designed to enhance 'grass-roots' authority. Ideally, clear leadership from the centre would then be balanced by a strong 'bottom-up' direction and control of services.

And in the longer term such a strengthening of District and unit level management might be a preliminary to a further cascade devolution of power in the NHS. Whilst today it may appear that Regional Authorities would dominate a Griffiths style NHS, the ultimate situation could well be one in which staff at or near the patient/service interface have much more real control. If nothing else, this should improve care standards by decreasing the tendency of more able people to move away from consumer contact, 'up' into the middle ranks of the administrative structure.

Administration or management?

In the first decade or two of the NHS's existence it was reasonable for most people involved in its administration to concentrate their attention just on making the unique new services work. Precipitating overt conflicts in a system the underlying robustness of which was uncertain could well have been seen as destructive behaviour. Many individuals like hospital and group secretaries developed a keen 'sense of the impossible'; that is, they tended to avoid direct clashes with powerful interest groups. Instead of fighting to identify and achieve desirable goals they more often confined their efforts to lubricating (and perhaps subtly influencing) interactions between other, dominant, actors on the NHS stage.

By contrast the established position and enduring place of the NHS in Britain today is clear. But so too are its shortcomings. The type of approach advocated by Griffiths and his colleagues is intended to promote and control change in a much more positive manner; it is about transforming the NHS into a managed rather than a merely administered service (Evans 1983, 1984).

However, this was, of course, also the goal of Keith Joseph's 1973 Act which introduced consensus management. By reducing the past isolation of the NHS administrative cadre from the rest of the service and involving personnel drawn from the most powerful sections of the health service community in management teams the architects of the post 1974 structure hoped to open the way for more positive action. Some authorities fear that the Griffiths' plan to appoint general managers at all levels could prove no more than a counterproductive reversion to the past, which might actively promote disharmony in the NHS by challenging the interests of key professional groups. Yet it is also widely acknowledged that the NHS could benefit from more positive leadership (Merrison 1984).

At this stage it is impossible to judge exactly how designating one member of each RHA, DHA and unit team as a general manager, with the power to if necessary short circuit consultative procedures and/or over-rule dissenting members, would affect the health service. No clarifying decisions have as yet been announced following the recent, brief, period of consultation, and the Management Inquiry's proposals are subject to a number of different interpretations.

One possibility, for instance, is that general managers at, say, District level would play the role of team co-ordinators without necessarily altering functional command lines like those between the District Nursing Officer and his or her nurse managers. Another less likely or desirable option is that the existing management teams would be either eliminated or to varying degrees isolated from direct involvement in unit activities. With regard to the latter level, where a very complex variety of alternative and overlapping structures has arisen (Shaw 1983), the

House of Commons Social Services Committee has particularly underlined the difficulties to be faced in establishing a general management function.

It has been suggested that concerns like these led the Secretary of State to delay implementation of the Management Inquiry's recommendations from April 1984 to the following year. However, April 1984 was always intended as the starting date, not the closing date, for such changes. Ministers have also pointed out that they wish to take as flexible an approach as possible towards adopting the Griffiths proposals. It is argued that it is up to each locality to adapt the spirit of the latter to its own needs when forming precise arrangments as to matters like delineating the general managers' roles. The implication is that the Management Inquiry's work is to be used pragmatically, not treated like holy text.

At this stage, therefore, comment must be confined to fairly broad points. First, it must be understood that no organisations can ever be run successfully without a high degree of consensus. The more complex its tasks and specialised its staff the more this is true. The objective of any health service general manager should not be to bypass a genuinely democratic process, but rather to ensure that all options likely to promote consumer welfare, however threatening they may be to sectional staff interests, are fully considered.

Although the consensus system as at presently structured in the NHS is in many respects viable and valuable it may sometimes fail to force the service into dealing with difficult questions like those which arise in situations where professionals' actions are not in line with their expressed concern for maximum patient wellbeing. Just as an excessively strong management should, and doubtless would, be resisted in the NHS if it tried to push through damaging policies, so Griffiths implies that the dangers of omission should also be fought. This philosophy accepts that the NHS is strong enough to face overt internal conflicts in the cause of better health care (Day and Klein 1983).

Second, it is proposed that general managers be selected from staff of any discipline. This is clearly in principle desirable, but in the case of District and Regional administrators problems could arise if they are not chosen to be the NHS managers. Many good administrators in such posts, often operating in close contact with authority chairmen, already carry out a general manager's task.

There is some genuine cause for concern here, made all the stronger perhaps by the fact that politicians often appear to have a schizoid view of this area. Whilst decrying spending on administration and bureaucracy they call for better management, without clearly defining the difference between the two. Roy Griffiths has apparently accepted that improving management may justifiably involve increasing overall 'administrative' costs in the NHS[14] (Griffiths 1984).

However, on the issue of the selection of general managers the Management Inquiry's concept of permitting staff from any background to be considered could be an effective way of by-passing restrictive practices which have led to the retention of poor NHS administrators. And although the process of identifying general managers could expose those administrators not so chosen to some considerable personal distress this does not necessarily invalidate the thinking upon which Griffith's ideas were based.

A third matter for comment relates to the fact that the 1974 reorganisation gave some NHS nurses a unique position as compared to their professional colleagues' status elsewhere in the world. They fear its loss. It is quite probable that the current functional/financial arrangements for the management of nurses by nurses would be significantly altered as a result of the Management Inquiry's proposals being adopted. The forebodings of this group were further stimulated by their professions' proposed lack of representation on the new Supervisory Board.

This situation may be welcomed by those who believe that nurse managers have often proved to be of limited intellectual quality,[15] and that existing arrangements have stood in the way of attempts to utilise nurse manpower and related NHS resources more efficiently. But against this the likely effects on nursing morale of any major changes could be extremely destructive, unless, perhaps, substantial efforts are made to improve the position of those currently lower down the current nursing hierarchy.

Finally, the reaction of the medical profession to the Griffiths report will be of critical importance. Some bodies, including the BMA, have expressed reservations: but on the whole the doctors' stance appears fairly positive to date. The acceptability or otherwise of the proposals in the field of management budgeting are likely to be a crucial determinant of whether or not clinicians will become more closely involved with, and sympathetic to, the NHS management process at the 'grass roots' level.

Incentives for action

It is by no means an original observation that in practice power in the health service often lies with the medical profession. It is the doctor who usually decides on the treatments necessary for patients, and so makes crucial resource allocations. This reality was unquestioned in the British health care system before 1946/48, in that medically qualified individuals were usually directly responsible for service administration. Indeed, in the local authority NHS services this was so right up to 1974. In many countries doctors automatically hold 'chief-executive' posts even today.

14 At under 5 per cent of HCHS revenue, administrative costs in the NHS are lower than those reported in most other public and private sectors (Kenny 1981). NHS manpower classifications include under the heading administration many clerks and secretaries whose work is closely involved in patient handling or supporting consultants in their day to day activities. However, against this much professional time is spent on committees and in other activities which can only be seen as administration. Yet they are costed as 'sharp end' work. The need to cut the latter spending in this context is usually neglected by those who criticise NHS administration. The additional cost to the NHS of introducing general managers at all levels could be £20 million or more, although the Secretary of State has suggested that part-time appointments might be considered. That is, individuals could combine managerial and other functions.

15 It would be well beyond the competence of OHE to judge the truth of such statements. Prejudice against the nursing profession unquestionably exists. It is reflected in, for instance, false claims that the relative number of administrative nurses has been vastly increased by the Salmon and Mayston restructuring and the 1974 reorganisation. However, nursing is unquestionably very hierarchical and it is possible that a refocusing of the profession's central concerns towards patient care rather than management would be desirable. Improved relative rewards for unit level staff and below could assist such a shift.

The creation of the new NHS management arrangements in the 1974 reorganisation was seen as a cautious challenge to medical authority, even though the management teams at District level then and now contain three doctors out of a total of six members. These are the consultant and GP representatives and the District Medical Officer, the successor to the old Medical Officer of Health.

However, in the event comments as to the 'breakdown of traditional medical authority in the NHS' (OHE 1977) were premature, if not entirely misguided. Despite the continuing emergence of other professional and labour groups, and despite the emphasis on planning and efficient management in the 1974 'theology', the medical profession has retained a great deal of its influence over the course of health care development in the UK (Haywood and Alaszewski 1980). And in cases where doctors on administrative teams have challenged other members of the profession, they have often become isolated and ineffective. Foreign observers, including informed commentators from the USA, have expressed surprise regarding the extent to which clinical freedom is still the basis of NHS decision making.

This is in many ways an encouraging fact, which can be better intellectually defended than could any radical extension of authoritarian planning and direction. But it is also true that resource limitations must inevitably affect the NHS, as experience in fields like renal medicine and cardiology clearly indicates. Clinical 'anarchy', in which patient care levels are determined by relatively random forces, cannot be seen as more desirable than a sensitive, clearly led but consensus based system for identifying NHS priorities. Assuming the latter can be established, the question arises 'how, given the reality of medical power and the essential desirability of local freedom of action for individual clinicians, can the NHS management effectively influence medical action?'.

The answer put forward by many (see, for example, Perrin *et al* 1978) relates to the provision of appropriate incentives. The potentially vital importance to the whole of the NHS of simple, flexible arrangements in this context is reflected in the 1983 Management Inquiry team's calls for a revision of the existing (recently modified but still highly complex) Whitley Council system for determining NHS pay levels and the introduction of more powers to vary personal rewards, so to encourage performance.[16] Similar thinking underlies its suggestion that clinical departments should have their own budgets. Given built-in incentives for thrift, including perhaps the possibility that savings may be utilised by those responsible for the extension of new types of care (ie virement), this approach has many attractions.

The most important research conducted in this sphere to date has focused on the concept of clinical budgets covering direct patient service costs (Wickings *et al* 1983, 1984). They have proved popular with many members of the medical profession. The Griffiths team recognised this, but urged the development of a slightly different idea, that of management budgeting. In this each budget holder has to make contributions to overhead costs like heating or laundry as well as meeting direct expenses.

Many possibilities for the further refinement for this type of system exist. However, for the purposes of this study there are just two main points to make. First, the introduction of truly effective management (and/or clinical) budgeting must rest on an adequate knowledge of the existing cost structure of the NHS and a clear idea of current and desired future activity rates in every sphere. The DHSS has already pioneered programmes of speciality costing (Magee 1981, Hillman and Nix 1982) and the types of information system envisaged by the Körner working party could increase District Health Authorities' capabilities in this sphere. But at present the establishment of an adequate data base has not been achieved in many parts of the NHS.

Second, should a full costing and activity monitoring system be achieved it may be asked whether the Management Inquiry's recommendations went far enough. It might ultimately be possible for a total cash economy to be established in the NHS, at least to the extent that interactions between Districts, Regions and other parts of the health economy (including private health facilities) could be valued and paid for directly by the responsible budget holders. The theoretical advantages of such a basis for the welfare states' health and social care provision, in contexts ranging from specialist surgery to the support of mentally handicapped people and their families, are very considerable. Individual choice, service flexibility, and savings from scale and competitively generated efficiency could all be encouraged.

Of course, against these gains there might also be significant new administrative costs. And presently simplistic systems, like, for instance, the system of payments to hospitals based on Diagnosis Related Groups[17] recently introduced in America, could bias services away from caring for the most difficult cases (Lancet 1983, Boerma 1983). Progress in this direction would, therefore, have to be carefully planned.

But despite the need for caution there is even now some room for experimentation. The decision of the DHSS to, for example, require the new Special Health Authority established to manufacture blood products to supply the rest of the NHS free of charge, rather than at the economic price, seems negative and could desirably be revised. In this particular case a shift to a neo-market within the state umbrella could well help to guarantee both tax payers' and patients' interests.

Consumer representation

Health care is a classically 'imperfect' area in economic terms. That is, it has many characteristics (including a widespread lack of consumer knowledge as to the likely outcomes of alternative treatment decisions and the need for third party funding) which may prevent the efficient functioning of a free market. This fact not only underlies the existence of the NHS and other 'socialised' forms of medicine. It also accounts for many of the special problems surrounding the supply of health related goods like pharmaceuticals.

Yet attempts to replace or supplement market forces

16 A precedent for this lies in the doctors merit awards, introduced by Bevan in the 1940s.

17 The US Medicare system has introduced a payment structure based on some 470 weighted standard fees to compensate providers for each case dealt with in each category. Although currently somewhat crude, expensive, and confusing, the DRG system has potential for future development.

with 'fairer' or 'better' resource allocation mechanisms can themselves have undesirable results. An obvious danger is that the wishes of consumers may be neglected in the face of national and local political considerations, pressure group lobbying, and unchecked professional power.

Broadly speaking, efforts to counterbalance such trends within the NHS can be grouped together under three main headings. First, there are the legal provisions and complaints systems described in Box VIII. These offer individual consumers some right of redress in cases where they have received poor care, although this is not as yet so in respect of matters pertaining to the clinical judgements of general practitioners. The NHS could well benefit from further strengthening its formal complaints procedures, in as much as patients may then gain a stronger and more secure sense of involvement in the working of the health service (Harrison and Gretton 1984).

Second, there are arrangements for consumer representation in the management of the health service. These range from the roles played by Ministers and by the Parliamentarians active on bodies like the Social Services Committee and the Public Accounts Committee to aspects of the work of Community Health Councillors and Health Authority members.

Third, there are provisions intended to help consumers to help themselves to use available services effectively. The advice given by CHCs and the Citizens Advice Bureaux is of value here, as are the efforts made by independent voluntary bodies and health educators. The recent establishment of the College of Health is an important example of the type of initiative which has taken place in this last context in recent years.

The issues raised by the development of consumerism in the NHS range from how positive, 'self help' attitudes can be most effectively encouraged in the population to whether or not CHCs should have a national voice. The Griffiths report acknowledged the work of *some* of the latter in relation to local health problems, and pointed out the likely value of systematic, 'market research' surveys of NHS consumers, wishes and opinions. It is via these that most commercial companies attempt to guage consumer requirements and attitudes, including those operating in the health sphere.

However, in the context of attempts to introduce a more 'business-like' management into the NHS the related questions of the future of the CHCs and the current structure and membership of the District Health Authorities deserve closer attention. In Keith Joseph's 1974 structure the division between CHCs and AHAs was introduced to enable the latter to manage rather than to represent. It was for CHCs to give a clear voice to local, district level consumer concerns and for AHAs impartially to make decisions in the light of such views, and all the other data at their disposal. Yet in practice health authority members with local authority and professional backgrounds may tend to act in defence of local, sectional interests whilst some CHCs (and their secretaries) may have developed managerial aspirations. These last have often been linked with the exercise of their powers to permit or delay hospital closures and to present alternative plans to the AHAs/DHAs.

It could thus be that some form of merger, or restructuring, of the current DHAs and CHCs will ultimately be seen as desirable. One possibility favoured by those antipathetic to the CHCs is that they should be eliminated, and their functions be incorporated into those of the local DHAs. A perhaps more workable alternative is that the CHCs should remain and that the DHAs be reconstituted as more explicitly managerial boards, possibly with NHS executive team staff membership included.

No private business would (or could) have only outside 'lay' individuals making key decisions. And as already suggested in an earlier part of this section many people may feel that the current health authority arrangements constitute only a 'sham' democracy, which is at root a confused 'left-over' from the voluntary and Poor Law traditions of British health care. Although change along this line would require legislation, and was thus beyond the self imposed remit of the Griffiths team, it would seem to be a logical extension of the Inquiry's thinking. Such deve-

Box VIII **Complaints systems in the NHS**

General Practitioner Services: Patients wishing to complain about GP care should write to their local Family Practitioner Committee (FPC) within eight weeks of the event causing concern. If the FPC thinks the doctor has acted in a way which violates his or her contract with the NHS it may deal with the complaint by an informal or a formal investigation. The latter involves setting up a seven person Medical Services Committee. People wishing to complain may contact their Community Health Councils for advice and support at the Committee hearing.

Hospital Services: Complaints in hospital should at first be made to the person(s) directly involved. Only if they can not satisfactorily settle the matter should it be made formal. This can be done within a year either verbally to a member of staff who will write it down or by letter to the Hospital or District Administrator.

Hospital treatment: Since 1981 a system for handling complaints about clinical judgement has been on trial in NHS hospitals. This involves, first complaining direct to the consultant involved. Second, informing the Regional Medical Officer. Third, the establishment of a two man independent professional review.

Unethical behaviour of doctors: If a patient or other individuals believes that a doctor has behaved unethically or unprofessionally he or she can report the matter to the General Medical Council in London. The sanctions available to this body include striking a doctor's name from the medical register. Issues dealt with by the GMC include neglecting patients, charging for free services, excessive drinking or other health problems amongst doctors, misuse of drugs and sexual misconduct.

The Health Ombudsman: The Health Service Commissioner(s) can investigate complaints about any aspect of NHS care management except those relating to clinical judgements, provided that future legal action is not planned. Complaints should be made within a year of the incident involved, and should first have been made to the authority concerned.

Note The National Consumer Council has recently produced a booklet called 'Patient's Rights' (NCC 1982). It examines all the area above and other relevant issues in detail, and provides instructions on how to complain, addresses and other useful information.

lopments could help further to clarify the role of CHCs (as well as that of health authority members) and so ultimately enhance the quality of their representation of consumer interests to the health service's management.

But desirable though better indirect consumer representation might be, especially if backed by an impartial complaints system, it could never guarantee the sort of consumer representation found on, say, the shop floor of a supermarket. Without opportunities for choice at the point of care delivery, NHS users must always in a sense be at a disadvantage compared to the purchasers of goods and or services offered by competing suppliers. Although health care overall is not a field well suited for unmodified free-market relations, people should be able to judge the adequacy of facilities like waiting rooms, the efficiency of, say, appointments systems, and the degree of attention and courtesy they are paid.

With this point in mind the following section of this paper examines the structure and working of the Family Practitioner Services. Despite the fact that this sector of the NHS may sometimes be thought of as undesirably isolated survivor of a pre-NHS form of care the fact is that many of the basic management ideas discussed above are already incorporated in, or could be relatively easily introduced into, the existing FPS structure. Further, an element of competition between the professionals involved already exists, and could be increased where appropriate. In a sense, therefore, this key field may provide a model of the future of health care in Britain, rather than merely a reminder of its past.

The Family Practitioner Services

The family practitioner services, provided by professionals each of whom has an independent contract with the Secretary of State, arguably embody the most popular, as well as the most cost effective, elements of the NHS (Simpson 1981, Ritchie *et al* 1981). But this sector of the health service has also been the subject of considerable volume of criticism. The dichotomy of opinion regarding the desirability or otherwise of the organisational arrangements for the FPS is reflected in the fact that the 'Merrison' Commission recommended the abolition of the English and Welsh Family Practitioner Committees, in favour of health authority administration of the FPS on Scottish and Northern Irish lines. Yet the government has introduced legislation intended to establish the FPCs as more independent bodies by April 1985.

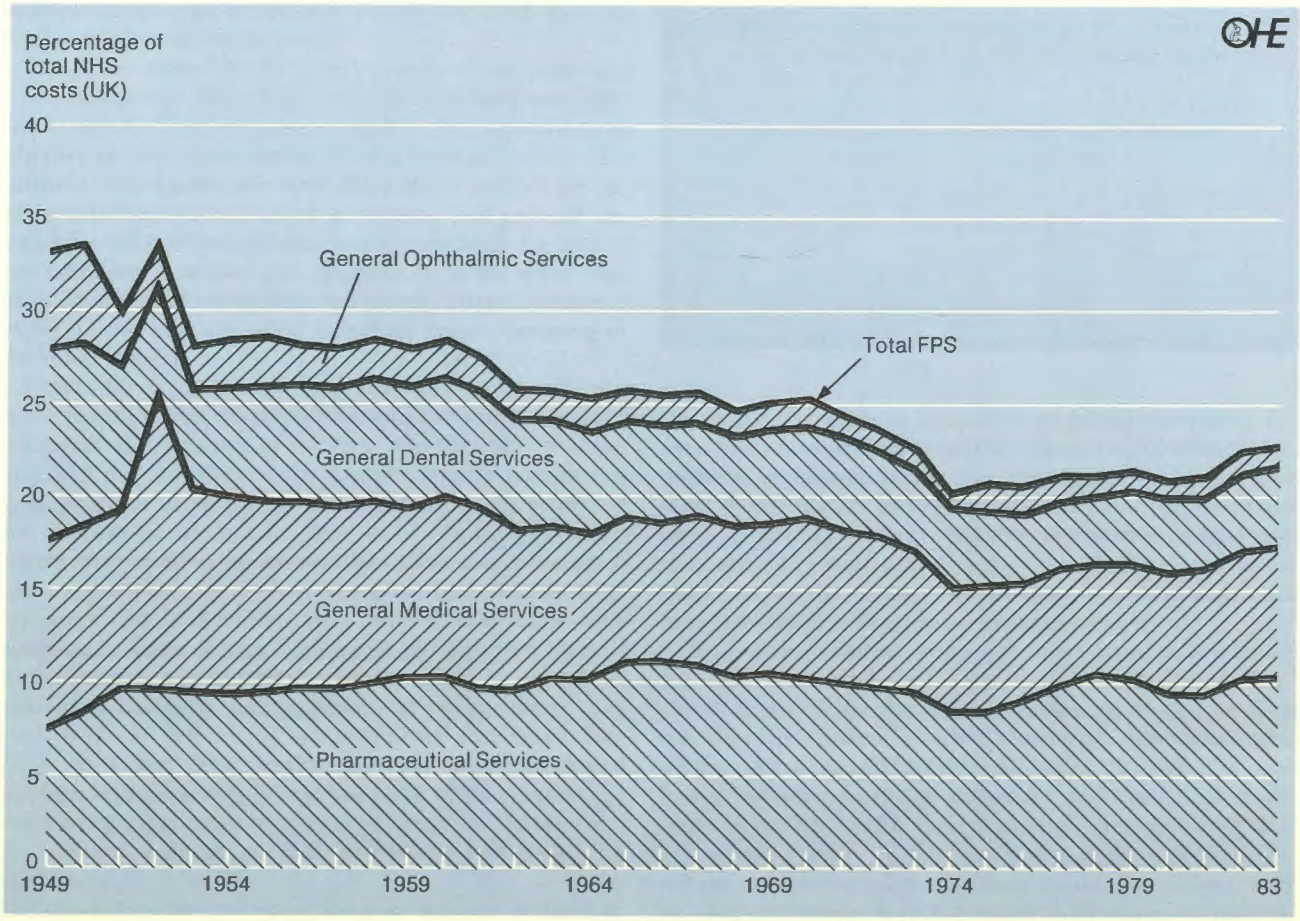
The background to this debate is long standing. As noted earlier in this paper the proponents of a unified NHS administrative structure have included the 1920 Dawson Committee, the BMA's wartime Medical Planning Commission and Kenneth Robinson's 1968 Green Paper on the health service. Even during the 1970s, the bulk of conventional thinking on NHS organisation, which has inevitably tended to reflect the interests of powerful groups based in the hospitals and 'main stream' administrative bodies, continued to condemn the separation of the FPS from the HCHS (OHE 1977). Inadequate planning and poor liaison between hospital and community services was largely attributed to this factor.

But more recent developments have tended to cast doubt on this naive diagnosis. First, it has become apparent that relatively simple organisational 'fixes' cannot necessarily cure the practical problems of an inherently complex care system. A more sophisticated approach may be to accept and even encourage structural plurality, and to stimulate co-operative interaction between groups via careful analysis and adjustment of the incentives influencing the behaviour of 'grass-roots' actors. If this view is taken then a strategy aimed at preserving and developing a strongly dualistic NHS, divided between primary community based and secondary and tertiary hospital based services, would seem viable.

A second reason for caution about calls for unification of the FPS with the HCHS is that, as pointed out in Box II on page 15, thinking on planning has changed since the 1960s and early 1970s. If incremental rather than large-step evolution is seen as desirable then the relative autonomy of actors like GPs may be an asset. If nothing else, it acts as a barrier to the introduction of the type of potentially destructive 'reforms' generated by planners who have too much formal power and too little knowledge of the informal dynamics of systems like the NHS (Anderson 1980).

And a third potential advantage of the FPS/HCHS split is economic. There is good reason to believe that a key reason why NHS costs are low in international terms is that a clear division exists between the generalist primary medical services and the specialist hospital provisions (Maynard 1983, Maxwell 1983, Poullier 1983). Administra-

Figure 8 **Gross cost of the FPS as a proportion of total NHS costs, UK 1949–83**



tive unification of the service, together with developments like the construction of large, 'mini-hospital' health centres, could blur the distinction between GPs and hospital doctors. It might also lead to a gradual leeching of resources away from the FPS, a danger which may be reduced by the current system, even though, as Table 4 and Figure 8 show, the share of NHS resources consumed by the 'open-ended' FPS has actually fallen by around a third since the early 1950s.

This is in part because of low spending increases on general dental and ophthalmic provisions. When patient payments are discounted it can be seen that the state's outlay on the former has not risen in 'real' (RPI adjusted) terms in the last thirty five years or so, whilst in the latter area it has fallen by a third. Such trends will be further enhanced by recent moves to restrict the supply of NHS spectacles and increase dental charges.

Taking these points together, there would seem to be little reason to believe that bringing the work of professionals like family doctors under the direct control of the English DHAs would be advantageous. Indeed, it may rather be that in the long term all NHS community services should be transferred to a strengthened FPS administration, although at present the government plans clearly ensure that the DHSS will retain firm control over the Committees' activities even after their new 'independence' is established. It would be unfortunate if this impaired the emergence of adequate local FPC managerial skills, as might for instance happen if too tight a grip were kept on administrative budgets.

Table 4 **Family Practitioner Services: percentage of spending on each sector, UK 1950–83**

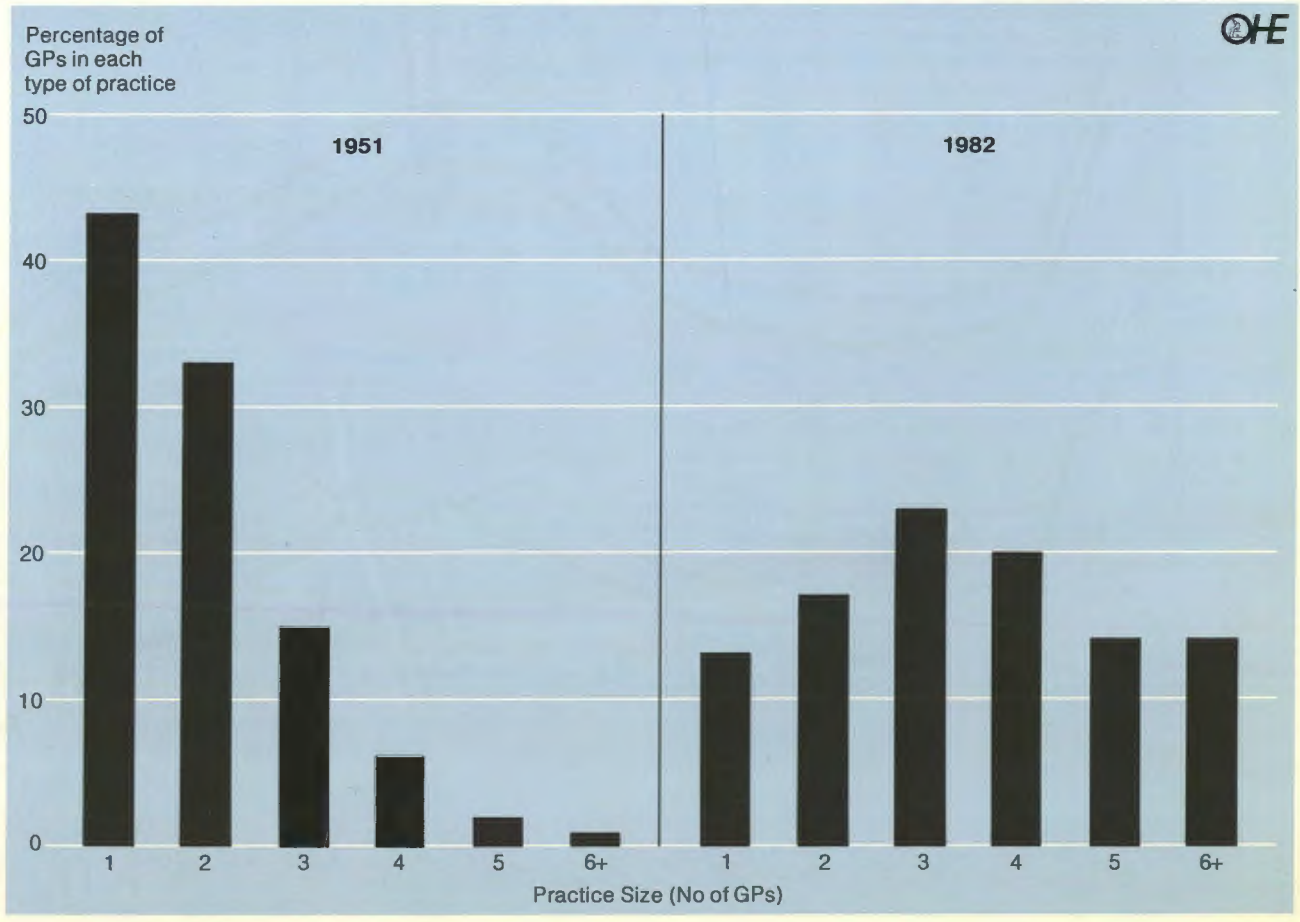
	Pharmaceutical %	*General Medical %*	*General Dental %*	*General Ophthalmic %*	*Total FPS as % NHS*
1950	25.0	30.0	29.4	15.6	33.5
1955	33.5	35.8	22.0	8.7	28.5
1960	35.5	35.2	22.3	7.0	28.4
1965	43.3	30.4	20.0	6.3	25.7
1970	40.3	34.4	19.7	5.6	25.3
1975	41.7	31.7	20.0	6.6	20.7
1980	45.8	30.7	18.7	4.8	20.9
1983	45.2	31.0	19.0	4.8	22.8

Nevertheless, despite such fears the future prospects for FPS development appear relatively bright, especially if the savings likely to be generated by the planned changes in general ophthalmic service provision, the computerisation of FPC activities, and the more efficient use of FPC manpower remain available for redeployment within the sector. It is against this background that the remainder of this section examines facets of the development and economic nature of the two most important parts of the FPS.

Family doctor care

Figures 9 and 10 show some of the very substantial changes which have taken place in the structure of

Figure 9 **Proportions of Family Doctors working in practices of various sizes, UK 1951 and 1982**



general medical care in the last three decades or so. Since the early 1950s, the total number of family doctors in the UK has risen by over 25 per cent, to some 30,000. Average patient list sizes per GP principal are down to around 2,200 in England and are as low as 1,800 for Scotland. The proportion of doctors working in groups of three or more has climbed from under a quarter to nearly three quarters. And numbers of ancillary staff working with family doctors, like receptionists and nurses, have also risen very significantly.

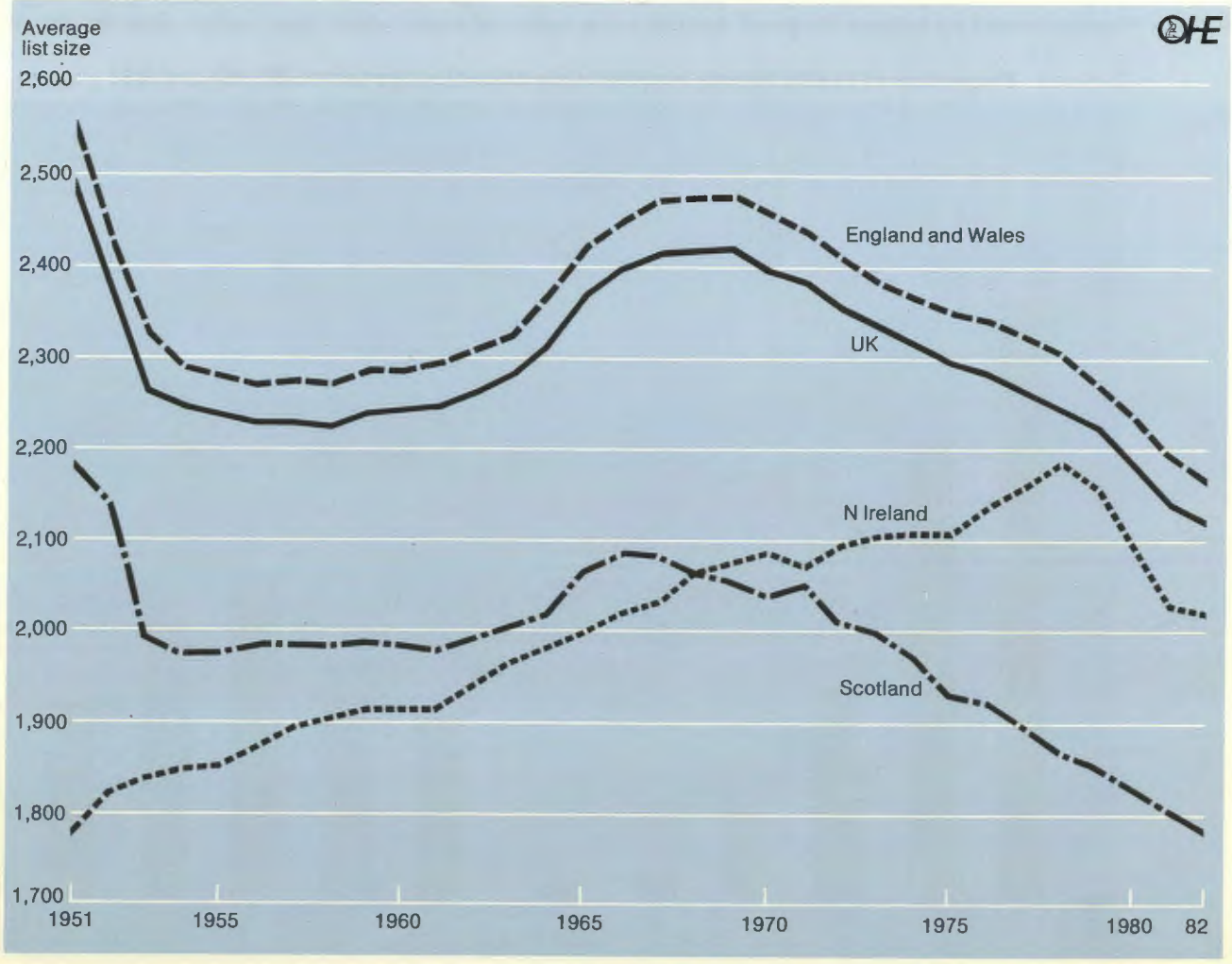
Further, the geographical distribution of practices has improved considerably. Whereas around a fifth of the population lived in underdoctored (designated areas in terms used by the Medical Practices Committee) in 1952, only about 2 per cent do so today (GMSC 1983, OHE 1984). This progress more than matches equivalent events in the hospital sector, whilst the changes in the structure and workload organisation of the GMS are even more impressive. Although list sizes have fallen it is argued that the workload of general practitioners has remained roughly constant (DDRB 1982) due to factors like increases in time spent with more complex cases, and the demands imposed by the co-ordination of practice team community support services (see also Birmingham Research Unit of the RCGP 1982).

In this last context it should also be noted that in recent years efforts have been made to extend general practitioners in-career educational activities, as well as to introduce more comprehensive post-graduate qualifications. As from 1982 all new family doctors have been required to have three years vocational training, including one as a trainee in practice.

All these examples of progress are of course encouraging, even though there are still areas where further improvements in general medical care standards and delivery are needed. It is undeniable, for instance, that the quality of service available in inner London and other major cities, like Liverpool and Glasgow, is not comparable to that available in regions like, say, Oxford.[18] These problems, the possible causes of and solutions to which

18 The reasons for inner city primary care 'deprivation' vary. In Glasgow, for instance, problems like vandalism and poverty predominate. The average age of GPs there is below the national average. In wealthier London the average age is well above the national average, and problems often relate more to factors like small lists.

Figure 10 **Average list sizes of unrestricted general medical practitioners, UK**



are discussed in Box IX, limit the options available for global NHS development in the affected localities. Yet it is precisely the inner city locations which may currently be most disadvantaged by the RAWP exercise.

This emphasises a second weakness of existing provisions, the sometimes poor co-ordination of GP, hospital and other forms of patient support and the exclusion of an adequate FPS input from the 1974 planning structure. It is here that the strengthened FPCs, capable of identifying local weaknesses through the application of measures like performance indicators and represented on bodies like the LA/NHS Joint Consultative Committees, could help to establish better procedures. Nationally or locally financed incentive schemes and special development projects could assist the direction of service evolution.

However, the possibility of local budgets raises a third issue, that of whether or not such FPS areas should be cash limited. This in turn leads to the question of whether or not the government has a satisfactory ability to control the 'demand determined' costs of family doctor care. This field was the focus of the controversial Binder Hamlyn study, commissioned by the DHSS in 1982 and as yet unpublished.

A satisfactory understanding of the NHS in this context can only be obtained from an examination of the differences in the cost structures of the community versus the

Box IX **The problems of inner city GP care**

The quality of family doctor and associated primary care facilities in inner city areas has been a subject of concern for some time. For example, Jeffreys (1970) raised many issues regarding the limitations of the services available in parts of London in the 1960s. The London Health Planning Consortium's 'Acheson' report (LHPC 1981) reiterated and amplified many of her concerns over a decade later.

Briefly, the arguments advanced in this context are based on two postulates. First, the needs of inner city populations differ from those of the majority of the country's people. There may be unusually high numbers of isolated, elderly individuals; of children in deprived and or single parent families; of vagrants; of mobile, unmarried young adults, and or of immigrant families whose beliefs, way of life and knowledge of this country may affect their access and attitudes to health care.

Second, the provision of primary care is subject to special influences in inner cities. Thus there may be relatively large numbers of elderly doctors working in single or dual practice; an unusually high use of deputising services, in part made possible by the numbers of other available doctors in urban localities; poor practice premises; and the special difficulties which the close proximity of a major teaching hospital can paradoxically cause in the community. Historically, it would appear that the concentration of resources in and attention on the activities of such large institutions has reduced local awareness of the need for, and the opportunities available for, improvements in primary care.

In a study conducted in 1980 Bolden (1981) offered a number of detailed observations regarding to the basic difficulties encountered by those wishing to improve primary care in inner cities and the factors which may help to generate solutions. He saw the following as obstacles to care developments:

- Planning activities which give no thought to the provision of primary care.
- Antagonistic attitudes towards doctors taken by some city authorities.
- The difficulty in obtaining suitable premises, either because sufficient land or alternative accommodation is not being offered by the authorities.
- The impossibility of trying to maintain a reasonable income in the face of declining practice populations and rising vandalism (which often has to be paid for personally by the doctor).
- The 'ivory tower' attitude of some local teaching hospitals, which make no attempt to liaise with the general practitioner and yet make increasing demands for limited resources on the assumption that care outside hospital does not exist, or, if it does, it is so inferior as to require little in the way of support.
- Obstruction within the profession by the Medical Practices Committee which until recently refused to consider the claims of high quality, vocationally trained doctors when competing with 'experienced' doctors for single-handed vacancies.

Bolden related poor primary medical care to:

- The operation of minimum list sizes for optimal financial gain, new NHS patients being refused entry.
- Sub standard practice premises, often of the lock-up type, which are not improved despite the availability of financial support.
- Lack of receptionist/secretarial support.
- Availability of care confined to minimum times.

He observed that factors reducing inner city problems included:

- The presence of an active, enthusiastic and highly competent FPC administrator.
- The involvement of a medical school in the problems of the community it served. This involvement was usually seen in the support offered to the practices which took undergraduates for general practice experience.
- Adequate ancillary help.
- An awareness by the doctors of basic practice organisation and simple management skills.
- The availability of property for decent practice premises, whether privately owned or for use as health centres.

The 1981 LHPC report on inner London primary health care put forward 115 recommendations in areas ranging from the organisation of general practice to the provision of community nursing and primary health education. In October 1983 the DHSS announced in response to the Acheson study group's work a 'package' of initiatives involving £9 million of new money to be allocated to DHA community and FPS services between 1983–84 and 1986–87. They include £2.5 million for GP premises improvements and some resources for the support group practices in urban areas.

However, the success of this programme appears limited to date. Not only are the amounts of money involved relatively small, but there has been confusion as to what precisely is available. It appears that more significant changes in inner city care may hinge on the practical outcome of recent negotiations relating to deputising service usage and GP retirement, together with the future emergence of FPCs as primary care planning agencies.

institutionally based NHS services, together with an appreciation of the nature of the GP's payment scheme. Regarding the first of these, the essential point is that hospital care typically involves high concentrations of capital and labour delivering relatively high marginal cost (for definition see Box X) services to limited numbers of consumers. By contrast, the much more diffused community services provided by professionals like GPs involve lower direct capital costs, lower manpower levels and less complex items of care required by large sections of the population.[19]

The current payment system for general practitioners was established in the mid 1960s. It involves a variety of allowances, capitation fees, expense allowances and item of service fees, the sum of which is intended to give the average doctor an income level decided upon by the Review Body on Doctors' and Dentists' Remuneration. (This last was set up after a Royal Commission in 1962.) Thus on the whole any increased earnings by one section of the GP community tend to be balanced by decreased earnings in another, particularly as in the long term extra item of service fee earnings may be consolidated into overall target earning calculations.

The combination of the two sets of factors noted above means that it is largely incorrect to think of the cost of the general medical services as being determined by fluctuations in public demand. Rather it is set by central negotiations, together with phenomena like variations in the numbers of GPs.

Seen in this light it is clear that rigid imposition of locality by locality or practice by practice budget limits could damage the systems' capacity to adjust for shifting workloads and differing individual levels of effort within nationally set economic parameters. More desirable options for cost control relate to manpower restraints, imposed perhaps by regulations on the retirement age of GPs or restrictions on the entry of doctors into the FPS sector, coupled with 'fine tuning' of the GP payment arrangements. Certain expense items, including those related to cars, staff and practice premises costs, could be modified, for instance, and measures designed to discourage unusually small list sizes, which lead to high unit spending, introduced.

Although in the long term an extension of more labour intensive forms of care delivered under the supervision of GPs, like, say home nursing, could require more precise budgeting requirements it thus appears that the basic framework of the existing arrangements is currently satisfactory. Indeed, they potentially combine peripheral incentives and consumer sensitive 'business' drive and enterprise with central planning and restraint, even in the much criticised area of GP prescribing. The mechanisms relevant to this last area are detailed below.

Medicines for the NHS: a British success

Figure 11 shows that NHS pharmaceutical expenditure, expressed in manufacturers' prices, has risen gradually as a proportion of the overall health service budget since the early 1950s. Even so, it still represents only about a tenth of total NHS spending. Given the range of new therapies introduced in the last three to four decades, the greatly increased complexity of medicines research, safety testing and licensing, and the relatively low share of national wealth directed to health in the UK, the record is arguably a highly satisfactory one. This is not least because this country has in the last thirty years become a major exporter of pharmaceuticals, which now contribute a net £600 million to the balance of trade.

However, like the general practitioners, pharmaceuti-

Box X **The economics of primary care – marginal versus average costs**

If an entrepreneur sets up a factory or allied facility to provide a good or service the average production cost of that good or service will of course be the overall expenditure involved divided by the total number (x) of units of output. The marginal cost of its production at any particular point will be the extra cost associated with making or providing just one more unit. Because the fixed cost of items like capital investment is included in the average but does not (within certain tolerances) feature in the variations in spending involved in the marginal calculation, the marginal cost of the X + 1th unit can be very much below the average cost.

This is often so in general practice, where the marginal cost of an extra consultation is virtually zero in many circumstances. Even when quite large fluctuations in demand occur, as in epidemics, GMS costs tend to stay relatively stable. Similarly, in part because of the nature of the Pharmaceutical Price Regulation Scheme in the UK and in part because of the large fixed cost element in pharmaceutical production, significant variations in volumes of drug usage do not usually have proportionate effects on the overall NHS drug bill. Factors like rises in manpower numbers or increased pharmaceutical industry research and capital investment are often more important determinants of FPS costs and NHS medicine spending.

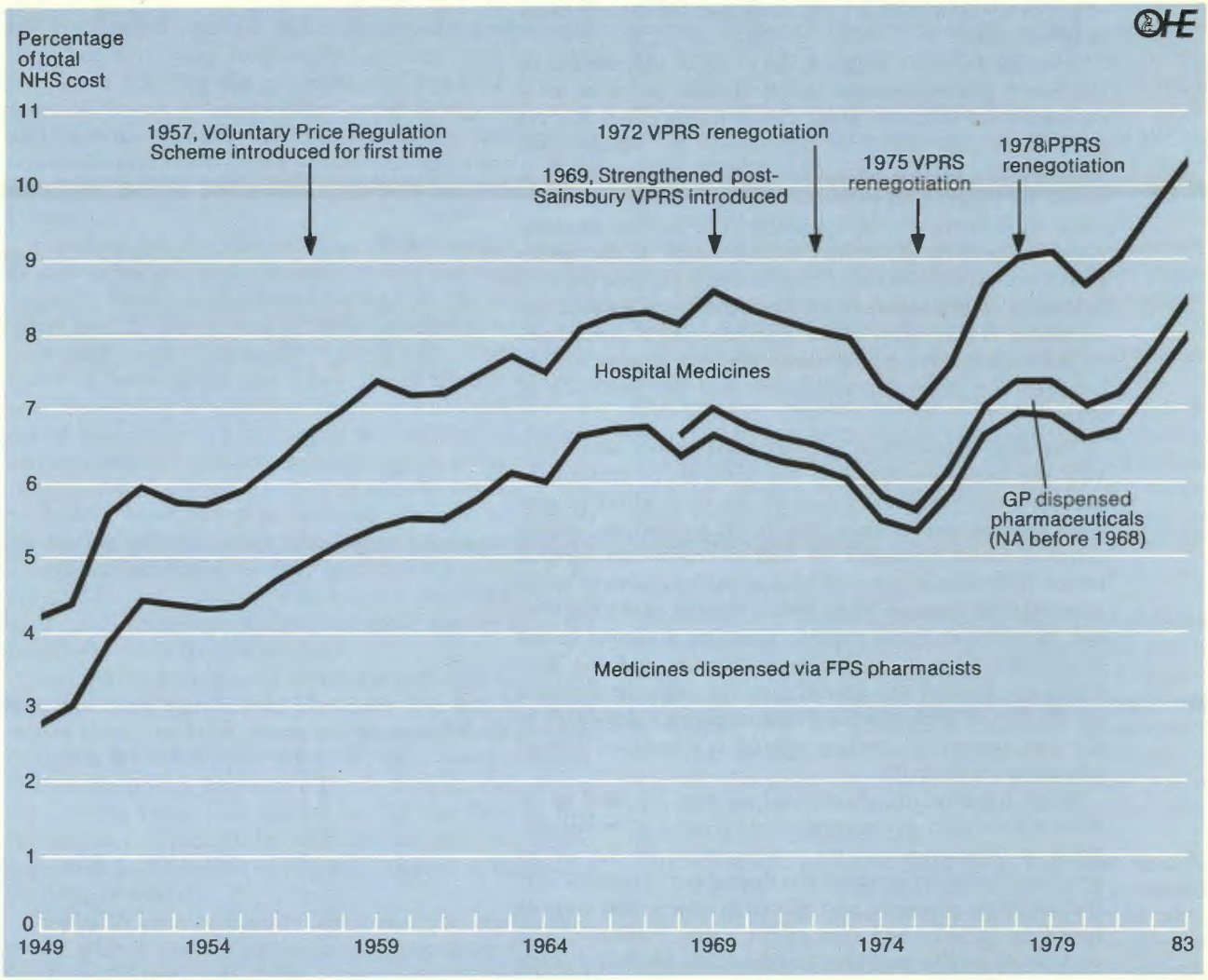
However, in some areas of NHS activity the marginal costs of care can be almost as high as the average figures. In the case of, say, renal dialysis, extra labour and even capital spending may be needed for small numbers of new patients. Costs will thus rise very much in line with the total numbers treated.

From an economic viewpoint it is clearly sensible to try to ensure that, wherever possible, desirable service expansions take place in areas where marginal costs are low, regardless of the average costs involved. Provided that extra hospitals or factories are not needed, and that increased manpower can also be avoided, care can be extended for very limited new outlays.

This is so in the FPS sector, where relatively small payments in the form of incentives can release major new types of health care effort. It is in part this economic fact which underlies the falling FPS share of NHS resources since the birth of the health service. Unfortunately, however, some politicians and even health planners do not appear to understand the full potential of flexible services like the GMS/GPS to accommodate changing technologies and social priorities in a highly cost effective manner.

19 These same elements, together with the nature of the logistical and related problems facing the hospital sector, also explain why the administrative provisions needed in the latter differ from those required by the FPS. It is inevitable that family doctors operate with an independence greater than that of their hospital colleagues. For much the same reasons that the Griffiths report recognised the power and influence of the consultants and so advocated strategies like management budgeting, the contractor relationship between GPs and the NHS seems to be a particularly valuable method of arranging their work.

Figure 11 **NHS pharmaceutical costs (in manufacturers prices) as a proportion of NHS cost, UK 1949–83**



cal companies have been vigorously attacked by some commentators during the last decade. The cost of the FPS pharmaceutical sector has been exposed to the most severe criticism, although in value terms the volume of medicines supplied via the non cash-limited FPS route has remained remarkably constant. It stands at around 80 per cent of the total NHS drug outlay.

It has been speculatively argued, for example, that reductions in the overall level of GP prescribing and a switch to generic rather than branded medicines could save 10 per cent or more of the £1,500 million NHS medicines bill. If so, it is often assumed, such resources could be directed towards patient care improvements and/or health service employee pay increases.

Views like these have received wide publicity. But their validity is limited. In discussing why this is so the remainder of this section attempts to provide an interpretation of the available facts which may help to create an understanding of problems relating not just to pharmaceuticals but to the effective management of the entire NHS.

The health service does not exist as an island isolated from the rest of the UK. This is implicitly accepted by all those who argue that the costs of NHS should be balanced against savings it generates in the rest of the community. Just as it would be absurd to advocate attempts to save local drug costs which actually drive up overall NHS outlays (as may happen when hospitals increase FPS workloads by refusing to supply their out-patients with medication) so too the effects of changed patterns of drug purchase on the British economy as a whole should be considered.

If the NHS were to 'save' by importing low cost medicines from abroad as a result of, say, compulsory generic substitution, yet in so doing were to drive up the UK imports bill and endanger employment here, the ultimate net loss of resources to the health service resulting from GNP declines could well be significant. And since it is in practice unlikely that money saved on medicines would automatically be reallocated to the main NHS budget the global loss to the health sector could prove to be substantial. Similar points apply to the problem of parallel importing of drugs from Belgium and elsewhere.

A second point to make is that basic economic structure of the pharmaceutical industry (in which there are high fixed relative to variable costs) is such that the marginal costs of medicines, both to producers and consumers, tend to be much lower than their average costs. The implications of this observation are discussed further in Box X; but for the purposes of this text the element to stress is that simple extrapolations relating factors like,

say, a decreased volume of prescribing on a *pro rata* basis to projected savings in the NHS medicines bill are not likely to be accurate.

It would therefore seem logical to argue that control of the NHS's pharmaceutical spend should be seen as a national level function. Many claims to the effect that FPS prescribers can somehow collectively be 'blamed' for expenditures in this sector are hardly more valid than would be suggestions that NHS Regions or Districts determine their own overall spending. The central negotiations underlying the terms incorporated in the DHSS's Pharmaceutical Price Regulation Scheme provide the fundamental determinants of UK medicine costs. As such the economic relationship of the pharmaceutical companies to the health service is in some respects similar to that between the general practitioners and the Secretary of State.

The aim of individual doctors must clearly be to provide the best care they can for patients. In relation to medicine use the prescription of the most effective possible therapy, rather than merely cheap therapy, makes sense in crude economic as well as traditional medical terms. Indeed, it might well be a sensible reform to make hospital drug costs an 'open ended' section of the NHS budget, in order to avoid current senseless attempts to cut local costs by juggling between Districts and the FPCs. Given the proviso that special controls might be imposed on the use of high marginal cost medicines anywhere in the NHS system this reform would not increase overall spending significantly.

More broadly, the above analysis may be used to reinforce a number of essential points related to recent progress in thinking about the management of the NHS in general. Wherever possible it is desirable to combine central strategic planning and global resource use control, based on an informed view of the entire economy, with maximum service provider freedom and flexibility at the interface with the patient. This stops bureaucratic rules getting in the way of attempts to tailor care to constantly changing individual and local needs, but can retain the advantages of government level policy formation.

Incentive systems, including on occasions provisions like item of service fees or management budgets with or without virement options, can provide a bridge between the centre and the periphery. But at the same time the creation of false economic signals should be strongly resisted, as ought systems which may divide the interests of health service staff from those of health service consumers. Otherwise morale will be undermined, along with the wellbeing of the population. To take an extreme example, it would be entirely counterproductive if, say, family doctors were ever to be paid in such a way that they were personally motivated to under-provide beneficial medicines to their patients, so saving the NHS a little and perhaps costing the British economy a great deal.

Fifty years on – an NHS for the 1990s

The comprehensive, predominantly tax funded system of health care pioneered by Britain in the 1940s has in many respects proved a success. If the NHS record is examined in terms of delivering technically adequate care to most people, of relieving the population of financial stress in times of illness, of moderating overall health care costs, and of demonstrating that the country has the political will and social solidarity to protect the interests of all its members, then its performance has been more than satisfactory.

Furthermore, the shortcomings of the NHS are neither as serious nor as unique as some of its critics suggest. For example, health care systems throughout the developed world have begun to face problems associated with their structural and functional complexity. Competition between professional and other power groups coupled with uncertainty as to how to measure and value the output of health services has begun to challenge traditional assumptions and patterns of authority in many nations. Governments' efforts to control the 'health care cost explosion' have added to internal tensions, as well as generating calls for better planning and management. To a considerable extent the only special characteristic of the NHS and its post 1974 problems is that it attempted to face up to such challenges earlier and more openly than did health providers based elsewhere.

Turning to more specific issues, the question of waiting lists and their significance illustrates the way in which stories about NHS failures may be exaggerated. Most other countries do not keep comparable data, and interpretation of the British figures is difficult. In fact, research for the 1976–79 Royal Commission on the NHS showed that the majority of patients on such lists are not, except perhaps in times of industrial dispute, exposed to significant hardship or hazard.

This is so even in controversial areas like hip replacement, where, despite unsatisfactory provision in some localities, 80 per cent of the operations' recipients are treated within a year of entry onto a list (OHE 1982). American rates for this form of surgery differ only slightly from Britain's, although Sweden's figures are over a third higher (Stocking 1984).

Regarding other 'high technology' interventions the NHS has achieved an internationally recognised excellence in areas like bone marrow transplant and cancer therapy. Yet in cardiac surgery and renal medicine the picture is less encouraging. For example, coronary artery bypass[20] operations are performed about seven times more frequently in America than they are here, and UK in-patient facilities for older would-be dialysis recipients are insufficient. Even regardless of achievements in the rest of Europe, the variations in levels of renal service provisions for adults between English Regions cannot possibly be justified. However, it would be wrong to extrapolate from such isolated failures in acute medicine so as to suggest that the NHS as a whole is near collapse or should be replaced by some alternative system.

Rather, it would seem more realistic to conclude that this country will in the foreseeable future continue to provide via the NHS a comprehensive health care system, in the main funded by tax raised resources. And relatively few people would disagree with the proposition that the NHS should continue to try to give each individual in the nation, regardless of his or her social status, the best care possible within the restraints set by the wealth of the country. Although the goal of health equity may, as Box XI discusses, be in practical terms very difficult and perhaps excessively costly to achieve, its value as a broad guiding principle remains considerable.

Yet at the same time this does not mean that the NHS could or should be 'set in aspic'. Like every other part of the social system it is in a state of continuous evolution. As the environment it works in changes and as new health problems and technologies arise, so the health service must adapt. As previous parts of this paper have shown, the NHS has, albeit in a somewhat painful and uneven manner, altered dramatically since its creation.

Within the framework of the as yet uncertain changes which will eventually flow from the work of the NHS Management Inquiry during 1984 and 1985, and the impact of reform in the family practitioner field, this final section takes a broad, longer term view of the possibilities open for further evolutionary development. It provides some speculative answers to the question 'what will the NHS be like in the 1990s?'.

Plurality and competition

When Aneurin Bevan was preparing his 1946 legislation Britain was just emerging from the rigours of the war. Its people were used to rationing and a very limited range of goods and services. Indeed, the Labour government was so worried that the population had lost 'market-place' skills that Sir Stafford Cripps established a special unit to rekindle consumer discrimination. His objective was to provide a motor to drive British industry to become more innovative and customer oriented.

In health the approach adopted at that time was, for good reasons, very different. The creation of a national health system with responsibility for caring for the entire population's needs was in many respects a desirable and logical step. But this does not mean to say that a single, monolithic service protected from competitive challenge from outside or within itself is likely to provide care in the most efficient manner. Sometimes it appears that moves to 'protect' the NHS from any change in the status quo are aimed either at merely preserving syndicalist interests or at exploiting the emotions of the electorate.

If this is indeed so, then the opportunities for recognising and supplementing NHS structural plurality discussed in this paper could well become a widely accepted reality of the health service in the 1990s. An essential move towards real progress in this context would be the establishment of a fully 'cash based' NHS internal economy.

In creating an environment in which the true economic costs of all items of service may be clearly perceived the latter could radically change the working style of the NHS, and facilitate new forms of internal and external interaction. Alternative care providers within the NHS might, in a controlled manner, compete to give services, and so gain extra funds. In the case of the hospitals, for instance, some form of payment system comparable to that already used for family doctors might eventually be introduced.

20 The efficacy of this procedure is now becoming clearer and British rates should be increased. Yet the operation has dangers, and profit motivated over-provision in the US may kill far more people than UK caution. This is certainly true with procedures like, say, hysterectomy.

Box XI **Inequalities in health**

The health of the British population varies between the sub-groups within it to a striking extent. The most commonly discussed aspects of such phenomena relate to occupational status. For example, the Black report (DHSS 1980) noted that, in the first month of life, babies born to parents in the OPCS social class V are about twice as likely to die as those in class I. In the remainder of their first year the former infants are four to five times more at risk of death than are the latter.

In all, people in social class V are about two and a half times more likely to die before retirement than those at the 'top' of the scale. For adults in their twenties the differences in actual life expectancy are about 3 years. Substantial variations in mortality, and morbidity, can also be found between geographical areas and between the sexes. In the latter case males have currently, at birth, some 6 or more years less life expectation than females.

The possible reasons for such differences range from the effects of poverty and material deprivation on the one hand to genetic or systematically selected physical variation on the other. It is interesting to note in this last context, for instance, that although Asian and West Indian populations in Britain may suffer relatively high infant mortality rates the life expectancy of adult male blacks seems to compare well with that of their white peers (DHSS1980, Scrivens and Holland 1983). Onc explanation is that fitter individuals may predominate in groups of migrants. Similarly, upward social mobility could be related to health status variations in the different sections of the white community.

However, the authors of the Black report argued that the main reasons for class shifts in mortality and morbidity are the disadvantages inherent in poverty. They thus put forward a series of suggested reforms which included better antenatal care, an enlarged health education programme and increased grants and benefits for certain vulnerable groups. The cost to the state would have been around £2,000 million (£1980).

These proposals did not meet government favour, in part perhaps because by the time the Black team, set up by David Ennals, had completed its work a Conservative administration was in power. The then Secretary of State Patrick Jenkin was subject to a considerable degree of criticism because of his apparent reluctance even to publish the working group's deliberations. Nevertheless, careful analysis of the report indicates that the policy proposals it put forward were not as well founded as some of its supporters may claim.

For example, on a statistical level the trends on which some of the Black conclusions were based may not have made sufficient allowance for changes in the age, ethnic and occupational structure of the population over time. Such factors could have helped to conceal relative improvements in the health status of the poorer sections of the population.

In relation to the health service, it may also be that some areas suffer unduly high rates of avoidable mortality because of factors related to local health care standards (Charlton *et al* 1983). Table XI.1 indicates some key elements of the pattern of variation observed, after adjustment for certain social factors. Although some commentators have suggested that GP care standards fluctuate on a class/geographical basis, rather more important disparities may well be related to specialist facilities.

Further, factors like cigarette smoking may account for some 20–30 per cent (or more) of the social class I–V differences in both adult disability and death rates (Burchell 1981, Laing *et al* unpublished). Whether it is correct to approach questions like higher smoking rates in the lower classes as a complex function of poverty, or whether it might be easier and more appropriate simply to regard such 'over-consumption' as a problem best tackled by, say, raised tobacco taxation, is a matter of debate.

Such speculations raise important questions as to how best to allocate NHS and other welfare resources in the face of health status inequities. Where specific interventions for particular groups can be shown to be effective and efficient then there is every reason to fund them. But in more uncertain situations it might be as well to accept that in dynamically developing social systems significant differences between the most and least advantaged members are likely to be found in almost any context. Provided that the health standards of the entire community are shifting upwards, it in theory may be satisfactory if the community invests in areas where general improvement can be expected. It is not necessarily logical or humane to pursue equity as an independent value, so to devote funds merely to health status equalisation rather than raising overall prospects as rapidly and certainly as possible.

At the same time non-NHS providers would be more easily able to tender for NHS contracts, not just in 'hotel function' areas like catering, but also for professional services like, say, pathology. Planning and managerial activities could similarly be enhanced by contributions from outside agencies, which on occasions might obviate the need for maintaining expensive, intermittently used, in-house capabilities.

In addition, carefully calculated financial incentives aimed at encouraging Regions, Districts, units, clinical teams and individual employees to pursue collectively agreed priorities as vigorously as possible will almost certainly be a more pronounced facet of the future NHS . The success of this approach depends on the NHS moving towards a cash based, item by item, system of accounting.

To some people the thought of such changes may be repugnant. But if the objective of the NHS is to serve the public as effectively as possible they in fact have much appeal. On occasions the persuit of greater efficiency may merely serve to conceal expenditure cuts. Yet those who stand to benefit most from intelligently structured reforms are not the well off and the articulate, who can already use the NHS to good effect. They are the less able groups like the mentally handicapped and the disabled elderly who are still at risk of being cared for not as dignified individuals but as part of a normally undifferentiated mass. Coupled with appropriate modifications to the social security system a shift towards a competitive, cash based, care structure could help many such people achieve a more acceptable style of life.

Politicians, managers and consumer sovereignty

Questions like 'how much should Britain spend on health?' have an undeniable political content. 'Who do we spend it on?' is perhaps even more a matter of relative values. In all advanced societies politicians have an impor-

Table XI.1 **Rankings of AHAs (on scores 1–6) on 13 mortality indices after standardisation for social factors (late 1970s)**

'Worst' 10 in England and Wales	*Perinatal mortality*	*Hypertensive disease*	*Ca cervix uteri*	*Pneumonia and Bronchitis*	*Tuberculosis*	*Asthma*	*Chronic rheumatic heart disease*	*Acute respiratory infection*	*Bacterial infection*	*Hodgkin's disease*	*Abdominal hernia*	*Maternal deaths*	*Anaemia*	*Overall rank score*
Walsall	5	4	6	6	6	3	6	6	6	5	6	4	4	62
Bolton	4	4	4	4	6	1	6	6	6	4	6	5	6	58
Sandwell	6	6	5	4	6	5	6	6	3	6	5	1	5	58
Wolverhampton	6	3	5	6	6	6	3	6	2	1	4	6	6	54
Lancashire	2	4	5	6	5	3	2	6	4	4	6	4	4	53
Warwickshire	6	5	4	2	5	4	4	4	4	6	3	6	5	52
Cleveland	5	1	6	6	6	4	3	3	6	5	6	3	3	52
Staffordshire	6	4	6	2	4	2	5	5	5	3	6	4	5	51
Birmingham	5	6	2	5	6	3	4	5	4	2	5	4	4	50
Bradford	4	5	5	5	4	6	1	5	2	3	2	6	6	50
'Best' 10 in England and Wales														
Hampshire	1	5	4	2	3	4	1	4	3	2	3	2	2	35
Cumbria	3	2	2	5	1	4	4	1	3	1	1	5	4	33
Suffolk	1	2	2	2	1	2	1	2	5	4	6	3	3	33
Avon	2	4	1	2	2	4	1	5	1	2	3	1	6	32
Bromley	3	3	4	1	5	1	3	2	2	5	1	2	2	31
Newcastle-upon-Tyne	3	1	4	3	2	1	4	1	2	4	2	3	4	31
Gloucestershire	1	2	3	5	4	2	1	4	1	2	3	2	1	30
Sheffield	3	1	1	1	1	1	2	6	4	6	4	1	1	29
Oxfordshire	1	1	1	2	2	2	3	3	2	3	4	3	2	28
Northern Tyneside	4	1	6	1	1	4	1	4	1	1	2	1	3	26

Source Charlton *et al* 1983.

tant role in forging the compromises necessary to create workable answers in such difficult areas. But this does not mean to say that once broad strategies have been agreed politicians should attempt to run the health services in a direct sense.

When they do so they often appear to be tempted to falsely present positive health care achievements as something they 'give' to the electorate, whilst denying completely any involvement for tough or unpleasant decisions. Efforts may be made to delegate apparent responsibility for the latter down to administrators or doctors working in particular localities.

Factors like these have in the past deprived the NHS of proper leadership, just as when civil servants or political interests intervene to distort sub-national administrative decisions on capital investment programmes or operational matters it may be deprived of appropriate local management. The NHS of the 1990s might be protected from such dangers by the creation of a more independent NHS Management Board, like that of a nationalised industry.

However the viability or otherwise of this concept will depend on how the recent, more limited Griffiths team proposals in this and other contexts work out in practice. Taking an optimistic view it is possible that by the next decade a stronger, but relatively small, central NHS body for England, led by an NHS Director General prepared to accept responsibility for all aspects of global NHS policies, would be balanced by more powerful local District authorities and family practitioner/community care authorities. Regions might play a less overt, but still important, planning and monitoring role.

But regardless of the extent of further devolution even the single act of creating an active Management Board could free the NHS to take more positive actions in areas like communicating with the public and investigating the latter's needs and wishes. At the present the 'public relations' function in the NHS is weak, perhaps because of the sensitivity and volatility of the political interests involved. Hence the service does not always respond adequately to misplaced (or indeed accurate) criticisms, although this may also in part be attributable to the fact that its capability in the sphere of health services research is very limited, as noted in Box XII.

Regarding this last observation a somewhat contentious possibility for the future is that the team places in Districts and Regions held by specialists in community medicine could, in some instances at least, be taken by individuals with what might be loosely described as a marketing role. The specialised doctors would then be free to conduct epidemiological and allied research at an appropriate level; this, alongside equally important social and economic studies, could help the health service to obtain a much clearer idea of the precise services it could and should aim to provide. Meanwhile the management teams would be better equipped to tackle the vital tasks of maintaining consumer (and staff) morale and generating confidence in the NHS and its policies.

Box XII **Health Services Research**

Research of an economic and or social nature has an important role to play in measuring the outcomes of different types of health care, in describing the networks of relationships involved in the process of service supply and in explaining how and why particular NHS policies are generated. Health care is a field where conventional market mechanisms cannot be relied on to safeguard and promote the populations' well-being. Thus research in areas like the costs and benefits of alternative services is clearly needed to help determine what patterns and scales of provision are most desirable.

There have been three main phases of health services research (HSR) development in England over the last twenty years or so. It currently appears that the NHS today is better placed to conduct appropriate investigations than it was in the less harmonious years of the middle and late 1970s. However, serious questions still remain as to the quantity and quality of HSR being done at present, and regarding which groups, working under whose auspices, are best able to produce the material needed. (See OHE 1980, 1983).

One topic currently under debate relates to the future of community medicine departments, and their contribution to this area. To date this speciality (which is not funded as part of the administrative body of the NHS) has apparently made only limited contributions to HSR, even with regard to the epidemiological work which medically qualified individuals may be equipped to conduct. One possibility for the future is that Districts and Regions should expand such departments to include social scientists in senior positions, thus to improve local capabilities in HSR, planning, and other consumer oriented investigations.

Alternatively, perhaps, specialists in community medicine with an interest in research might in future prefer to work in seperate units. Those more oriented towards administration and related activities could possibly be more closely integrated into the non-medical management structure of the NHS, whilst still offering the special skills and insights of a medically qualified person (see text).

Yet this last must always be a two way process. Just as the NHS must communicate to the public so its users should be free to effectively express their requirements from the health service. No management controlled system can obviate the need for independent consumer participation in the process of determining care supply, although in an area like health there is always a danger that the voices of those most in need of services will be drowned out by others. Even where genuinely competitive systems can be introduced, they will only work in a desirable fashion if consumers understand accurately their interests.

This observation suggests that raised educational standards will play a crucial role in making the future NHS more genuinely efficient. The achievement of this must largely depend on events in the schools and other institutions outside the health sphere. But one possibility relevant to the internal structure of the NHS of the 1990s is that Community Health Councils might be strengthened. This could perhaps be done by giving them more extensive powers in relationship to complaints about hospital and FPS services and enhancing the resources they might be able to contribute to local health educational efforts, especially in the sphere of prevention.

Although such ideas obviously conflict with those of commentators who question the value of the CHCs, the reality is that it could well be politically difficult to disband such bodies, and that some of them at least have already proved capable of conducting very worthwhile work.

A commitment to primary health care

Throughout the foreseeable future the NHS, and indeed all other major country's health care systems, will be exposed to conflicting pressures. On the one hand governments and paying consumers wish to control health care costs. And on the other all sections of the community will continue to press for higher health care standards, including the use of more sophisticated techniques and the provision of better support for the increasing elderly population.

In facing this challenge the UK possesses one major advantage: it has a unique primary health care system based on the family practitioners. A vital task for those wishing to ensure the success of the NHS in the 1900s will be to build on the latter so that it might play an even stronger future role.

It is arguable that this could be partly achieved by relating all the main community services, including health visiting and home nursing, more closely to general medical practice. Indeed, perhaps even social workers could be encouraged to link in to practice based teams, all the members of which might ultimately be independent contractors. Although there are those who argue that a hierarchical organisation for functions like nursing and health visiting will always be necessary to maintain professional standards, a more egalitarian structure might be appealing to many staff members. The current popularity of practice nursing positions illustrates this point, and the viability of proposals along these lines could be enhanced if some alternative form of care monitoring system could be introduced.

The extent to which medically qualified individuals should be involved in influencing the activity of other professionals will remain highly controversial. But, as in the hospitals, family doctors could well be encouraged to expand the managerial aspects of their vocation in the next decade or so. Although elaborate arrangements for the control of professional functions within each profession may be practical in large institutions, the diffused community services must rely to a high degree on techniques which inspire personal integrity and initiative and mutual guidance between actors in contact 'on the ground'. General practitioners should themselves be constructively influenced by sustained close contact with other groups, particularly if the interactions between them are guided and facilitated in each locality by appropriately constituted FPCs/primary health care authorities.

However, the main task of the medical profession is to practice medicine. This must involve accurate diagnosis, and often the prescription of medicines alongside other social, psychological and direct care (that is, nursing) inputs.

One of the central lessons to be derived from the section of this paper on the history of health care in the UK is that changes in medical technology have had, and will in

future have, a major influence on the overall demands on and structure of the health care system. Part of the reason for the naive predictions of some of the NHS's original architects regarding the long term social and economic impact of the post war service was that they failed to appreciate this point adequately.

Although in hospitals medicines are frequently used only to facilitate other procedures, like surgical operations, in general practice they are often the central element in medical care. They provide an ideal vehicle, where effective and safe, for treating very large numbers of people. And future advances in the sphere of pharmaceutical medicine will very probably equip family doctors to cure or prevent a much wider range of diseases than is at present possible. Although such trends are unlikely to bring the country back full circle to a situation like that at the start of the last century, when hospital care was still a rare form of medical intervention, they will in the period leading to the year 2000 almost certainly shift the main focus of health care activity further into 'community' rather than institutional settings.

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