Local Health Authority Services

(17) A major part of the rise in expenditure by local health authorities (£7 million of the £11 million increase from 1949–50 to 1953–54) was the result of rising prices. The rise of £4 million in the real volume of goods and services purchased occurred principally in the ambulance, domestic help and home nursing services (paras. 57–58).

THE CAPITAL COST OF THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES—1948 TO 1954

General

(18) The amount of capital expenditure by the National Health Service has been relatively small throughout the five years. This expenditure has two components, expenditure on building up stocks which has fluctuated between £4 million and minus £2 million in different years, and a fairly steady rate of about £12 million a year of capital expenditure on fixed assets (paras. 59–60).

(19) As prices of building work and other capital assets have risen substantially over the period, the rate of capital expenditure in real terms has progressively declined. As a proportion of national fixed capital formation, the fixed asset expenditure of the Health Service has been small and declining (from 0·8 per cent. to 0·5 per cent. in the five year period) (paras. 60–61).

Hospital capital investment

(20) Fixed capital expenditure is almost wholly attributable to hospital work. About 10 per cent. of expenditure has been for major extensions to hospitals and a further 21 per cent. of expenditure has been for ward accommodation. Expenditure on accommodation for staff has accounted for 19 per cent. of the total.

(21) The rate of fixed capital expenditure on hospitals has averaged about one third of the pre-war rate in real terms. Approximately 45 per cent. of all hospitals were originally erected before 1891; and many are regarded by expert opinion as seriously in need of replacement or radical reconstruction (paras. 62–69).

FUTURE TRENDS IN THE COST OF THE NATIONAL HEALTH SERVICE

(22) We cannot attempt to forecast how the cost of the National Health Service is likely to vary in, say, the next twenty years; we can only point the way to some of the factors which will have a bearing on the future cost—e.g., the rate at which the country may be able to make good the existing deficiencies in the Service; the rate at which the hospital capital investment programme can be expanded; fluctuations in the level of wages and prices; changes in medical techniques and in the incidence of disease and accidents; possible variations in the rates of charges paid by patients; the effect of population changes and other social factors on the use made of the Service, etc. (paras. 76–78).

(23) From an analysis of the hospital population on the census night, 1951, the authors of "The Cost of the National Health Service in England and Wales" have considered in particular the effect of demographic and other social factors on the demand for hospital care, and the effect of projected population changes on the future cost of the Service (paras. 79–89). Their main conclusions are summarised below:—

(*a*) Compared with the demands made by single men and women (and, to a lesser extent, the widowed) the proportion of married men and women in hospital even at age 65 and over is extremely small.

(*b*) Among married men and women, the rise in the proportion in hospital with advancing age is not at all dramatic; it does not reach very high levels even after age 75—only 1·5 per cent. of married males aged 75 years and over were in National Health Service hospitals, while the corresponding figure for married females was not more than 2·4 per cent.

(*c*) For all types of hospital and in relation to their numbers in the total adult population, the single, widowed and divorced make about double the demand on hospital accommodation compared with married people.

(*d*) About two-thirds of all the hospital beds in the country occupied by those aged over 65 are taken by the single, widowed and divorced.

(*e*) The bulk of the population of mental and "chronic" hospitals are single people. Of the single and widowed men and women aged over 65 needing hospital care, most are to be found in these two types of hospital. The married state and its continuance thus appear to be a powerful safeguard against admission to hospitals in general and to mental and "chronic" hospitals in particular.

(*f*) An analysis of the Government Actuary's estimates of the population of Great Britain in 1979 shows that among those who make much the heaviest claims on hospital accommodation, the number of single women of pensionable ages will actually decline, while the number of single men of such ages will increase by only a negligible figure.

(*g*) An attempt is made to estimate the order of magnitude of additional future costs to the Service arising *solely* as a result of projected population change taken as an independent, isolated factor. Changes in age structure *by themselves* are calculated, on a number of drastically simplified assumptions, to increase the present current cost of the National Health Service by 3½ per cent. between 1951–52 and 1971–72. A further increase of 4½ per cent. is attributable to the projected rise in the total population of England and Wales (using the official projection figures). In total, therefore, population changes *by themselves* are not likely to exert a very appreciable effect on the future cost of the National Health Service.

PART II

THE GENERAL STRUCTURE OF THE NATIONAL HEALTH SERVICE

93. Our remaining terms of reference are "to suggest means, whether by modifications in organisation or otherwise, of ensuring the most effective control and efficient use of such Exchequer funds as may be made available; to advise how, in view of the burdens on the Exchequer, a rising charge upon it can be avoided while providing for the maintenance of an adequate Service; and to make recommendations."

An "Adequate Service"

94. Before we can deal with the many questions implied in these terms of reference, we must consider at the outset what is meant by the provision of an "adequate service".

If the test of "adequacy" were that the Service should be able to meet every demand which is justifiable on medical grounds, then the Service

is clearly inadequate now, and very considerable additional expenditure (both capital and current) would be required to make it so. We need only mention the deficiencies which would have to be made good in the provision of mental hospitals, mental deficiency institutions, services for the chronic sick, hospital out-patient departments, domiciliary health services, the dental services, etc. To make the Service fully "adequate" in these terms, a greatly increased share of the nation's human and material resources would have to be diverted to it from other uses.

95. Nor is it clear that such a service, even if it were to become "adequate" by this criterion, would remain so without continually increasing expenditure. The growth of medical knowledge adds continually to the number and expense of treatments and, by prolonging life, also increases the incidence of slow-killing diseases. No one can predict whether the speeding of therapy and the improvement of health will ultimately offset this expense; there is at present no evidence that it will; indeed, current trends seem to be all the other way. There is every reason to hope that the development of the National Health Service will increase the years of healthy life per head of the population, but there is no reason at present to suppose that demands on the Service as a whole will be reduced thereby so as to stabilise (still less to reduce) its total cost in terms of finance and the absorption of real resources.

96. It should not be forgotten, however, that the National Health Service is a wealth producing as well as a health producing Service. In so far as it improves the health and efficiency of the working population, money spent on the National Health Service may properly be regarded as "productive"—even in the narrowly economic sense of the term.

97. But even if it were possible, which we very much doubt, to attach a specific meaning to the term "an adequate service" at a given moment of time, it does not follow that it would remain so for long with merely normal replacement. There is no stability in the concept itself: what might have been held to be adequate twenty years ago would no longer be so regarded today, while today's standards will in turn become out of date in the future. The advance of medical knowledge continually places new demands on the Service, and the standards expected by the public also continue to rise.

98. We conclude that in the absence of an objective and attainable standard of adequacy the aim must be, as in the field of education, to provide the best service possible within the limits of the available resources. It is clear that the amount of national resources, expressed in terms of finance, manpower and materials, which are to be allocated to the National Health Service, must be determined by the Government as a matter of policy, regard being had to the competing claims of other social services and national commitments, and to the total amount of resources available. The development of the National Health Service is one among many public tasks in which objectives and standards must be realistically set and adjusted as time goes on both to means and to needs.

It is still sometimes assumed that the Health Service can and should be self-limiting, in the sense that its own contribution to national health will limit the demands upon it to a volume which can be fully met. This, at least for the present, is an illusion. It is equally illusory to imagine that everything which is desirable for the improvement of the Health Service can be achieved at once.

Our main task

99. It appears to us that the fundamental questions inherent in our remaining terms of reference are:—

(i) In what manner should the money allocated annually to the National Health Service be distributed between the competing needs of each branch of the Service and the various authorities within each branch?

(ii) What form of organisation will most efficiently and most economically provide and control these services?

(iii) By what means can the Health Ministers, Parliament and the public be assured that the Service is providing the best value for money spent?

(iv) Where, if anywhere, is there any opportunity for effecting substantial savings in expenditure, or for attracting new sources of income?

Distribution of available resources

100. As we have already suggested, the total amount of the country's resources to be allocated annually to the National Health Service is, and must remain, the responsibility of the Government, which must relate the needs of the National Health Service to other competing demands.

As it would be impracticable to discuss the distribution of these resources among the various authorities in the National Health Service until it has been decided what form of organisation will use these resources most efficiently and economically, we pass straight on to a review of the administrative organisation itself.

THE BASIC ORGANISATION OF THE NATIONAL HEALTH SERVICE

101. Before examining in detail the services provided under the three branches of the National Health Service, we consider first the basic administrative structure of the Service as a whole and the proposals made to us for radical alterations.

England and Wales

102. Very briefly, the present system of organisation in England and Wales is as follows:—

At the head of the Service is the Minister of Health, advised by the Central Health Services Council and a number of Standing Advisory Committees. In accordance with the National Health Service Act, 1946, it is the Minister's duty "to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services" in accordance with the provisions of the Act.

103. The services provided under the Act (which are available to everyone in the country and are *not* dependent on any insurance qualification) may be divided into three main branches:—

(i) *The Hospital, Specialist and Ancillary Services* provided through the agency of 14 Regional Hospital Boards, 36 Boards of Governors of teaching hospitals and 388 Hospital Management Committees. The Chairmen and members of Boards of Governors and Regional Boards are appointed by the Minister, and the Chairmen and members of Hospital Management Committees by their Regional Boards. The Chairmen and members of both Hospital Boards and Management Committees give their services in a voluntary capacity.

(ii) *The Family Practitioner Services* (i.e., the general medical service, pharmaceutical service, general dental service, and the supplementary ophthalmic service) administered by 138 Executive Councils. The members of the Councils serve in a voluntary capacity, and are appointed by the Minister, the local authority, and certain local professional committees. The Chairman is elected by the members of the Council. There is one Executive Council for each local health authority area except in the case of 8 Executive Councils each of which covers the areas of two authorities.

(iii) *The Local Health Services* (i.e., maternity and child welfare, domiciliary midwifery, health visiting, home nursing, domestic help, vaccination and immunisation, prevention of illness, care and after care, ambulance transport, local mental health services, and health centres) provided by 146 local health authorities—i.e., the councils of counties and county boroughs and the Council of the Isles of Scilly.

These three branches of the Service are described more fully in later sections of the Report where we also outline briefly the public services as they existed before the Appointed Day. For the moment, we are concerned only with the general pattern.

Finance

104. The net cost of the local health services (see (iii) above) is met by the local health authorities themselves with the aid of a 50 per cent. grant from the Exchequer. Most of these services are provided free, but charges may be made for some of them.

The Exchequer finances in full the remaining services except for certain payments made by patients; and for some receipts which are appropriated in aid of the Service, the largest being an annual payment from the National Insurance Fund (£36,218,000 in England and Wales in 1953–54), and the superannuation contributions paid by employers and persons engaged in the Service (£23,597,101 in 1953–54).

Scotland

105. At the head of the Service in Scotland is the Secretary of State, advised by the Scottish Health Services Council and a number of Standing Advisory Committees.

106. The hospital specialist and ancillary services (including clinical teaching facilities) are provided through the agency of 5 Regional Hospital Boards and 84 Boards of Management. There are no separate Boards of Governors for the administration of the teaching hospitals in Scotland. Medical Education Committees have, however, been constituted for each of the 5 Regions to advise the Regional Boards on the administration of the hospital and specialist services in their areas in so far as they relate to facilities for teaching and research. The members of the Committees are appointed in part by the Universities, in part by the Regional Boards and in part by the Secretary of State.

107. The family practitioner services are administered through 25 Executive Councils, and the local health services by 55 local health authorities (i.e., the 31 county councils, (including 2 joint councils) and the town councils of the 24 large burghs). Because of the relatively large number of local health authorities in Scotland, responsibility for the provision of the ambulance services and health centres rests with the Secretary of State and not with the local health authorities. The ambulance service is provided through the

agency of the Scottish Ambulance Service in association with the hospital and specialist services.

108. The finance of the Service in Scotland is organised essentially on the same basis as in England and Wales.

POINTS RAISED IN EVIDENCE

Proposals for Basic Reorganisation

109. In reviewing the basic structure of the Service and proposals for its modification, we have been very conscious of the fact that the National Health Service has been operating for only seven years, and that, in the early years, many of the newly constituted authorities could not reasonably be expected to do more than cope with the flood of day-to-day problems which came before them. The evidence we have had suggests that, only in the last two or three years, have many authorities begun to consider seriously their long-term problems, to make plans for meeting them, to improve co-operation between the various branches of the Service, to effect economies, and to make the best use of the existing administrative machinery. The real test of the present organisation therefore lies not so much in the experience of the last seven years as in the results likely to be achieved in the next seven years. If fundamental changes were now to be made in the administrative structure, new authorities would find themselves faced with new problems and the whole process of adjustment and adaptation would have to be gone through all over again.

110. Moreover, despite certain weaknesses to which we shall refer later, our evidence has made it clear that the Service's record since the Appointed Day has been one of real and constructive achievement. As we have shown in Part I of our Report, the rise in the cost of the Service between 1948 and 1954, when expressed in real terms (i.e., at constant prices), was quite small; while many of the services provided were substantially expanded during this period.

111. We believe therefore that unless an overwhelming case could be made out for any basic reorganisation of the Service, it would be in the best interests of the Service to leave the present administrative structure undisturbed. We might add that this view was shared by the great majority of authorities and organisations who submitted evidence to the Committee.

112. With these considerations in mind, we have examined the following proposals for radical reorganisation of the Health Service:—

(i) That there should be one statutory authority responsible locally for the administration of all the branches of the National Health Service.

(ii) That responsibility for the hospital service should be transferred either immediately or by stages to the local health authorities.

(iii) That the work of Executive Councils should be transferred to the local health authorities or Regional Hospital Boards.

(iv) That the National Health Service functions exercised by the Central Departments should be transferred to a National Board or Corporation.

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Proposed unification of the Health Services

113. Many people, both before and after the Appointed Day, have criticised the tripartite structure of the National Health Service because of

(*a*) the difficulty of integrating the services provided by the three branches of the National Health Service, particularly in relation to the maternity and child welfare, tuberculosis, mental and aged sick services;

(*b*) the danger of duplication and overlapping between the three branches of the Service;

(*c*) the difficulty of adjusting priorities within the Health Service, when three separate administrative organisations—two financed wholly by the Exchequer and the third partly by the Exchequer and partly by the local rates—are responsible for the provision of the services;

(*d*) the danger that the Service may develop into a National *Hospital* Service, with all the emphasis on curative medicine, instead of a National *Health* Service in which prevention will play as important a part as cure.

114. In order to solve these major problems of the Service, some have recommended the appointment of statutory *ad hoc* health authorities, on the lines of the present Regional Hospital Boards, with their members appointed by the Health Ministers(1) and their expenditure financed wholly by the Exchequer. We have been told that these all-purpose authorities would be in a position to ensure that the hospital, family practitioner, and home health services(2) are properly integrated, and that the health services generally are organised and financed in the most efficient and economical way possible. They would, for example, be able to balance the needs of the institutional and domiciliary services without being influenced by such financial considerations as the probable burden on the local rates.

115. Even apart from practical considerations such as the question of the composition of such all-purpose authorities, we consider this suggestion unacceptable because it would remove from the local health authorities their important domiciliary health services and would create a division between different types of public health work at least as unfortunate as the present divisions within the National Health Service. It would, moreover, drive a wedge between the home health services now provided by local health authorities under Part III of the National Health Service Act and the welfare services provided by local authorities under Part III of the National Assistance Act—a division which would, in our view, be calamitous. The aim in future should be to combine the local authority health and welfare functions as closely as possible, and we could not give our support to any recommendation which would seek to tear them apart.

116. For these reasons, we conclude that the only form of major reorganisation which calls for serious discussion is one which would integrate the three branches of the National Health Service without depriving the local authorities of their existing domiciliary health functions—i.e., a reorganisation which would add responsibility for the hospital service and/or the Executive Council services to the present duties of the local health authorities.

(1) We use the term "Health Ministers" throughout the Report to signify the Minister of Health and the Secretary of State for Scotland.

(2) We use the term "home health services" to denote the domiciliary health services (including maternity and child welfare clinics) provided by local health authorities under the National Health Service Acts.

Proposed transfer of the Hospital Service to the Local Health Authorities

117. The witnesses who have argued the case for the transfer of the hospital service to the local health authorities have contended that there is a fundamental weakness in its present administrative structure; namely, that the Regional Hospital Boards and the Hospital Management Committees (Boards of Management in Scotland) who are responsible for managing the hospital service are not responsible for finding the money to finance it, and have no direct responsibility to the electorate for their actions. It is suggested, therefore, that the hospital service should take its proper place with other local health, welfare, and social services under the unified administration of the local authorities whose members are democratically elected by the public, and who can be relied upon to provide an efficient and economical service. This would be in line with the history of the development of the health services in this country, and also in keeping with our tradition of democratic government.

118. These witnesses go on to point out that the present division between the hospital service and the services provided by local health authorities under Part III of the National Health Service Act has had other unfortunate repercussions, e.g.:—

(*a*) Too great an emphasis has been placed on the curative aspects of the Health Service and too little on prevention. The clinicians in the hospital service are said to be taking less and less interest in the social and preventive aspects of ill-health and to be increasingly concerned only with the treatment and cure of disease.

(*b*) It is obviously in the interests of economy and efficiency that, wherever possible, patients should be treated in their own homes by their general practitioners (with the support of the local health authority services) in preference to their being admitted to hospital where the maintenance costs are so high. As the hospital service and the local health authority services are provided through two separate organisations, however, and as the first is financed wholly and the latter only 50 per cent. by the Exchequer, there is no financial stimulus to ensure that developments are carried out where they are most needed, i.e., in the domiciliary services of the local health authorities. Some authorities may be reluctant to develop their home health services and thereby to increase the local rate burden when the avowed intention is to ease the load on the hospital service which is 100 per cent. Exchequer financed. The present administrative structure and its method of finance may therefore be distorting the proper priorities in the development of the National Health Service as a whole.

(*c*) It is difficult to provide an integrated service for patients when responsibility for its provision is divided. In the case of the maternity services, for example, the hospital authorities are responsible for institutional confinements and consultant services; the local health authorities for domiciliary and clinic services; and the Executive Councils for the family practitioner service. In the case of the tuberculosis services, the hospital authorities are concerned with the curative aspects and the local health authorities with prevention. In the services for the aged sick the responsibility is shared between hospital authorities, local health authorities, welfare authorities, and Executive Councils. In the services for the mentally ill and mentally deficient there is division of responsibility again between the institutional and domiciliary services.

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119. All these services it is argued could be organised more efficiently, and to the benefit of the patient, if one authority were responsible for their provision. Moreover, it would then be possible to build up the preventive services to a level which would attract sufficient professional officers of the highest calibre; and to give hospital doctors a better understanding of the socio-medical aspects of ill-health.

120. Again, if the hospitals were transferred to the local authorities, the services of the local authority Treasurer, Engineer, Architect, Legal Adviser etc. would be available to the hospital service as to any other local authority service, with a consequent saving in salaries and staff now duplicated at Hospital Management Committee level.

121. The witnesses who made this proposal appreciated that the finance of a local authority hospital service would present a serious problem. The product of a penny rate in England and Wales is £1,417,798 while the annual cost of the hospital service is in the region of £300 million. Clearly, therefore, the local authorities would not be able to bear this additional financial burden without substantial Exchequer support. One suggestion put forward in oral evidence to the Committee was that the Exchequer might pay to the local authority a unit grant in respect of each hospital bed maintained by the authority, covering a substantial proportion of the total running costs—say 80 per cent. The additional expenditure incurred by the local authority over and above the Exchequer contribution would rank for the present 50 per cent. Exchequer grant. The poorer authorities would be further helped through the operation of the Exchequer Equalisation Fund.

122. For the planning of a local authority hospital service, it was suggested to us that Joint Authorities should be appointed regionally to decide how and where the hospital services should be developed in the Regions. Once a decision had been reached by the Joint Authority (e.g., to construct a new hospital) the local authority of the area in question would be responsible for providing the building; and the costs, both capital and current, would be shared by all the authorities whose ratepayers made use of the beds. Capital works would of course be financed by loan.

The contrary view

123. The great majority of our witnesses, however, while admitting the existence of many of the difficulties mentioned above, have firmly maintained that the time is not ripe for any radical alteration in the structure of the hospital service; that the present problems are mainly "teething troubles" in the development of a new service; and that they can be solved without transforming the whole structure of the service. These witnesses have also pointed out that:—

(i) Local authority areas in general are wholly irrelevant to the administrative needs of the hospital service.

(ii) The local authority record of hospital management bears out the contention that local authority services are always uneven in standard. The present administrative structure has greatly improved and levelled up the general standard of hospital services throughout the country.

(iii) Past experience suggests that a system of administration based on Joint Boards and constituent local authorities would be unlikely to work efficiently or smoothly, particularly in planning the development of a hospital service. In the past, Joint Boards themselves have been labelled "undemocratic"; lacking in financial responsibility; and too far removed from the influence of the rate-payers.

They have also been criticised for separating the services entrusted to them from the rest of the main machinery of local government.

(iv) In the interests of sound local government, local authorities should retain at least a 50 per cent. stake in the cost of any service provided by them. In the case of the hospital service, this would involve an intolerable burden on the local rates which could not be contemplated at least without some radical reorganisation of local government finance.

(v) The difficulties arising out of the existing tripartite structure of the Service have been greatly exaggerated, and there is no reason to believe that they would be eliminated by handing over administrative responsibility for two or more branches of the Service to the local health authorities.

(vi) The professions would not welcome any proposal to transfer the hospital service to the local health authorities (cf. the following extract from Dr. Rowland Hill's evidence before the Select Committee on Estimates[1]:

> "The relationships between our profession in the past and local authorities in many parts of the country have not always been of the happiest, especially in the hospital world. Local authorities, of course, were very new owners of hospitals, and if it had not been for the war and the National Health Service our relations with local authorities, as the years went by, might have grown happier. It is true to say that the one thing the medical profession dreaded before 1948, and this applies to general practice as well as to hospitals, was the dread that they would find themselves placed under the local authorities. That dread might have been ill-founded and in the passage of some generations might have been shown to be ill-founded, but on that date it is a fact that it was a deep fear."

124. We have also noted that some local health authorities are themselves opposed to the proposed transfer, and that others would prefer to postpone any decision on this question until it is known to what extent local government is likely to be reformed in the foreseeable future, and how far their finances are likely to be reorganised.

Our own view

125. We do not feel that a convincing case has been made out for transferring the hospital service to the local health authorities. It seems to us that the present tripartite structure of the National Health Service has much deeper roots than the Acts of 1946 and 1947. It is in the main the outcome of the evolution of medical and social services in this country during the last hundred years; and we do not believe that radical changes in the structure of the National Health Service would be the right way of seeking to solve the undeniable problems which arise from this division of functions. We think that these problems can and will be solved by less drastic measures if the Service is given a period of stability. Habits of co-operation need time to grow and in so far as they are at present weak, we believe that the cause lies in the newness of the Service, rather than in any organisational weakness.

126. Moreover, we do not believe that a closer integration of the services would necessarily be achieved simply by unifying the control under one administrative body. Any administrative system has inherent in it the prob-

[1] The Eleventh Report of House of Commons Select Committee on Estimates, H.M.S.O. 1951, page 28.

lem of securing a proper co-ordination of its various parts, and the transfer of statutory responsibility to a single authority will not in itself do much to solve the problem.

127. As for the practicability of the proposal, we doubt very much whether the local authority machine would be able to carry the additional burden of the hospital service. A great deal still remains to be done by the local authorities in the development of their home health and welfare services, and it seems to us that their energies might be expended more profitably in this direction than in attempting to take on the whole of hospital administration in addition. Bearing in mind also that some local authorities themselves would be reluctant to accept responsibility for the hospital service; that the bulk of the medical profession would be opposed to the suggestion; and that the financial burden would be intolerable unless the Exchequer grant were so substantial that it would render local government responsibility merely illusory, we feel confident that, whatever the merits of the proposal, it is not a practical proposition at the present.

128. With further reference to the financial burden, we have noted that the cost of the hospital service, if grant-aided to the extent of 50 per cent. by the Exchequer, would represent on average (on present assessments) an additional rate burden of about 8s. in the £ to the local health authorities in England and Wales. The rate burden could of course be reduced by increasing substantially the rate of Exchequer grant, but we would see no purpose in transferring the service to the local authorities if by far the greater part of the cost were to be borne by the Exchequer.

129. As we have noted above, it has been suggested by some of our witnesses that the question of responsibility for the hospital service should be reconsidered after local authority areas have been reformed and local authority finance reorganised. We cannot believe however that any reform of local government in the foreseeable future is likely to go far enough to affect the issues we are now considering. Some form of regional authority will always be required for the efficient planning of a national hospital service, and if the service were to be managed by the local authorities, Joint Boards (or some similar bodies) would be necessary to carry out this planning function. The service would then be administered through the Health Departments[1], Joint Boards, local authorities, and presumably hospital managing committees. This administrative structure would not be calculated to improve the co-ordination of the service either at the national level or at the officer level "on the ground"; and would simply create new problems in the relationship between Joint Boards and local authorities.

Transfer of certain classes of Hospital to Local Health Authorities

130. Perhaps we should mention at this point the suggestion made by some of our witnesses that all maternity, tuberculosis, chronic sick, and infectious diseases hospitals, and all mental deficiency institutions should be transferred at once to the local health authorities. This suggestion was usually put forward as an interim measure pending the transfer of the whole hospital service to the local health authorities, but there were some who recommended its adoption, whatever the future administrative organisation might be, because it was felt that the unification of these services was necessary in the interests of efficiency and economy and also in the interests of the patient.

131. Whilst appreciating the need for the closest possible link between the domiciliary and institutional aspects of the maternity, tuberculosis, chronic

[1] By the "Health Departments" we mean the Ministry of Health and the Department of Health for Scotland.

sick, and the other services mentioned above, we do not favour the proposal to transfer the hospitals concerned to the local health authorities as it seems to us that the hospital service would be hopelessly disrupted if responsibility for its provision were divided between Regional Hospital Boards and local health authorities.

Proposed transfer of the work of Executive Councils to Local Health Authorities or to Regional Hospital Boards

Transfer to Local Health Authorities

132. Our attention has been drawn to the Report of the Royal Commission on National Health Insurance,[1] published in 1926, which recommended that "Insurance Committees should be abolished and that their work, very much in its present form, pending any remodelling and unification of the Health Services should be handed over to committees of the appropriate local authorities with possibly a co-opted element." The Commission advanced two reasons for this recommendation:—

(i) "Unification of local effort on health services is a consideration that should, in our view, be paramount whatever the success of isolated pieces of machinery that now exist.

(ii) The evidence we have heard convinced us that whatever may have been the position at the outset and whatever the aims of the framers of the Act, in real fact these committees have not now sufficiently extensive or sufficiently improved duties to justify their existence as independent administrative bodies. . . . The duties are now of a routine character and could equally well be performed by the same officials working under the control of the local authority."

After reviewing the functions of Insurance Committees generally, the Royal Commission concluded that the most important duty of the Committees was to enquire into complaints arising from the provision of medical benefit (including the supply of drugs); but the Commission saw no reason why such enquiries could not be made equally well by a Medical Services Sub-Committee appointed by the local authority.

133. Some of our witnesses have maintained that this recommendation of the Royal Commission is as valid today as it was in 1926 in that the Executive Councils, which have succeeded the Insurance Committees, are still largely concerned with work of a routine nature which could equally well be carried out by the local health authorities; while the need still remains to integrate more closely the health work of the local authorities and the family practitioner services.

134. These witnesses have usually agreed, however, that some special provision would have to be made to deal with the complaints brought against doctors, dentists, chemists and opticians, as it might be considered undesirable to have these professional matters debated by the local authorities themselves. One of the suggestions put forward for meeting this difficulty was that these disciplinary cases should be decided by the appropriate Services Committee with a right of appeal direct to the Minister.

135. The great majority of our witnesses, however, have maintained that the Executive Councils are now playing a much more important role in the National Health Service than the Insurance Committees ever did in the National Insurance scheme. The Executive Councils have to deal with a

[1] Report of the Royal Commission on National Health Insurance. Cmd. 2596 (H.M.S.O., 1926).

wider range of functions and with a greatly increased public demand for the family practitioner services. Their statutory duties may appear to be somewhat restricted, but the Councils are suitably placed to take a wide view of the medical services as a whole, and have served as a useful mouthpiece for general practitioners who have been able to feel that they retain a measure of self-government in the Service.

136. It is clear too that the great majority of the medical profession would be strongly opposed to any suggestion involving the transfer of administrative responsibility for the family practitioner services to the local health authorities.

Transfer to the Regional Hospital Boards

137. An alternative suggestion we have heard for integrating at least two of the branches of the National Health Service is that the work of Executive Councils should be transferred to the Regional Hospital Boards. We have been told that one of the most unfortunate results of the National Health Service has been the widening of the gulf between the hospital and the general practitioner, and that the gulf might be bridged by making the Regional Boards responsible for the administration of the family practitioner services. The needs of general practice would then be fully considered regionally in the planning of the hospital and specialist services.

138. Here again, however, the great majority of our witnesses have opposed this suggestion mainly on the grounds that:—

(*a*) The Regional Board areas are quite inappropriate for the efficient administration of the family practitioner services, which operate within relatively small geographical areas;

(*b*) The Boards themselves, being primarily planning and policy-making bodies, are not suitable for taking over the detailed work now carried out by Executive Councils;

(*c*) The general practitioners would not welcome Regional Board control any more than local authority control.

Our own view

139. We agree with the great volume of our evidence which has borne witness to the fact that the existing Executive Council machinery has worked well at reasonably low cost, is fully acceptable to the professions, and should be left broadly intact at this stage. We agree that there is need for the closest possible co-operation between the family practitioner, local health authority and hospital services, in the interests of patients, the profession, and the Exchequer; but we do not believe that this co-operation would be achieved simply by making either of the organisational changes referred to above. The problem of co-operation has been tackled more effectively in some areas than in others and as we have already said, where integration is lacking the reasons are probably to be found more in the personalities concerned than in any defects of organisation. Moreover, so long as the general practitioners are paid under a contract for services, we cannot see any major savings being achieved by changes in organisation.

140. We endorse, therefore, the view of the Cohen Committee on General Practice which says:—

> "The Committee favours the retention of the present method of administering the provision of general medical services through Executive Councils and Local Medical Committees. Five years' experience has revealed no fundamental defect and testifies that the present administrative structure represents a successful evolution from the system of administration which was used in the National Health Insurance scheme before 1948."(1)

141. In later sections of the Report, we deal more fully with the organisation of Executive Councils (paras. 428–443); the vitally important relationship of the general practitioner to the local health authority and hospital services (paras. 504–508, and 616–619); the general question of co-operation between the three branches of the National Health Service and with the welfare services provided by local authorities under Part III of the National Assistance Act (see Parts V and VII of the Report); and the future role of preventive medicine in the National Health Service (paras. 615–622).

The case for a National Board or Corporation

142. The question was raised by one or two of our witnesses whether a Government Department was an appropriate body to administer a National Health Service, and whether a National Board or specially constituted Corporation would direct the Service (and particularly the hospital service) more efficiently and more economically.

143. We are satisfied, however, that a Service which costs the Exchequer more than £400 million per year must be accountable, through a responsible Minister, to Parliament. There is no proper analogy with the nationalised industries which are revenue earning. We have taken note of the comments expressed on this matter in the White Paper of 1944 on "A National Health Service".(2)

> "The exact relation of this proposed body [i.e., the specially constituted corporation] to its Minister has never been defined, and it is here that the crux lies. If, in matters both of principle and detail, decision normally rested in the last resort with the Minister, the body would in effect be a new department of Government . . . If, on the other hand, certain decisions were removed from the jurisdiction of the Minister (and consequently from direct Parliamentary control) there would be need to define with the utmost precision what these decisions were. Clearly they could not include major questions of finance. Nor could any local government authorities responsible for local planning or administration reasonably be asked to submit to being over-ruled by a body not answerable to Parliament."

144. As we see it, the great merit of a National Board, so far as the hospital service is concerned, would be to make possible the interchange of staff between the central body and the authorities at other levels of hospital administration. Some of the difficulties of the present system of administration arise from the fact that the Health Departments are manned by officers of a different service from that administering hospitals at the regional and group levels.

We do not believe, however, that this advantage would justify the appointment of a new Board or Corporation whose constitution alone would pose a host of difficult problems. Nor do we believe that the appointment of a National Board would in itself improve the integration of the health services.

145. As for the local health services provided under Part III of the Acts of 1946 and 1947, we have already made clear our view that these services should continue to be administered by the local health authorities. Moreover,

(1) Central Health Services Council.—Report of the Committee on General Practice within the National Health Service. (H.M.S.O., 1954), para. 28.

(2) Cmd. 6502 (H.M.S.O., 1944), page 13.

we agree entirely with the view expressed in the Government White Paper, quoted above, that such authorities could not be made responsible to a National Board or Corporation for the administration of their health services.

146. We conclude therefore that the Minister of Health and the Secretary of State for Scotland should continue to remain directly responsible to Parliament for the administration of the Health Service.

GENERAL CONCLUSIONS ON THE STRUCTURE OF THE NATIONAL HEALTH SERVICE

147. We believe that the structure of the National Health Service laid down in the Acts of 1946 and 1947 was framed broadly on sound lines, having regard to the historical pattern of the medical and social services of this country. It is very true that it suffers from many defects as a result of the division of functions between different authorities, and that there is a lack of co-ordination between the different parts of the Service. But the framers of the Acts of 1946 and 1947 had not the advantage of a clean slate; they had to take account of the basic realities of the situation as it had evolved. It is also true that even now, after only seven years of operation, the Service works much better in practice than it looks on paper. That it should be possible to say this is a remarkable tribute to the sense of responsibility and devoted efforts of the vast majority of all those engaged in the Service, and also to their determination to make the system work.

148. We are strongly of opinion that it would be altogether premature at the present time to propose any fundamental change in the structure of the National Health Service. It is still a very young service and it is only beginning to grapple with the deeper and wider problems which confront it. We repeat what we said earlier—that what is most needed at the present time is the prospect of a period of stability over the next few years, in order that all the various authorities and representative bodies can think and plan ahead with the knowledge that they will be building on firm foundations.

149. The present National Health Service is both too recent in origin and also bears too much the imprint of the historical circumstances from which it sprang, for any one to be able to do more than make a guess at the lines along which it may be expected to evolve. Those who have spent the greater part of their working lives under quite different conditions—for example consultants serving voluntary hospitals in an honorary capacity; Medical Officers of Health; members of local authorities in charge of municipal hospitals—these and many others have not always found it easy to adapt themselves to the new order of things. Some of the strains and stresses of the National Health Service are attributable to the difficulty experienced by many, who had grown up under the old system, when called upon to operate a service administered on different lines. Longer experience of the working of the Service and the gradual emergence of a new generation may make comparatively simple many things which now appear difficult or impracticable.

150. What is essential is the recognition that the hospitals, the general practitioners and the local authorities have each an indispensable task to fulfil in their respective spheres. They are however each severally only a part of a single National Health Service; and the efficiency of the Service depends not merely on the quality and quantity of the work that each of these branches performs within its own sphere, but on the degree to which they co-operate with one another to accomplish the ends for which the Service as a whole exists.

151. We conclude therefore that no sufficiently strong case has been made out for transferring either the hospital service or the Executive Council services to the local health authorities, nor for transferring the Executive Council services to the Regional Hospital Boards.

In our view, a more important cleavage than the division of the National Health Service into three parts is that between the hospital service and the services provided by the local authorities under Part III of the National Assistance Act, and we come back to this point in Part V of our Report when dealing with the services relating to the care of the aged.

152. Having reached this general conclusion, we now go on to examine in detail the hospital, family practitioner and local health authority services in turn. For each of these services, we shall describe:—

(i) the public services which existed before the inception of the National Health Service;

(ii) the services provided under the National Health Service Acts;

(iii) the main suggestions made to us in evidence for improving the efficiency and economy of the Service; and

(iv) our considered views on those suggestions.

While this may seem at first glance to be a rather lengthy form of presentation, we feel that it will serve a useful purpose to have this material summarised and placed on record in our Report.

PART III

HOSPITAL AND SPECIALIST SERVICES

Brief History Pre-1948

England and Wales

153. Before the introduction of the National Health Service in 1948, there were two distinct systems of public hospital provision in this country—the voluntary hospital and the municipal hospital—each with its own separate origins and traditions. In fact, on the Appointed Day, 1,143 voluntary hospitals with some 90,000 beds were taken over by the National Health Service in England and Wales, and 1,545 municipal hospitals with about 390,000 beds. Of this latter number some 190,000 beds were occupied by patients in mental and mental deficiency hospitals, and there were nearly 66,000 beds still administered under the Poor Law. In Scotland 191 voluntary hospitals with about 27,000 beds were taken over and 226 municipal hospitals with some 37,000 beds.

Voluntary Hospitals

154. The voluntary hospitals varied enormously in size and function, ranging from the well equipped large general hospital (with distinguished specialists and consultants available) to the small cottage hospital served in the main by local general practitioners. A few of the voluntary hospitals could trace their origin back to mediæval ecclesiastical foundations, but the great majority had come into existence since the middle of the 18th century.

Each hospital had its own governing body which usually delegated its management functions to a Chairman, House Governor (or other officers) acting in conjunction with an Executive or House Committee. The medical care of the patient was entrusted to the visiting physicians and surgeons, etc., who jointly comprised the medical staff and acted in an advisory capacity