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

to the governing body. Each governing body planned its own service for the public as it thought best, subject to the conditions laid down by its constitution. Income was of course derived from voluntary subscriptions, donations or endowments, and payments by patients.

Municipal Hospitals

155. The municipal hospital service had developed from a wide variety of sources. There were the hospitals and institutions administered under the Poor Law, and the general hospitals maintained by local health authorities since 1930 under their public health powers. These together represented a very wide service, at every stage of development from the chronic sick wards of the Poor Law Institution to the fully equipped hospital with highly skilled staff. There were, too, the infectious diseases and isolation hospitals, tuberculosis sanatoria, mental hospitals and mental deficiency institutions, many of which were provided through Joint Boards or Joint Committees of the responsible authorities.

At the beginning of 1948, the authorities responsible for providing the municipal hospitals were generally the councils of counties and county boroughs—with the exception of the infectious diseases hospitals which were normally administered by the councils of county boroughs, boroughs, urban districts and rural districts in accordance with schemes drawn up by the county councils. The services were financed from the local rates with some indirect Exchequer assistance through the operation of the block grant to local authorities under the Local Government Act, 1929.

The local authority hospitals were administered through the department of the Medical Officer of Health whose representative at each hospital was a medical superintendent directly responsible to him for the whole administration of the hospital (excluding such matters as finance, building and stores, in which the clerk, steward or engineer of the hospital might be responsible to the local authority's treasurer, clerk, stores purchasing department, or engineer). During the 1930's however there was a tendency to give a measure of direct responsibility to the clerk or steward (and to the matron) for their respective duties, and to give these officers direct access to their opposite numbers at the Town or County Hall.

Charges

156. Local authorities were required to charge patients what they could reasonably afford towards the cost of treatment and accommodation provided (except in the infectious diseases hospitals where the authority had a discretion), and the voluntary hospitals usually followed the same practice. Many people made provision for this liability by joining one of the hospital contributory schemes, which undertook to meet the cost of hospital treatment, etc., in return for a weekly subscription. The total membership of these schemes was about seven million without reckoning dependents; and the voluntary hospitals shortly before the war were deriving from them about one half of their total receipts.

Scotland

157. In broad outline the development of the hospital services in Scotland was similar to that in England and Wales, but in 1948 the voluntary hospitals in Scotland were providing much the bigger part of the institutional service for the treatment of acute medical and surgical conditions. Only at a fairly late period did the local authorities enter the general hospital field, and at the Appointed Day there were less than a dozen local authority general hospitals, practically all of them in the four cities. The tradition of the Scottish voluntary hospitals was to afford free treatment. There had been little

development of the pay bed system; and it was not customary in Scotland to ask the patient in ordinary wards to make a payment towards the cost of his treatment.

Emergency Hospital Scheme

158. This very brief note on the historical background would not be complete without a reference to the war-time Emergency Hospital Scheme which had a considerable effect on the development of the country's hospital services. This Emergency Service was responsible for adding in England, Wales, and Scotland about 65,000 hospital beds, by the erection of new and the extension of existing buildings; also for upgrading many of the surgical and other facilities at hospitals; developing specialised treatment centres; and providing recovery and convalescent homes. Here was the beginning of an organisation which sought to plan the hospital service as an integrated whole and to transform the patchwork of individual hospitals into a coherent regional scheme.

A National Hospital Service.

159. The experience of the Emergency Hospital Service, the results of a survey of the hospitals of the country carried out with the help of the Nuffield Trust, and the influence of the Beveridge Report of 1942, all combined to demonstrate the need and inspire the preparation of plans for the reorganisation of the nation's hospital service. These plans were brought to fruition in the Acts of 1946 and 1947 which transferred most of the hospitals in the country and their staffs, to the Minister of Health and the Secretary of State for Scotland. Less than 300 hospitals, mostly quite small, were disclaimed and remained under private management.

Hospital Services provided under the National Health Service in England and Wales

160. The National Health Service Act of 1946 charges the Minister with the duty of providing, throughout England and Wales, hospital and specialist services " to such extent as he considers necessary to meet all reasonable requirements ".

Under the service, in-patient and out-patient treatment of all kinds is provided, together with consultant advice in the patient's home where necessary. The hospital accommodation provided by the service includes general and special hospitals; maternity accommodation; sanatoria; infectious diseases units; chronic sick hospitals; mental hospitals and mental deficiency institutions; out-patient clinics; and convalescent homes.

161. All hospital property, whether land and buildings or equipment, is vested in and belongs to the Minister. There are in all some 3,200 hospitals (with about 477,000 available beds) and clinics, etc., in the service and a staff of over 320,000 employed whole-time and 70,000 part-time. Further services are provided by contractual arrangement with a number of institutions which remain privately owned.

162. In addition to the provision of drugs when prescribed, various kinds of appliances (e.g., surgical boots, artificial limbs and wheeled chairs) are provided for patients through the hospital service where necessary.

163. Normally patients are referred for hospital treatment by their family doctors, and they may use the hospital service whether they are being treated by their family doctors privately or under the National Health Service. If they are too ill to visit hospital (either by public transport or by ambulance) the family doctor can arrange for a consultant to visit the patient at home.

Where patients use public transport to and from hospital, the travelling expenses may be refunded in cases of hardship, after an assessment of the patient's means by the National Assistance Board.

164. The great majority of patients are accommodated in general wards, but in many hospitals there are a number of " amenity beds " in single rooms or small wards where patients who desire privacy which is not considered necessary on medical grounds may be accommodated for a charge of 6s. or 12s. per day depending on the size of the room. In all other respects, such patients are treated in the same way as patients in general wards, and no charge is made for treatment or normal maintenance.

At some hospitals, a number of " pay beds " are also set aside for the use of patients who prefer to make private arrangements to be treated by a consultant of their own choice. The patient using one of these beds is required to pay the full cost of maintaining it in addition to the fees of the consultant providing the treatment. In most instances there is a maximum limit to the fees that a consultant may charge to patients occupying pay beds.

Of the 477,000 beds provided in the service in England and Wales, only about 6,000 are set aside for use as amenity beds and approximately the same number for use as private pay beds. (See also paragraphs 416–424 below).

Charges

165. Apart from the amenity bed and pay bed accommodation already mentioned, the hospital and specialist services are generally available free of charge to patients under the National Health Service. Charges may, however, be made for:—

(*a*) The supply of appliances of an unduly expensive type or their replacement or repair; or the replacement or repair of any appliance previously supplied which is damaged owing to carelessness.

(*b*) The supply or replacement of dentures and glasses to *out-patients* where the examination or sight testing took place on or after 21st May, 1951.

(*c*) The supply of drugs and medicines to *out-patients* on or after the 1st June, 1952; and the supply, repair or replacement of certain appliances to out-patients ordered or prescribed on or after 1st June, 1952.

(*d*) Private out-patient treatment.

(*e*) Recoveries under the Road Traffic Acts from car users and insurance companies of payments which they are required to make where hospital treatment is required following a road accident.

(*f*) Certain miscellaneous items. (See Appendix 4).

The charges referred to in (*b*) and (*c*) above were introduced by the Acts of 1951 and 1952 and were part of the measures designed to keep the net cost of the Health Service within £400 million per year; in the main they were a corollary to the introduction of similar charges for the general practitioner services. Further information about the hospital charges (showing the people who are exempt, and the income yielded by the charges in England and Wales in 1953–54) is given in Appendix 4.

How the Hospital and Specialist Services are provided in England and Wales

Non-Teaching Hospitals

166. In the case of the non-teaching hospitals, the services in England and Wales are provided through the agency of 14 Regional Hospital Boards and 388 Hospital Management Committees.

Regional Hospital Boards

167. Each Regional Hospital Board is responsible for a Hospital Region whose boundaries were designed to ensure that the Board's services could be linked with a University and its associated medical school or schools. There is one teaching hospital in each of the ten Hospital Regions in the provinces, and 26 teaching hospitals (12 undergraduate and 14 post-graduate) in the areas of the four Metropolitan Hospital Regions. The Regional Boards have no control, financial or other, over the teaching hospitals in their areas, though they have the right to nominate a certain number of members to the Boards of Governors of teaching hospitals. The populations served by the Regional Boards range from 4½ million to 1½ million (approx.). (In Appendix 6 we show the areas of the Hospital Regions in England and Wales and, in Appendix 6A, the estimated population, the number of Hospital Management Committees, the number of hospitals and clinics, and the number of beds in each Region.)

The Minister is responsible for appointing the Chairman of each Regional Board and such other members as he thinks fit after consulting the associated University, organisations representative of the medical profession, the local health authorities in the Board's area, and such other organisations as appear to the Minister to be concerned. (See Part I of the Third Schedule to the 1946 Act). The numbers of members serving on Regional Hospital Boards range from 21 to 31.

Functions of the Regional Hospital Boards

168. Under the general guidance of the Ministry, and in collaboration with the Boards of Governors of teaching hospitals, the Regional Boards are responsible for planning and co-ordinating the development of the hospital and specialist services in their Regions and for generally supervising(1) the administration of the services (particularly in relation to expenditure). Because of their planning responsibilities, the Regional Boards are also entrusted with the duty of drawing up and carrying out (with the Minister's approval) programmes of capital works for all the non-teaching hospitals in their Regions. They also have responsibility for:—

(*a*) appointing the Chairmen and members of Hospital Management Committees;

(*b*) appointing(2) and paying the senior medical and dental staff at non-teaching hospitals; and, since the end of 1952, approving any increases in Hospital Management Committees' staffing establishments within certain broad categories;

(*c*) allocating the Region's maintenance moneys(3) to Hospital Management Committees and approving Hospital Management Committees' estimates of expenditure;

(*d*) making contractual arrangements with institutions outside the service for the provision of additional beds; and

(*e*) running the blood transfusion and mass-radiography services.

Functions of the Hospital Management Committees

169. Under the general guidance of the Regional Hospital Boards, the day-to-day running of the hospitals is entrusted to Hospital Management

(1) For our observations on the development of the powers and functions of Regional Hospital Boards and Hospital Management Committees, see paras. 194 to 231.

(2) Since December, 1952, the Minister's prior approval has been required for additional appointments within certain categories.

(3) Maintenance moneys are the sums allocated to meet the current costs of running the hospitals.

Committees appointed by the Regional Hospital Boards. At present there are 388 Management Committees, each responsible for the administration of a group of hospitals or a single hospital (usually a large one such as a mental hospital or mental deficiency institution) in accordance with regional schemes approved by the Minister. The Management Committees appoint and pay all the staff employed at their hospitals (except the senior medical and dental staff who, as already indicated, are appointed by the Regional Boards), but in recent years have required the Regional Boards' approval to increases in establishments within certain broad categories.

The Chairman of a Hospital Management Committee is appointed by the Regional Hospital Board who also appoint such other members as the Board think fit after consulting with the local health authorities and Executive Councils in the Board's area, the senior medical and dental staff employed by the hospitals in the Hospital Management Committee Group, and such other organisations as appear to the Board to be concerned (see Part II of the Third Schedule to the 1946 Act). The number of members serving on Management Committees ranges from 9 to 28. It is the practise of most Hospital Management Committees to appoint House Committees for each hospital (or a number of hospitals) within the hospital group.

Functions of the Boards of Governors

170. In the case of the teaching hospitals (i.e., those hospitals which, in addition to providing hospital services for patients, also provide clinical facilities for the undergraduate or post-graduate training of medical and dental students) the hospital and specialist services are provided through the agency of 36 Boards of Governors who are directly responsible to the Minister for the management and control of the teaching hospitals in the country.

In general, therefore, the Boards of Governors combine the functions of a Regional Board and a Management Committee. They carry out their own capital works and expend their maintenance moneys in accordance with estimates approved by the Ministry, and are responsible for appointing their own staff. In recent years, the Boards have required the Ministry's prior approval to the appointment of additional staff within certain categories.

The Minister appoints the Chairman of each Board and such number of other members as he thinks fit. A certain proportion of the members are nominated by the University with which the hospital is associated, by the Regional Hospital Board, and by the medical and dental teaching staff of the hospital; the remainder being appointed by the Minister after consultation with such local health authorities and other organisations "as appear to the Minister to be concerned" (see Part III of the Third Schedule to the 1946 Act). The number of members serving on a Board of Governors at present varies from 16 to 30.

Voluntary service of members

171. All the members of Boards of Governors, Regional Hospital Boards and Hospital Management Committees give their services in a voluntary capacity and receive payment only for loss of earnings and additional expenses incurred in attending meetings etc., and for their travelling and subsistence expenses.

The Ministry's role

172. We have been told that, since the introduction of the Service, it has been the Ministry's aim to allow Boards and Committees a wide measure of autonomy in the administration of hospitals, subject always to the Minister's overall responsibility to Parliament. The Minister issues memoranda of

guidance to Hospital Boards and Management Committees; and officers of the Ministry regularly meet the Chairmen and senior officers of Regional Boards and the senior officers of Boards of Governors for discussions on matters of general interest.

Other Hospital functions

173. Certain functions relating to the hospital service remain outside the financial responsibility of the hospital authorities. The more important of these are:—

(i) *Acquisition of land and buildings.* The power to acquire land and buildings is reserved to the Minister, though proposals usually originate with the hospital authorities concerned.

(ii) *War Pensioner Hospitals and various related services.* The Ministry are responsible for the direct administration of the hospitals which were formerly administered by the Ministry of Pensions; also for the provision of artificial limbs etc., supply and upkeep of invalid tricycles (formerly provided by the Ministry of Pensions on an agency basis for National Health Service patients).

(iii) *Public health laboratory service.* This service, which is distinct from the pathological laboratories in hospitals, is provided by the Medical Research Council on an agency basis. It is intended to assist in the diagnosis, control and prevention of infectious disease. Its work includes the bacteriological examination of specimens in laboratories established throughout the country and is carried out in close co-operation with Medical Officers of Health.

(iv) *Area nurse training committees.* Under the Nurses Act, 1949, responsibility for nurse training arrangements is now vested in committees answerable to the General Nursing Council. There is one Committee for each regional hospital area with financial responsibility for tutorial expenses.

(v) *State Institutions.* Broadmoor Institution and the Rampton and Moss Side Hospitals for Mental Defectives with dangerous or violent propensities are administered directly for the Minister by the Board of Control.

How the Hospital and Specialist Services are provided in Scotland

174. There are five Regional Hospital Boards in Scotland serving populations varying from 2,800,000 in the Western Region to 190,000 in the Northern Region;(1) in four of the Regions there is a university medical school, the fifth Region being based for geographical reasons on Inverness. At the commencement of our hearings the membership of Regional Boards varied from 30 in the Western Region to 17 in the Northern Region, but by April, 1955, when a three-year programme of reduction in the size of the Boards had been carried out, membership varied from 24 in the Western Region to 15 in the Northern, North-Eastern and Eastern Regions.

There are at present 84 Boards of Management, the number of hospitals under the control of individual Boards ranging from one to seventeen. The Boards administer some 400 separate hospitals and institutions, with about 64,000 available beds and a staff of approximately 45,000 employed whole-time and 9,000 part-time. The members of Boards of Management are appointed by the Regional Hospital Boards in the same way as the members

(1) In Appendix 7, we show the areas of the Hospital Regions in Scotland; and, in Appendix 7A, the estimated population, the number of Boards of Management, the number of hospitals and clinics, and the number of beds in each Region.

of Hospital Management Committees in England and Wales; Chairmen of Boards of Management are however elected by the members themselves from their own number.

There are in Scotland no separate Boards of Governors for the teaching hospitals, teaching hospitals being administered by Regional Hospital Boards through Boards of Management in the same way as other hospitals. To advise Regional Hospital Boards on the administration of the hospital and specialist services in their areas, so far as they relate to facilities for teaching and research, the Scottish Act of 1947 provides for the constitution of Medical Education Committees. There are no corresponding bodies in England and Wales. The members of the Committees (who elect their Chairman from among their own membership) are appointed partly by the associated University, partly by the Regional Hospital Board and partly by the Secretary of State.

175. Apart from the significant difference in the Scottish method of administration of the teaching hospitals the general organisation of the hospital and specialist services is substantially the same in Scotland as in England and Wales. The Regional Hospital Boards in Scotland have, however, a somewhat different role from the Regional Hospital Boards in England. They act as agents of the Secretary of State in the provision of hospital and specialist services; they also act as principals in relation to Boards of Management, who are responsible to them generally for the management of the hospitals. Broadly the functions of the Regional Boards may be looked upon as serving two main purposes—the manipulation of resources (hospital facilities, specialists, highly specialised equipment and certain auxiliary services) that need to be deployed on a regional basis; and the control of expenditure generally.

There is no separate Public Health Laboratory Service in Scotland, laboratory services being provided by the Regional Hospital Boards as part of the hospital and specialist services. Blood transfusion services are provided by the Scottish National Blood Transfusion Association, a voluntary body working in association with the Regional Hospital Boards through a series of Regional Committees; practically the whole of the Association's expenditure is met by advances from the Exchequer.

HOSPITAL STAFFING

Control of establishments in England and Wales

176. Preceding paragraphs of the Report have described how responsibility for the appointment of hospital staff in England and Wales is shared between Hospital Boards, Boards of Governors and Hospital Management Committees. The staff themselves are not employed directly by the Ministry and are not therefore civil servants. Their rates of pay and terms and conditions of service are settled by negotiation between the Management and Staff Sides of the appropriate Whitley Councils, and hospital authorities may not depart from these agreed rates without the authority of the Minister. Table 14 in Part I of our Report shows the growth in the number of staff employed in the hospital service in England and Wales since the Appointed Day.

177. The expenditure of hospital authorities on salaries and wages accounts for more than 60 per cent. of the total cost of the hospital service. In the latter part of 1950 therefore the Ministry decided, as one of a number of measures designed to secure economies in the service, to carry out a review of hospital staffs with the object of fixing establishments in four main categories—namely medical and dental, nursing, administrative and clerical, and

domestic and catering staff. The review was conducted by small teams of experts who visited hospital authorities and submitted recommendations to the Minister to enable him to determine the appropriate establishments for each authority.

A very thorough review of administrative and clerical staff has now been completed, and the establishments which have been approved as a result of its recommendations show a reduction of approximately 3 per cent. in the previous establishments, i.e., in relation to the services as they existed when the review was carried out. In addition, a substantial number of staff have been regraded by agreement with the authorities concerned, following the recommendations of the review teams. This does not suggest that there was any large inflation of clerical and administrative staffs at that time. Any increases in the approved establishments now require the prior authority of the Regional Hospital Board in the case of Hospital Management Committees, and by the Ministry in the case of Regional Hospital Boards and Boards of Governors.

In the case of staffs other than administrative and clerical, it soon became apparent that a detailed review of each hospital staffing arrangement would take a very long time indeed if it were to be carried out only by teams sent out from the central department. It was decided therefore that the task of reviewing the staffs of Hospital Management Committees should be entrusted to Regional Boards,(1) and that direct reviews by central investigating teams should be restricted to the staffs of Regional Boards and Boards of Governors themselves.

178. Before making any increase in the establishments of staff (other than administrative and clerical) as they existed at 5th December, 1952, all hospital authorities are now required to seek the prior authority of the Ministry (in the case of Regional Boards and Boards of Governors) and of the Regional Boards (in the case of Hospital Management Committees). For the purpose of these controls, the staffs concerned are grouped into four broad categories:—

(*a*) medical and dental staff of the grades of consultant, senior hospital medical officer, senior hospital dental officer, senior registrar and registrar (i.e., the senior medical and dental staff for whose appointment Regional Hospital Boards and Boards of Governors are responsible);

(*b*) other medical and dental staff (i.e., for whose appointment Hospital Management Committees and Boards of Governors are responsible);

(*c*) nursing and midwifery staff;

(*d*) all other staff (i.e., other professional and technical staff, domestic staff, maintenance staff, etc.).

179. In December, 1952, hospital authorities were also asked to review their establishments to effect any possible reductions within these categories generally; and to counter-balance any necessary increases in staff by effecting reductions elsewhere. In particular, in the case of staff employed in category (*d*) above, the Ministry suggested that hospital authorities should aim at a reduction of 5 per cent. in the numbers employed by October, 1953, where this could be effected without detriment to the service provided for patients.

180. One of the results of the staffing controls is that Regional Hospital Boards and Boards of Governors cannot now make any additional consultant appointments without first obtaining the approval of the Ministry.

(1) For our observations on the powers and functions of Regional Hospital Boards, see paras. 194–231.

POINTS RAISED IN EVIDENCE

Proposed Merger of Boards of Governors and Regional Hospital Boards in England and Wales

181. One of the major suggestions put forward by some of our witnesses for the reorganisation of the hospital service was that the service would be administered more economically and more efficiently if the Regional Hospital Boards in England and Wales were made responsible for the teaching as well as the non-teaching hospitals in their Regions. The reasons put forward in support of this suggestion include the following:—

(i) The planning and integration of the hospital and consultant services in the Regions would be greatly facilitated if the service were managed by only one Hospital Board instead of by two or more Boards as now. In some of the smaller provincial Regions in particular, the teaching hospital may be providing the general hospital services for an important section of the Region, and it is an embarrassment to the Regional Board that the management of those services should be in the hands of a separate Board of Governors. We have been told for example of cases where teaching hospitals have gone ahead with capital development schemes without considering the needs of the regional service as a whole.

(ii) The average costs of maintaining patients in teaching hospitals are very much higher than those of the non-teaching hospitals, and this could be held to indicate that the teaching hospitals are receiving more than a fair share of the available resources. Moreover, the maintenance costs of the teaching hospitals in Scotland (where the teaching hospitals are already administered by the Regional Boards) are considerably lower than their English counterparts. The following figures for the year 1953–54 have been quoted in support of this contention:—

1953–54

	England and Wales			Scotland	
	London Teaching Hospitals	Provincial Teaching Hospitals	Non-Teaching General Hospitals	Teaching Hospitals	Non-Teaching Hospitals
	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.
Average weekly *cost of maintaining an in-patient in 1953–54	22 18 7	17 11 4	13 13 4	14 10 4	11 15 8

* Too much reliance must not be placed on these figures as giving an accurate representation of the true weekly costs of maintaining an in-patient; even after notional adjustments have been made to exclude the cost of out-patient departments, and to correct for the vacant bed factor the figures can only be regarded as approximations. They do, however, afford a reasonably satisfactory picture of the relative order of magnitude of the costs of teaching as compared with non-teaching hospitals.

(iii) There would be a more even spread of medical knowledge throughout the Regions and a better distribution of medical and nursing manpower in an integrated service administered by one Regional Board. An unfair proportion of doctors and nurses appear to be now attracted to the teaching centres. The special needs of the teaching hospitals and universities would not be overlooked by the Regional Boards; and, if necessary, special arrangements could be made to safeguard their teaching functions (c.f. the position of the Medical Education Committees in Scotland).

(iv) The teaching hospitals tend to skim off the cream of the clinical work in the Regions, and show too little interest in the care and treatment, e.g., of the chronic sick.

(v) The costs of administration would be reduced if one Board were responsible for all the work now carried out by the Regional Hospital Board and the Board of Governors.

The contrary view

182. On the other hand, we have heard a great volume of evidence supporting the separate status of the teaching hospitals, mainly on the following grounds:—

(i) The teaching hospitals are concerned not only with the care and treatment of the sick, but also with the undergraduate and post-graduate training of medical and dental students, and with research and "innovation"—i.e., the development and application of new methods of diagnosis and treatment. It is inevitable therefore that their running costs and staffing establishments should be higher than those of the non-teaching hospitals; that medical and nursing staff should be attracted to the teaching centres; and that problems of teaching hospital administration should differ from those of the regional hospitals.

(ii) If the teaching hospitals were administered by the Regional Boards, their power to select patients—a power which is vital to their teaching function—would be gradually whittled away. As one of our witnesses said "The admission of patients to the teaching hospital should be selected and controlled with a view to securing a good variety of types of disease, including those which provide the most suitable illustrations of physiological and pathological principles to students in the early stages of their clinical courses." Regional Boards, being primarily concerned with the treatment of the sick, would be under very great pressure to admit patients to the teaching hospitals to relieve the pressure on the non-teaching beds, even though the patients in question were not of the type required to meet the needs of the teaching centres.

(iii) The Regional Boards already carry a considerable administrative burden under the present division of functions, and have a great many problems of their own to solve. Their progress would only be delayed if the additional problems of the teaching hospitals were thrust upon them. Moreover, the Regional Boards are less well acquainted with the functions and needs of a teaching hospital than the existing Boards of Governors, who have an intimate knowledge of the hospital staff and of the medical schools. The transfer of administrative responsibility would restrict the teaching hospital's freedom of research and innovation to the detriment ultimately of the whole hospital service.

(iv) In at least one Hospital Region (the North-West Metropolitan) it would be quite impracticable for the Regional Board to take over responsibility for the 14 teaching hospitals in the Region, unless the size of the Region also were reduced; and even so the administrative difficulties would be immense.

(v) Problems arising out of the planning and co-ordination of the regional and teaching hospitals can be overcome by co-operation

between the Regional Boards and Boards of Governors. A new administrative structure is not needed for this purpose.

(vi) The quality of doctors in the Health Service depends first and foremost on the adequacy of the medical education provided in the teaching centres. The high quality of the education now provided is due to the long standing traditions enjoyed by the teaching hospitals. Any merger with Regional Boards would lead to the loss of that individuality and of those special qualities which are vital to the provision of adequate medical education.

(vii) There is no reason to believe that any material savings in administrative costs would be achieved by a merger of the Boards of Governors with the Regional Hospital Boards.

(viii) Our attention has been drawn in particular to the recommendations made in the Goodenough Report(1) which served as a basis for the administrative structure adopted in the National Health Service Act, 1946, so far as the teaching hospitals were concerned. The report defined "adequate facilities" for the training of medical students in the following terms:—

"Clinical facilities provided should cover so far as is practicable the whole field of medical knowledge and be in close proximity to each other if wasteful expenditure of time, labour and money is to be avoided. In selecting cases for admission a teaching hospital must have regard to teaching requirements."

With regard to the management of these facilities, the Report went on to say—"If a parent teaching hospital is to function efficiently as an institution for medical education and is to work in close association with the medical school, certain administrative conditions must be satisfied. The first is that the governing body of the hospital shall acquire an intimate knowledge of the institution and its staff. Such a governing body must be personal to the hospital . . . The facilities required for successful teaching will not readily be provided if the management of the hospital is in the hands of a body administering a number of hospitals and having to act on principles applicable to all."

By establishing separate Boards of Governors for the 36 teaching hospitals in England and Wales, the National Health Service Act, 1946, recognised the need for special administrative arrangements for teaching hospitals (because of their dual role), and also for a close administrative link between the medical school and the postgraduate institute which provides the undergraduate or postgraduate teaching and the hospital which gives facilities for that teaching. As already indicated, the constitution of the Boards of Governors provides for a nomination of a proportion of the members by the University with which the hospital is associated, the medical and dental teaching staff of the medical school linked to the hospital, and the Regional Hospital Board in whose area the hospital is situated.

Some of our witnesses have suggested that the principles which led to the acceptance of this administrative pattern in 1946 are as valid now as they were then, and that subsequent experience has proved the desirability of preserving the separate administration of these important teaching centres.

(1) The Report of an Interdepartmental Committee on Medical Schools. H.M.S.O., 1944.

Our own view

183. We do not feel that a convincing case has been made out for transferring the teaching hospitals to the Regional Hospital Boards.

It seems to us that one of the dangers of a national hospital system lies in over-standardisation and uniformity. There is a distinct advantage therefore in preserving the separate status of the teaching hospitals outside the Regional Hospital Board framework. In the past, the great advances in medical techniques and knowledge have come from the teaching centres, and these benefits have accrued thereafter to the non-teaching hospitals. In our view, it would be a short-sighted policy now to subordinate these institutions upon which so much depends for the future development of the service, to the Regional Hospital Boards. The medical and nursing standards of the whole service are set by the teaching hospitals who send out trained staff to work in the regional hospitals. It is entirely fitting therefore that the standards of the teaching hospitals themselves should be maintained at the highest possible level.

184. If the teaching hospitals continue to maintain the standards and the reputation to which they are in our view entitled, it is inevitable that they will attract medical and nursing staff more readily than the non-teaching hospitals, whatever administrative system is adopted. This is a fundamental characteristic of the teaching hospital and is not the result of their separate administration under Boards of Governors. So far as the nurses are concerned, we have been told that some might refuse to take up employment in the service if an appointment could not be secured with a teaching hospital, while it does not follow that nurses deliberately diverted from teaching hospitals would necessarily accept posts elsewhere.

185. The special role of the teaching hospitals, however, does not imply that the Boards of Governors should work in isolation from the other authorities providing services under the National Health Service Acts. Nor should they resent the same careful examination of their annual expenditures as that carried out with other hospital authorities, to ensure that good value is received for money spent, and that savings are effected both in money and manpower wherever possible.

186. From the evidence we have heard, it is clear that some Boards of Governors and Regional Hospital Boards have solved the problem of co-operation satisfactorily and are planning their services and working together in very close harmony.(1) Relations in other areas are not so harmonious, and where this is the case, there is evident need to ensure that the services of teaching and non-teaching hospitals are developed together to their mutual advantage. This is not a question of machinery, but of the will to co-operate, and we consider it a matter of very great importance that all Boards of Governors and Regional Hospital Boards should do their utmost whether through the use of Joint Committees or other means, to effect a smooth administration of the hospital service as a whole.

187. The introduction of a more satisfactory system of hospital costing should make it possible to throw more light on the relatively high running costs of the teaching hospitals in England and Wales—particularly the London teaching hospitals. So far as the actual control of expenditure is concerned, however, we do not believe that the Regional Hospital Boards would be any better placed than the Ministry to make the annual allocations of money to

(1) We welcome in particular the arrangements for seconding nurses from the teaching to non-teaching hospitals to help meet staffing shortages: e.g., in the treatment of patients suffering from tuberculosis.

the teaching hospitals and to examine their annual running costs. The Ministry is in a position to weigh the needs of one teaching hospital against other teaching hospitals in the service, while many Regional Boards would be judging the disparate needs of one teaching hospital against a large number of non-teaching hospitals in their Regions. In our view therefore it is appropriate that the Ministry should continue to carry out this function in preference to the Regional Boards. When a more satisfactory system of hospital costing is in operation, it will give Boards of Governors, in conjunction with the Ministry, a better opportunity for examining their detailed running costs in order to ascertain the precise reasons for their excess over the corresponding costs of other hospitals in the service and for seeing whether the excess is entirely justified. It has been put to us that in the past some Boards of Governors have not taken this matter as seriously as they might—perhaps because the existing Costing Returns have been regarded as inadequate for the purpose of carrying out any realistic comparison of costs. There can be no doubt that the relatively high costs of the teaching hospitals are a source of irritation to, and criticism by, many Regional Boards and Management Committees, and the onus lies on the Boards of Governors to prove that the whole of their expenditure is in fact fully justified.

188. In short, while we support the separate administration of teaching hospitals through the Boards of Governors, we would stress that their separate status brings with it a heavy responsibility both for the fullest co-operation with other organisations in the Health Service and for the most efficient and economical management within the teaching hospitals themselves. If the teaching hospitals are to justify their special position, they must demonstrate, as a number of them already do, both their willingness to co-operate with the Regional Hospital Boards in fulfilling their obligations to the Regions in which they are placed and also their determination to keep expenditure within reasonable bounds.

189. The comment is often heard that the teaching hospitals in Scotland are already administered by the Regional Hospital Boards; that their running costs compare favourably with those of the non-teaching hospitals in Scotland; and that this arrangement has been working satisfactorily since the Appointed Day. Why therefore, it has been asked, was a similar arrangement not adopted in England and Wales in 1946? The main answer to this is that in at least three of the five Hospital Regions in Scotland, a high proportion of hospital beds at the Appointed Day was in the teaching hospitals; and if the administration of those hospitals had been entrusted to separate managing bodies, the Regional Boards concerned would have been left with little or nothing in the way of hospital services to administer. In England and Wales, on the other hand, even the smallest Regions contained hospital resources outside the teaching hospitals sufficient to provide responsibility for a Regional Board.

190. There is a difference of opinion whether or not the standards of the Scottish teaching hospitals, as compared with those in England and Wales, have suffered as a result of their administration by Regional Boards, e.g., by hindrance of their teaching and research functions, and by reductions in capital and maintenance allocations to a more uniform standard. Some hold the view that progress in the Scottish teaching hospitals has not been hampered in the least by the administrative structure; some hold a contrary view; while others maintain that, although some developments in the teaching hospitals have been postponed in favour of developments of more immediate advantage to regional hospitals, the causes are to be found in the general

financial stringencies of the service and not in the form of organisation adopted. We believe, however, that in any case the historical background to the Scottish and English services differs so widely that it would be unwise to attempt to draw conclusions from the Scottish service for application to the hospital service in England and Wales.

191. We have examined in detail an analysis of the running costs of one of the London teaching hospitals and compared them with those of a Scottish teaching hospital; but the breakdown of the figures available was insufficient to enable any firm conclusion to be reached about the relative efficiency of the way in which money was expended in the two hospitals. It was encouraging to note, however, that the two hospitals concerned had themselves taken the initiative in making this examination, with a view to finding out the precise reasons why the running costs of the English hospital exceeded those of the Scottish hospital. It is by constant enquiries and comparisons of this sort that hospital authorities will, in the end, be able to pinpoint the reasons for abnormally high expenditure in a hospital unit, and discover whether there are any means of effecting real and lasting economies. A better system of hospital costing will undoubtedly assist the hospital authorities in this task.

192. With regard to the general trend of hospital running costs since the Appointed Day, we have already pointed out in Part I of our Report (para. 28) that the running costs of the teaching hospitals in England and Wales (excluding the cost of consultants and specialists) have increased at a rate lower than that of the non-teaching hospitals. It is impossible to say, however, to what extent this trend would have been changed if the cost of consultants and specialists could have been allocated to the relevant hospitals. In any event, until some standard is available in the hospital service for relating administrative efficiency to the cost of the services provided, it will be impossible to judge the relative efficiency of management of the teaching and non-teaching hospitals. We return to this point in paragraphs 334 to 367 of our Report.

Conclusion

193. Accordingly we recommend that the teaching hospitals in England and Wales should continue to be administered by Boards of Governors appointed by, and responsible to, the Minister of Health.

We might add that the great majority of our Scottish witnesses favoured the existing system whereby the teaching hospitals in Scotland are administered by Regional Hospital Boards, and we do not desire to make any recommendation for the reorganisation of the service there in this respect.

Powers and Functions of Hospital Boards and Management Committees in England and Wales

194. Most of the witnesses who have represented Hospital Boards, Management Committees and others concerned in the running of the hospital service have been satisfied that the powers of Boards and Committees are adequate to enable them to carry out efficiently their functions under the National Health Service Acts; but they have all regretted that they are unable to exercise their powers to the fullest extent because of the controls imposed centrally by the Ministry of Health and regionally by the Regional Boards. It is not surprising that, in a service of this kind where statutory responsibilities are so loosely defined, there should be wide differences of opinion as to the amount of control which should properly be exercised at each level of management, i.e., at the level of the Ministry, Regional Boards, Management Committees and House Committees in the case of the non-teaching hospitals,

and the Ministry, Boards of Governors and House Committees in the case of the teaching hospitals. Nor is it surprising that each level of management should urge the one above to loosen its controls and to leave more responsibility to its agents. A problem which is common to all large organisations is how to devise a measure of control and supervision over a national service which will ensure that the public are provided with an efficient service at a reasonable cost; and yet without stifling the initiative or restricting too closely the responsibilities of those who are providing the service "on the ground".

Before going more fully into this matter, we wish to review the history of events in the hospital service since 1948, as revealed by our evidence.

195. Our attention has been drawn first to the statements made by the Government in 1946 when the National Health Service Bill was being debated:—

Hansard: Vol. 422, *No.* 128, *Col.* 208. "This scheme provides that the regional boards with their local management committees are to enjoy a high degree of independence within their own field."

Hansard: Vol. 422, *No.* 128, *Col.* 209. "Moreover, the boards, and under them the hospital management committees, will have a very considerable amount of financial freedom so far as administration is concerned. At the beginning of each financial year they will prepare their annual estimates. Their budget of course will have to secure approval, but when once it has been approved, it will be for the Board to spend the money, put at their disposal by the Exchequer, as they think best, up to the limit of the sum that has been approved. There will be a wide discretion concerning that global sum, and not, as some critics tell us, central control over the detailed items of financial expenditure."

Standing Committee C, starting 15.5.46, *Col.* 77. "All kinds of devices are to be provided in order that these administrative bodies, the management committees and the house committees of the hospitals, and the regional boards, shall have very considerable elbow room."

Hansard: Vol. 426, *No.* 185, *Col.* 469. "... the central principle of the Bill, under which the House places on the Minister the responsibility of these services, inevitably means that he must have agents. Every single instrument must be an agent, because when any instrument ceases to be an agent, the contract is broken. Having established that principle, it is then necessary to provide that the central responsibility which the House places upon the Minister to provide a service, does not result in the service becoming too highly centralised in its administration. That is precisely what the scheme provides. It provides for the establishment of Regional Boards; it provides for management committees and for house committees. In fact, the scheme, right through, provides for measures of decentralisation, so that individuals in a locality can have as much influence as possible over the medical and hospital services."

196. These intentions were repeated in early circulars issued to the hospital authorities by the Ministry and it is clear that many authorities assumed from these statements that they would be granted a high degree of freedom of administration, and that the hospital service (being financed by the Exchequer) would be able to call on unlimited resources to make good its deficiencies and to provide all necessary developments.

197. When supplementary estimates were presented in the first two financial years of the hospital service, however (£22 million in 1948–49 and £45 million in 1949–50) and when they were followed by the economic crisis and the rearmament programme in 1950–51 and 1951–52, a number of

measures were taken centrally by the Ministry to tighten up the financial controls in the service and to regulate hospital staffing establishments. These measures, which are described in more detail in paragraphs 177–180 and 267–268 of the Report, had an adverse and discouraging effect upon hospital authorities and particularly upon the Regional Hospital Boards who felt that their position had been undermined by the Ministry's intervention in the financial field. It was this situation which led to the following statement by the Select Committee on Estimates in their Eleventh Report.(1)

"The Ministry of Health must ... either decide to give greater scope to the Regional Hospital Boards than they at present enjoy, or alternatively they must move towards reorganising the service on the basis that the functions of the Regional Hospital Boards are primarily of a planning and advisory nature. The choice between these alternative courses is a major question of policy."

In our view, this period of doubt as to the future role of the Regional Hospital Board did real harm to the service and still continues to colour the views of many of those who have discussed with us the distribution of powers and functions among the hospital authorities.

198. Since 1951, however, there has been a gradual building up of the Regional Hospital Boards both in the financial and other fields. They now receive global allocations annually from the Ministry for distribution as they think best to their Hospital Management Committees; they approve transfers of expenditure between subheads in Hospital Management Committees' accounts, and increases in Management Committees' staffing establishments within certain categories; and also follow up points raised in auditors' reports on Hospital Management Committees' accounts. The Ministry too have tended to work increasingly through the Regional Boards. It is probably truer now than at any time since the Appointed Day to say that the Regional Hospital Boards are generally responsible for the supervision of the hospital services in their Regions.

199. The feeling still lingers among some Management Committees, however, that steps should be taken to reinstate the system originally—and allegedly—envisaged in 1946, and to give a larger measure of independence to the Management Committees subject to the overall planning and guidance of the Regional Hospital Boards. As a result of the financial and staffing controls, and of the search for economies, we have been told that the Regional Boards and the Ministry have interfered progressively in managerial matters which are not primarily their concern. Witnesses have criticised in particular the large number of circulars emanating from the Ministry which have "created a dangerous feeling that everything will be covered by a circular some time or other; ... this feeling will inevitably diminish the sense of individual initiative and responsibility that is an essential prerequisite for successful management." Some witnesses have appreciated that the Ministry's interventions in hospital management were perhaps inevitable owing to the country's financial difficulties in the post-war years, but most of them have expressed the hope that the intervention will be temporary and not permanent. A few have suggested, however, that those Management Committees who complain about the present controls have been slow to learn the lessons of financial "accountability" in a service which is financed out of public funds and for which the Minister is ultimately responsible to Parliament.

(1) Published by H.M.S.O., 1951. See para. 53.

200. Whilst welcoming the improvement in their position since 1951, the Regional Boards generally have criticised a number of controls which are still retained by the Ministry, and in particular :—

(i) the requirement that a Regional Board or Board of Governors must obtain the prior approval of the Ministry to any additional consultant appointment, or to any increase in the clerical and administrative establishment of the Board's own staff. It is suggested that, having decided on the amount of revenue funds to be allocated annually to a Hospital Board, the Minister should leave the question of staffing establishments to the Board themselves since the Ministry cannot be in a position to know all the local circumstances which may lead a Board to make an additional appointment;

(ii) the requirement that Hospital Boards must seek the prior approval of the Ministry to any building works costing more than £10,000 and to any acquisition of land. Boards have pointed out that, under the present procedure, long delays are incurred and work is duplicated while the Ministry examine building schemes first with sketch plans, then with working drawings and bills of quantities, and finally at the tender stage. These delays make it more difficult than ever to control the already complicated capital programmes. Varying suggestions have been made therefore for raising the £10,000 limit for building works to £25,000, £30,000 or £50,000, bearing in mind the heavy increase in building costs since the war. Similar complaints have been made about the delays involved in receiving the Ministry's approval to acquisitions of land and buildings.

201. Differing views have been expressed about the Ministry's practice of issuing circulars to Hospital Management Committees as well as to Regional Hospital Boards, though all have agreed that the numbers of circulars are too great. Some would like to see circulars sent, as in Scotland, only to the Regional Hospital Boards who would be responsible for informing their Management Committees of the matters which affect them. Others see no objection to the circulars being sent direct to the Management Committees, particularly as a large number of them relate to Whitley Council agreements and other matters which must be communicated speedily to Management Committees who are generally responsible for their implementation.

202. Most Regional Boards also criticised the Ministry's procedure (which has since been revised) for following up centrally the recommendations made in auditors' reports on Hospital Management Committees' accounts. We deal with this matter more fully in paragraphs 299–308 of the Report.

203. In summarising these points, however, it would be unfair to leave the impression that the hospital service is full of complaints about the present distribution of powers and functions between the Ministry and the constituent authorities. On the contrary, we have been impressed by the improvement over the years in the relations between the Hospital Management Committees, the Regional Boards and the Ministry, through regular meetings of Chairmen, members, officers, and other means. We have been impressed also by the quality of the evidence submitted by the hospital authorities to the Committee, by the deep interest shown by the witnesses in the future welfare of the hospital service, and by their keenness to search out the most efficient and satisfying means of developing its administration. We have the feeling that all the levels of management now have a much deeper knowledge of each other's problems than they had perhaps

four or five years ago, and that they are learning to live together with a due regard for each other's rights and responsibilities.[1]

Powers and Functions of Regional Boards and Boards of Management in Scotland

204. In Scotland relationships between the central Department, the Regional Hospital Boards and the Boards of Management have developed on somewhat different lines from those in England and Wales. The general functions of the Regional Hospital Boards are defined by regulations, and the functions exercised on their behalf by the Boards of Management in the day-to-day management of hospitals are established in administrative schemes made by the Regional Boards under section 12 of the Scottish Act. From the outset it has been a cardinal point in the administration of the hospital and specialist services in Scotland that the Regional Hospital Board has a general control over the activities of the Boards of Management in its area; and it is significant that the Department of Health for Scotland have never dealt directly with Boards of Management. Thus, while the Regional Hospital Boards have always been looked upon as responsible for the general planning of the hospital and specialist services, they have also had a clear executive function in the general supervision of hospital administration and in particular have been charged with control of the expenditure incurred by Boards of Management. In the early years of the service the control exercised by the Regional Hospital Boards in most Regions was fairly close, but since then the tendency has been for the Regional Boards to put increased responsibilities on the Boards of Management themselves. The Regional Boards are responsible for the appointment of specialists and other senior medical and dental staff; they are also responsible for the appointment of the Secretaries and Treasurers of the Boards of Management and of Medical Superintendents, these appointments normally being made by the Regional Board on the recommendation of a Joint Committee containing an equal representation of the Regional Board and of the Board of Management concerned.

205. Our attention was drawn to a memorandum issued in June, 1952 by the Department of Health for Scotland on the relationship between Regional Hospital Boards and Boards of Management. The underlying object was to provide a reasoned statement of policy concerning matters of administrative machinery, with a view to assisting Regional Boards and Boards of Management to achieve a mutually satisfactory relationship. In Scotland it has always been explicit that in carrying out their functions of hospital management Boards of Management are the agents of the Regional Hospital Boards and are accountable to them. This is the essential basis of this system of financial control; but one of the main purposes of the Department's memorandum was to make it clear that Boards of Management, while answerable to Regional Boards for decisions on expenditure after the event and for keeping within their budgets, were not in the position of agents who decide nothing without prior approval. With this aim in mind the number of heads under which budgets are approved have been reduced in recent years so as to give Regional Boards and Boards of

[1] We have taken note of the following opening paragraph of the recently published Annual Report for the year 1954 of the King Edward's Hospital Fund for London:—

"The years 1953 and 1954 will perhaps go down to history as marking a turning point in the life of the nationalised hospitals in this country. Seen from the standpoint of the King's Fund there can be little doubt that the grave anxieties that hung over the early years of the Service have ceased to look as menacing as they did. It is no longer felt that the cost of the hospitals is getting out of hand, nor is it felt that restraint upon expenditure must inevitably lead to frustration."

Management greater freedom of decision and correspondingly increased responsibility. In the same way specific and detailed controls, such as the control of staff numbers, have been avoided so far as possible.

206. The evidence which we had from Scottish bodies suggests that the existing relationship between the Regional Hospital Boards and the Department of Health for Scotland is on the whole satisfactory. The degree of control exercised in the different Hospital Regions appears to vary. There are indications that some of the larger Boards of Management, particularly those responsible for the main teaching hospitals, consider that their responsibilities tend to be encroached upon by the Regional Hospital Boards. The general tendency of the Regional Hospital Boards, however, has been to relax substantially the controls that they initially maintained, the object being to give the Boards of Management as much discretion and responsibility as possible in carrying out their tasks of day-to-day management, on the understanding that they may be called upon after the event to justify their actions.

Our own view

207. We should make it clear at the outset that we consider two levels of management—i.e., the regional and group levels—to be essential for the efficient administration of a service which deals with more than 3,000 hospitals in England and Wales and some 400 in Scotland. We do not agree therefore with those who have recommended that:—

(*a*) the Regional Boards should be abolished, or

(*b*) that the number of Regional Boards should be increased (e.g., to 40 in England and Wales), and the Hospital Management Committees (and Boards of Management in Scotland) eliminated altogether.

If there were say 40 Regional Boards in England and Wales, it seems to us that their areas would be too small for efficient planning and yet much too large for the efficient management of hospitals. The service undoubtedly requires both regional authorities covering areas large enough for purposes of planning and general supervision, and also group management authorities with responsibility for the day-to-day running of the service.

A further advantage which we can see in the existence of a system of Regional Hospital Boards is the scope which it affords for some measure of variation in the way in which problems of the hospital service are treated in the different Regions. While it is essential that matters of major policy should be determined centrally, it is desirable, in the interest of avoiding excessive uniformity and standardisation that the individual Regional Boards should have adequate freedom both to experiment and to adopt measures which have regard to their own special conditions and requirements.

208. Having accepted the existing structure of the hospital service broadly in its present form, we have now to consider the role which should be played by the Regional Hospital Boards, Hospital Management Committees and Boards of Management in the operation of a national hospital service.

209. Before the Appointed Day, there were two main patterns of hospital management in this country. On the one hand, the local authority hospitals were "managed" by the authority's Medical Officer of Health along relatively centralised lines: not only "general management" but also the specialised services (such as engineering) were centred in the Town or County Hall. Over the local authority the Ministry exercised control and influence to the extent normal in a local government service. On the other hand, the

voluntary hospitals were fully autonomous, each having its own governing body.

210. When the National Health Service was introduced, both these patterns were either partly or wholly displaced. All hospitals are now managed by Committees. None of them is autonomous; all derive their funds ultimately from the Exchequer; and all are accountable for making the best use of these funds. The varying patterns which existed before the Appointed Day have now been moulded into one single national hospital service.

211. We are of the opinion that the primary need now is to give more emphasis, in England and Wales, to the Regional Boards' responsibility for the general oversight and supervision of the service (in addition to their planning functions), though without in any way detracting from the Hospital Management Commitees' direct responsibility for day-to-day management. We agree therefore with the trend which appears to us to have been taking place in the distribution of powers and functions since 1951.

It should be clearly recognised throughout the service in England and Wales that Hospital Management Committees are responsible to their Regional Boards for the efficient administration of their services, and that the Boards in their turn are responsible to the Minister. We understand that this is the system which prevails in Scotland where it has been established both in principle and in practice since the inception of the National Health Service; and we believe that it represents the proper relationship which should exist between these different levels of management and trust. As the Regional Hospital Boards have the task of allocating regional funds between the Management Committees, they must have the knowledge to enable them to make the right allocations, and to satisfy themselves that Management Committees are exercising their functions in a responsible and efficient manner, and that there is no unnecessary expenditure of public funds. We derived from our evidence the strong impression that some Regional Hospital Boards feel that they lack the authority for fulfilling this role, not through any insufficiency of formal powers, but because their responsibility for supervision has lacked both the necessary support from above and the necessary acceptance from below. To some extent this is inevitable in a new service. The acceptance of authority (by which we do not mean dictation) is only one aspect of a relationship which takes time to grow and which, when developed, links the different levels of management in a nexus of mutual dependence. To create this relationship is a major duty of all concerned at every level.

We consider that it is neither necessary nor desirable to define in detail the powers and functions of each level of management. We are confident that Boards and Committees can be relied on to find their own means of striking a balance; and if, exceptionally, they should be unable to reach agreement on any matter, the issue can be referred to the Health Departments for settlement. This is the normal administrative practice in any chain of command; each level of management must learn to "carry along with it" the authorities for whom it is responsible; and in a unified service each level must equally recognise its duty to act responsibly as members of the larger organisation.

212. We conclude that Regional Hospital Boards should be told, and Hospital Management Committees should accept, that the Regional Boards are responsible for exercising a general oversight and supervision over the administration of the hospital service in their Regions. It is a corollary of this recommendation that the Ministry should leave the task of supervising the Hospital Management Committees to the Regional Boards and should not itself undertake this task over the head of the Boards.

Prior approvals

Building works

213. We appreciate the reasons why the Health Departments have found it necessary to require Regional Boards to seek their prior approval to hospital capital developments of appreciable size. The Departments must ensure, for example, that the larger capital works in the service are carried out in accordance with their general policy; that the work itself is planned on sound and economical lines; and that due economy is observed at stages subsequent to the preparation of sketch plans (i.e., in the scrutiny of working drawings, bills of quantities and tenders).

214. Having accepted the approval procedure in principle, therefore, we have directed our minds to the question whether the limit of £10,000 is the right one for the operation of this particular control. Bearing in mind that the figure of £10,000 was originally laid down in 1948, and that building costs have risen substantially since that time; and bearing in mind also the expansion of the hospital capital programme contemplated in the next three years, we would consider that a figure of £50,000 would more truly represent the type of building proposals which will in future warrant detailed examination and prior approval by the central Health Departments. We recommend, therefore, that the limit be raised to £50,000.

215. The control of capital works which has caused us more concern, however, is the additional one which is operated by the Treasury. Under the present procedure, the Health Departments are required to seek the prior authority of the Treasury to all building works costing £30,000 or more; in the early years of the Service this limit was as low as £10,000. This procedure involves the Treasury in the examination of about one-half of the total hospital building work, or an average of about two proposals a week.

The justification for Treasury control of this order appears to be based on a number of considerations. In the first place, this is a relatively new service with no "natural" financial checks (such as exist, for example, in the local authority services), and the Treasury would wish to ensure that there is an effective procedure of scrutiny and that proper standards are established. Secondly, the Treasury, as the central finance department, would desire to feel satisfied that all hospital authorities are fully conscious of the need for the greatest possible economy in the use of the public funds entrusted to them: the examination of individual schemes provides material in at any rate one important direction for assessing the degree of financial responsibility exercised by those administering the service in the Regions. Thirdly, the Treasury can at times bring to bear experience and practice in related fields of public policy.

216. We do not deny that there is substance in these contentions from the standpoint of the Treasury; although we would point out that there is reason to believe that a great deal of time and effort has been expended in the past in briefing the Treasury about relatively small building works and in seeking authority to proceed. There is, however, a further possible type of control—where individual schemes which may raise issues of general health policy are submitted to the Treasury. We were relieved to hear in our evidence that the Treasury does not normally seek to exercise this kind of control, because it seems to us to be open to grave objections. The right point at which the Treasury should bring its influence to bear in such matters is surely in discussion with the Health Departments over the formulation of policy, in so far as this is related to the spending of public money. Once agreement has been reached on the general lines of policy, the Departments should have the full discretion, and of course the responsibility to

Parliament that goes with the exercise of that discretion, to implement the policies which have been agreed upon. We feel that, in the interests of a proper relationship between the Health Departments and the Regional Hospital Boards, it is undesirable that decisions of the Departments on individual schemes, which have been taken in the light of a thorough and expert consideration of all the circumstances, should be liable to be challenged and conceivably over-ridden by the Treasury.

217. Subject to the foregoing observations, our primary concern is whether the existing limit of £30,000 is the right one. We have just proposed that the figure for the submission of schemes by the Regional Hospital Boards to the Health Departments should be raised from £10,000 to £50,000. Having regard further to the increasing scale of capital expenditure in the hospital service; to the desirability of avoiding vexatious and frustrating delays; and to the fact that proposals for hospital building will already have been closely examined at two levels of control, i.e., by the Health Departments as well as by the Regional Hospital Boards; we recommend that the lower limit for the approval of hospital building works by the Treasury be raised from £30,000 to £100,000.

It may be that at some future date these controls can be relaxed still further, if building standards can be laid down centrally for hospital building construction, as they have for the school building programme. We return to this point in para. 315 of our Report when dealing with the question of hospital capital investment.

There can be no doubt that some substantial relaxation in the existing control of hospital capital works will ease the Regional Boards' difficulties in planning their annual capital programmes, and will greatly facilitate the expansion of hospital capital investment which is contemplated in the coming years.

The acquisition of land

218. We have noted the criticism expressed in recent reports of the Public Accounts Committee of cases where Hospital Boards have acquired property for allegedly urgent purposes and have not brought it into use even some years after its acquisition. While we appreciate that, in some instances, the Boards may have felt that they had good reasons for the delay in bringing the properties into use—e.g., owing to their inability to meet the costs of adaptation within their restricted capital allocations—we doubt whether the whole of the delays could be justified on these grounds. It is not an uncommon experience for persons and authorities closely associated with the development of a service to be somewhat over-eager in their purchases of land; and, in our view, there is a good case for the retention for the time being of the existing Departmental and Treasury controls over the acquisition of land and buildings for hospital purposes. We do not therefore make any recommendation for the relaxation of these controls.

There is a further point which we have borne in mind in reaching this conclusion. The total amount provided in the National Health Service Estimates to cover expenditure on the acquisition of land and buildings is strictly limited and is not shared out between the Regional Boards. It is unavoidable, therefore, that the Regional Boards should make out their case for the acquisition of land etc. to the Health Departments. All hospital properties are in fact acquired in the name of the Minister and the Secretary of State.

Control of Hospital Staffing Establishments in England and Wales

219. It seems to us that, in a well established service with an effective budgetary control, it should not be necessary to require managing bodies

Prior approvals

Building works

213. We appreciate the reasons why the Health Departments have found it necessary to require Regional Boards to seek their prior approval to hospital capital developments of appreciable size. The Departments must ensure, for example, that the larger capital works in the service are carried out in accordance with their general policy; that the work itself is planned on sound and economical lines; and that due economy is observed at stages subsequent to the preparation of sketch plans (i.e., in the scrutiny of working drawings, bills of quantities and tenders).

214. Having accepted the approval procedure in principle, therefore, we have directed our minds to the question whether the limit of £10,000 is the right one for the operation of this particular control. Bearing in mind that the figure of £10,000 was originally laid down in 1948, and that building costs have risen substantially since that time; and bearing in mind also the expansion of the hospital capital programme contemplated in the next three years, we would consider that a figure of £50,000 would more truly represent the type of building proposals which will in future warrant detailed examination and prior approval by the central Health Departments. We recommend, therefore, that the limit be raised to £50,000.

215. The control of capital works which has caused us more concern, however, is the additional one which is operated by the Treasury. Under the present procedure, the Health Departments are required to seek the prior authority of the Treasury to all building works costing £30,000 or more; in the early years of the Service this limit was as low as £10,000. This procedure involves the Treasury in the examination of about one-half of the total hospital building work, or an average of about two proposals a week.

The justification for Treasury control of this order appears to be based on a number of considerations. In the first place, this is a relatively new service with no "natural" financial checks (such as exist, for example, in the local authority services), and the Treasury would wish to ensure that there is an effective procedure of scrutiny and that proper standards are established. Secondly, the Treasury, as the central finance department, would desire to feel satisfied that all hospital authorities are fully conscious of the need for the greatest possible economy in the use of the public funds entrusted to them: the examination of individual schemes provides material in at any rate one important direction for assessing the degree of financial responsibility exercised by those administering the service in the Regions. Thirdly, the Treasury can at times bring to bear experience and practice in related fields of public policy.

216. We do not deny that there is substance in these contentions from the standpoint of the Treasury; although we would point out that there is reason to believe that a great deal of time and effort has been expended in the past in briefing the Treasury about relatively small building works and in seeking authority to proceed. There is, however, a further possible type of control—where individual schemes which may raise issues of general health policy are submitted to the Treasury. We were relieved to hear in our evidence that the Treasury does not normally seek to exercise this kind of control, because it seems to us to be open to grave objections. The right point at which the Treasury should bring its influence to bear in such matters is surely in discussion with the Health Departments over the formulation of policy, in so far as this is related to the spending of public money. Once agreement has been reached on the general lines of policy, the Departments should have the full discretion, and of course the responsibility to

Parliament that goes with the exercise of that discretion, to implement the policies which have been agreed upon. We feel that, in the interests of a proper relationship between the Health Departments and the Regional Hospital Boards, it is undesirable that decisions of the Departments on individual schemes, which have been taken in the light of a thorough and expert consideration of all the circumstances, should be liable to be challenged and conceivably over-ridden by the Treasury.

217. Subject to the foregoing observations, our primary concern is whether the existing limit of £30,000 is the right one. We have just proposed that the figure for the submission of schemes by the Regional Hospital Boards to the Health Departments should be raised from £10,000 to £50,000. Having regard further to the increasing scale of capital expenditure in the hospital service; to the desirability of avoiding vexatious and frustrating delays; and to the fact that proposals for hospital building will already have been closely examined at two levels of control, i.e., by the Health Departments as well as by the Regional Hospital Boards; we recommend that the lower limit for the approval of hospital building works by the Treasury be raised from £30,000 to £100,000.

It may be that at some future date these controls can be relaxed still further, if building standards can be laid down centrally for hospital building construction, as they have for the school building programme. We return to this point in para. 315 of our Report when dealing with the question of hospital capital investment.

There can be no doubt that some substantial relaxation in the existing control of hospital capital works will ease the Regional Boards' difficulties in planning their annual capital programmes, and will greatly facilitate the expansion of hospital capital investment which is contemplated in the coming years.

The acquisition of land

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Control of Hospital Staffing Establishments in England and Wales

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to seek the approval of the next higher authority to each and every increase in staffing establishments. In principle, therefore, we accept the view that the control from above of staffing establishments in the hospital service in England and Wales should be relaxed as soon as is practicable.

220. We are satisfied, however, that, for the time being, an exception must be made for the appointment of additional consultants and junior hospital medical staff. The Ministry have a more complete picture than the Regional Boards themselves of the distribution of consultant services both geographically between Regions and between the various specialties. When considering applications for additional consultant appointments, therefore, the Ministry are able to take account of such factors as the uneven geographical spread of consultants and the difficulties arising through a shortage of suitable candidates in particular specialties (e.g., anaesthetics). Moreover, the total number of consultants employed in the service has a very strong influence on the running costs of the service in future years. These seem to us to be convincing reasons for retaining the Ministry's control of additional consultant appointments, at least for the present.

221. So long as it is necessary to retain the central control of consultant appointments, we feel that there are good grounds for some degree of control being exercised also over junior medical staff establishments. For example, the junior medical staff appointed by Management Committees must fit in with the Regional Board's plan for the appointment of senior medical staff and it is appropriate therefore that Regional Boards should have a say in the staffing establishments of junior hospital medical staff.

222. Accordingly we recommend that the existing controls over the appointment of consultants and junior hospital medical staff in England and Wales be retained, but that the controls over other categories of staffing establishments be relaxed as far and as fast as possible.

In recommending the relaxation of certain of the controls, we wish to emphasise the desirability that hospital authorities themselves should carry out reviews of their staffing establishments at regular intervals. Experience has proved the value of systematic reviews of hospital staff[1], and it would be unfortunate if the ground gained were to be lost because of the failure on the part of hospital authorities to undertake these reviews. It is indeed a vital function of any management to keep staffing levels continually under inspection. Whilst we appreciate the reasons why the Ministry found it necessary to send out their own review teams in the early years of the service to fix hospital staffing establishments in certain categories, we do not think it desirable that this practice should be repeated in future. Henceforth, responsibility for ensuring economy in the use of hospital staff should remain fairly and squarely with the Regional Hospital Boards and Boards of Governors—with the proviso that the Boards must seek the authority of the Ministry to any additional consultant appointments.

Staffing controls in Scotland

223. We understand that in Scotland hospital authorities are not required to seek the prior approval of the next higher authority for additional staff appointments, as they are in England and Wales. The control of staffing establishments in Scotland has in recent years been exercised primarily through the amount of finance allocated in the annual budgets. In 1954–55,

(1) At 31st May, 1955, we understand that the review of the clerical and administrative staff showed a saving of 2·8 per cent. in England and Wales, i.e. in relation to the services as they existed when the review was carried out, while a saving of 5·8 per cent. was achieved in the domestic staff of the teaching hospitals in England and Wales in which establishments had been fixed after a central review.

however, we have been told that there was some overspending of hospital estimates, some of which seems to have been attributable to the employment of additional staff for whose salaries no provision had been made in the approved estimates, and it may be that some more specific control will be found to be necessary in this field at least for some time to come. Accordingly we recommend that the Department of Health for Scotland should consider the desirability of adopting a similar procedure to that suggested for England and Wales, at least so far as the appointment of consultants is concerned.

Medical consultation at the Regional level

Regional Medical Advisory Councils

224. We have considered carefully the suggestion that statutory Medical Advisory Councils should be established in all Hospital Regions, and should represent for example, the consultants, the University, the Medical Officers of Health and the general practitioners in the Region. We have been told that, if Regional Hospital Boards are to do effectively the work of planning the medical services in the hospitals throughout the Regions, it is important that they should have the most fully representative medical advice possible. It is contended, therefore, that if Medical Advisory Councils were constituted in all Regions on the lines suggested, the Regional Boards would have available the collective advice of the profession and the Universities, and a useful link would be provided between the hospital service, local health authority services and the general practitioners. Moreover, it is argued that the Regional Boards would then be better equipped to carry along with them the consultants, Medical Officers of Health and general practitioners in their Regions and would have their goodwill and active co-operation in the implementation of the Boards' decisions. Our attention has been drawn in particular to the arrangements which have already been made in the Welsh and Liverpool Hospital Regions where Medical Advisory Councils have been set up by agreement between the Regional Board and the medical profession, the local health authorities, etc.; and we have been informed that these Councils have functioned well and that the relations between the Boards and the consultants in these Regions are more satisfactory than in others where this type of joint consultation is lacking.

225. It seems to us that there are three aspects of this proposal which should be carefully distinguished and considered separately on their merits. There is first the suggestion that the Regional Boards should obtain their advice on medical matters from a body nominated largely, if not wholly by the profession themselves; there is secondly the desire to establish formal machinery to secure adequate consultation between the Regional Boards and the senior medical staff they employ; and thirdly there is the aim to provide a further link between the hospital, local health authority and general practitioner services.

226. On the first of these aspects, there is little doubt that the medical profession would welcome the appointment of statutory Medical Advisory Councils in all Regions in order to ensure that the Boards obtain the collective advice of the profession on all matters affecting the medical side of the hospital service; and this suggestion was strongly supported by representatives of the Royal College of Physicians and the British Medical Association in the evidence they presented to us. In our view, however, this suggestion would seem to be open to a number of objections. In the first place, if the Advisory Councils were composed mainly of persons nominated by the bodies concerned it would mean imposing on the Boards an advisory body which they themselves had not chosen to act as their advisers. Secondly,

there would be no guarantee that the profession would nominate a properly balanced team of persons with the appropriate personal and other qualities. Thirdly, if the Councils were to be mandatory it would be necessary to define their functions and in particular the circumstances in which the Boards would be required to consult them before reaching a decision. Fourthly, if there was a conflict of view between the Board as a whole and its Medical Advisory Council, the Board could find itself in a very embarrassing situation. Although we consider that not all of these objections are of equal importance, there is sufficient weight in them, taken together, to deter us from recommending the establishment of statutory Medical Advisory Councils for all Regional Hospital Boards.

227. On the second aspect, we hold that effective joint consultation is much to be desired in the interest of the smooth and efficient working of the service; and we are not satisfied that the need for making adequate provision for this is sufficiently realised by all the Regional Boards. In our view, it is right that the Regional Boards should discuss their plans and future policies with those who will be largely responsible for carrying them out, and that the profession should have an opportunity of expressing their collective view. Consultative machinery of this sort is as important to the hospital service as it is to any commercial or business undertaking. We appreciate that in the past Regional Boards have consulted with a number of representative bodies from time to time—e.g. the regional consultants and specialist committees of the British Medical Association, and with the Royal Colleges, the Local Medical Committees, and the Regional Liaison Committees (which include the Medical Officer of Health); but we believe there would be much to be said for the setting up of a single consultative committee for each Region to strengthen the link between the senior medical staff and the Regional Hospital Board. We therefore urge the Boards in all Regions to review their arrangements for joint consultation with the profession, and to consider whether medical consultative committees could with advantage be set up at regional level to ensure that decisions on medical matters of wide general import are not taken without proper consultation with those who will be affected by them.

228. On the third aspect of this proposal, we need hardly emphasise the advantages of associating the views of the Universities, Medical Officers of Health and the general practitioners with those of the consultants actually employed by the Regional Hospital Boards. It is perhaps unusual to include representatives of outside interests in consultative committees of this kind; but in this particular instance it is so important to integrate the medical aspects of the hospital, local health authority and general practitioner services, that we feel the inclusion of representatives of the Universities, the Medical Officers of Health and the general practitioners on each regional consultative committee would be of great value. We therefore suggest that Regional Boards should give prominence to this aspect when reviewing their arrangements for joint consultation with the profession.

Issue of circulars

229. We have considered very carefully the complaints made by witnesses about the large number of circulars issued by the Health Departments since the Appointed Day. From an analysis of the circulars issued by the Ministry of Health between 1950 and 1953, it would seem that about one third were concerned with Whitley Council matters (rates of pay, conditions of service etc.) which must be communicated to all hospital authorities in any event; and that the number of circulars concerned with other topics has fallen

steadily since 1950. It has to be borne in mind also that there are many matters which must be passed on to hospital authorities through Ministry circulars because

(*a*) they are of national interest, or

(*b*) they notify authorities of agreements negotiated centrally, or

(*c*) the hospital authorities themselves have pressed for central guidance.

Indeed, many of our witnesses have urged us to make recommendations which if adopted would clearly necessitate the issue of Ministry circulars.

230. It may be that the attitude of some hospital authorities to this matter has been coloured by the experience of the early years of the service when circulars were issued in rapid succession on a wide variety of subjects, and when management bodies and their officers were unaccustomed to this experience and were not often consulted on the form and content of the circulars issued. This was probably unavoidable in the circumstances ruling at the time. With the regular consultations which now take place between the Chairmen and officers of Hospital Boards and representatives of the Ministry, and between Regional Hospital Boards and their Management Committees, it is most unlikely that a Ministry circular on an important matter of policy would now be issued without the knowledge of, and without taking account of the views of, the hospital authorities concerned. No doubt therefore, this will be a source of less irritation in the future than it has been in the past. Beyond recommending that the Health Departments should keep the number of directions to a minimum, we have no wish to add any further comment on this matter.

231. As there are so many circulars which must be passed on in full to all Hospital Management Committees, we are not inclined to recommend that the Ministry of Health should in future issue circulars only to Regional Boards and Boards of Governors and never direct to Hospital Management Committees. A recommendation to this effect would put the Regional Boards to a great deal of unnecessary work which would increase the cost, but not necessarily the efficiency, of the service. It is true that this method of distributing circulars appears to be working satisfactorily in Scotland, where the hospital service is, of course, on a much smaller scale than in England and Wales, but we doubt if its extension to England and Wales would be desirable. It seems reasonable to us that both Departments should continue their existing arrangements in this matter.

Regional Hospital Board Areas

232. From the evidence we have heard it would seem that the present areas administered by Regional Hospital Boards are generally satisfactory despite the wide variations in size and population. The largest population served by a Regional Board in England and Wales is approximately 4½ million and the smallest about 1½ million; the corresponding figures for Scotland being about 3 million and 200,000 respectively.

Any regional division is bound to be arbitrary in some measure; but the selection of the 14 Hospital Regions in England and Wales and the 5 Regions in Scotland was done with care, regard being had in the main to geographical considerations, lines of communication, established teaching hospitals, etc. A considerable amount of planning of consultant and other services has been carried out in the last seven years on the basis of the existing Regions; and any extensive rearrangement of regional boundaries or the creation of new Regions would, in our view, be wasteful and undesirable.

233. It may be noted that in 1947 the view was held that five of the larger Regions in England and Wales might need to have Committees with delegated powers to serve sub-areas of their Regions; and the Boards concerned were advised to set up these Committees with their own staff and offices, as follows:—

(i) *North Lancashire and South Westmorland.* It was intended that this Committee should include members of the Manchester and Liverpool Regional Boards; but the Committee was in fact never set up and we understand that the need for such a Committee has not since been felt.

(ii) *Devon and Cornwall.* The Committee was duly set up by the South Western Regional Hospital Board but has recently been dissolved and wound up by general consent.

(iii) *North Wales.* The Committee was set up and contained members of both the Welsh and Liverpool Regional Hospital Boards, but we gather that it functions purely as an advisory body and not as a sub-authority with delegated powers.

(iv) *Cumberland and North Westmorland.* This Committee was set up by the Newcastle Regional Hospital Board and our evidence suggests that it has worked well and still continues to function satisfactorily.

(v) *Hampshire, Dorset and the Salisbury District of Wiltshire.* This Committee was set up as the Western Area Committee of the South West Metropolitan Regional Hospital Board—i.e. the Board with the largest population in England and Wales—and in recent years has been given a wide measure of delegated responsibility for the administration of the hospital and specialist services in the Western Area of the Region. This responsibility relates to the spending of capital and revenue money, the planning of the specialist services, and the appointment of specialists and registrars; but it does not extend to the mental and mental deficiency hospital services in the Western Area. We understand that this measure of delegation was agreed between the Ministry, the Regional Board and the Western Area Committee in 1953 after long consideration of the question raised in the Eleventh Report of the Select Committee on Estimates whether the western part of the South West Metropolitan Region should be given a Regional Board of its own. After seeking the views of all the bodies concerned, and having carefully considered their recommendations, the Minister concluded that the criticisms made by those who wanted a new Region could probably be met more economically, and without the loss of the advantages at present deriving from the existence of a single Region, by delegation of powers more freely to the Western Area Committee rather than by creating a new Region and a new Board. It is too early yet to judge the efficacy of the new arrangements.

234. We think the history of these Committees and their sub-areas since the Appointed Day bears out the conclusion that on the whole the Hospital Regions as they now exist are not too large for the exercise of the Regional Boards' functions. Moreover, we have heard nothing in our evidence which would lead us to believe that the Boards in the larger Regions have proved less satisfactory than those in the smaller Regions as the agents of the Health Departments in administering the hospital and specialist services.

We offer no recommendation, therefore, for the revision of the existing Regional Hospital Board areas.

Hospital Groupings

235. The great majority of our witnesses have agreed that the existing hospital groupings are generally satisfactory, and that the savings achieved by any regrouping would be insubstantial. It is also generally agreed that some tidying-up might now be carried out, with advantage, by Regional Boards, particularly to eliminate some of the smaller groups which scarcely seem to justify the appointment of a separate Management Committee. Some witnesses have favoured the creation of larger hospital groups within which more power might be delegated to House Committees; but others have argued that if a hospital group is so large that it requires substantial delegation of responsibility to the House Committee level, then the group is too large for efficient administration.

236. We have also heard the suggestion that mental hospitals should as a rule be amalgamated with general hospitals because of the clinical advantages that would accrue from a closer link between the two types of hospital. Against this suggestion, many witnesses have contended that a separate Management Committee is essential for the future development of the mental health services, so that the mental hospitals may compete on equal terms with the general hospitals for a fair share of the regional funds. The special needs of the mental hospital are said to justify the appointment of separate Hospital Management Committees.

Our Own View

237. At the Appointed Day, the intention appears to have been to set up, wherever practicable, hospital groups of a "satellite type" i.e., composed of a main general hospital and a number of related subsidiary units such as cottage hospitals, maternity hospitals, convalescent units, etc. In functional groups of this kind, there was no need to devolve executive functions to House Committees, and a strong case could be made out for combining the posts of group secretary and hospital secretary of the main hospital. It was no doubt in this context that the Ministry advised hospital authorities to give no executive powers(1) to their House Committees and normally to appoint the group secretary to act as hospital secretary of the largest hospital in the group.

In practice, however, there have been many divergences from the pattern of the "satellite" group; some for reasons of geography, history and tradition; others because Boards have deliberately chosen to set up larger hospital groups containing a number of large or medium sized hospitals and several smaller units and clinics. No doubt the Boards believed that larger groups of this sort would provide more economical and efficient administrative units. As a result of these divergences from the "satellite group", the present pattern of hospital groupings shows a wide variation, ranging from the group which consists of a single unit with less than 100 beds to the group which contains several large hospitals and smaller units with a total number of beds exceeding 3,000.

238. We feel that the time has now come for Regional Boards to review their hospital groupings and in particular to consider whether it would be in the interests of sound and economical management to split up some of the large groups, and to amalgamate some of the very small groups. By the very small groups we mean those which consist of one hospital unit with relatively few beds, and for which a separate Hospital Management Committee would seem to be unnecessary. We ourselves favour the

(1) See para. 242 below.

"satellite" type of group as being the one most suited in size and function to management by a single Hospital Management Committee, and we would prefer that the larger groups be broken down, wherever practicable, to bring them into line with this concept of the ideal hospital group. We appreciate that this proposal is likely to involve the appointment of additional Management Committees but the extra cost would be relatively small and, in our view, would be outweighed by increased efficiency in the administration of the service. It seems to us that many of the questions which have been raised in our evidence about the powers and functions of House Committees have been due to the creation of groups which are too large for unified administration under one Management Committee. The ideal group ought to be small enough to allow the Management Committee to have a close and natural interest in all its component units, and to enable the Committee to carry out efficiently all its executive functions without having to delegate any of them to subordinate House Committees. In short, if a hospital group is of the right size, there should not be room for two administrative bodies (the Management Committee and the House Committee) each possessing executive functions of its own.

239. In cases where it is found impracticable—perhaps for reasons of geography—to split up one of the larger groups, we would recommend that the Management Committee should delegate more responsibility to the hospital secretaries in the group or, if this does not fully meet the case, should be allowed to strengthen the position of some of its House Committees. We return to this matter in the next section of our Report[1] where we deal with the powers and functions of House Committees. These larger groups, however, should, in our view, be quite exceptional, and there should be few instances (if any) where a Management Committee might find it necessary to delegate increased responsibility to its House Committees.

240. We might add that, where a larger group is found to be essential, it is open to question whether the group secretary can also carry out the duties of hospital secretary in the largest hospital of the group, without detriment to the efficient administration either of the group, or the hospital, or both. Whilst it may be argued that a group secretary, without any hospital appointment, may become too remote from hospital affairs and too engrossed with committee work pure and simple, there would be less likelihood of this danger arising if it were made a requirement that all group secretaries should have served for a specified period as hospital secretaries; if the status of the hospital secretary himself were improved; and if the office of the group secretary was situated in the main hospital of the group so that he might be easily accessible to the hospital staff and, in particular, to the senior medical and nursing staff.

241. With regard to the mental hospitals and mental deficiency institutions, the weight of our evidence would seem to be in favour of these hospitals and institutions being managed separately under their own Management Committees and not in combination with one or more general hospitals. This is in fact the normal pattern in the hospital service. We fully appreciate the need for a clinical link between the mental hospital and the general hospital but it seems to us that this link can be adequately maintained without combining the managing bodies themselves.

House Committees in England and Wales

242. In the early years of the service, the Ministry issued a circular[2] which said that, in order to avoid the creation of a three-tier system of

(1) See paras. 242–248 below.

(2) R.H.B. (49) 107/B.G. (49) 92.

hospital administration, Hospital Management Committees should not in any circumstances confer executive powers on their House Committees, e.g., to appoint staff and spend Exchequer money. The Ministry added that, in their view, House Committees could make their best contribution to the service by stimulating and maintaining a lively local interest in hospitals; by looking after the welfare of patients and staff; making recommendations to their Management Committees on the day-to-day running of hospitals and on new developments of the service; managing individual hospital's share of the Management Committee's "non-Exchequer funds"; and by serving as a training ground for future Hospital Management Committee and Regional Hospital Board members.

243. Many of our witnesses, whilst fully appreciating the value of the work done by House Committees, have agreed that the Ministry were right to limit the executive powers of House Committees in this way. In their view any increase in the powers granted to House Committees would hinder the development of the "group idea" and of group loyalties. These witnesses have maintained that, if a hospital group is so large that the Management Committee finds it necessary to delegate considerable administrative responsibility to the House Committees, then the group itself is probably too large for efficient administration and should be reduced in size. It would be wrong to seek a solution by increasing the powers of the House Committees. Spending powers, and the power to appoint staff, etc., should be delegated to the appropriate senior officers by the managing body.

244. Other witnesses, on the other hand, have suggested that undue emphasis has been placed on the "hospital group" since the Appointed Day at the expense of the individual hospitals and that the time has come to experiment with some increased measure of delegation from Management Committees to House Committees. If the House Committee is intended to serve as a recruiting ground for future Hospital Management Committee members, it should be given executive responsibility on a scale sufficient to attract members of the right quality. Indeed, we have been told that some House Committees are already exercising powers wider than those envisaged in the Ministry's circular, and without any apparent harm to the service.

Our own view

245. The principles enunciated in Circular R.H.B.(49)107/B.G.(49)92 still seem to us to be generally sound, and we note that they were supported by the Bradbeer Committee's Report[1] on the Internal Administration of Hospitals. As we have already indicated, if a hospital group is of the right size the Management Committee itself must closely control the management of the individual hospitals in the group, and must keep a firm hold on the group's expenditure. In the ideal group there is insufficient room for two bodies with executive and spending powers. Moreover, if too much authority were delegated to House Committees, the danger of overspending would be seriously increased and, if spending powers were to be dispersed too widely throughout the group, the needs of hospitals would not be met in their proper order of priority.

(1) The Report of a Committee of the Central Health Services Council on the Internal Administration of Hospitals. (H.M.S.O., 1954), paras 233–238.

246. The pressure for increased delegation of powers to House Committees may, as we have already suggested, be a symptom of other defects in the structure of the hospital group, e.g.:—

(i) The existing Hospital Management Committee group may be too large and too widely scattered, and may need to be broken into more than one group.

(ii) There may be insufficient delegation of powers to hospital secretaries at each of the unit hospitals.[1] Some Management Committees may be seeking to give powers to their House Committees which should properly be delegated to their officers.

We have already made clear our view that Regional Boards should do all in their power to correct any defects of hospital grouping, and that Management Committees should consider whether there are additional powers which could properly be delegated to their hospital secretaries. Even after this action has been taken, however, there may still remain one or two large groups in a Region where it might be considered appropriate to strengthen the powers of the House Committees.

247. We fully endorse the view that House Committees are doing excellent work in the hospital service, particularly in furthering the welfare of patients, in retaining the interest of the local community in their hospitals, and in preventing hospital staffs from becoming too isolated from their managing bodies. The House Committees can also form a useful link with the Leagues of Friends who are making such a valuable contribution in the voluntary field to the work of the hospitals.

House Committees in Scotland

248. We understand that in Scotland House Committees do not exist on the same scale as in England and Wales, and only in one or two of the five Regions are there House Committees whose membership contains persons other than members of the Board of Management. The question whether House Committees should have executive responsibility has not therefore arisen in any significant way in Scotland, and no circular has been issued on the subject by the Department of Health for Scotland.

Volume of Committee Work

249. We have heard a great deal of evidence about the elaborate sub-committee structure which has been set up by some Management Committees, and the mass of paper work (and waste of time and effort) which it entails. In some groups, it has led to a great many matters of relatively minor importance being considered and decided in committees and sub-committees instead of being delegated to responsible officers. This is a development which in our view is much to be deplored. There is a real danger of the administrative side of the National Health Service getting bogged down in a morass of committees. Any unnecessary committee work is an unmixed evil: it absorbs the time and energies of many people who ought to be carrying out their primary duties; and it slows down decisions and delays action which otherwise could and should be taken more promptly. On the other hand where managing bodies concentrate more on matters of policy and their implementation, and where responsible officers have authority to take decisions within the policies laid down by the management, the efficiency of the service is clearly increased.

[1] The Report of a Committee of the Central Health Services Council on the Internal Administration of Hospitals (paras. 229–230).

250. Accordingly we recommend that all Management Committees and Boards of Management should now review their arrangements with the aim of simplifying their committee structure and reducing the volume of work, for example, by increased delegation of authority to responsible administrative officers. We are confident that this delegation would be facilitated if the hospital secretary were given a higher status in hospital administration and if the post of hospital secretary were to become a normal starting point to a hospital administrative career at group or regional level. (See also paragraph 396.)

Appointment and Composition of Hospital Boards and Management Committees

251. All our witnesses representing the hospital authorities have agreed that the present system whereby the Minister appoints the Regional Boards and Boards of Governors, and the Regional Boards in turn appoint their Management Committees (Boards of Management in Scotland), is working satisfactorily and calls for no radical change. Against the suggestion that the system is undemocratic, they have pointed out that the Minister himself is responsible to Parliament, and that there are good grounds therefore for granting him the right to appoint the agents who are to carry out his policies in the Hospital Regions and in the teaching hospitals.

252. We have heard differing views from other witnesses, however, about the method by which members are appointed, and also about the composition of the membership, with particular reference to the appointment of medical members to Boards and Committees.

Method of appointment

253. Since the Appointed Day, successive Health Ministers have adhered to the principle that members of Boards and Committees are appointed as individuals for the personal contribution they can make to the efficient running of the hospital service, and not as delegates or representatives of outside bodies. Ministers have therefore firmly resisted proposals put forward from time to time by the profession, the local authorities and others, that they should be entitled to nominate a proportion of the members to serve on Regional Boards, Management Committees and Boards of Management. The Ministers have always been willing to consider the recommendations put forward by representative bodies, but they have always reserved the right, in the case of the Regional Boards, to decide which of the names recommended should be appointed. The Regional Boards have reserved the same right in making their appointments to the Management Committees and Boards of Management after consulting all the bodies concerned.

254. The proposal that a proportion of members of Boards and Committees should be nominated by outside bodies has been re-stated to us in evidence submitted by the medical profession and the Associations of Local Authorities, and the following reasons have been put forward in their support:—

(i) The danger of the present system of appointment is that it will lead ultimately to over-centralisation and to loss of responsibility at the hospital management level.

(ii) It also produces appointments which are not always entirely non-political in character.

(iii) The fact that Boards and Committees are appointed and not elected makes it all the more important that a substantial proportion of the membership should comprise representatives of the local authorities who have been elected by the people.

(iv) If the local health authorities, medical profession, and Leagues of Friends, etc., were entitled to make their own nominations, there would be a healthier atmosphere in the managing bodies, more local interest, and less danger of " in-breeding ".

255. On the other hand, all the witnesses we have heard from the Regional Boards, the Management Committees and the Boards of Management have without exception opposed the suggestion that local authorities and others should be empowered to nominate their own representatives to serve on Boards and Committees. If this proposal were implemented, we have been told that it would bring the hospital service into the field of local politics; it would divide the loyalty of members between their hospital authority and their nominating authority; and would convert Boards and Committees into centres of competing interests instead of managing bodies owing sole allegiance to their hospitals; it would also interfere with the collection of a balanced team of suitably qualified persons. Moreover, in the case of the larger Regional Boards, it would be quite impracticable for every local health authority in the Region to be represented on the Board. In the Newcastle Region, for example, with a total Board membership of thirty, there are fourteen local health authorities. If each authority had the right to nominate one representative to the Board, it would be impossible to find room for all the other interests concerned. There is the further disadvantage that nomination by outside bodies might create too rapid a turn-over in the membership of Boards and Committees. A fairly stable membership is desirable in the administration of the hospital service over a period of years.

Our own view

256. We have no doubt in our own minds that the Health Ministers must reserve to themselves the sole right to decide who shall be appointed to the Regional Boards, and that members must be selected solely for the contribution they can make to the efficient running of the hospital service. The present system is an essential corollary of a service organised on an agency basis. The Ministers must aim—as we believe they do—to preserve a certain pattern of membership which will take account of all the interests concerned in the Service, including the local health authorities, the consultants, the general practitioners, the voluntary organisations, the " consumers ", and people whose life interest has been in the hospital field. They must also seek to build up a membership which will be reasonably distributed over the Region on a territorial basis. But in our view, they cannot accept an arrangement which could bind them to accept the nominations of the various outside bodies concerned. If the right of nomination were granted to one or two bodies, others would soon be claiming a similar right and it would be quite impracticable to satisfy them all. The best solution therefore is to allow all interested bodies and organisations to submit their recommendations to the Ministers and to leave the Ministers to choose as members those who are most likely to complete the pattern outlined above.

Medical Membership

257. We have heard a great deal of evidence for and against the inclusion of medical members on Regional Boards, Hospital Management Committees and Boards of Management. Those who favour the inclusion of medical

members have pointed out that the hospital service is basically a medical service and that the managing bodies should therefore include among their membership some who represent the medical profession. So long as medical members are in a minority, their votes by themselves cannot sway the decisions of the managing bodies, but their advice and experience can be invaluable to their lay colleagues who, after all, have the last word through their majority vote.

258. Those who have opposed the appointment of medical members have argued that the proper role of the doctor in the administration of the hospital service is to advise the managing bodies, but not to exercise a vote in any of their decisions. In the field of local government, for example, the Council always has the advice of the Medical Officer of Health and of any other experts concerned in a matter under discussion, but the Council is responsible for reaching any decisions, and the Medical Officer of Health (and any other technical adviser concerned) has no right to exercise the vote. These witnesses have suggested that medical and technical advice given in this way carries more weight, and is considered more carefully by managing bodies, than if it had been received from doctors or technicians serving as members of the bodies themselves. So long as the proper machinery exists in the hospital service, therefore, to make available to Hospital Boards and Management Committees the views of the professions concerned, there is no need to appoint medical members to serve on Boards and Committees. Indeed, as the interests of the profession are likely to be affected by some of the decisions taken by managing bodies, there is a good case for excluding them from their membership. If medical members were taken off the Boards and Committees their vacancies might well be filled by representatives of the local authorities and of the " consumer interest ".

259. A few of our witnesses, while not opposing outright the inclusion of medical members on Boards and Committees, have expressed alarm at the high proportion of medical men now serving on the Regional Boards, and at the increases which have apparently been taking place in many Regions in recent years. In 1954–55, for example, the medical membership on Regional Boards in England and Wales averaged 32 per cent. Seven Boards exceeded the average, one of them reaching 42 per cent.; and only three had less than 26 per cent. In comparison with 1953–54, the figures revealed an increase in medical membership in no less than seven Regions. These witnesses maintained that the figures were too high and that they showed an over-weighting of medical membership often to the exclusion of representatives of the consumer interest.

260. From a review which we have made of the membership of Hospital Management Committees in seven Hospital Regions in England and Wales, it would seem that the proportion of medical members varies widely between Committees. Some Committees have 30 per cent. to 40 per cent. of their membership made up of members of the medical profession, while others (usually those responsible for the management of mental hospitals and mental deficiency institutions) have only 5 per cent. to 15 per cent. The average for each Region normally falls within the range of 20 per cent. to 27 per cent. In Scotland, the average percentage of medical members serving on Boards of Management in four of the Regions varies from 18 per cent. to 23 per cent.; and in the fifth Region is approximately 35 per cent.

Our own view

261. We do not think it would be proper, in a service of this kind, to exclude medical members from Hospital Boards or Management Committees.

It is true that Hospital Management Committees, Boards of Management and Regional Hospital Boards already have machinery for obtaining medical advice at the group and regional levels, but this does not, in our view, make it any less desirable to have on the Boards and Committees themselves a proportion of medical members who can join in the discussions and exercise a vote. Their inclusion gives invaluable advice to the lay members on medical aspects of hospital management, and in return it helps the doctors to understand more fully the broader administrative problems in the hospital service.

262. We see no reason, however, why the proportion of medical members should exceed 25 per cent. in any one Board or Committee, and we find it surprising that one of the Boards should have reached 42 per cent. in 1954–55. We presume that the increases in some Boards in recent years may have been due to the introduction of general practitioners and Medical Officers of Health to Regional Boards where they had not previously been represented—a tendency with which we entirely agree. It should be borne in mind also that any University representative who is medically qualified will be classed as a "medical member" on a Board or Committee and will, therefore, inflate the proportion of medical membership.

Nevertheless, even after allowing for these factors, we doubt if the total number of medical members on a Regional Board or Management Committee should exceed 25 per cent. and we recommend that this figure should not be exceeded save in quite exceptional circumstances.

263. We should perhaps point out that, while it is the Ministry's policy that the staff employed by a Management Committee should not serve as members of the Committee by which they are employed, it is in fact possible for senior medical and dental staffs to serve on their own Management Committees because their contracts are made with Regional Boards and not with the Committee itself.

264. In conclusion, we should like to record an interesting suggestion put forward in evidence that, in the interests of efficiency, the membership of Boards and Committees should be reduced to a nucleus of six or eight members each, and that vacancies should be publicly advertised and suitable candidates appointed by an Appointments Board. It was suggested that Board members should be paid a full-time salary, and Committee members an "honorarium". This suggestion was coupled with proposals defining the functions of the Ministry, Regional Hospital Boards and Management Committees, the main purport of which was to limit considerably the matters for which the Minister was answerable to Parliament, and to increase the powers and responsibilities of the hospital authorities. The ultimate sanction of Boards against Committees and the Minister against Boards would be the decision not to reappoint members as vacancies occurred.

Whilst appreciating the reasons behind these proposals, we do not feel that the organisation proposed would be appropriate to the National Health Service. The Regional Hospital Boards are intended—at least in part—to represent the community, and, in our view, if they were transformed into small bodies of paid "Directors", their whole character would be changed. The possible gain in administrative efficiency, even if it were to be achieved, would be bought at too high a price.

HOSPITAL FINANCE AND ACCOUNTS

Description of Present Procedures in England and Wales

General

265. The financial structure of the hospital service is designed to fit in with the Treasury procedure whereby annual estimates are submitted for approval some months before the beginning of each financial year, and revised estimates prepared (and approval to supplementary estimates sought if need be) during the course of the year.

Cash is advanced to the hospital authorities on monthly requisitions. Hospital accounts themselves, however, are kept on an income and expenditure basis and the actual expenditure for the year is shown in financial statements audited by auditors appointed by the Minister. Summaries of these accounts are transmitted to the Comptroller and Auditor General who lays them together with his report thereon before Parliament. The summary accounts presented to Parliament are prefixed by a statement reconciling them with the Exchequer cash issues.

Any underspendings over the year are surrendered to the Exchequer.

Current expenditure

Preparation and approval of estimates

Procedure up to 1950–51

266. Under the budgetary system introduced at the outset of the National Health Service, annual estimates of expenditure in considerable detail were prepared by hospital authorities in the autumn of each year in respect of the next financial year, and submitted to the Ministry for examination and approval. In the case of Hospital Management Committees the estimates were reviewed and summarised by the Regional Boards before being referred to the Minister. These estimates formed the basis of the Ministry's Parliamentary estimates.

For approval purposes, the detailed estimates were grouped together into a number of subheads and each hospital authority was free to vary the detailed estimate figures provided the total expenditure under any one subhead was not exceeded during the financial year. The amounts approved related to the hospital group as a whole, and the authority was free to vary the allocation of any subhead between individual hospital units within the group.

About half-way through the financial year revised estimates were prepared by hospital authorities and approved by the Minister in the same way as the original estimates. At this stage, savings anticipated under one or more headings could be transferred to other subheads of expenditure with the consent of the Minister, or in the case of Management Committees of the Regional Board acting on his behalf.

Procedure in 1950–51

267. The decision announced in March, 1950, that the Ministry's estimates for 1950–51 must be regarded as the limit of expenditure on the Service, led to some modification of this procedure and to an increased measure of control. The object was to avoid a repetition of the supplementary estimates to Parliament which had been presented in 1948–49 (£22 million) and 1949–50 (£45 million). The principal measures taken in 1950–51 were as follows:—

(i) All hospital authorities were required to send the Ministry a monthly return of expenditure showing (for each heading of account under which approval was given) how the expenditure to the end of the preceding month compared with the due proportion of the approved estimates. Where the returns showed overspending, everything practicable (having regard to the needs of patients) was done to eliminate the overspending. Management Committees were required to send copies of the return to the Regional Board who were authorised to take action to reduce the rate of expenditure where overspending was revealed.

(ii) It was made a condition of approval of the estimates of hospital authorities that expenditure under each heading of accounts should be limited to the amount approved for that heading; that anticipated excesses must be reported to the Minister under the procedure outlined in (i) above; and that savings were not to be used on new or extended services without his express consent. The authority of Regional Boards to approve transfers between the accounting subheads of Management Committees was thereby withdrawn.

(iii) The Principal Regional Officers of the Ministry were brought into close touch with hospital authorities as liaison officers, both by attendance as observers at meetings of Boards and Committees, and by receiving papers relating to the more important meetings.

Procedure in 1951–52

268. The decision to impose a limit of £400 million on the net cost of the National Health Service in 1951–52 involved a substantial reduction in the Ministry's first estimates for that year (based on the estimates of hospital authorities); and this could only be met by reducing the hospital estimates themselves. Regional Boards and Boards of Governors were accordingly notified of the total amount that would be made available to them for the year and asked to draw up fresh estimates (under the approval subheads) within those totals. Regional Boards took similar action with Management Committees. Boards and Committees were also informed that as no supplementary estimate would be allowed during the year, all increases in expenditure, from whatever source arising, must be contained within the total sums allotted. Regional Boards were advised to create regional reserves in order to meet contingencies and emergencies, and in order to ensure that such development projects as might be possible during the year would be financed and carried out in the proper order of priority. The Ministry itself created a small reserve for the Boards of Governors. The measures initiated in 1950–51 were also continued with slight modifications.

Procedure in 1952–53 and subsequent years

269. To reduce the duplication of effort involved in preparing one set of estimates in the autumn, and another after being notified of the total annual allocation, a new procedure was brought into operation in relation to the year 1952–53. Under it, Regional Hospital Boards and Boards of Governors of teaching hospitals were required to submit, by the end of October, broad forecasts of the amount required

(*a*) to maintain services at the level likely to be attained by the beginning of the next financial year; and

(*b*) to meet the running costs of urgent developments and improvements.

More recently, however, the Boards have been asked to support these forecasts by fuller explanations of the reasons for increases or decreases than were previously requested.

270. In the light of these forecasts and of the latest available information as to probable total expenditure in the current year, the amount to be included in the Ministry's estimates for hospital running costs in the following year is settled in December or January in consultation with the Treasury subject of course to later approval by the Government and Parliament of the estimates for the National Health Service as a whole. Provision was at one time included to cover both the possibility of future price variations and of future increases in salary and wage rates; more recently this has been omitted, but an undertaking given that additional allocations which may involve the presentation of supplementary estimates to Parliament will be made subsequently, if and when necessary, to meet the cost of unforeseen increases in salary and wage rates and that adjustments will also be made subsequently for changes in price levels if need be.

271. The national total having been determined, the Ministry, in January and February, notify Regional Boards and Boards of Governors of the sum likely to be made available to them in the forthcoming year (including, for Regional Boards, an amount for developments). Within the following month or six weeks the Regional Boards in their turn make allocations to Hospital Management Committees for running their existing services. Within their fixed totals each hospital authority draws up its detailed estimates under a limited number of subheads which are approved in the case of Hospital Management Committees by the Regional Boards, and in the case of Regional Hospital Boards and Boards of Governors by the Ministry. By this means, each hospital authority is made aware of the total sum it will have available before the beginning of the financial year.

It will be noted that as a natural corollary of the new procedure, the power to approve the estimates of Hospital Management Committees was completely delegated to Regional Hospital Boards, and their authority to approve transfers between subheads restored.

272. Regional Hospital Boards' estimates of expenditure on their own services are approved by the Ministry under six headings:—

Central administrative expenditure of the Board.
Blood transfusion service.
Mass radiography service.
Payments to specialists and registrars.
Payments under contractual arrangements.
Other expenditure.

273. The estimates of Hospital Management Committees and Boards of Governors are normally approved (by Regional Boards and by the Ministry respectively) under the following twelve heads:—

(1) Administration—central expenses of the Committee or the Board.

(2) Hospital Maintenance:—

Salaries and wages
- (i) Medical and dental staff.
- (ii) Nursing staff.
- (iii) Other staff.

Provisions.
Uniforms and clothing.
Drugs, dressings, medical and surgical appliances and equipment.
Fuel, light, power, water and laundries.
Maintenance of buildings, plant and grounds.
Domestic repairs, renewals and replacements.
All other expenses.
Less:—

Direct credits (e.g., recoveries from staff for board and lodging, receipts from farms, canteens etc.; receipts from local authorities under user agreements).

(3) Other expenditure—all expenses other than on administration or hospital maintenance.

274. When making their allocations to Hospital Management Committees out of the total sum made available by the Ministry for the Region as a whole, Regional Hospital Boards set aside and retain varying sums as "regional reserves", normally limiting their initial allocations to the sums estimated to be required by each Committee to maintain the services at the level existing at the beginning of the year. The provision included by the Ministry in the regional total for developments and improvements of the service, (or some part of it), is normally withheld by the Board until the Committee needs to incur the expenditure concerned. In this way the Regional Boards secure that the best use is made of the limited amount of money available for development and improvement of the service. The revised estimates of Management Committees, submitted half-way through the year when the outcome for the year can be more clearly foreseen, are submitted to the Boards under the approval subheads and any transfers between subheads of the amount originally approved, for which good cause is shown, are usually authorised at this stage. The Boards themselves submit revised estimates of their own expenditure to the Minister for approval.

275. In the case of the teaching hospitals the Ministry retains a small central reserve for developments and contingencies. Issues from the central reserve are made as occasion arises; and transfers between subheads, where warranted, are approved by the Ministry at the revised estimates stage.

276. Briefly then, under the present arrangements, the total annual sum to be spent on the maintenance of the hospital service is first decided after consultation between the Ministry and the Treasury. The Ministry then share out the total sum between the Regional Boards and Boards of Governors; and the Regional Boards in their turn, after making allowance for their own needs, share out the regional allocation between the Hospital Management Committees whose estimates are finally approved by the Boards under the approval subheads listed above. The estimates of Boards of Governors are approved by the Ministry under the normal approval subheads.

How the shares are calculated

277. We understand that, in deciding what amount shall be allocated annually to the various hospital authorities, the Ministry now apply the following general procedure:—

(1) The total amount available is first divided between the Regional Hospital Boards as a whole and the Boards of Governors as a whole, broadly in proportion to the expenditure of these two groups in the last year for which actual figures are available.

(2) The Regional Boards' share is then divided out among the individual Boards as follows:—

(*a*) A limited amount is set aside for the running costs of new developments and improvements to be started during the year. This is divided up between Boards partly by reference to population, and partly by reference to the capital projects likely to come into operation during the year.

(*b*) The remaining sum is available for the maintenance of the existing services and, if it is substantially less than the total of the Boards' own forecasts of their requirements, the adjustments necessary to bring the total estimates within the national sum available are effected as follows:—

(i) The revised estimates of each Board for the current year—which constitute the basic figure—are compared with the Department's own estimates of the probable outcome for the year and an adjustment made for any apparent inflation of these figures which cannot be satisfactorily explained.

(ii) The Board's forecast for the ensuing year is then compared with their revised estimates for the current year and the increases (or decreases) attributed to various factors are scrutinised and, if necessary, modified in the light of statistical data (where relevant) and any explanations submitted by the Board as well as the national trends. Examples of the factors involved are the additional cost of price increases and wage awards up to the latest practicable date, and of recent developments and improvements; and on the other hand savings arising from such measures as the completion of projects which will reduce running costs.

(iii) An overall saving on running costs is expected also as the result of measures taken by Boards and Committees to achieve continuing economy and improve efficiency. Those Boards in whose Regions general costs are higher than the average are expected to contribute proportionately more than those in the Regions where costs are generally lower.

Provisional allocations worked out on this basis are then discussed informally with officers of the Boards, and amended if necessary in the light of those discussions. The final allocations are then formally notified to the Regional Boards.

278. The allocations to Boards of Governors for the maintenance of existing services are worked out in much the same way as those for the Regional Boards, but no specific allowance is made in them for the cost of development projects. The Ministry themselves keep a small sum in reserve for developments to meet demands as and when they arise.

Income accruing to the hospital service

279. Income accruing to the hospital service from the charges paid by patients and from other sources is not available to the Hospital Board or Management Committee which collects the money. The income is appropriated-in-aid of the Ministry's Vote for the National Health Service.

Estimates procedure in Scotland

280. In Scotland the general procedure adopted in the preparation of estimates has been much the same as in England and Wales, but the tendency has been towards a progressive reduction in the number of heads in the approved budgets of Regional Hospital Boards and in turn of the heads under which Board of Management budgets are settled within the regional total; the detailed procedure differs in the several Regions.

POINTS RAISED IN EVIDENCE

Method of allocation

281. On the whole, we have heard few complaints against the present method of allocating revenue funds to Regional Boards and Boards of Governors, though all concerned would welcome an increase in the amounts allocated to enable necessary development schemes to be carried out. We gather that there was considerable irritation at the degree of central control introduced in 1950–51 and 1951–52 at the time of the economic crisis, but the revised procedure followed in subsequent years (see paragraphs 269–278 above), appears to have met most of the Boards' objections. The criticism is still made, however, that the system favours most the authorities who showed the least degree of financial responsibility in the early years of the service.

282. We agree that the main weakness of the present system of allocating revenue funds is the apparent lack of a consistent long term objective, and we have considered very carefully whether any formula might be devised (related to regional populations, numbers of beds and/or other factors) which might serve as a guide to the Health Departments when sharing out the annual allocations to Regional Boards. We have concluded, however, that any national formula would have to be weighted to take account of such a wide range of variables in Hospital Regions that it cannot be considered as a practical proposition at least for the present. Hospital Regions do not necessarily represent the "catchment areas" for the hospitals in their areas, and may take a large number of patients from adjoining Regions. Hospital Management Committee groups in their turn are not associated with any specific geographical area. Again, the costs of different types of hospital bed vary so widely that no simple formula could be devised to take account of the varying distribution of beds in the Hospital Regions.

283. We have noted, moreover, that the capital allocations, being calculated on a population basis (with a 5 per cent. weighting in favour of the seven Regions needing special help in England and Wales) are already doing something to level up the standards of the service throughout the country. Some further degree of levelling is effected through the method of allocation of revenue funds, and by the large capital schemes financed centrally by the Departments. The expanded capital programme recently announced by the Government should make a material contribution to this end. (See paras. 316–317.)

On balance, therefore, we have concluded that the present system, though it has certain weaknesses, is probably the best that can be devised in present circumstances; and we are confident that, with the growing experience of Regional Boards and the Health Departments in examining annual estimates, the system can be made to achieve its object of securing that the available sums are distributed where they are most needed in the interests of the efficient working of the service as a whole.

In general, we hold that in a public service which is paid for almost entirely out of public funds, a measure of financial limitation is essential at all times if there is to be efficiency and economy of administration. Furthermore, when there is virtually no limit to what could be desirable on medical grounds it is vital that the responsible authorities should be faced with the necessity of establishing their priorities and of recognising that the satisfaction of the more important and urgent requirements must entail some sacrifice at the lower end of the scale. There must be a clear and ungrudging appreciation of the fact that if more money is expended

in one direction it must mean (unless there is an increase in the total resources placed at the disposal of the Service) that less is available to be spent in other directions.

Rewards for efficient and economic management

284. The suggestion has been put forward, both in the evidence to this Committee and elsewhere, that some method should be devised for "rewarding" Hospital Management Committees who prove themselves to be efficient and economical in their handling of Exchequer funds. As many of our witnesses have pointed out, however, the difficulty is to determine in any individual case whether the savings achieved in a hospital group are due to genuine economies—and, if they can be shown to be genuine, whether they should have been achieved some years earlier. We understand that many Management Committees have now come to accept the view that it is their duty to make economies in the service wherever possible and that any "savings" should be pooled regionally to finance necessary developments of the service on a regional basis. We found it most encouraging to note the development of this responsible attitude among hospital authorities. Indeed, the main concern of many Hospital Management Committees now is not that they should be rewarded for efficient management, but that they should not be penalised for realistic and responsible budgeting in earlier years.

285. We gather that, as a result of frequent discussions between Chairmen, members, and officers of Regional Boards and Management Committees; and of increasing experience of groups' estimating and spending habits, Regional Boards are now generally aware of the Management Committees which have consistently followed in the past a responsible financial policy both in budgeting and in spending; and they are influenced by this knowledge when sharing out the regional allocations, making money available for hospital developments, and considering requests for virement.[1] In future therefore, Hospital Management Committees are unlikely to be penalised for economical spending as some of them were perhaps at the time of the economic crisis when overall "cuts" were hurriedly made in hospital estimates to meet an urgent situation.

286. We conclude that it would be impracticable to give direct financial rewards for underspendings to one Hospital Management Committee in a Region without doing an injustice to other Committees which have budgeted closely and spent up to the limit of their estimates. Moreover, we think it is a misconception to suggest that financial incentives of this kind are a proper way to ensure the efficiency of Hospital Management Committees. No doubt Regional Hospital Boards in dealing with the applications of their Hospital Management Committees will have regard to the ability they have shown for exact budgeting and efficient administration; but the fundamental difficulty, of which this is a symptom, seems to us to be a wider one. It is very difficult to measure the efficiency of units in a service of this kind, whether relatively to each other or to some defined standard; yet without some yardstick of "success" which can be recognised at all levels it is hard to foster that realistic sense of achievement which acts as a guide, an incentive and a reward in other fields of activity. This is not a question to which we, as a Committee, can hope to provide a satisfactory answer, but we trust that it will be carefully considered by all who are concerned with the running of hospitals in the National Health Service.

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(1) Authority to transfer expenditure from one subhead to another.

The block grant and the carry-over of unspent balances in the case of current expenditure

287. In the earlier years of the National Health Service there was a strong body of opinion both within the hospital service and outside it in favour of block grants, to meet current expenditure for three to five year periods, being made to Regional Hospital Boards and through them to Hospital Management Committees, on the grounds that this would be conducive to greater efficiency on the part of those in charge of hospitals. It was contended that, knowing what sums would be received during the coming three or five years, hospital managements would be able to plan ahead with a secure basis of knowledge of the finance that would be available to them. Evidence to this effect was given to us by a number of our witnesses. On the other hand we also have had a good deal of evidence which pointed to a growing realisation of the fact that the apparent security resulting from a system of block grants would be largely illusory. Over 60 per cent. of the costs of the hospital service consists of wages and salaries; rises in wages and salaries, as also in the prices of food, drugs and other supplies, the possible extent of which could not be foreseen over a period of even three, let alone five years, could completely upset the budgeting of the hospitals.

288. Accordingly the great majority of our witnesses instead of pressing for block grants to finance current expenditure, put forward a proposal of a more modest character, namely that the hospitals should be permitted to carry over to the next financial year any unspent balances of the sums nominally allotted to them in respect of the preceding year. This would seem at first sight to have the great advantage that it would act as a direct stimulus to economy, since the hospital which by good management had effected a saving on its estimated expenditure would not suffer the annoyance of surrendering that saving to the Exchequer, but would be able to spend it for some other purpose. It would further have the advantage of lessening the temptation of hospital authorities to spend up to the limit of their estimates even when this is not absolutely necessary—although this is a temptation which, according to most of our evidence, is now more firmly resisted than it was in the early years of the service.

Some of our witnesses who favour this proposal have pointed out that, if hospital authorities wish to be sure of avoiding any overspending each year, they must in fact plan to underspend. But, as hospital budgets become more and more stretched, Hospital Management Committees become more and more reluctant to plan deliberately for an underspending. This reluctance would be overcome if the underspendings could be carried over to the next financial year.

289. The criticisms which have been made against this proposal are numerous and include the following:—

(i) There is the major difficulty of ascertaining whether the underspending is due to a genuine saving in expenditure as a result of better organisation, more economical use of staff, drugs, etc., or to some other cause. Underspending may occur because the estimate itself has been inflated, and in this case there is no reason why it should be rewarded. Or, again, provision may quite properly have been made for some contingency which did not materialise in the year in question.

(ii) Furthermore, of two hospitals, one may have been so economically run in the past that there is virtually no scope for further economies; the other may have been less strictly managed and it may still be possible to effect savings on an important scale. The retention by the latter of its unspent balances would scarcely seem fair to the former unless there is some other way of rewarding its economical management.

(iii) Indeed, if the unspent balances of the Hospital Management Committees in a Region totalled say 2 per cent. of the Board's annual allocation in a given year, and if this 2 per cent. were to become a first charge on the Board's budget in the succeeding year, then the remaining sum, available for distribution to the Committees in the Region, would be only 98 per cent. of the amount they might otherwise have expected to receive. If we assume the Board's allocation from the Ministry to be the same amount in both years, it would seem to follow inevitably that the Committees which had no such surpluses to their credit must suffer a cut of the order of 2 per cent. in their budgets in the second year. If this process were continued year by year and the Board's allocation from the Ministry remained unchanged, the position of Committees which always spent up to the limit of their budget would progressively deteriorate; and this despite the fact that their failure to achieve surpluses might well have been due to no lack of economy on their part, but was a consequence of careful and accurate budgeting in the past. It is difficult to imagine that such a system would be acceptable to Hospital Management Committees which found themselves in this situation.

(iv) There might be underspendings on food or in other directions which could be detrimental to the main objects for which the hospital exists. There can be false economy as well as true economy.

(v) In approving annual estimates, the aim is to give hospital authorities what they need to maintain their services. The carrying over of an unspent balance would, in fact, give the authorities more than the sum to which they would be entitled on the basis of their approved estimates.

(vi) Savings achieved in a service financed by the Exchequer should accrue to the benefit of the taxpayer. The Parliamentary system does not allow the carry over of unspent Exchequer balances except in the case of grants-in-aid, and the expenditure on the hospital service cannot be regarded in any sense as a " grant-in-aid ".

(vii) It does not appear to be the case that hospital authorities in general do in fact increase their overall rate of spending in the later months of the financial year. In any event, as many of our witnesses have pointed out, it is natural that Hospital Management Committees should curtail their spending under certain sub-heads in the early months of the year until it is clear how the budget is likely to work out. This is a matter of wise planning and not of careless spending in the later months of the year.

Our own view

290. We are of the opinion that the weight of argument is against the adoption of block grants to meet current expenditure in the hospital service, and that the same conclusion holds good with regard to the proposal that Regional Hospital Boards and Hospital Management Committees should be empowered to carry over unspent balances. Advocates of block grants for the hospital service often cite the analogy of the system of quinquennial grants for the current expenditure of the Universities administered by the University

Grants Committee but the analogy is not really a valid one. The Universities have important revenues of their own from fees and endowments, and the Exchequer contribution is a grant-in-aid of these revenues. It is not appropriate to speak of a grant-in-aid for the hospitals when virtually the whole of their expenditure is met out of public funds. From the point of view also of the public finances the difference in scale is so great as to render any direct comparison invalid. As against an annual grant of about £25 million for the Universities there must be set an expenditure of about £320 million a year on account of the hospitals alone in England and Wales and Scotland. It is one thing to give a guarantee for five years ahead of £25 million a year, and quite another thing if the sum in question is of the order of magnitude of £320 million and absorbs an appreciable part of Government revenue. There is moreover no intermediary body which could fulfil for the hospital service the role played by the University Grants Committee in relation to the Universities.

291. As regards the carrying forward of unspent balances, we fully appreciate the great importance of encouraging and stimulating true economy in the hospital service. But, in our view, the stimulus should be provided by methods which are less open to objection than the simple carrying forward of unspent balances. We agree entirely with the view expressed by the Select Committee on Estimates for 1950–51 in their Eleventh Report:—[1]

> "... the amount of money included in a year's estimates of a hospital authority was not the year's income of that authority, but was merely the limit of permission to spend. When a saving has been made on an estimate it generally means that the authority has found itself able to provide the service in question at a lower cost than was allowed for in the estimate; it follows that the Ministry ought not, in the absence of some special reason, to approve an estimate in the following year for the same purpose and of the same size as before. If hospital authorities could carry forward unexpended balances it would in effect be requiring the Ministry to approve estimates for amounts exceeding the cost of the services in question by the amount carried forward."

292. This question is of course closely tied up with the introduction of a more efficient costing system into the hospital service. So long as the annual maintenance funds are allocated mainly on the basis of the amount spent in the preceding year, hospital authorities will naturally be reluctant to incur an underspending at the end of a financial year. What is needed therefore is some effective standard of efficiency against which the expenditure of a hospital may be judged, both in the examination of past expenditure and in the allocation of future funds. We deal with this aspect more fully in paragraphs 334–367 of the Report.

293. Regional Hospital Boards and Hospital Management Committees would do well in any case to remember that the services they administer form only a part of the National Health Service and that any underspending on hospital estimates may serve to balance some overspending in another subhead of the National Health Service Vote, e.g., on the pharmaceutical service. Underspendings on the hospital service are not necessarily "lost" to the National Health Service as a whole. In 1952–53, for example, when there was an underspending of over £10 million on the hospital service (ignoring the earmarked salaries and wages reserve) this sum was available to help meet substantial excesses in that year on, for example, the pharmaceutical services and the general dental service.

[1] Published by H.M.S.O., 1951 (see para. 23).

Approval subheads

294. The view is held in some quarters that the available funds in the hospital service would be used more efficiently if Hospital Management Committees and Regional Hospital Boards were authorised to transfer expenditure from one estimates subhead to another without the vexation and delay involved in seeking the approval of the next higher authority to the transfer. Some witnesses have therefore recommended the abolition (or failing that, a reduction in the number) of the approval subheads.

295. The great majority of our witnesses, however—including those most directly concerned with the preparation of hospital estimates—have seen no objection to the present system of approval by subheads, nor to the number of subheads involved. They have pointed out that Hospital Management Committees generally break down the subheads still further for their own purposes, and find no difficulty therefore in preparing their estimates in the form required by the Boards. Requests for virement have not been numerous and approval has normally been given by the Regional Boards.

296. Representatives of the Regional Boards have generally recommended the retention of the existing subheads as a means of effecting broad financial control over the service, and ensuring that money is spent on the purposes for which it is authorised. They have pointed out, moreover, that the monthly reports of expenditure made by Hospital Management Committees would be meaningless if the figures were not broken down under the approval subheads.

297. The Ministry also favour the retention of the approval subheads for the following reasons:—

(i) The Minister must be prepared to account to Parliament for the way in which hospital budgets are spent and cannot therefore divest himself of some general oversight of expenditure.

(ii) It is not unreasonable that hospital authorities should be required to explain variations in the subheads of expenditure which they had in mind when preparing their original estimates.

(iii) The service is not yet sufficiently stable to justify the granting of total annual allocations to Hospital Management Committees without any analysis by subheads.

298. Our attention has been drawn to the fact that, in Scotland, the annual allocations to Regional Boards are made under four heads only, i.e., hospital running costs, specialist services, administration, and other expenditure. The Scottish Boards in their turn approve the estimates of Boards of Management under a varying number of subheads (only two in the South Eastern Region and five in the Western Region) which are considerably fewer than those used in England and Wales. We understand, however, that it is in fact the practice of Boards of Management in Scotland to break down their estimates into subheads broadly in line with those used in England and Wales and subsequently to notify their Regional Boards of the estimates analysed in this way. The Regional Boards are thus in much the same position as their English counterparts in supervising the expenditure of their Boards of Management, the only material difference being that the Scottish Board of Management is not required to seek the formal approval of the Regional Board to any transfer of expenditure. There is nothing in the Scottish practice that would lead us to suppose that the estimates procedure in England and Wales might be improved by reducing the number of approval subheads. Accordingly we do not recommend any alteration of the existing practice in this matter.

Audit of Hospital Accounts

The pre-1954 procedure

299. At the time when we were taking oral evidence from Regional Hospital Boards, we heard a great deal of criticism against the procedure followed in England and Wales for auditing hospital accounts. We were told that the audit in England and Wales was undertaken by auditors appointed by the Minister to audit accounts (including those relating to non-Exchequer moneys) of Regional Hospital Boards, Boards of Governors, Hospital Management Committees, local Executive Councils and certain miscellaneous authorities. The Ministry maintained that this arrangement made it possible to direct and control the audit throughout on a uniform basis and to organise the service on an economical staffing basis. The Ministry had considered whether Regional Hospital Board Treasurers might be employed on the audit of accounts of Hospital Management Committees but, apart from the fact that such an exception from the general arrangements for centralising audit would have led to the employment of more staff, it was thought that it would also involve Treasurers in conflicting loyalties.

The practice was therefore for the auditors to report to the Minister, as necessary, after each interim visit, and also after the completion of the audit for the year. The hospital authority was furnished with a copy of the final audit report and in the case of a Hospital Management Committee a copy was also sent to the Regional Hospital Board. Where necessary, the Department made representations to authorities about matters reported by auditors and when this was done following an interim visit, a copy of the auditor's report, or an extract from it, was sent to the authority.

300. In Scotland, however, the Secretary of State took the view that as the Regional Boards were made responsible for the expenditure incurred by Boards of Management it would assist them in exercising that responsibility effectively to entrust the local audit of the books and records of the Boards of Management to the Regional Hospital Board Treasurer, acting on behalf of the appointed auditor. The auditors of the Department confined their audit to a more general examination of the financial procedure of the Boards of Management and the audit of the consolidated accounts prepared by the Regional Boards.

301. A straight comparison of the numbers engaged on audit work in the two countries showed that 280 were employed in England and Wales and 120 in Scotland. In comparing these figures (which were of course proportionately much higher in Scotland than in England and Wales) it should be borne in mind that the audit of endowment and other trust funds in Scotland was left to auditors in private practice, whereas in England and Wales it was undertaken by the same auditors as audited the Exchequer accounts. The Health Departments explained to us that, while centralisation of the work in England and Wales was thought to be conducive to economical staffing, it was probable that the main reasons for the proportionately much higher numbers in Scotland were:—

(i) that audit staff in Scotland were employed on special duties—e.g. the examination of costing statements and subsequent investigations—as well as on audit.

(ii) that Boards of Management in Scotland do not employ finance officers as most Hospital Management Committees do in England and Wales.

(iii) that more detailed checking was undertaken in Scotland than in England and Wales.

(iv) that audit visits were made more frequently, varying between four and twelve visits a year, in Scotland, whereas in England and Wales visits were generally made three times a year.

Suggested revision

302. The evidence we received from Regional Boards in England and Wales was generally in favour of the suggestion that the Boards should have power to carry out an "efficiency audit" of their Hospital Management Committees' accounts. We were told that this would enable Boards to check whether Hospital Management Committees were spending their funds economically and on the purposes for which they were authorised, and would also facilitate the annual examination of Hospital Management Committees' estimates and comparisons of varying levels of hospital expenditure. The existing audit carried out by the Ministry was not, we were told, producing the information required.

303. Those who opposed this suggestion did so on the grounds that:—

(*a*) many Hospital Management Committees would resent the increased interference (implied by an efficiency audit) by Regional Boards in matters of hospital management, and

(*b*) a regional audit would be more costly in money and manpower.

If the introduction of a regional efficiency audit was found to be impracticable, however, most Regional Boards made it clear that they wished to be associated more closely with the audit carried out by the Ministry, and with the follow-up of points raised in the auditors' reports. They also requested that copies of all interim reports should without exception be sent in full to the Hospital Management Committees and Regional Boards concerned.

304. In Scotland, we heard some witnesses who objected to the Regional Board's Treasurer acting as the auditor, but there were others who preferred the Treasurer's audit to one carried out by the Department of Health.

Revised procedure—1954

305. Towards the end of 1954, however, the two Health Departments decided to revise their audit procedures in such a way that they are now operating broadly on similar lines. In future, in both countries the audit of the accounts of Hospital Management Committees (and of Boards of Management in Scotland) will be undertaken centrally by officers of the Departments and follow-up action will be left primarily to the Regional Hospital Boards.

306. Thus, in England and Wales the main responsibility for follow-up action on auditors' reports on the accounts of Hospital Management Committees—hitherto undertaken by the Ministry—has now been delegated to Regional Hospital Boards. The Boards are now responsible for ensuring that suitable action is taken by the Committees on matters included in the reports of the auditors, except for a relatively few items where for special reasons they are asked to wait for the Ministry's advice as to the action to be taken. The Boards are required to inform the Department of the action taken in each case.

An alteration has also been made in the arrangements for dealing with interim reports of the auditor, copies of which will be sent in full to the authorities concerned and, in the case of a Hospital Management Committee, to the Regional Hospital Board also.

307. In Scotland, the audit of the accounts of Boards of Management is now undertaken centrally by officers of the Department, with some consequent

reduction in the scope of the audit and in the overall numbers of audit staffs employed. All audit reports on the accounts of a Board of Management are now submitted simultaneously to the Board of Management, the Regional Hospital Board and the Department. Regional Hospital Boards are then responsible for follow-up action on the reports and for informing the Department of the action taken.

Our own view

308. This revised procedure seems to us to provide the right solution to the problem of hospital audit. It leaves the Minister and the Secretary of State with the duty of carrying out the audit itself, and properly associates the Regional Boards with the follow-up of points raised in the auditors' reports. The proposal to introduce a "regional efficiency audit" is not in our view relevant to this matter. It is clearly part of the duty of a Regional Board to ensure that money is spent by Hospital Management Committees on purposes for which it is authorised; also to encourage Hospital Management Committees to compare their costs and continually to be seeking explanations for varying levels of expenditure. This is part of the normal function of management and is already being exercised—perhaps in varying degrees—in all Regions. It is a function which will no doubt be emphasised more successfully when departmental costing is introduced into the service. But it is not a function which need be associated with the technical audit of accounts. We see no objection therefore to—indeed there is considerable advantage in—reserving the audit to the Minister of Health and the Secretary of State for Scotland, so long as the Regional Boards are closely associated with the follow-up of the auditors' reports.

By an "efficiency audit" we understand a procedure which would estimate the efficiency of the service which a unit is rendering. As we point out elsewhere (para. 367), the best examination of accounts throws only an indirect and partial light on the value of the service provided. It should undoubtedly be one of the main functions of a Regional Hospital Board to inform itself of the efficiency of the units in its Region, but for this important duty the audit now under consideration can make little if any contribution.

HOSPITAL FINANCE—CAPITAL EXPENDITURE

Present method of allocation

309. The procedure in England and Wales for determining the capital amounts to be made available annually to Regional Boards and Boards of Governors (who alone are empowered to carry out capital works in the hospital service) is summarized below: the procedure in Scotland is essentially the same.

310. The Government decides, having regard to other claims upon the national resources, how much shall be made available to the Ministry for investment in the services for which it is responsible. The Ministry in turn allocates the greater part of this sum (in so far as it is intended to cover hospital capital expenditure) to the Regional Boards and Boards of Governors, retaining a reserve for contingencies and for selected large schemes which would be too costly for individual Boards to include in their own capital programmes. The allocation to Regional Boards is calculated mainly on a population basis, but a special allocation representing five per cent. of the total national sum available for capital expenditure is distributed in favour of seven Hospital Regions needing special help.

In 1953–54, for example, the Ministry planned to spend £8 million on hospital capital investment in England and Wales; £5·7 million being allocated to Regional Boards and £1·3 million to teaching hospitals. In addition, £½ million was earmarked for a small programme of special large schemes, and a small amount for contingencies. In the following year, the central reserve for large special schemes was increased to £1 million and an additional £1 million which became known as the "mental million", was reserved for providing extensions for mental hospitals and mental deficiency units.

311. Having been notified of the capital sum allocated to them, the Hospital Boards then submit their capital estimates to the Ministry, giving details of the capital works to be undertaken during the coming financial year (including the works carried over from the preceding year) and the amounts likely to be spent on them. The capital estimates are examined and approved by the Ministry, but individual schemes costing more than £10,000 require the Ministry's specific authority before they can be started. Before the year 1953–54, the Ministry's prior approval was required for any schemes costing more than £1,000, and in extending the limit to £10,000 the Ministry have reserved the right to examine the individual projects costing less than £10,000 if the project is one of special interest.[1]

The Ministry, in their turn, require Treasury authority for any building works costing more than £30,000.[1]

Acquisition of land

312. The power to acquire land is reserved to the Minister, and Regional Boards and Boards of Governors must therefore seek the Ministry's prior approval to any acquisition of land (including buildings). The Ministry require Treasury authority for any acquisition of land costing more than £2,000 (where the land is required for future developments) and for all acquisitions of buildings costing more than £10,000.[1]

POINTS RAISED IN EVIDENCE

Hospital capital investment

Its size and adequacy

313. All our witnesses have agreed that the annual capital allocations since the Appointed Day have been quite inadequate to meet the urgent needs of the hospital service—in particular to provide:—

(i) additional and improved accommodation for mental and mentally deficient patients, chronic sick, out-patients, etc., to rectify shortages and to meet basic medical needs.

(ii) additional X-ray facilities, pathological laboratories, operating theatres, etc., to enable existing resources to be used to the maximum advantage.

(iii) new hospitals to serve the needs of shifting populations, e.g., in the New Towns.

(iv) new accommodation for some of the teaching hospitals.

(v) modernisation of buildings and plant both to improve the quality of the service provided and to reduce running costs.

314. In Part I of our Report we have already quoted figures from the Memorandum by B. Abel-Smith and R. M. Titmuss which show that hospital capital expenditure in 1952–53 was running at about one-third of the level

[1] We have discussed the prior approvals of building works and acquisitions of land—and made certain recommendations thereon—in paras. 213–218 of our Report.

operating in 1938–39—and this in spite of the fact that the capital assets in the service had been seriously (though unavoidably) run down during the war years and immediately after.[1] We fully appreciate the reasons why Governments in the last seven years have been unable to make larger amounts of capital available to the service—e.g., the recurring economic crises and the competing demands of other services and industries—but we are satisfied that the present totally inadequate rate of capital expenditure cannot be allowed to continue much longer without serious harm to the hospital service.

315. In considering what should be the size of a programme of capital works for the hospital service it is important to bear in mind that capital expenditure in general cannot be divorced from expenditure on running costs. Regarded from this standpoint, there are three types of capital outlay which can be distinguished:—

(*a*) Revenue-saving schemes. A number of Regional Boards in their evidence to us have stressed the opportunities in their Regions for capital works which, if carried out, would reduce running costs in the future—e.g., new boilers, modernised heating arrangements, laundries, bakeries, etc. One Board, for example, listed schemes costing £207,000 which were estimated to "save" £29,000 per year either in terms of cash or improved services. In another Region, works to the value of £658,000 (on mechanical stoking, fuel economisers, gas and steam sterilisers, and central linen rooms) were estimated to save £213,000 per year on revenue expenditure. Improved boiler plants and heating services would, of course, help the national economy by saving fuel as well as money. Hitherto the Boards have been unable to include any substantial amount of this class of work in their capital programmes, since the regional capital allocations have been so small and the number of development schemes urgently needed to meet the needs of patients has been so large; though we note that since 1953–54 the Department of Health in Scotland has set aside a small proportion of its capital allocation specifically for revenue-saving schemes. We would, however, point out that expectations of considerable reductions in current expenditure, as a result of what are termed revenue-saving schemes, may be only partially justified in the event. When, for example, new heating or steam-raising plant is introduced it will often be the case that advantage will be taken of the opportunity to improve the standard of heating or increase the amount of steam raised. The hospital will get better value for its money and the unit cost of the service provided by the plant will probably be lower; but the running costs per annum in total may be the same or even higher than before. On the average, however, it would seem reasonable to assume that there should be some reduction in running costs from capital outlay for revenue-saving schemes.

(*b*) Capital may be expended for purposes of modernisation and extension; such as enlarged and improved out-patient departments; increased facilities for X-ray or pathological investigations; new accommodation, equipment, etc. arising out of the appointment of additional consultants, and so on. The great bulk of the capital sums spent on hospital building works since the inception of the service (amounting in all to approximately £58 million, for the whole of Great Britain for the years 1948–49 to 1953–54), has taken this form; and it has undoubtedly been of the utmost value in raising the levels of quality and performance of many of the hospitals throughout the country. But on the basis of the accumulated experience of the last seven years, it has been estimated that each million pounds of capital expended for development purposes of this nature may entail on the average an increase of £400,000 in annual running costs. There is also the further consideration that additions to existing facilities carry with them the need for certain kinds of manpower and woman-power, the supply of which is not capable of indefinite extension.

(*c*) Capital may be expended for the purpose of providing new hospitals, some of which will increase the total number of beds and facilities provided in the hospital service while others will entail the closure of existing beds. It is likely that the provision of new hospitals in either of these forms will lead to an increase in annual running costs, but at a proportionately lower rate than that quoted in (*b*) above. It has been estimated, for example, that the programme for the provision of new hospitals which is now contemplated for the years 1956–57 and 1957–58 may give rise to an increase of £150,000 in annual running costs for each million pounds of capital invested. Here, too, there is the further problem of finding the manpower and woman-power required for staffing the new hospitals, and particularly the new mental hospitals.

This brings us to the question whether it is in fact practicable to arrive at a realistic concept of genuine "replacement" of capital assets in the hospital service. The question of the nature and amount of capital replacement in the hospital service seems to us to raise wide and important issues of policy. In particular, we would draw attention to the following considerations:—

(i) The effects of changes in the quality of the service. Improvements in quality will as a rule increase the cost of replacement.

(ii) The probable effective life of hospital buildings. This in turn is influenced by what has been happening to the quality of the service, and by changes in medical standards.

(iii) Social, medical and other factors affecting requirements for hospital facilities in the future. We have referred in Part I of our Report (paras. 79–83) to the importance which social factors can have in connection with the future needs of the National Health Service. It is equally true that changes in medical technique can affect the kind of replacement that is desirable. A more rapid turnover of beds would diminish the number of beds that would otherwise be needed. Again, it is quite conceivable that hospitals of a certain type which are performing a useful service today will not be required for this purpose twenty or thirty years from now. Hence it does not follow automatically that all hospitals which could be held now to be at the end of their effective life should be replaced.

(iv) The future of hospital building costs. The situation in this respect would be greatly changed if it should prove possible to achieve for the hospital service results comparable with those which have already been attained in the building of schools. We are informed that, as a result of the introduction of standard building costs, it has been possible to reduce very substantially indeed the capital cost per place in real terms in new primary schools since 1949. The problem is clearly much more complex in the case of hospital building; but this matter is now under consideration by a Study Group set up by the Ministry of Health, and it is to be hoped that a similar

[1] See paras. 64–69 of our Report.

technique may be applicable at least in some branches of hospital construction.

316. As we have already stated, we have heard a great deal of evidence as to the capital needs of the hospital service; and we had already reached certain provisional conclusions when there came the announcement on 9th February, 1955, by the Minister of Health and the Secretary of State for Scotland of the Government's plans for increasing the rate of hospital building in England and Wales and Scotland in the next three years, subject to the voting by Parliament of the necessary funds. It is intended that the building programme shall be expanded in two ways, first by starting a number of new major building projects including new hospitals, and secondly by making a special allocation for "plant replacement and redeployment". In England and Wales it is proposed, in 1956–57 and 1957–58, to start major new building projects to a total value of £7½ million and £10 million respectively, and, for the plant replacement and redeployment programme, £2 million will be made available in the first of the years and £4 million in the second. Quite apart from these amounts, there will be £9 million available in 1956–57 and £10 million in 1957–58 for capital expenditure on other works. The total annual capital expenditure involved in the two years is expected to be in the region of £13 million and £18 million respectively.

In Scotland, hospital capital expenditure is to be increased from its present level of £1,900,000 to £2,200,000 in 1956–57 and £2½ million in 1957–58. Of the additional funds thus made available, £50,000 in 1956–57 and £150,000 in 1957–58 will be used to supplement the present special programme of plant renewal, on which £800,000 altogether will be spent in the three years from 1955–56 to 1957–58. The balance will be used to increase the number of major building schemes, and it is planned to put in hand schemes to a total value of £3 million during these three years.

317. In welcoming this announcement as an important move in the right direction, we wish to make some comment on two aspects of general policy relating to capital allocation. In the first place we agree with the present arrangement whereby each of the Health Departments retains a central reserve for financing large capital schemes which cannot be carried out by individual Boards on their own capital programmes. Indeed, as more capital is made available to the service in the coming years, we would suggest that a due proportion be set aside to increase the amount of the central fund held for this purpose. In the case of large capital works such as new hospitals, it is right that priorities should be settled at the national rather than the regional level, so long as Regional Boards themselves cannot all be allocated sufficient capital to enable them to finance the larger schemes themselves. It is not possible to define in strict terms what is meant by a "large scheme", since this will vary according to the amount of capital allocated to the service in any one year, and the way in which the amount is shared between the Boards themselves. A Board with an annual allocation of £750,000 for example, will be able to include larger schemes in its regional programme than a Board with only £250,000. At the present, we believe the "large schemes" are those costing £250,000 (or rather less in the case of the smaller Regions). The adjustment of these figures from time to time is a matter which can be left to the Health Departments in the light of the circumstances appertaining each year.

Secondly, we are in favour of the policy adopted by the Government of earmarking special capital sums for "revenue-saving" schemes. In the absence of such specific allocations, Regional Hospital Boards will always be under strong pressure to confine their capital programmes to schemes of direct therapeutic value to patients; and past experience shows that this is

a pressure which in general they have not found themselves able to resist. We believe that it is right that Boards should conform to a national policy in this field of capital expenditure and that allocations should be made annually for the specific purpose of financing revenue-saving schemes. Boards should prepare programmes for schemes of this kind over a reasonable period and Departments should insist on their being carried out according to programme, leaving no discretion for the money to be spent for any other purpose.

318. We come now to the question of what, in our view, should be the size of the annual capital sum to be allocated to the National Health Service. We note that the amount contemplated under the recent Government proposals for the year 1957–58 is £18 million for England and Wales, and £2½ million for Scotland, making £20½ million in all.

In making recommendations on this subject, we are fully aware of the over-riding importance of the general economic situation of this country, and of the fact that a capital programme for the National Health Service must depend upon the economic policy adopted by the Government of the day in the light of that situation. It has also of course to be viewed in terms of the relation which the capital needs and current costs of the National Health Service bear to other fields of capital and current expenditure for which the Government is responsible.

319. Subject to these considerations, having regard to the advanced degree of obsolescence of many hospitals in this country and to the very large arrears of capital expenditure resulting from the virtual cessation of hospital building since 1938, we are of opinion that £30 million annually would be a desirable rate of capital expenditure for the National Health Service at which to aim over the seven years succeeding the year 1957–58. We would point out that, on the basis of the estimate given in Part I of our Report (paragraph 64), it would appear that a capital sum of roughly £30 million with building costs at their existing level should be broadly equivalent to the £10 million of the capital expenditure in England and Wales for hospital purposes in the year 1938. We recommend further that out of this annual capital allocation of £30 million, some 10 per cent. or about £20 million in all should be earmarked specifically for revenue-saving schemes during the course of the seven-year period, 1958–59 to 1965–66.

We appreciate that it is an essential corollary to this recommendation that there should be a corresponding increase in the current annual allocations to meet the consequential increase in the annual running costs of the service.

Finance by loan

320. To facilitate a more rapid expansion of the hospital capital programme, some witnesses have suggested (though others have disagreed) that hospital capital works should be financed by loan, the loan interest and sinking fund charges being borne either by the Regional Hospital Boards or by the Ministry. Finance by loan, we were told, would be particularly appropriate for revenue-saving schemes, as the loan interest and sinking fund charges could be met from the savings accruing from the new capital works.

321. We feel, however, that there are strong arguments against this suggestion and we mention in particular the following:—

(i) The cost to the Exchequer of raising funds by borrowing would be appreciably greater through time than if they were derived from taxation.

(ii) The Health Service is not a revenue producing service and virtually the whole of its expenditure is financed out of public funds; there is no analogy, therefore, with the public utility undertakings.

(iii) So long as the level of annual capital expenditure is of such an order that it can be met out of annual budgetary revenue and is likely to be a recurrent requirement of the hospital service, there would seem to be good reason for not departing from the normal practice of central Government finance with regard to the raising of funds for capital purposes.

322. Taken in conjunction, these arguments seem to us to be conclusive, and we do not favour the raising of funds for capital purposes in the hospital service by means of loans.

Maintenance of capital assets

323. As the capital assets in the service do not appear in any balance sheet even at a nominal value, and as hospital authorities may be tempted to reduce their expenditure on the maintenance of assets in order to make more money available for the therapeutic needs of patients, it seems to us that there is a real danger that the upkeep of hospital buildings and plant may be neglected. We have no doubt that a great deal has been done since the Appointed Day to make good the deficiencies caused by the war and post-war years, and some of our witnesses have indeed maintained that the total capital value of the assets in the service is now higher than in 1948. Others, however, fear that there may have been some decline. Nevertheless, we are left with the impression that at no level from the Ministry to the hospital is there sufficient consciousness of responsibility for capital assets at all comparable with that felt in a business concern, where they are carried in the balance sheet and their maintenance and depreciation are recognised as priorities necessary to maintain the capital assets of the undertaking. As one of our witnesses said—" the absence of a proper system of capital accounting is to be regretted, as interest and depreciation (or loan redemption) should be important features in the assessment of the cost of projected developments, but are not, in fact, recorded in either estimates or accounts."

324. As hospital budgets have become tighter each year, there is of course the added danger that Hospital Management Committees may decide to save on their building maintenance subhead in order to meet overspendings in other subheads—a practice which, however understandable, does not help to maintain the capital assets of the service. It is an obviously false economy to spend money on the expansion of the service without having regard to the state of existing assets. In fairness it should be noted that until 1953 hospital expenditure on building maintenance was itself restricted by the Ministry as part of the national control of building materials and labour. Even since the lifting of these restrictions, however, we have reason to believe that building maintenance subheads have often been " raided " to make hospital budgets balance over the financial year.

325. We understand that a Working Party in the Ministry of Health is now considering this matter of building maintenance and in particular the question whether standards can be laid down nationally to cover such matters as the frequency of external painting, specifications for materials, etc. We do not know yet what the Working Party's conclusions are likely to be; but it seems to us in any event that there is a strong case for making Regional Hospital Boards responsible for allocating sums annually to Hospital Management Committees for the specific purpose of maintaining assets and

for that purpose only.[1] This would have the incidental advantage that Hospital Management Committees would be encouraged to spread their maintenance work more evenly throughout the year, as they would no longer be tempted to hold back work until the latter part of the financial year (January to March, when weather conditions are often unfavourable) as a cushion against possible overspendings on other subheads. Regional Boards and Hospital Management Committees should therefore be asked to work out schemes designed to ensure that proper standards of maintenance are observed in their Regions. The technical advice required to enable Boards and Committees to perform this duty might be provided either by the Boards themselves employing expert staff, or by the Boards (or their Management Committees) employing outside firms on a contractual basis. In any event, the Regional Boards should be responsible ultimately for ensuring that the maintenance work in the Regions is properly carried out. Boards and Committees should decide locally the best means of meeting this need.

The proper maintenance of these capital assets is a matter of the greatest importance in the long run. It appears to us right that the Regional Hospital Boards which are the agents responsible to the Health Ministers for the allocation of public money (including capital) to the Hospital Management Committees should also be responsible for ensuring that the fabric of the hospitals in their Regions is being suitably maintained.

Block grant and carry-over of unspent balances in the case of capital expenditure

326. We have heard a great deal of evidence in support of the suggestion that some more flexible arrangement should be devised for planning and financing hospital capital works, e.g. a block grant for five years; permission to carry-over any unspent balance; or a percentage " float " (say of 10–15 per cent.) for annual overspendings or underspendings during a five-year period. The arguments generally put forward in support of the case for more flexibility are:—

(i) a twelve-month period is too short for planning capital works and involves Hospital Boards in four or five reviews of the capital programme each year, any of which may lead to sudden stops and starts in the building works. Boards cannot be expected to hit the capital target accurately each year, but would be able to plan and carry out their capital programmes more efficiently and more smoothly over a five-year period.

(ii) If Boards find that they are likely to have a balance in hand towards the end of a financial year, they tend to insert small capital works of lesser priority into the capital programme, because these are usually the only schemes which can be started in the short time available. It is undesirable that the priorities in the capital programme should be distorted in this way.

(iii) When capital allocations are so small, Regional Boards cannot afford to " lose " any unspent balance at the end of the financial year.

327. We agree that there is more substance in these arguments than in those for the block grant and carry-over of unspent balances in the case of current expenditure. Nevertheless, we do not feel that they are strong enough to warrant a recommendation from this Committee which would involve a revolutionary change in Government finance. We are strengthened in this

[1] We understand that the sum provided for building maintenance has in fact been specifically earmarked for that purpose in 1955–56.

view by the fact that Regional Boards are now finding considerably less difficulty in spending up to the limit of their capital allocations than in the early years of the service when the machine was not geared up sufficiently to cope with the annual programmes, and when their execution was hampered by building restrictions, licensing requirements, etc. In table 41 we produce figures showing the approximate amounts allocated for capital works in England and Wales for the years 1948–49 to 1953–54, the actual amounts spent, and the resulting underspendings or overspendings in each year.

TABLE 41

Hospital Capital Expenditure—Annual overspendings and underspendings in the years 1948–49 to 1953–54*

England and Wales

£m. at actual prices

Year	Boards' allocation	Special schemes controlled by the Ministry, and Contingencies	Total amount allocated	Actual Expenditure	Over-spending + Under-spending −
1948–49 ...	7	—	7	5·3	− 1·7
1949–50 ...	8·8	—	9·8	8·3	− 1·5
1950–51 ...	9·7	—	9·7	8·4	− 1·3
1951–52 ...	8·7	0·9	9·6	9·1	− 0·5
1952–53 ...	7·1	1	8·1	8·6	+ 0·5
1953–54 ...	7·2	1	8·2	8·2	Nil

* All the figures quoted are approximate.

It will be observed that the heavy underspendings occurred in the years 1948–49 to 1950–51, and we are inclined to believe that the views of many of our witnesses have been coloured by the experience of those early years.

328. There is a further argument against the block grant and carry-over of unspent balances in the case of capital expenditure. If capital resources, in terms of manpower and materials, are not used in the year for which they are allocated, it does not necessarily follow that they will be available in succeeding years. Boards should plan to ensure that as far as possible capital is used in the year for which it is allocated. Moreover, it is the total amount of finance that is forthcoming which limits the size of any investment programme, and not whether the money is available on an annual basis or over a term of years. Although shortage of finance in any given year will affect the execution of capital works during that year there seems no valid reason why it should interfere with the efficient planning of a capital programme.

329. For these reasons, we conclude that no sufficient case has been made out for the block grant nor for the carry forward of unspent capital balances.

330. We have noted that, when making their announcement of the Government's plans for increasing the rate of hospital building for England and Wales and Scotland (see para. 316 above) the Health Ministers gave an indication of the capital allocations likely to be made available for the hospital service not only for the current year 1955–56, but also for the two succeeding years 1956–57 and 1957–58. We welcome the adoption of this procedure which will enable Hospital Boards to be notified of the annual amounts of capital likely to be allocated to them over a three-year period and not, as previously, for one year only. We appreciate that any forward notification must be provisional and might have to be modified if there were

to be a sudden national emergency. But an indication of the amounts likely to be forthcoming annually in a three-year period would, we feel, go some way to meeting the difficulties experienced in the past by Regional Hospital Boards, and in particular would facilitate the forward planning of hospital building works. It must be recognised that this would not be a block grant for three years in as much as the amount of capital that could be expended in any one year would be limited to the amount allocated in respect of that year.

Given this advance notification for two years ahead as well as for the current year, and given the substantial increase in capital allocations recommended above, we doubt if the question of the block grant and the carry forward of unspent capital balances will remain an issue of importance with Regional Boards in the future, particularly as they are now so much more skilled in the art of planning a capital programme over a twelve-month period.

Distinction between current and capital expenditure

331. A number of our witnesses have recommended that the present distinction between current and capital expenditure should be either abolished or considerably relaxed to enable hospital authorities, e.g. to use any savings on their current account to finance small capital works. It is suggested that this proposal would enable them to carry out many of the small capital schemes which mean so much to the individual hospitals, and which would increase the efficiency of many hospital departments.

332. It seems right to us, however, that a clear distinction should be drawn between current and capital expenditure in the hospital accounts, and that there are obvious dangers—not the least of which would be the inflation of annual estimates—if the Management Committees were encouraged to effect savings on the one account to finance capital works on the other.

333. We are not in favour of altering the existing arrangements in this matter so far as they relate to the service in England and Wales. We have noted that in Scotland, however, in accordance with the definition of capital laid down by the Department of Health, any purchase of furniture or equipment, etc., costing more than £20 is treated as capital expenditure whether the article purchased is a replacement or an addition. In England and Wales, on the other hand, the cost of replacing furniture and equipment, etc., is treated as current expenditure and only the cost of furnishing and equipping new accommodation (e.g., a new ward or nurses' home) is treated as capital expenditure.

The practice followed in England and Wales seems to us to be the more desirable of the two, and we therefore recommend the Department of Health to consider the adoption of the definition of capital now employed in England and Wales.

We appreciate that, at a later date, the definitions of capital adopted in both countries may have to be reviewed in the light of the reports of the Departments' Working Parties on Hospital Costing (see paragraphs 344–348 of our Report).

HOSPITAL COSTING

General

334. We cannot better introduce the subject of hospital costing than by quoting the following paragraphs from the Report on Costing Investigations of the King Edward's Hospital Fund for London.[1]

"When the National Health Service Act came into operation, thinking in hospital circles was still dominated by a pattern of hospital accounting

[1] Published in September, 1952. (See Appendix A, paras. 85–94.)

which dates back to 1869, when the Uniform System of Hospital Accounts was introduced into the Queen's Hospital, Birmingham. This System was revised and adopted by the King's Fund in 1906 and, as amended, it was the system in force in the great majority of the voluntary hospitals in the country in 1948:

"The system prescribed by the Ministry of Health in Statutory Instrument No. 1414 is for all practical purposes similar to this system. Thus hospitals have at present no sound basis upon which to meet to-day's perplexing financial problems, referring particularly to the use of the accounting system as an instrument of control over expenditure; to form a guide for the preparation of reliable budgets; and as a means by which much needed decentralisation of authority may be introduced with adequate control at the centre. . . .

"Important defects of this system are well illustrated in the following example. If we take the X-ray Department, we find that (i) plates and films are merged in 'Medical and Surgical Appliances and Equipment'; (ii) Laundry—if by contract—under 'Laundry'; (iii) Water under 'Water'; (iv) Salaries of Radiographers under 'Salaries and Wages—Professional and Technical Officers'; Nursing staff in this department under 'Salaries and Wages—Nursing'; X-ray clerks under 'Administration and Clerical'; (v) Renewals and Repairs under 'Maintenance of Buildings—plant and grounds'. Stated thus, the cost of the X-ray department has no significance. By reason of the fact that its constituent elements are merged with other elements merely because they have a similar designation, it is incapable of being considered in relation to any activity whereby its efficiency, and its effective use may be measured. The same comments apply to nearly every department and service of the hospital.

"When regard is had only to the wide range of differences in the nature and extent of the specialised services available, a fact much in evidence during our investigation, it is obvious that the subjective classification of expenditure is inadequate for reliable comparisons to be made between hospitals. Again, many of the heads of expenditure reflect the domestic facilities afforded by hospitals, but these facilities depend upon the proportion of resident staff, which varies considerably, and of which at present no account is taken.

"Some hospitals possess elaborate and most up-to-date apparatus for radiology and various forms of electrical treatment, while in others the equipment may be very limited and the volume of work comparatively negligible. Some hospitals have laboratories for bacteriology and pathology, etc., especially equipped and employing large staffs; in others little or no work of this kind is performed. Again, massage and remedial exercises are now recognised as valuable forms of treatment. In some hospitals this work is practically non-existent, whereas in others there is special provision, both of staff and apparatus. The average number of beds occupied in two hospitals may be the same, but one may possess all recognised special departments and the other only some of them, or perhaps none at all. One may possess two operating theatres; the other four; and so on. There are also marked differences in the physical layout, internal arrangements, residential services, and the nature and extent of the training and research work carried on. Finally, one hospital may have capacity for a greater output than is demanded of it or vice versa.

"Perhaps the most important defect of the present system is that the whole of 'Hospital Maintenance Expenditure' on in-patients is

reduced to the unit of cost 'per occupied bed', a unit which is calculated for each subjective heading of expenditure. Where so many different kinds of services are concerned the great majority of which have no direct connection with 'occupied bed', and so many variations exist between hospitals, an all-in unit of cost 'per occupied bed' cannot be accepted as a reliable unit of cost."

335. In England and Wales the system of hospital costing adopted in the National Health Service was introduced in its present form in 1950-51. The Hospital Costing Returns for that year were published in June, 1952, and similar returns have been published each year thereafter. The Returns have revealed striking differences in hospital costs even in cases where the hospitals concerned might seem at first sight to be reasonably comparable. The figures in the Returns do not, of course, distinguish the running costs of individual hospital departments, and notional adjustments are made in order to exclude the cost of out-patient attendances from the maintenance costs of hospital beds. As many of our witnesses have pointed out, therefore, the Returns do no more than point the way for further investigations into varying levels of cost; they do not themselves indicate any answers. The problem is made more difficult by the great diversity in the size and function of hospitals, and by the wide variations in the age and layout of buildings.

The Ministry informed us that the main object of publishing the figures in the Costing Returns is to encourage investigations by hospital authorities into the reasons for these differences between hospitals that are prima facie comparable. The Regional Hospital Boards have been asked to make reports on their investigations to the Ministry.

336. In Scotland, there has been in operation a subjective system of costing designed to take into account variations in the rate of occupancy of patient beds. This system of costing brings out composite unit cost figures which serve as a basis of comparison between hospitals of the same type. The data are published annually by the Department of Health for Scotland, and a series of special investigations has been conducted in the light of the pointers given by comparison of the unit costs.

337. Despite their defects, the Hospital Costing Returns are, in the Ministry's view, serving a useful purpose. They are helpful in pin-pointing apparently excessive items of expenditure which the local bodies may be able to investigate and put right if there is no good reason for them. They also help to suggest ways of securing more efficient use of resources without necessarily securing overall savings, e.g., the possibility of reducing the average cost per patient by securing a fuller occupancy rate. Most of our witnesses also have agreed that regular enquiries into varying levels of cost are a valuable exercise in themselves, despite the known limitations of the available statistics; and we gather that it is now the practice of most Hospital Management Committees to carry out such investigations in conjunction with their Regional Boards. One Board reported that they had queried 615 items of Hospital Management Committee expenditure in 1950-51 because the costs exceeded the regional average. Ninety-six of these items related to seven Hospital Management Committees. As a result of the Board's enquiries, 73 of these 96 items showed an improvement in 1951-52 and 1952-53 as compared with the regional average; 2 showed no change; and 21 showed a deterioration.

It is relevant to note that cost investigations do not necessarily lead to reduced expenditure. We heard of one instance where a Management Committee agreed to improve the feeding standard in one of their mental hospitals because the costing figures had suggested that the standard was falling below what was required to meet the needs of the patients.

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338. We should also add that some of our witnesses believe that more use could be made of the existing Costing Returns without incurring the expense of introducing a more elaborate costing system. They claim that the existing statistics and information, properly analysed, could be made to produce comparable results at less cost in money and manpower. They have added that it would be an advantage to employ expert accountants or industrial consultants to interpret the costing figures and to evaluate standards of management efficiency etc., for the guidance of Management Committees and hospital officers. This would stimulate and encourage those people in the service who are prepared to take a keen interest in hospital costing. One such investigation in a Hospital Region produced recommendations showing savings of £11,000 per year on an annual budget of £400,000. These witnesses have doubted whether the cost of introducing an elaborate departmental and unit costing system could ever be worth the savings likely to be achieved thereby. In reaching this conclusion they have been greatly influenced by the belief that variations in the cost of medical services are often due to differing medical techniques employed by the clinical heads of hospital departments, and that no system of hospital costing, however elaborate, can be expected to have any effect on those techniques.

339. The majority of our witnesses are convinced, nevertheless, that investigations into hospital costs will never achieve the best results until more precise costings are available to prove to heads of hospital departments how and why their expenditures have varied from year to year and how they compare with the costs of other comparable departments elsewhere. As the existing Costing Returns contain so many defects, there is a tendency on the part of some Management Committees to devote their energies more to explaining away their higher costs than seeking out the root causes. More accurate costings are required therefore to bring home responsibility for abnormally high expenditure.

Departmental and Unit Costing

340. In 1952, the King Edward's Hospital Fund for London[1] and the Nuffield Provincial Hospitals Trust[2] submitted reports to the Minister (which had been prepared at his request) on the result of their investigations into hospital costing. Both reports were in agreement in recommending:—

(*a*) that the existing accounting system based on subjective analysis of expenditure, as prescribed in Statutory Instrument No. 1414, be discontinued;

(*b*) that an accounting system based on the departments and services of the hospital be substituted, modified where necessary for small hospitals;

(*c*) that the expenditure of departments be reduced, where appropriate, to costs per unit of work performed;

(*d*) that the budget and budgeted unit costs for each hospital follow the accounting pattern referred to in (*b*) and (*c*) above;

(*e*) that normal accounting principles be introduced, including the preparation of an income and expenditure account and a balance-sheet.

341. They were not in complete agreement, however, on the stages by which the departmental system should be introduced, nor on the nature and complexity of the units of cost to be employed. The King's Fund recommended, for example, that the expenses of general service departments (laundry, boiler house, kitchen, etc.), should be distributed to the "patient's accounts" (i.e., the wards, X-ray, out-patient departments, etc.), so that the total cost of each might be ascertained as part of the normal routine accounting procedure. The Nuffield Trust, on the other hand, regarded the production of departmental costs on a prime cost basis as the first essential. To quote their own words:—

> "If the pattern of the costing system follows the pattern of the administration of a hospital, a separation of expenditure on patient departments from general service departments is automatically made, and each responsible member of the staff is made aware of expenditure incurred by him for his department and of variations in that expenditure which can be controlled by him. Cost over which he has no control is excluded. The spread of expenditure on any one department over all other departments served by it is of lesser importance, and in fact only necessary for special purposes, and for the calculation of the total cost of an in-patient and out-patient at the end of each financial year."[1]

342. In the same year, a Report by the Costing Sub-Committee appointed by the Committee of Regional Hospital Board Treasurers,[2] set out their proposals for hospital cost accounting which differed from the Reports of the King Edward's Fund and the Nuffield Trust in that they recommended the retention of the existing subjective accounts system supplemented by measures designed to show a departmental analysis, including the cost per in-patient and cost per out-patient.

343. After considering these three Reports, and consulting representatives of hospital authorities, the Ministry decided that it was not practicable at present to contemplate the complete replacement of the existing subjective accounts system by one based on the departments and services of a hospital. Their reasons for reaching this conclusion included the following:—

(i) If an attempt were made to introduce a departmental costing system and to drop the subjective accounts at one and the same time, the hospital administrative machine would almost certainly be overstrained and financial chaos might result.

(ii) A great deal of the information provided under the subjective heads of account would always be required by the Department, the Treasury and Parliament, e.g., to show the total amounts spent on salaries, wages, drugs, provisions, etc.

(iii) As it was not intended at this stage to apply full departmental costing to all hospitals, there was in fact no alternative but to retain the existing subjective system of accounts in the hospital service, and to superimpose on it a departmental costing system in those hospitals where it was required.

344. The Ministry agreed with the view, however, that in at any rate the larger hospitals, a system of departmental and unit costing (which was supplementary to a subjective analysis of expenditure in the accounts) would be of value to hospital administrators and would facilitate efficient and economical spending. As the views differed widely about the most practicable system to be adopted, the Ministry set up a Working Party[3] charged with the duty of working out details of an agreed practical and departmental

(1) King Edward's Hospital Fund for London—Report on Costing Investigation for the Ministry of Health. London, September, 1952.
(2) Nuffield Provincial Hospitals Trust—Report on an Experiment in Hospital Costing. London, 1952.

(1) Report of the Nuffield Trust. Appendix VII, para. 11.
(2) National Health Service—Hospital Cost Accounting. Second Report of the Costing Sub-Committee appointed by the Committee of Regional Hospital Board Treasurers.
(3) Report of the Working Party on Hospital Costing. H.M.S.O., 1955.

unit costing system, on the basis that a subjective accounts system would be retained and with the fullest possible regard to the need for economy in money and manpower. The Working Party were asked to suggest also to what types and sizes of hospital their proposed costing system or systems should be applied. The Working Party which began their work in November, 1953, included representatives of the Ministry, the King Edward's Fund, the Nuffield Trust, and Regional Board Treasurers, together with other representatives of the administrative and financial sides of the various types of hospital authorities concerned. With some reservations[1] the Working Party finally reached the following broad conclusions:—[2]

(*a*) The introduction of a full departmental costing system should be evolutionary, i.e., starting with the hospitals where the greatest amount of money is being spent and gradually bringing into the field other hospitals where a full system appears to be warranted by the facts.

(*b*) The Working Party's "main scheme" of full departmental costing should be applied initially only to hospitals of the acute and mainly acute types with an annual expenditure of £150,000 or more; and no Management Committee or Board of Governors should be required to work the scheme at the outset in more than one hospital in its group. Some 200 hospitals in England and Wales would be affected by the "main scheme".

(*c*) The "main scheme" followed generally the recommendations of the report of the King Edward's Fund, i.e., that the cost of the general services departments should be re-allocated to the medical departments. The Working Party report went a little further, however, in recommending that the in-patient and out-patient costs should also be compiled from the departmental costs. This detailed costing would of course be carried out by hospital authorities only once per year. Interim costs statements would be produced at more frequent intervals, for purposes of internal management, based on the prime costs of the departments and services concerned.

(*d*) Hospitals other than those referred to in (*b*) above should, for the time being, be required to undertake a simpler costing system based on a subjective analysis of expenditure. With a view to keeping these arrangements as simple as possible no attempt should be made to redistribute the expenses of service departments to user departments. Where circumstances permit, however, hospital authorities concerned with hospitals spending more than £50,000 per year and with a large number of out-patients should consider developing their simpler costing arrangements on the basis of the "main scheme" outlined above.

(*e*) The expenditure of particular departments and services should, where expedient, be reduced to costs per unit of working performed.

[1] Two members of the Working Party entered a reservation to the Report to the effect that "before any uniform system of departmental costing is applied so widely as the Report recommends, there should be an experiment on a more limited scale with a view to assessing more closely the value of a unit system to the hospital service, the advantages and benefits to be derived from it and whether it justifies the expense. We therefore favour a drastic reduction in the number of participating hospitals to a total of about fifty." The two members added "We feel that it has yet to be demonstrated that a uniform system of costing will be of permanent value to hospital administration or that the high cost of introducing and running it will be justified by improvement in efficiency and elimination of extravagance." (para. 29.)

[2] See para. 26 of the Report of the Working Party.

(*f*) For the present, depreciation charges should be set up only in respect of certain plant and equipment used in diagnostic and X-ray departments and in laundries. With regard to hospital buildings, the Working Party considered it preferable to ignore notional depreciation charges and to leave the nature and age of hospital buildings to be dealt with generally as one of the factors in comparing varying levels of hospital costs.

(*g*) Much more research and experience would be necessary before a departmental costing system could be used as an aid to the central distribution of funds.

(*h*) Before departmental costing could be introduced, a system of pricing stores would need to be developed in many hospitals.

(*i*) The Working Party concluded by emphasising "not only that the production of costing statements does not of itself secure any useful purpose but also that their use for inter-hospital comparison affords no proof that one hospital is either more or less efficiently managed than another. Comparative costs, whether between different periods in the same hospital or different hospitals in the same period, do, however, give useful pointers to lines of enquiry which could profitably be followed but to be of maximum use to Management Committees it is essential that enquiries into apparent abnormalities should be vigorously pursued as soon as possible after the end of the period to which the figures relate."

345. We understand that the Working Party came down in favour of full departmental costing for the "main scheme" in preference to a system based on prime costs only, because they considered that although prime costs are useful for making comparisons within a hospital they are less useful for comparing one hospital with another; and also that it is extremely difficult in practice to define prime costs with any degree of precision. On balance, therefore, they felt that a full departmental costing system would be more valuable in the larger hospitals.

346. The Working Party's report made little reference to the use of hospital costing in local budgetary control and management, mainly, we understand, because the Working Party considered that their first duty was to devise a workable system of departmental costing and to suggest to which hospitals it should be applied. Once a departmental costing system has been introduced into the service, however, it should naturally follow that hospital administrators and heads of departments will have available information which will enable them to compare the budgeted expenditure of hospital departments with the actual expenditure incurred during the year. This is a new concept which will have to be put across to hospital authorities by a process of education.

Scotland

347. In May, 1953, a Working Party was also appointed by the Department of Health for Scotland with terms of reference broadly similar to those of its English counterpart. The conclusions of the Scottish Working Party, however, which are summarised below, differed considerably from those of the English Working Party:—

(i) The Scottish Working Party decided to present an interim report only, in the first instance, because they felt that they would like to have an opportunity of studying the results of a wider application of departmental costing in the hospital service before making final recommendations on a general costing scheme. While the

Working Party was satisfied that departmental costing was a practical proposition and that its potential value as an aid to efficient hospital administration justified its development in the hospital service, they were not entirely satisfied that full departmental costing as an aid to financial control at departmental level, etc., had been convincingly demonstrated by the two experiments already carried out in Scotland. They found it significant, for example, that the Glasgow Royal Infirmary had started with a scheme of full departmental costing but had subsequently changed to one based on prime costs only. One of the difficulties facing those running the experiments had been the lack of any opportunity to make comparisons with departmental costs at other comparable hospitals.

(ii) The Scottish Working Party therefore recommended in their interim report the introduction of a costing system based on prime costs only which would be applied initially to 30 hospitals in Scotland. When Regional Boards and Boards of Management had been able to study the progress of the scheme and the use made of it over a reasonable period of time, the Working Party would review the matter again and consider what further recommendations, if any, were necessary.

(iii) The Working Party preferred the system based on prime costs because:—

(*a*) it was simpler;

(*b*) it would require little in the way of additional staff;

(*c*) it would be more acceptable to hospital managements and staff;

(*d*) full departmental costing involves apportionment of costs which depends to some extent on guess-work. Hospitals cannot be relied on therefore to follow the same methods of apportionment in all cases;

(*e*) uniformity between hospitals in costing procedure would be more easily obtained by this means.

348. The recommendations of the English and Scottish Working Parties are now being considered by the Health Departments in consultation with the hospital authorities. We understand that the attitude of the Departments at the present is one of caution. They believe that a period of evolution is needed to enable experience to be gained and hospital authorities to be educated as to the advantages and uses of hospital costing. The value of departmental costing lies in the use made of the figures produced and hospital administrators and staffs must be educated to take an interest in the annual costs of hospital departments and their variations in time and space.

Our own view

349. We have reviewed the history of hospital costing in some detail because we regard it as an important aspect of our terms of reference. The hospital service absorbs by far the greatest share of the country's expenditure on the National Health Service; and it is important, in the interests both of the service itself and of the public, that every means possible should be devised to ensure that the available resources are used to the best advantage.

We are of opinion that a good case has been made out for the introduction of departmental costing into the hospital service and that it should be started experimentally in the first instance in a limited number of hospitals and expanded subsequently in the light of experience. Whilst we would agree

that the subjective accounts must be retained at least for the time being, we would suggest that their retention be reviewed at a later date, after departmental costing has been expanded in the hospital service, to see if their continued retention is in fact essential. We are not concerned at this stage whether full departmental costing (as recommended in the "main scheme" of the English Working Party's report) is to be preferred to a costing system based on prime costs only (as recommended in the Scottish Working Party's interim report). Indeed, there are many advantages in our view in carrying out experiments on two different schemes in England and Wales and Scotland, so that experience may be gained over a wider field and future extensions of hospital costing devised in the light of that experience. We would welcome therefore, the adoption of the two Working Parties' reports broadly in their present form.

350. We are convinced, moreover, that the present system of relying entirely on subjective costing is unsatisfactory because it fails to reveal to the heads of hospital departments how the annual expenditure of their departments varies in time and space; and, more important still, how the actual expenditure of their departments at the end of the financial year compares with the budgeted expenditure at the beginning of the year. No doubt these budgetary controls will be exercised more easily in the service departments of a hospital (e.g., catering, laundry, boiler house, etc.) than in the clinical departments; but we believe that all hospital departments whatever their type would learn a great deal about their costs and standards of efficiency if they carried out this exercise regularly each year. The hospital service would then be more truly "accountable" than it is now for the money it is spending year by year out of the National Health Service budget. Hospital managements too would find it easier to ascertain the reasons for disparate levels of expenditure in hospital departments which are, prima facie, comparable.

351. We would urge the importance therefore of establishing at the hospital and departmental levels a system of effective budgetary control which will enable hospital managements in suitable cases to set their standards of efficiency each year and to judge at the end of the year whether those standards have been achieved. It is at the unit hospital level where economies can be effected, and it is essential therefore that all hospitals should have a system of accounts which will make their budgetary control effective. As soon as practicable, hospital departments should forecast annually how they propose to spend with maximum efficiency the money allocated to them, and should be required to account for any wide discrepancies at the end of the financial year. By this means we believe that the heads of hospital departments will be given a sense of responsibility to see that, as far as may be, their forecasts are achieved.

It should be the concern of the Health Departments vis-à-vis the Regional Hospital Boards and Boards of Governors; of the Regional Hospital Boards vis-à-vis their Management Committees; and of the Hospital Management Committees vis-à-vis their unit hospitals, to see that these budgetary controls are properly exercised throughout the hospital service. The lack of such controls in the past has, in our view, been a serious omission in the National Health Service.

352. We appreciate that departmental costing will involve hospital doctors, administrators, and other staff in some additional work, but the amount should not be excessive and we trust that all concerned will co-operate to the utmost in order to make a success of this vital aspect of hospital management. (See also para. 367 below.) Costing schemes should be regarded not as a means of imposing restrictions on the service but as a means of ensuring that the best value is obtained for the money spent.

353. We wish to endorse the point of view expressed in the following paragraph (para. 105) of the King Edward's Fund Report on Costing Investigation from which we have quoted earlier in this section of our Report.

> "Few hospital authorities would admit that their problems of management to-day are less complex than those of a good size commercial undertaking. It has been said that where the profit-earning motive is absent, as in State services, accounting is of little use as an instrument of control; also that a business has to make things pay but a government has to get things done. We submit that there is no difference in substance between these two points of view. The idea of specific performance underlies both. In business it is found desirable to install effective accounting methods as an instrument of control over expenditure, and we consider it equally desirable to set up a similar system to control the expenditure of public funds. To hesitate to do so is tantamount to saying that as public work cannot be interpreted in the form of profit or loss, it does not matter how it is done, or what it costs."

354. Additional expenditure will it is true be incurred in the introduction of departmental costing—and there are widely varying views as to the amount involved—but from the experience of the two experiments already carried out in Scotland, it would seem that the cost will not be unreasonably heavy once the scheme itself has been introduced (i.e., after a proper system of stores accounting in quantity and value has been installed in hospitals where it is not already in operation). It should be noted therefore that in certain hospitals proper stores accounts (which are essential for the avoidance of waste and loss) would be a by-product of departmental costing and should be set off against the additional expenditure incurred in its introduction. It is likely, too, that departmental costing will provide an impetus to the introduction of mechanised accounting systems in Regions where they are not yet in use; and this would, we think, lead to some overall economy.

In short, we have little doubt in our own minds that departmental costing will more than repay the cost of its introduction in promoting increased efficiency and a fuller sense of responsibility for spending among all those concerned with the running of hospitals.

Other Measurements of Efficiency

355. We appreciate that hospital costs alone do not necessarily reflect the efficiency of hospital management and that they are better examined with other statistical indices such as bed occupancy, length of stay of patients, bed turn-over, turn-over interval, waiting time, staffing ratios, etc. It is one of the problems of management—and a particularly difficult one in the case of the hospital service—to find the right indices for measuring efficiency and we have noted with interest the efforts which have been made so far by the Health Departments to find the right answers.

356. It was of course only with the advent of the National Health Service that it became possible to collect, and therefore to use, hospital statistics on anything like a uniform basis, so that they might be used for comparisons which might in turn lead to improved efficiency. As the Ministry of Health pointed out to us, the Department were dealing here with a completely new field, and their first task was to discover the figures which would be useful to the Ministry, to Regional Boards, Boards of Governors and Management Committees, for their different purposes. A Ministry Working Party spent a good deal of time in considering what figures should be collected and, subsequently, in reviewing all the hospital returns in the light of experience. The results of this revision will all be embodied for the first time in the

Hospital Statistical Returns for 1955 and it is hoped that these will remain unchanged for some little time so as to enable comparative information to be built up. In future, the annual volume of hospital statistics will be put on a new basis following the recommendations of the Ministry's Working Party.

357. As the field is new, it has been necessary to devise and try out various ways of using the figures obtained. Average occupancy of beds, length of stay of patients, bed turn-over, turn-over interval, waiting time, etc., are all concepts that have their value in measuring the efficiency with which beds are being used, though none of them is much use by itself. Another effort to provide comparable figures has been the devising of unit systems of measuring the work done in pathological, radiological and physiotherapy departments.

358. In the Scottish Northern Hospital Region a survey of all in-patient treatment (other than mental hospital treatment) has now been in hand for several years. The essential data for each in-patient are entered on punched cards, thus making detailed analyses possible.

Similar surveys are being conducted in a few general hospital groups in other Scottish Regions. Surveys of this kind, which provide data of a clinical nature, are of value not only in an assessment of the hospital service in the areas concerned but in providing a check upon the interpretation of the routine statistics collected from hospitals generally.

359. A survey of hospital morbidity is also in progress conducted by the General Register Office on behalf of the Ministry. This consists of collecting information on a sample basis about patients admitted to hospitals showing the age, sex, etc., reason for admission, the length of stay, the final result, etc. So far this has been carried out in a few hospitals only but the project is being widened rapidly. Its main use is in showing the reasons why patients are admitted and assisting hospital planning from this point of view.

360. Other steps have also been taken to study the use of statistical techniques at the hospital level, e.g., the King Edward's Fund study on Bed Occupancy which has aroused a good deal of interest and was commended and followed up by a Ministry memorandum(1) on the use of hospital beds. Statistical material has also been circulated to the Senior Administrative Medical Officers of Regional Boards and discussed with them in order to interest them in the subject; and other material has been circulated to Secretaries of teaching hospitals to enable comparisons to be made. The Ministry have no doubt that interest in this subject is growing and that in some places it has led to effective improvements in the use of beds.

361. As the Ministry pointed out to us in oral evidence the level at which these figures can be useful must also be borne in mind. National figures, for example, can provide averages and trends on a very broad basis. As part of the process of educating hospital authorities, there has been some exposition of national and other trends as shown in the statistical returns, e.g.,—the Report of the Chief Medical Officer in 1952, Chapter 13, and in the Ministry's Annual Report for 1953, pages 7–9.

362. For the future, the Ministry told us that:—

(a) There is still a good deal of room for improvement in the accuracy of returns and in their prompt collection and also in the presentation of the statistics collected.

(1) H.M. (54) 89.

(b) It seems clear that there are other statistical techniques which might well be devised and used for comparative purposes, e.g., by relating the hospital morbidity statistics with the hospital returns.

(c) There is also some prospect of being able to arrive at a closer estimate of need for hospital facilities of various kinds than the rather subjective guesses which have been made in the past.

The Ministry hope that, with the appointment in the Department from July, 1955, of a statistician and the development of a statistical unit under him, it may be possible to make some further progress in these fields.

363. As we have already mentioned in paragraph 325 of our Report, the Ministry have also recently appointed a Working Party to consider whether some objective standards of building maintenance might be worked out for the hospital service—e.g., to produce a list of operations, such as painting, the cost and frequency of need for which might be laid down.

364. In our view, the Health Departments have been proceeding on the right lines in their continued search for statistical indices which will be helpful to hospitals in improving their management efficiency; and we trust that all hospital authorities and the staffs concerned will continually study the available statistical material to see what steps might be taken in hospital departments to improve the efficiency and economy of the service. The statistics themselves do not provide the answers; they only point the way for further enquiry and investigation.

For the future, however, we believe that it would be helpful if the Ministry of Health and the Department of Health for Scotland were to set up a "Research and Statistics Department" which could devote the whole of its time to statistics and operational research generally. This piece of administrative machinery (which we describe in more detail in Part VII of our Report) would, in our view, speed up considerably the seeking out of new indices and would provide material which would be helpful to the Departments' administrators in the formulation of new policies. It is a matter for regret that for the first seven years of the service, the Ministry should have been without the services of a qualified statistician.

365. We have also noted with interest the establishment by the Ministry of Health in July, 1954, of an Organisation and Methods Service(1) on an experimental basis, to give advice to hospital authorities (at their own request) on various aspects of hospital administration which seem to offer scope for improved efficiency—e.g., on the keeping of medical records, on out-patient appointment arrangements, stores procedures, wage paying systems etc., etc. It is too early yet to judge the value of this experiment or of similar services provided by industrial consultants under contract with the hospital authorities themselves; but, at a later date, when sufficient experience has been accumulated, the Ministry will consider whether there is a permanent need for such a service and if so on what scale it should be provided. In the Ministry's memorandum H.M. (54) 64, it was suggested that the Department might prepare memoranda from time to time "containing any conclusions of general interest that have been reached by the investigators as a result of the individual studies, and to circulate these memoranda to all hospital authorities, thereby spreading the benefit of the investigations over the widest possible area." We agree that this is a useful method of comparing standards of efficiency within the service, and might well form one of the duties of a central Research Department, acting in conjunction with the Ministry's administrators and the Organisation and Methods Service.

(1) See H.M. (54) 64.

366. To sum up, we welcome all the efforts which have been made, and are still being made, both centrally and locally, to make hospital authorities and heads of hospital departments aware of their standards of efficiency, not only in the spending of money, but in the management of the service generally. When the right information is made available to responsible officers, and at the right levels of management, the stage is set for the examination of standards of performance in hospital departments both internally and in relation to other comparable departments elsewhere. The information is worthless, however, unless hospital managements make full use of it; and we trust that the Health Departments, Hospital Boards and Management Committees will continue to encourage all concerned to take a close interest in, and to study carefully, all the material relating to hospital costs and measurements of efficiency generally. As we have already said, this is the best way to ensure that the available resources are used to the best advantage. It may entail the appointment of additional administrative, clerical and statistical staff, but it would be a short-sighted policy to criticise such expansion of staffs as is required for this essential piece of hospital administration.

367. We have repeatedly in this Report referred to the efficiency and economy of administration. We should regard it as unfortunate if opposition to the compilation of departmental costs or similar data were to be based on the mistaken idea that any conclusions could be drawn from these figures as to the professional standards or competence of doctors in different hospitals. It is, of course, self-evident that in the exercise of their medical functions, doctors are in a position to influence the amount of public money expended in hospitals; and it is important that they should recognise the responsibility that rests with them in this respect. Even in matters of medical practice, such as prescribing of drugs, doctors should be aware of the cost; although it does not follow that this knowledge should affect their action when deciding what is best for their patient. The operation of a system of departmental costs will require the willing co-operation of those concerned with hospital administration, not least the doctors; and it is much to be hoped that this will be obtained.

NON-EXCHEQUER FUNDS IN THE HOSPITAL SERVICE

The position in England and Wales

368. In addition to the funds provided by the Exchequer, hospital authorities have varying amounts of income of their own from endowments, gifts, etc., which are now generally referred to as "non-Exchequer Funds". These funds, which may be spent for any purpose relating to the hospital service (including research), may be divided broadly into two categories:—

(i) those which were in existence on the Appointed Day;

(ii) those which have been received by Hospital Boards and Management Committees since the Appointed Day.

All the endowments in category (i) which belonged to non-teaching hospitals on the Appointed Day were collected into a central fund (the Hospital Endowment Fund) and freed from all existing trusts.(1) One half of the net capital of the fund was then shared notionally between Hospital Management Committees according to the number of beds controlled by the Committee, and

(1) Except certain endowments which were given to hospitals or trustees between the passing of the National Health Service Act and the Appointed Day (see the proviso to Section 7 (4) of the National Health Service Act, 1946). Such endowments were not transferred to the Hospital Endowment Fund but were vested in the Hospital Management Committee.

the annual income from each share is paid over by the Ministry to the Management Committee concerned. The other half was shared between Regional Boards on the same basis and, by administrative arrangement, most Boards have distributed four-fifths of their receipts from the fund among the Management Committees in their areas, so as to even up the amount of endowment money available to each Committee.[1] The distribution of the funds between hospitals remains extremely uneven nevertheless, and those hospitals with the smallest funds are often most in need of the amenities which these funds could provide.

369. The Minister has power to hand over to hospitals a share of the capital itself in the Hospital Endowment Fund, but this power has never been used. After certain existing liabilities had been discharged, the value of the securities in the Hospital Endowment Fund at the Appointed Day was approximately £20 million. The market value of the securities in the Fund at the 31st March, 1954, was about £17,878,500.

370. The endowments which belonged to teaching hospitals on the Appointed Day were not collected into the central fund but were by statute vested in the Boards of Governors and freed from existing trusts.

371. Under the National Health Service Act, 1946, hospital authorities still have power to accept gifts and legacies for hospital purposes, and considerable sums are in fact contributed each year. The uses to which these funds are put depend of course on the terms of the trust; and if for example a particular hospital is specified in the trust, the funds may be devoted to that hospital only.

372. Although these non-Exchequer Funds are commonly used to provide amenities for the patients and staff (and are therefore often known as "Amenity Funds") there is nothing to prevent their being used to meet the ordinary running costs of hospitals, so long as the terms of the trust are not broken in the case of gifts and legacies received after the Appointed Day. Many hospitals do in fact spend endowment moneys on purposes for which Exchequer money could properly be used, e.g., for the cost of furnishing a nurses' home but for which Exchequer money is not available at the time. The Ministry have been careful not to discourage this practice.

373. These non-Exchequer moneys do not form part of the Exchequer account, but they are subject to audit by the Minister, and the statutory bodies are required to furnish annual statements relating to them. An account of the transactions of the Hospital Endowment Fund is presented to Parliament each year.

The position in Scotland

374. Under the Scottish Act of 1947 hospital endowments (including those of the teaching hospitals) were transferred initially to the Boards of Management pending the making of schemes by a Hospital Endowments Commission constituted under the Act. The Commission completed its task of making schemes in 1955. Under these schemes a proportion of the endowments (the total annual income of which is about £470,000) has been transferred from the Boards of Management initially holding them to other Boards of Management; small endowment funds have been established for each of the Regional Hospital Boards; and endowments producing an income of about £100,000 per annum have been transferred to the Scottish Hospital Endowments Research Trust, a body constituted under the Hospital Endowments

[1] The total amount of income from the Hospital Endowment Fund distributed to Regional Hospital Boards and Hospital Management Committees in respect of 1953–54 was £666,000.

(Scotland) Act, 1953, to assist the conduct of research. The accounts of the endowment funds held by the Boards of Management and the Regional Hospital Boards are audited by auditors appointed by the Boards themselves.

Appeals for Funds

375. Successive Ministers have adhered to the policy that hospitals should not make public appeals, either directly or indirectly, for voluntary contributions towards the cost of the hospital service; though the hospitals do of course remain free to accept gifts, etc., and have been encouraged to seek the help of voluntary workers in the service where appropriate.

In the early years of the National Health Service, this ruling was applied very strictly and members of hospital authorities were debarred even from taking part in the activities of such voluntary bodies as Leagues of Friends. These bodies in their turn were not allowed to operate from hospital premises.

376. In recent years, the rules have been considerably relaxed. Members of hospital authorities may now take part in the activities of voluntary bodies, and permission has been given for occasional meetings of voluntary bodies on hospital premises, and for collecting boxes to be set up in hospitals for specified purposes. It still remains the rule however that a member of a hospital authority cannot be associated in his official capacity with an appeal for funds by a voluntary body and that no public appeals can be made by the hospital authorities themselves.

POINTS RAISED IN EVIDENCE

Voluntary effort in the Hospital Service

377. Before dealing with the points made in evidence on this subject, we should like to pay a warm tribute to the work which has continued to be carried out by voluntary bodies in the hospital service since the Appointed Day. There were many who thought that the introduction of a National Health Service would mark the end of voluntary effort in the nation's hospitals; but the experience of the last seven years has proved that the link of voluntary service between the public and their hospitals has been renewed and in some cases strengthened, particularly in the last few years.

378. It is often forgotten that the members of Regional Boards, Boards of Governors, Hospital Management Committees and Boards of Management are themselves giving their services voluntarily to the management of our hospitals, and the country is indeed fortunate in having so many people who are willing to devote a substantial proportion of their time in this way to the hospital service. Quite a number of these members have appeared before us to give oral evidence, and we have been impressed by their deep interest in the future development and efficiency of the hospital service.

379. In addition, a great deal of invaluable work is being carried out voluntarily by Leagues of Friends (usually associated with a particular hospital or group of hospitals), the Women's Voluntary Services, the St. John Ambulance Brigade, the British Red Cross Society, and others. Their work includes the visiting of patients in wards; arranging outings, concerts and parties; acting as receptionists in out-patient departments; running library, "trolley" and canteen services; making up dressings; providing occupational therapy for long-stay patients; providing additional amenities and comforts for hospital patients and staff; and following up discharged patients to help with their after-care. By these means—and many others too numerous to mention—the voluntary organisations are helping to maintain the vital

link between local communities and their hospitals. They are bringing the outside world to the hospital patient, and making the public better informed about their hospital services and the needs of the patients treated by them. We are of opinion that there is still much scope for more voluntary effort throughout the hospital service, but particularly in the mental hospitals and chronic sick hospitals where the needs of patients are great but not always so widely appreciated. We have noted with pleasure the continuing increase in the number of Leagues of Friends and the encouragement given to them officially by the Health Ministers in recent years. It seems to us that the continuance and further expansion of voluntary service is one of the surest ways of maintaining the essential humanity and vitality of the hospital service and preventing the development of that enemy of human welfare—institutionalism.

Voluntary contributions

380. In order to raise funds for the provision of amenities for patients and staff, it is the practice of Leagues of Friends and other voluntary organisations to make appeals locally for voluntary contributions. Some of our witnesses have suggested that it would be preferable if Hospital Management Committees, Boards of Management and Boards of Governors themselves were authorised to make such appeals, including appeals for the financing of small capital works. We have been told that this would stimulate public interest in the local hospitals and would encourage a sense of independence and responsibility at hospital group level.

381. Others have pointed out that public appeals by hospital authorities for specific purposes, and especially for capital works, could be a source of embarrassment to Management Committees and to Regional Hospital Boards, whether the appeals were successful or not. We have also been told that undue prominence should not be given to hospital appeals as there are other statutory services, e.g., the care of the aged in their own homes and old folks' homes, where there is an equally great need for voluntary help and funds.

382. In our view—and this is in agreement with the great majority of our witnesses—it is entirely appropriate that appeals for voluntary contributions should continue to be made by the voluntary bodies (for purposes mutually agreed between the bodies and the hospital concerned) but not by Management Committees, Boards of Management, Boards of Governors or Regional Hospital Boards themselves. In some cases, e.g., where capital works are involved, we appreciate that the concurrence of the Regional Hospital Board might be needed before an appeal is launched. There is need for the closest possible co-operation between hospital authorities and voluntary organisations in this and in all other matters concerned with voluntary services; and this is a field in which the House Committee can play an important part; but we do not consider that the hospital authorities should themselves take part in launching a public appeal for hospital funds.

383. We note that many hospitals are now spending endowment moneys on purposes for which Exchequer money could properly be used; and we see no reason why they should not continue to do so. If a hospital authority wishes to improve the furnishings or the standard of building construction in a new wing or hospital department, which would cost more than the amount of Exchequer money available at the time, we think it entirely appropriate that the hospital authority should finance the "element of improvement" out of their non-Exchequer funds, if they so desire, and if the terms of the Trusts permit. No doubt certain Boards of Governors may consider using their endowment funds in this way when the time comes to make a start on their new building programmes. We have noted that some Boards of Governors already are applying their non-Exchequer moneys to the provision of new hospital buildings.

HOSPITAL BOARDING CHARGE

384. Most of our witnesses have been reluctant to discuss the question of a boarding charge for hospital in-patients, on the grounds that this is primarily a political issue outside their concern. Those who have expressed an opinion, however, have been generally opposed to its introduction.

The case for the charge

385. The case for the charge is based on the contention that there is likely to be some saving in the home expenses of the patient while in hospital (particularly in feeding costs), and therefore that patients might reasonably be expected to pay a weekly boarding charge, say of 21s. per week, during their stay in hospital.

There is the further argument that, for reasons of financial benefit, patients may actually be encouraged to go into (or stay longer in) hospital in preference to being nursed at home, particularly in the case of the aged sick and maternity patients.

386. It is only fair to add however that we have heard no evidence to suggest that there are in practice any large number of patients who receive hospital treatment which is not justified either on medical or social grounds though some maternity cases may fall into this category. It is after all the doctor in charge of the case who decides when a patient shall be admitted or discharged, and, with the continuing pressure on hospital beds, the patient is unlikely to remain in hospital any longer than is necessary either for his treatment or for making alternative arrangements for his accommodation.

387. Historically there are perhaps two further arguments which might be called in aid of a hospital charge:—

(i) It was the custom of both voluntary and municipal hospitals in England and Wales long before the National Health Service to make a charge to hospital in-patients for board as well as for treatment.

(ii) In the Beveridge Report (para. 434) there was some discussion of this matter ending with the statement: "But if it appears equitable to make such a charge it may be expedient to make it, if only in order to avoid making it appear profitable to the patient to stay in the hospital when he could go home."

The case against the charge

388. Most of our evidence on this subject has drawn attention to the difficulties that would be met in devising a workable scheme for hospital charges, the strong opposition which would be aroused against its introduction, and the valid objections which can be put forward against the hospital boarding charge itself. In particular we have been told that:—

(i) The financial advantage to the patient of being in hospital has been exaggerated. Hospital patients and their families have to meet a number of incidental expenses (including the cost of visiting) which may offset any savings. In any event, if the patient is an insured person, he makes some payment indirectly after eight weeks in hospital through the reduction of his insurance benefit, and may suffer a further reduction after twelve months.

(ii) The time when a patient is in hospital is the time when he most needs help and sympathy, and his recovery might be retarded by financial worry due to the existence of a hospital charge. Moreover, it is desirable that there should be no financial barrier of any kind between the patient and any hospital treatment he may need.

(iii) If a boarding charge were to be levied, many patients would be unable to pay it—in particular the long-stay patients. Either the National Assistance Board would have to pay their charges, or the patients would have to be exempted. In either event, the net yield of the charge to the Exchequer would be much reduced.

(iv) There are a number of complications which would arise in deciding which other classes should be exempted from the charge. Apart from the long-stay patients, those with claims of greater or less strength include the following:—

Servicemen treated in civilian hospitals.

War pensioners being treated for their disability.

Sufferers from tuberculosis and infectious diseases.

Children (for whom local education authorities have at present a duty to secure free medical treatment).

Persons who are in hospital for only a day or so, from whom it might be difficult to collect charges.

Clearly the greater the number of exemptions allowed, the smaller would be the yield from a boarding charge.

(v) The cost of collecting the charges would not be inconsiderable, as hospitals have at present no real machinery for making a collection. If every hospital authority required, say, two extra staff for this purpose, the total cost of collection in England and Wales alone might approach £½ million per year.

Amount yielded by the charge

389. Assuming a weekly charge of 21s. for all patients including children, and assuming that there would be no exemptions or bad debts, the annual yield for England and Wales would be about £23–£24 million. Against this sum, however, must be set off a large but unknown amount to be paid by the National Assistance Board; and additional payments would need to be made out of the National Insurance Fund through discontinuance of the present reduction in insurance benefits made where the recipients have been in a National Health Service hospital for more than eight weeks.

If all long-stay cases (i.e., over eight weeks) were exempted, the yield would be reduced by more than half; and if in addition all the exemptions listed in para. 388 (iv) were authorised, the yield would probably fall to one-third or one-quarter, i.e., about £6–£7 million.

In Scotland, where half the total of hospital beds are occupied by long-stay patients, the product of a guinea charge per week would be unlikely to yield more than £1¼ million per year.

Our own view

390. Having regard to the relatively low yield likely to be obtained from a hospital boarding charge (after all the probable exemptions have been taken into account), and to the practical difficulties, the cost of collecting the charge, and the strenuous opposition which would be aroused on humanitarian grounds against its introduction, we feel that the case in favour of

imposing the hospital boarding charge has not been made out and we do not recommend its introduction.

In the case of the maternity services, there may be some substance in the suggestion that the demand for hospital beds has been increased to some extent by the financial advantage of receiving free board and treatment in hospital; but we must point out that this advantage has been lessened in recent years by the "home confinement grant" which has been payable under the National Insurance scheme since October, 1953, to mothers who are confined at home. The amount of the grant was £3 until May, 1955, when it was increased to £4.

HOSPITAL STAFF

Recruitment and Training of Administrative Staff

Present arrangements

391. We understand that each separate employing authority in the hospital service has been delegated power to appoint its own administrative and clerical staff. Little is known about the practice followed in appointing senior staff and the method of selection used, but it is known that authorities have had difficulties in recruiting staff of the calibre required. A small number of authorities have adopted training schemes in an attempt to select and train candidates who are thought likely to prove suitable in the future for senior positions in the service. Some authorities have co-operated in joint schemes to provide a variety of experience in different hospitals for selected trainees and assistance is given towards the cost of acquiring qualifications. Many of these schemes are temporary arrangements pending the introduction of a national scheme.

The King Edward's Hospital Fund for London have for some years provided an Administrative Staff College designed not only to provide refresher courses for senior hospital officers and courses for more junior staff, but also to act as a centre for research and study into problems of hospital administration. The courses provided are residential.

Criticism of the present arrangements

392. A great many of our witnesses who represented the hospital authorities have expressed concern at the unsatisfactory nature of the present arrangements for the recruitment and training of administrative staff in the hospital service. Because of the lack of central planning, we were told that it was impossible to determine not only the numbers of administrative staff needed for the service in the future, but also how the recruits to the service could best be trained to give them the necessary experience for taking on the higher designated posts in the service. A national recruitment and training plan was needed to enable the hospital service to compete with the Civil Service, the nationalised industries, commerce and private industry generally, for a fair share of the best material available at all levels of entry to the service. Local and regional training schemes were not, and could not be, a satisfactory substitute for a nationally organised scheme.

393. We have heard a number of proposals for the introduction of a national scheme which would, for example,

(*a*) provide a number of designated training posts (linked with the King Edward's Hospital Fund Administrative Staff College, to ensure that a period of concentrated study and instruction in the College was included in the "training circuit");

(*b*) provide for the selection of trainees both from within the service and from outside (including University graduates) by a Central Committee or Commission;

(*c*) relate the number of training posts to the number of designated posts likely to fall vacant each year.

394. The working out of any such scheme is, however, a matter in which the Whitley Council has an interest, and we understand that the details are now under consideration. In these circumstances, it would be inappropriate for us to discuss the matter in our Report. None the less, we regret that there should still be no provision nationally for recruitment and training in respect of the administrative side of the hospital service, and we recommend that such provision be made at the earliest possible date. In our view, it should include:—

(*a*) Methods of entry into the service.

(*b*) Avenues of promotion.

(*c*) Training.

(*d*) A structure and salary grading of posts such as will provide sufficient people of the right calibre at all levels of hospital administration.

(*e*) Proper arrangements for publicising and advertising posts.

With regard to recruitment, it is desirable that some provision should be made for late entrants, so that place could be found amongst others for a limited proportion of University graduates in the service. But the intake of such persons should not be overweighted, in order not to prejudice the prospects of promotion in the service of those who had entered it at an earlier age. It is indubitable that the hospital service will not be able to compete for administrative staff on equal terms with other occupations unless it is known that the service itself provides reasonable chances of promotion, on grounds of merit, to the more responsible and better paid posts.

395. A proper career structure is a matter of the utmost importance for the well-being and efficiency of the service, but evidence that we have received makes it clear that the present position is by no means satisfactory. Thus we have been told that the channel of promotion from hospital secretary to the higher designated posts is highly uncertain; and that it is possible, for example, for a person with no practical experience of administration at hospital level to become a group secretary or a Regional Board secretary. Such appointments must act as a disincentive and we consider that when the service has developed a proper career structure with adequate provision for training and promotion, it should not, save in very exceptional circumstances, be necessary to fill such posts from persons drawn from outside the service.

396. As we have indicated earlier in our Report, we believe that the hospital secretary holds one of the key positions in the service; for it is the unit hospital which spends the money and it is there that economies must be sought out and applied. It is axiomatic that the quality of administration in the hospital service must depend first and foremost on the quality of the hospital administrators themselves. But there are grounds for believing that the position and status of the hospital secretary have been impaired in some measure in the process of building up the "group idea", and this we regard as a regrettable consequence of what is otherwise a sound concept. We recommend that steps should be taken to ensure that the prospects, responsibilities, salary, and other conditions of service of hospital secretaries are such as to attract persons of the right quality to these highly important posts.

397. We conclude that a suitable training scheme covering administrative staff throughout the hospital service is very badly needed, and should not be further delayed. Furthermore, we would draw attention to the desirability of making effective provision for the advertising and publicising of vacant posts, so that applications can be received from candidates employed in the different Hospital Regions.

If effect is given to these recommendations, we feel confident that the standard of administration in the service will be strengthened and its efficiency improved.

Whole-time and part-time consultant appointments

398. A good deal of criticism has been voiced—both in the evidence to this Committee and elsewhere—about the disparity between the financial inducements offered under the present terms and conditions of service for part-time consultant appointments in the hospital service, as compared with the basic whole-time rates. In particular, we have been told that the scales are weighted in favour of the part-time consultant by

(*a*) the inclusion of travelling time (up to a maximum of ½ hour each way to and from his main hospital) in the *paid sessions* of the part-timer;

(*b*) the payment of his travelling expenses to and from home (up to a maximum of ten miles each way);

(*c*) the payment for domiciliary visits, at the rate of 4 guineas per visit, up to a maximum of 800 guineas per year. No extra payment is made to the whole-time consultant for any domiciliary visits he may make;[1] and we understand that general practitioners rarely call upon whole-time consultants for this class of work;

(*d*) the adjustments made in favour of the part-time consultant, when computing the number of notional half-days on which his salary is reckoned. We understand that the Regional Board first assesses in terms of hours per week what is the average amount of time required by an average practitioner to perform the duties attaching to the part-time post. The total number of hours per week is then converted into notional "half days" per week by dividing them by 3½. If the resulting figure is fractional the consultant is allowed the next highest whole number of half days as follows:—

Number of hours worked per week	*Number of notional "half days" on which salary is reckoned*
Up to 3½	1
Over 3½ and up to and including 7 ...	2
" 7 " " 10½ ...	3
" 10½ " " 14 ...	4
" 14 " " 17½ ...	5
" 17½ " " 21 ...	6
" 21 " " 24½ ...	7
" 24½ " " 28 ...	8
Over 28	9

(*e*) The weighting made in favour of the part-time consultant appointment, as compared with the whole-time basic rate, in calculating the salary to be paid for the number of notional half days worked.

(1) We understand, however, that arrangements have recently been made whereby whole-time consultants may, subject to certain conditions, be paid for domiciliary consultations (see H.M. (55) 107).

The table below shows the proportion of the whole-time salary payable in relation to the number of notional half days worked.

Number of notional half days	*Proportion of Salary* (Expressed as elevenths of the whole-time basic rate)
1	$1\frac{1}{4}$
2	$2\frac{1}{2}$
3	$3\frac{3}{4}$
4	$4\frac{3}{4}$
5	$5\frac{3}{4}$
6	$6\frac{3}{4}$
7	$7\frac{3}{4}$
8	$8\frac{3}{4}$
9	$9\frac{1}{2}$

It will be noted that the "weighting" in favour of the part-time appointment varies from $\frac{1}{4}$ to $\frac{3}{4}$ (expressed in elevenths of the whole-time basic rate) according to the number of notional half days worked. We understand that the weighting is intended to cover time spent on emergency calls and committee work.

399. In addition to these benefits, the part-time consultant is of course able to continue with his private practice outside the National Health Service and also, we understand, enjoys certain advantages in the assessment of his income tax liabilities. Admittedly, these privileges are not connected directly with the consultant's terms and conditions of service, but we mention them because they must clearly form part of the financial inducement which leads individual consultants to decide whether to accept the whole-time or part-time appointment.

400. We have heard differing views about the consequences of these unequal rewards, and about their practical effect. Some have gone so far as to recommend that the part-time appointments should be abolished altogether,[1] and whole-time appointments substituted throughout the whole hospital service. These witnesses have suggested that the part-time consultant must inevitably have a divided loyalty between his private practice and his hospital duties. The whole-time consultant, on the other hand, has no temptation to disregard his hospital duties, and his services cost the Exchequer less per contractual session than those of the part-time consultant. Moreover, if all part-time consultants were to be replaced by whole-time staff, fewer deputies would be required in the service and the demand for junior staff would decrease accordingly. Finally a universal whole-time consultant service would prevent any differences of opinion—which have arisen in the past between the profession and the Regional Hospital Boards—whether a particular appointment should be whole-time or part-time.

401. The majority of our witnesses, however, have favoured the retention of the part-time consultant service and the following are some of the reasons which have been put forward in support of their case:—

(i) So long as private practice and hospital pay beds continue, provision must be made for part-time consultant appointments in the hospital service.

[1] This would require an amendment to Section 12 of the National Health Service (Amendment) Act, 1949, which added the following proviso to Section 66 of the 1946 Act and Section 65 of the 1947 Act—"Provided that regulations made under this Section shall not contain any requirement that all specialists employed for the purpose of hospital and specialist services shall be employed whole-time."

(ii) The services of many eminent consultants could only be obtained through a part-time contract.

(iii) One of the most beneficial results of the National Health Service has been the spread of the consultant services to the remoter areas of the country. This improvement has been due, in some degree, to the provision of consultant services on a part-time as well as a whole-time basis.

(iv) Emergency medical and surgical cover in hospitals can often be provided more cheaply and effectively by two part-time consultants than by one whole-time consultant.

(v) Private practice (including not only the treatment of private patients, but also private work on behalf of the Courts, Insurance Companies, etc.) gives the consultant a wider outlook in his work and prevents his becoming too remote from the world outside the hospital.

(vi) The majority of part-time consultants work longer hours than they have contracted to do. This is particularly true of the part-time consultant who has contracted to do the maximum number of sessions allowed under a part-time contract (i.e. 9 notional half days). We gather that it is the custom of many Boards now to allow the consultant himself to decide, in appropriate cases, whether to accept a whole-time or part-time contract, although the duties will in either event be those of a whole-time appointment. One Board told us that they estimated that their part-time consultants generally were putting in 10 per cent. more hours than they had undertaken to do in their contract. (Other witnesses, however, have added that some whole-time consultants also do more than their contractual sessions; and that the amount of work done by a consultant, whether whole-time or part-time, depends more on the personalities involved than on the type of the contract made.)

Distribution of part-time and whole-time consultants

402. Table 42 shows the sessional distribution of part-time consultants in England and Wales at 30th June, 1955 and in Scotland at 31st December, 1954:—

TABLE 42

Sessional Distribution of Part-time Consultants in England and Wales and Scotland

No. of Sessions (half-days) worked	Percentage of part-time consultants who do the No. of sessions in the first column	
	England and Wales	Scotland
9	58·12	27·2
8	11·58	34·5
7	7·74	23·4
6	5·89	7·6
5	4·49	2·0
4	3·74	2·5
3	3·44	1·5
2	3·13	0·8
1	1·87	0·5

Average No. of sessions worked by part-time consultants ...	*England and Wales* 7·25	*Scotland* 7·6

It will be observed that the average number of weekly sessions worked by part-time consultants is high, and that in England and Wales the "maximum part-timers" constitute the great majority of part-time consultant appointments (58·12 per cent.). It is interesting to note that there is also a stronger tradition of whole-time consultant service in Scotland than in England and Wales. At 31st December, 1954, 45 per cent. of the consultants practising in the National Health Service in Scotland held whole-time contracts, whereas the comparable figure for England and Wales at 30th June, 1955, was 32·09 per cent.

Our own view

403. After carefully considering the many suggestions and views which have been received on this subject, we have concluded that, in the interests of the hospital service, there is a valid case under existing conditions for the retention of part-time consultant appointments in addition to whole-time appointments. We consider it very desirable, however, that Regional Boards should be free to appoint whole-time consultants in cases where it is deemed to be necessary in the interests of the service. We trust that joint consultation between Regional Boards and the medical consultative committees (to which we have referred in para. 227 of our Report) will lead to agreement between the Boards and the medical profession, and will prevent the emergence of differences of opinion over the conditions of appointment such as have been known to occur in the past.

404. We are also of opinion that it is undesirable that the financial arrangements relating to the consultant service should be such as to provide a financial inducement to a consultant to apply for a part-time rather than a whole-time appointment.

HOSPITAL MEDICAL STAFF

New specialist grade

405. We understand that the medical profession and the Health Departments are now discussing proposals for re-organising the structure of hospital medical staffing. We ourselves have no wish to offer any general comments on this complex question, but there is one aspect of hospital medical staffing which will, we hope, receive careful consideration.

A great many of our witnesses have expressed the view that the hospital service needs a new specialist grade (e.g. assistant surgeon, assistant physician, etc.) which would offer a permanent position in the career structure of the service, and which would be below the grade of the consultant. The arguments we have heard in favour of this proposal include the following:—

(i) The medical manpower situation in the hospital service requires that a grade of this type should be introduced to provide the skilled personnel needed to cope with the volume of work—a need which cannot be met satisfactorily by short-term appointments of the registrar type.

(ii) Service in the new grade would not be in any sense a dead-end career; holders of the post would be entitled to compete for consultant appointments. They would, of course, work under the direct supervision of a consultant.

(iii) Many consultants would then be able to divest themselves of a considerable amount of routine work (which could be borne by the assistant physicians and assistant surgeons, etc.), and would be free to devote more of their time to the more complicated and recondite aspects of their specialty. The full consultant would undertake duties commensurate with his standing and would decide and prescribe what tasks might properly be allocated to the other members of his team. This, in turn, would lead to a more economical and efficient use of the available resources in the larger general hospitals.

(iv) The new grade would also improve the outlook for the registrars in the service, and facilitate the abolition ultimately of the appointments in the senior hospital medical officer grade which have found little favour with the profession.

Our own view

406. We ourselves welcome the suggestion that, as part of the re-organisation of hospital medical staffing, provision should be made for a new specialist grade, below the grade of consultant, which would offer a permanent position in the career structure of the hospital service.

HOSPITAL MEDICAL ADMINISTRATION

England and Wales

407. From the evidence we have received, we would endorse the view of the Committee on the Internal Administration of Hospitals(1) that "the development of medical administration under the National Health Service(2) is in some respects defective" (see para. 62 of the Report). We have noted—and find ourselves in general agreement with—the Committee's observations on the functions of medical staff committees at hospital level, medical advisory committees at group level, and on the Ministry's memorandum(3) on medical committees in hospitals and hospital groups.

408. The Report goes on to say:—

"So far, we think, few will disagree. But the question immediately arises how the detailed day-to-day work of medical administration, as distinct from greater or lesser questions of policy, is to be handled. Much of it is, as it certainly should be, done by a consultant and his juniors in the department concerned. But there will inevitably remain a fairly large field outside the scope of any particular consultant in which executive decisions need to be taken by a medical man, or by a layman acting on medical advice, without waiting to seek the the views or authority of a committee. In our view this work should be the responsibility of a single member of the senior medical staff.

"Before 1948, this function was traditionally performed in the voluntary hospitals, through the house governor and secretary, by the chairman of the medical staff committee in conjunction with the R.M.O., R.S.O. or senior resident house officer according to the size of the hospital. In many local authority hospitals the function fell to the medical superintendent, acting with his established deputy and other senior medical officers, but complicated by the fact that the medical superintendent was responsible to his employing authority, through the medical officer of health, with headquarters outside the hospital.

"The objections to the voluntary hospital arrangement have been discussed earlier in our report but our considered view is that in the

(1) Central Health Services Council—Report of the Committee on the Internal Administration of Hospitals (H.M.S.O. 1954) (see paras. 62 to 84).
(2) i.e. in England and Wales.
(3) R.H.B. (53) 91/H.M.C. (53) 85/B.G. (53) 87.

smaller general hospitals it can still be regarded as satisfactory, especially with the impetus which medical staff committees should gain from the Ministry's recent memorandum. In larger hospitals where the system is found in practice to continue to work well, it is one acceptable alternative. . . .

"But for the reasons discussed we do not think that the old voluntary hospital arrangement can now be expected, in most of the larger general hospitals, to produce really effective medical administration. Something more is needed. Nor do we advocate the appointment of medical superintendents with the powers and duties formerly exercised by the medical heads of municipal hospitals. We think it would be both unrealistic and wrong in principle to recommend any one pattern throughout the service. An alternative—applicable, we believe, in most of the larger general hospitals—is to appoint as medical administrator one of the consultants who has the talent, the taste and the time for this kind of work, on the lines suggested in the following paragraphs.

"The medical administrator must be a consultant in active clinical practice. His administrative duties and the amount of his time he needs to devote to them will, naturally, vary from hospital to hospital and will depend on local factors such as the size of the hospital, the pressure of clinical work, the nature of the services provided and of the hospital buildings and the amount of administrative work his fellow-consultants are able and willing to undertake. Generally, we do not think he should be required to, or should, give more than a reasonable proportion of his time—we cannot get nearer than that—to administration. But whatever the proportion, we regard it as essential that he should not be penalised financially for the time he devotes to medical administrative work as we have described it. When the content of medical administration is examined it transpires that practically the whole of it, if not directly concerned with the medical treatment of an individual patient, is indispensable for the adequate medical treatment of the patients as a whole. . . . In our view, therefore, medical administrative work at this level should be paid on the same basis as other clinical work. It will become impossible to find first-class men willing to take on the considerable burden involved if there is to be any risk of financial loss."

409. The following further points are made in the Report:—

(*a*) The medical administrator must work in the closest association, as a member of the tripartite team, with the matron and lay administrator.

(*b*) The medical administrator's appointment should be for limited periods—say for four or five years—and should be renewable at the end of that time.

(*c*) The post must be one into and out of which a consultant can move without adverse effect on his salary.

(*d*) The medical administrators should be selected jointly by representatives of the medical staff committee and of the Hospital Management Committee, with one or more representatives from the Regional Board who could put the Board's point of view from the clinical angle. Formal appointment as medical administrator would then be made by the Hospital Management Committee and any necessary adjustment of the consultant's contract made by the Board.

(*e*) In order to help meet the needs of medical administration, and to attract young men into this field of work, a new R.M.O. or R.S.O. grade should be recognised, in non-teaching hospitals, covering salary ranges between the lowest registrar salary and the highest point in the grade of senior hospital medical officer. To quote the Report again—"Whilst it is not suggested that such appointments would be necessary in all general hospitals, the new grade (in addition to its clinical value) would be useful in hospitals where the consultants find it difficult to take on much administrative, on top of clinical, work."(1) The new grades "would provide the officers concerned with a mixture of clinical and administrative work, a reasonable salary and a training ladder for senior administrative as well as clinical appointments. It would relieve consultants of work more suitable to junior staff. And it would introduce into medical administration generally a continuity at present lacking in the registrar grades."(2)

410. We have drawn so extensively on the Report of the Committee on the Internal Administration of Hospitals because we feel that exceptional weight attaches to the unanimous recommendations of this large and expert body, which devoted four years to the investigation of the existing system of hospital administration; and because this matter of medical administration is one which can have an important bearing upon hospital efficiency and costs. As we see it there are three main aspects which come into question:—

(i) Making the most efficient use of available resources—e.g. the control of admissions and discharges; bed turn-over; co-ordination of out-patient clinics and bed allocations; control of infection, etc. etc.

(ii) Seeking economies both generally and in relation to such matters as prescribing of expensive drugs, use of X-ray films, purchase of equipment etc.

(iii) Providing a medical administrative link with the family practitioner services and the local health authority services outside the hospital.

Our own evidence has satisfied us that there are good grounds for believing that in hospitals where medical administration is weak there is room for improvement under all these three heads and particularly under (iii).

411. For these reasons we warmly endorse the recommendations of the Committee on the Internal Administration of Hospitals, which we have quoted above, and trust that they will be implemented without delay.

Scotland

412. We have noted that Scottish tradition has always favoured placing the medical administration of the hospital in the hands of a medical superintendent, and that this practice has continued since the Appointed Day. Normally, the responsibilities of the medical superintendent extend to all the hospitals in the group administered by one Board of Management and he is therefore a "group medical superintendent", his office being usually situated at the main hospital in the group. We understand that there is only one large general hospital group in Scotland which has no medical superintendent.

413. We have no wish to disturb the practice which has, by tradition, been followed in Scottish hospitals for many years, and we therefore offer no recommendation on this matter. We are aware that the Committee on the Internal Administration of Hospitals did not recommend the introduction

(1) See para. 81 of the Report.
(2) See para. 84 of the Report.

of group medical superintendents to the hospital service in England and Wales, but we see no reason why the two countries should not continue to go their separate ways on hospital medical administration.

414. We have had a considerable amount of evidence however from Scottish witnesses (including the Chairmen of Regional Hospital Boards) indicating that it is becoming increasingly difficult to recruit men of the right calibre to undertake the work of hospital medical administration, and it has been put to us strongly that the remuneration of medical superintendents is insufficient to attract the right sort of men. It is outside our scope to make any specific recommendations on this matter; but it is clearly one that is of great importance for the efficient working of the service. It should certainly be investigated and if it is found that the salaries of medical superintendents are inadequate to maintain proper recruitment they should be revised.

415. We are glad to note that the Scottish Standing Advisory Committee on Hospital and Specialist Services has recently appointed a sub-committee to consider how medical participation in the control and management of hospitals can best be secured in Scottish conditions, with special reference to the employment of medical superintendents and the constitution of medical staff committees.

AMENITY BEDS AND PAY BEDS

General

416. In paragraph 164 above we have already explained what is meant by "amenity beds" and "pay beds" which are provided by hospital authorities under sections 4 and 5 respectively of the National Health Service Act, 1946. At 31st December, 1954 there were 5,905 amenity beds and 5,893 pay beds in England and Wales. Together therefore, they represented less than 2·5 per cent. of the 476,944 available staffed beds in England and Wales; and the pay beds alone represented less than 1·25 per cent. In the period June to December, 1954, the average occupancy of amenity beds was 80·5 per cent. (of which 39·8 per cent. were non-paying patients) and of pay beds 67·46 per cent. (of which 32·11 per cent. were non-paying patients).

In Scotland there are about 2,100 amenity beds and 900 pay beds, the great majority being in mental hospitals and mental deficiency institutions. The number of pay beds in Scotland represents about 1·5 per cent. of the available staffed beds.

417. These figures indicate that the number of "private" beds (whether for use under section 4 or section 5 of the National Health Service Act, 1946) represent a very small proportion of the total available beds in the Health Service. We would agree that the first claim on this limited accommodation should be for those hospital patients who are in need of privacy on medical grounds, whether or not they are prepared to pay for a private bed. Secondly, we feel that it is right, on humanitarian grounds, that a proportion of the private accommodation should be set aside for use as "amenity beds" by those patients who desire privacy even when it is not considered essential on medical grounds; the patient then pays for his privacy and in all other respects is treated in the same way as patients in general wards. So far, we think few will disagree with what we have said.

418. Opinions differ, however, about the merits of setting aside "pay beds" in the hospital service for the use of patients who wish to make private arrangements to be treated by a consultant of their own choice, and are willing to pay the full cost of the accommodation and treatment provided. There are some who would recommend the abolition of pay beds on the grounds that they enable a certain number of patients to "jump the queue"

in hospital waiting lists. Others maintain that the existence of private consultant practice makes it necessary that some pay beds should be provided in the hospital service; and our attention has been drawn to the fact that the continued provision of such beds was assumed when arrangements were made with the profession at the inception of the National Health Service.

419. Whilst appreciating the reasons why some have objected to the provision of pay beds, we do not ourselves believe that the objections are strong enough to warrant the abolition of pay beds in the hospital service. If there is any "jumping of the queue" it cannot amount to very much when account is taken of the relatively small number of pay beds at present provided in hospitals. In our view a more important issue is that hospital authorities should not keep pay beds empty any longer than is absolutely necessary, and we return to this question in succeeding paragraphs.

We accept, therefore, the provision of private accommodation in National Health Service hospitals, both for patients who need it on medical grounds and for those who are prepared to pay for it, either in the form of an amenity bed or a pay bed. So long as the present shortage of hospital accommodation continues, however, we would deprecate any expansion in the number of amenity beds and pay beds which would be at the expense of the available free beds in the service.

Rate of occupancy

420. We have heard some criticism about the low rate of occupancy of amenity and pay beds in the service generally, which has continued despite the efforts made by the Ministry and hospital authorities to effect an improvement. In the interests of efficiency it is clearly desirable that all hospital beds, whether free or not, should be used to the fullest extent possible, and we hope that all concerned will continue to seek means to achieve the highest occupation rates practicable. We appreciate that the figures of percentage occupancy may themselves be misleading, particularly in hospitals where only a few amenity beds and pay beds are provided. In hospitals where, for example, there are only four pay beds—two reserved for males and two for females—any percentage occupancy figures will be quite meaningless. Nevertheless, our evidence suggests that some improvement might be effected in this field, e.g. by making the public more aware than they are now of the amenity beds provided in the service, and by using amenity beds and pay beds more often for non-paying patients when the need arises. These are not, of course, new suggestions; they are already well known to the hospital authorities, but more might be done in some areas to give effect to them.

Level of charges

421. We have been told that the main reason for the low occupancy of pay beds by paying patients is the high level of charges now ruling in the service generally. The Act requires that the user of a pay bed shall pay charges "designed to cover the whole cost of the accommodation and services provided for the patient at the hospital, including an appropriate amount in respect of overhead expenses". In 1953, new regulations were made enabling some small reductions to be effected in the charges, but in many hospitals they still remain at a level which can only be afforded by those with ample means. In three Regions which we examined in detail we found for example that the charges for pay beds in maternity hospitals ranged from £25 18s. per week to £14 per week.[1]

It will be noted from these figures how widely the charges fluctuate even between hospitals which, on the face of it, might appear to be comparable.

[1] These figures exclude the fees paid by paying patients for the consultant of their choice.

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Moreover, we have been told that the fluctuations do not always reflect the standards of the service provided.

422. The generally high level of pay bed charges and their wide variations between comparable hospitals have led many of our witnesses to suggest that the present method of calculating the charge should be abandoned altogether and one of a number of alternatives substituted in its stead, e.g.:—

(*a*) An arbitrary charge, considerably lower than the existing charge, should be fixed nationally, to enable a greater proportion of the population to use hospital pay beds. The continual increase in the enrolment of new members by Provident Associations, etc. proves that many people are anxious to use pay beds and to have the consultant of their choice, and are willing to make the necessary financial provision for this purpose by insurance. Their numbers would be increased still further if the pay bed charges could be reduced; and the occupancy rate would thereby be raised.

(*b*) Standard charges should be laid down each year either nationally or regionally for all hospitals or groups of hospitals and should be based on the average cost of a pay bed during the preceding year, according to certain categories of hospital, e.g. London teaching hospitals, provincial teaching hospitals, non-teaching general hospitals, etc. etc.

423. We do not ourselves believe, however, that it would be advisable to depart from the principle that the user of a pay bed, having contracted out of the free hospital service, should pay the full cost of the accommodation and services provided, while making his own arrangements for paying the consultant of his choice. Hence we do not recommend the adoption of an arbitrary charge which would be demonstrably lower than the actual cost of the facilities provided. No doubt pay beds would be used more widely by paying patients if the charges were reduced, but we believe that the charges would have to be reduced very substantially indeed to effect any large increase in demand—so much so that the net effect would most probably be a loss to the Exchequer as compared with the present position.

424. We have carefully considered whether the adoption of regional or national average charges for particular categories of hospital would be preferable to the present system, but on balance, we see no real advantage in their adoption. An average charge, calculated nationally or regionally, might remove some of the objections to the present range of charges, but it would cause many users of pay beds to pay more than the cost of the services provided, and it would be little compensation to them to know that other users were paying less. After considering the effect of introducing regional averages for certain categories of beds in three Hospital Regions, we have concluded that there was no reason to believe that average charges would produce any better relationship between the charge and the value or quality of the services provided than that produced under the existing charging provisions. We therefore offer no recommendation on this matter.

HOSPITAL SUPPLIES

425. Supplies purchasing is clearly an extremely important aspect of hospital management and one which will repay a close investigation; we therefore welcome the appointment in 1955 of a special Committee of the Central Health Services Council "to investigate and report on the organisation of all forms of hospital supplies, including their purchase, storage and issue, throughout the National Health Service". We understand that the

Committee (under the Chairmanship of Sir Frederick Messer, C.B.E., J.P., M.P.), will be taking evidence from a wide range of bodies and organisations both inside and outside the National Health Service. We do not propose therefore to offer any recommendations on this subject in advance of the Committee's report.

426. From the limited evidence we have heard on this matter, we are left with the impression that hospital authorities generally have not yet taken full advantage of the enormous volume of knowledge and well tried practices in supplies purchasing which are already common to all large undertakings in this country. In our view, it is desirable that these practices should be ascertained and applied wherever practicable to the hospital service to ensure that the best value is obtained for the money spent. It is true that this process has been under way in the hospital service since 1948, both centrally and in certain of the Hospital Regions, but progress appears to us to have been slower than might have been expected.

PART IV

THE FAMILY PRACTITIONER SERVICES

Administrative Organisation

The Insurance Committees before 1948

427. Immediately before the inception of the National Health Service, the general practitioner service under the National Health Insurance scheme was administered by Insurance Committees of which there were 129 in England, 17 in Wales, and 54 in Scotland. In England and Wales there was one Committee for each county and county borough (and one for the Isles of Scilly), and in Scotland one Committee for each county and large burgh (with one exception).

There were 20–40 members in each of the Insurance Committees in England and Wales and 30–40 in Scotland. The membership of the Committees in England and Wales was made up as follows(1):—

Three-fifths of the members represented insured persons;

One-fifth appointed by the local authority concerned;

1 doctor appointed by the Minister (except on Committees with less than 30 members);

1 doctor appointed by the local authority;

2 doctors appointed by the Local Medical Committee.

The remaining members (from 1–4) consisted of chemists or women members appointed by the Minister.

Briefly, the duties of the Committees were:—

(*a*) to make arrangements for the medical treatment of insured persons,

(*b*) to make arrangements for the supply of drugs, medicines and certain appliances to insured persons,

(*c*) to keep lists of doctors and chemists providing the services, and registers of the persons on the panel of each doctor,

(1) The membership of the Committees in Scotland was made up in much the same way.