therefore recommend that the representation of Regional Hospital Boards and Hospital Management Committees be substantially increased. This will have the dual effect of bringing greater experience of hospital management to Whitley Council discussions and also of helping the Management Sides to carry the hospital managers along with them in implementing their decisions.

If it is felt that there would be serious objections to increasing appreciably the total membership of the Management Sides, consideration might be given to a reduction in the number of official representatives of the Health Departments. Normally the Ministry will have only one official view to put forward to the Management Side, while the hospital authorities themselves may have a number of differing views; and we imagine that some of the members representing the Departments must already be serving more in the capacity of advisers than spokesmen. We would see no objection to their continuing to do so (i.e., as advisers without an official seat on the Management Side) if it were found desirable to cut down the official representation. The Health Departments' representation would then consist of a smaller number of "official" members with such additional "advisers" as the Departments might consider to be necessary in any instance.

Consultation with Hospital Managements

696. Whilst appreciating that arrangements are already made for consultation between the Management Sides and hospital authorities on many matters relating to the hospital service, we note the absence of any formal machinery in the Whitley system for ensuring that the people directly concerned with the management of the hospital service are consulted by the Management Side when major salary claims (or other important matters relating to terms and conditions of service) are being considered. The increased representation of employing authorities on the Management Side, which we have already suggested, should be of help; but this should not be regarded as a substitute for prior consultation. We recommend, therefore, that the Health Departments should review the present arrangements for consultation with Regional Hospital Boards, and should invite Regional Hospital Boards to review their arrangements with Hospital Management Committees, in order to make certain that the Management Sides of the Whitley Councils are as fully aware as possible of the views of these authorities before decisions are reached on matters which will affect them.

Delays

697. Another major cause of concern about the operation of the Whitley system is undoubtedly the long delays frequently experienced in reaching decisions in the Functional Councils, and in obtaining the Ministry's authority for (or refusal of) variation orders under the Remuneration and Terms and Conditions of Service Regulations. It is no doubt the resulting irritation which has led many employing authorities to press for more discretion locally in applying salary scales to their staff.

Our evidence has suggested that these delays are due in part to defects in the Whitley machinery and partly to the immense burden of work which has fallen on the Whitley Councils since the Appointed Day. It should be remembered that, in the early years of the Health Service, few Management or Staff Side members had any great experience of national wage agreements and negotiations; and yet they had to deal with an enormous problem in sorting out the wide range of differing grades of staff and rates of pay which had been inherited from the pre-National Health Service days. As the burden of work decreases, as further experience is gained, and as the consultative machinery becomes more effective, we are hopeful that the Whitley system

will be able to operate more smoothly and speedily in the future than it has done in the past. If further provision can be made in national agreements for local variations to meet local needs, a considerable amount of work may be saved and frustration avoided—and this in turn will help to make the Whitley machinery more efficient and more acceptable to the people operating the Service than it has been in the past.

698. In conclusion we should perhaps mention the criticisms we have heard of the practice whereby the Health Departments are required to consult the Treasury in advance about the financial commitments arising from proposed increases in salary scales. Whilst appreciating the reasons for the criticism, we do not consider that the Departments can divest themselves of this requirement since the National Health Service is financed out of moneys voted by Parliament. In the last resort, the decisions reached in Whitley Council procedure must be acceptable to the Government if they are to be approved by Ministers for general application throughout the Health Service.

PART VII

GENERAL

Proposed Research and Statistics Department

699. In the section of our Report dealing with hospital statistics and other measurements of efficiency, we made our first reference to a proposal which we regard as one of major importance, i.e., that the Ministry of Health and the Department of Health for Scotland should set up a Research and Statistics Department which would devote the whole of its time to statistical investigation and operational research in general.

700. We are of the opinion that the knowledge at present available about the working of the National Health Service is inadequate and should be considerably extended and improved, since it is only on the basis of such knowledge that the right decisions can be made for the future development of the Service. We need to know more, for example, about the economics of hospital management, e.g., what is the most economical size of a hospital to undertake any specific functions; about the nature and causes of differences of morbidity in different Hospital Regions; about the changing patterns in the use of drugs in the National Health Service, and also about their cost; about the incidence of charges on particular sections of the community, (revealing, for example, the extent to which demands have been postponed or abandoned and the effect which this will have on the future pattern of supply); about the relative costs of institutional and domiciliary treatment; and so on. Again, as existing hospital waiting lists are notoriously unreliable, some careful study is required to assess more accurately the extent of the unsatisfied demand on the hospital services. These are only a few examples of the many fields which would be worthy of more detailed investigation in future years.

701. It is with these objectives in mind that we recommend the Health Departments to set up a Research and Statistics Department whose main task would be to consider what information is now lacking as to the working of the National Health Service and how this information might best be produced. We have already welcomed the fact that the Ministry of Health has appointed a statistician earlier this year; but we regard this as only the first step towards the formation of a separate Department within the Ministry. We see no

reason to think that a large staff would be needed for this purpose since we have in mind that, once the Research Department had established that an enquiry into a particular aspect of the Service was desirable, such bodies as the Medical Research Council, the Nuffield Trust, the King Edward's Fund, the Social Survey, or the National Institute of Economic and Social Research would normally be invited to do the necessary research work—as in fact they have done on numerous occasions in the past.(1) Public funds, in so far as they are needed, should be made available for this purpose.

702. The Research and Statistics Department would function as the Intelligence Branch of the Health Departments, working in the closest co-operation with the Departments' administrative and medical staff; and would be constantly engaged in the search for facts and information which would enable administrators to make right decisions for the future development of the Service: above all, it should be looking out for the right sort of questions that ought to be asked. It would in short be an aid to wise administration. The cost of providing the Research Department should not be large; and we would regard the additional expenditure as a sound investment which would yield its return in the form of a wiser use of the community's resources in the future. We believe that, in the past, a good deal of uninformed criticism has been directed against the employment of staff who are needed for the collection of statistics and information which are vital to the efficient management of any large-scale concern. In our view, such criticism is short sighted and should not be allowed to obstruct the development of this essential aspect of National Health Service administration.

703. We have already expressed the view in Part III of our Report that a Research and Statistics Department would help to speed up the process of seeking out new statistical indices to measure the efficiency of the Service—a process which we regard as of great importance. Another of its functions might be to study the enquiries and research work carried out by individual authorities within the Service (e.g. Regional Hospital Boards and Boards of Governors), and to make known to other authorities any findings which could be of general value. We have in mind, for example, the very instructive report on "The Recovery Home in the Hospital Service" which was produced in 1953 by a Joint Committee of the Liverpool Regional Hospital Board and the Board of Governors of the United Liverpool Hospitals; and the work on "Hospital and Community" by T. Ferguson and A. N. MacPhail. The Research Department might also consider, in conjunction with the administrators of the Health Service, whether additional Health Service accounts might be prepared each year in a form which would be more suitable for "policy purposes" than the existing Appropriation Accounts; and also how price indices can best be constructed so as to give a truer picture of the changing real costs of the Service. The investigation which has just been carried out by B. Abel-Smith and R. M. Titmuss (cf. Part I of our Report) gives an indication of the potential value of the type of cost accounting which we have in mind.

(1) We need only refer by way of illustration to the important clinical studies and trials carried out by Professor Bradford Hill and his colleagues under the auspices of the Medical Research Council; the valuable enquiries into hospital costing by the Nuffield Trust and the King Edward's Fund; the recently published studies by the Nuffield Trust into the functions and design of hospitals; the study of hospital bed occupancy by the King Edward's Fund; the inquiries by the Social Survey into the use of hearing aids and the wearing of spectacles etc.; and the review of the cost of the National Health Service which was made under the auspices of the National Institute of Economic and Social Research and has formed the basis of Part I of our own Report. We would also take this opportunity of expressing our appreciation of the excellent work that has been done by the General Register Office in connection with the study of hospital morbidity statistics, and the hope that this work will be continued and extended in future.

We do not suggest that this list of functions is comprehensive. Clearly the work of a Research Department will cover a wide range and will be constantly changing as the Service develops. What we do suggest is that its work could make a most valuable contribution towards the efficient administration of the National Health Service.

Co-operation within the Health Service

Background history

704. A great deal has been said and written since the Appointed Day about the need for co-operation and co-ordination within the National Health Service, and throughout our Report we ourselves have made frequent references to this important aspect of the administration of the Service. It would be unfortunate, however, if the impression were allowed to take root that the organisation of the National Health Service as it was introduced in 1948 was responsible for disrupting the country's health services. A glance at those sections of our Report which describe the health services as they existed before 1948 will show how responsibility for their provision was divided at that time between a multiplicity of authorities. It was, in fact, only with the advent of the National Health Service that any attempt could be made to provide an all-embracing service for the nation's health.

705. Moreover, it was to be expected that the creation of a new service on a national scale would throw up problems of integration and co-ordination many of which existed before the Appointed Day, but had never been the concern of a single planning authority. We have already quoted the statement made in the Report(1) of the Central Health Services Council on Co-operation that "the need for co-ordination in the health service was emphasised but was not created by the National Health Service". We might quote further from the same report—"It is unreasonable to look for perfect co-ordination in so vast a concern as the National Health Service. Over half a million people are engaged in the Service. It is the third largest concern in the country. Many organisations which have much more unitary structure and a more strictly utilitarian purpose have suffered from their own severe problems of internal organisation and have had to examine in the same way the relative advantages of geographical and departmental devolution. All concerns which surpass the grasp of one individual reveal difficulties of internal co-ordination and integration. The central planning staff can do a certain amount but the greater the delegation to the periphery, the greater the problem of maintaining internal cohesion."

706. It is true that the National Health Service produced a division of responsibility in the administration of some services, notably those for the treatment of tuberculosis, which had previously been provided by a single authority; and we have made some reference to the problems arising out of these divisions in our Report. These problems, however, should not be allowed to over-shadow the real achievements of the National Health Service in other fields, e.g., in the provision of a regionally planned hospital service.

707. We have opened this section of our Report on this note, not because we underestimate the importance of co-operation within the Health Service, (our Report speaks for itself on this matter), but because we feel that too little credit may have been given in the past to the degree of integration achieved through the introduction of the Health Service itself in 1948, and through the steps subsequently taken by the statutory authorities concerned to improve the co-ordination of the three branches of the Service.

(1) Central Health Services Council—Report on Co-operation between Hospital, Local Authority and General Practitioner Services—H.M.S.O., 1952 (see paras. 9 and 10).

708. In 1952, the Central Health Services Council's Committee on Co-operation reviewed some of the methods which had been used either in the Acts themselves or by subsequent administrative and local action to improve co-operation in the National Health Service, and they summarised the methods as follows[1] :—

(*a*) Interlocking membership between the different statutory authorities;

(*b*) Exchange of papers between authorities;

(*c*) Ad hoc Ministry circulars on particular problems;

(*d*) Greater ad hoc co-operation among officers;

(*e*) Ad hoc meetings between members or officers of the various authorities;

(*f*) Standing Joint Liaison Committees on special subjects;

(*g*) Standing Joint Committees for general liaison purposes.

The Committee then went on to recommend the appointment of local joint health consultative committees for convenient groupings of local health authorities, Executive Councils and Hospital Management Committees (to be known as "local health service areas"). We understand that committees of this type have been set up in a few Regions and are working with a measure of success; but this recommendation has not been implemented in the majority of Regions.

Points raised in Evidence

709. We ourselves received a great deal of evidence, both written and oral, on the subject of co-operation within the Health Service, and it falls broadly within two main categories. There are some who believe that co-operation will never be achieved to the extent required so long as responsibility for administering the Service is divided between hospital authorities, Executive Councils and local health authorities. The witnesses who held this view—and they were very much in the minority—have recommended that the solution is to be found in the unified administration of the Service through a single statutory authority. We have already considered this suggestion and discarded it for the reasons outlined in Part II of our Report.

710. The great majority of our witnesses have maintained that further improvements in co-operation will only be achieved at what has been called the "working level" i.e., between the general practitioner, and the hospital doctor; between the hospital almoner and the health visitor, and so on. In other words, the duty to co-operate is merely one aspect—though none-the-less an important one—of the work of all the key persons employed in the hospital, local authority and Executive Council services; and further improvements will only be effected if the persons concerned can be brought to understand what this duty implies.

There has been little enthusiasm among most of our witnesses for the creation of new machinery to improve co-operation; and we have found a general reluctance to add to the proliferation of committees already existing in the Service.

Our own view

711. It seems to us that, if the National Health Service is to work properly, co-ordination is needed at three levels—first, centrally, so as to ensure that all three branches of the Service are associated together in carrying out a single national policy; secondly at the level where the national policies are applied to local circumstances—for example, between Regional Boards and Boards of Governors, to secure an integrated hospital service in both teaching and non-teaching hospitals; between Regional Boards, Boards of Governors and local health authorities to secure an efficiently planned and organised maternity service; between hospital authorities, local authorities (both health and welfare) and Executive Councils to plan an integrated service for the care and treatment of the aged etc.; and thirdly at the personal level where individual workers in the Service must co-operate to help a particular patient.

[1] See para. 43 of the Report.

712. The first of these requirements can be met through the central administration of the Ministry of Health and the Department of Health for Scotland. The second and third have been achieved by a variety of means and with varying success, in different parts of the country; but we have no doubt that there is still room for improvement in many areas. We agree, however, with those who have expressed the view that any marked improvement is unlikely to be achieved by the introduction of new co-ordinating machinery. In the areas where co-operation is still lacking, what is now needed more than anything else is a change of heart among those concerned, and particularly, we feel, on the part of the hospitals. We have the impression from our evidence that many hospital authorities could give more thought than they do at present to the integration of their plans and working procedure with the local health authority and general practitioner services. There may have been grounds for this omission in the past, when the newly constituted authorities were engrossed with their day-to-day problems within the hospitals, and had little opportunity to cast a wider view over the National Health Service as a whole. In future, however, they should have more time to devote to the needs of other branches of the Service and to the future role of the hospital in a properly integrated health service. Hospital authorities must appreciate that the hospital service is not a separate part of the Health Service, isolated from the world outside; but is part and parcel of all the services provided for the health and welfare of the patient—preventive and curative, domiciliary and institutional. Hospital in-patient treatment is indeed the last line of defence after the failure of preventive health measures, home treatment, and hospital out-patient treatment.

713. We have made clear in our Report where we think the need for further co-operation still exists in some parts of the Service, and we do not propose to repeat our recommendations in detail in this section of the Report. We would emphasise, however, that co-operation has been achieved successfully in some areas of the country where there has been a determination to see that it should succeed; and we have no doubt that the authorities and individuals in other areas could achieve the same degree of success if they are made aware of the need and are ready to make the effort required.

714. There is one practical proposal which we would suggest for improving co-operation within the Health Service—namely that the Medical Officer of Health, or a member of his staff, should be given an honorary appointment on the medical staff of a hospital.. It seems to us that the following advantages would accrue from the adoption of this suggestion :—

(*a*) It would encourage development of a closer link between the hospital services and the local health authority services, particularly those for the prevention of illness, care and after-care provided under section 28 of the National Health Service Act, 1946, and section 27 of the Scottish Act of 1947.

(*b*) It would bring the Medical Officer of Health into personal touch with the consultants and administrative staff of the hospital to which he is attached.

(*c*) It could help to improve the economical administration of the ambulance service.

715. We would suggest, moreover, that certain specified rights should be attached to the honorary appointment offered to the Medical Officer of Health —first that the Medical Officer of Health should be, as of right, a member of the medical staff committee of the hospital; and secondly that he should be able, as of right, to take charge of outbreaks of infection, (e.g., food poisoning) arising in hospitals. We have been told of instances in the past where hospitals have attempted for some weeks to deal with outbreaks of infection in hospital wards before calling in the local Medical Officer of Health, who by his training is an expert in epidemiology. It would be to the advantage of all concerned if the Medical Officer of Health were in a position to take action at once in the event of an outbreak of infection in hospital wards.

From this closer contact between hospital medical staff and the Medical Officer of Health, we are hopeful that each may come to understand more fully the other's problems in the administration of the Health Service and both may come to work together towards the more efficient organisation of a unified National Health Service.

716. In Part III of our Report we made a further suggestion of a practical nature when we recommended that Regional Boards should review their arrangements for consultation with the medical profession and should consider the appointment where necessary of medical consultative committees at the regional level containing representatives of the consultants, the University, the Medical Officers of Health and general practitioners in the Region. As we have already pointed out, the appointment of such committees in Regions where machinery of this type is lacking at present, could do much to improve the integration of the hospital, general practitioner and local health authority services.

717. For the rest, we can only re-iterate that the Health Departments, the hospital authorities, Executive Councils and local health authorities should continue to give prominence to the need for co-operation in their constant endeavours to achieve a fully integrated National Health Service.

National Insurance and the Health Service

718. We have been continually reminded in our evidence that a great many people still believe that they pay for the National Health Service through their National Insurance contributions; and that, having paid their contributions, are entitled to take the greatest possible advantage of any free facilities available under the National Health Service Acts. Every effort has been made by the Health Departments, particularly in the early years of the Service, to correct this misunderstanding, but apparently with little effect. We wish to emphasise strongly that the National Health Service is not an insurance scheme and that its benefits do not depend on the payment of insurance contributions by the users of the Service. It is true that an annual payment (which in 1953–54 amounted to £36,218,000 in England and Wales) is made by the National Insurance Fund towards the cost of the National Health Service, but this represents only a very small proportion of the gross cost of the Service (over £460 million in England and Wales in 1953–54). Moreover, it should be clearly understood that the services provided under the National Health Service Acts are available to all persons in this country and are not dependent on any insurance qualification.

719. This brings us back to the point we made in Part V of our Report (para. 620) namely that every individual in the country should recognise

that he has a responsibility for keeping himself well in so far as this lies within his control, for keeping himself informed of the facilities provided by the National Health Service, and for learning how to use those facilities intelligently.

Our final comment

720. We were asked in the last part of our terms of reference "to advise how, in view of the burden on the Exchequer, a rising charge upon it can be avoided, while providing for the maintenance of an adequate service".

In Part II of our Report, we concluded that in practice there is no objective and attainable standard of "adequacy" in the health field, and that the Government must decide each year what amount of national resources may be allocated to the National Health Service, having regard to the competing claims of other social services and national commitments. Once the resources have been allocated, the aim must be to provide the best service possible within the limits of the allocation.

We also concluded in the same part of our Report that no major change is needed in the general administrative structure of the National Health Service to secure a more efficient and economical organisation.

721. We have sought to ascertain where, if anywhere, there is opportunity for effecting substantial savings in expenditure, or for attracting new sources of income, within the existing structure of the Service; but it will be clear from what has been said in the various sections of our Report that we have found no opportunity for making recommendations which would either produce new sources of income or reduce in a substantial degree the annual cost of the Service. In some instances—and particularly with regard to the level of hospital capital expenditure—we have found it necessary, in the interests of the future efficiency of the Service, to make recommendations which will tend to increase the future cost.

722. In considering the more distant future there are a large number of factors at work, some of which, as we have pointed out earlier, will lead to an increase in the cost of the Service, while others will operate in the opposite direction. It is quite impossible at the present time to forecast which of these tendencies will ultimately prevail; though it is obvious that, so far as financial cost is concerned, in the sense of the amount of money spent on the Service, a great deal will depend upon what happens to the value of money and therefore to the future trend of prices and wages.

723. It certainly should not be concluded that we have found the present organisation and administration of the National Health Service to be free from defects. In particular there is much need to integrate more closely the hospital, family practitioner and local health services, and also the welfare services provided by local authorities under the National Assistance Act. We also believe that the hospital service has been somewhat slow to adopt certain methods and techniques of management which have proved their worth in other large-scale undertakings, for example, in making adequate provision for the maintenance of capital assets, making full use of budgetary controls, devising the most economical means of purchasing supplies, making provision for a national recruitment and training scheme on the administrative side of the service, etc. Our recommendations (summarised in Part VIII of our Report) for helping to overcome these and other weaknesses in the Health Service should improve the efficiency of the Service, though the amount of the savings likely to be achieved thereby cannot be calculated in terms of Exchequer money.

724. These weaknesses apart, and allowing for the manifold shortcomings and imperfections inherent in the working of any human institution, we have reached the general conclusion that the Service's record of performance since the Appointed Day has been one of very real achievement. As is shown in Part I of our Report, the rising cost of the Service in real terms during the years 1948 to 1954 was less than many people imagined; and moreover, many of the services provided were substantially expanded during the period. This is not the place to summarise all the developments referred to in our Report, but we would mention in particular the up-grading of many hospitals, the expansion of hospital in-patient and out-patient treatment, the increase in the number and the better distribution of consultants, the development of the health-visiting, home help and ambulance services, and the improved care of the aged.

725. The administrative organisation of the hospital service, with its Boards and Management Committees composed entirely of voluntary members, may be a novel one (particularly having regard to the size of its annual budget); but the experience of the last seven years does not suggest that the organisation has failed to cope with its heavy responsibilities or to control, with greater regard for economy than is commonly credited, the large sums of Exchequer money which have been devoted annually to the Health Service. As we have already pointed out, the annual capital allocations for the hospital service have, in our view, been inadequate, but there can be no doubt that the hospital authorities have made very good use of the limited sums made available to them. Any charge that there is widespread extravagance in the National Health Service, whether in respect of the spending of money or the use of manpower, is not borne out by our evidence.

726. Looking to the future, it is clear that there are long-term problems of high importance confronting the National Health Service, not a few of which can only be solved by the medical profession itself; and which will call for all the qualities of statesmanship and adaptability that it can command.

727. Our detailed review of the hospital, Executive Council and local health authority services has strengthened us in the view which we first expressed in Part II of our Report—namely that the Service now requires a period of stability during which all the various authorities and representative bodies will be able to plan ahead on the basis of the experience gained in the last seven years.

We hope that the comments and suggestions we have made in our Report may be helpful in pointing the way for future developments, and also in weighing the merits of the many proposals put forward, both from within and outside the Service, for improving the efficiency and economy of the National Health Service.

PART VIII

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

728. Before setting out in summary form the recommendations we have made in the main body of our Report we wish to draw attention to a consideration which has been present in our minds during the whole of our deliberations. The National Health Service has only been in operation now for seven years, and no doubt in due course there will be further developments which cannot at present be foreseen. We regard our recommendations

as those which are appropriate in the light of the circumstances as we find them; and we are fully conscious of the fact that with the passing of time new conditions will arise which could call for recommendations of a different character. In making our own recommendations it has been neither our intention nor our desire to prejudge what may be found necessary in the future.

THE COST OF THE NATIONAL HEALTH SERVICE

729. In Part I of our Report we review, with the aid of a Memorandum by B. Abel-Smith and R. M. Titmuss, the present and prospective costs of the National Health Service in England and Wales. The main conclusions of the review are summarised in paragraph 92. The cost of the Health Service in Scotland is analysed in Appendix 2.

THE GENERAL STRUCTURE OF THE NATIONAL HEALTH SERVICE

730. In Part II of our Report, after reviewing the basic organisation of the National Health Service and the main proposals put to us for radical alterations, we arrive at the following conclusions:—

(1) *Proposed unification of the Health Services*

We do not favour the suggestion that statutory ad hoc health authorities should be appointed to administer the hospital, family practitioner and local health authority services. Other reasons apart, we consider this suggestion unacceptable because it would remove from the local health authorities their important domiciliary health services and would create a division between different types of public health work at least as serious as the present divisions within the National Health Service. It would, moreover, drive a wedge between the home health services now provided by local health authorities under Part III of the National Health Service Act and the welfare services provided by local authorities under Part III of the National Assistance Act—a division which would, in our view, be very undesirable. In our view, the only form of major reorganisation which calls for serious discussion is one which would integrate the three branches of the National Health Service without depriving the local authorities of their existing domiciliary health functions—i.e., a reorganisation which would add responsibility for the hospital service and/or the Executive Council services to the present duties of the local health authorities. (paras. 113–116.)

(2) *Proposed transfer of the Hospital Service to Local Health Authorities*

We do not feel that a convincing case has been made out for transferring the hospital service to the local health authorities. Some form of regional authority will always be required for the efficient planning of a national hospital service, and if the service were to be managed by the local authorities, Joint Boards (or some similar bodies) would be necessary to carry out this planning function. The service would then be administered through the Health Departments, Joint Boards, local authorities, and presumably hospital managing committees. This administrative structure would not be calculated to improve the co-ordination of the service either at the national level or at the officer level; and would simply create new problems in the relationship between Joint Boards and local authorities.

As for the practicability of the proposal, we doubt very much whether the local authority machine would be able to carry the additional burden