

Radicalism and Reality in the National Health Service: Fifty Years and More

edited by
Karen Bloor

THE UNIVERSITY *of York*

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The Editor:

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Introduction

Karen Bloor

The British National Health Service came into existence on the 'Appointed Day', 5th July 1948. It provided universal access to comprehensive health care, funded by taxation and free at the point of use. The radical creation of the NHS nationalised 1,000 hospitals owned and run by a variety of voluntary bodies, and 540 hospitals operated by local authorities; and it extended free access to general practitioners from the 21 million people covered by the 1911 insurance scheme to the entire population.¹ Funding of the NHS through general taxation, and public provision of care, have remained the hallmarks of the NHS over its fifty year history. The NHS is currently the largest employer in Europe, with a workforce of over 1 million and annual expenditure of around £45 billion.

The Minister responsible for introducing the NHS, Aneurin Bevan, described it as:

the biggest single experiment in social service that the world has ever seen undertaken.²

This kind of experiment requires realistic and careful academic appraisal. Since it was founded in 1963, the University of York has developed a particular interest and expertise in analysing the results of this 'experiment', by evaluating health care and health policy in the United Kingdom. Researchers in the Institute for Research in the Social Sciences (previously the Institute for Social and Economic Research) and in other departments around the University have pioneered social science research into health. Research into health economics at York, notably by radicals such as Professor Jack Wiseman, Professor Alan Peacock and Professor Alan Williams resulted in the establishment of the Centre for Health Economics (CHE) in 1983, under the direction of Professor Alan Maynard and now Professor Michael Drummond. CHE is a leading centre of research applying the discipline of economics to health and health care, and from CHE other research centres have developed – in 1986 the York Health Economics Consortium was created to provide consultancy and applied research and training to the NHS; and in 1994 the NHS Centre for Reviews and Dissemination was established to provide reviews of the effectiveness of treatments and the delivery and organisation of health care.

Research and teaching in health economics is also carried out in the Department of Economics, and considerable health related work is carried out in the Department of Social Policy and Social Work, particularly in the Social Policy Research Unit, the Centre for Housing Policy and the Social Work Research and Development Unit. More recently, the Department of Health Sciences and Clinical Evaluation has been founded as a multidisciplinary teaching and research department seeking and applying evidence about health and health care; and the Department of Health Studies specialises in the education and training of health and social care professionals.

It was therefore appropriate for the University of York to celebrate the fiftieth anniversary of the National Health Service with a series of lectures during May and June 1998. The

lectures, published in this volume, describe and analyse the ‘social experiment’, examining the past, present and future of the NHS.

Professor Anne Digby is a leading social policy historian, and her paper considers the creation of the National Health Service. It analyses the tension between historical forces for continuation, and those for radical innovation, during the period prior to the 1948 changes and during the early years of the NHS. This tension between radicalism and reality has continued over fifty years.

Alan Williams, Professor of Economics at York, examines the enduring ethical dilemmas involved in the practice of medicine, the need for transparency in priority setting and the doctor’s role in it. Rationing in the NHS requires a radical and explicit approach, addressing the reality of scarce resources and the need for choice.

Professor Marshall Marinker, a prominent thinker in general practice and primary care, looks at the NHS in the 1960s and 70s, decades where general practice came to the forefront of the NHS. General practice is also characterised by tensions between radicals (a group in which Professor Marinker may include himself) and more conservative forces in the medical profession.

Alan Langlands, Chief Executive of the NHS in England and the most senior health service manager in the UK, gives a fascinating description of the NHS in the 1980s, including the development of general management in the NHS and the introduction of the ‘internal market’ under the Thatcher government. The radicalism of the Thatcher government was tempered by the reality of the popularity of the National Health Service, and change in the health care system was less than elsewhere in the public sector.

Hugh Bayley is Member of Parliament for York, a former member of the University of York and a key advisor to the current government’s health team, as Parliamentary Private Secretary to the Secretary of State for Health. His paper outlines current government health policy and the reforms suggested for a ‘New NHS’. The clash between radicalism and reality in these reforms is evident and will provide further study for the York research group.

Finally, Alan Maynard, Professor of Economics at York and Chair of York District Hospital NHS Trust, considers the future of the NHS, and suggests some radical and realistic policy alternatives which will ensure the continuation of the NHS for another fifty years.

I feel privileged to have been able to organise this lecture series and to edit this resulting volume. The authors of these lectures have all, in different ways, contributed substantially to the development and the current strength of the NHS.

Returning to the words of Aneurin Bevan, he said that:

We know what happens to people who stay in the middle of the road. They get run down.³

Bevan believed that a radical approach to change was essential, to avoid being run down by conservative forces in the health care system. The authors of this volume have never been happy in the middle of the road, and they accept the positive aspects of tension between radicalism and reality in the NHS, which has characterised policy development in UK health care. All the authors are committed to the goals of the NHS and to the role of good research in achieving these goals. While celebrating the 50th anniversary we look forward to the next fifty years of the NHS, and to the next fifty years of health research at York!

Karen Bloor

August 1998

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Chapter 1

Continuity or Change in 1948? The Significance of the NHS

Anne Digby

Introduction

This year we celebrate the existence of 50 years of the NHS, which by now has become a central and much-loved British institution. The British NHS was unique in the world in using the resources of general taxation, rather than private or public health insurance to finance a comprehensive system of health care.¹ The incursion of the state into the finance and administration of the NHS was part of a wider expansion of collectivist responsibilities in a number of emerging welfare states in different countries during the 1940s. Although the NHS was conceived harmoniously (as indeed are most births), once the implications of its conception were realised, gestation was contested by various sectional interests. Its early days were thus marked by considerable uncertainty. In my judgement, a Whiggish historiography on the socially desirable changes brought about by the NHS has often tended to obscure the tensions and uncertainties which accompanied it. One example of early uncertainty was the statement by Aneurin Bevan, the Minister of Health and forceful architect of the new service, when he commented about patients that 'it was absolutely necessary that we should first of all allow people to behave before we could form a view of what that behaviour pattern of the population would be in respect of spectacles, dentistry, drugs, and doctors.'²

The circular which was delivered to every home in the country shortly before the inception of the new service emphasised its novelty:

Your new National Health Service begins on 5th July. What is it? How do you get it? It will provide you with all the medical, dental, and nursing care. Everyone – rich or poor, man, woman or child – can use it or any part of it. There are no charges.³

In contrast to present-day concerns about escalating demand, the government actively sought to increase demand for health care at the inception of the NHS. The circular stressed three key attributes of the NHS: medical comprehensiveness, free at the point of access, and social inclusiveness. All were new and implied decisive change. Reading the confident statement in the circular distributed reinforces the idea that this NHS had sprung fully formed, and was the product of a national consensus on the need for change of a certain, defined kind. However, it was not as simple as that. Historical changes rarely are, or historians would shortly become the dinosaurs of academic life.

This paper focuses on the creation of the NHS, and its first years until the early 1960s, not to give a comprehensive history but to discuss the extent to which the new health service embodied continuity as well as change, and thus looked backwards as well as forwards.

1. Causes and aims of the NHS

The crucible of the Second World War had been significant in bringing the NHS into existence. As the social policy analyst, Richard Titmuss, commented 'when human lives are cheapest, the desire to preserve life and health is at its highest.'⁴ At a turning point in the war, at the end of 1942, Beveridge's blueprint for post-war welfare reform was published. This assumed a national service for health as part of a comprehensive set of social welfare measures. The Beveridge Report specified that:

A comprehensive national health service will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary, institutional, general, specialist or consultant, and will ensure the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents.⁵

The method of paying for this utopian recommendation – whether by a social insurance contribution or some other mechanism – was left open. Two years later the wartime coalition government's rather more cautious White Paper 'A National Health Service'⁶ was issued. A landslide Labour victory in the general election of 1945 made possible a more radical transformation in health services. But given the multiple interests involved, there were many issues that needed to be agreed. Rather than a unified unitary system, the NHS emerged as, effectively, a tripartite scheme. Arguably this hindered the development of a cohesive and equitable health service. One element in the administrative structure was radical, the other two had substantial continuities with the institutional set up before World War II.

The revolutionary element involved hospitals. During the war the Emergency Hospital Scheme had pointed to the desirability of setting up a comprehensive system to replace the huge interwar complexities of a thousand voluntary, and two thousand municipal hospitals, many still retaining a stigma from their earlier poor-law use.⁷ However, the disadvantages of uneven interwar institutional provision had to some degree been counter-balanced by greater grassroots participation than was to be the case under the NHS.⁸ Centralisation in 1948 therefore involved some loss of local knowledge and of professional expertise.⁷ Before 1939 the growth in municipal medicine had seemed to point to a future structure organised around it. Instead Bevan produced a nationalised structure of hospitals, albeit one which was subdivided into 14 regional health boards in England and Wales, and another five in Scotland.

The nationalised hospital structure, with its regional administration, was the radical central feature of the NHS. This structure centralised hospital services round the major teaching hospitals, in line with progressive clinical thinking, thus bringing the support of elite medical groups behind the proposals. Local municipal services in public and preventive health continued under local government (local health authorities), forming the second

component in the tripartite NHS structure. This arrangement secured the support of another important interest group behind the proposed new service – that of the local authorities. In the third part of the new structure, general practitioners were left under Executive Councils, which were a continuation of the old National Health Insurance Committees under a new name.

2. General practitioners

To analyse the comparative weight of elements maintaining continuity with those creating change, the arrangements for general practice and for patients must be examined before considering more briefly other issues. The NHS replaced the national health insurance scheme (NHI) which had begun in 1911 for poorer manual workers in employment. They were mainly male workers, and few females qualified. Unlike the German scheme upon which the British system of social insurance had been modelled, the NHI did not include dependants – wives and children – of the workers, and hospital treatment was also excluded from its provisions. It was therefore socially and medically exclusive, whereas the NHS was designed to be inclusive.

In 1946, the Minister of Health was anxious not to erode the hard-won settlement enacted in the National Health Service Act of 1946 by conciliating sectional interests more than was absolutely necessary to get the scheme off the ground by the start date of July 1948. The main obstacle to this objective was the British Medical Association, representing the rank and file members of the medical profession. The BMA represented three-quarters of all doctors on the Medical Register, and had an inglorious record of privileging doctors' remuneration over wider health concerns.⁹ To its critics the BMA represented the 'petit-bourgeois' of medicine – the traditional independent entrepreneur in general practice. Its anti-government and anti-NHS stance was thus predictable.¹⁰ But an important constraint on the BMA as a professional association was its inability to speak forcefully and monolithically for a unified profession. It represented non-élite GPs and was outflanked by a more powerful pressure group, the specialists, whose interests were safeguarded by the Royal Colleges. These had rapidly secured from the government concessions which gave consultants highly privileged positions in NHS hospitals. This devolution of power to elite groups within the medical profession was hardly a promise of later cost-effectiveness.^{11,12}

Medicine was a liberal profession. The BMA powerfully articulated issues of 'professional freedom' and therefore played on their members' anxiety that they would become like civil servants, and would lose their independence.¹³ 'We were afraid of being taken into a salaried service, and ordered about, and [of] getting a much smaller salary.'¹⁴ The Labour Party's pamphlet, *A National Service for Health* of 1943¹⁵ (written by a Socialist Medical Association member), had stated that the medical profession should be organised as a salaried service. In the period before the NHS came into effect, increasingly militant

rhetoric was matched by an absence of movement in the stances of the two sides. In their plebiscites the medical profession continued to demonstrate a generally hostile view of impending changes.¹⁶ Finally, with time running out, Bevan offered GPs concessions over their form of payment, opposition from general practitioners crumbled, and the BMA Council pledged support only three weeks before the NHS was to take effect.¹⁷ In the plebiscite 8,639 GPs voted in favour of, and 9,588 against, the amended act.

What had ordinary doctors achieved? The amended NHS legislation did embody a major campaigning issue of the BMA, in retaining capitation payments (whereby remuneration was based on numbers of patient) and with doctors as independent contractors within the NHS. Both arrangements are still operational today. The new service also mirrored many GP's traditional individualistic and curative medical concerns. It thus sidelined many of the more idealistic hopes of the younger and more left-wing members of the medical profession who had hoped for more social and preventive medicine.

Doctors whose professional lives spanned the watershed of 1948 have sombre recollections of this period of transition, because they felt generally uncertain about what the NHS implied. The quotations in this section come from oral interviews with elderly doctors remembering the period of change with less than fond recollection. Not all doctors had the time to go to BMA meetings – especially if they had rural practices. ‘We didn't know what it was going to do ...we didn't know [what] we were going to get paid. And we didn't know whether we were going to get any compensation.’¹⁸ GPs considered that the financial elements of the NHS settlement treated them illiberally. Traditionally, doctors had been free to buy and sell practices; this was the main source of their capital and vital to their eventual retirement income. In this context compensation for the abolition of sale of the goodwill of practices was a major issue. Some £66 million was allowed for compensation but payment was generally postponed until the actual date of their retirement. Half a century later, elderly GPs still considered their compensation terms to have been inadequate. ‘We had a very poor deal’, one GP concluded.¹⁹

Evaluations of the NHS settlement differed, but GPs' morale was at first low. General practice was perceived to be the Cinderella service of the early NHS. General practitioners were dissatisfied about the initial NHS remuneration settlement. There had been an increase above 1939 levels of only 20% on net income. The extent to which this undervalued their contribution was suggested by the later Danckwerts Award of 1952, which raised GP's remuneration 100% above the 1939 level, or 85% above that of 1948.^{20,21,22} However, there was consensus that the NHS had made income more secure with guaranteed payments from the state, and with no more bad debts.^{23,24}

The NHS had a strongly differentiated impact. Generational differences were highlighted amongst general practitioners with some older doctors going for early retirement rather than facing what they feared would be a radical change.²⁵ (This is similar to more recent

experiences during the 1990s when the new GP contract produced an exodus from the profession). In contrast, the younger generation who had only recently come out of medical school, or who had served in the army, thought that the new health service reflected some of their ideals about practice, especially the fact that it was free at the point of access. One reflected that 'I wasn't a militant for commercialism, apart from the fact that I had to earn a living ... I was interested in wanting to help people'.²⁶ For the younger generation there were different problems from older doctors, not least in acquiring a practice. It was no longer possible to buy into a practice, and the consent of the Local Executive Council was needed to start up. Entrants were supposed to be steered to 'under-doctored' areas, so that inequalities in patients' access to doctors could be redressed, but progress towards giving geographical equity for patients was slow.²⁷ Some younger and more idealistic doctors were disappointed at the failure of the new service to develop the health centres which had been included in the legislation, and at one stage had been seen as a central building block in creating a health – rather than a sickness – service. Although health centres were still retained in the legislation, only 14 health centres opened between 1948 and 1960.²⁸ (In 1980 there were 1267, and in 1990 1515 health centres in Great Britain). The lack of health centres as the focus for extended preventive or social medicine meant that the resemblance to the partial system of public medicine before 1948 seemed strong.

Doctors in different sorts of practice had to make very varied adjustments to the new conditions of the NHS. This bore strong similarities to the situation experienced after 1911. Then the erstwhile Victorian 'club' or 'sixpenny' doctors who had treated the poorer members of the community had effortlessly adopted a fast throughput of NHI or panel patients, because their prior conditions of practice had been very similar. In much the same style, after 1948 those GPs who had run a largely panel practice adjusted smoothly to the NHS. They also benefited because the wives and children of their former male panel patients now came to them as well. But there was some generalised ill-feeling about the speed with which more entrepreneurial doctors signed up patients for the NHS, so that there was a redistribution of patients away from those doctors who were still holding out for a better deal under BMA leadership.²⁹ Interestingly, history was repeating itself in that this was comparable to complaints after the 1911 act that the 'sixpenny doctors' had signed up huge numbers of panel patients very quickly.

For those who had run a practice before 1948 which was mainly or wholly composed of private patients, there was a more uncertain period of adjustment; not least because it was initially uncertain whether these patients would remain private or opt for free treatment under the NHS. Doctors' own views showed some generational variation with older doctors tending to like private patients. Younger ones found them either uncongenial or else perceived their expectation of superior treatment to be uneconomic, and so often deliberately ran down, or ended, the private list.²⁹ What needs historical emphasis, however, is that private patients disappeared much more rapidly than doctors had

envisioned before the NHS took effect. The swiftness and completeness with which the middle-class patient opted for the NHS found general practitioners unprepared. 'We were really quite surprised at the number of people in the really big houses who took advantage of the NHS right away'. 'My own former private patients lost no time in presenting their [NHS] cards. Very few remained aloof.'³⁰

General practitioners had grossly underestimated the impact the new health service would make. Rather than a socially inclusive and egalitarian new health service, many had envisaged it merely as an extension and enlargement of the national health insurance scheme for the working class, and so had not anticipated a comprehensive service. Nor have historians appreciated the unexpected scale and speed of this enormous change in the social character of primary care, in which private practice with the middle class all but disappeared overnight.

Incorporating the better-educated patients into an NHS practice was not in itself unproblematic, however, and we have seen that some younger GPs resented their demands for more time and attention.³¹ In the most common situation where there was a majority of NHS patients, with an admixture of fewer, paying, middle-class patients, there was alleged to be no difference in the clinical treatment given to a practice's NHS and private patients, apart from preferential treatment over visiting.³² During earlier parliamentary debates on the NHS, critics of a proposed bipartite system of free and paying patients had predicted that it would involve a two-tier system of care, and that this would then erode confidence in the new health service.³³ In the event, this concern was removed by the very small numbers of surviving private patients. Only a few all-private practices remained. These retained their clientele through offering high quality service.³⁴ A Welsh medical woman explained why she and her sister (who were in partnership), concluded that the NHS was not for them, although in principle they were generally in favour of the NHS.

We felt that we wouldn't be able to give the necessary essential time to each patient in order to get good results and therefore informed our patients to register with a state doctor. We did not expect them to come to us. However, as it happened, contrary to expectation – and before we realised it – we were still practising, and so decided to carry on.³⁵

General practitioners entered the new service apprehensively. Not only were there anxieties as to the balance between private and public practice but there were worries – not well-founded – that the NHS would restrict prescribing freedom.³⁶ Trepidation was aroused that bureaucratic record keeping would grow although, retrospectively, there was disagreement about how much this had actually happened. The long-term significance of the virtual disappearance of private practice was important. Including middle-class patients, who previously had been used to paying the market cost of their health care, contributed to a new service which was geared to better standards than had been found in the preceding panel system serving only working-class patients.

3. Patients and doctors

The NHS not only involved a social widening of the patient body but a free service, and related changes in patient-doctor relationships. Most GPs agreed that the main changes brought about by the NHS concerned patients – ‘everybody could have access to a doctor’. Earlier huge patient anxieties about the cost of ill-health, and about whether a doctor’s bill could be paid were now laid to rest. These apprehensions were found not only amongst patients but also doctors – since they could be faced with considerable bad debts, amounting to nearly a tenth of gross income. Significantly, doctors saw the NHS as having brought about an improvement in doctor-patient relationships. ‘I liked it, because it meant that I could just not worry about sending bills to patients’, stated one medical practitioner.³⁷ Several reflected that the NHS was a boon because psychologically it was much easier to be a doctor, in that money did not come between you and the patient.³⁸ Another implied that competition for patients had lessened after 1948 because ‘there wasn’t the same fear of people wandering’.³⁶ Allegations of ‘patient-pinching’ between doctors diminished, although they did not altogether disappear. Professional opinion differed as to whether any changes had occurred in the status of the doctor, and on related developments in the character of doctor-patient encounters. While some thought doctor-patient relationships had already become more egalitarian during the war, others considered that this had occurred only after 1948. Again doctors’ opinion was divided as to whether the new service involved a loss of deference.^{23,37} One practitioner remarked that although ‘you were still held in great respect’ patients became more assertive, “I’m changing my doctor”, if you didn’t comply.³⁹

There were built-in structural disincentives to good patient care in the NHS’s general medical service which stemmed from the capitation system of doctor’s remuneration continued from the preceding NHI. The lack of incentives to spend money on improvement of services was similarly reminiscent of the preceding panel system when there had also been an under-investment in accommodation, in new techniques and treatments, and in ancillary help for the doctor.⁹

Conspicuous inequities in the distribution of health care were inherited by the health service in 1948. Such inequalities amongst the British population remain an issue in current social policy debates. Before the NHS the health needs of many poorer women and children had suffered because of their exclusion from the panel system. In 1933, for example, the Women’s Health Enquiry had found that nearly one in three working-class mothers had sought no professional advice or remedy for their problems. These women were heavily concentrated in the lowest income groups, suggesting that the cost of treatment was a significant disincentive in seeking help. The enquiry found that women were most likely to consult a professional over serious conditions – rheumatism, bad legs, or gynaecological troubles.⁴⁰ In 1948 previously untreated conditions, notably what were referred to as ‘women’s chronic internal complaints’, (together with cases of measles and

whooping cough amongst children), were conspicuously numerous amongst cases freely treated by the NHS doctor.⁴¹ As we have seen, at the inception of the NHS the Ministry of Health promoted the service amongst potential consumers. However, an unexpectedly huge backlog of need resulted in an unanticipated high rate of demand for health care. Even GPs had been unaware of the unmet needs amongst the dependants of their panel patients. The extent of this demand varied according to practice and area, a point obscured in general accounts of the NHS.

How great was the surge in demand? One precise indicator was the number of prescriptions made out by doctors. Between the last month of the old pre NHS system (June 1948) and the third month of operation of the new health service, monthly numbers of prescriptions actually doubled. NHS doctors clearly enjoyed their new-found freedom to prescribe without reference to the patient's ability to afford the medicine.⁴² The advent of new pharmaceuticals also transformed therapeutic potential in general practice, although take-up, and thus prescription costs, varied enormously between doctors. An imposition of a prescription charge in 1951 acted as some deterrent, but this was not sufficient to reverse a rising national drug bill.⁴³

The reputation of doctors stood high since they seemed at last to have the therapeutic armoury to conquer many diseases. The availability of new drugs, especially of antibiotics, helped doctors with what they regarded as the 'old horrors' of TB, tonsillitis, sepsis, diphtheria, scarlet fever, or pneumonia. Mortality from infectious disease amongst children fell dramatically. As a historical footnote to this it is interesting to note that an earlier generation of doctors, whilst welcoming these new drugs, also considered that they had phased out an age of heroic doctoring. Some felt that earlier the titanic eight day struggles with pneumonia had given them 'tremendous satisfaction', and had also earned them a hard-won respect in the community that was no longer possible for their successors.⁴³

By 1960 the cost of pharmaceuticals had outpaced the cost of the general medical service. This was not because doctors were writing more prescriptions per patient than hitherto; the numbers of prescriptions per person was virtually the same in 1948 as in 1960 – 4.7 compared with 4.8. (It was only in later years that numbers of prescriptions climbed such that in 1990 it was 7.7 items per head on average annually).⁴⁴ The increased cost was due to the rising cost of the new powerful pharmaceuticals, as the average net cost per prescription more than doubled between 1949 and 1965.¹ Thus, even in the early years of the NHS the escalating cost of pharmaceuticals had emerged as an issue, although the rising cost of drugs and medical technology was less obvious than it has since become.

Whilst free health care was undoubtedly a great boon to patients, the system militated against individualised care, not least because a large maximum list size was permissible. For a single-handed GP this was at first 4000 patients, later reduced to 3500. In 1950 the average list size was 2500, by 1992 this had been reduced to only 1875.⁴⁵ Both the NHS

and the preceding panel system had a capitation system which gave doctors an incentive to spend as little as possible on their patients, although how individual doctors translated this financial imperative into medical practice varied.

The average time which a GP could give to a patient varied remarkably little during the twentieth century. The present day NHS has five to six minutes of contact-time: one to get from the waiting room to the doctor, and five minutes for an encounter. This is slightly better than the NHI after 1911 when it was three and a quarter minutes in the surgery or four minutes on a visit.⁴⁵ These short encounters with the doctor did not of course aid communication between patient and doctor. In other respects the manner in which the new health service was financed contributed to a narrowing of service in general medical practice, with much less dispensing except for a few special cases in remote rural practices, and a steep overall decline in the amount of minor surgery which was performed.

4. Hospital services

A more positive outcome was a more efficient maternity service. General practitioners' record of interwar obstetrics was one with some serious failings.⁹ In England and Wales the advent of an NHS Obstetric List – for those doctors with a specialist qualification in midwifery – meant that fewer and better qualified practitioners assisted with more confinements, thus facilitating greater experience in medical maternal care. And, in theory at least, patients had rather better access to hospital pathological services through their GP, compared to the previous situation where this had been mainly channelled via consultants. However, in practice the GP's new and extended access to laboratory facilities or X rays could be frustrated by the uncooperative attitude of hospitals.³⁶ Before the NHS many patients had been unable to afford the three guineas fee for a consultant, so that referrals were constrained.⁴⁶ Clinically, a benefit of the new free health service was the improved access to hospital consultants.^{23,36} And the overwork experienced by many general practitioners after 1948 has led to the conclusion that this may also have contributed to the more frequent referrals of patients to specialists in hospitals.

Whilst virtually every member of the population had a general practitioner, the take-up of hospital services only gradually increased. By 1964 about one in five of the population was utilising in- or out-patient facilities.¹ The much more cohesive structure of tertiary care after 1948 led to efficiency gains, and hence to better patient care. But the buildings of most hospitals owed more to historical continuity than to change. The new hospital building programme developed only slowly from 1955. Within the hospitals advanced specialist services became available; there were huge strides in the tests conducted in pathological services, and hence a surge in diagnostic potential. In addition, there were improvements in orthopaedics, an expansion of maternity facilities, and more advanced surgery.

5. Resource issues

These developments had knock-on effects on the finances of the NHS. Hospital nationalisation shifted the burden of health care costs from varied, mainly local, sources to the national exchequer in a way that very few contemporaries appreciated would have such momentous consequences. Overnight the NHS became the third largest civilian employer in the country. In its first two years NHS expenditure grossly exceeded initial estimates, leading politicians to assume that health costs would continue to be explosive in the future. This was inconsistent with a contemporary expectation that the input from taxation to the new health service should be limited to the amount obtained from national insurance contributions (circa £400 million per annum).¹ Hence additional revenue had to be targeted. Labour introduced dental and eye charges in 1951, resulting in Bevan's resignation over the betrayal of free health care. The Conservatives introduced prescription charges the following year. Very early in its history the NHS thus moved into a so-called 'crisis' of resources and funding, a situation which has since become endemic.

It was paradoxical that, contemporary with these fears about how sustainable the new service was in financial terms, came a political and administrative weakening of the body administering the NHS – the Ministry of Health. In 1951 the ministry was reduced in responsibilities and size, and its minister relegated to non-cabinet status. A succession of short-stay ministers then characterised the department. With good reason the period from 1948 to 1964 has been authoritatively characterised by Charles Webster, the official historian of the NHS, as being one of 'resource starvation and policy neglect'.²

Inquiries during the 1950s, however, indicated that the service was reasonably efficient and cost effective. The Guillebaud Committee was set up in 1952, with economic analyses provided by Brian Abel Smith, and its Report concluded that there had been no widespread extravagance. Instead it recommended further expenditure (to the horror of the Treasury), and no fundamental changes in the service. Not surprisingly sterner critics of the NHS called the Report 'a blue book full of whitewash'.³ Viewed from the perspective of the 1990s it is clear that the early NHS took up only a modest proportion of national resources. In its first full year of operation, 1949, the NHS absorbed 3.9 per cent of GDP, rising to 4.2 per cent in 1950, presumably as a result of the backlog of demand. For the next few years although health expenditures were growing, GDP was increasing still more, so that the figure stabilised at around 3.5 per cent. In 1958, however, health expenditures as a percentage of GDP began to rise, and did so steadily throughout the 1960s, until in 1970 they comprised 4.7 per cent of GDP.⁴ Interestingly, the amount of the cost borne by direct charges and the national insurance contribution doubled from 9.4 % of gross cost in 1950/1 to 19.5% in 1963/4.¹

6. Conclusion

To the historian, the anxieties of the 1990s over scarce resources therefore appear very familiar. Resource constraints, and concerns over escalating costs, were a feature of the NHS from the very beginning, as they had been of the national health insurance scheme before that. A gap between the service as a popular ideal and some perceptions of its practical performance in delivering health care was – and is – also a resilient feature of the NHS.⁶ Whether perceptions were/are themselves accurate is another tenacious issue.

On the Appointed Day, 5th July 1948, when the NHS came into effect, a ‘Leader’ in the *Guardian* stated that:

the passing of the milestone will be hailed with a chorus of praise, some of it perhaps complacent. ...[but] One must think of the health service as a huge national organism in process of growth, not as a creation of magic called forth out of the void by the wand of the Minister of Health.⁴⁸

This reference to the ‘process of growth’ was apt, as my evolutionary sketch of the early years of the NHS has tried to suggest, with its emphasis on continuity as well as on change. In this paper issues have been highlighted which characterise both the historical early years of the NHS and modern policy debates – including patient expectations, inequalities in provision, and problems of funding.

Studies have indicated that the new service tended to distribute resources ‘according to past precedent rather than proven need.’¹ Inherited class, sex and regional inequalities in health were then extended into the future, as the well-publicised Black Report of 1980 clearly demonstrated.⁴⁹ A north-south divide in health care continued, with better hospitals and services in the more affluent areas of London and the south-east of England.¹ Although the NHS was much more centralised, the lack of co-ordination that had characterised pre-war institutional complexities lingered into the new NHS structure with a devolved administration which involved about 800 bodies.²⁰

Within the NHS many features were in key respects therefore dependent on what had gone before, so that elements of continuity were strong. Such continuities were weakest in the hospital sector and strongest in general medical practice. The NHS reorganised – but did not radically transform – general medical care.³⁴ In the perceptions of its GPs the NHS was very much an evolution of – rather than a decisive break with – the preceding national health insurance scheme.¹⁰ Much of the standard of care and social ethos of the general medical service under the NHS was a continuation of the old panel system.^{21,50} It is perhaps insufficiently appreciated, for example, that many of the detailed regulations for the national health insurance scheme were merely transferred into the NHS.⁵¹ After 1948 the major change in general practice was the extension of free-at-the-point-of-access health care from the minority of insured working-class males who had been panel patients since

1911, to the whole population: to women and children as well as men, to the middle class as well as the working class.

So if, as I have argued, continuities were so strong, how has the idea of the NHS as a fundamental turning point occurred? In popular understanding at the time, discontinuities in 1948 were magnified because the NHS came to symbolise an expansionist social policy which gave hope in the midst of war-time and post-war austerities.⁵² Subjective perceptions assumed importance in engendering a sense of a new world. As time passed, changes which had preceded or followed the inception of the NHS, and which in any case had different rationales, tended to be aggregated with the NHS, thus helping to manufacture the sense of an historical watershed. For example, GPs whose practice continued across the alleged divide of 1948 reflected that social changes in doctor-patient relationships that had actually pre-dated the NHS (in the greater social egalitarianism of the war years), or post-dated it therapeutically (with new drugs, especially antibiotics during the 1950s), were conflated in historical perception with 1948.

In order to appreciate the full significance of the reforms of 1946/8, it is necessary to pose a counterfactual question. What kind of health care would have been available if the NHS had not come into existence? In particular, if free-at-the-point-of-access health care had not existed, would working-class patients have been able to benefit from the expensive new pharmaceuticals which transformed post-war medical treatment? Without the NHS it seems highly likely that they would have been denied access to them. Similarly, economic constraints would have become increasingly relevant as more advanced – and ever more expensive – medical technologies also extended frontiers of specialist competence. In the absence of the NHS, a deepening divide would have separated the affluent from the poorer British citizen, and an invidious two-tier system of health care would have continued in which many of the benefits of modern medicine were unavailable to a substantial part of the population.¹⁶

In my judgement we should celebrate the creation of the NHS in 1948 as marking a fundamental change in the system of British health care. We should also recognise, however, that the idiosyncratic shape of that divide was historically conditioned, and that the continuities which resulted from this have substantially contributed to the kind of problems that have beset the NHS during the subsequent half century.

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Chapter 2

Medicine, Economics, Ethics and the NHS: A Clash of Cultures?

Alan Williams

1. Ethics and the practice of medicine

The practice of medicine has always been fraught with ethical dilemmas. Historically these have mostly been concerned with finding rules of conduct designed to prevent the powerful and knowledgeable doctor from taking advantage of the weak, vulnerable and ignorant patient. This has given birth to a code of ethics which requires a doctor to tell the truth, to respect the autonomy of the patient, and to deal justly with patients. It has focused attention on the doctor-patient relationship as the keystone of medical practice, and on the importance of sustaining it as a trusting relationship. The doctor is also expected to use his special skills to preserve life, to alleviate suffering, and to do no harm.

It will immediately be evident that these objectives frequently pull in different directions. Is life to be preserved no matter what its quality, and even when the patient no longer wishes to go on living? What if the alleviation of suffering is likely to shorten someone's life? And if a treatment carries a significant risk of doing harm, does that risk rule it out from further consideration, or should the possible harm be weighed against the possible benefit, and a judgement made as to where the balance of advantage lies? Who should make that judgement: the experienced doctor or the frightened patient? Does respecting the autonomy of the patient mean that the patient should be told the whole truth, and given full responsibility for the decision and its consequences? Or, if telling the truth is likely to add to the patient's anxiety and distress, is the doctor ethically justified in trying to avoid this by discreetly assuming responsibility and quietly getting on with things? What about dealing justly with patients? Does that mean treating cases which are clinically identical in exactly the same manner without showing any favouritism because of a patient's personal circumstances, or should a patient who is being kept off work and losing money because of a condition be given priority over someone in a job where the same condition has a less severe impact? Is it right to take grandma into care, when she would rather stay with her daughter-in-law, but the daughter-in-law has had enough, and, for the sake of her marriage and her children's welfare, wants grandma out. Whose interests are paramount?

I catalogue these common dilemmas to demonstrate that inherent in medical practice is the task of resolving ethical issues, and that these particular ethical issues have nothing whatever to do with economics. They arise because medicine has many different objectives, none of which can be pursued single-mindedly, so compromises have to be made. Different doctors, appealing to the same code of ethics, may come to different conclusions in comparable circumstances. So we may expect considerable variation in

practice policies from one doctor to another, even when they are equally knowledgeable about the science of medicine, and equally conscientious individuals. They need only differ in the weight they attach to the different principles of medical ethics.

2. Economic incentives and the practice of medicine

Economics introduces some complicating factors to medical practice. Being a doctor is a way of making a living, and a highly respected one. Some doctors are effectively small businessmen, renting premises, hiring staff, buying equipment and consumables, and hoping to make a big enough surplus at the end of the year to provide for themselves and their families a standard of living that is an adequate reward for their poorly-paid years of training and for the onerous responsibilities they shoulder. Is this likely to affect their clinical behaviour in any way? It would be very surprising if it did not.

To take a simple example, doctors pay to maintain the capacity of their practice to see and treat patients, but they do not pay for the time of patients. So you would expect them to organise their practice so that the resources they pay for are kept busy, but the resources that cost them nothing can be used freely. Patients therefore sit around waiting for doctors and nurses. Doctors and nurses do not sit around waiting for patients. Yet the time of patients is also valuable. My dentist asks me to go and see him every six months even if nothing is wrong with my teeth, and if I refuse this invitation three times he threatens to strike me off his list. Going to see him incurs transport costs and occupies at least an hour of my time, for a ten minute 'check-up' which typically reveals nothing. Suppose he had to pay me £20 an hour for my time, and meet my travel costs, if *he* initiated the visit. Would his enthusiasm for regular six monthly check-ups remain unabated?

At a more strategic level, it is well known that the way in which doctors are paid has a significant effect on their practice pattern. If they are paid a salary which does not depend on their pattern of work, they behave differently from when they are reimbursed on a fee-for-service basis. This responsiveness creates a powerful set of incentives that can be used to induce doctors to change their pattern of practice. Is this responsiveness unethical? It would be if doctors deliberately did things that were harmful to patients simply in order to make money. But as I have already indicated, the balancing of risks and benefits is part of everyday clinical practice, and even in the absence of any financial incentives to change in one direction or another, different doctors will strike the balance in different ways. In this grey area we are likely to observe a clustering of decisions at one end of the spectrum instead of at the other end, but all within a zone that is conventionally regarded as 'ethical'.

These financial incentives are not peculiar to National Health Services, indeed they can be observed in operation far more blatantly in private or quasi-private systems. The notion that doctors are now being forced to think about money for the first time, instead of thinking solely about benefits to patients, is nonsense. Doctors have always been acutely

conscious of the need to be cost-effective in the use of one key resource, their own time. There are many competing demands upon their time which, at the margin, have to be balanced one against another. There is time to be spent with the patient in front of them at the moment. But there are also patients waiting or scheduled to see the doctor next. There is teaching or training to be done, a management meeting to attend, some research data to enter and analyse, a new member of staff to appoint, the children to be picked up from school, letters to write, telephone calls to make. There is constant pressure to think about the most effective use of the scarce resource of time, and whether it would be a good idea to hire somebody to take on some of these tasks. The doctor as practice manager has to consider the costs and benefits of each practice activity, and choose that mix of activities that maximises the benefits from the limited resources at their disposal. Although this may not be recognised as an economic problem, to be solved by applying well-established economic principles, that is indeed what it is, and doctors have been at it for decades, long before the National Health Service was introduced.

3. The National Health Service and the practice of medicine

What difference is made by the existence of a National Health Service? The fundamental difference between a centrally-tax-financed public health care system, and any private or quasi-private system, is that access no longer depends on the patients' (or their insurers') willingness and ability to pay, but upon some notion of 'need'. To short-circuit what could be a rather complex debate about the appropriate meaning of 'need' in this context, it will be simply taken to mean a person's capacity to benefit from health care. People cannot need something which will confer no benefit upon them, and a person waiting for large benefits has a greater need than someone waiting for small benefits. However, who is to judge a person's needs, as opposed to their desires or demands? Not all needs can be met, and needs have to be prioritised, so a disinterested expert is required to do it. Who are the experts in judging the likely benefits of health care? Why, the doctors of course! So the prioritisation of needs comes to be seen as a clinical matter for doctors to sort out. Since doctors have always had to decide which cases are urgent and need immediate treatment, and which can wait a while, they are already well practised at this painful task.

This additional responsibility creates a new ethical dilemma for them. At one and the same time they have to think:

1. What is the best I *could* do for this patient if I ignored the consequences for all other patients?
2. In the light of all the competing demands from other patients, what is the most I *should* do for this one?

The first part of this deliberation is concerned with clinical excellence, no matter what the costs. The second part is concerned with cost-effectiveness. Many doctors complain that the second part is really not part of ethical medical practice, which they believe enjoins

them to do everything they can for each and every patient no matter what the costs. But one of the principles of medical ethics which I listed at the outset was to deal justly with patients. Not counting the costs of your actions means not caring about the sacrifices that are imposed on others. In a resource-constrained system the 'costs' of treating one patient are resources that might have been devoted to another patient, whose health will be worse by being deprived of them. Hence the need for prioritisation, to ensure that what is sacrificed is less beneficial than what is done. This is what being cost-effective means.

4. A clash of cultures?

This prioritisation according to needs, conducted on behalf of society at large, brings with it a demand for doctors to be more publicly accountable for their actions and policies. Alongside the patients, and the doctors' colleagues and families, there is now another party involved, the citizen-taxpayers or their representatives. Thus the balancing act has become still more complex, with the doctor trying to keep his practice viable, while at the same time doing his best for his patients, but observing policies about prioritisation and the use of resources that are acceptable to the citizen-taxpayers. It is an unenviable task.

Unfortunately, it has not been made any easier by the reluctance of the official representatives of the citizen-taxpayers (the professional politicians) to put their heads above the parapet and accept responsibility for this unavoidable prioritisation of needs. Indeed they sometimes come close to pretending that no prioritisation is necessary, and assert that all clinically determined needs will be met. But that disingenuous statement conveniently ignores the fact that these 'clinically determined needs' are the outcome of the very prioritisation process which they had dropped into the laps of the doctors and, in the manner of Pontius Pilate, conveniently washed their hands of. But since clinicians have limited budgets, and there are far more beneficial treatments than can possibly be afforded, this pretence is patently false. The world is not flat, it is round. And it is just not good enough for those in a position of responsibility to say that it looks flat from where I stand.

In a democratic society which depends for its efficient functioning upon openness, accountability and a well-informed citizenry, what should be happening is a systematic effort to bring home to the citizen-taxpayers the nature of the dilemmas that have to be faced, the options available and their likely consequences, and some consideration of the principles which should inform policy. There are some important strategic issues that need to be posed bluntly and clearly. Would you like treatments to be equally available no matter where you live, *or* would you like local discretion to respond to local circumstances? *You can't have both.* Would you like to reduce inequalities in people's lifetime experience of health, *or* would you like to avoid discrimination by age? *You can't have both.* Would you like absolute priority for life threatening conditions, *or* would you like more resources devoted to the relief of pain and physical disability? *You can't have both.* And so on.

The most effective route into people's homes, through which these issues could be presented graphically and in a balanced way, is television. But although there are a small (but increasing) number of programme makers who are willing to attempt this exercise in civic education, the more attractive option is the shock/horror/conspiracy/scandal mode of operation, ending with a demand that heads should roll. But this is not a drama peopled with 'goodies' and 'baddies', but a series of dilemmas in which virtually all of the actors can legitimately claim to be acting ethically and conscientiously. They simply differ in the weight they attach to different objectives.

Some would argue that in the absence of consensus it is less disruptive to keep things as quiet as possible and leave these matters to be settled by knowledgeable and conscientious people in private. In the public's mind the knowledgeable and conscientious people are the doctors, certainly not the politicians. What makes it very difficult for me to accept this apparently easy way out is that I observe that doctors' interests as providers of health care often dominate their role as representatives of patients' interests. In addition they are in no position at all to speak authoritatively for the citizen-taxpayers, whose interests are distinct from (and more detached and long term than) those of current patients. Moreover, it is possible to detect an increasing degree of resentment in the medical profession that, as the foot soldiers at the battle front, they are left to improvise a tactical plan with whatever resources headquarters provides them with, but without any clear guidance about strategic objectives or rules of engagement. In that situation, the infantryman's role is not a happy one! Would it not be better to take the bull by the horns and make an attempt to engage the public in a responsible debate about priority setting in health care, about the tensions between the potential of modern medicine, the resource constraints, and the ethical principles that should guide the resolution of those tensions? It seems to me to be the only responsible and constructive way forward.

Chapter 3

The NHS in the 1960s and 70s: The Invention of General Practice

Marshall Marinker

Introduction

General practice, first configured a century-and-a-half ago was, until the 1940s, little different in its clinical intentions and practice from the consultant trade. The most discernible difference was in the lower social status of the general practitioners, and in the higher social status of patients visiting consultants. The National Health Service created the necessary environment for the invention of a different sort of clinical intention, and therefore a distinctive form of practice.

Modern British general practice, as the idea is now understood, was invented in the course of the 50 year history of the NHS. Major modifications took place in the 1960s and 1970s, the decades under consideration in this paper. This paper does not describe the unfolding of the macro-history of general practice in the NHS, but examines the micro-politics of the consultation.

The changes described in the ways in which general practitioners thought about 'what is wrong' with the patient can, with hindsight, appear nothing more substantial than the vagaries of fashion. However, it is argued here that these fashions, far from being idiosyncratic, in fact reflected deep debates about the purpose of medicine. New insights were constantly being imported into practice from such diverse fields as epidemiology, psychoanalysis, sociology, social psychology, management theory, political philosophy and moral theory.

Like a succession of tides washing over the foreshore of clinical general practice, each of these disciplines left behind distinct sediments of language, values and strategies. The partial* history described in this paper – excavates these sedimentary layers by digging into a number of geological strata. However, in history as opposed to archaeology, it is necessary to describe the dig upwards from the bottom.

Seven layers are unearthed: the deepest and oldest is the illness as narrative; then the patient as diagnosis; the family as patient; the illness as puzzle; the illness as risk; the patient as community, and, finally, in both senses the most superficial layer, the illness as commodity. The focus of this history is the 1960s and 70s, and the story describes the successive emergence of contrasting models of illness, an emergence that cannot be too neatly parcelled into decades. In its telling it is necessary to stray back in time in order to suggest causes, and forward, to postulate consequences. As with all events, decades are inadequate receptacles for holding history.

* Partial, in the sense of brief and therefore incomplete; partial, also, in the sense of partisan.

1. The illness as narrative

The oldest stratum reveals the deep debt of academic general practice to epidemiology. By the beginning of the 1960s, public health academics like Maurice Backet were measuring workload and perceived morbidities in general practice, and demonstrating an incidence and prevalence unguessed in the hospital dominated medical education of the time. Pioneering general practitioners like John Fry¹ and Keith Hodgkin² chronicled the natural history of patients whom they looked after, continuously, over many decades.

Although expressed in quantitative terms, they afforded qualitative insights into ‘the illness as narrative’ – the unfolding of the diagnosis and natural history of the chronic conditions that, with the recession of the acute diseases earlier in the century, came to dominate the clinical work of doctors. Everything that followed in academic general practice began with this epidemiological critique: while the hospital was a zoological garden of morbidity, general practice was a window on the whole ecosystem of illness. And, of course, it was argued that it was the NHS universal access to general practice that constituted the necessary pre-conditions for this epidemiology.

The narrative at the time, however, remained limited by the vocabularies of the specialist clinicians and the public health doctors, whose words were minted in the laboratory and the post-mortem room. What followed, the second deepest stratum, was ‘the patient as diagnosis’ – the notion that the patient, and not just the disease, is the object of the doctor’s enquiry. This required more than an extension of the clinical vocabulary. It required the development of a new language.

2. The patient as diagnosis

I came into general practice – with the tranquillisers – at the end of the 1950s. The following is a quote from an advertisement in a 1960s medical journal:

The Sixties. It is ten years since Librium became available. Ten anxious years of aggravation and demonstration, Cuba, Vietnam, assassination and devaluation, Biafra and Czechoslovakia. Ten turbulent years in which the world-wide climate of anxiety and aggression has given Librium – with its specific calming action and its remarkable safety margin – a unique and still growing role in helping man meet the challenge of a changing world.³

The only alternative to Librium was some sort of human understanding. In 1939 the psycho-analyst Michael Balint had arrived in the United Kingdom as an émigré from Hungary, where a repressive far-right political regime had made the professional life of its Jewish intellectuals, and by association the practice of psychoanalysis, all but untenable. In the Hungarian model of psycho-analytical training, the first case treated by the trainee-

analyst was supervised by the trainer, so that attention was paid both to the trainee's relationship with the analyst-trainer, and to the relationship between the trainee-analyst and his patient.

It was this 'double-decker' trainer/trainee relationship that shaped Balint's later approach to training and researching with general practitioners, and determined the pattern of reflective case-discussion which constituted the work of what he called his 'training-cum-research seminars'. Later it was to form the model for what is now called 'case discussion' in the training of future general practitioners: this was and remains the powerful analogue in general practice, of the hospital's clinico-pathological conference.

Psychoanalysis was always much more a moral philosophy than a psychiatric treatment. It was never much of that. On reflection, I think that Balint saw his work with general practitioners as a powerful vehicle for psycho-analytical 'evangelism' (Balint uses the term 'apostolic function' to describe the doctor's values and style), in pursuit of a moral agenda. That moral agenda concerned the notion of a basic wound in the personality of the patient, and the promise of psychological redemption if the price were to be paid, the price being a willingness to touch the wound and face the pain.

All of this was part and parcel of the psycho-social agenda in the 1960s and early 70s – the valuing of feelings and the assumptions of intimacy in the consultation. On reflection, however, these new intimate consultations were not much less paternalistic, controlling and sexist than the insensitive bio-mechanical medicine that the Balintians disdained. The Balint movement flowered in the world of 'flower power' and the sexual freedom purchased by the invention of the pill. This was the world described by The Beatles – swallowing 'purple hearts' ('Mother's little helper') to get through the day. It was the pervasive prescription of the hypnotic barbiturate canary coloured capsule called Nembutal that found expression in 'We all live in a Yellow Submarine'. Balint spoke to the values of the Beatles' social critique – in songs like 'Eleanor Rigby', whose lyric still reads like any number of entries into the medical record of so many patients at that time.

Many of Balint's general practitioner associates and co-researchers (I was one of them) became highly influential in the RCGP, and therefore influential in the development of British general practice. This moral agenda therefore, so much in tune with the ambient culture of the 1960s, remained little challenged until the 1990s.

Many of the ideas in Balint's classic book '*The Doctor, his Patient and the Illness*'⁴ became amalgamated into the language of general practice, for example the use of 'the drug doctor', with its attendant pharmacological analogues about the 'dose' of doctor, timing, signs of toxicity and so on. This idea was soon powerfully incorporated into the profession's growing emphasis on personal doctoring and the creation of 'personal lists', as practice partnerships grew larger. Balint's metaphor of the doctor-patient relationship as a 'Mutual Investment Company' underpinned the emphasis that doctors increasingly gave

to the benefits of continuity of personal care, and provided a psychological rationale for it. All of this found expression in a variety of GP research agendas, far removed from Balint's methodology.

Although the earlier Balint work focused on so-called interesting or problem patients, by 1970 Balint was leading a research team concerned with patients on long term medication⁵, or 'repeat prescriptions' – patients who seemed anything but interesting, and no longer a problem. This was the first time that this now much researched phenomenon was mentioned in the medical literature. It was a narrative description of patients in whom the original diagnosis (almost invariably a 'physical' illness, though rarely reliably supported by any strong clinical evidence) was treated by a regimen of medications, usually in low and sub-therapeutic doses, over very long periods of time. For the most part these patients appeared remarkably 'well' and unproblematic on such treatment.

In fact, providing there was no interruption of the prescription – which typically involved little contact with the doctor, or at most a highly ritualised consultation with scant evidence of any clinical content – peace reigned. If the prescription were to be interrupted or examined, the peaceful 'contract' was breached, and a mayhem of new illness and disturbed relationships ensued. How could this mysterious collection of 'findings' be understood? What sort of treatment was this? And for what sort of diagnosis?

This research came to the unusual conclusion that the treatment was the diagnosis, or rather that the relationship between diagnosis and treatment was not logical and linear, but phenomenological and reciprocal. No research since has further tested this assertion. The study was a blind end, and a promising methodology, a potentially revolutionary approach to understanding the evolving nature of general practice, died prematurely in the 1970s, with the death of Michael Balint.

Twenty years later, in 1992, Donald Crombie⁶ and colleagues provided a strong clue about where this approach might have led. Reviewing the variability of their data from the Second National Morbidity Study, they concluded that so great were the differences between the sorts of diagnoses that even neighbouring doctors recorded, that we simply lacked a common diagnostic language. Medicine had still not developed agreed criteria for naming perhaps most of the conditions that general practitioners encounter. Often 'diagnosis' was not so much the rationale for the treatment chosen; it was the alibi for the treatment.

This does not suggest that general practitioners were not diagnosing and treating their patients appropriately. Rather, it suggests that in the absence of a vocabulary to describe those diagnoses that they were attempting to make 'simultaneously in physical, psychological and social terms', doctors reverted to the use of 'politically correct' language for the purposes of epidemiological research. To express faithfully the complexity of 'what is wrong' would require not morbidity labels pasted onto laboratory

findings, but free narrative based on critical appreciation of the text. In the latter 1990s a new generation of researchers was to come to a similar conclusion. But that is another story.

3. The family as patient

The next stratum is the family as patient – and indeed, the family as illness. This concerns more than the extension of clinical enquiry beyond the individual to the domestic group. The National Health Insurance Act of 1911 had provided workers, earning a maximum of £2 per week, with the free services of a general practitioner of their own choice. However, the dependants of those insured under the provisions of the 1911 Act were not covered by its provisions, but were eventually covered by sickness clubs and friendly societies. Nonetheless, the idea of family doctoring can be traced back to the early 19th century. It persisted, despite its unclear meaning, ambiguous origins, uncertain support among patients, and potential moral hazards.⁷

In the 1960s and early 1970s, on both sides of the Atlantic, the idea of family doctoring enjoyed huge vogue. Despite the fact that its National Health Insurance antecedents were positively exclusive of families, National Health Service general practice, with its new emphasis on family record keeping and continuity, placed the family at the centre of a romantic and sentimental, but largely unexamined, philosophy of medicine.

In 1976 I argued, in the Albert Wander Lecture at the Royal Society of Medicine, that the inherent conflicts of interest, and breach of confidentiality, between different members of the same family and household relating to the same doctor, rendered ‘family medicine’ inimical to personal, advocacy and ethical care. This mild and reasonable analysis landed me in deep hot water. In the USA these ideas were greeted with dismay, and at one international conference – in Ann Arbor – I was described with distaste as ‘the pathologist from England’. Colleagues back home were also not much impressed, or much influenced, by my critique.

The importance that many persistently attached to the notion of ‘family’, during decades that saw a steady decline in the traditional two-parent family as the societal norm, probably does not lie in a belief that doctors might have in the family’s influence on the diagnosis or its management, let alone in any theoretical model of the family as patient.^{8,9,10} It probably lies more in the semantic overtones of intimacy and biography suggested by the word ‘family’. The purpose that ‘family medicine’ served in the USA was political in two senses. It created the territory of a professional group struggling to find its own space in a world dominated by a belief in salvation by advancing technology. And it spoke for the family values of the American conservative moral majority. Here it was just muddled and mushy sentimentality.

4. The illness as puzzle

The next sedimentary layer in this archaeology strengthened the myth of objective truth in the clinical dialogue, a truth that could be found by distinguishing a clear diagnostic message from all that background noise that the patients were making. This was 'the illness as puzzle'.

Although originating in the hospital-based teaching of transatlantic medical schools, Laurence Weed's introduction of disciplined medical record keeping in the late 1960s marked a renewed attempt to obliterate the patient's story of the illness as told in the patient's own language.¹¹ The patient's biography was finally to be replaced with a new narrative convention – the medical detective story or 'Problem Oriented Medical Record'. 'The diagnosis as puzzle', and the diagnostic task as puzzle-solving (misleadingly described by Weed as problem-solving), is still required in the clinical notes of training practices, and has its latest manifestation in the computerised records of the 1990s. It was a move away from the oral tradition of implicitness and intuition in clinical judgement, which was to culminate later in clinical audit, Evidence Based Medicine, guidelines and contracts.

The point of the Puzzle Oriented Medical Record is that the puzzle predicts, and therefore predetermines, the solution. The solution to the chess problem 'mate in three' cannot be arrived at by playing the ace of spades. Clinical problems rarely present in a unidimensional form, as in a game of bridge or chess. Yet in clinical medicine, the tradition of puzzle oriented thinking is dominant. Perhaps the reason lies in the habits of clinical research. The clinical researcher, as in so many fields, rarely begins with the question 'What method will best secure an answer to my question?' Rather the rigorous methodologist begins with 'What are the questions that can best be answered by my chosen method?' To the hammer all problems are nails: to the epidemiologist all answers are to be sought in studies of populations. This entails some exquisitely teasing problems for the general practitioner, problems which were to escalate in the 1980s. Which leads to a very rich seam.

5. The illness as risk

This is the stratum of 'the illness as risk' – the extension of 'what is wrong' from time past and time present, where it has traditionally been sought, into the future. Dynamic psychology is much concerned with the individual's past – with the archaeology of thoughts and feelings. Sociology is much concerned with a description of present social structures, their impact on contemporary social life and illness behaviour. Epidemiology (by searching for antecedent causes of subsequent illness) focuses the general practitioner's attention on the patient's future.

It was epidemiology that offered an alternative temporal frame. 'What is wrong' and 'how we know it' were no longer to be confined to the cause and nature of the present illness, but extended to the possibility of future illness.

A number of factors can be identified in the growth of preventive medicine, in the general practitioner's agenda. Early diagnosis was always a valued goal, and the pursuit of this gave rise to some of the earliest and most important epidemiological studies to be published from general practice.¹² Similarly, in the management of established disease, secondary prevention was and remains the basic aim of treatment. But at the outset of the NHS, general practitioners were little involved in primary prevention – intervention before the onset or declaration of the disease.

The eventual dominance of prevention and the diminution of risk, in the clinical intentions of general practice, can be traced to a number of inter-acting influences. As a result of the Doctor's Charter in 1966 there was an accelerated growth of new premises capable of housing primary care team members whose participation in primary health care had been greatly facilitated by it. Health screening activities, like blood pressure checks, urine testing, developmental assessments and so on, could be undertaken in other than the doctor's consulting room, and by other than the doctors. David Armstrong has suggested that general practice adopted these additional tasks as a consequence of its move into purpose built premises.¹³ The more elaborate and differentiated the social spaces of the new buildings, the more possible, indeed necessary, it became to 'map' the patient's illness onto the building, the spaces of the receptionist, the doctors, the nurses, and eventually the extended primary care teams.

The new preventive agenda, which marked a distinct re-writing of the doctor's previous concern to diagnose disease and offer treatment, involved three desiderata. First a redefinition in future-oriented terms of 'what is wrong'; second, a new source of information in regard to 'how we know it'; and, third, the spatial reconfiguration of the doctor's premises.

In 1974 Denis Pereira Gray¹⁴ argued that 'the introduction of doctor-initiated consultations for symptom-free people has made the old definition of the word patient inappropriate'. I took the opposite view and urged that the word patient be reserved for someone in a clinical relationship with a doctor – that to assume that persons on the doctor's list were patients 'could only result in an invasion of privacy ... and a loss of integrity in the doctor/patient relationship.'¹⁵ Preventive medicine by the mid-1970s had become, for many of the most influential thinkers in general practice, what Gray called 'our supreme objective'.¹⁶ In the light of events, not least a decade later in the 1989 GP's contract, it became increasingly clear that, as with the issue of 'family medicine', I had quite lost the argument.

One of the consequences of obliterating the fine distinction between persons on the general practitioner's list, and those who, by consulting, become patients, was that 'what is wrong' was transformed into 'what may happen'. The illness became a prediction, it was reconfigured as a potential weakness in the system, a human failing of behaviour, in which effort to change must be invested now, in the expectation of benefit later.

This quest for early intervention, the diagnosis and treatment of the still well, had strong philosophical and historical links with another precept of public health medicine – the pursuit of social justice. Nothing better illustrates the attempt to pursue these two public health goals in general practice than the work of Julian Tudor Hart,^{17,18} a general practitioner, most of whose professional life was devoted to the health care of a South Wales (originally coal mining) village community, where he also directed a research unit funded by the Medical Research Council (a quite remarkable and unique achievement).

In many ways Hart offered a stark but coherent alternative to the model that derived from the work of Balint, to whom he nonetheless paid real respect. He criticised the Balint model on three counts. First, Hart believed that despite its claim to be patient-centred, the model was in fact doctor-centred; patients were given scarcely more opportunity than before to define their own problems in their own terms. Second, that the model, despite its holistic philosophy, separated the psychological from the organic, and all but ignored the latter. Third, that the approach ignored the social context: that it concerned itself with 'one-person clinical medicine'.

What Hart's reservation about 'one-person clinical medicine' might mean becomes more clear when he relates the so-called Platt-Pickering controversy. In 1952, Sir George Pickering demonstrated that high blood pressure was not a discrete condition, an identifiable morbid state like chicken-pox (the patient either had the disease or had not), but rather that levels of blood pressure were continuously distributed in populations. Lord Platt, and most other members of the then medical establishment, resisted this view for many years, although the evidence for Pickering's findings (and not only in relation to blood pressure) mounted. Platt and his supporters held that high blood pressure was in fact a discrete disease. Eventually 'Pickering's heresy' became official wisdom.

Hart portrayed this as an example of the historical struggle between scientific discovery (the heroes of which would include Galileo, Copernicus, Newton, Darwin, and Harvey) and professional orthodoxy, and from it he drew a strangely politicised conclusion. The Platt-Pickering controversy was presented as a battle between the natural historians (those like Platt who sought theory through the careful and repeated observation of individual patients over time), and the experimental scientists (of whom Pickering is here the shining example). Hart's reservation of the term scientist for Pickering, and denial of it to Platt, however, was very special pleading. Most of the classical diseases that medicine recognises today, resulted from the orderly but imaginative observations of physicians

who were natural historians – men like Graves (the thyroid), Bright (the kidney), Addison (the adrenal), and so on.

Hart was scathing about natural historians. Swales¹⁹ believed that, even if the two philosophies could not be reconciled, they would at least continue in fruitful conflict. Hart, ever the idealist, disagreed. Similarly his own openly Marxist analysis of the role of the doctor in society, and Balint's scarcely concealed Freudian analysis, appeared also to be irreconcilable. Yet somehow in the general practitioners' practical business of looking after patients, and managing a practice, these contradictory views had to be, and were, reconciled. The fact that Pickering was proven to be right (and in something very important indeed), and Platt wrong, was advanced as part of the argument for fundamentally shifting the doctor's gaze: 'The new concept we need is anticipatory of health rather than treatment of disease'. Crucially he argued: '...to be consistent with science, (medicine) must serve whole populations according to their needs, rather than be merely available to individual demanders or purchasers of care...'.¹⁶

6. The patient as community

'Individual demanders' might be thought another term for 'patients': here they are presented as usurpers of a superior client, the community. The level of 'the patient as community' illustrates the consequences for the individual of a population-based philosophy of clinical care. The systematic collection of data on mortality and morbidity and health impairment began in the nineteenth century, and the evidence of social and geographical inequalities in health has been unassailable and constant over time. Since the 19th Century libertarian reformer Chadwick,²⁰ such morbidity and mortality statistics had driven reform of the public health, of the Poor Laws, and other attempts to ameliorate the suffering of the poor, and the sense of social injustice.

What is remarkable is that the spectacular advances in health care technology in the second half of the twentieth century, and the advent in 1948 of the National Health Service with its founding principle of social equity, although accompanied by general improvements in health, appeared to have had little effect on the continuing relative social class and geographical differences. These persisted and widened in study after study throughout the past fifty years, but came finally to the fore in the debate about how to sustain and develop the NHS, with the publication in 1980 of a report from a working group set up by the then Secretary of State for Social Security, and chaired by Sir Douglas Black.²¹

In 1971, nine years before the appearance of the Black Report, Hart¹⁸ had published an article on health care inequalities in *The Lancet*, and coined a ringing phrase of immense political resonance: the Inverse Care Law. What was important about this article was the linking of two key themes of public health – the prevention of excess morbidity, and the pursuit of social justice. Indeed all the evidence from public health epidemiology (about

the relationship between poverty, ill-health and premature mortality) pointed inexorably to the need for one obvious experiment: the redistribution of wealth. This was, of course, an essentially socio-political, rather than an evidently health service agenda. Or was it?

Hart's philosophy was set out, seventeen years later,²² when his public health agenda for general practice became fully developed. He called it the 'fusion of epidemiology with primary care'. This fusion would, again, redefine the general practitioner's understanding of 'what is wrong' and 'how we know it'. What emerged from his arguments was the relocation of the patient's illness from 'in here' (in the body-mind of the individual), to 'out there' (in the socio-economic characteristics of the community). The illness was transformed into a measure of the patient's social and economic deficit. However, once 'out there', the identity of the patient, the differentiation between patient and person, and between individual person and class of persons, became problematic.

Hart advocated a fundamental shift in the doctor's gaze. The task of medicine, in this world-view, is not primarily to respond to persons who become ill, but to respond to the people – who are deprived of their health by an unfair society. This paradox, the polarity between a personal responsive medicine of persons, and an equitable and protective social medicine of populations, remains a deep and potentially unstable San Andreas Fault in the geology of general practice, and still confounds our thinking about NHS planning.

7. The illness as commodity

This story is incomplete without reference now to the 1980s. The present and surface archaeological layer – 'the illness as commodity' – describes the clinical implications of contemporary cost-benefit and similar analyses from health economics. There are subtle continuities between early wishes from the Left for a public health agenda in general practice, and, in the 1980s, from Conservative Government's wish for a market agenda.

Surprisingly, and ironically, Hart's insistence on the supremacy of quantitative descriptions of health care found an unlikely echo in the changes brought about in 1989 by the Thatcher Government's reforms of the NHS,²³ and what followed. The paradox is that while Hart's intentions and those of the authors of *Working for Patients* were opposite in theory and political orientation, the language (of producers and consumers) in which they were both couched revealed intriguing similarities. Hart²⁴ saw the consultation as 'the point of production of critically important decisions which affect all other (health related) consumptions'. It was a new language, perhaps one could say the introduction of moral arithmetic into the story of general practice.

The 1991 reforms introduced the expectation of a high degree of explicitness about everything – diagnosis, treatment, expected outcome, and entitlements. This explicitness was to be expressed as quantities, and as costs (of what was to be purchased, what

provided, and what foregone). For general practice, the impact of all this was disorienting. Explicitness could be, and was, presented as self-evidently desirable, and a morally sound characteristic of a public service. But, for the most part, the clinical work of the general practitioner had been characterised by implicitness, not explicitness, and there were compelling reasons for this, as this paper has suggested.

The government's reforms were inspired by the goal of efficiency, and, given its right-wing political philosophy, this was believed to be achievable by creating a market – albeit an internal and modified one. Markets require that their goods be explicitly described, truthfully quantified, and competitively costed. In this bright new light of accountability, how were the general practitioners to express and preserve the values of the Balint model – the complexity and uniqueness of 'what is wrong', and the role of empathy and intuition, as well as of observation and measurement, in 'how we know it'? In their totally different ways, what I dare to call in the same breath the Tudor Hart and Thatcher models confronted the general practitioners with similar difficulties.

For the first time the relationship between state and clinician in general practice became substantially determined by economic factors and state defined controls. Targets were set that referred to rates of performance – for example in childhood immunisations, screening for cervical cancer, prevention of coronary heart disease, measurement of health status in old age, and so on. These targets directed the doctor's gaze away from the individual patient to the population, and, with this shift, came the threat of a de-focusing or loosening of the personal, implicit contract with the patient, as the public, explicit contract between the doctor and the state was tightened. This was not yet the era of outcomes research. But the era of process control had dawned bright, clear and uncompromising.

The rationing of health care had always been a part of the general practitioners' work, but had previously been implied rather than stated. Now, particularly in fundholding practices, and in the tension between fundholding and non-fundholding, the general practitioner's ethical duty to advocate justice for the individual patient became strained by the additional ethical duty to achieve distributive justice for the community. 'What is wrong' became coloured by new perceptions, and by conflicting priorities.

Economists, in the search for a moral basis for rationing (that is the rank ordering of the patients' illnesses so as to decide who and what may defensibly be denied), devised an arithmetic of cost and likely benefit from treatment – expressed, for example, as 'quality adjusted life years'. 'What is wrong' (because it implied 'what should be done') now carried explicit burdens of 'worth' that could also be expressed in monetary terms.

Fuzziness could not be tolerated in such a rigorous estate. The medical profession seized the opportunity to move to a science-based clinical practice, since if choices must be made, they had better be made on sound statistical evidence. Sackett and colleagues,²⁵ whose earlier work had demonstrated the value of reliable quantification as an aid to clinical

decision making, introduced what in the 1990s became another ‘evangelical’ movement – Evidence Based Medicine (EBM).²⁶

As the criteria for diagnosis and treatment were increasingly to be determined by combing the world research literature, and adducing best evidence, a growth industry was created in the production of clinical guidelines, protocols and algorithms. The advent of EBM and guidelines promised to reduce the wide variations in practice which could best be explained by the idiosyncratic habits of thought and action on the part of doctors, rather than by any responsiveness to the needs and predicaments of individual patients. The anxiety was that in reducing the former, the latter would be sacrificed. The danger emerged in the early 1990s that the combined forces of government policies, explicit contracts and guidelines, might force the understanding of ‘what is wrong’ into procrustean beds of mechanistic and reductionist thought; that ‘how we know it’ would come to be synonymous only with evidence of a particular kind – that deriving from rigorous randomised controlled trials.

8. The resulting landscape

My seven strata of general practice language and ideas were: the illness as narrative, the patient as diagnosis, the family as patient, the illness as puzzle, the illness as risk, the illness as community, and, finally, the illness as commodity. These have been described as orderly layers of fashion and world views, laid down at seemingly regular decade-long intervals of time. But of course that is not at all how things have happened. Rather, over the years, these strata have erupted, folded, fissured and been eroded by the harsh winds and scouring tides of government dictat, the vagaries of public concern, and the posturing of medical leaders and organisations. This is what we see today as simply the familiar rough old landscape of general practice.

Policy makers and health professionals, among whom I number and value not least the health care managers, would do well to look below the surface landscape and consider the all too easily taken-for-granted complexities of general practice’s geology and archaeology. Carlisle said that history was nothing but the biography of great men. I’m no more convinced of that, than I am by the pretensions of historicism. But the history that I have just related (or caricatured), can be read as a competition between the imaginations, values, aims and methods of two of the giant figures in the landscape of general practice that I placed before you this evening – Michael Balint and Julian Tudor Hart.

That competition continues today. It constitutes the unresolved paradox of general practice and primary health care – which are two quite separate ideas. Separate ideas that are usually and misleadingly treated as though they were synonyms. This paradox, if it is not managed, will continue to confuse and confound the current plans for a primary care health service.

Strange to think that – behind the opaque screens of contemporary medical politics, health care policy, and the struggle by all the stakeholders to say what they mean by that mysterious and teasing term ‘general practice’ – what is still creating all the racket is the sound and fury of the noisome ghosts of Karl Marx and Sigmund Freud, struggling for the heart and mind of the British general practitioner.

9. Conclusion

It is possible to hint at what may be to come in general practice and the NHS, at what new sedimentary layers of evidence, theories and politics will be laid down in the coming decades. This is a dangerous game, because if you have been doing this sort of thing in public for as long as I have, your past prophecies are still lying around in print to mock and embarrass you.

In the preface to a recently published collection of essays spanning more than three decades, the American writer Saul Bellow reflects on the emotions generated by re-reading ones own published judgements and soothsayings of years past. He comments wryly on the great satisfaction that it gives ‘...to have rid oneself of tenacious old errors. To enter an era of improved errors’.²⁷ So be warned.

Imminent bio-technical developments will make it far easier and far safer to shift major clinical tasks from the responsibility of hospital-based to community-based services. More radical still, the particulation of medicine into narrower and narrower fields of biotechnology seems to me to predict the absolute necessity for a generalist clinician-manager to function not simply as gatekeeper to the hospital services, but as case manager throughout both the hospital and community illness career of the patient.

Experiments with new configurations of primary and secondary care will inevitably demand a perpetual flexibility in roles and tasks. We must anticipate fundamental change in the forms and configurations of a service which still, at the close of the 20th century, bears the strong lineaments of its 19th century blueprint. I am, for example, not at all confident that the primary care task of the general practitioner will prove as important, or as structurally relevant to the future needs of the service, as the generalist task. Generalism will provide the key.

Generalism, but not, I suspect, necessarily general practitioners. It seems likely that in the near future, their past roles and tasks will be further developed and eventually re-distributed between new groups of professionals, whose skills-mixes will derive from those whom once we used to call doctors and nurses and pharmacists and social workers and psychotherapists.

The success of the National Health Service was predicated on the invention of British general practice. The most important contribution of general practitioners – their enduring

values of intimacy, continuity, coherence, and the management of paradox and of innate clinical uncertainty – may be judged, as they themselves depart, by what they will have made possible in the future.

NB. Some material for this lecture is contained in my chapter 'What is wrong' and 'How we know it': Changing concepts of Illness in General Practice; in '*General Practice under the National Health Service 1948-1997*' (eds. Horder J, Loudon I, Webster C) 1998, by permission of Oxford University Press.

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Chapter 4

The UK NHS in the 1980s: The Development of General Management

Sir Alan Langlands

Introduction

1998 is a time to celebrate the achievements of the National Health Service and the people who work in it. However, in a changing world no organisation, however great, can stand still. The NHS needs to modernise to meet today's needs – it needs to focus on improving health, tackling inequalities and improving the quality of health services. These objectives are at the heart of the Government's policies for the next ten years.

Commenting on the development of general management and the 1980s might be considered the short straw in this series – partly because of the narrowness of the topic and partly because the 1980's were a pretty unhappy time in the NHS. To overcome this, a broad definition of general management is adopted in this paper, and three landmark events in the 1980s are considered:

- the publication of the Griffiths Report in 1983,¹ which changed the management of the NHS for all time;
- the publication of the House of Lords Science & Technology Committee Report in 1988² which started the NHS down a long path of improving the quality of clinical services – a key management task; and
- the publication of the Black Report in August 1980³ illustrating the wider determinants of health and the need to avoid an insular approach to management in the NHS.

These three issues sit most comfortably with my own beliefs about what is important in the NHS, and they have resonance today and for the years ahead. So, whilst drawing on the past, this paper will look forward to the future.

1. The 1980s

Reflecting on the 1980's at a personal level, I was having a whale of a time. In May 1981 I moved from Edinburgh – off the back of what seemed like several winters of discontent – to London, to run the Middlesex Hospital. When I arrived, I found that the Area Health Authority which appointed me was to be abolished and that I was required to apply for a new job in a new Health Authority, located in a new Region.

Whilst coping with the devastating effects of the IRA bombings in central London, the occasional Embassy siege, tackling a pervasive drugs problem in the West End, working through the development of new services and trying to develop better community services

in North East Westminster, I went through the rigmarole of applying for, and getting, the job of merging the Middlesex and University College Hospitals (UCH).

The Government's plan at that time was to remove the Area Health Authority tier with 435 early retirements at a cost of £9 million. In the event there were 2,830 early retirements at a cost of £54 million. From this it was learned that organisational change costs money, and drains experience, energy and purpose from the organisation. This is a lesson that has to be re-learned every five years or so but, of course, next time it will be different.

I happily ran the Middlesex and UCH together, recognising the huge opportunity which has now been fulfilled across London of strengthening the Medical Schools through merger and integration with the multi-faculty colleges. Along the way, I dealt with my part of the longest running pay dispute in the NHS and the Lawson cuts in which about 1% was lopped off the NHS budget in a 'dawn raid' immediately after the 1983 election. There are two important points to note here:

- Whilst the pay dispute resulted in three million working days being lost (and an increase in waiting lists) it ended a decade of industrial unrest in the NHS and resulted in years of calm, broken only by the ambulance strike in 1989. It also won the nurses a Pay Review Body, following their no strike policy;
- Life was tough financially between 1982 and 1987, during the reign of Norman Fowler. Volume spending on hospital and community health services – what the NHS could buy after pay and price rises - was largely static. This was ultimately to induce the crises which led to the introduction of the internal market.

Courtesy of the Griffiths Report, in 1985 I stopped being an administrator and became a general manager, complete with three year contract, individual performance review and performance related pay. The Royal College of Nursing claimed that none of us knew our coccyx from our humerus, but I was later to take great comfort from the fact that Christine Hancock, who became the General Secretary of the RCN, was one of the most effective of the early General Managers. The lack of money made it a grind, and tight budgets and too many central initiatives led to discontent. Resentment resulted from the suspicion that the Government, despite its protestations to the contrary, had ulterior motives along the route of privatisation.

This financial restraint and suspicion of privatisation boiled over in 1987. John Moore had arrived as Secretary of State in June and failed to recognise the depth of the financial crisis in the NHS. In November he was taken ill and became the first serving Secretary of State to use the private sector. The fight had gone from the NHS and towards the end of 1987 we saw:

- the Institute of Health Service Managers begin a review of NHS finance⁴ (the Government was sitting on its hands)

- the withdrawal of free eye and dental check ups
- a grave shortage of intensive care nurses
- 80 nurses from St. Thomas' hospital picketing Parliament
- the three most senior Royal College Presidents calling for the government to act now to save the NHS.

By the end of the year, the Acting Secretary of State, Tony Newton, had allocated an extra £101 million to bail out the NHS and to deal with the damage of the Great Storm. On 25th January, Mrs. Thatcher announced on Panorama that a review of the NHS was underway, and on 28th January it was initiated. This led to the development of the internal market⁵ and, being pretty sure that it could not work in its original form, I left the NHS in the summer of 1989 for pastures new. But I returned less than 18 months later – having looked at many other health systems around the world – convinced that it had to work. The NHS model was basically sound. The rest, as they say, is history, and we approach our 50th birthday in much better shape than our 40th.

So the NHS in the 1980's was a game of two halves. In the first half, social policy was not paid much attention. Mrs. Thatcher was a supply side politician – she was interested in industry, the economy, taxation and forcing out the trade unions. Her powerful instinct was to roll back the frontiers of the state and to tackle professional self interest. But she was also a realist and always recognised that radical change in the funding and status of the NHS might be a bridge too far. In the second half, Sir Roy Griffiths emerged as a voice of sanity and reason, first with his report on improving the management of the NHS and then with his report on Community Care. Kenneth Clarke – first as Norman Fowler's Minister of Health and then as John Moore's successor as Secretary of State – also gave the NHS back its fight. He was tough on the professions, but from 1988 onwards he began to secure some relatively generous settlements from the Treasury, after years of financial drought. Both Clarke and Griffiths believed in the fundamental principles of the NHS. The end of the 1980s also saw the beginning of the 'new public management', with the separation of purchasers and providers and the new disciplines of competition, assessment and accountability.

And so to my three landmarks from the 1980's:

- the first Griffiths Report on general management in the NHS;
- the House of Lords Select Committee Report on Science & Technology;
- the Black Report.

2. The Griffiths Report 1983

The Royal Commission on the NHS, chaired by Sir Alec Merrison, and published in 1979,⁶ noted that there were too many tiers in the NHS, too many administrators, and a marked

failure to take decisions quickly. This was echoed in a review of management in the NHS from 1960 to 1982 by a team from the Nuffield Institute,⁷ which found that:

- power and influence was located in professional and occupational groups rather than among managers;
- ‘consensus management’ led to ‘lowest common denominator decisions’ or a tendency towards the status quo resulting in slow, incremental change;
- producers were favoured over and above consumers;
- managers tended to be reactive in response to the activities of other more influential players (such as the clinicians), rather than pro-active.

The Royal Commission considered the idea of introducing general management into the health service, replacing professionally dominated consensus management teams with general managers and chief executives. But this was rejected, largely because it was not thought to be compatible with professional independence (note how this term has now been replaced with professional self-regulation). Instead the Commission recommended that the centre should give further guidance on the role of consensus management teams, and that the role of the hospital administrator should be expanded.

Although Mrs. Thatcher was slow to tackle issues of social policy she had other priorities; the country’s sluggish economic performance demanded increased scrutiny of how public funds were being spent. Performance indicators were introduced and health authorities were held to account for performance through an annual review process. A whole raft of measures were introduced to promote efficiency, such as the Rayner scrutinies,⁸ and cost improvement programmes. But in a significant and highly controversial move, Roy Griffiths, the Chairman of Sainsburys, was asked to review the management of the NHS. Along with three businessmen and three support staff he took eight months to conduct a review and make recommendations, which were published in October 1983⁹ (and introduced in the House of Commons on the day that Neil Kinnock took over as leader of the Opposition).

The 24 page report (which took the form of a letter to Norman Fowler) was devastating, and provided sharply observed contrasts with the private sector:

Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question.¹

The recommendations did not result in legislation, or lever extra funding for the NHS. Nevertheless, they produced the single largest change in the NHS since 1948. Looked at from where we are now, Griffiths’ recommendations were straightforward:

- managers should replace administrators, and a general manager (regardless of discipline) should be identified at authority level;

- consensus management should be scrapped
- a Health Services Supervisory (soon to be Management) Board at the centre should be set up, comprising a small strong, multidisciplinary group, which would set corporate direction for the Service. Instead of the Permanent Secretary at the Department of Health (the most senior civil servant), the Chief Executive of the Management Board (renamed the NHS Management Executive, then just plain NHS Executive which it is now) would be responsible for running the Service operationally;
- each unit of management should have a total budget to manage, and clinicians should be involved in managing it. Cost improvement programmes should be established;
- clinicians should be involved more closely in management – Griffiths saw this as being of ‘critical’ importance. He noted that doctors should be looked upon as ‘natural managers’ and this should be recognised in doctors’ undergraduate and postgraduate training;
- treatments should be evaluated to make sure they were effective in clinical and cost terms.

The report was followed by 18 months of consultation, and most of the recommendations were implemented in 1985. But although the recommendations were revolutionary, the desired change in culture was slow in coming. Five years later in 1989, the Nuffield Institute again reviewed management culture in the NHS.⁹ It noted that:

- clinicians were still not engaged in management – they still worked according to consensus and diplomacy and resented line management. Tensions were building. As Day and Klein put it, the management approach had shifted from a system ‘based on the mobilisation of consent to one based on the management of conflict’;¹⁰
- the non-medical professions had accepted general management (and resented the fact that the medics had not, and were ‘getting off scot free’);
- management agendas were dominated by finance, and the quality of clinical services was not on the agenda at all;
- very little attention was paid to the patient (the service had its face to the centre and its ass to the customer!).

That was only five years on from Griffiths, and no one has ever pretended that the NHS could change its culture fast.

Griffiths had sown the seeds of a new management style and they were growing but the political pressure for change was irresistible. Changes under the rubric of the term the ‘New Public Management’ were heralded in the 1989 NHS White Paper *Working for Patients*⁵ and largely implemented in April 1991. This was part of Mrs. Thatcher’s quest to break up large public bureaucracies, devolve budgets, encourage competition between purchasers and providers to improve consumer choice and efficiency.

Griffiths himself was concerned about these changes. He thought that they were too complex and that management in the NHS would take their eyes off the ball of improving quality, cost effectiveness and staff motivation. There were many clues to this in his 1991 Audit Commission lecture.¹¹ For example, he said of the internal market proposals:

When you have got rid of the fringe questions and the brouhaha you are back to three things which can be translated into any organisation. First, and most important, the quality of goods or services you are providing. Second, are you providing that quality reasonably economically? Third, how do you motivate the staff in advance of the first two? I don't believe you can do anything unless you motivate staff.¹¹

The most revolutionary step taken in *Working for Patients* was to give family doctors budgets to manage directly, linking clinical decision-making with the responsibility of managing a budget. GPs volunteered for the GP fundholding scheme, and managed it with marked enthusiasm. They proved to be the natural managers that Griffiths (who had worked on an essentially hospital based model) wanted to encourage. By 1997 over 50 per cent of the English population was registered with a fundholding practice.

The benefits of family doctors (and nurses) managing a budget are accepted by the new Government in the recent White Paper *The New NHS*.¹² While fundholding will be abolished, it will be replaced by 'Primary Care Groups' – groups of primary care teams, including GPs and community nurses, covering 100 000 population, and managing a sizeable budget for most primary and secondary care services. Their opportunity is to ensure that the health needs of their local population are being met through the development of primary and community based services and to ensure that their patients are well looked after in the secondary sector.

In Trusts, doctors and some nurses are becoming much more comfortable in managerial roles. The Medical and Nursing Directors in Trusts are impressive, and have expanded the pool of potential chief executives. The days of the talented generalist (people like me!) may be numbered. The British Association of Medical Managers do good work, and the Royal Colleges (especially in Scotland) are pushing forward training in general management of postgraduate doctors. The seeds of all of these changes were sown in the 1980s. In a recent BMJ editorial, of which Roy Griffiths would have approved, Professor Donald Berwick wrote 'great doctors do not make great health care. Great doctors interacting well with all the other elements of the health care system make great health care'.¹³ This is recognised by the government who want to improve the quality of clinical services and the performance of the system as a whole.

3. Research and Development

As noted earlier, Griffiths thought that the knowledge available on the effectiveness of treatments in clinical and cost terms should be strengthened to support good management.

My second landmark in the 1980s is the report of the House of Lords Select Committee on Science and Technology, published in 1988² which led to the creation of a research and development programme for the NHS in 1991. In their report, *Priorities in Medical Research*,² the Select Committee argued that the NHS should be brought into the mainstream of medical research and that it should do more to initiate research.

The NHS R & D initiative has increased awareness of technological progress and provided the means to assess its impact prospectively. It is beginning to encourage NHS policy-makers, managers and clinicians to operate from the basis of knowledge rather than belief. The challenge now is to minimise delays in implementing research findings and to ensure that information on the effectiveness and costs of treatment is more readily accessible.

This information will be the basis on which standards of health care will be set, by the new National Institute of Clinical Excellence (NICE) which was heralded in the recent White Paper *The New NHS*,¹² and in the first two National Service Frameworks (on mental health and coronary heart disease), which will be published next year. This information will also be the basis on which national organisations such as the Audit Commission and the new Commission for Health Improvement, will assess the quality and value for money of care provided in the NHS. Until now the R&D programme has focused on evaluating clinical interventions, for example new technologies. However a new programme is also being established to produce, and promote the use of evidence about how the delivery and organisation of services can be improved.

Generalising good practice across the NHS is still a major challenge. It cannot be disseminated simply by exhortation. Progress will depend on aligning planning and funding decisions, investment in education and training, better public information and improved information and decision support systems for clinicians working in hospitals and primary care settings. Success may also depend on modernising pay and reward systems.

The R&D initiative, and all that has followed from it, is important in its own right, but it is also crucially important for the development of management in the NHS. Improving the focus on the quality and cost effectiveness of services and ensuring that there is a common basis for working with professional staff is an essential pre-requisite for progress. The seeds were sown in the late 80s but there is still a great deal to do.

The objectives of the NHS have not changed since 1948. They are:

- to promote health
- to prevent ill health
- to diagnose and treat injury and disease, and
- to care for people with longer term needs.

My comments so far have been about the health system rather than the wider determinants of health, and they have been very management orientated, reflecting my remit. The danger in this is that it may encourage an insular approach. The NHS was very inward looking and self obsessed in the 1980s, but the commitment to partnership working and improving health began to grow in the 1990s and is now at the heart of the government's policy programme. It is for that reason that the publication of the Black Report is examined as the third landmark in the 1980s.

4. The Black Report

In 1977 the Labour Government's Secretary of State for the Department of Health and Social Security (DHSS), David Ennals, commissioned Douglas Black, the Chief Scientist at the DHSS, to chair a 'Working Group on Inequalities in Health' and produce a report.³ The Working Group showed that death rates for almost all causes were higher in social classes four and five (the most deprived groups of the population), than social classes one and two, and that mortality rates for social class four and five had changed little over time or may even have deteriorated. The report also clearly demonstrated that the determinants of ill health lay outside of the NHS – relating more to income, employment, education, housing, transport and lifestyle than the availability and quality of health services.

The report was produced in 1980, by which time a Conservative Government had been elected. The new Secretary of State, Patrick Jenkins, tried to bury the report. It had limited circulation (260 copies), it was duplicated not properly printed, and it was circulated on the Friday before the August Bank Holiday (a date calculated to guarantee minimum press coverage). The report contained 37 recommendations which, unfortunately for the new Government, had significant resource implications, such as an increase in child benefit. Other recommendations, also rejected at the time were subsequently accepted. For example Black suggested that:

national health goals should be established and stated by government after wide consultation and debate. Measures that might encourage the desirable changes in people's diet, exercise and smoking and drinking behaviour should be agreed among relevant agencies.³

However, the incoming Government would not accept the link between poverty and unemployment and ill health, still less to take an active/direct role in reducing poverty. No immediate action resulted.

In 1986 the Health Education Council commissioned Margaret Whitehead to update the evidence on inequalities in health. Her review was published in '*The Health Divide*' in 1987,¹⁴ and the findings produced an uproar in election year since they showed that inequalities between socioeconomic groups had actually increased over the previous ten years.

But while the main message of both reports, the need to tackle inequalities in health, was largely ignored at the time, another message – of developing a strategy to improve population health – was not. In 1992 the first ever such strategy, *The Health of the Nation*,¹⁵ was published. As Black had recommended, targets in key areas such as relating to coronary heart disease, cancer, sexual health, mental illness and accidents were set, and how health authorities and local authorities might work together, and with other agencies, to achieve them.

Population health is also high on the agenda of the current Government. The recent green paper, *Our Healthier Nation*,¹⁶ sets out two key objectives:

- to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free of illness;
- to improve the health of the worst-off in society and to narrow the health gap.

The Green Paper also reaffirms (like the Black Report, and *The Health Divide*) the wide number of factors which have influence on health, such as genetic inheritance, socioeconomic factors, environment, lifestyle, as well as access to services. This message is little different to the one in Seebohm Rowntree's study of poverty and town life in the city of York one hundred years ago.¹⁷

But what is different now is that there is a Government commitment to tackle these issues in a sustained way. The Green Paper suggests the action that can be taken at three levels to achieve health targets: Government and national organisations; local organisations and communities; and individuals, and focusing on four key areas:

- heart disease and stroke;
- accidents;
- cancer;
- mental health;

Much of the contribution the NHS can make is in the middle level, by forging partnerships between agencies, for example with social services, local schools, local businesses and voluntary organisations. So far, eleven Health Action Zones (HAZs) covering six million people have been initiated, to be 'hot-houses' of cross-agency working, in order to improve health locally. This first wave of HAZs are being evaluated and this will provide a good opportunity to spread good practice. A second wave of HAZs will be announced later this year. The Health Improvement Programmes, to be developed mainly between health authorities, NHS Trusts, the new Primary Care Groups, and Social Services, are the main vehicle for developing a local strategy for improving health and health care.

But what has all this to do with NHS management? The Black Report,³ *The Health of the Nation*¹⁵ and the new Green Paper *Our Healthier Nation*¹⁶ stress the need for cross agency

working and partnerships to achieve change, and improve health. Cross agency working does not fit very well with either a hierarchical centralised management style (seen in the NHS up to the early 1980s), or a devolved market 'laissez-faire' style (favoured by the previous Government). Instead partnerships and networks are required to steer a course between these two extremes of management style.

Management gurus have talked about 'networks' for at least ten years, and in the NHS they may be still more slogan than real. Networks and partnerships across different groups are based on reciprocity, trust and cooperation, and require investment to work. Rhodes has suggested that a 'diplomatic' management style is required by the centre to shape and develop this approach.¹⁸ Networks consist of complex webs of interrelationships between organisations, and cannot be controlled by a traditional hierarchy. The continuing management challenge for the NHS will be to combine the central drive on national objectives (such as reducing the health gap) with the diplomacy and investment required to achieve progress in local communities through partnership working.

5. Conclusions

In taking a historical approach focusing on the 1980s, many important contemporary issues facing the Service have been missed, for example human resources strategy, information management and technology, the forthcoming Social Services White Paper, and the rise in public expectations. These are the things that interest me now, but, at a personal level, the development of NHS general management in the 1980s was exhilarating.

Far from being a quiet decade as far as management was concerned, the 80s should be remembered for the seismic changes promoted by the Griffiths Report. The decade also provided a basis for further significant change in strengthening the scientific base of the NHS through the R&D programme, and confirming the need to improve healthy life and reduce inequalities through strategic alliances and partnerships.

The history of management in the NHS has closely reflected the balance of power between three key players: the State (representing taxpayers); the medical profession; and the public as consumers. A concordat between the State and the medical profession for the first 40 years of the NHS enabled the State to set the overall budget for the Service, and allowed professionals to practice largely free of interference. The 1980s saw a shift in the balance between the State and the medical profession, played out on management terms. This has continued into the 1990s, and will do so in future. What has up to now been largely ignored by policy-makers (with a few exceptions) is the growing power of the public as consumers. This will be probably the major force shaping management of the NHS in future. But that is for another day.

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Chapter 5

The New NHS:

Current Health Policy and Practice

Hugh Bayley M.P.

Disclaimer

This paper describes current government health policy, and is based on publications and ministerial documents. However, as a Parliamentary Private Secretary and not a member of the government, this paper must be viewed as a personal statement by Hugh Bayley, rather than representing government views.

Introduction

In the Prime Minister's foreword to the White Paper *The New NHS*¹ the National Health Service is described as

the greatest act of modernisation ever achieved by a Labour government. It banished the fear of becoming ill that had for years blighted the lives of millions of people.

It is instructive to see the Prime Minister, who has created the concept of New Labour, and is keen to stress modernisation and change in the Labour Party, using Bevan's cliché 'the removal of fear' as a statement of modernisation. The Prime Minister would stress that although the approach and policies of the Labour Party have changed, the core values of equity, accessibility, accountability and high quality of health care have not changed. These enduring values are reflected in current policy.

In the 50 years since the NHS was created, there have been huge changes both in the health status of the population, and the nature of health care provided by the NHS. The NHS cannot therefore stand still, but needs to keep modernising at a quickening pace, to reflect the increasing rate of change in medical technology.

The process of change in health care since the general election has been driven by a commitment to pilot change, to experiment, to examine what works and what does not. This is a contrast with our predecessors, who dreamed up, behind closed doors, a new structure, a new administration, new policy for the NHS and then imposed it on the NHS nationally without piloting or evaluation. New initiatives such as the primary care act pilots (PCAPs)² and Health Action Zones (HAZs) will be trialled and evaluated to ensure that these new approaches to delivering health care benefit the NHS as a whole.

1. Problems of the internal market

*The New NHS*¹ gave a central commitment to abolish the internal market which was the hallmark of Conservative changes to the NHS described in 1989³ and introduced in 1991.⁴ The Labour Party has always maintained that the internal market was flawed. It was inappropriate to believe that a complicated service like health care would obey simple market principles.

When buying tomatoes, a consumer can assess the price and quality of the product before making a choice. Health care is much more complex. People do not seek health care in itself but the prospect that their health will improve as a result of the service. An elderly person does not want a hip operation, but the ability to walk again. So the benefit obtained from health care is not the service itself but the outcome brought about by health care. Some of the outcomes of health care are collective, benefits for which we all pay as taxpayers, but resulting in collective gain for the population as a whole rather than individual gain.

These complexities mean that simple rules of supply and demand, which the Conservatives believed would drive up quality and drive down costs, do not apply. Even Adam Smith in the *Wealth of Nations* in 1776⁵ accepts the importance of ensuring that certain public services are not subject to market principles. This was ignored when the internal market was imposed on the NHS, with its high administrative costs of implementation. However, when the outcome of market forces threatened to change radically the way health services are provided, for example the distribution of health services in London, the Conservatives backed off and had a commission of enquiry, in effect state planning.

There were four major flaws of the internal market, which explain the Labour Party's continuing opposition to it:

- *It was inefficient.* I recall in the last Parliament being told by the Chief Executive of a mental health trust in the North of England that he saw it as his job to launch a new therapy each year, and to create a demand for it so that more patients would be referred to his hospital and he would therefore increase the income to the Trust. That inefficiency came from the culture of competition rather than collaboration, with Trusts unwilling to share best practice or resources even when they were not in direct competition. Before my election to Parliament, I worked with two Trusts in the Mersey Region which shared the same buildings and, until they sought Trust status, shared the same team of anaesthetists. After Trust status, they were no longer happy to share this team, despite the anaesthetists keenness to work for both Trusts to retain expertise in both general acute and specialist acute services.

- *It was inflationary:* it created an incentive for health Trusts to increase the amount of spending on health care and stimulate public demand for health interventions, sometimes for less pressing conditions. It increased the throughput of patients and in some cases increased the cost per case of providing treatment.
- *It was inequitable:* distribution of resources was inequitable between fundholding and non-fundholding general practices, and between different regions of the country. There was also inequitable division of costs, which had to be borne by different groups of patients. When emergency admissions increased, costs fell on patients of non-fundholding practices but not on the budgets of fundholders. Current Ministers are committed to creating a fair health service, where patients are treated according to clinical need.
- *It was bureaucratic:* in the last Parliament the Conservatives admitted that since the introduction of the internal market the costs of administration of the health service had increased by £1 billion per year. The Audit Commission, evaluating costs and benefits of GP fundholding,⁶ found that in the first few years, savings or improvements in patient care had been valued at £206 million, but at an increased administrative cost of £232 million. If the money had been put into clinical services, more would have been achieved for the same resources. One GP fundholder told the Labour Party before the election that for a single contract worth £150,000 he had received over 1000 different communications. One inner city teaching trust told us that they had contracts with 900 different funds and had issued 40,000 invoices during a single year. One health authority in the south processed 60,000 invoices, usually for single episodes of treatment, at an administrative cost of 8 per cent of their budget. It was an extremely bureaucratic experiment.

The Labour government is replacing the internal market with a system of integrated care, replacing the culture of competition between health providers with a culture of co-operation, and replacing complicated annual contracts and extra-contractual referrals with longer term commissioning agreements.

2. The New NHS

2.1. *General principles*

Current health policies are based upon six principles:

- To renew the NHS as a genuinely national service, so that patients get fair, equal and prompt access to consistently high quality services across the country.
- The delivery of services to new national standards will be a matter of local responsibility. Clinical staff are responsible for clinical standards, as well as being best placed to shape services locally.

- The NHS will work in partnership with other agencies. The 'Berlin Wall' between the health service and social care providers must be broken down. As part of a strategy to avoid a winter crisis in the NHS last winter, resources were earmarked for social care, so that patients could be discharged once they were fit. Although the money was allocated to health authorities this was on the understanding that it would be used to purchase social care packages. We also seek partnerships more widely with local authorities, for example with housing and education departments, and across government departments. This commitment is reflected in the establishment of the first Health Action Zones and the appointment of a Minister for Public Health.
- To improve efficiency, so that every £ in the NHS is spent to maximise care for patients.
- To shift to a focus on quality of care, making quality the driving force for decision making in health care.
- To restore public confidence in the NHS. The public pay for the health service and are stakeholders, and the NHS must be made responsive to public needs, accountable to patients and open to public scrutiny.

2.2. *Quality and equality*

In summary, to use two of the Secretary of State's watchwords, the NHS must provide *quality* and *equality*. To achieve greater equality in the health status of people in society, the government must achieve greater social equality, improving access to good education, good housing, employment and other factors influencing health. The Green Paper *Our Healthier Nation*⁷ shows starkly that the likelihood of death, represented by the standardised mortality ratio (SMR) of a woman who is unemployed is one third greater than the overall population, and for women in employment it is 20 per cent less. SMRs (death rates) are falling for almost all groups within society, but the one group where this is not falling is that of young males, which is the group which has the highest unemployment rate. The government's 'New Deal' to provide a bridge into employment for young people, and other 'Welfare to Work' initiatives, are in part health strategies, as well as economic and social strategies. We have created for the first time in this country a Minister for Public Health, who has responsibilities not just in the Department of Health but for auditing and evaluating the health impact of policies across government departments.

To achieve greater equality in health care it is necessary to improve the quality and accessibility of services, and to ensure that standards in the poorer performing units improve and approach the performance of the best. Quality is a broad term which encompasses the effectiveness of treatments, the environment of care and the professionalism, skill and compassion of the staff delivering care. The recent publication of the government's strategy for improving quality in the NHS *A First Class Service*⁸ expands the proposals in the White Paper¹ and provides a framework for legislation.

The White Paper¹ committed the government to introduce a statutory duty for NHS Trusts to provide high quality care, whereas at present the only statutory duties of Trusts are financial duties – to break even and stick to capital spending guidance. Changing the legal requirement is an important first step to changing attitudes about quality in health care. Balancing the books is important, but the quality of care must be the top priority.

There is a need to identify good clinical practice, to disseminate this information in the form of guidance to those delivering care, and to hold Trusts and health care professionals accountable for providing this level of care. The White Paper therefore introduced two new national agencies, the National Institute of Clinical Excellence (NICE) which will draw on the best clinical research and publish information on good clinical practice, and the Commission for Health Improvement (CHI) to audit the application of those clinical standards within the NHS.

2.3. Clinical governance

Clinical governance in NHS Trusts will make a reality of the new statutory duty to ensure quality and bring together responsibilities for financial and clinical outcomes. All NHS Trust boards will have the responsibility to ensure that their organisations have in place proper processes to assure and improve clinical quality. There will be reports on quality with annual accountability to Regional Offices of the NHS Executive. Clinical governance will be expected to echo the principles of corporate governance and to mirror its importance at board level. There will be appropriate flexibility in the mechanisms Trusts adopt to deliver clinical governance, which will and should reflect different local circumstances and existing arrangements.

Clinical governance is a new way for everyone in the NHS to deliver high quality health services. A named senior consultant, nurse or other health care professional will take the lead, but every health care provider and manager will have a part to play – only by adopting a multidisciplinary approach can the best standard of care be delivered. Clinical governance will build on existing systems of quality control and ensure that explicit, evidence based clinical standards are implemented. It will help to ensure that lessons are learned when things go wrong, and also when things go well.

It is important to emphasise that the principles of clinical governance will apply in primary care as much as in the acute sector. As Primary Care Groups move towards Primary Care Trust status, they will need to demonstrate that they are fully incorporating the principles and practice of clinical governance.

Health care relies on trust and confidence – patients put their lives in the hands of health professionals every day. Clinical governance will give a level of assurance that this faith is well placed, by setting clear standards and ensuring transparency so that outcomes can be scrutinised and patients know that clinically appropriate interventions are provided.

The government continues to support the principle of professional self regulation, with its specific professional standards, while clinical governance provides the framework for supporting this at local level. Management frameworks can only provide the scaffolding upon which to build the structure of high quality services. Ultimately the strength of the structure depends on the strength of individual practitioners.

Staff need to develop and maintain their clinical skills, and the government is committed to working with professional and regulatory bodies to strengthen continuing professional development. The White Paper¹ states that 'the government will continue to look to individual health professionals to be responsible for the quality of their own clinical practice'. Continuing professional development (CPD), based on principles of life long learning, is a duty for all professional staff. Advances in medicine and technology, increased emphasis on patient partnership, and the need to work across health and social care make CPD vital in supporting the changing nature of practice for all clinicians. CPD is however wider than this: it includes communication skills, working with others and making the best use of systems that are available. It is also about development of understanding within and between clinical teams, which is vital to delivering high quality, patient centred care.

The problems revealed in paediatric cardiac surgery in Bristol give a clear example of the terrible events that can result from a lack of transparency and accountability in health care, and failure to listen to patients and 'whistle blowing' staff. Measures will be introduced to prevent repetition of the tragedies seen recently at Bristol and in screening programmes in Exeter and Kent. There will be a rolling programme of reviews, and every NHS Trust will be visited by the Commission for Health Improvement (CHI) every three to four years. CHI will also have special powers to investigate when there are particular problems in any Trust and it has a vital role in introducing new safeguards for patients and restoring public confidence in the NHS. When problems of screening emerged in Exeter, there was advice given in the Department of Health that they should be buried, as they could create a scare and women would stop attending screening. I believe that if problems are not addressed in an open way this does far more to undermine confidence in the NHS than to identify problems when they exist.

2.4. The National Institute for Clinical Excellence

The White Paper¹ also establishes the National Institute of Clinical Excellence (NICE), which will be driven by and involve all the professions, and will introduce a new coherence and prominence to information about clinical-effectiveness and cost-effectiveness. Reports will be produced like that published recently by the Clinical Standards Advisory Group (which will be incorporated into NICE) on stroke care,⁹ which illustrated variable levels of care and rehabilitation around the country. The consultative document *A First Class Service*⁷ shows how NICE will set markers and how the NHS

should react to clinical advice once clear national information about what works in health care is produced and disseminated. Health authorities will be provided with authoritative evidence about clinical- and cost-effectiveness, to replace the plethora of sometimes weak and fuzzy guidance which currently deluges health care providers.

At the moment we have the worst of all worlds, where proven treatments and technologies do not get introduced quickly enough, and some drugs and treatments are introduced too quickly before they are proven. This is bad for the patients and for the taxpayer. Once drugs or other interventions are introduced into the NHS it is important that they are evenly available across the whole country. NICE will make the appropriate clinical information available to all doctors and health authorities.

National guidance needs to be acted on locally, and the guidance produced by NICE should be implemented consistently across the NHS. This will be monitored to ensure that unacceptable variations in patient care do not persist. The degree to which its guidance is implemented will condition whether the role of NICE is strengthened or augmented in future.

The guidelines produced by NICE will dovetail with national service frameworks which will be developed for key care areas and disease groups, initially for mental health and coronary heart disease. These frameworks will establish principles for the pattern and level of services, and will be an important element of activity to 'level up' standards. They will also help to reduce some of the unacceptable variations in care and outcomes, and the new Commission for Health Improvement will review their implementation.

2.5. National Survey of Patient and User Experience

A national survey of patients will monitor quality of care, and listening to patients will be particularly important in the new NHS. Currently we do not collect adequate information about patient views in a systematic way, and there is a dearth of information which can be used to draw comparisons nationally or to track trends over time. A new national survey of patients' and carers' experience will therefore be carried out annually, starting this year, at health authority level. Results will be published nationally and locally, and for the first time in the history of the NHS there will be systematic evidence to enable the NHS to measure its performance against the aspirations and experience of its users. This information will feed into the new National Performance Assessment Framework, and will help to provide a more balanced view of NHS performance.

3. Summary

After 18 years in opposition, the Labour Party is hungry for change in the health service and elsewhere in government. The legislative log jam created by constitutional change, especially for Scotland, Wales and Northern Ireland has meant a very busy first year, and

this has limited the time available for other legislation. Because of these pressures, no health bills were introduced in the first year of the new government, yet many of the changes described above will require legislation for full implementation.

During the first year of the new Parliament, despite the lack of opportunity to change the laws in health care, revenue funding for the NHS has been increased by £2 billion. £300 million extra was provided in 1997-98 which, aided perhaps by the assistance of the weather, avoided a winter crisis in the NHS. £1.2 billion has been added by the Labour government to the £0.9 billion increase for the NHS in 1998-99 agreed by the previous Conservative government. A further £500 million has been provided this year to cut waiting lists, a difficult and costly pledge which was made in the election period, but one which will be achieved by the new government.

The Private Finance Initiative is now working, to start building new hospitals in the NHS, which was not the case before the election. A Green Paper has been produced to put a new emphasis on public health,⁷ including tackling inequality through partnerships for health, and giving greater priority to a narrower range of public health targets. Trust boards are being made more representative, accountable and open to the public. Of the new appointments to Health Authorities and Trusts since the last election, just over half are women, and the number of members from ethnic minorities has doubled to 9 per cent, a gender and ethnic balance which is not mirrored in Local Authorities or other parts of the State.

The new Labour Party is in many areas of policy seeking to define and implement a 'third way'. In health this means no return to the old style 'command and control' of the NHS in the past, but also abolition of the Conservative 'second way', the unfair and inequitable 'internal market'. A 'third way' emphasises the value of collaboration and co-operation rather than competition in health care, while retaining such benefits as there were in the 1989 reforms, such as the ability for GPs to shift spending from drugs to other therapies, and the increased leverage that primary care exerted over the pattern of secondary health care provision. The new NHS aims to improve the quality of care by national and local agencies, and listening to users.

The NHS cannot be turned around overnight, and to achieve the aims of a 'modern and dependable NHS' will require ten years of reform, piloting and evaluation. The Labour government is planning a ten year programme of renewal of the NHS, and the Labour Party plans to be in government for at least ten years to implement this programme.

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Chapter 6

The Future of the UK NHS: Where to Next?

Alan Maynard

Introduction

In the next fifty years most effort, intellectual and practical, will be focused on improving the provision of health care. Here the dominant influence, for good and evil, is the doctor. The medical profession remains a conservative force in the NHS. For example publication of mortality rates by Health Authority in 1987 was greeted with horror by the Royal College of Surgeons. Only eleven years later has the College accepted the need for these comparisons, as the Secretary of State for Health has belatedly accepted this technology following surgical deaths of children in Bristol.

Medical practice has to be set in context. Over two hundred years ago the French philosopher Voltaire exhibited a scepticism about medical practice which is as relevant now:

Doctors prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing.

More recently, George Bernard Shaw remarked:

I presume nobody will question the existence of a widespread popular delusion that every doctor is a man of science. . . . It does happen exceptionally that a practising doctor makes a contribution to science . . . but it happens much oftener that he draws disastrous conclusions from his clinical experience because he has no conception of scientific method and believes like any rustic, that the handling of evidence and statistics needs no expertness.²

It is unfortunate that such 'scepticaemia'³ does not yet infect the curricula of medical schools and clinical practice!

Gazing into crystal balls is always hazardous, particularly given the power and conservatism of the medical profession. A thesis explored in this paper is that the NHS will gradually eradicate the problem of private affluence and public squalor by becoming a service which is better managed, by which I mean there will be better control of resource allocation to produce efficient health care practices in civilised surroundings. Only when the Service is better managed will deficiencies in care be identified and strategies to invest resources be efficiently devised and deployed. Without such management there is a risk that new resources will be used to fund fads and wheezes of dubious cost-effectiveness.

The proposals outlined below do not involve:

- i) changing the tax financed, cash limited demand side of the NHS;
- ii) changing patient access to health care: need will continue to be the determinant of access to treatment;
- iii) maintaining the institutions and practices of the supply side of the NHS: change in hospital care, medical practice and the regulation of pharmaceuticals are unavoidable.

The hard pressed staff of the NHS may not have to work harder, but they will be required to change and work more efficiently.

Coverage in this paper is selective. The goals of the NHS are discussed, and four policy areas reviewed where there is a need to innovate and experiment. These are capital (the private finance initiative); primary care; clinical governance and waiting lists. The recurrent theme throughout the paper is that poor management and underfunding (public squalor) in the NHS ensures resource wastage and avoidable ill health for the population.

1. The Goals of the National Health Service

1.1. Introduction

There is a tendency for politicians and policy makers to be reluctant to define their goals: after all if they say what they are trying to achieve, the electorate could hold them accountable! Politicians prefer to focus on 'redisorganisations' of the structure of the NHS and become so obsessed with this detail that they do not ask or answer the obvious question: how will this facilitate achievement of our policy goals? And what is the evidence base for the proposed reforms?

Albert Einstein summarised this, arguing:

The perfection of the means and the confusion of the goals seems to be the characteristic of our century.

There are at least three goals in the minds of NHS policy makers: cost control, efficiency and equity. What is the nature of these goals? What is their ranking?

1.2. Cost containment

The Chancellor of the Exchequer is obsessed with fiscal rectitude. This concern has little economic logic in a public sector characterised by Galbraith's 'private affluence amidst public squalor'.⁴ However, cost control is necessary to control the avarice of providers.

NHS expenditure is funded by plundering the resources of households (figure 1).⁵ Households can be 'robbed' by general taxation, social insurance (disguised taxation),

private insurance premia or user charges. This funding creates an NHS budget which pays for the services of providers: hospitals, doctors, nurses, the pharmaceutical industry. Thus the income of providers is always equal to the expenditure of households. Provider advocacy of increased funding is both a decision to take money from households and to line the pockets of providers.

The pharmaceutical industry markets 'wonder drugs' with hype and poor evidence when effectiveness is often not well established (due too often to poor clinical trials) and cost-effectiveness is often unknown. It is essential to be able to contain the drug industry, and its media advocates who regurgitate their advocacy. This can be done by either market competition or tax financed global budgets.

Managed competition in the USA has controlled health care expenditure for five years at around 13.6 per cent of GDP.⁶ Recently the 'pressure cooker' has begun to overheat, demonstrating that markets can control provider avarice temporarily but eventually their thieving ingenuity leads to the by-passing of controls and increased generation of incomes and jobs for providers.

Single source (tax) finance with a fixed (global or cash limited) budget appears to be a relatively effective means of cost containment. Countries as diverse as Great Britain, New Zealand, Germany, and Sweden have been able to stabilise and reverse growth of health care budgets. The Thatcher government initially worked to move to private insurance with tax financed services for the poor. Thatcher was convinced however of the error of her ways, in part as a result of academic policy research and lobbying. She argued in 1983 as socialist Aneurin Bevan had before her:

The principle that adequate health care should be provided for all, regardless of their ability to pay, must be the foundation of any arrangements for financing health care.⁷

Subsequently the focus of most policy discussion has not been the demand side (finance) but inefficiency in supply. However occasionally provider groups finance reports such as

Figure 1: The expenditure-income identity



Source: Reinhardt 1978⁸

Healthcare 2000 which advocate new funding sources (e.g. user charges) as a means of breaking cost controls and lining their shareholders pockets.⁸ This is normal practice, should be seen for what it is (self interest), and consigned to the fairy tale section in libraries!

1.3. *Efficiency*

Crude devices like cash limits do not ensure that scarce NHS resources are used efficiently. What information is needed to identify efficiency?

- *efficacy*: clinical trials are used to determine the relative effects of an innovative treatment (e.g. a drug) relative to a control (which may be a placebo). The information from such trials demonstrates efficacy – the effects of an intervention when used within treatment protocols for a carefully selected population.
- *effectiveness*: the failure to evaluate drugs and other (e.g. surgical) procedures on the general population means that interventions once in general use may have effects radically different to those from trials which demonstrate efficacy. For instance clinical trials often exclude the elderly who tend to be the major users of the new interventions when in general use. Also if care is delivered by unsupervised trainees, particularly in surgery, performance may be very variable and trial results not generalisable.
- *opportunity cost*: appropriate measurement of effectiveness in terms of the impact of the intervention on health status (the length and quality of the patient's life) is a crucial element in resource allocation. However, if a goal of the NHS is to spend £44 billion to maximise improvements in the health of the population, access to health care has to be based on the benefits and costs of competing interventions. To get the biggest 'bang for the buck' in health care requires that resources be targeted at those patients who obtain the greatest benefit in health care at least cost.

This basic NHS rationing principle is denied by politicians, for example Alan Milburn denied the existence of rationing on Newsnight in December 1997, clearly demonstrating that an excess of spin doctoring can addle the brain! One of his Tory predecessors, when asked by an academic to be open about rationing allegedly replied 'Bugger off – I want to be re-elected!' Both Labour and Conservative politicians when in power are hypocritical and inconsistent: they deny the need to ration whilst at the same time 'redisorganising' the service in an attempt to make the rationing process more efficient. The 'internal market',^{9,10} attempted this, and the National Institute of Clinical Excellence and the Commission for Health Improvement continue the attempts in a different way.¹¹ In reality, doctors, nurses and managers accept their rationing role in all their practices. The problem is that the evidence base to inform clinical choices is very poor, and their best endeavours are likely to fail due to gross deficiencies both in the evaluation of treatments and policy changes. Decision makers, be they doctors treating patients or politicians 'redisorganising' health care systems, all too rarely are 'confused' by facts!

1.4. *Equity*

Social values about the distribution of access to efficiently provided health care appear to vary. Is society really concerned only with maximising improvements in the health status of the population (allocating resources efficiently)? The agents of society, both politicians and managers, clinical and non-clinical, appear to behave differently. Politicians divert resources to vote maximising waiting time initiatives which are not efficient. Clinicians may be motivated by the individual ethic and use resources until and beyond the point where the clinical effect is zero. Such 'humanity' has high opportunity costs, depriving other patients of care from which they could benefit more.

Alan Williams has argued in favour of weighting the efficiency goal by age: the 'fair innings' argument.¹² The elderly who have had a fair innings should be deprived perhaps even of efficient interventions and the resources saved should be redirected to enhance the length and quality of life of younger people who have not had a fair innings, even if this care is relatively inefficient.

Alternative equity weights could be related to preferential treatment of the poor, but such distribution does not seem to be electorally attractive to the present and recent right wing governments or to their electorates!

Whatever the equity weights, the policy issues are:

- how much will be transferred at what opportunity cost in terms of resources and health status (quality adjusted life years)?
- what principles will be used to determine its allocation to the group which gains?
- what will be the effects on behaviour? For example, would redistribution from the middle classes to the poor increase the demand for private health care insurance?

Whilst politicians avoid such equity issues, researchers and health service practitioners will continue to debate their intrinsic merits and practicality. Government rhetoric (e.g. the 1997 White Paper)¹¹ makes little reference to these issues with Ministers loosely interchanging terms to create confusion (e.g. clinical-effectiveness and cost-effectiveness), and being singularly imprecise about their equity (redistributive) goals. Is this a product of their stupidity or political chicanery?

2. Four policy areas

2.1. *Introduction*

The focus of the analysis that follows is on four areas of policy. Firstly there is a need to discuss a current unfortunate policy, that of waiting list reduction. Then three areas where better management and appropriate resourcing, mostly marginal to 'oil' change, would reduce NHS inefficiency: the reform of primary care, the private finance initiative and clinical governance (the latest Blurred phrase to mean management of doctors!).

2.2. Waiting list issues

The Blair government made five pledges in the 1997 election and the Prime Minister is adamant that they be met to ensure re-election. Some lunatic in the Labour 'spin factory' made waiting lists one of these pledges. In so doing resource misallocation has been ensured. The election pledge is to reduce waiting lists by 100,000 compared to April 1997 and have no-one waiting over 12 months. To facilitate the achievement of these goals an additional £500 million has already been made available. This money is being used to recruit staff to increase long term capacity in anaesthesia, surgery, urology, orthopaedics and ophthalmology. The assumption is that this funding is recurrent. Thus the distortion in resource allocation is long term.

The election pledge can be likened to the construction of a cross, which policy makers are currently carrying. The leader of the martyrs, the Prime Minister, has climbed it and nailed himself to it: pain seems unavoidable!

Waiting lists are, as Alan Williams observed,¹³ a product of doctors' demand for care. Patients demand health, and go to GPs who demand health care on their behalf. They may then be referred to hospital consultants who supply health care for them. Waiting lists therefore result from the demand and supply decisions of GPs and consultants and their prioritisation of patients.

Consultants prioritise on grounds of health 'need' and social factors (e.g. employment circumstances). However, these criteria are often implicit, individual (consultants may use different criteria) and are not always derived from the evidence base. General practitioners, like their consultant colleagues, produce considerable variations in medical practice by using often implicit decision making criteria. As a consequence interventions such as non-symptomatic wisdom tooth extraction and the repair of non-symptomatic varicose veins may inflate list sizes.

There is an urgent need to develop and apply the evidence base to inform the creation of explicit treatment thresholds. Both GPs and consultants are rationing access to care but their aristocratic Royal Colleges fail to offer referral and treatment guidelines for the proletariat, leaving them instead to 'do their own thing' and waste NHS resources.

The risk for government is that supply will create its own demand, with waiting lists and times being inflexible downwards. If there are new consultants they will wish to create demand for their practices, both public and private. GPs, seeing more capacity, will change treatment thresholds and refer more patients, thus ensuring waiting times which maintain the demand for private practice by consultants.

One policy to mitigate this would be to remove the maximum part time contract for consultants and insist upon NHS contracts being full time. This would remove the perverse incentive which tempts consultants to inflate waits to generate private income.

However, such a policy might be costly (in terms of wage inflation) and require the full deployment of the monopsonistic power of the government to counter the BMA's monopolistic power. Can someone in the process of crucifixion beat up his opponents?! Political pain from continuing waiting list increases may concentrate minds and lead to new contracts for consultants and GPs.

With better control it would be possible to allocate resources in better relation to ability to benefit. At present new (waiting list) resources are focused on a narrow range of services. Patients wait unacceptably for other types of service (e.g. a mental hospital bed, radiotherapy after breast cancer surgery and neurological investigation of chronic diseases) as these do not count against the 'new Labour' pledge. The result may be that these other services may become of poor quality; deprived of resources to save and improve patients' lives. This public squalor is created by political fixation with waiting lists and should be abandoned so that there is an open debate about access or the rationing of care.^{14,15}

2.3. Primary care

For some time now the religious of our society have recited a prayer for 'a primary care led NHS'. These religious include politicians like Mary Poppins (Virginia Bottomley), Del Boy's Uncle Albert (Frank Dobson), and no doubt the recently appointed Doris Karloff (Anne Widdecombe), together with policy wonks in academia. Such people continually spout this tract from their pulpits, failing both to define their terms and to offer evidence to support their claims.

What has been happening in primary care during the last decade? The data (Table 1) offer a *prima facie* case for arguing that before we invest further, the cost-effectiveness of such investment should be demonstrated.

Table 1: General Medical Services

<i>Staff (England)¹⁶</i>	1985/86	1995/96	growth rate (%)
General medical practitioners	24035	26702	11.1
GP practice staff (WTE)	27394	59476	117.1
Practice nurses (WTE)	2211	9966	350.7
<i>Organisation (England)¹⁶</i>			
Average list size	2068	1887	-8.8
<i>Consultations (UK)¹⁷</i>			
Total (million)	238	293	23.1
Consultations per GP	8030	8896	10.7

Most of primary care remains a 'black box' driven by the GP contract. GPs are independent contractors, self employed and contracted to the local health authority to provide services to patients on their list. From 1966 until 1990 the GP contract specified that the practitioners would 'provide those general medical services provided by a General Practitioner'. This I dubbed the John Wayne contract: 'a GP's got to do what a GP's got to do!'. But, of course, no-one was quite sure what a GP did, or indeed does!

In an effort to remedy this loose language a senior civil servant and some of his friends had a nice lunch and, on the back of the menu, they mapped out the 1990 contract which Ken Clarke bludgeoned on to the profession whilst remarking about 'rattling their wallets'! This demonstrated two 'iron laws':

- financial incentives change behaviour. The graduated systems of payment (more payment for more coverage) for immunisation, vaccination and cervical cytology have led to much greater coverage for these services. GPs are human: wave a tenner and they follow!
- luncheon companions do not always know the evidence base well! For example, what is health promotion? An obvious programme would be monitoring smoking and achieving 'quits'. Unfortunately the definition of health promotion was initially imprecise. A Sheffield GP claimed the health promotion payment for showing a Jane Fonda workout video, and had to be reimbursed! Minor surgery payments are paid for removing 'lumps and bumps', and have led to high activity rates in primary care but no reduction in similar activities in hospital. At £120 per session, patients are valuable assets for GPs!

The absence of evidence about efficiency might induce, in the prudent, greater care about further investment in this sector. It is necessary to ask whether or not the service demonstrates cost-effectiveness. The Primary Care Groups will have a challenging task 'herding GP cats'. Furthermore they will have to act swiftly to prevent further incursions by the private sector. Their growth is due to lack of NHS access to primary care. Why should we not have access to surgeries in the evenings and at weekends convenient to patients, rather than in daytime office hours and with weekend co-operatives convenient to providers? Providers should provide what consumers want, not what providers want! *GP First* now has nine Medicentres in railway stations and Sainsbury's stores in London, Sheffield, Gateshead, Solihull and Dudley. Will these grow, fragment patient records and induce changes in the NHS? The use of salaried GPs, particularly in Health Action Zones, seems likely and, if the price is right, this will attract young doctors into general practice. Skill substitution and nurse practitioners are likely to be increasingly needed as patient list sizes rise.

However, a problem, perhaps *the* problem in primary care, is inadequate management: resources are not controlled and allocated in ways in which patient health status

improvements are maximised: a group of shopkeepers has to go through a transformation into an efficient supermarket! Perhaps an answer is the use of market mechanisms as a catalyst for change?

General Medical Services expenditure is approximately £50-60 per capita. Why not put local GMS services out to tender at a per capita price of around £55, adjusted for relative need? This would require careful specification of contracts, in a manner similar to the Private Finance Initiative, and clarification of performance targets. The letting and running of contracts would require appropriate management inputs rather than public sector parsimony. Such a notion seems worthy of experimentation and some private sector companies (e.g. Maurice Henchey at Healthcall) are anxious to bid. They seem confident of being able to provide good service and, of course, if they failed they would lose the contract. An obvious venue for such experimentation is the Health Action Zones, where salaried GPs and nurse practitioners might be able, if properly managed, to provide cost-effective care for deprived populations.

It seems that Government's intention was to manage primary care more efficiently with cash limited budgets allocated by formula and with rigorous clinical governance. This process has been circumscribed recently by Ministerial cowardice. The negotiating committee (the General Medical Services Committee) of the GPs' trade union (the British Medical Association) threatened to agitate the 'troops' and poll them to reject the notion of primary care groups. The government caved in to this threat and may have, at worst smothered, or at best retarded the development of primary care groups.¹⁸

2.4. Capital issues

NHS Trusts are required to make a 6 per cent return on the value of their capital stock and break even. The usual method of 'balancing the books' and meeting these statutory requirements is to use capital for revenue purposes. This means that the fabric of the hospital deteriorates and consequent 'savings' are used to employ, for example, nursing staff to maintain patient care in a decaying physical environment.

In 1993 the Conservative government initiated the Private Finance Initiative (PFI). The apparent pretext for PFI was to reduce public sector capital funding, for the purposes of the Public Sector Borrowing Requirement and Maastricht, and to improve capital investments. Interestingly the Tory PFI included the possibility of putting clinical services out to tender if doctors agreed to it. The Labour version of PFI excludes clinical services: they are, after all, more protective of that endangered species, the doctor!

The PFI is complex. Initially the private sector demonstrated that it was a poor innovator: contracts reflected what they had done last time and marginal changes proved complex and slow to evolve, generating considerable rewards for lawyers. This is unsurprising given the nature of the contracting processes. For example the South Buckinghamshire PFI hospital deal involved 147 contracts. Obviously there is a contract for the funding; the

other 146 contracts are for specific services which will be provided within the hospital. Each of these specifies price, volume and quality and will usually be re-tendered every five years. All contracts can be defined and let at high quality levels: standards which might not normally be achieved in the NHS due to lack of specificity, as NHS quality can always be reduced due to financial circumstances.

The result of such PFI is to insulate certain areas of the hospital's activity from 'efficiency savings' or cost cutting exercises when financial times are bad. Thus, instead of cutting capital, a 'distressed' Trust will have to meet its financial targets by cutting services other than those protected by PFI contracts. This could mean cuts in the labour force, such as reduced staffing on wards.

Thus, because the political system has a short decision framework (let's survive the week!), PFI offers to some groups (e.g. MRI for radiology) insulation from the political/financial cycle and may induce resource misallocation. Typically politicians cut back capital expenditure when economic circumstances are poor. In a PFI world new projects can be slowed but implemented projects can only be made cheaper by depressing standards either when particular contracts are re-tendered at 3-5 year intervals or elsewhere in the organisation.

The PFI changes the capital problems by isolation, but could worsen revenue problems, which may not have been the intention of government. A more appropriate policy for capital would be improved regulation of NHS capital allocations. However, any remedy for this public sector market failure could intensify revenue allocation problems considerably. As Harold Wilson argued, 'a week is a long time in politics'¹⁹ and thus such regulation whilst economically sensible may be unacceptable politically.

2.5. Clinical Governance

According to the dictionary governance is defined as the regulation and control of proceedings. Clinical governance is therefore about the management and regulation of the medical profession. The Government has placed its faith in the self regulation of the profession, which some would argue is rather like backing a pantomime horse in the Grand National. The Presidents of the Royal Colleges have all signed up to this policy and are currently clambering on to the horse. These are hardly the lean, fit jockeys that might be useful! Are they carrying a big stick to speed things up a little? If so, does it involve loss of College membership (and hence NHS consultant status) for the lame who damage patients?

The government's policy consists of an interesting array of new institutions. The National Institute for Clinical Excellence (NICE) will sift the knowledge base to identify and promulgate evidence based practice guidelines. To determine whether practitioners use such guidelines, the Commission for Health Improvement (CHIMP) will review the performance of clinicians in Trusts and general practice. CHIMP will be armed with

powers to recommend the removal of Chief Executives and Chairs who fail to ensure that quality care is provided to the local population. Adequate funding of NICE and CHIMP are essential if they are to be real, rather than 'virtual' organisations.

If non-clinical management fails it is often because of clinical inadequacies. Dismissal of managers will not remedy poor clinical practice. How will NICE and CHIMP deal with poorly performing clinicians? One pessimistic prediction is that they will continue current practice, leaving it to reluctant reporters of inadequate practice and the enhanced powers of the General Medical Council to mitigate problems often all too late.

Such problems will be increased by medical capture of NICE and CHIMP. The possibility of this is enhanced by Government policy. It seems that, after wasting hundreds of millions of NHS resources on medical, then clinical audit, Government may repeat history. It is essential to improve the knowledge base about the cost-effectiveness of competing therapies and practice thresholds. However, you can lead a horse (even a pantomime horse!) to water but cannot make it drink. What incentives are there for the medical profession to heal itself?

One possible incentive could be reaccreditation. At present the trainee Registrar learns by doing and by studying for College membership. Once appointed, and provided he does not interfere naughtily with patients, the consultant is unlikely to be removed from practice even though his knowledge from Medical School may be outdated, inappropriate and even dangerous to patients. Dr Iain Chalmers, Director of the UK Cochrane Centre, remarked that he 'used to be a proper doctor. Some patients suffered quite seriously from my doing what I had been told to do in medical school'.²⁰

Medicine has made significant contributions to health but it is necessary to ensure that practitioners are up to date. The Royal Colleges fail to do this and a system of reaccreditation is needed. Every five years doctors would be tested to ensure the possession of an adequate knowledge base and appropriate manual skills. Failure in such tests would lead to obligatory retraining, probationary practice and removal from the Register if practice cannot be raised to a proper standard.

Another incentive for good practice would be the removal of unnecessary regulatory constraints which inhibit competition from other professions. Appropriately trained nurse practitioners seem able to diagnose, prescribe and refer in many cases as well as GPs. Some of the literature demonstrates considerable possibilities for skill substitution, for example 30-70 per cent of the tasks of GPs may be done as well by nurses.²¹

Clinical governance requires:

- the triumph of knowledge over medical opinion. As Feinstein, an eminent US physician, remarked, 'the agreement of experts has been the traditional source of all the errors through medical history'.²²

- appropriate incentives to ensure that knowledge affects practice immediately.

The current government's touching belief in professionalism belies a history of the Royal Colleges' failure to take the issue of efficient health care seriously. The Royal Colleges need urgently to heal themselves!

3. Overview

The messages in this paper for the next fifty years of the NHS are strong and simple:

- Please identify and rank policy objectives to facilitate efficiency and accountability. Global, tax financed budgets permit cost control: keep them. Be clear about the trade-offs between efficiency and equity objectives and take an explicit policy position on these to determine the conditions under which patients will be able to access care.
- Abandon the myopia of waiting lists: this government has embarked on the road to Calvary. How can the Prime Minister and Secretary of State for Health be saved from crucifixion and the damnation of corrupting efficient resource allocation in the NHS?!
- Reform primary care! This has grown but remains poorly managed on a cottage industry basis. Would competitive tendering between public and private agencies in Health Action Zones and elsewhere act as a catalyst to change practice and contracts?
- Reform capital rationing: the PFI is complex, of unproven efficiency and insulates sectors of care from resource reallocation. How better to ensure an adequate capital stock?
- Adopt vigorous clinical governance: the government places considerable emphasis on the profession regulating itself. Is reaccreditation an essential means to drive principles into practice?

These last three areas need greatly improved management, public or private, in the next decade and beyond. The NHS has a clear future but its efficiency (rationing access on the basis of ability to benefit per unit of cost) remains poor, and supply side reform is essential. The medical profession are a crucial group in this reform. The structure, conduct and performance of the profession are inadequate and need to be improved more rapidly. This requires significant investments in information, education and reaccreditation.

As ever it is useful to proceed in hope and with a wary eye on the doctors' behaviour. To return to Voltaire, he thought:

the role of the doctor is to amuse the patient while nature takes its course.

In the second half century of the NHS, let us hope that the amusement is evidence based and cost-effective!

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