CREATION AND CONSOLIDATION

> We ought to take a pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world—put the welfare of the sick in front of every other consideration.[1]

At the time of its establishment in 1948 the National Health Service was recognised as a remarkable experiment in health care. Alone among its capitalist partners, the United Kingdom offered comprehensive health care to its entire population. On the basis of finance from general taxation, all of its services were free at point of use. This huge public service was recognised by outsiders as the outstanding example of 'socialised medicine' in the western world. Aneurin Bevan, architect of the new service, adopted the most ambitious remit for his creation, which he was apt to call 'the most civilised achievement of modern Government'.

On the basis of its unusual characteristics, from the moment of its inception, the NHS came under the national and international spotlight. Particular interest attaches to the conspicuously political character of the UK health service. To a greater degree than elsewhere, funding and policy became the province of the politician and the civil servant. Everywhere else health care was subject to political intervention, but the UK was unusual in the extent to which politicians assumed command and took over the levers of control for the entire health care system. This was an awesome responsibility. In some respects Bevan's mission was accomplished. Over the course of time the NHS consolidated its position and developed into a prestigious national institution. The high standing of the NHS in the eyes of the public, consistently displayed over a long period, is of course primarily a testimony to the consistent record of achievement of a dedicated health care workforce.

The historical record suggests a less generous estimate of the contribution of governments, politicians and bureaucrats. Notwithstanding their habitual claim that the NHS is granted the highest priority, in practice it has been mismanaged, neglected and starved of resources. Thereby the work of the NHS workforce has been seriously handicapped and services have fallen short of the standards taken for granted elsewhere. In response to growing public alarm and the sense of crisis that has overtaken the NHS, health issues have steadily moved up the political agenda until they now occupy the front line of British politics. The troubled history of the political stewardship over the health service constitutes the central subject matter of this book. A closer look at the controversies surrounding the origins of the health service enables us better to understand how easily Bevan's great dream was translated into disappointing reality.

Flawed Inheritance

It would be an error to regard the NHS as a spontaneous creation. The very scale and complexity of the formative process testify to the substantial scale of existing health services. In common with other advanced Western economies, the UK experienced a steady expansion in its health services. As a consequence of a long process of accretion, by the outset of the Second World War voluntary agencies and public authorities had built up a formidable array of services at least nominally covering the basic medical needs of all sections of the population. From the mid-nineteenth century, direct state intervention in health care had steadily increased. Following a pattern common to other European states, the UK accumulated a large body of legislation addressed to the control of public health, the regulation of the health-care professions, and the provision of services to many different client groups. Through the mechanisms of the poor law, public health, education, and health insurance, central and local government between them provided and financed an ever-increasing range of health services, until by 1939 a few of the more affluent and most progressive local authorities were within sight of providing a comprehensive health service.

Expansion of the public sector reduced the role of voluntary

agencies, but the voluntary sector retained its importance. It even proved capable of generating resources sufficient for the rebuilding of some major hospitals. Indeed, in the course of the inter-war period, many new voluntary bodies were established in response to the escalating problems of poverty and ill health associated with the economic depression.

The process of incremental growth operating over the course of more than a century has sometimes fostered the impression that by the start of the Second World War a comprehensive health service was so near to accomplishment that its final institution represented an inevitability. Any such construction tends to overlook the shortcomings of the health-care system and underestimate the obstacles to further change. The path to the NHS was by no means an inevitable and logical progression. There was no smooth process of evolutionary change and a noticeable absence of consensus over most basic aspects of health-care policy. Informed opinion was indeed united over the merit of maintaining decent standards of health, but this was little more than a commonplace of civilized society, for the most part a vacuous assertion, since its denial was inconceivable.

In practice any step towards translation of pious sentiments regarding health care into practicable objectives was liable to expose clashes of ideological loyalty and stir up conflict between affected vested interests. Consequently, the transition from the haphazard assemblage of pre-war health services to the NHS was characterized by protracted and intense dispute, during the entire course of which the final outcome remained in doubt. It was perhaps inevitable that the publicly-funded health services would continue to expand, but throughout the Second World War the scale and character of this reform remained an entirely unsettled question.

Chaos and Depression

Despite the high status of the great teaching hospitals, continuing successes in medical research, and some impressive initiatives undertaken by local government, during the inter-war period it was impossible to disguise the overall sense of disquiet about the state of the UK health services. By comparison with many other advanced

Western economies, including the white dominions, the UK's health services were falling behind, and these deficiencies showed up in the international league tables of health indices. An embarrassing gulf opened up between the aspirations of enlightened planners and realities on the ground. Whereas the important Dawson Report of 1920 had looked forward to the creation of a coordinated system of comprehensive health centres situated in garden-city environments, the greater part of the population continued to live in conditions of Dickensian squalor. These slum-dwellers were denied the basic amenities of civilized life and of course they lacked access to health services of even a decent minimum standard, let alone the advantage of the new forms of treatment made possible by advances in medical science. Social investigations amply testified to the damaging consequences of poverty, ill health, and inadequate sources of social support. The worst affected were working-class women. As dependants, they were even excluded from meagre National Health Insurance (NHI) medical provisions. They lacked the material resources adequately to support their families and were therefore forced to deny themselves medical assistance or even an adequate diet. Their adversity was compounded by the absence of access to family-planning services.

Although there occurred a series of marginal improvements in health services, throughout the inter-war period there was a palpable sense of crisis, even panic, about the lethargic pace of improvement and the absence of effective leadership from the health departments. Even the big rationalization attempted through the Local Government Act of 1929 was unsuccessful in instilling confidence. Commenting on this development, W. A. Robson complained about the continuing 'multiplication of health authorities and the disintegration of function'. With respect to the health services as a whole, he regretted the continuing 'waste, inefficiency, chaos, and worst of all, a failure to envisage the health of the community at different ages and different stages'. This latter criticism was aimed at the bewildering range of agencies supplying health care, which deprived any individual of continuity of treatment. Robson called for application of the principles of integration, unification, and simplification in the organization of health care to

guarantee the protection of the health of all members of the community 'from womb to grave'.[2]

Improving economic conditions in the late 1930s failed to reduce the sense of alarm. Writing in 1937, the chief author of the Dawson Report expressed concern that health care was being damaged by the isolation and widening administrative division between services. He particularly regretted that there existed two rival hospital systems, the public sector and the voluntary hospitals, 'duplicating and even conflicting, without machinery in existence for coordinating their activities'.[3] The recently formed and influential social-science pressure group, Political and Economic Planning (PEP), the body that produced the only comprehensive review of the British health services undertaken before the Second World War, complained about lack of unity in the two hospital systems; the 1,000 voluntary hospitals were 'self-governing institutions, jealous of their independence and only loosely associated with each other', while the 3,000 public hospitals were distributed between hundreds of separate local authorities only remotely regulated by the health departments.[4] As witnessed by the wartime surveys of hospital facilities, any area was likely to illustrate the chaos of the situation, as, for instance, when the South Wales surveyors discovered that in their area ninety-three hospitals were being provided by forty-six local authorities. Functioning entirely independently of the local authorities and of one another, there were also forty-eight voluntary hospitals. With some understatement, the surveyors concluded that 'the integration of all these hospitals would have many advantages'.[5]

Even within any one local authority, health functions were distributed between many committees, operating without coordination and therefore liable to dangerous lapses, as witnessed by a notorious typhoid outbreak that occurred in Croydon in 1937. Adding further to the confusion of the situation, a further entirely independent entity was the cumbersome NHI administration, established in 1911, the main function of which was supplying minimum financial relief during sickness and 'panel-doctor' services for the low paid on the basis of weekly deductions of income for the so-called 'health stamp'.

World War and Planning for Reconstruction

It took a second world war to shatter the inertia of the established regime. In anticipation of likely air-raid casualties amounting to at least 300,000, with remarkable speed and efficiency an Emergency Medical Service was set in place. PEP pointed out that 'the bombing plane, by transforming the nature of warfare, has forced on us a transformation of our medical services'.[6] The *Luftwaffe* achieved in months what had defeated politicians and planners for at least two decades. For the purposes of war, all hospitals were coordinated together under the civil defence regional administration. This regional organization supervised the training and distribution of professional personnel and the modernization of hospitals; it also organized for the first time a regional blood transfusion service, a national public health laboratory service, and regional specialist facilities for services as diverse as rehabilitation, fractures, plastic surgery, neurology, and psychiatry. The need for emergency action to introduce these services was itself a reflection of the backwardness of facilities for specialist treatment. It was self-evident to planners that the nation's capacity to engage in warfare with ramifications affecting the entire population was likely to be handicapped by its inability to exploit the capacities of medical advance. Just before the war the Director General of the Emergency Medical Service complained that his initial surveys had confirmed the 'low standard of hospital accommodation in the country as a whole'; even the prestigious teaching centres were 'structurally unsafe or woefully antiquated' and therefore unable to meet the needs of the emergency services.[7] Although the Emergency Medical Service was allocated the resources to transform the acute and casualty services, as the wartime regional surveys indicated, many parts of the old system were left untouched by its activities. Indeed, the successes of the Emergency Medical Service were dependent on its appropriation of the better hospital facilities of all types, with the result that the plight of large numbers of vulnerable and long-stay patients became even worse; these most deprived members of the community were exposed to humiliating conditions arguably little better than the concentration camp.

The Emergency Medical Service and related support services

demonstrated the remarkable capacity to make up for lost ground and prepare for a bombing catastrophe on a scale that mercifully failed to materialize. So impressive was this great constructive enterprise that PEP in common with many others called for the immediate conversion of the Emergency Hospital Scheme into a National Hospital Service.[8] This obsession with ambitious schemes for peacetime reconstruction reflected a spirit of euphoria that took hold of the intelligentsia during the darkest days of the war. Although the main energies of the nation were absorbed in the desperate struggle for survival, 'post-war reconstruction' was pursued with the greatest seriousness as a task of complementary importance. The outburst of planning activity in the fields of health and welfare at this time prompted Richard Titmuss to draw attention to the paradox that 'when human lives are cheapest, the desire to preserve life and health is at its highest'.[9]

The Emergency Medical Service and general cry for radical change emanating from many different groups of planners forced the health departments to accept the need for a substantial measure of reform to meet the needs of a future peacetime situation. As a first step, the Minister of Health promised that after the war the government would establish a comprehensive hospital service. It was envisaged that existing local authorities would undertake planning, but the actual service would involve a partnership between the public and voluntary sectors. As a concession to advanced thinking, it was agreed that the new service would be designed on the basis of areas substantially larger than existing local authorities.[10] Any intention to limit post-war changes to the hospital service was soon undermined by Sir William Beveridge, whose audacious scheme for reconstructing social security included as a prior 'assumption *B*' that a 'national health service for prevention and comprehensive treatment' would be available to all members of the community.[11] In fact Beveridge was merely the most eloquent and strategically best-placed exponent of this call for radical overhaul of the health services. Directly parallel to the Beveridge Report, a group of Fabians outlined a similar ambitious scheme for the reconstruction of social security, also assuming the establishment of a comprehensive state medical service.[12] Reflecting opinion at the grass roots, the Nuffield Social Reconstruction

Survey recorded widespread demand for the replacement of the panel system by a comprehensive state medical service.[13]

Although the government was divided over its response to Beveridge, his report both reflected and released a tide of expectation that could not be stemmed. Indicative of the high level of anxiety concerning the defectiveness of the existing system, the idea of a national health service evoked spontaneous and passionate support from all sections of the community. Beveridge became the convenient focus for more determined agitation for a new health service for the entire population, capable of supplying the most modern forms of treatment and care without the humiliation and stigma associated with established agencies of charity, the poor law, or public health.

The fresh spirit of solidarity and altruism associated with war has perhaps contributed subsequently to a spurious impression that such an obviously desirable objective as an efficient health service represented a readily achievable objective. While the relevant interest groups spontaneously subscribed to this aspiration, it was immediately evident that they would pursue without compromise their totally divergent and incompatible ideas about realizing the objective of modernization. Accordingly, the interest groups responded to Beveridge by retreating to their entrenched positions. The bitter jealousies that wrecked the pathetically limited pre-war efforts at reform resurfaced during the Second World War and precluded the prospect of achieving consensus over the shape of the new health service.

Preparations for reform took place in an atmosphere of noisy conflict. This was not merely a temporary perturbation among negotiating parties. The polarization of attitudes experienced at this time was deeply damaging and it cast a long shadow over the future NHS. This episode reflects badly on all the parties. The planners were inflexible in their thinking, wedded to out-of-date conceptions of local administration, and misguided about the character and power of opposition forces, especially within the medical profession. The latter persisted with constructions of the future entirely determined and shaped by their financial self-interest and ideologies rooted in the distant past.

The main running in the wartime negotiations was made by the

Ministry of Health and the local-government associations, a long-standing and comfortable partnership which represented the biggest power block on account of the importance of the former as the main agent of policy-making and the latter as the dominant provider of services. They envisaged that a comprehensive health service would be established by further extending the powers of existing local authorities, with the formation of joint bodies to overcome difficulties associated with the small size of existing local-government entities. This formula represented minimum interference with the established policy regime within the Ministry of Health. It was expected that voluntary hospitals would continue in some kind of partnership with the municipal sector, but it was anticipated that this would be a temporary device, since the voluntary hospitals would prove incapable of sustaining themselves. The radicalism of the new plan centred on primary care; general practitioners were to be employed directly by local authorities, thereby losing the autonomy associated with their status as independent contractors under the NHI system.[14] It was also assumed that as quickly as feasible general practitioners would be assembled into groups to work alongside other local-authority staff in purpose-built health centres.

Notwithstanding its limitations, the above plan at least represented a significant step towards objectives that had defeated generations of public-health planners. At least since the Royal Sanitary Commission Report of 1871, reformers such as Sir John Simon, author of the classic *English Sanitary Institutions* (1891), or Sidney and Beatrice Webb, through the medium of the Minority Report of the Poor Law Commissioners (1909), had attached high priority to the goal of unifying all state-provided health services in any one natural area of administration under a single agency of local government. The proposals of the Coalition Government, first formulated in 1943, were the first officially sanctioned scheme to approximate to this objective. This plan aimed to assemble all publicly funded health services under some forty bodies constituted from single local authorities or combinations of them. Voluntary hospitals constituted the only stumbling block to complete integration.

The bureaucrats completely miscalculated about the acceptability

of their scheme. Ironically, their own earlier dismissal of the Dawson Report on account of its oversimplifications and lack of political realism now became the basis for the attack on the official scheme. From the traditionalist camp, neither the voluntary hospitals nor the general practitioners were willing to contemplate being swallowed up by the unified system. The voluntary hospitals sought guarantees to prevent local government exercising a stranglehold over the public subsidies they were promised, while their staffs resented the prospect of being reduced to the rank of public-health employees. General medical practitioners insisted on continuing separate administration of their service and retention of their status as independent contractors.

In the spring of 1943 the government embarked on confidential discussions on its provisional plan; in modified form, this scheme was then described in a long, diffuse, and confusing White Paper, *A National Health Service*, issued in February 1944.[15] The government's proposals were heavily criticized, especially by medical organizations and the voluntary hospital lobby. In an effort to conciliate these interests, in 1945 a further White Paper was drafted by the Conservative caretaker administration. The agent of appeasement was Henry U. Willink, the Conservative Minister of Health. The details of Willink's scheme were circulated to all members of the medical profession, but the White Paper was never released on account of Conservative ministers' estimate of its likely unpopularity and vulnerability to criticism.[16]

The mature proposals emerging in 1945 under Willink, after more than four years of wartime preparation and debate, entailed reversal of many characteristics of the scheme originally promulgated within the Ministry of Health. It was now suggested that local government would retain direct control only of the services that it had traditionally administered. For the purposes of planning over wider areas, it was proposed to establish area planning bodies and regional planning councils, which were conceived as a forum for joint effort by local authorities, voluntary hospitals, and the medical profession. It was anticipated that regional councils based on the areas of influence of university medical schools would take on the crucial task of advising the minister on the development of hospital specialities and the appointment of all consultants and spe-

cialists. The joint authorities of local government of the earlier proposal were scrapped and replaced by area planning bodies, which would assume statutory responsibility for producing a plan for the whole health service for each group of local authorities. In order to satisfy voluntary hospital sensitivities about direct relations with local authorities, it was agreed that disbursements from the local rates would be transferred through the medium of specially established area 'clearing houses', while hospital-planning would be largely devolved to hospital-planning groups working in direct collaboration with the regional councils. General medical practitioners were promised continuity of their existing arrangements for employment through a proposal to replace existing Insurance Committees by new 'local committees', fulfilling similar functions. Accordingly, general practitioners would remain as independent contractors; their payment would continue on the basis of capitation rather than salary; private practice would continue to be permitted. Health centres would survive as an option, but without affecting the contractual situation of general practitioners, and such health centres were to be regarded as a limited and 'controlled experiment' overseen by the central department. Having failed to produce a scheme acceptable to the professions, the government abandoned its earlier proposals for controlling the distribution of general practitioners in the interests of improving services in depressed areas. Previous government proposals had envisaged the establishment of a Central Medical Board to regulate the distribution of general practitioners and operate other professional controls. In response to an antagonistic response to this form of 'central direction', this proposal was now dropped. A final important concession to general practitioners was the government's agreement to allow the continuation of the established custom of the sale and purchase of goodwill.

The above proposals represented a major retreat from the 1944 White Paper. In particular, the long-established goal of unified administration under local government was now abandoned. The new proposals not only froze local-government participation at its current level, but also made local authorities subservient to area and regional planning bodies in which non-elected representatives would exercise a substantial voice. Local authorities were even

threatened with the prospect of intrusion by non-elected professionals and other outsiders into their statutory health committees.

By this stage the health scheme was on the verge of becoming a particularly unhappy compromise, incapable of commanding support from any group, and offensive to all. Even some of the experts within the Ministry of Health regretted many of these concessions, which among other things had resulted in the 'abandonment of the cardinal principle of combining planning and execution in the same hands, but also the creation of a planning and administrative system of almost unworkable complexity'.[17] The local-authority associations recognized that departures from the original scheme had fundamentally eroded their power to plan and control the new health service. The medical profession and the voluntary hospitals knew that they had gained ground, but were hungry for yet further concessions.

In summary, negotiations conducted during the Second World War resulted in substantial capitulation to the medical and voluntary hospital lobbies, but at the cost of alienating Labour and local government. The bureaucrats were divided among themselves, but the majority of the planners sided with local government, which exposed them to bitter attack, especially from the British Medical Association (BMA). The objective of translating the Beveridge 'assumption *B*' into reality was no nearer realization in 1945 than it had been in 1942.

Labour in Power

The landslide victory obtained by Labour in the summer of 1945 presented an opportunity for decisive leadership on social policy; indeed Labour was pledged to an ambitious welfare-state programme. Labour had long been committed to establishing a comprehensive health service and this pledge was reaffirmed in its policy document *National Service for Health*, published in April 1943, coinciding with the launch of the Coalition Government's similar plan. Within the Coalition, Labour ministers tried to force the pace of health-service reform. After the collapse of the 1943 plan, Labour only reluctantly accepted the 1944 White Paper and it was dis-

trustful of all further modifications, which it viewed as an erosion of the uneasy compromises embodied in the White Paper.

At the outset of the Attlee administration it was uncertain whether Labour would abide by the 1944 White Paper, or revert to the more radical alternative embodied in its own policy document or the Coalition's original plan. The uncertainty was increased by the appointment of Aneurin Bevan as Minister of Health. An ex-miner from South Wales, Bevan was notorious as a backbench irritant and leftist political maverick. This untried hand and the youngest member of Attlee's Cabinet was now given control over one of the largest departments in Whitehall; in this capacity he assumed power over housing and health, two of the biggest and most difficult undertakings for the post-war administration and fundamental to the maintenance of its credibility. Collapse of the government's housing and health reconstruction programmes after the First World War provided a doleful reminder of the pitfalls of Bevan's assignment.

Bevan quickly dispelled doubts about his abilities for decisive and constructive action. Civil servants understood that the Ministry of Health was now headed by a figure of much greater political stature than his recent predecessors. Bevan immediately gained the confidence of junior staff engaged in the health-service planning operation, one of whom recorded her impression that the new minister 'really cared about the way in which the people lived.'[18] This charisma and general capacity to inspire confidence was vital for the ambitious mission upon which Bevan was embarking. At all levels within the health service and among the population at large, Bevan tried and succeeded to a substantial degree in stimulating the belief that the new health service was a bold advance in which the UK was showing the way forward for civilization as a whole. Helpfully, Bevan's charismatic qualities were complemented by the more mundane gifts required to steer his programme through delicate negotiations both within the Cabinet and with outside interests. His pragmatism, common sense, and instinctive regard for the practical solution enabled his ambitious plan for transforming the health service to be realized in the remarkably short space of three years. Bevan therefore succeeded in dispelling

the pessimism generated by many years of futile wrangling about the future of the health service, and he launched the new service on a new note of optimism.

At the outset of this great constructive enterprise, Bevan's gifts were not appreciated by senior officials within his department. The latter were firmly wedded to the Willink compromises and they were clearly determined to forge ahead with legislation on this basis. They were particularly protective of the independent status of the voluntary hospitals. Bevan's inclination to personal initiative was treated as an irritating diversion. The Permanent Secretary warned him that it was 'a pity to discard a plan which gives us much, if not all, of what we want, which is practically ready, and which would have a very large measure of agreement in its passage'.[19]

Bevan ignored this advice. To the chagrin of his senior officials, on the crucial question of the hospital service he struck out in an entirely fresh direction, which placed the emphasis on the scarcely considered alternative of nationalization. Perhaps within a couple of weeks of his appointment, he was already considering a scheme for bringing all hospitals under a single public authority controlled by the minister. Indeed these early deliberations about nationalization even considered adopting a regionalized and nationalized system for unification of all health services, except perhaps for the independent contractors.

Once Bevan had reached his conclusion, he moved quickly to regain the initiative in policy-making, much to the disconcertment of his own senior officials and the outside negotiators, especially the medical profession. During the war the profession had successfully cultivated a regime of continuous negotiation to the point where, by a process of attrition, it had successfully wrenched policy-making out of the hands of the government and effectively annexed it under its own control. Bevan declined the invitation to adopt the subordinate status imposed on his predecessor. He immediately re-established the minister's supremacy in policy-making, acting with remarkably little reference to outside interests, Whitehall departments, or even his own senior officials or ministerial colleagues. By disentangling himself from these impediments, Bevan broke out of the regime of interminable negotiations and

tentative policy documents. With the aid of his little group of immediate advisers, within a few weeks Bevan had drawn up a firm plan; with little alteration this was translated into legislation within the space of a year.

Bevan's key proposal for a nationalized and regionalized hospital service was tried out on Cabinet colleagues on 11 and 18 October 1945, followed by discussion of his proposals for the abolition of the sale and purchase of medical practices on 3 December, and finally detailed consideration of the whole NHS scheme on 20 December 1945, 8 January and 8 March 1946. Considering the importance of the issues under consideration, these ministerial deliberations were little more than cursory, except on the sole issue of hospital nationalization, where Herbert Morrison led an abortive rearguard action in favour of the municipal alternative. These discussions paved the way for publication on 21 March 1946 of the National Health Service Bill and a White Paper containing an outline of the proposed legislation.[20] Although there had been many press leaks concerning Bevan's ideas over the previous six months, it was not until this date that his full intentions became evident. Owing to determined leadership from Bevan and only weak obstruction from an ineffective opposition in parliament, with remarkably little amendment the NHS legislation passed into law on 6 November 1946. With a similar lack of difficulty the Scottish health service legislation was set in place in 1947.

The New Plan for Health

Bevan's mature proposals represented a mixture of audacity and prudence. In some respects they were slightly less radical than the scheme originally contemplated in 1943. Unification of all health services under a single system of administration was regarded as impracticable and was abandoned in favour of the tripartite scheme already implicit in the plan inherited from the caretaker administration. The decision to adopt different forms of administration for hospitals, public health, and independent-contractor services represented a concession to the local authorities and the independent contractors, who were promised continuity of their existing forms of administration, which of course also possessed the additional

advantage of saving planners from wrestling with big administrative changes on too many fronts simultaneously. However, this complex administrative system, the details of which are indicated in Fig. 1.1, risked creating a series of parallel, unequal, incompatible, and unintegrated health services, a danger counteracted by promises of active intervention on the part of the minister and high expectations concerning the role of the complicated central consultative machinery inherited from Willink's scheme. Although, like the new school system, the NHS was commonly called 'tripartite', in practice it was considerably more complicated than this.

The dominant and most original feature of Bevan's scheme lay in its proposals concerning the nationalization and regionalization of the hospital service. Although neither of these ideas had previously been regarded as practicable by the department on account of their known contentiousness, both attracted firm advocates among the experts. Indeed, regionalization of health administration and regional local government had been widely canvassed during the Second World War. This trend of thinking about local administration was consistent with advanced ideas about medical organization, especially among the hospital medical specialities, where many expert groups produced schemes for future development premised on the assumption of moves towards regionalization. With these aspirations in mind, R. C. Wofinden aptly summarized the medical case for regionalization:

> It was significant that in all these plans for future health services the key word was 'regionalisation' generally with the university medical school acting as focal point. There are obvious advantages in regional organisation. It allows economy of buildings, staff, and equipment, and enables the staff, by providing more clinical material, to become more proficient in their specialty. Further, well-equipped centres are available for training and research purposes. Modern transport arrangements have provided a satisfactory answer to the original criticisms against regionalisation . . . There must be some co-operation to perfect services on a wider scale and to do away with narrow parochial boundaries which so often prevent individuals from obtaining treatment merely because they do not reside within the appropriate area. Regionalisation would appear to be the answer.[21]

These conclusions, written shortly before Bevan's plan was unveiled, indicated receptivity among leading hospital planners to

the form of regionalization embodied in Bevan's new scheme. However, despite close harmony of attitudes, neither Wolfinden, nor other leaders of consultant opinion, seemed to appreciate that Bevan also was considering nationalization as a serious proposition.

The idea of using the Emergency Hospital Service as a springboard for the nationalization of hospitals had occasionally been canvassed during the Second World War in both England and Scotland, but this idea had been rejected in all the major planning documents. Although Labour favoured evolution towards a municipalized hospital service, its policy statements were careful to avoid offence to the voluntary sector.

There is virtually no direct evidence about the course of Bevan's thinking, but it is quite likely that his solution grew out of consideration of post-war reconstruction as a whole, especially with respect to his joint responsibility for housing and health. During the war there had been mounting concern about the ability of local government to take on all of the tasks of reconstruction lying within its traditional ambit, especially on account of the massive task of rebuilding and rehousing, and with the prospect of ambitious plans for the expansion of services such as education and health. Local government had been further handicapped by the government's decision to defer consideration of both local-government reorganization and the overhaul of the rate system of local taxation. Although the antiquated system of local government had performed creditably during the war, there was little confidence in its ability to take on all the tasks envisaged for the post-war period. Advocates of local-government reform singled out the health services for illustrating the weakness of the existing local-government system. In particular, the creation of a modern, integrated hospital system seemed beyond the capacities and purse of local government. Reflecting this conclusion, in January 1945 *The Economist* called for the creation of 'the new Medical Service on a national basis, wholly financed from national resources and embracing part or all of the health services which form so large a part of the local authorities' total expenditure'. It was pointed out that the nationalization alternative was less objectionable to the medical profession and perhaps even palatable to the voluntary

hospitals, whereas both were vehemently antagonistic to any form of local-government control of their services.[22]

Although nationalization and regionalization were recognized as radical concepts, Bevan was not alone in favouring these alternatives. He was indeed aligning himself with a distinct body of expert opinion. These conclusions also fitted in with his own reservations about the capacities of local government and his ideas about the modernization of medical institutions. By emphasizing the scale and cost of the opportunities offered by housing and other developments remaining within local-government control, he calculated that local government would at least be reconciled to being relieved of the responsibility for the new health service and to the sacrifice of the major part of its traditional health-service functions. Since the voluntary hospitals were no longer financially viable and would be completely dependent on public subsidy, a change in their status was inevitable. Bevan calculated that the voluntary sector would regard nationalization as infinitely preferable to municipalization.

Bevan urged that the nationalized and regionalized scheme was an essential prerequisite for social and geographical equality: to 'achieve as nearly as possible a uniform standard of service for all', or to ensure that an 'equally good service is available everywhere'.[23] Also, to universalize the rudimentary specialist and consultant services, or reconstruction of the bomb-damaged and obsolete hospital stock, required a new system of organization transcending the limitations of local-government boundaries, and it needed resources on a scale beyond the competence of the rate system, even given the most generous level of the standard subsidies available from exchequer sources.

Nationalization permitted escape from the limitations of local-government divisions and made possible the full integration of all types of hospital. The system could be designed afresh, 'starting again with a clean slate'.[24] The minister's administrative agents were the regional boards (soon called Regional Hospital Boards (RHBs)), which exercised control over 'natural hospital regions'. The final proposals identified fourteen of these natural regions in England and Wales (London and the Home Counties being split segmentally into four regions, with Wales constituting a single region), and five in Scotland. It was envisaged that the regions

would be responsible for the application of government policy, overall strategic planning, budgetary control, and some specific duties such as determining the development of specialities and consultant appointments. Bevan's scheme envisaged the maximum degree of delegation to local administrative bodies (initially called District Committees, soon renamed Hospital Management Committees (HMCs)), which would be concerned with the day-to-day management of groups of hospitals for each 'natural hospital district'—defined initially as an 'area able to support a general hospital or combined group of hospitals big enough to employ a full specialist staff for all normal needs'. It was anticipated that a characteristic local hospital group would contain about 1,000 beds. Geographical division was not in practice attained, since it was found more convenient to delegate mental and mental-handicap hospitals to specially designated HMCs. These constituted about one-third of the HMCs. Many of the remaining HMCs administered considerably fewer than the 1,000 beds originally anticipated. Half of these general HMCs contained fewer than 1,000 beds, while fifty possessed fewer than 500. At the local level the hospital system was therefore considerably more fragmented than originally intended.

In line with latest medical thinking, the 'natural hospital regions' were defined with respect to the catchments and spheres of influence of the major teaching hospitals—single undergraduate teaching hospitals outside London, or groups of these hospitals in the metropolitan regions. The only major point of disagreement between Bevan and his Scottish colleague related to the teaching hospitals. At first, in England and Wales it was proposed to exempt the teaching hospitals from state control, whereas in Scotland their nationalization was favoured from the outset. Bevan quickly changed his mind; the teaching hospitals were nationalized, but it was agreed to preserve their independent administration; each was granted its own Board of Governors, providing direct links with the central department, thereby avoiding subservience to the regional board. As indicated by Fig. 1.1, this represented a major complication of the 'tripartite' arrangement, and it was subversive to the unified regional conception, as, for instance, expressed by experts such as Wofinden, cited above. Scotland integrated the

teaching hospitals into the regional structure from the outset. This constituted the main administrative difference between the health services north and south of the border.

Nationalization of municipal hospitals left for consideration the fate of the small and miscellaneous rump of remaining local-authority-administered health services. After briefly considering their assimilation into the regional system, Bevan elected to leave these services in the hands of local government. Local Health Authorities (LHAs) were constituted from existing county councils and county boroughs. This was a helpful concession to local government, and it also made sense, since many of the services were self-contained, related to the local-authority welfare services, or to the School Health Service administered by Local Education Authorities (LEAs). It was therefore agreed to leave the Medical Officer of Health (MOH) in charge of such functions as maternity and child welfare, domiciliary midwifery, health visiting, home nursing, home helps, care and aftercare services, vaccination and immunization, and other activities connected with public health and health education. Local authorities also retained control of the large ambulance service, and they were promised an important new function, the provision and maintenance of health centres, which it was hoped would 'be developed as fast and as widely as possible'.[25] These health centres were intended to house not only local-authority staff, but also the independent contractors.

Bevan reaffirmed his predecessor's compromises concerning the separate administration of independent-contractor services. At the local level it was agreed to administer the services provided by general medical practitioners, general dental practitioners, opticians, and pharmacists, by committees (soon called Executive Councils) that were essentially renamed Insurance Committees inherited from the panel system. The Executive Councils followed the geographical pattern of the LHAs, except that in eight cases county towns were assimilated with their surrounding county areas. The main features of Bevan's modified tripartite scheme are summarized in Fig. 1.1.

Labour revived the proposal for a central committee to control the distribution of medical practices (soon called Medical Practices Committee), which had featured in the 1944 White Paper, but had

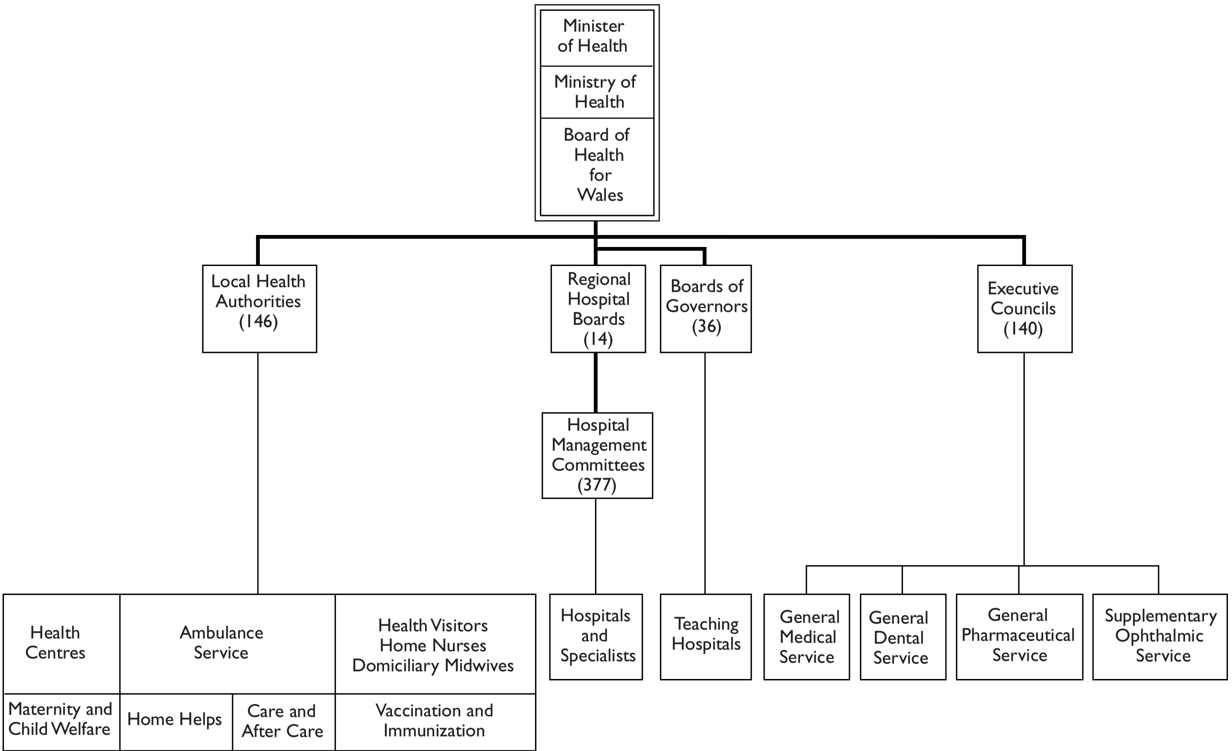

Figure 1.1. The National Health Service in England and Wales, 1948

been scrapped by Willink at the insistence of the BMA. The Medical Practices Committee possessed additional importance, since its controls on distribution would undermine the system of selling the value of practices, to which the profession was attached and had successfully defended in negotiations with Willink.

Consistent with the aspirations of the Beveridge Report, from the date of the earliest planning documents it had been assumed that the new health service would be universal (available to all), comprehensive (including all services, both preventive and curative), and free (involving no payment at the point of delivery). These three important ideas were carried over into Bevan's scheme without demur. However, there was much ambiguity about these principles and some of this opacity persisted into the Bevan proposals.

The BMA had opposed universality of the new service on account of undermining opportunities for private practice among general practitioners, but Willink had held on to this idea, and the BMA had given way on account of many other gains in its negotiations. The principle of universality was therefore no longer in dispute when Bevan assumed office.

The comprehensive principle was accepted by all concerned, but reservations existed on many fronts: owing to the special character of the services involved, there was opposition to infringing upon the independence of the Board of Control by ending the separate administration of the mental health services. On account of the shortage of trained practitioners, during the early planning stages there was hesitation about attempting to provide comprehensive dental and ophthalmic services. Some marginal services such as the children's service were divided between government departments and were candidates for rationalization, but the case for inclusion in the NHS was not regarded as compelling. Finally, many other services, such as the School Health Service and the occupational health services, fell under other government departments which were unwilling to contemplate their assimilation into the NHS. Bevan ended these uncertainties: the mental health services were included, but the Board of Control was allowed to continue with a more limited remit; comprehensive dental and ophthalmic services were included, but there were uncertainties about the final

form these services would take; to avoid controversy with other government departments, such functions as the school and occupational health services remained outside the NHS.

The issue of charging for services was especially sensitive, rousing passions and fears among the people about exploitation by unscrupulous practitioners and purveyors of patent remedies, means-testing, unaffordable doctors' bills, and other humiliations connected with charity and the poor law. The 1944 White Paper contained the assurance that the 'new service will be free to all, apart from possible charges when certain appliances are provided . . . the costs of the new health service will be borne partly from central funds, partly from local rates and partly from the contributions of the public under any scheme of social insurance which may be brought into operation'.[26]

In explaining the sources of finance for his scheme to colleagues, Bevan repeated almost exactly the 1944 White Paper statement quoted above.[27] As indicated by Table 1.1, the proposal for nationalization of hospitals brought about a sharp change in the balance of contributions from the three sources of funding. The new system extinguished the small but unquantifiable contribution from voluntary sources, and also sharply reduced the share from local-authority rates. The effect was to transfer virtually the whole

TABLE 1.1. *The cost of the health service, England and Wales, 1938–1945* (£m.)

Sources of funding	1938/9 (actual)	1944 (estimate)	1945 (estimate)
Social-security contributions	11.2	35.7	35.7
Central taxation	3.0	48.3	103.3
Local taxation	40.3	48.0	6.0
Voluntary sources[a]	11.5	—	—
TOTAL	66.0	132.0	145.0

[a] It was assumed that the voluntary contribution would decline after the Second World War, but the extent of this reduction was uncertain.

Sources: Ministry of Health, Department of Health for Scotland, *A National Health Service*, Cmd. 6502 (London: HMSO, 1944); Bevan, 'Proposals for a National Health Service', CP(45)339, 13 Dec. 1945, PRO CAB 129/5.

burden of financing the health service to central taxation, of which the social-security contribution was part. Bevan's memoranda were strangely lacking in precision about estimates of costs or justification for changes in funding arrangements, but he urged that, since there were uniform rates of insurance contribution, it was essential to guarantee an equal quality of treatment for all, something attainable only by transfer of the burden of the service to the exchequer.[28] Elsewhere Bevan justified this new balance as being consistent with socialist commitments to progressive taxation and related redistributional objectives. The promise of a free service was a principle to which Bevan became irrevocably attached, as indicated in the bold declaration comprising the first page of the leaflet, *The New National Health Service*, distributed to all homes at the outset of the new service:

> It will provide you with all 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, except for a few special items. There are no insurance qualifications. But it is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

Such unambiguous assurances concerning absence of direct charges reflect the sensitivity of this issue among the public, for whom this reassurance constituted one of the greatest attractions and a major source of relief from anxiety. On the basis of his experience in overseeing the introduction of the new service, Sir George Godber confirms that freedom from charges and doctors' bills was for the population and the professions alike 'the most satisfying thing about the Health Service'.[29]

As already indicated, Bevan went further than his predecessors in promising a scheme involving an explicit egalitarian commitment and a first-class standard of treatment, thereby implying emancipation from the preoccupation with the 'minimum' or subsistence standards that had characterized earlier welfare proposals. Bevan's model was therefore the private wing of the voluntary hospital rather than the poor-law infirmary—hence his frequent promises to eliminate the second-class types of treatment and to 'generalize' or 'universalize' the best standards of treatment and care, and thereby 'place this country in the forefront of all countries of

the world' in its medical services.[30] The Attlee administration somewhat casually fell into line with Bevan's proposal, without any real sense of the momentous scale of the financial commitments that would be entailed in establishing services on the ambitious scale envisaged in Bevan's health plan.

Renewed Confrontation

Although Bevan's scheme was implemented almost as originally conceived, this outcome was far from certain in 1946. On account of its unambiguous rejection of the discredited pre-war system and the prospect of building still further on the already substantial improvements experienced during the Second World War, the public was overwhelmingly supportive of the new scheme. The media were also generally appreciative. Even organs not particularly sympathetic to Labour such as *The Times* and *The Economist*, although expressing reservations, also accepted that, with respect to the crucial issue of hospital organization, Bevan's solution was superior to any previous alternative. Indeed *The Economist* even suggested that Bevan had succeeded in proving that, contrary to the assertions of the great Lord Dawson, it was possible to combine 'socialism in its administration with individualism in its practice'.[31]

The high expectations and euphoria concerning the new health service among the public and the media contrast with the predominantly sceptical response among many medico-politicians. Among the power-brokers there was dissatisfaction both with the policy and with Bevan's way of doing business. Bevan was in no doubt about the potential controversiality of his proposals. At the outset he warned Cabinet colleagues that there would be an outcry from both the voluntary hospitals and the local authorities. He was less certain about the response of the medical profession, but on the whole he believed that they would be satisfied that the new service would offer them a 'square deal'. On this basis he thought that the 'profession would be solidly behind it'.[32]

The above construction turned out to be entirely at odds with events. The voluntary hospitals and the local authorities lamented their losses, but neither mounted sustained opposition against Bevan's proposals. Only the medical profession, and more

particularly the powerful BMA, elected to fight and succeeded in driving its thorn deeply into Bevan's flesh.

Most of the major negotiating parties could decently bury their pride and become reconciled to Bevan's scheme. The voluntary hospitals were relieved to have escaped control by local government; they took comfort from the high degree of independence granted to teaching hospitals and the prospect that they would be granted a substantial voice in hospital management at all levels. In general the new hospital system was modelled more on the voluntary pattern than on its municipal competitor. The local authorities were dissatisfied, but, since most of the large authorities were Labour controlled, they were disinclined to disrupt a scheme that was clearly greatly to the advantage of their constituents.

From the outset of negotiations it was evident that the medical profession comprised an uneasy alliance of diverse interests. Bevan's scheme finally disrupted the unity of this coalition. The consultant élite had long been favourable to regionalization and they were prepared to contemplate nationalization as a means to realize this objective. In addition, Bevan's scheme offered many other tangible benefits to hospital medical staff. The senior staff were rescued from their honorary status, whereby they gave their services without charge in voluntary hospitals in anticipation of compensatory returns from private patients, who were increasingly treated in the exclusive private wings of the same hospitals, the proliferation of which exercised a notorious distorting effect on the voluntary system in the twentieth century. Consultants were offered either full-time or part-time contracts. The latter enabled them to engage in private practice in return for a small reduction in salary; to facilitate this private practice, the pay beds of voluntary hospitals were carried over into the NHS. Consultants were also granted a generous system of distinction awards to compensate for any loss of private earnings and reward excellence in their professional accomplishments. Furthermore, hospital medical staff were promised involvement at all levels in the management structure. There was nothing in the Bevan scheme meriting militancy and non-cooperation on the part of consultant staff. The politically dominant element within the Royal Colleges therefore assumed the role of peacemakers.

The threat of non-cooperation stemmed from the general medical practitioners and general dental practitioners. The former dominated the BMA and they were mobilized by an aggressive and battle-hardened leadership. The responses of the BMA were conditioned by memories of its past failures extending back to at least 1911; its leaders were determined to reverse their earlier humiliations. They therefore entered into negotiation with maximum distrust and unwillingness to compromise. Employing techniques of megaphone diplomacy imitative of totalitarian regimes, the BMA set about shaping the new health service in accordance with its own policies. As already noted, by virtue of hard negotiation the representatives of the profession had effectively wrecked the plans framed by Coalition ministers and they had been particularly successful in securing concessions relating to general practice. By reversing some of these decisions, Bevan renewed fears that Labour was preparing to conscript general practitioners into becoming full-time salaried servants of a state medical service. The Bevan plan therefore stirred up all the fears traditionally associated with the threat of full-time salaried service under the MOH. No amount of disclaimers on the part of Bevan, or assurances concerning essential continuity with the panel system, were sufficient to alleviate these anxieties.

The BMA accordingly embarked on a campaign to expunge all features of Bevan's proposals identified as eroding the established employment conventions applying to independent contractors. Their targets of attack perhaps seem rather trivial from our later perspective, but at the time they were regarded as essential and non-negotiable demands; unless they were met in full, the whole profession seemed likely to boycott entry into the new service. The intransigence of the profession was confirmed regularly at representative meetings of the BMA and by three plebiscites of the entire profession.

The profession made four main demands: first, that the sale and purchase of goodwill associated with medical practices should be allowed to continue; secondly, that the basic salary component in remuneration should be eliminated and that payment should be entirely by capitation; thirdly, that the proposed controls over the distribution of general practitioners should be dismantled; and,

finally, that the minister should not constitute the final point of appeal in the tribunal structure applying to general medical practitioners threatened with termination of their NHS contracts.

Final agreement over these demands was not reached until a few weeks before the new health service was due to commence. As late as February 1948 the parties were in a situation of stalemate and were trading insults. At this stage the profession voted eight to one absolutely to reject the NHS Act. With the help of mediation from the consultant leadership, the two sides retreated from their embattled positions and reached a reasonable compromise. The minister made no concession over the abolition of the sale and purchase of goodwill, but an enhanced package of compensation was confirmed. Dispensing with this old imposition was positively welcomed by a substantial section of the profession, especially younger entrants, for whom it entailed a substantial burden of debt. Bevan offered minor concessions with respect to the tribunal structure and the procedures of the Medical Practices Committee, but neither of these was likely in practice to impinge on the lives of the great majority of practitioners. Bevan's only significant concession related to the small basic salary component of remuneration, which was eliminated, except for a limited category of practitioners, for whom the terms of eligibility were strictly defined. Furthermore, Bevan promised and quickly introduced amending legislation to rule out the introduction of salaried service. With these concessions, opposition rapidly melted away in time for the new health service to be introduced in a spirit of harmony on 5 July 1948, the same 'Appointed Day' as other components in Labour's social-services reforms.

Appointed Day

Despite the late start in preparations and various delays along the way, the high level of dedication of the staff involved, both in the central departments and all the various employing bodies, meant that the lost ground was made up and the NHS was introduced with remarkable smoothness. As Sir George Godber recollects, 'there were forebodings of chaos on the Appointed Day but in the event, on 5 July 1948 services were given to patients just as they

had been during the previous week'.[33] The introduction of the NHS entailed the creation of very few new medical services; the two main changes from the point of view of recipients were relief from direct charges and access to existing services for large groups who had previously been excluded. The change was more evident to staff, who transferred from a multiplicity of employers to the more uniform structure of the NHS employing authorities, with terms of employment and levels of remuneration being for the most part determined by a newly established Whitley Council structure.

Only when all the assembled elements had been brought together was the vast scale of the new health service fully evident. The employees and contractors of the new service amounted to about 500,000, which made the NHS the third largest non-military organization in Great Britain, being exceeded only by the British Transport Commission and the National Coal Board. The dominant group was the hospital staff of about 360,000, of whom about 150,000 were nurses and midwives. The 3,100 hospitals provided no fewer than 550,000 beds, of which nearly 200,000 were located in the mental-health services. By comparison, the LHA and Executive Council sectors were small-scale operations, employing or contracting 26,000 and 55,000 professional staff respectively.

The parts of this huge and disparate organization fell into place with remarkable speed and tranquillity. Helped by the charismatic leadership of Bevan, the staff of the various parts of the NHS soon achieved a sense of corporate unity and came to share Bevan's sense that they were part of a prestigious national service, capable of achieving in peacetime something like the feats of collective action and patriotic sacrifice recently witnessed in the special circumstances of total warfare. Echoing the sentiments of Bevan, Sir George Godber remarks on the 'odd euphoria about what had been done and a tendency to pride ourselves on having the finest health service in the world'.[34]

The most conspicuous feature of the new situation was the deluge of demand. It was also clear that short-term action to provide false teeth, spectacles, and hearing aids on a massive scale was merely the first step towards a hugely expensive long-term programme of modernization, the realistic execution of which would

entail in perpetuity the commitment of resources on a scale way beyond any of the projections that had hitherto emanated from the health departments. Events, therefore, immediately exploded as fallacious any notion that the health service would be utilized sparingly, that it would represent a long-term economy, or even possibly become a self-liquidating expenditure commitment. Indeed, quite the opposite scare took hold. The sceptics suggested that the new health service constituted such a drain on resources that the economy would be wrecked and the nation thereby risked plunging into totalitarianism.[35]

Political Trustees

The establishment of the new health service is often thought to have marked the beginning of a long period of tranquillity, effectively removing the NHS from the province of political disagreement. With the emergence of this consensus over the virtues of the NHS, the political parties might have competed with one another to shower benefits on this favoured child of the welfare state. There certainly existed a greater measure of political agreement, giving expression to a great deal of vacuous rhetoric, but the politicians neither guaranteed the patrimony of the new health service, nor offered effective leadership over policies relating to health and health care. For the most part, the situation between 1948 and 1964 was characterized by resource starvation and policy neglect.

In his address to the medical profession, Bevan promised to devote himself to giving them 'all the facilities, resources, apparatus and help I can, and then to leave you alone as professional men and women to use your skills and judgement without hindrance'.[36] This objective was by no means easy to attain. Under the NHS legislation a high level of responsibility rested on the minister with respect to policy and finance. In particular, the standard achieved within the health service depended on the success of the Minister of Health's advocacy during each round of public expenditure negotiations. If a low threshold was set at the outset, it was likely to prove difficult subsequently to achieve the quantum leap to a higher threshold. Notwithstanding Bevan's high level of commitment and senior Cabinet position, it proved beyond his capacity to negotiate a stable

mechanism for assuring the health service of an adequate flow of resources for all, or even the majority of its essential needs.

Bevan's negotiating position was weakened by the huge and unanticipated overspend on the new health service during its first two years. The bald facts are indicated in Table 1.2. This record looks particularly bleak against the wartime estimates listed in Table 1.1 and the financial memorandum to the NHS Bill, which confidently set the gross cost of the new service at £152 million. The unexpectedly large demand in all the independent-contractor services provided the main explanation for the rise in costs. This excess was stoutly defended by Bevan as a temporary perturbation and a reasonable cost of humanitarian relief directed mainly to the elderly and the poor. His explanation gained credibility when expenditure turned out to run exactly on course in the year 1950/1.

Neither Bevan nor his health service emerged unscathed from the overspending experience. Sceptics within the Labour Cabinet, headed by Morrison, exploited this issue to cause Bevan maximum political embarrassment, in the end precipitating his resignation from his new post as Minister of Labour and from the government in April 1951 over the Cabinet's decision to end the free service and impose health charges. This crisis was also more fundamentally damaging, since it supplied alarmists with ammunition concerning the potentially explosive costs of the new health service. This enabled the Treasury to trap Labour not only into introducing direct health-service charges, but also into imposing a ceiling on

TABLE 1.2. *The cost of the National Health Service, England and Wales, 1948–1951* (£m.)

Estimate	1948/9		1949/50	1950/1
	9 months	Annual rate		
Original	198.4	268.0	352.3	464.5
Final	275.9	373.0	449.2	465.0

Source: J. S. Ross, *The National Health Service in Great Britain* (London: Oxford University Press, 1952), 15.

exchequer resources for the health service. This idea persisted for a decade. Throughout the 1950s convention determined that the contribution to the health service from direct taxation should be limited to about £400 million at 1950 prices; after allowing for inflation, all increases in expenditure above this level were expected to derive from such expedients as efficiency savings, cuts in fees to independent contractors, increased health-service charges, or increases in the National Health Service Contribution paid in connection with National Insurance. The latter was the post-1948 descendant of the 'health-stamp' deduction from pay made under the 1911 NHI scheme. The £400 million norm effectively became an arbitrarily imposed low baseline from which it was extremely difficult to escape. Thereby, even strongly justified bids for increased expenditure tended to be rejected on account of the need to keep NHS spending within its artificially constructed limits.

The brief overspending episode at the beginning of the NHS cast a long shadow, contributing to a seemingly indelible impression that the NHS constituted the bottomless pit for public expenditure. This construction was never supported by the evidence, and the 1950s provided a useful test case for its demolition. Indeed, even at the time of maximum alarm it was difficult to sustain a case for the excessive cost of the NHS. In 1952 the government set up an independent committee under the experienced Cambridge economist, Claude W. Guillebaud, to investigate this problem. In connection with this investigation the Guillebaud Committee commissioned an economic analysis undertaken by Brian Abel-Smith under the instruction of Professor R. M. Titmuss. No part of this powerful investigative process discovered evidence of waste within the NHS; the investigators were generally satisfied that the service was delivering a high quality of service in an economical manner. They were not even convinced of the need for health-service charges. They also urged that additional resources were required, particularly to support hospital modernization and the extension of community care.[37] These findings came as a shock and a disappointment to the government, which was expecting to use the Guillebaud Report as an instrument for imposing a regime of even tighter retrenchment on the new health service. Instead, the Guillebaud Report served the opposite purpose, while the Abel-

Smith and Titmuss investigation established itself as a classic defence of welfare-state expenditure. After this frustrating experience, no subsequent administration has dared to set up an independent inquiry into the cost of health care in the UK.

Taking the period from 1950 to 1964 as a whole, if current expenditure on the NHS is deflated using an NHS price index, it is seen that there was an average annual increase in expenditure of about 2.5 per cent, but with half of the increase being concentrated into the last five years. This pattern reflected the general course of public expenditure, itself affected by a rate of growth in the economy averaging at about 2.3 per cent during the 1950s, which is less than the growth rate in other comparable Western economies. During the lean years between the Korean War and the disastrous Suez expedition, the NHS was the main target for economies in social expenditure, imposed to finance the UK's operations as a world power. Following the 1959 general election, fought by Macmillan on the theme of 'preservation of prosperity', there followed a phase of expansion, with a growth target of 4 per cent. This ushered in a general increase in public expenditure, in which the NHS absorbed its share, facilitating for the first time since the health service had begun such major initiatives as the hospital plan. Notwithstanding this upturn, the annual rate of growth in public resources devoted to health care and indeed welfare in general was considerably in arrears of the UK's Western partners.

After a long period of relative wage stability, the slide towards wage-led inflation was evident during the final years of the Macmillan administration. The Macmillan government resorted to a pay pause, after which some attempt was made to adopt a 'guiding light' set between 2.5 and 3.5 per cent, but wages tended increasingly to move ahead of these limits. As noted below, the situation concerning pay determination for doctors and dentists was stabilized only after a Royal Commission and the establishment of a new review body. To the relief of the government, the review body kept in line with the guiding light during the first years of its operation, but, as indicated in the next chapter, this created such resentment that the Wilson administration was driven into making generous compensatory awards. For others in the NHS sector, the Whitley system operated to keep pay within the government

guidelines, but at the cost of a build-up of demoralization that exercised its adverse effects during later administrations. This problem is well illustrated by the experience of the nurses and midwives, the largest group of personnel within the NHS. After accepting economic pay rises in the course of the first decade of the service, the nurses insisted on a revaluation exercise, which in 1959 resulted in a 12 per cent pay increase. However, this left nurses in arrears of comparable groups, even non-graduate teachers, while manual groups in the NHS improved their position relative to nurses. Consequently, the nurses returned to their demand for revaluation, but this was rejected, and in the summer of 1961, the pay pause was used to rule out this objective. Enoch Powell, the new Minister of Health, used the nurses to indicate his own political commitment to strict interpretation of government pay policy, which in the spring of 1962 provoked the nurses into their first concerted public campaigning over their pay grievances. Given the intransigence of Powell, the nurses twice took their case to the Industrial Court, which awarded increases in 1962 and 1963 totalling 14 per cent, compared with the 5 per cent regarded as the upper limit within the government's pay policy as interpreted by Powell.

In 1950/1, the first year of stability of NHS spending, the new service absorbed 4.1 per cent of GDP; thereafter, there was a steady decline in the proportion of national resources absorbed by the NHS to reach a level of about 3.5 per cent in the mid-1950s, after which there was a slow rise, until the level of 4.1 per cent was regained in the year 1963/4, the last year of the Conservative administration. Unlike many other public services, owing to an important policy change introduced by Labour and built upon by the Conservatives, it was possible to offset increases in the cost of the NHS by higher charges and an increased NHS Contribution. In 1950/1 direct charges and the NHS Contribution accounted for only 9.4 per cent of the gross cost of the NHS, whereas in 1963/4 they supplied 19.5 per cent of the cost.

On the basis of various objective comparisons, the NHS was also not particularly successful in the competition for resources. In 1950/1 the NHS absorbed about 25 per cent of total government social spending, whereas in 1963/4 this had fallen to 20 per cent. By comparison, education, which more successfully forced itself

ahead to become a main policy priority, increased its share of social expenditure from 18 to 26 per cent over the same period.

By virtually all criteria, over the 1948–64 period the NHS cannot be regarded as a drain on national resources. Indeed, its costs were contained without difficulty, to the extent that resources were denied for obvious and urgent prerequisites, such as those connected with demographic change, medical advance, capital investment, or policy changes needed to keep up with rising expectations and the pace of improvement experienced elsewhere in the Western world. The inferior status of the health service was disguised by the political rhetoric; this effectively induced a sense of complacency concerning the state of the NHS, which vanished from the headlines. Owing to the effectiveness of this propaganda, reinforced by the evident improvement on the previous system, habitual stoicism and misplaced confidence among the public concerning the prospects for improvement, and a general disinclination to criticize a cherished national institution, the new health service drifted into a political limbo and thereby risked becoming a neglected backwater of the welfare state.

This story of decline is confirmed by the sequence of events in Westminster and Whitehall. The NHS was adversely affected by machinery-of-government changes even before Bevan's resignation from the government. The Cabinet reshuffle in January 1951 was taken as an opportunity to break up the Ministry of Health by transferring its housing and local-government functions to the new Ministry of Town and Country Planning. The much-reduced Ministry of Health was almost exclusively concerned with the health service; it was no longer an attractive career opportunity for high-flyers within the Civil Service and its minister no longer merited a seat in the Cabinet. The break-up of the Ministry of Health was therefore distinctly disadvantageous to the NHS. The Minister of Health remained outside the Cabinet from after the departure of Bevan for the rest of the life of the Ministry of Health, except for the brief period from July 1962 until May 1964.[38] A further disadvantage stemmed from the rapid rotation of Ministers of Health; no fewer than eight ministers held office between Bevan's transfer to the Ministry of Labour and the 1964 general election. None of these figures exercised anything like the influence

of Bevan, although, on the grounds of their high political profile, both Iain Macleod and Enoch Powell have attracted the attention of analysts.

Although Macleod and Powell were blood brothers in the formation of the new One Nation Conservative grouping, and in this context jointly produced the pamphlet *Social Services: Needs and Means*, published in 1952, their political paths soon diverged, and this was strikingly reflected in their records as Ministers of Health. Macleod effectively purged residual rancour towards Bevan's health service in the Conservative Party. According to Macleod's revisionism, the new health-service was viewed as the logical culmination of a respectable tradition rooted in the social philosophy and sanitarian reforms presided over by Disraeli. As Minister of Health, Macleod was quietly protective of the health service and he continued to use his influence in the interests of continuity of health policy as he subsequently rose through the Cabinet ranks.

Powell started with the same benign attitude towards the health service but his brief spell as Financial Secretary to the Treasury induced a hardening of attitude. His inflexible pursuit of economy in social spending, in which the health service was a main target, contributed to the celebrated confrontation between the Treasury team of ministers and the rest of the Cabinet, ending with the resignation of the Chancellor of the Exchequer, Peter Thorneycroft, as well as his junior ministers Powell, and Birch in January 1958. On the basis of his undoubted ability, Powell soon returned from the wilderness to become Minister of Health, in which capacity he embarked on an exercise of self-vindication by once again applying his retrenchment philosophy to the health service. The confrontation with the nurses mentioned above was merely one manifestation of this effort, and further characteristic interventions concerning health-service charges and the NHS Contribution are noted below. Powell was the last Minister of Health actively to subscribe to the view that the health service was a realistic target for economies in public expenditure.

In the main, after the departure of Bevan, although evident tensions existed between the Conservative right and the Labour left, the two parties converged in their policies. The issue of charges was particularly controversial, but it was Labour which introduced

dental and eye service charges in 1951 and only narrowly avoided introducing the prescription charge. As Labour's Chancellor of the Exchequer before the 1951 election defeat, Hugh Gaitskell actively advocated increased charges and cuts in services well beyond anything contemplated by any of his successors, Labour or Conservative.

The Conservatives periodically increased both dental and eye service charges; they also introduced the prescription charge in 1952; this was increased in 1956 and again in 1961. The biggest policy change in the financing of the NHS related to the NHS Contribution. There was some vague idea, usually, but wrongly, attributed to Beveridge, that the contribution from the National Insurance Fund to the NHS should be set at about 20 per cent of the cost of the service. This norm was not, in practice, observed, with the result that the share from the NHS Contribution during the early years of the NHS steadily declined from about 10 per cent to reach a low point of about 6.5 per cent in the mid-1950s. Thereafter, owing to a policy initiative stemming from the Prime Minister, Harold Macmillan, the NHS Contribution was substantially increased on three occasions until its share reached a peak of about 16.5 per cent of the gross cost of the NHS at the date of Macmillan's retirement. This episode is not much remembered, but it represented the only point in the history of the NHS when there was a determined attempt to transfer to an insurance basis of funding. This idea was pursued with vigour by Macmillan and a few Cabinet allies, but it was actively opposed by other Conservative ministers. This policy seemed viable until 1961, when it came to a grinding halt owing to the zeal of Enoch Powell, who simultaneously imposed a substantial increase in the NHS Contribution, a higher prescription charge, and increased dental and eye charges. Although these increases were introduced, they were deeply damaging politically, and no further attempt was made during the 1959–64 administration to pursue this combination of measures, or to reintroduce the idea of basing the funding of the NHS on a hypothecated tax raised through the social-security system. The Treasury was by no means consistent in its attitude to the funding of the NHS, but the nearest thing to an authoritative conclusion emanated from the interdepartmental Working Party on

NHS Finance chaired by F. E. Figgures, which expressed scepticism about all alternatives to the existing system of funding based on general taxation.[39] The arguments contained in the Figgures Report proved apposite and convincing on the many future occasions when alternative methods of funding the NHS were reconsidered.

A National Hospital Service

The hospital service was in all respects the dominant element within the new health service, to the extent that unkind critics called the NHS a 'National Hospital Service'. From the outset of preparations for a new health service rationalization of the chaotic hospital system dominated the attention of policy-makers. The new system of regional hospital administration was the most radical aspect of the Bevan plan. It constituted by far the largest feature of the new service, whether measured by resources invested, or by personnel employed. At the beginning of the health service the hospital sector absorbed about 54 per cent of the available funds; this increased steadily until it reached a peak of about 70 per cent in 1975. As the most innovative feature of the new service, for which high expectations were aroused, the hospital service absorbed almost the entire health-service planning effort. Indeed, it was the only part of the NHS for which a plan developed, although in England and Wales comprehensive regional planning was undermined by the administrative separation of teaching hospitals, and also by ambiguities in relations between the regions and HMCs.

The birth of the NHS coincided with the dawn of a golden age of high-technology medicine. Before the Second World War, despite some notable advances, treatment for many acute conditions was limited in its effectiveness and often hazardous to the patient. By 1948 the situation was changing rapidly. Notable advances included the widespread availability of natural and synthetic antibacterials, anticoagulants, reliable blood transfusion, innovations in anaesthetics, diagnostic X-radiology, and electrocardiography, as well as more refined techniques of pathological investigation, and mechanization in the operating theatre. Such revolutionary changes transformed the capacities of hospital medicine and created conditions for the

proliferation of medical and surgical specialities, which were capable of performing on a substantial scale a range of ambitious interventions that were virtually unknown before the Second World War. The continuation and ever-accelerating pace of these developments entailed inescapable increases in funding, as well as a much larger and more skilled workforce. Without these increased material and human resources, the expanding life-saving capacities of modern medicine would remain incompletely realized.

It was anticipated that a coordinated system of hospital services, radiating out from large regional teaching and research centres, would directly or indirectly dominate all aspects of care. Academic centres of excellence were expected to become spheres of enlightenment that would transform the practice of medicine and lead to enormous benefits in treatment and health. Anticipating this extraordinary sense of therapeutic optimism, in 1945 the Oxford regional commissioners had already referred to the 'growing consciousness, both within and without the medical profession, that our Hospitals, of which we are rightly proud, should spread their influence over a still wider sphere'. This was the best means of response to the modern belief in the 'supreme importance of Health', or the aspiration to 'Perfect Health' and of 'an urgent desire to promote the mental and physical fitness of our race for the exacting tasks which lie ahead'.[40]

Arguably the greatest permanent achievement of the early NHS was its rapid establishment of a universal specialist and consultant service. Even by 1950 there existed the nucleus of a comprehensive district general hospital system, with specialist staff sufficient at least for providing basic cover in general medicine, general surgery, and obstetrics and gynaecology. In the course of the first decade of the service there was rapid build-up of specialists in support services such as anaesthetics, pathology, and radiology, and also in such areas as psychiatry and geriatrics. By 1964 the foundations were also in place for regional specialities such as plastic surgery, neurosurgery, thoracic surgery, and radiotherapy.

The growth of advanced specialist treatment exposed to an even greater degree the inadequacies of existing hospital accommodation, much of which dated from the age of Florence Nightingale, with a substantial nucleus of the buildings dating from the

original foundation of the voluntary hospitals in the mid-eighteenth century. As Sir George Godber pointed out, the NHS was saddled with hospitals 'largely old and defective in structure, wrongly located, not only had to waste effort maintaining service with inefficient plant, but also had to spend what little capital there was making these bad old units usable for modern treatment'.[41] Every type of hospital was defective, but massive institutions housing some 200,000 mental-illness, mental-handicap, and chronic elderly patients were the worst. As the North West Metropolitan region frankly admitted:

> The Board inherited mental hospitals, some of which are in the neighbourhood of a hundred years old and most of them have been victims of damage and destruction by bombing during the last war. In addition, they were in varying degrees of disrepair, and generally were ill-adapted to the needs of patients under treatment in them. The patient population in the hospitals was predominantly composed of chronic and long-stay patients in various stages of deterioration resulting from prolonged hospitalisation.[42]

With the improving economic position, a great national building effort was initiated, spawning huge new housing developments and new towns, replete with such public buildings as schools of all types. Provision of these amenities underlined the failure of the NHS to capture its share of capital resources. Consequently the new community developments possessed neither hospitals nor health centres, and they continued to be served by any old hospital that happened to be located in the vicinity. As Sir George Godber recollected, the slender resources available were dedicated to repairing bomb damage and supplying desperately needed facilities such as outpatient and casualty departments, operating theatres, X-ray departments, and pathology laboratories. Any extra resources were used for replacing antiquated heating systems or attempting to improve the amenities of overcrowded wards. Patching and extending existing hospitals was in many respects a false economy. There was an urgent need for entirely new hospitals, ranging from district general hospitals for new centres of population to teaching hospitals, almost all of which required complete rebuilding.

On the basis of its initial survey of needs, even the small Oxford

region estimated that it required £3.5 million for urgent schemes, whereas the allocation for capital needs in the first full year of the service was a miserly £225,000. Oxford was in advance of most other regions in preparing its capital development plans; it also enjoyed good relations with the central department. Even with these advantages the Oxford region was not able to begin work on its highest priority scheme until 1957. This was the first district general hospital to be started in England under the NHS. The modest first phase of this Princess Margaret Hospital at Swindon, comprising mainly out-patient facilities, was completed in 1959; the larger second phase containing ward blocks was completed in 1964, leaving two further stages of this half-completed hospital, still to be constructed. The nearest equivalent in Wales was the West Wales General Hospital at Glangwili near Carmarthen, the first phase of which was opened in 1959. Swindon and Glangwili were two out of a total of only six such schemes in England and Wales at this date. In Scotland the first separate hospital development was the main part of the small hospital at the Vale of Leven, south of Loch Lomond, which was opened in 1955. Most of the capital investment in Scotland before 1960 was directed into modest schemes of improvement.

In England, the problems faced by a large region are illustrated by the North West Metropolitan RHB. This possessed the largest agglomeration of new towns; it listed ten urgently required major building projects, the total cost of which amounted to some £30 million. The total resources available annually for capital outlays of all kinds averaged little more than £500,000 for most of the first decade of the NHS, but it then climbed steadily from 1960 onwards, reaching a peak of about £7 million in the mid-1960s. From a situation in the first decade of the health service where the outlay on new hospitals was negligible, it became possible to plan these developments with realistic chances of their completion. The Queen Elizabeth II Hospital for the new towns of Welwyn/Hatfield was opened by the Queen in July 1963. This was the first district general hospital to be completed since the beginning of the health service. This was quickly followed by the Wexham Park Hospital in Slough and two other largely rebuilt hospitals. These developments in the North West Metropolitan region comprised

merely one segment in the new ring of hospitals serving the Home Counties, which progressively reduced reliance on hospital facilities in central London.

The modest rises in staff and limited investment in new facilities yielded substantial returns, as measured by the increase in the hospital workload. For instance, in the North West Metropolitan region, in the period 1949–64, with about a 5 per cent reduction in occupied beds, there occurred a 60 per cent increase in the number of in-patients treated and a reduction of about 35 per cent in the average duration of stay in hospital. The total out-patient attendances increased by 23 per cent, the new out-patient attendances by 46 per cent, and the accident-and-emergency attendances by 40 per cent. These figures were paralleled by spectacular increases in such inputs as quantities of blood supplied by the regional transfusion service, or the units of bacteriological, biochemical, haematological, and histological tests performed by pathology departments. This greater diversity and productivity in the diagnostic field were made possible by such innovations as automation of testing procedures, application of tests involving radio-isotopes, computerized scanning techniques, including the use of ultrasound, and advances in endoscopy.

By 1964 the equivalent of 20 per cent of the population in a hospital region was likely to utilize some in-patient or out-patient service in the course of a year. The character of hospital work was changing not only on account of medical advance but also because of epidemiological and social factors. For instance, in orthopaedics, older conditions relating to the effects of tuberculosis and rickets faded away to be replaced by such problems as poliomyelitis, which was at its height in the 1950s. Orthopaedics greatly advanced during the Second World War; technical improvements and the introduction of new materials brought about further advances in treatment and permitted more rapid rehabilitation. Fresh challenges to orthopaedics arose from the toll of accidents associated with modern transport. Orthopaedics also became more concerned with multiple corrective operations on infants with congenital deformities who would formerly have perished, but now survived owing to advances in paediatrics and neurosurgery. At the other end of the age scale, orthopaedics became involved in the repair of frac-

tured necks of the femur among large numbers of elderly patients who would have remained disabled in earlier times. The work of chest surgeons was no longer dominated by tuberculosis, but was increasingly concerned with the new evil of lung cancer attributable to tobacco-smoking. Cancers became diagnosed earlier and were better understood as a result of advances in the national cancer registration scheme, while treatment and management altered continually in line with innovations in drug treatment and radiotherapy.

As considered further in Chapter 2, owing to medical preference and social fashion, the early years of the new health service witnessed a strong move for hospital maternity departments to be recognized as the normal location for childbirth. Maternity departments thereby became leading features of new hospital schemes. The advantages of hospital confinement were particularly evident for sick or premature babies, where special-care baby units constituted an important new development. Intensive-care facilities were also relevant for many of the new and advanced surgical specialities, such as cardiac surgery, which by 1964 was able to offer as routine many interventions such as valve replacements and correction of septum defects. Such open-heart surgery had required the development of heart–lung machines, and advanced surgery in general was dependent on the availability of advanced equipment in anaesthetics such as the Barnet Ventilator. By 1964 a start had been made with the installation of implantable pace-makers as an alternative means to assist those with cardiac abnormalities.

The process of innovation and improvement extended slowly into the intractable environment of the long-stay hospitals. With the help of small injections of funds, some steps were made towards creating a more humane environment. More important was the emergence of a more constructive approach to therapy. In the early years of the new service, a small band of innovators demonstrated the effectiveness of rehabilitation regimes. By such means, even before the Report of the Royal Commission on Mental Illness and its sequel, the Mental Health Act of 1959, the tide of growth of in-patient numbers had been arrested. This trend was reinforced by important innovations in drug therapy, which stabilized hitherto serious conditions and opened up the possibility for treatment as

out-patients of individuals who hitherto would have been destined to join the helpless legions of the institutionalized. The proven success of these new modes of treatment opened up the prospect of a complete break with the old institutional system. Quite quickly, the plans for new district general hospitals were modified to include psychiatric units, the first to be opened being that at the Queen Elizabeth II Hospital in Welwyn. It was anticipated that the centre of gravity of mental health services would gradually switch from the old mental hospitals to these new psychiatric units.

By 1964 the hospital service possessed a firm record of achievement in the relief of suffering. This was rendered possible by virtue of additional resources, but equally important were the gains in efficiency brought about by transfer from the chaotic market of the pre-war period to the planned system of the NHS. However, there remained the unremitting problems experienced in meeting the demand for hospital modernization with slender resources. The failure to invest in hospital modernization was an increasing cause of political embarrassment. The newspapers drew attention to the contrast between modern hospitals springing up throughout Europe and the UK's dilapidated hospital stock. Russell Brock, the distinguished thoracic surgeon, soon to become President of the Royal College of Surgeons, attacked the duplicity of the political parties for unscrupulously deriving political capital from their support for the NHS, but in practice allowing the UK hospital system to degenerate to a state where it was both derelict and dangerous.[43]

The first significant concession by the government was announced on 1 July 1955, when a list of some twenty major capital projects was given official approval, but there was no timetable for these schemes, or guarantees about expenditure to meet these commitments. Many of these schemes had still not been started by 1962. The first tangible targets for spending on hospital development were laid down by the Guillebaud Report in 1956, which calculated that £30 million a year would be required to replace the existing hospital stock over a reasonable period. Thereafter this poorly authenticated figure became adopted as the scientific basis for hospital planning. The first significant political commitment in response to Guillebaud was contained in the 1959 Conservative

general-election manifesto, which promised to 'double the present capital programme'. This represented the fruits of the campaign launched by the Minister of Health in July 1958. Following the government's adoption of a five-year plan for school building, Derek Walker-Smith insisted on parity of treatment for hospital building. Only in 1960 was the case for a 'New Deal', 'New Look', or 'Forward Look' for hospitals accepted by the government; in recognition of the large scale of individual hospital building schemes, it was agreed to adopt a ten-year plan. Health authorities were notified about preparations for this plan in January 1961, and a White Paper collating the schemes submitted by regions was published in January 1962.[44] This hospital plan and its subsequent revisions constituted the blueprint for hospital development. It was envisaged that capital investment in hospitals in Great Britain would rise steadily to reach about £50 million a year by 1964. It was anticipated that, through a slow process of replacement of obsolete facilities, the district general hospital containing some 600–800 beds, serving a catchment population of 100,000–150,000, would become established as the basic building block for planning purposes within the hospital service and indeed for the health service as a whole. This hypothesis was built on slender intellectual foundations, and it was outlined in only the vaguest terms in just five pages of the 280-page White Paper. On the basis of the available evidence, it was far from certain that the bed norms adopted for the various specialities were realistic. The plan tended to understate the needs of services where expansion was envisaged, but overestimate the capacity for contraction in services where economies in provision were both sought and needed to prevent escalation in costs. The net effect of this reasoning was consistently to apply minimum values for the component costs of modernization. Consequently, even by 1964 it was evident that the hospital plan would be hugely more expensive than first envisaged. Initial expectations concerning completion by 1970/1 of 90 new and 134 substantially remodelled district general hospitals, together with 356 other major schemes, were soon consigned to the realms of fantasy. Despite this shortfall in the capacities of the hospital building programme, the new policy at least converted hospital renewal into a feasible option. For the first time since before 1914 comprehensive

new hospital facilities became a conspicuous feature of the capital investment landscape.

Primary and Community Care

Independent-contractor services administered by Executive Councils, together with the miscellaneous services administered by LHAs, comprised the disciplines soon to be known as primary and community care. These services were immediately important for remedial and emergency purposes; they also served a crucial front-line function, the effectiveness of which was essential for relieving pressure on expensive hospital facilities. From the outset it was also appreciated that for a diversity of client groups optimization of these services represented a more humane and desirable alternative to hospital care.

Although admittedly administrative relics, and not specially favoured by planners, the Executive Council and LHA services represented a point of stability and continuity, which was in some respects helpful, since they were called upon for a much larger burden of work than originally anticipated. The extent of their contribution is illustrated by the explosion of demand for medication after the Appointed Day. In June 1948, the last month of NHI, 6.8 million prescriptions were dispensed by chemists; by September this monthly figure had climbed to 13.6 million. The drug bill was one of the greatest expanding costs of the new health service. It increased from £18 million in the first year of the service to £114 million in 1963/4. Even allowing for price changes, this represented an increase of about 250 per cent. At the beginning of the service the cost of the pharmaceutical service was only about half the cost of the general medical service. The pharmaceutical service overtook the general medical service in its costs in about 1960 and was about 40 per cent greater by 1964. This change was brought about primarily by the growth in costs of individual prescriptions rather than by their number, indicating the remarkable advances brought about by the 'pharmaceutical revolution'. In 1951 the average number of prescriptions per person a year was 5.2, while in 1964 it was only 4.4, which was a very modest figure considering that a progressively higher level of demand might have been expected

from an ageing population. In constant price terms, the average net ingredient cost per prescription increased by about 210 per cent between 1949 and 1964. This change reflected the rapid pace of pharmaceutical innovation. Not only had the majority of drugs dispensed been unavailable before the onset of the NHS, but about 45 per cent of the preparations dispensed in 1965 could not have been prescribed in 1960.

Big advances were made with respect to both drug therapy and vaccines. Both contributed to the more effective control of acute infectious diseases, many of which ceased to be regarded with the dread that had been associated with their names before the First World War. A few recent discoveries such as sulphonamides, penicillin, and streptomycin were in use at the beginning of the NHS; by 1964 these were joined by dozens of other natural and synthetic antibacterials. Other important advances during this period were recorded with respect to corticosteroids, anti-hypertensives, anti-inflammatories, oral diuretics, analgesics, anti-epileptics, and psychotropic agents. In 1961 the introduction of oral contraceptives into general use represented a revolution in itself; among many repercussions of this change, as discussed in the next chapter, it forced the government to review its policy regarding family-planning services.

The inexorable rise in the drug bill caused alarm in government circles; many expedients to arrest this trend were tried, but none succeeded. In 1957 the Voluntary Price Regulation Scheme (later the Pharmaceutical Price Regulation Scheme) was introduced to curb the profits of pharmaceutical companies, but in the short term this generated only trivial savings. Each increase in direct charges produced only a temporary reduction in the number of prescriptions dispensed. In 1959 the government-appointed Hinchliffe and Douglas committees reported on prescribing practice in the health service, but neither offered prospects of significant economies. Indeed, from the government's perspective they made matters worse by concluding that prescribing practice, although not always efficient, was not generally irresponsible, that innovation would result in escalating costs, and that prescription charges were undesirable.

Apart from introducing ethical dilemmas, the advances in drug therapy introduced dangers as well as benefits, as indicated by the

tide of congenital deformities consequent upon the introduction of thalidomide in 1960, or by a rising problem of addiction, much of which was associated with the misuse of drugs available on prescription. The thalidomide tragedy underlined the need for more effective systems for the regulation of medicines than existed under the early NHS. On a voluntary basis, with the agreement of the pharmaceutical industry and the medical profession, in 1963 the government established the Committee on Safety of Drugs to advise on marketing, clinical testing, and adverse reactions of drugs. This Committee was given a statutory status and renamed the Committee on Safety of Medicines under the Medicines Act of 1968, which introduced more comprehensive arrangements for the control of drugs.

The NHS gave rise to a more concerted effort by LHAs to promote vaccination and immunization. Prior to the Second World War, vaccination for smallpox had been the only one of these procedures to be undertaken systematically. Immunization for diphtheria and BCG vaccination for tuberculosis had been available but not widely utilized. By 1964 protection against diphtheria, tuberculosis, poliomyelitis, whooping cough, and tetanus were available as a matter of routine. The control of tuberculosis was also advanced by systematic campaigns of mass miniature X-radiography among the civilian population. These had their origins during the Second World War, but were continued and extended under the NHS.

The torrent of demand experienced by general medical practitioners and pharmacists also applied to a small and struggling workforce of dentists and opticians, who accommodated a far greater volume of services than had been anticipated or allowed for in the financial estimates of the new health service. During the first eight months of the new service, the rate of demand for the general dental service ran at about eight million cases a year, which was twice the expected level. One-third of the patients treated required dentures, which indicated the terrible state of the nation's teeth and the extent of the backlog of demand. By the tenth anniversary of the new service, the balance had swung towards conservation dentistry, with dentures accounting for only one-tenth of the cases treated. Pressure on the general dental service steadily increased, with the result that the already severe shortage of trained dentists became

even more acute. By 1964 the UK was well in arrears of its Western neighbours in its ratio of dentists in relation to the population. This problem looked set to become steadily worse owing to the continuing resistance to fluoridation of water, the unfavourable age-structure among dentists, and the failure to implement in full the recommendations of the McNair Committee, which reported in 1956 on the crisis of recruitment in dentistry.

Although, as its name suggests, the Supplementary Ophthalmic Service was introduced as a stop-gap arrangement pending the development of a comprehensive hospital-based eye service, it proved to be cheap, effective, and popular; it was thereby the least problematical part of the Executive Council services. In the first eight months of the new service, some five million persons had their eyes tested and were able to select from ten different types of spectacle frames available free of charge. In 1950, when the industry was at last able to meet the full demand, about the same number had their eyes tested and the public was supplied with no fewer than 8.3 million pairs of glasses. After this initial peak, both sight tests and the supply of spectacles continued at a steady rate of about five million a year.

Some of the remedial functions of the new health service were met through the hospital service, which by 1968 had supplied some 600,000 hearing aids, but also such old-fashioned items as auricles, ear trumpets, and speaking tubes. The hospital service also provided large numbers of such varied items as surgical shoes and boots, artificial eyes, wigs, wheelchairs, and hand-propelled tricycles. For the most severely disabled, in line with provision for war pensioners, the new service also supplied power-propelled tricycles, which became the object of much experiment, with both electric and petrol-driven varieties. In the first decade of the new service, the old, open motorized invalid vehicles were superseded by all-weather machines which were designed to imitate saloon cars with their steel or glass-fibre bodies, hydraulic controls, and modern suspension units. The more advanced machines even contained folding invalid chairs for use at the end of journeys. Although small in scale, these facilities indicated the real attention of the new service to the needs of the severely disabled.

From the time of the Dawson Report, the ideal of unified

primary and community-care services had been tied up with the concept of the health centre. This idea was carried over into the new health service, providing an opportunity for all classes of independent contractors and LHA staff to work in cooperation. In practice medico-political tensions virtually precluded agreement on the establishment of health centres embracing both groups of staff. In the rare cases where concord was achieved, the health centre tended to be blocked by the health departments on the grounds of resource constraints, since virtually all funds available for health-service capital investment were pre-empted by the hospital sector. Consequently the health-centre plan was abandoned, thereby hindering functional unification of the primary and community services, and preventing attainment of their greater parity with the powerful hospital sector. The handful of health centres existing under the early NHS were a heterogeneous collection of institutions, some inherited from before the NHS, a few experimental centres mainly financed by philanthropic bodies, and a handful of new health centres only roughly conforming to the expectations of the NHS legislation. The latter were modest in their scale and pretensions, and, in the absence of leadership from the central department, they were not conspicuous for any concerted drive towards integration of functions. A review of health centres conducted in 1960 concluded that they failed to promote the kind of cooperative practice intended by the original planners, even to the extent that, in the few cases where independent contractors and LHA staff worked under the same roof, the two groups were partitioned off from one another; indeed even groups of general practitioners working in such centres developed no collective working relationship.

The virtual death of the health-centre concept under the early NHS contributed to the ossification in their pre-NHS form of the services administered by Executive Councils and LHAs, thereby impeding any shift towards a modern system of primary and community care. The general practitioner's surgery or the maternity and child-welfare clinic remained much the same unedifying environment as it had been during the Depression. In most respects the new health service conspicuously failed to reduce the traditional atmosphere of animosity and suspicion that for at least half a

century had characterized relations between the MOH and the general medical practitioner. In the past this cold war had not particularly mattered, but in the new health service absence of an effective working relationship was disastrous for the development of the primary and community services and, of course, fatal to the balanced development of the health service as a whole.

There was a real danger that general practice might retreat into its ghetto, deteriorate, and ultimately face extinction. The backward state of general practice at the beginning of the health service was described at length and in alarming detail by J. S. Collings in the *Lancet* in 1950. This review was greeted with fury at the time, but it is now generally accepted as a statement of the true situation. As summarized by Sir Theodore Fox, the editor of the *Lancet* at the time, the practices inspected by Collings were characterized by 'poor premises and equipment, deficient organisation and declining morale. Many practitioners inevitably deteriorated; ceasing to be the family doctors of the past, they did not fully use the methods of the present.'[45]

It was particularly difficult to ensure that medical practitioners were reliably informed about the most efficient therapeutic agents and educated to prescribe economically, reliably, and to the safety of their patients. The big differences in prescribing costs and habits exposed in the Hinchliffe and Douglas surveys, even between neighbouring general practitioners, suggested that many of them were not equipped to optimize the benefits of the therapeutic revolution.

Although the NHS excluded general practitioners from much of the hospital work that they had previously undertaken, they were by degrees granted full access to hospital diagnostic and pathological facilities. However, this important asset was exploited unevenly. A study of general practitioners in a large north-western industrial town reported in 1962 that three-quarters of the requests for hospital pathological facilities emanated from only one-quarter of the doctors, who were usually the younger and more recently qualified practitioners. The full range of available diagnostic facilities was exploited by some 10 per cent of these doctors. This neglect to employ the available diagnostic tools resulted in failure to detect identifiable and treatable asymptomatic conditions such

as diabetes. In view of such findings, it is not surprising that Forsyth concluded his review of evidence concerning the state of general practice before 1966 on the gloomy note that 'the family doctor is far from fulfilling the role assigned him within the NHS'.[46]

In the early years of the NHS the prospects for general practice were far from auspicious. Young practitioners were discouraged by the collapse of the health-centre scheme and by a system of remuneration that was indifferent to professional competence and enlightenment. More established practitioners lapsed into a perpetual state of distraction over NHS remuneration levels, which they regarded as a cheat. There was a vacuum of leadership owing to continuing divisions between the bureaucrats and medical politicians, rooted in their endless wrangles over pay and the legacy of hard feeling lingering over from a variety of old disputes going back as far as 1911. The medical schools and medical education were dominated by the hospital specialities. The NHS closed the door on flexible career patterns; it was no longer possible to combine hospital specialization and general practice; the high-flyers took command of the hospital specialities, regarding general practice as the province of the failure. General practice seemed to belong to an ageing remnant left over from the panel system, and to those doctors satisfied to play an ancillary role as 'gatekeepers' determining access to hospital services. Increasing specialization within the medical profession, entailing the elimination of general practice elsewhere in the West, suggested that the UK also was likely to fall into line with this aspect of modernization.

In the event, general practice not only survived, but slowly struggled to its feet and achieved a respectable and independent professional identity. Although the main consolidation took place after 1964, even before that date there were some encouraging signs of improvement. The Danckwerts Award of 1952 removed the worst complaints about levels of remuneration. Residual anxieties were quelled by a full review of the pay problem, conducted in an authoritative manner by the Royal Commission on Doctors' and Dentists' Remuneration chaired by Sir Harry Pilkington, which reported in 1960. This not only produced further economic gains, but set in place the Doctors' and Dentists' Review Body, which was designed to remove the confrontational system for determin-

ing pay. Although this objective was not always attained, in general the review body served the profession extremely well. Naturally, this has not given the government much satisfaction, but its failure to evolve a better alternative has allowed this method of pay determination to survive with little alteration until the present.

Changes in pay arrangements following the Danckwerts Award introduced minor incentives to group practice. A special fund was established to assist those doctors wishing to improve their practice premises. At the beginning of the health service about half of the independent general practitioners, known as 'principals', were practising single-handed; by 1964 this had fallen to one-quarter. The larger and more active partnerships proved to be a credible substitute for health centres. They led the way in the building of attractive practice premises, the employment of ancillary staff, and the utilization of hospital diagnostic facilities. Eventually, in a few areas with more innovative MOHs, attachment schemes were devised whereby local-authority staff were located in general practices rather than working separately on a territorial basis. At first this arrangement was largely confined to district nurses, but its success paved the way for the attachment of other local-authority staff. This innovation therefore constituted an important step in the development of the primary-care team. By 1964 group practices were the norm, but the groups were still extremely small; only 3 per cent of groups comprised six or more general practitioners. The predominant small-group practices were therefore not able to avail themselves of the full benefits of attachment schemes or other vehicles of collective activity.

In 1953 a minor change in medical education introduced an intern year following the undergraduate clinical period. This first year of vocational training involved no direct component relating to general practice, but it set a precedent, and experimental schemes were introduced in a few areas enabling trainees to gain experience of both hospital and general-practice work. The further development of education in general practice, as well as improvement in professional standards, became the special province of the College of General Practitioners, which was founded in 1952 and by 1964 had achieved a position of settled authority.

The steady advance of the hospital medical specialities and the

introduction of a long-term plan for hospital development underlined the need for more coherent policy guidance on primary and community care. This was especially urgent from the perspective of the government, since optimization of the capacities of these front-line services was indispensable for containing within reasonable limits the cost of the potentially ruinously expensive hospital development programme. Pressure for accelerating the development of local-authority residential and domiciliary services emanated from the Guillebaud Committee in 1956 and from the Report of the Royal Commission on Mental Illness in the following year, with the intention of reducing reliance on long-term hospital care for the elderly and the mentally ill. From the earliest stages of the campaign for a long-term hospital programme, it was also recommended that there should be a 'shift away from hospital and institutional treatment towards community care'.[47] Consistent with this aim, the Deputy-Chief Medical Officer insisted that 'hospitals must be organised primarily for the support of home care', for which purpose he called for much greater cooperation between medical staff from the three parts of the NHS.[48] Thereby both the terminology and the concept of community care assumed importance at this early stage in the history of the NHS, but the realization of this aspiration was much slower to come about.

In practice, local health and welfare services were treated as a low priority in the government's social programme. These services were therefore a favoured target for cuts in each expenditure round. Indeed, the gradual build-up of hospital capital development itself contributed to pressures for cuts in community care. Although ministers promised balanced development of the three parts of the health service, in practice plans for primary and community-care services were framed in order to avoid significant expenditure commitments. Even implementation of small policy advances, such as the establishment of standardized training for non-graduate social workers following the recommendations of the Younghusband Report of 1959, minor steps towards establishing a chiropody service, or permitting local authorities to provide a meals-on-wheels service, were held back for years, with the consequence that in 1964 these elementary and economical reforms were only just being realized.

In order to prevent the impression of complete inactivity and as a defensive measure against likely criticism, the Ministry of Health asked local authorities to provide information concerning their current services and intentions about medium-term expansion plans. In order to give this miscellaneous collection of information greater authority and a semblance of unity with the hospital plan, in April 1963 it was issued as the Community Care White Paper.[49] This was even more provisional and vulnerable to criticism than the hospital plan. It made virtually no attempt to establish objectively defined norms of provision for the many component services, merely assuming that the present pattern of services would be slowly expanded. This approach possessed two unfortunate limitations: first, the plans for expansion were unduly modest, especially considering the need for accelerated development of community care; secondly, no attempt was made to establish uniform standards, or even to reduce some of the more glaring disparities in provision between local authorities. Shortcomings in the estimates for expansion in community-care staff were exposed by the National Institute of Economic and Social Research (NIESR), which compared the local-authority plans for expansion between 1962 and 1973 with its own estimates based on the proposition that it was desirable to raise standards to the level of the 20 per cent best-performing authorities. Projections for expansion regarding three main community-care professional groups are summarized in Table 1.3. This indicates the extent to which notions of expansion held within central and local government were open to question.

TABLE 1.3. *Projected increases in selected community-care staff, England and Wales, 1962–1972* (%)

Staff	1963 White Paper forecast	NIESR estimate
Health visitors	44	88
Home nurses	27	70
Social workers	66	145

Source: D. Paige and K. Jones, *Health and Welfare Services in Britain in 1975* (Cambridge: Cambridge University Press, 1966), 112–13.

Even the relatively lay perspective of the NIESR implied that the bureaucrats needed to double their targets for expansion, while other expert voices believed that even greater increases, as well as major changes in policy direction, were needed to achieve a realistic programme of community care.

Although a limited exercise, the community-care policy document at least possessed a degree of government authority. Some thought was given to a similar policy statement on general practice, but in view of the risk of offending the medical politicians and on account of fear of expenditure consequences, it was decided to remit the question of the future of general practice to a low-status investigation conducted by a subcommittee of the Standing Medical Advisory Committee of the Central Health Services Council. Paradoxically, the resultant report, produced by a committee of experts chaired by Annis Gillie, a prominent woman general practitioner and leading figure in the College of General Practitioners, was superior to both the hospital and community-care plans. It was based on sustained investigation and contained a reasoned defence of its proposals, neither of which was a feature of the two White Papers.[50] The Gillie Committee was handicapped because of its remit, which excluded expenditure issues, and on account of background interference by the Ministry of Health, which prevented trespass into sensitive policy areas. Departmental intervention steered the Gillie Committee away from support for many reforms, including reorganizing the health service, reducing the maximum list size, accepting deputizing arrangements, or introducing stricter regulation of obstetric practice, all proposals which either possessed expenditure implications or were likely to be politically contentious. The scope of the Gillie Committee was therefore severely limited. In the main its report encouraged widely supported trends that were already underway, such as inducements to group practice, or loans for practice improvement, and greater assistance with provision ancillary help. A series of recommendations related to the improvement of general-practice vocational training in line with the thinking of the College of General Practitioners. By contrast with the 1961 Platt Report on hospital medical staffing, the Gillie Report rejected the idea that general practitioners should enhance their status through service in hos-

pital as 'medical assistants'. The Gillie recommendations envisaged some participation in the hospital service in such fields as psychiatry or obstetrics, but located the main field of work in the autonomous sphere of group practice.

Persisting Inequalities

The various parts of the new health service were successful in meeting immediate objectives relating to the extension in the scope and scale of services according to the most pressing priorities of the time. On the other hand, none of the sectors addressed itself effectively to problems connected with geographical and social inequality. The NHS therefore tended to mirror and perpetuate the accumulated idiosyncrasies and inequalities in health-care provision contained in the inherited system, which in the main reflected deep-seated patterns in the distribution of wealth, which had determined that those sections of community experiencing the greatest problems of ill health were provided with the worst health services. At the outset of the new health service, the better hospitals and more generous services tended to be concentrated in the areas around London, whereas the least well-provided hospital regions coincided with the former depressed areas, which in the main were the centres of heavy industry.

Although some measures were taken to iron out the worst anomalies concerning the distribution of general practitioners or the provision of consultant services, the impact of these efforts was limited. The resource distribution system therefore tended to preserve the disadvantages of the deprived regions. It was also evident that disadvantage with respect to one part of the health service was not likely to be compensated for by more generous provision in another. The metropolitan regions and their neighbours possessed the more generously resourced hospital service, also the greater concentration of general practitioners, group practices, and dentists, as well as the lion's share of younger and more innovative practitioners. Conversely, the northern regions and Wales were likely to have the less-well-resourced hospital service, the least concentration of general practitioners, group practices, and dentists, and a preponderance of older practitioners. Since there was no retirement

age for independent contractors, there were large numbers of older practitioners, including many in their eighties, who were likely to be out of touch with modern and safe practice. In 1958 about 16 per cent of dentists were aged over 65, while 7 per cent of general practitioners were aged over 66.

Inferior quality of service and lower patient expectations also followed the gradient of resource provision. Thus in the more prosperous south-east of England better-qualified dentists predominated and conservation dentistry gained ground more rapidly, whereas in the industrial areas there were greater numbers of the untrained '1921 dentists' and a predominance of extractions and dentures. In London and the south-east in 1958, for every tooth extracted, more than three were filled, but in Wales and the north of England less than one tooth was filled for every one extracted.

In 1952, comparing the West Midlands and the south-west of England, the latter held a 26 per cent advantage with respect to the number of general practitioners per 100,000 population; by 1963 this gap had been reduced to 20 per cent. The original intention of Bevan to correct imbalances in the distribution of general practitioners was almost completely thwarted by the obstructionism of the BMA. Consequently, in 1964 the distribution still reflected the historic pattern, with average list sizes ranging from 3,116 in the Burton-on-Trent Executive Council at one end of the league table to 1,434 in Radnorshire at the other extreme.

At the start of the health service the Manchester and Sheffield regions were at the bottom of the league table of consultant numbers, while the North West Metropolitan region was at the top. At this stage, estimated in whole-time equivalents, there were 17.5 consultants per 100,000 population in the North West Metropolitan region, with 8.2 per 100,000 in the Sheffield region. The corresponding levels for 1965 were 22.8 per 100,000 population in the North West Metropolitan region and 11.8 per 100,000 in the Sheffield region, which represents increases of 30.3 per cent and 43.9 per cent respectively. The gap between the two regions therefore narrowed, but the metropolitan region retained a comfortable advantage over its northern partner. The higher concentration of teaching hospitals provided the main explanation for the huge lead of the metropolitan regions at the beginning of the

health service, and this was sufficient to guarantee a continuing advantage. The league table of regions was not entirely unchanging. At the start of the NHS, Newcastle was firmly among the impoverished regions with respect to consultant numbers, but by 1964 it had joined the leaders. However, with respect to the independent-contractor and community services, with the exception of Newcastle itself, the area covered by the Newcastle hospital region remained conspicuously backward.

Although the occasional voice was raised concerning the questionable character of the mechanism for resource distribution within the hospital service, this issue never attained the prominence it deserved during the early years of the NHS. The first tabulation designed to draw attention to disparities in resource distribution dates from 1950, when the Welsh Hospital Board pointed to its own disadvantageous position. The first more elaborate presentation seems to date from 1964. Although this adopted a different methodology from the Resource Allocation Working Party (RAWP) a decade later, it is useful to draw together, as shown in Table 2.2, the 1964 calculation, the findings of RAWP relating to the mid-1970s, and the situation arrived at in the 1980s indicating the full impact of the RAWP system.

Despite their limitations, the calculations made in 1964 are valuable for indicating the large scale of the disadvantage of the less-favoured regions. Also, since the situation had changed little since 1948, the tabulation from 1964 arguably gives some indication of the scale of the inherited disadvantage of these regions that the NHS had singularly failed to address. Therefore, although the NHS had laudable consequences from the perspective of the poor, the historic north–south divide in social welfare and health care remained very much in evidence. This inertia with respect to questions of spatial resource distribution was obviously a substantial obstruction to progress with the declared egalitarian objectives of the new health service.

Awkward Questions

Unquestionably the health service gave ample proof of its capacity to deliver great humanitarian benefits at a surprisingly low cost.

Many of the limitations of the NHS were attributable to shortage of resources. Consumers tolerated this situation with their habitual stoicism; but unlike their attitude to earlier disappointments, they were optimistic that the new system was basically sound and able to move forward as circumstances permitted.

Resource constraint was indeed a main handicap, but, as indicated above, the problems of the new service were more deep-seated than was realized by the public. Despite a superficial impression of well-being, the health service was riddled with anomalies and basic flaws. The interests of social justice were hardly served by the distribution of resources according to past precedent rather than proven need. It was also not clear that resources were used to the best effect, or with regard to the stated policy priorities of the government. By contrast with the above-mentioned Guillebaud Committee and the Abel-Smith and Titmuss investigations, the Public Accounts Committee and the Select Committee on Estimates were less concerned with inadequate resources than with evidence concerning profound inefficiencies in their utilization. The main targets for criticism were the new hospital administrative bodies, which were regarded as extravagant and badly managed. Persistence of this reputation provided a ready excuse for denying the health service additional resources, even for purposes for which there was a proven need and where the investment represented a contribution to longer-term economies. Within Whitehall and among experts on the machinery of government, the new and unfamiliar system of administration adopted for the NHS was, therefore, not regarded as a success. Rather, it was the object of distrust on account of its complexity, lack of accountability, confused management arrangements, and alleged inefficiencies.

Of course, the complexity of the system was not a matter of design, but a reluctant necessity, aiming to accommodate a variety of powerful interest groups. The resultant arrangements were suspect; such fundamental goals as the balanced development of the system, functional unity and continuity of care, or the promotion of such important objectives as teamwork within primary care, or community care within the local-government sector, were dependent on effective leadership from ministers and their bureaucrats, which proved well beyond their capacities, especially before 1960.

The performance of the Ministry of Health noticeably improved after 1960. This advance was assisted by the appointment of Sir Bruce Fraser as Permanent Secretary and Sir George Godber as Chief Medical Officer. The former was the first Permanent Secretary in modern times to be recruited from the Treasury. Sudden retraction of the Treasury's objections to a long-term plan for hospital building was the first fruit of this change at the top of the Ministry of Health and it ushered in a new phase of constructive partnership. The experienced Sir George Godber adopted a robust approach to his duties, reasserting the role of the medical administrators within the department and providing much-needed leadership in the many areas where changes in policy required delicate negotiation with the various arms of the medical profession. Under Fraser and Godber various working parties were instituted which laid the foundations for the Family Doctors' Charter and new medical management structures adopted in the hospital system.

It was inevitable that at some stage the longer-term viability of the tripartite system of administration should come into question. In line with the prevalent ethos in social administration at the time, the Ministry of Health and other advocates of the status quo placed their faith in the capacity of cooperation to overcome problems associated with the over-complicated administrative structures of the NHS. Despite exhortation from ministers and reports on cooperation from committees of the central consultative structure, there remained persistent and serious problems of duplication, fragmentation, and lack of cohesiveness, all characteristics horribly reminiscent of the defects of services before the NHS. The passage of time produced no evidence of meaningful cooperation between the three main arms of the health service. Although introducing some elements of simplification, the system adopted in Great Britain in 1948 divided responsibility for the new health service between no fewer than 850 main administrative bodies. In any one natural geographical area it was likely that services would be distributed between a variety of autonomous health authorities, each with its separate tradition and fiercely protective of its autonomy. The situation was in some respects more complicated than before the NHS, when, with respect to such services as maternity and child welfare,

tuberculosis, or the mental sector, some individual local authorities had provided reasonably comprehensive services. In such fields, the new health service effectively disrupted some hard-won gains in continuity of care.

The dysfunctional characteristics of the NHS administrative system were particularly evident in areas such as Tyneside where numerous authorities were crowded into a small geographical area, or when it was necessary to develop services for new towns, such as Milton Keynes, which compared in scale with major cities. When Humberside was created as a new health service administrative unit in 1974, it was constituted from no fewer than six LHAs, six Executive Councils, and eight HMCs belonging to two different regions.

With the above disadvantages in mind it was inevitable that the case for reorganizing the health service should eventually force itself onto the political agenda. No encouragement for this move emanated from the Ministry of Health, which used its influence to determine that a series of independent reports, beginning with the Guillebaud Report of 1956, were unsympathetic towards reorganization. This view prevailed, for instance, in the Salmon Report on nursing administration and the Farquharson-Lang report on hospital administration in Scotland, both dating from 1966. However, the line against reorganization was difficult to hold. Already in 1956, Sir John Maude's long note of reservation to the Guillebaud Report had called for the administrative unification of the health service under local government.[51] The same conclusion had been reached by Aneurin Bevan, who since 1945 had accepted that 'If at some future date local government can be reorganised on a wider regional basis—as we all want to see it—a situation may well arise in which we could adapt this system of hospital regional boards to the reorganised local government system, and perhaps get the hospital services back into a more modern form of local government.'[52] Both Maude and Bevan had no doubt been influenced by the revival of plans for local-government reorganization, which inevitably revived consideration of the merits of reversion to local-authority control over the health services.

Apathy on the part of the Ministry of Health and assertiveness from the local authorities created conditions for a recapitulation of

earlier competitions for dominance. Not to be left out of the race, as after the First World War or at the outbreak of the Second World War, the medical profession buried its internal differences in order to mount a spirited pre-emptive strike. With the advantage of their superior forces, specialized knowledge, and a powerful investment of political energy, the doctors were well equipped to outpace all their rivals. The vehicle for their initiative was a committee formed in 1958 by nine leading medical organizations to review the state of the medical services in Great Britain. This committee, under the chairmanship of Sir Arthur Porritt, the former Olympic athlete and leading surgeon, completed its report in November 1962.[53] This report contained a competent and critical survey of the health services, but it is primarily remembered for its conclusion that requisite improvements in health care were unlikely to be attained without reorganization of the health service. The Porritt Report called for assimilation under a single authority of all health services located in each natural area of administration. In most respects this represented a revival of the model favoured by the Dawson Report of 1920 and the BMA in 1938. Accordingly, the Porritt Report rejected local-government administration of a unified health service. It was therefore firmly outside the tradition represented by the Royal Sanitary Commission, the Minority Report of the Poor Laws Commission, Sir Robert Morant in his capacity as architect of the Ministry of Health, and this department during the first decades of its existence.

Although not widely publicized, or particularly well received even within the medical profession, the Porritt Report became the effective catalyst to furthering the case for reorganization. Only with difficulty was the Gillie Committee dissuaded from giving explicit backing for the Porritt Report. Nevertheless, the Gillie Report, like most other expert reports after this date, concluded that effective integration of functions was unlikely to be attained without reorganization. This conclusion clearly echoed the mood at the grass roots, indicating that mutual suspicions between the various professional groups were at last beginning to fade. John Revans, the Senior Administrative Medical Officer of the Wessex region, and a member of the Gillie Committee, in November 1962 issued a questionnaire to all general practitioners asking them to

state what further hospital facilities they would like provided, on the assumption that 'sooner or later greater integration would appear to be inevitable'.[54] Wessex was also the area with the fullest development of schemes whereby LHA staff were attached to general-practice groups. In both Scotland and Wales the BMA quickly drew up schemes for the application of Porritt principles to their health services and there was sympathy for this development in Northern Ireland. Thus by 1964 the principle of reorganization was widely conceded throughout the UK. Apart from higher levels of funding, this was seen as the single most effective measure likely to bring about improvement in the efficiency and effectiveness of health care. The groundswell of support for reorganization was impressive and it suggested a new mood of constructiveness and commitment to the NHS on the part of the medical profession, but this opportunity for fundamental reappraisal required, as a necessary condition for its success, leadership or at least a degree of compliance from the Ministry of Health. Given the sovereign position of the Ministry, little progress could be made without its acquiescence. In the event, the bureaucrats displayed their customary reticence, with the result that the opportunity for decisive action soon melted away; reorganization was thereby converted into an intractable problem, delayed for a decade, and then accomplished without conviction or success.