ATTLEE MEMORIAL LECTURE - FEBRUARY 1993

THE NATIONAL HEALTH SERVICE - PAST, PRESENT AND FUTURE

given by
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I much appreciate the honour of being invited to give the 11th Attlee Lecture. Unlike my 10 predecessors I did not know Earl Attlee well, but I did know him. In my last year at school back in 1933, I spent an afternoon and evening with him, culminating in a mock House of Commons debate, conducted in front of the whole school, in which Major Attlee was Home Secretary and I was Prime Minister. I have always remembered, though not always followed, his advice on public speaking, "Keep it short and sharp" but, sadly, I have not yet had the opportunity to put into practice the detailed advice he gave me as to how to behave as Prime Minister.

The National Health Service is a most appropriate subject for a meeting of the Foundation formed 25 years ago to honour the Prime Minister who launched it in his broadcast to the nation on 4th July 1948, and the London Hospital is a very appropriate place, both because of its own very considerable contribution to the N.H.S, and because it has served the inhabitants of the East End, who meant so much to Earl Attlee, since people first came to live in the green fields of Whitechapel.

The "N.H.S. - past, present & future" is an enormous subject, especially as its origins before 1948 have as much bearing on its strengths and weaknesses today as anything that has happened to it since. I shall, however, follow another bit of advice given to me in 1933 by Major Attlee - "Tell the truth as you see it and don't stop till you've told it all."

It was back in 1909 when Beatrice Webb and others referred to the idea of a state medical service in a minority report on the Royal Commission to Reform the Poor Law. The National Health Insurance Act followed in 1911, enabling working men to get General Practitioner care on the 'Panel', but Boards of Guardians were left to continue providing services for maternity and child welfare, infectious diseases, TB, VD, the mentally ill and handicapped, and for the infirm in the Workhouses. The only hospital care available to those not in a Workhouse was provided by Voluntary Hospitals run by Charities.

In 1912 the Guardians of the City of Birmingham decided to try to turn their two main workhouse infirmaries into general hospitals for the acute sick, funded by the rates and available to anyone. Almost at once the Great War intervened and the experiment really got under way only in 1918. And the same year saw another stepping stone on the road to the N.H.S. when Lord Dawson of Penn, physician to the London Hospital, argued the need for a National Health Service in the Cavendish Lectures.

The following year the Ministry of Health was established and promptly appointed Dawson to chair a committee to consider medical and allied services. So 1920 saw the laying down of what may fairly be called the foundation stone of the N.H.S., the publication of the Dawson Report.

It recommended a National Health Service funded by the state, free at the point of delivery, to provide what Dawson called Primary & Secondary care. Primary care was to be centred on publicly funded Health Centres from which teams of whole-time salaried doctors, dentists, pharmacists, nurses, midwives and health visitors would provide both preventive and therapeutic services. Secondary care would be given in hospitals and the planning of it would be integrated with that of Primary care. The Service would set out to meet all needs and would be organised on a Regional basis.

That report is still generally recognised as a blueprint for a modern comprehensive health service. It bears a striking resemblance <u>not</u> to the service we have today, but to the kind of service which many subsequent reports (up to and including Tomlinson) suggest we should be working towards.

Dawson reckoned "we would move towards it by instalments, almost by stealth." The first instalment began with the success of that experiment in Birmingham which showed that general hospitals for the acute sick could be funded off the rates and manned by whole-time salaried physicians and surgeons of the same standard as the staff of Voluntary Hospitals. It is appropriate to note that 3 of the first surgeons to staff Dudley Road Hospital, Birmingham, all received their training as First Assistants here at the London hospital - Hamilton Fairley, McNeill Love and George Huddy.

Other cities developed similar hospitals and then in 1929 the Poor Law was abolished. City and County Councils were required to take over the functions of Boards of Guardians and to provide Municipal Hospitals. By 1939 Municipal Hospital beds out-numbered those in Voluntary Hospitals by 4 - 1, an astonishingly rapid development which I was privileged to watch at close quarters because the surgeon appointed Chief Medical

Officer to Birmingham in 1912 was my father. So as a student here at the London in the late 1930's I was able to compare the country's largest Voluntary Hospital with its largest and oldest Municipal Hospital.

Both differed from most hospitals of today in that they were extremely quiet and spotlessly clean. They differed from each other in that Dudley Road Hospital cost the ratepayers of Birmingham quite a lot, whereas the London Hospital cost the state nothing. The highly distinguished physicians and surgeons gave their services free, as did the lowest form of hospital life, (who provided most of the day-to-day medical care) we students.

Here at the London everyone was united in their determination to offer the highest possible standard of care to as many of the local poor as the lay governors thought could be cared for at that standard. The hospital was nearly always nearly full. Extra beds were never put up and the lay governors might decide from time to time that certain types of patient would not be admitted.

Back home at Dudley Road everyone was united in their determination to give the highest possible standard of care to everyone who needed admission, irrespective of the condition from which they suffered. When the hospital was full, extra beds were put up, first in the wards, then in the corridors, then the balconies.

So the two types of hospital, differing in their aims and practice, complemented each other. But the Voluntary Hospitals, though facing increasingly grave financial problems, greatly disliked the idea of ever coming under the control of Local Authorities.

The problem of how to combine those two kinds of hospital in a single service was solved by Hitler. It was estimated (on the evidence of the Spanish Civil War) that 300,000 beds would have to be provided in Britain for civilian air-raid casualties in the event of war with Germany. When it came, without more ado all hospitals were recruited into a temporary Emergency Medical Service divided into 5 Scottish and 12 English Regions, with London divided into 10 sectors, 2 of which came under this hospital. 50,000 additional beds were raised, and National Blood Transfusion and Public Health Laboratory Services were established.

Somehow that seemed to galvanise everyone into a state of excitement about the future of medical services in Britain. Throughout the next few years, 1940 - 1943, the country was fighting for its life and not too successfully.

They brought Norway, Dunkirk, the Battle of Britain, the Blitz, the Battle of the Atlantic and the fall of Singapore, but astonishingly, they were years in which government and all kinds of individuals and institutions combined to plan, jointly, proper medical services for after the war. Official reviews revealed 85% of the population keen on a state medical service. Everyone from the Royal College of Physicians to Picture Post hastened to design one. The B.M.A. set up a Medical Planning Commission under the chairmanship of Sir Henry Souttar, surgeon to the London Hospital.

In October 1941, the Coalition Government announced that as soon as maybe after the war it would ensure a comprehensive hospital service.

In February 1942, a committee was set up under Sir William Goodenough to recommend what should be done about medical education in a National Health Service, because half the country's medical students were trained in medical schools belonging to and run by 13 Voluntary teaching hospitals in London.

In June 1942, a committee was set up under Sir William Beveridge to decide what to do about National Health Insurance. The Beveridge Report was published just 6 months later, recommending what we call the 'Welfare State' and including, of course, a National Health Service.

That was December 1942, and the following month the Ministry of Health prepared a draft N.H.S. Bill modelled on the Dawson plan. The Coalition Government announced its commitment to a National Health Service, pointing out that it would be many years before a full range of services could be provided. In March 1943, Churchill broadcast these plans to the nation.

Then, in early 1943, things changed. For one thing, the war changed - from 1943 on, we were not exactly winning, but we were certainly no longer losing. Anyway, attitudes began to change - certainly, the attitude of the B.M.A. changed or, at least, that of its leadership, though perhaps the leadership was not fully representative of the members who, like most other doctors in 1943, were scattered around the world and soon to be scattered even more. But the leadership became anti Health Centres, anti whole-time service, anti salaries. It ceased to plan with the Department of Health and began to negotiate instead.

Nevertheless, the White Paper on the N.H.S. published in February 1944 was still modelled on the Dawson plan. It outlined an integrated decentralised service, based on Regions, with a major experiment in Health Centres, and all new G.P's to be whole-time and salaried for at least their first 4 years.

In May of the same year, 1944, the Goodenough Committee on Medical Education reported, recommending a University education for all doctors, followed by post-graduate practical training, beginning with a pre-registration year. The London Medical schools were to be reduced from 13 to 12, removed from teaching hospital control and funded by the State through a University Grants Committee as Colleges of London University. Some London teaching hospitals should be resited and the medical colleges should have access to groups of hospitals. The report attracted little attention because it coincided with the Normandy invasion, but the government approved it and when the war was over the University Grants Committee began to implement it, thus deciding the direction in which medical education was to develop from then on.

One year later, in April 1945, a first draft of the N.H.S. Bill was prepared and printed but not published because in May came Victory in Europe and the end of the Coalition Government. In the ensuing general election, the N.H.S. was not an issue as both main parties were committed to it. Labour was elected and Mr. Attlee appointed Aneurin Bevan as Minister of Health.

Nine months later, in March 1946, the N.H.S. Bill prepared by Aneurin Bevan was published. To almost everyone's surprise, it was very different from the White Paper of the previous year and from all previous plans.

1) The concept of an integrated service was abandoned. Instead, there would be 3 separate services: 1 for hospitals, 1 for local authority services, and 1 for general practitioner services. Another was added later for medical health services, making 4 separate services, each responsible to the central Ministry of Health or Department of Health for Scotland.

2) All hospitals would be taken over by the State and administered by the government departments through a two-tiered system of Regional Hospital Boards and Hospital Management Committees. Teaching hospitals in England and Wales would be directly responsible to the Minister of Health.

3) Hospital medical staff would be salaried but could be part-time if they wished.

4) Private and amenity beds would be available in all state hospitals.

5) Local authorities would lose control of their hospitals but remain responsible for other services and for the Ambulance Service and for any Health Centres that might be built.

6) G.Ps. would not be required to join the N.H.S. but would remain outside it and contract with it to provide for everyone those same services on the panel that they had been providing for insured men since 1911.

So the N.H.S., instead of being based on the new concept of Primary Health Care delivered from Health Centres, was based on the pre-existing system of health care. It had evolved in Victorian times when most of what medicine had to offer could be provided by general practioners in the home or surgery, in a nursing home or cottage hospital. Those who were not on the panel and could not afford a general practitioner, went to the nearest hospital casualty department or to a dispensary.

Many countries had developed a similar system but here in Britain it had two features which were, and still are, almost unique. Here there was and still is a firm divide between G.Ps. and hospital doctors. G.Ps. did not and do not have admission rights to anywhere other than a small cottage hospital. Hospital doctors see only those patients referred by G.Ps. or who come to hospital as emergencies. This long-standing divide with G.Ps. and hospital doctors was powerfully reinforced when hospital doctors became employees of the N.H.S. and G.Ps. remained outside it.

Our hospitals too were, and until recently remained, organised in an almost unique way. Whereas in most countries there are departments of medicine, surgery, psychiatry, etc., each with its own head or clinical director, in Britain a hospital has had as many independent clinical units as it has physicians and surgeons appointed to its staff. In 1946, therefore, the pre-existing pattern of health care was not a very satisfactory one on which to base a National Health Service.

The B.M.A. and many doctors, particularly G.Ps., nonetheless favoured the continuation of the old system and the public were happy that family doctoring which previously had been restricted to those women and children who could afford it, would now be available to all. The media demanded immediate action and the quickest way forward, in view of the various vested interests, was to set up the N.H.S. in separate parts and leave the G.Ps. - who it was still hoped would provide most of the care - outside the service as sub-contractors.

Ironically, those who might have been expected to oppose the Bill, such as Labour members of Parliament who had been hoping for a salaried service in hospitals and health centres, voted for it. Those who might have been expected to acclaim it most, such as the B.M.A. leadership, campaigned vigorously against it. But Royal Assent was received in November 1946, and the day appointed for the start of the service was set for 5th July 1948 - leaving 18 months for the Health Departments to plan a service quite different from the one they had been planning for so long.

So the National Health Service, conceived somewhere between 1909 and 1918, went through a gestation period of at least 30 years before labour was induced and a precipitate delivery took place - circumstances likely to result in the child being born with some congenital handicaps. In some ways 1948 was not altogether a bad time in which to start the service. After 6 years of war and 8 years of rationing, the population was probably healthier than at any time before or since. And the health professions were still regrouping after the war and longing to settle down again, preferably in a familiar system.

On the other hand, despite the commitment to the enormous task of providing comprehensive medical care for the entire population from day one, the N.H.S. could not offer on day one anything that was not there before - not a single nurse, or doctor, G.P. surgery, health centre or hospital. And the buildings that were available, which had been inadequate in the 'thirties, were in a deplorable state by the late 'forties. Most voluntary hospitals had only been able to afford minimal maintenance before the war, and many municipal hospitals were in converted infirmary buildings. More than half the hospitals taken over in 1948 were over 50 years old - many were over 100 years old. Many had suffered extensive war damage, none had had more than a lick of paint for 8 years. Surgeries were in little better condition.

More important still, all the hospitals and all the surgeries had been designed for, or adapted to, the medicine of the 1930's, the medicine of "Dr. Finlay's Casebook". It is quite difficult to realise now that in the 1930's surgery was beginning to advance but had not yet sub-divided into specialties other than eyes and ears. There were a few departments of neurosurgery, the oldest of them here. Separate orthopaedic departments were rare. Only Henry Souttar of the London Hospital had operated on a heart valve. The first ever paediatricians were still in post. Medicine, as opposed to surgery, was comforting but largely ineffectual, bar a few breakthroughs like insulin and, in 1938, the first sulphonamides. Psychiatry was very suspect. We had no psychiatric consultant here, only a registrar attached to the physicians interested in neurology.

In the 1930's, the wealthy had had their illnesses at home or in a nursing home, attended by G.P's and visited by a physician or surgeon. Those specialists, as they were then called, did a great deal of travelling. Those on the staff of the London would often call on this hospital to send nurses from its private nursing staff to care for their distant patients. When not required for such duties the private staff augmented the number of trained nurses in the wards. Hospitals in the 1930's, voluntary and municipal, were for the poor who were reluctant to enter as so many of those who had done so had failed to come out alive.

In 1948 the premises designed for that 1930's kind of medicine now had to provide something very different, for medicine had changed much during the war because of advances such as antibiotics, major improvements in anaesthesia, blood transfusions, all leading to great and rapid developments. Prevention had not greatly advanced, but more diseases could be cured, many more could be diagnosed with much greater precision, and far more could be treated. More important - medicine had become concerned with disorders of function, of mind as well as of body, and not solely with disorders of structure (organic disease) with which British medicine had been preoccupied for the previous 100 years. Medicine at the end of World War II was rapidly becoming as different from the medicine of the 1930's as that was from the medicine of mediaeval times.

It had also become capable of causing harm unless used in precisely the right way at the right time. At one extreme it could be safely applied by rule of thumb by non-medically qualified personnel. At the other, it had become so complex as to need a team of doctors, nurses and other professionals, using facilities in purpose-built premises. All too often, the precise diagnosis required for safe and effective therapy began to depend upon careful assessment of not only the physical and chemical, but also the psychological and social aspects of disease. Medicine was becoming holistic, individualised, slow and expensive. So the N.H.S. set out to provide that new medical care with not only a Victorian pattern of health care delivery but with grossly inadequate resources and a desperate need for new buildings.

But capital investment was impossible, not just because there were so many other urgent demands on the public purse, but because the running costs of the N.H.S. turned out to be far greater than had been expected. The first year's cost had been estimated at some £130m., but another £52m. had to be found for the first 9 months. Prescription charges had to be imposed and capital expenditure on hospitals - which had been £35m. in 1938/39 - was limited to an average of £7m. for each of the first 5 years of the N.H.S. In the 10th year it rose to £19m. just over half of what was spent in 1938/39. Part of the service's escalating running costs were due to the Dankworth Award which resulted in considerably higher fees for General Practitioners, back-dated for several years. Fortunately, some used that windfall to improve their premises.

Nonetheless, in the 50's the service kept going - people got treated - medicine advanced and became more specialised - and until specialist departments could be built up in district hospitals, people flocked to teaching hospitals; the N.H.S. paid the travelling costs, and people waited. But waiting caused no surprise or complaint; everyone had been queuing for everything from at least 1939. Besides, the old reluctance to be admitted to hospital was still there.

What the service depended on in the 50's was its staff, or rather the fact that hospital staff of all kinds had long been used to hard work and used to responding automatically to emergencies and making an extra effort. The greatest burden undoubtedly fell on junior hospital doctors, young house officers (pre-registration came into force in '53), registrars and senior registrars - many of them ex-service men who had taken up medicine after the war and had wives and children. They were seeking the post-graduate training they knew that modern medicine required - they got experience but little formal training and no training programmes. They worked appallingly long hours with ever-increasing responsibility, frequently having to change jobs, putting up with miserable accommodation and with such poor pay that many had to sacrifice rare weekends and holidays by deputising for general practitioners. Their seniors took the attitude that when they were young they had no pay at all.

The consequence was emigration. When the little old lady asked "Where do all the awful medical students go and the nice young doctors come from?" she was informed correctly that the awful medical students go to America and Australia and the nice young doctors come from India and Pakistan. At the time we had 2,500 overseas doctors working in hospitals in England and Wales, but the Willink Committee set up by Government to report on medical manpower said we were in danger of having too many doctors and entry to the medical schools was reduced.

But at the end of the 50's the B.M.A. and the Royal Colleges set up a committee under Sir Arthur Porrit to review the N.H.S. after 10 years. I joined it half-way through as the representative of the College of Physicians and found it enthusiastic about the N.H.S. but worried about its division into separate compartments. It recommended Area Health Authorities in which all services would be integrated. It favoured group practices rather then health centres. It called for the Departments of Health to facilitate the post-graduate practical training which doctors needed so badly.

By the 60's medical advance had combined with social and economic changes to alter the pattern of disease. There was less acute illness, especially in the young; conditions like osteomyelitis, diphtheria, rheumatic fever, acute nephritis, were becoming rare. Tuberculosis was coming under control and antibiotics were increasingly effective. But demand for medical care, instead of falling continued to rise, not least because of chronic disorders.

All of a sudden it was clear that we, like every other country, were desperately short of doctors. We were producing 1,500 p.a., of whom 200 returned to the countries such as Norway and S. Africa from which they had come. The University Grants

Committee, of which I was then a member, considered a government minister's outspoken view that we needed 24 new medical schools at once. We, however, busy implementing the Goodenough Report of 1944, were well aware that all our 30 existing medical schools were out of date, so it was decided to combine expansion with modernisation: to build one new school and start rebuilding all the others to about twice the previous average size - and to provide each with one or more modernised teaching hospitals. This vast investment began in Scotland and the provinces, and by the end of the 60's we had doubled our rate of production of doctors, and modernised many schools. Sadly, capital monies ran out in the 70's before some of the London schools, such as this, were reached.

The 60's also saw new attitudes and new activity in regard to post-graduate training and continuing education. The Departments of Health which had previously declined to play any part in the training of doctors, now accepted that the responsibility of ensuring practical training after University graduation was theirs, and that they must also help to keep doctors up-to-date by providing facilities for continuing education. That change of attitude was largely due to a new Chief Medical Officer, George Godber, who had himself been trained at the London Hospital. He looked to the London for help at the Ministry for Health in undertaking its new training activities and press-ganged me into working there as a part-time P.R.O. for the next 5 years. I found myself working with people who were wholly dedicated to running the best possible service - but not all aware of the great changes that had taken place and were still continuing in medicine.

Better conditions for junior hospital doctors began - study leave, better facilities, better pay, and over the next decade 300 post-graduate medical centres (with facilities for training and education, including libraries) were built in district hospitals in England and Wales. The Family Doctor Charter introduced incentives to raise standards in general practice, and a Royal Commission on Medical Education set in motion arrangements for proper post-graduate training programmes and for monitoring them. Rapid progress was made but the profession asked for time to consider vocational training for General Practice, which did not become mandatory for another 10 years.

The Royal Commission also recommended the rationalisation of the 12 London medical schools and 20-odd post-graduate institutes into 6 university medical centres, each eventually adjoining a multi-faculty university college. It also recommended an independently chaired committee for London to ensure that long-term plans were not nullified by short-term interests. The vested interests concerned promptly ensured that there was no committee.

But on the whole the 60's saw the Health Service progressing rather well. It was able to provide more of the increasing amount medicine could do - demand continued to rise, people were less fearful of hospitals and increasingly anxious to go there when ill.

It is paradoxical that in a decade when young men in the media and in show business made fortunes making fun of the established order of things, and it became fashionable to be contemptuous of the customs and attitudes which had guided people in the past - in that same period people's faith in most things was destroyed but their faith in medicine grew greatly. Expectations became grossly inflated - medicine seemed to many to be the cure for all man's ills.

And with the 70's the ills came thick and fast intensifying demand, but the oil crisis and consequent collapse of the national economy which caused the ills, also caused cutbacks in the service, and fewer of the demands upon it could be met. It was decided to re-allocate resources, to reduce the annual allocations to regions which, for whatever reason, had been better funded in the past, in order to increase the funding of those which previously had received less.

The main cuts fell on London but were, to some extent, buffered by money from another source. The Royal Commission on Medical Education had recommended additional money for London medical schools to enable them to employ the academic clinical staff they had previously lacked. The U.G.C. now provided the money and the University divided it, not into 6 groups with inexplicable irresponsibility, but between all the 12 schools and 20 post-graduate institutes. This school gained nearly £1m. a year, Bart's about £½m. and the two combined to appoint staff jointly. Elsewhere professors and senior lecturers mushroomed filling the gaps left by N.H.S. cutbacks but storing up problems for the future.

In 1974 the Hospital Service was re-organised into a system of Regional Health Authorities, Area Health Authorities and District Management Teams. Greater local representation was achieved at Area level. District Management teams required to manage by consensus found that getting agreement to anything, other than to disagree, was a slow business. Regions, Areas & Districts all carried G.P. representatives but had no possible way of achieving local change in the general medical services, and virtually none in Local Authority services either.

For the first time strikes spread to the N.H.S., closing hospitals and building up waiting lists. Threats of strikes by junior hospital doctors led, not to improved pay which would have been justified and cheaper in the long run, but to overtime payments. The old ethos of reacting to emergencies with immediate extra effort without immediate extra reward, which had served the N.H.S. so well in the 50's, took a knock from which it has not recovered.

A sillier mistake was to have even more serious financial repercussions in the long term. As in all other countries, Britain, from the Elizabethan Poor Law in 1601, had had a mixture of private and public health care. The N.H.S. made the public sector the major component of this public/private mix, but Bevan had been careful to write into the Act the provision of private and amenity beds in all hospitals. Suddenly, when the N.H.S. had most difficulty in meeting rapidly increasing demands and people were certain to turn more and more to the private sector, it was decided to separate it from the N.H.S. - to close private beds in N.H.S. hospitals. As a result, the inevitable increase in the private sector was met by building scores of private hospitals separated from the N.H.S., depriving it of money and staff.

In 1979 the Royal Commission on the Health Service recommended a modest increase in funding but no major change, save a limited list of drugs. It rejected transferring the service to local government, supported consensus management of the hospital service, but on balance thought there was one tier too many.

At the end of the 70's the failure of London University to rationalise its 30-odd medical institutions led to the Flowers Report, reducing the medical schools from 12 to 8 but leaving most of the post-graduate institutes unaffected.

Here in Tower Hamlets great efforts were made to try and establish the borough's first ever Health Centre - Newham already had two.

Through the 80's the demand for new types of care (repairs or replacements of hips, knees, heart valves and arteries) competed with care for an increasing number of elderly, with calls for better care of the handicapped and mentally ill, and with calls for the quick relief of every kind of discomfort. I remember the furious complaint of an unmarried lady in Newham at being kept waiting for treatment of infertility.

The public was no longer prepared to wait patiently for treatment, though on average 40% of those offered out-patient appointments in Newham failed to turn up. Increasing demand fuelled much-publicised dissatisfaction. The health professions tended to claim that all would be well if only the N.H.S. was given more money. It was, though the annual increase in the 80's was less in real terms than the increase in the 70's. The Government's response was to seek greater efficiency, more productivity and less wastage.

In '81 came Re-organisation, doing away with the Area Health Authorities established in '74 and creating District Health Auhorities with managers instead of teams attempting to achieve a consensus.

In '83 the Griffith Report suggested there seemed to be no way in the hospital service of implementing a policy even if one were decided upon, and recommended more management by managers. Hospital staff, despite or because of repeated re-organisation and new types of management, actually succeeded in treating 20% more patients in the 80's, but the attention of the public remained rivetted on dissatisfaction and then on two White Papers occasioned by the clamour.

In '86 came the paper on "Promoting Better Health", proposing the biggest changes since 1911 in the kind of care G.P's could contract to provide, and a greater degree of accountability.

In '89 came the White Paper entitled "Working for Patients" which proposed splitting responsibility for buying health care from that of providing it. District Health Authorities and some general practices would become purchasers. Funded according to the size and composition of their populations, their function would be to buy the best service they could from a variety of providers. Hospitals might, if they wished, be freed from regional & district control and become Trusts contracting with purchasers to provide specific services.

Medical audit would be instituted to assess quality of performance, and individual accountability increased by new consultant contracts. The previously relatively low administrative costs in the hospital service would be increased to provide staff to begin measuring health care needs and to cost medical care procedures.

The changes heralded by those two White Papers were put into effect on 1st April 1990 - it is too early to tell what the results of them will be, but they amount to a radical change in the service. The end of an era, the end of Round One - so, as Magnus Magnusson would say, "Let us take a glance at the score."

First and foremost, we can expect medicine to go on advancing but it is hard to tell in what direction it will go. Maybe molecular biology will make a breakthrough in the field of preventive medicine, allowing the prevention of some genetic disorders or even the prevention of genetic vulnerability to disease of environmental origin. That would be a reminder that the best contribution medicine can make to the prevention of disease is by research.

We have, of course, to note that despite the continuing growth of medical knowledge, it is still surrounded by oceans of ignorance. We do not know the causes of many of the common illnesses of today, nor of many of the main causes of death.

Medicine's power to harm has grown still greater. Its safe application often requires that careful investigation which is costly and stressful so that people would often rather have the rapid labelling and prompt prescription of the 30's, or its contemporary counterpart "alternative medicine". Even so, the public remains anxious to have all that orthodox medicine has to offer, and to have it promptly, painlessly, in comfortable surroundings, as near to home as possible, administered by highly competent professionals - and the public also wants all that compassionate comforting which up to 60 years ago was just about all medicine had to offer - and would like to have it delivered to the door by day or night. So, demand continues to exceed supply and probably exceeds need also - only in dentistry has there been any evidence that need exceeds demand.

It is clear that the health needs of one area differ from those of another and are likely to continue to do so, therefore over-centralisation of a service is undesirable.

Integration of preventive and therapeutic services is essential at the level of primary health care, as Dawson thought. Failure to integrate primary & secondary care leads to inco-ordination, inefficiency and waste. Quality & economy go together. The right diagnosis followed by the right treatment, given under the right conditions, is not only best for the patient but also cheapest in the long run.

The average home is not an appropriate place in which to practice contemporary medicine which requires properly equipped and staffed primary health care centres and hospitals. <u>That increasingly large proportion of medical care which requires hospital conditions cannot be given effectively and economically anywhere else.</u>

People frequently need help from more than one specialty, and all specialties need expensive scientific and technological back-up. Specialties should not be practised in isolation. Casualty departments in hospitals which lack a range of special departments cannot provide more than first aid. It follows that hospitals now have to be large whether anyone likes it or not, but size cannot now be measured in beds, which relate to only one and not necessarily the main form of care given in hospital. Size depends on the number of departments and other resources concentrated in an institution and on the amount of work it does.

Patients whose clinical problems are beyond the scope of large multi-departmental district hospitals need to be transferred to a hospital specially equipped to deal with such problems by virtue of academic units and the back-up of the University next to which it is situated. These University medical centres are not only an essential health service resource but are vital to medical education and research and serve as pacemakers and standard setters.

It is important to note also that, in contrast with the past, it is now easier to make a good specialist (whether nurse, doctor, physiotherapist or whatever) than a good generalist. Maybe it takes an exceptionally long time to make a good general manager. It is also easier to up-date or re-train specialists than generalists.

It is clear that every country can benefit from a mixture of public and private health care. The proportion of one to the other will vary from time to time, but it is impossible to conceive of a time when the state is not required to provide the vast majaority of care.

In the light of all that, there is no escaping the fact that the N.H.S. has been hampered by a lack of resources, especially at the start, by over-centralisation and by rigid compartmentalisation which has perpetuated an inappropriate pattern of health care delivery.

Other countries which had a similar way of delivering medical care before the war soon found it changing as medicine changed - some ceasing to have general practioners of the old kind and all having to concentrate costly health care resources into fewer but larger centres from which teams of mostly non-medically qualified personnel reach out into the periphery.

Here in Britain our particular version of the pre-war system of health care was fixed by the N.H.S. and has remained fixed, not least perhaps because people got the idea that to alter the N.H.S. in any way would be sacrilege. General practitioners and hospital services remain separate and local authority services are not too well co-ordinated with either. Even if hospital services can now be more closely related to local needs, G.P. services cannot because their contract is decided nationally by the government in negotiation with the B.M.A.

Up till now accountability in regard to the general medical services has been conspicuous by its absence. The bill for drugs prescribed by G.Ps. has remained open-ended - last year it came to £3½ billion, accounting for nearly half the cost of primary care, and the public buys another £40m. worth of drugs

per year of its own choosing over the counter. Way back in '48 Bevan said "I shudder to think of the cascades of medicine pouring down British throats."

On the other hand hospitals have had to operate within strict cash limits set annually in a continuing effort to control expenditure. Frustrating though that can be for those trying to cope with rising demands, it has nonetheless resulted in the concentration of resources. Every year we have ended up, despite opposition from every quarter, with fewer but larger hospitals better suited for modern medicine.

So far as health care personnel are concerned, our 45,000 doctors are facing yet further re-organisation and confusion. The N.H.S. had brought them more control over the work done by hospitals than they had previously enjoyed, but in the 80's much of that control passed to managers, and still more in the 90's under the new arrangements. At times they may be prohibited from practising because the money has been used up, but they still have to face the complaints of those waiting to be treated. Hopefully, purchasers and providers will soon be able to work together more efficiently.

G.Ps. on the other hand are better off than they were and appear to be more content with the new contract than they expected to be. But the new accountability has scarcely begun to be put into effect.

At the end of Round One, our hospital premises are infinitely better than they were at the start of the service, but general practitioner premises have not improved to the same extent. Nearly half are judged to be below minimal standards, more than half in London. Many more nurses, practice nurses, community nurses, community psychiatric nurses, physiotherapists, medical social workers and others are now engaged in primary health care, but the setting up of primary health care teams is slow, partly because of the lack of accommodation.

So far as education and training are concerned, G.Ps. have now to undergo 3 years vocational training but it is still possible to become a principal in general practice at an earlier age in Britain than anywhere else. Our specialists, however, are required to undergo a post-graduate training which is considerably longer than anywhere else in the world. They have not necessarily profited as much as is desirable from their over-long University education but their excessively long training ensures that they have mastered the knowledge and skills relevant to their particular branches of medicine. Major changes have occurred in the education & training of all the other health care professions, adapting them to modern practice and leading to much improvement even if nurses are now perhaps in danger of getting more education than training.

So far as the service given by the N.H.S. is concerned, Britain continues to spend less on health care than do many other countries although the estimate for '93/94 was some £360 thousand million - considerably more than the £134m. forecast for 1948/49. But more care is provided than in many countries and most of it is provided at a higher standard.

So far as life-threatening conditions are concerned, the British public are receiving, in my opinion, better care than is provided by any other health service in the world mainly, perhaps, because of the quality of the staff. It helps too that the public which is by and large extremely grateful for the care received, realise that hospitals now grow out of equipment as quickly as children grow out of shoes, and responds to appeals even though, all too often, these are made in a disorganised and uncoordinated fashion.

We have not yet found a way to cope with a sudden increase in the need for admissions. Hospitals are kept at full bed occupancy and there is no modern equivalent to the abandoned practice of putting up extra beds like, for example, opening up a moth-balled ward.

So far as conditions which affect the quality of life, like new hips and knees, are concerned, the public has to wait for a short time if the treatment is medical, and for much longer if it is surgical. As a result, those who are able to do so leave the queue and get private treatment.

So far as the elderly are concerned, the living conditions which can help to keep them out of hospital remain in short supply, leading to early admission on the one hand and delayed discharge on the other.

The mentally ill have all too often been turned out of their old but quite lavish accommodation so that they may not be deprived of life in the community which, for many of them, consists of walking the streets by day and sleeping in cardboard boxes at night.

We have some of the best general practitioners in the world and a great many others. They provide a great deal of care besides acting as gate-keepers to the hospital service. Many are not part of primary health care teams and are not anxious to become part. Many rely on deputising services. Many employ counsellors to whom they refer those patients, estimated at 6 million, who come to them each year complaining of emotional problems and mild depression. Not all the counsellors have received training for their role.

But scattered all over the country are excellent practices, not necessarily in Health Centres, manned by good doctors with a new and enthusiastic approach to the part they should play in the Health Service.

Primary health care does need improving and the new determination to improve it by more money and by funding health centres is welcome. It is, however, dubious whether that alone will dramatically lessen the need for hospital care. Nor would it be wise to restrict patients who fear they may be facing an emergency situation from going to hospital to find out if they are, until equally cheap and effective means of doing so have been provided elsewhere.

The idea that hospital care can be reduced by "doing more in the community" suggests that we have still not fully broken free from our addiction to that much-loved Victorian pattern of medical care in which most of what medicine had to offer was provided by the family doctor. The suggestion is supported by the terminology still in use. Sir Bernard Tomlinson and Mrs. Bottomley still refer to doctors' "surgeries" and "teaching hospitals". Yet surgery has ceased to be something which can safely be done in surgeries, and all hospitals have long since become teaching hospitals - only a few of which form part of university medical centres, the siting of which depends on the siting of universities rather than on the propinquity of a large population. What's more, in reality hospitals are just as much a part of the community and of community services as are doctors' surgeries, health centres, homes for the aged and public lavatories.

It will be some years yet before the full effects of the changes of 1st April 1990 become apparent. At the very least there should be valuable improvements in the previously primitive information systems of the N.H.S. - it should be possible more accurately to measure need and to cost the means of meeting it. Hopefully there will be great improvement in primary care, a greater understanding of what hospitals are for and of what they need. Whatever happens, however, it will still be necessary to integrate primary and secondary care, so the sooner General Practitioners become employees of the Health Service, rather than sub-contractors of it, the better.

Until then, it would help if the public could come to understand that it has a Health Service which has triumphed over many difficulties and which, though cheaper than most, is probably the best there is anywhere. Taken all in all, it is not capable of immediately meeting all demands or <u>even all needs at all times,</u> but it is totally unreasonable to assume that it could be.

But unhappily the N.H.S. has long since passed beyond the comprehension of most journalists who confine themselves to sensational and alarmist reports or to stirring up party political strife. Actually, looking back, there have been very few occasions when the N.H.S. has been subjected to political dogma, but many when changes have been made too hurriedly or

at an inappropriate time out of political expediency occasioned by media campaigners. Sadly, misrepresentation of the N.H.S. in the media is likely to continue until such time as journalists are, like doctors and nurses, licensed to practice only after successfully completing a training which inculcates respect for accuracy and a sense of responsibility. Until then it would be wise to preface all pronouncements on the N.H.S. in the media with a government health warning:

"This is likely to damage your health service."