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Conflict and Consensus

Rosemary Davies
Christine Farrell

Working papers of the Royal Commission on the NHS

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CONFLICT AND CONSENSUS

An Analysis of the Evidence Submitted to the Royal Commission on the National Health Service 1976–1979

by Rosemary Davies and Christine Farrell

Foreword by W G Cannon
Director, King's Fund Centre

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FOREWORD

The publication in 1979, and within a few months of each other, of the Report of the Royal Commission on the National Health Service and the government's consultative document 'Patients First' were events which will shape the future of health care in this country. Two concepts recur like a ground bass throughout the Report of the Royal Commission. First, the measurement of 'health' and of its effectiveness is at best an uncertain science; secondly, the lay public, as well as the professional and non-professional worker, must be well informed so that they may contribute to such urgent tasks as the setting of priorities.

The King's Fund is glad to have the chance to assist in the task of exchanging ideas on key subjects by publishing in the form of Project Papers a number of the documents prepared for the Royal Commission. This venture has the support both of the Chairman of the Royal Commission, Sir Alec Merrison, and of its Secretary, Mr David de Peyer, and the Fund is grateful to them both in agreeing so readily.

The papers which will be appearing in this series during 1980 are mostly those which were written for the Commission. The opinions expressed in the papers are those of the authors and do not necessarily reflect the views of either the members of the Royal Commission or of the King's Fund. They do, however, represent some of the best thinking on a wide range of complex subjects. They have been selected and edited slightly for publication by Christine Farrell, who was principal research officer to the Royal Commission. It is a pleasure to acknowledge the help which the Fund has received from her and from Rosemary Davies in preparing them.

The consultative document lays down a timetable for change to be effected between now and 1983. The task now is 'to get the Health

Service moving in the right direction'. An important part of the Fund's role is to try to bridge the gap between those who conduct research and those who can put findings into practice. We hope that this series of papers will make a significant contribution to a debate, which has as its maxim 'that patients must always come first'.

W G Cannon
Director, King's Fund Centre

February 1980

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PREFACE

The Royal Commission on the National Health Service was announced in November 1975 by the then Prime Minister, the Right Honourable Sir Harold Wilson. The first meeting of the Commission took place in May 1976 and after three years a final report was published in July 1979.

Royal Commissions have been used extensively as part of government advisory machinery throughout the past two centuries, along with select and departmental committees. In this century alone, about 140 Royal Commissions were appointed to consider topics as varied as the press, marriage and divorce, common land and the constitution. There are two common views of the function of Royal Commissions; one is that they are set up by governments in order to 'buy' time when faced with particularly difficult problems which seem incapable of immediate resolution; the other view is that they are agencies which can be used to provide an independent assessment of complex and sometimes controversial, public problems. There is probably some truth in both these views, but undoubtedly Royal Commissions are instruments of government, and as such, contributors to the policy making process.

It is because of this contribution that we are now publishing a collection of papers which were prepared during the life of the Royal Commission on the NHS. This first pamphlet, an analysis of the evidence submitted to the Royal Commission during the period 1976–79, demonstrates some of the problems and difficulties with which the members of the Commission were faced. It reveals the wide range of complex problems to be considered and the conflicting views about the cause and resolution of these problems amongst bodies representing NHS workers and other agencies concerned with the NHS. Subsequent papers in the series will deal with a range of topics considered by the Royal Commission, including nursing, finance, hospital services, management in the NHS and the organisation of personal social services.

The main purpose of publishing some of the background papers prepared for the Commission is to make available to students of health services and health policy much useful information which was collected during the Commission's life, but not fully used in the final report.

This first paper is different to the material to be published in subsequent pamphlets because it was prepared after the Commission had completed its work. The papers which will follow were prepared by individual members of the Commission, by individual members of the full-time secretariat or by outside experts at the request of the Commission. When considering the whole series of pamphlets some caveats about the material should be borne in mind. Although each pamphlet contains material on a discrete area, it by no means represents the full range of information made available to the Commission on this subject. The material has been chosen for publication because it offers a useful contribution to a chosen area and/or presents new or not readily available information.

We are grateful to King Edward's Hospital Fund for London for giving a grant to enable this material to be produced, and to the Polytechnic of North London where this project has been based.

Christine Farrell
Rosemary Davies

INTRODUCTION

Between May 1976 when the first request for written submissions was despatched and July 1979 when the final report was published,the Royal Commission on the NHS received almost 2,500 pieces of written evidence, more than any other Commission or departmental committee since 1945. The number of submissions highlights the importance of an institution which employs about one million people and services nearly all UK citizens, and the topicality of health issues such as the 1973/74 reorganisation of the health service, the pay beds debate, the recent rise of industrial action in the NHS, and the effects of the economic climate of the early 1970s on the provision of health services.

With hindsight, it is tempting to impose a rationality and consistency on the mountains of paper which dominated the first few months of the Commission's deliberation. In reality the evidence, all of which was circulated (in complete or summarised form) to each Commissioner, arrived at Commission House in a fairly haphazard fashion. Given the logistics of compiling evidence for important and representative bodies such as the Confederation of Health Service Employers (COHSE) or the British Medical Association (BMA), it is not surprising that the early pieces of evidence received were from individuals who, responsible for none but their own view,were able to write immediately to the Commission. It was not until the later months of 1976 that the Commissioners were able to read submissions from the more influential and representative bodies.

Views expressed in the evidence vividly illustrated the conflicting views expressed within the service. For example,the issue of the proper role for fledgling Community Health Councils (CHCs) aroused considerable controversy. The Northamptonshire Family Practitioner Committee (FPC) commented:;

> 'It is doubtful whether CHCs were in fact fulfilling the role for which they were cast...steps should be taken to dispense with their services.'

This view was not untypical of the particular interests of FPCs. The opposing view expressed by one trade union, the Association of Scientific Technical and Managerial Staff (ASTMS):

> 'they [CHCs] have little power, and there is much scope for widening their functions and their power.'

was echoed by other bodies including the trade unions and CHCs themselves. The evidence contained many other examples of conflict, such as discussion of which management tier might be removed and whether private practice should be included within or excluded from the NHS. Rather than restate these and other debates which formed the basis for the Royal Commission's work and final report, our aim here is to summarise and analyse the content of the major evidence submissions.

It has been pointed out that Royal Commissions are appointed 'at least partly for the purpose of obtaining facts and opinions about the subject of [their] mandates', and that they are expected 'to take all reasonable steps to ensure that their deliberations reflect all the significant and relevant information bearing on their terms of reference'.[1] Balancing, weighing and evaluating written and oral evidence is therefore one of the main tasks which faces Royal Commissions and departmental committees. Their work may be carried out in a variety of ways, but normally one of their primary functions is to receive and hear the opinions and views of those people who are concerned with the issues encompassed by their terms of reference. The nature and strength of this evidence will to some extent determine the issues which are dealt with by these committees.

Our objective in producing this analysis is to document the nature of the evidence submitted to the Royal Commission on the NHS. Although the Commission's report devotes a considerable amount of attention to the evidence it received and quotes extensively from submissions, the report itself was influenced by many other factors of which the Commission's

1 Cartwright T.J. *Royal Commissions & Departmental Committees in Britain* Hodder & Stoughton. 1975. p 126.

own views and the research it commissioned were the most important. We felt that there was a case for presenting a straightforward review of the issues discussed by the major groups of organisations concerned with the NHS.[1]

Reading through more than 2,000 submissions is no mean feat, so although the evidence referred to here is available in the Public Records Office, we hope to have helped students of health policy and others who might be interested in the problems of the NHS, towards an appreciation of the contribution which the evidence made to the Royal Commission on the NHS.

1 It should be noted here that the Royal Commission's terms of reference concerned the whole of the United Kingdom. However, in this analysis we have tended to use the evidence submitted by the major organisations within England. Sometimes these Associations cover membership in the rest of the UK and it can be assumed that comments on the functionings of the health service in England do apply to the rest of the UK, except, of course, where organisation differs as for example the absence of FPCs in Scotland, and the integrated health and personal social services under the Health and Social Service Boards in Northern Ireland.

THE PATIENTS' VIEW

One of the Commission's earliest stated tenets was that 'the interests of the patient must be paramount'[1] . Therefore before turning to the view of the major bodies submitting evidence we look first at the way the patients' view was expressed to the Commission. A recurrent problem for health service planners, for political groups, for committees of enquiry, for academics and for consumer groups is to find out what are the views and experiences of the 'average' NHS patient. One of the main advantages of a Royal Commission is that it is open to submission from individual consumers and from large influential organisations alike. However, in considering the nature of the evidence submitted by individuals, it can only be concluded that the Commission must have been disappointed if it hoped that patients, through individual submissions, would illuminate its path when considering their interests.

Approximately 800 submissions were received from individuals and less than half of these were from patients. Given that these were amongst the first pieces to be received by the Commissioners, their impact was particularly important. However, it is difficult to deduce how representative the views of people who choose to write to Commissions and Committees are. Furthermore, since the majority of these submissions were of a specific, personal and anecdotal nature, it is difficult to discern consistent problems highlighted by patients which would have been amenable to discussion within the Commission.

Consequently, in order to gauge the consumer view from the evidence it becomes necessary to rely on the evidence submitted by consumer organisations and community health councils and their counterparts in Scotland (Local Health Councils) and in Northern Ireland (District

1 *Royal Commission on the National Health Service.* Cmnd. 7615 London. HMSO July 1979. para 1.8.

Committees). The Commission was well served by the CHCs, since 80% of all CHCs in England submitted evidence. The evidence from this source formed a major part of the total volume of all submissions. On the whole CHCs, LHCs, and DCs commented on a wide spectrum of topics, and did not confine themselves to issues directly relating to patient care.

THE COMMUNITY HEALTH COUNCILS

Structural issues concerned all CHCs and they commented on duplication, excessive bureaucracy and waste. Most argued that one tier should be abolished and felt that this should be the Area Health Authority (AHA). Waste resulting from trained clinicians spending most of their time on administrative chores, was regretted. Dewsbury CHC specifically commented that the loss of valuable expertise and consequent expense in this process was particularly noticeable in the nursing profession, 'Salmon has neither benefitted patients nor staff'.

Whilst administrators and professionals complained that coterminosity at area level was an unnecessary straitjacket, the CHC view was that coterminosity at district level would help the interface of the NHS and local authority services in the future. Locally, lack of integration was particularly noticed in the provision of after-care for the elderly, the mentally ill and mentally handicapped. Many CHCs recommended more joint funding to solve this problem. Again in contrast to the professional view, the CHCs welcomed joint consultative committees (JCC) with Wakefield (East) CHC hoping they would not become 'a paper facade'. Furthermore they wished to see a consumer view represented on JCCs, health care planning teams and indeed FPCs. FPCs themselves aroused a great deal of comment. Specific problems arising from the independence of the FPC and its practitioners were repeatedly mentioned; for example the obscurity and inefficacy of complaints procedures; open-ended budgets mocking attempts at planning; the lack of monitoring of family practitioner standards; and the arbitrary way in which GPs are able to strike patients off their lists. In general the consumer view was that FPCs should be more accountable. Kettering CHC commented 'there should be more light and

air brought into FPCs and especially in the complaints procedure of the Service Committee'.

The CHC submissions were most illuminating as demonstrations of the consumer view in their coverage of more grass roots issues. A number of CHCs referred to criticisms of appointments systems as assuming patients can plan for illness and need for GPs. Also the power and role of untrained receptionists as allocators of GPs' time was criticised. Deputising services were a further cause of concern for some CHCs. The contrasting nature of demand for services, and indeed of CHCs, in rural and urban settings was illustrated by the lack of consensus on the desirability of health centres. Those in favour of further and speedy development of health centres were generally inner-city CHCs. Rural CHCs also expressed concern about the declining number of pharmacies and inadequate transport facilities to take patients or relatives to hospital. Furthermore this problem was said to be exacerbated by the increasingly centralised hospital services.

THE CONSUMERS ASSOCIATION AND THE PATIENTS ASSOCIATION

The Consumers Association dealt in very broad terms with health services and did not present issues and problems which were relevant to patients at a micro-level. They recommended the establishment of an independent and representative 'Committee on Priorities for Health Care' to determine rational criteria for the distribution of resources and the determination of priorities between competing groups. They maintained that medical training should put more emphasis on causes of disease, prevention, primary medicine and long-term care of the chronic sick and the elderly. They also suggested that health education for consumers should be increased and the promotion of government policies for health, such as compulsory seat-belt wearing, should be regarded as more important than appeals to individuals to live more healthy lives. They argued for greater flexibility in moving resources from one sector to another as need changed, for example the cost of maternity care was continuing to rise despite the decrease in the birth rate. They contended that re-organisation had failed to delegate responsibility downwards; that local management should be allowed to

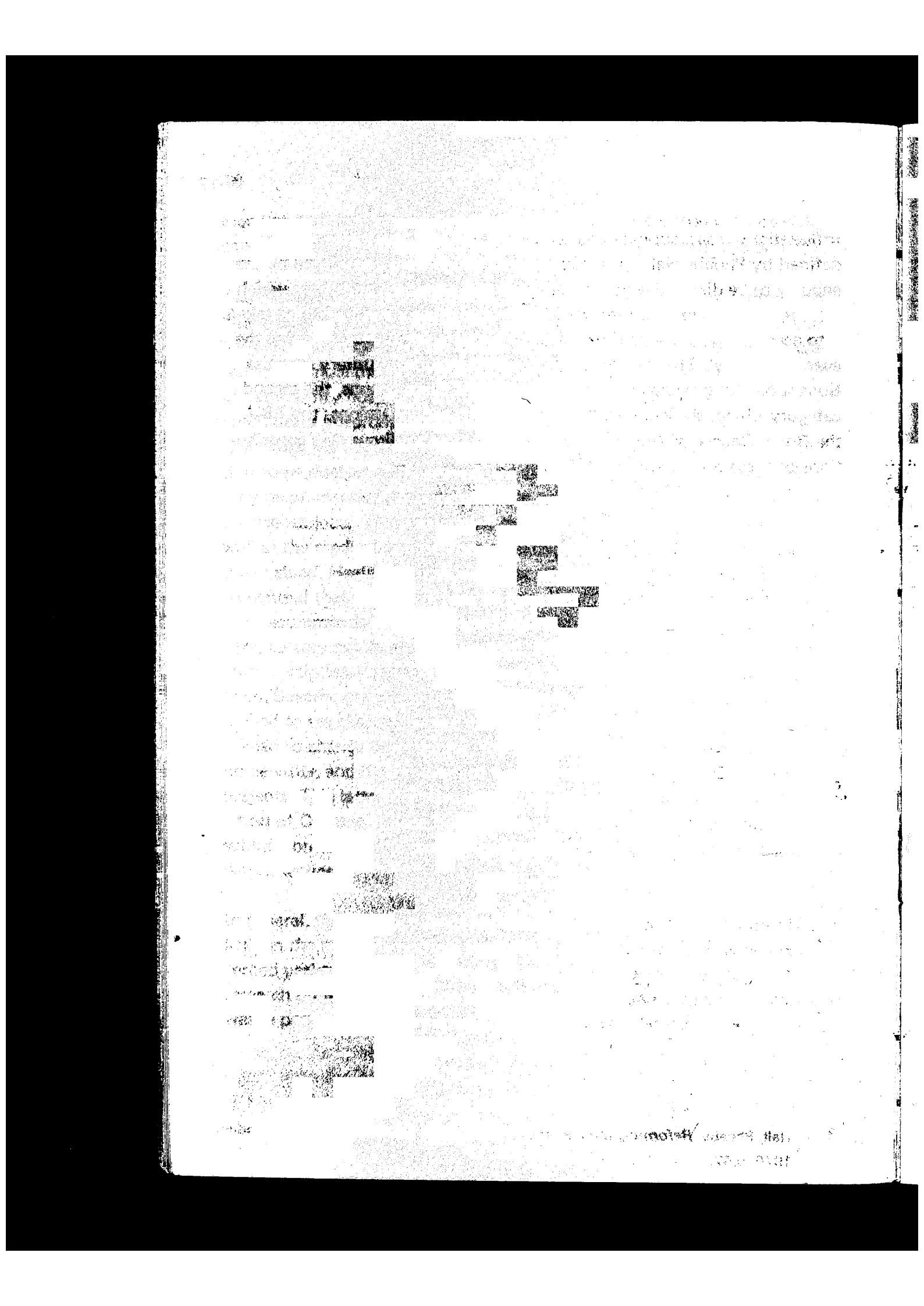
manage; and that morale amongst workers might be boosted by careful capital investment in selected projects which would benefit the patients.

The Patients Association offered helpful pointers to particular problems facing patients and consumers in hospital and in the general practitioner's surgery. They regretted the loss of status of the family doctor and suggested for example the development of GP beds in hospital; the establishment of community hospitals; and the involvement of GPs in the assessment of community hospitals; and the involvement of GPs in the assessment of new drugs. At the same time the Patients Association deplored the fact that some doctors still behaved in a dictatorial manner to patients and they recommended more emphasis in medical education on behavioural science subjects. They welcomed the decision to test ability in English, as well as the medical competence of immigrant doctors whose contribution they valued. Health Centres were not wholeheartedly welcomed but it was recognised that they were here to stay. Consequently the Patients Association recommended that transport facilities should be provided to allow patients easy access to these centres. They insisted that whilst valuing the multi-disciplinary approach the doctor must be seen to be the head of the team. Specific problems faced by patients which the Patients Association wished to see changed were: the difficulties experienced by patients who wished to change their doctor; the failure of doctors in some areas to make home visits; and the problem of finding dentists willing to treat NHS patients. This latter problem was further illustrated by the National Association of Citizens Advice Bureaux who devoted the whole of their submission to specific cases of problems encountered by patients using dental services.

In general, the evidence from patients and consumer organisations offered little in the way of empirical material to illustrate the issues which concerned patients most. The Royal Commission's decision to carry out research on patients attitude to hospital services and access to primary care was in part motivated by a need to fill this particular gap.

Influential written submissions tended to fall into two categories as defined by Phoebe Hall[1], there are, 'those which were considered by the enquiry to be distinctive and well-argued and presented and those which were received from organisations and groups whose views had to be taken into account by virtue of their status or importance in implementing the eventual policy'. The former category might include voluntary organisations submitting evidence related to particular client groups, the second category obviously includes the major health service unions, the BMA, the Royal College of Nursing, etc.. We go on now to discuss the contributions of these organisations.

1 Hall, Phoebe. *Reforming the Welfare.* Heinemann Educational Books. London 1976. p.42.



THE TRADE UNION VIEW

The NHS is the largest single employer in the UK and political and industrial relations issues are felt to be more complex within the public sector. The Trade Union Congress (TUC) and the major health service unions submitted comprehensive written submissions by the summer of 1977. Their submissions were written in the context of the continuing debate on devolution, the imminent report on the Whitley Council system by Lord McCarthy[1], and the report of Resource Allocation Working Party (RAWP).

As a backcloth to their submissions, all the major health service unions and the TUC reiterated their commitment to a national health service universal in its coverage, and free at the time of need. This comment from COHSE illustrates the general commitment of the trade union movement to the NHS, 'We regard the Health Service as sacrosanct in that the concept is one of the finest social measures taken by any nation and it must develop in order for it to do the job it was intended to do. The service must be protected from cuts in expenditure. At times of national economic problems it is more important than ever that the health and personal social services be geared to function at the highest level of efficiency. Health is far too important an investment in the future for it to be the subject of cut-backs in expenditure.'

Finance

The trades unions argued, often with the aid of comparative international statistics, that the NHS was underfinanced, and that public expenditure cuts should be resisted on all fronts.

ASTMS, COHSE, the General and Municipal Workers Union (GMWU), and the TUC presented briefly the arguments for and against insurance based health care and concluded that such a system would be thoroughly

1 *Making Whitley Work*, A review of the operation of the National Health Service Whitley Council System, London, HMSO 1976.

inequitable, bearing heavily on the low income groups and the chronically sick. All the unions agreed that the NHS must be funded for general taxation. Health service charges were rejected on principle but it was also argued that their revenue was minimal, meeting less than 3% of the total NHS budget. The National Insurance contribution quoted as contributing 6% of NHS revenue was heavily criticised as anachronistic and regressive. GMWU, the National and Local Government Officers Association (NALGO), the National Union of Public Employees (NUPE) and the TUC recommended its abolition.

Concern was expressed about the policy of reducing capital expenditure. ASTMS and the GMWU considered this policy to be short-sighted. Not only did it place burdens on their members working within obsolete and unsuitable surroundings, but it also increased maintenance costs of old buildings and inefficient working conditions added to the current expenditure of the NHS.

The capital/revenue debate led on to discussion of resource allocation. In general the trades unions were critical of the RAWP report which was published a few months before they submitted their evidence. Despite a consensus that resources should be allocated in a more equitable and rational manner, the deliberations and conclusions of RAWP were roundly criticised. The TUC argued that the main difficulty in reallocating resources was the problem of measuring the effect of altering particular resource inputs. Congress exhorted the DHSS to develop research on measuring the effectiveness of particular allocations of finance. COHSE, GMWU, NALGO and the Transport and General Workers Union (TGWU) were more critical. They considered that this 'Robin Hood' exercise (as COHSE named it) ignored the intra-regional differences in the need for health care; ignored the wide disparity between classes in their apparent vulnerability to serious disease; and ignored the number of redundancies following from nil growth in one region. The general conclusion was that an averaging out exercise was taking place, with more favoured areas being brought down to the level of the least favoured. The trade union view maintained that this was not the solution but that the total level of service should be brought up to that of the best endowed regions.

Structure

The basic tenet of re-organisation, namely to provide a unified health service, was supported by all the trade unions. They agreed that the 1973/74 re-organisation had failed to fulfil this objective. They felt that the present structure was excessively bureaucratic and undemocratic. They shared a diagnosis, but their recommended cures differed. COHSE and GMWU recommended abolition of the area health authority (AHA); NUPE and TGWU recommended amalgamation of the regional health authority (RHA) and the AHA; NALGO recommended that the DHSS should delegate more power to RHAs; and the TUC admitted to no clear consensus on which tier should be abolished.

Another feature of the existing structure which the trade unions felt inhibited unification was the continued independence of family practitioners. This independent contractor status was also seen as hindering the development of health centres. COHSE quoted the fact that only 17% of general practitioners worked in health centres in 1975. They also supported the views of some CHCs and AHAs in recommending that FPCs become sub-committees of AHAs. COHSE and GMWU recommended the abolition of the independent contractor status. ASTMS, NALGO, NUPE and the TUC recommended the introduction of a salaried service as an alternative to the independent contractor status which in turn would remove the need for an independent FPC as presently constituted.

A further obstacle to total integration of the health service was seen by some unions to be the fact that personal social services relating to health remained within the local authorities where they were placed as a result of the Seebohm re-organisation. COHSE and NUPE argued that personal social services relevant to health should become part of the NHS. NALGO and the TUC criticised the failure of JCCs to assuage the problems of separation, pointing to particular problems resulting from lack of coterminosity in London. They argued for a better system of liaison at the interface of the NHS and the personal social services.

Democracy in the NHS

All the unions argued for more democracy within health authorities. They

criticised the continued presence of those who the GMWU referred to as 'noteable worthies and perhaps over-worked local authority councillors' on health authorities and argued consistently for democratically based committees. GMWU for example provided a blueprint for a new District Health Board made up not of directly elected representatives but 25% representing the CHC; 20% the wider trade union movement; 30% the NHS workers, and 25% from local authorities. COHSE and NUPE recommended that 50% of authority members should be directly elected by the public. Furthermore, in order to achieve the objective of industrial democracy the unions argued in favour of a much larger and more specific representation of health service employees on health authorities. The CHCs were applauded as the only remotely democratic innovation in the re-organised service. Whatever structural reforms individual unions recommended they supported the role of the CHC as representing the consumer, unhampered by managerial considerations.

Private Practice

Consistent with their wholehearted commitment to the philosophy behind the creation of the NHS, the unions were unanimous in their submissions on private practice. Pay beds was one of the most topical issues at the time of submission, so it is not surprising that private practice within and outwith the NHS was dealt with at length. The trade union movement considered that private medicine distorted the availability of health care and equality of access to it, and that it inequitably absorbed scarce resources. Indeed COHSE recommended that private health care establishments should pay an annual levy to the NHS for each employee trained at public cost. There was criticism of the 1976 Health Services Act and it was recommended that pay beds should be phased out more quickly, and that more restrictions should be placed on the development of the private sector outside the NHS. NUPE reflected the trade union view when it commented 'It is the ultimate objective of our union to end completely the existence of private medicine, both inside and outside the NHS'.

Voluntary Services

Both NALGO and COHSE expressed concern about the role of volunteers

in the NHS. It is rare throughout the evidence from all organisations and individuals to read anything other than praise for volunteers. But in this context NALGO and COHSE pointed out that the wholesale introduction of volunteers into the NHS at times of cuts would reduce the quality of service, would offer no guarantee of continuity of provision and might damage the conditions of service of paid members of staff. This they argued occurred despite the laudable objectives of volunteers.

These issues discussed above, finance, structure, private practice, and the use of volunteers are topics considered in submissions from most of the major organisations. However, there were a number of significant issues which the trade unions covered in depth which did not occur consistently in other submissions: they were, occupational health services, the pharmaceutical industry and collective bargaining.

Occupational Health Services

All the trade unions submitted lengthy and helpful pieces on occupational health services. This was an area of obvious concern to them and was covered less thoroughly in evidence from other organisations. Their arguments related to two issues: the need for an occupational health service for NHS workers; and the relationship of any occupational health service to primary care and hospital services.

GMWU deplored the standards of health and safety in health service establishments. They offered examples of inadequate arrangements for the disposal of toxic waste; inadequate safety provision in laboratories; and lack of health and safety training for all hospital staff. NUPE deemed this area so important that they included examples of specific hazards in four hospitals noted in a 1976 NUPE survey. The trades unions urged the implementation of the recommendations of the Tunbridge Committee of 1968 for the establishment of an occupational health service for the NHS. They queried the validity of continuing Crown Immunity from the 1974 Health and Safety at Work Act for the NHS and other services.

The trades unions were also concerned about the overall standards of occupational health services. They censured government for not fully implementing the 1974 Health and Safety at Work Act ostensibly because

of lack of finance, and considered that a rationalisation and expansion of research into toxic substances, work hazards, occupational disease and injury to be imperative. COHSE and NUPE recommended that a comprehensive occupational health service should be an integrated part of the NHS with health and safety services staffed by trained personnel available at the workplace. However, TGWU and the TUC did not argue that occupational health should become an NHS function, rather they wished to see links between the two services strengthened, and the improvement of health and safety at work in line with the 1974 legislation.

The trades unions' discussion of occupational health often led onto consideration of preventive medicine. Here their view reflected the consensus throughout the evidence that health education and preventive measures, such as screening, should be improved. However they dissented from the general view in one respect. The GMWU for example, contended that excessive emphasis on personal responsibility in areas such as smoking and drinking belied the fact that these activities were often a response to environmental factors such as poor housing or indeed a response to high-pressure advertising. NUPE too maintained that the emphasis on individual action to promote health begs the question of how far an individual can be said to fully determine his or her own life style. This point was illustrated by use of standardised mortality ratios indicating that the incidence of death from all causes, for males aged 15—64 in social class five was far higher than for the other social classes: class variations in health still persist. The function of government, they argued should be to pursue environmental improvement policies and identify constraints such as cigarette advertising which affect preventive health programmes.

The Pharmaceutical Industry

The pharmaceutical industry was unanimously criticised by all the major unions submitting evidence. NALGO noted that the total cost of NHS prescriptions increased by 32% between 1973 and 1975. Some disagreement as to how to remedy the situation is discernible. For example, ASTMS considered that the prescribing powers of doctors should not be limited by approved lists or generic prescribing, but that potent price vetting machinery and public ownership of one comprehensive manufacturer of pharmaceuticals should be initiated in order to remove excess profiteering.

COHSE, NALGO, NUPE and the TUC maintained that the market objectives of the pharmaceutical industry and the social objectives of the NHS made for an anomalous relationship. They argued for the nationalisation of the pharmaceutical industry to remedy duplication of research, overpricing of drugs and wasteful promotion and advertising. COHSE considered that until nationalisation occurred, doctors should be encouraged to prescribe drugs by their generic name and that advertising by drug companies should be restricted.

The GMWU noted that despite the 1965 Sainsbury Committee finding substantial excess profits and the Monopoly Commission Report on the supply of Librium and Valium, successive governments have taken insufficient action to curb some activities of the pharmaceutical companies. They argued for a State presence in the pharmaceutical industry covering research, development and promotion; nationalisation of at least one UK-owned drug company; a system of planning agreements between DHSS and all companies supplying the NHS; and the utilisation of the special patent rights of the Crown. They also recommended that promotional expenditure by drug companies be replaced by information for GPs; and that moves towards generic prescribing which they quote as falling from 85% in 1950 to 5% in 1977 should be encouraged. An examination of other NHS supplying industries was also suggested.

Negotiating Machinery

The Whitley Council system of negotiating machinery in the NHS was under the scrutiny of the McCarthy Committee during the first part of the Commission's existence. Consequently, some unions mentioned collective bargaining only 'en passant' commenting that they had submitted evidence to McCarthy on this issue. However, ASTMS and NALGO did submit evidence on this subject. In addition NALGO submitted a supplementary piece in March 1978 offering a critique of the McCarthy recommendations.

ASTMS contended that the Whitley Council structure needed dismantling and that the new negotiating machinery should deal with the problems of employees with separate machinery for persons of independent contractor status. Professional organisations which were not bona fide trade unions

should be excluded. ASTMS argued that a major improvement would be the development of agreed procedures for settling problems at the work-place: centralised machinery should become 'a forum for consultation and co-operation between organisations with each organisation free to accept or reject a bargain at the conclusion of negotiations as its members may determine'.

NALGO was less contentious, arguing for the rationalisation of the Whitley system. Improvements would follow, they said, if the Treasury was represented on the management side at a high level obviating the need for frequent reference to senior levels for Treasury 'approval' or 'clearance'; if the secretariat of the management side were trained in industrial relations; and if staff side representation was restricted to representatives of TUC affiliated trade unions, with the professional bodies perhaps taking only an advisory role. NALGO rejected the idea of direct negotiations with the DHSS; any extension of independent review bodies; or the idea of politicians being involved in the negotiating machinery. NALGO's response in March 1978 to the McCarthy Report was that it contained very little which was new and evaded the major issues.

Thus in general, the Commission received a consistent and comprehensively documented view from the trade union movement. However, the issues which became so pressing in the winter of 1978/79 when the Commissioners were involved in their final deliberations, namely that of industrial relations within the NHS, were perhaps not as well covered in the evidence of 1976/77 as might have been expected or desired.

THE HEALTH AUTHORITY VIEW

It is impossible, given the differing roles of members and officers of RHAs and AHAs and the nature of the problems facing the administrators of the reorganised health service, to present a discrete health authority view. It is intended here to cover first, the general view expressed by the only body representing all these disparate elements, namely the National Association of Health Authorities (NAHA); second, to cover the regional view expounded in the submissions from the Regional Chairmen and from the Regional Administrators; third, to cover the view of area members and officers through individual submissions; fourth, to cover the view at district level; and fifth, to present a summary of the evidence from the Society of Administrators of Family Practitioner Services.

THE NATIONAL ASSOCIATION OF HEALTH AUTHORITIES

NAHA, an England and Wales body representing members and officers in the NHS at all levels was able to make few clear recommendations. This is best illustrated by their submission on FPCs. They quoted some authorities as feeling that the FPC had an equivocal role based on an uneasy and anomalous compromise which separated the administration of the family practitioner services from the rest of the NHS. However, they made no recommendations since the Society of Administrators of Family Practitioner Services obviously did not support this view.

Similarly NAHA felt precluded by the nature of its membership from involvement in the debate on 'which tier too many'. However, despite coming down on neither side they asserted what the Associations of Regional Administrators, Regional Chairmen and Regional Treasurers supported: the gradual progression towards single district areas. They also referred to the straitjacket of coterminosity which concerned other organisations giving the administrators' view.

NAHA discussed alternative methods of administering the NHS. They rejected the idea of a public corporation taking over responsibility for the

NHS, arguing that this would not provide the continuity some believed it would. They also rejected the suggestion that the NHS might be best administered by local authorities. This they felt would result in patchy service provision and fail to improve upon the widest community involvement, best met at present by the membership of health authorities.

Again on the issue of resources NAHA pointed to questions rather than answers. Whilst welcoming RAWP, it noted issues which required more examination; for example the continued need for separation of funds into capital and revenue expenditure; the exclusion of financing of the family practitioner services from the calculation; the need for further research; and the implications for social services in each locality.

NAHA censured those who maintained that the NHS was on the brink of disaster. It offered a fillip to the faithful, referring to the comparative value for money the health service provides and the main benefit of reorganisation, namely a comprehensive and systematic approach to planning. However, they also noted what is repeated throughout many of the submissions, that the consultation involved in planning had become so cumbersome that the machinery must be simplified. They listed all the bodies that might have to be referred to in making plans, the CHCs, the local authority through the JCC, the joint staff consultative committees, the FPC, the local advisory committees and sometimes the voluntary organisations.

CHAIRMEN OF ENGLISH REGIONAL HEALTH AUTHORITIES

The Chairmen of English RHAs submitted a concise memorandum confined to an issue central to their work; NHS management below DHSS. They argued their case thoroughly and persuasively. They recommended that the present framework of RHAs and AHAs was broadly correct. Arguments were presented against the abolition of regions; it would add to the DHSS burden; it would run counter to improved methods of resource allocation; it would hamper the reorganised pattern of planning and monitoring; and it would remove the facilities for providing services such as blood transfusion and ambulance services.

At the area level the Regional Chairmen doubted the validity of rigid adherence to the principle of coterminosity; they saw duplication at area and district level; and felt that the area level was often too remote from operational affairs. Their recommended cure was to rationalise areas into single district areas. In London they recommended consideration of a larger number of single-district areas coterminous with London boroughs. Such reforms would increase member involvement at a local level; there would be a member authority relating directly to the CHC; there would be a reduction in the number of headquarters; more senior managers would be available at the local level with a potential for improved decision-making; and the planning process would be speeded up. The consequent staff problems were considered, and the Chairmen concluded that insecurity was so great at present that staff would welcome recommendations ending the unsatisfactory structure provided a generous personnel policy accompanied change.

The Regional Chairmen also reviewed the structure of family practitioner services. They recommend that in order to enable RHAs and AHAs to plan total health care, the Commission should consider FPCs becoming a sub-committee of AHAs; AHAs being empowered to investigate complaints into contractor services, and a method of budgetary control which might be exercised in relation to contractor services.

THE REGIONAL ADMINISTRATORS

The Regional Administrators supported the recommendations of their Chairmen but their submission covered a wider spectrum of issues. They argued against a central independent corporation distinct from the DHSS to control the NHS, and supported the structure below the DHSS as recommended by the Chairmen. Membership of authorities was reviewed, but the administrators considered that direct elections might be a chimera, turn-outs at local elections being traditionally low. Furthermore, discussion would be hampered by traditional political polarisation; and many members who have had valuable expertise and experience would be lost to the health service. They concluded that there were advantages in a proportion of members being appointed as at present, but expressed a preference

that the rest of the members might be elected during separate elections in parallel with local government elections.

Abolition of CHCs was recommended by the Regional Administrators. Their public representation role should be taken over by the new single district AHAs, some of whose members would be directly elected. FPCs were also to be radically changed and it was recommended that they should become a sub-committee of the AHA with methods for more stringent control of expenditure. Again coterminosity was seen as an artificial imposition in many situations, and the Regional Administrators contended that one of the main problems of liaison between health and personal social services was not the need for identical boundaries, but the unwillingness of local authorities to attach importance to collaboration.

The fundamental tenet of RAWP, that funding for health should be related to measured need was applauded. And the Regional Administrators urged the crucial importance of researching and producing realistic health indices. Medical manpower planning must also be linked to resource allocation in order to improve the maldistribution of doctors throughout the UK. Furthermore, a sensible medical career structure needed to be introduced in order to assuage the dissatisfaction of doctors who were trapped in training grades. The establishment of more consultant posts or a sub-consultant grade was recommended by the Regional Administrators.

THE AREA HEALTH AUTHORITIES

The opinion of members and officers of RHAs seem to be well represented by the evidence of their national associations. However, no bodies exclusively representing members and officers of AHAs submitted evidence. Furthermore, although area specialist advisory committees covering the majority of AHAs submitted evidence, less than 50% of AHAs and only 1 Area Team of Officers (ATO) submitted evidence.

The AHAs tended to confine themselves to structural problems, avoiding the ideological and political issues. There was general agreement that there

was one tier too many. There was support for the concept of single-district areas from multi-district and single-district AHAs. Oxford AHA, one of the largest single-district areas in the NHS, reflected the general view and backed it up with experience, commenting that they had been able to control from the centre without stifling local initiative. Only one AHA preferred the abolition of the RHA. But the majority of AHAs put in a plea for the reduction of powers of the RHA and indeed the DHSS. It was felt that the role of RHAs should be restricted to the planning and monitoring of services.

At the other end of the reorganised NHS structure, the CHCs were also criticised. Some AHAs doubted their possible value in single-district areas, where the consumer view could be represented by the member of the authority. Others were doubtful about the value of CHC members attending AHA meetings; and some members of one AHA reflected a more extreme view 'they [CHCs] serve no useful purpose and should be abolished'. Certainly, the majority of AHAs considered that the role of CHCs needed analysis. They were unanimous in the approval of the present method of appointment of members to authorities. In contrast to the trade union view, no AHA argued for greater democracy in the NHS and, indeed, Kent AHA maintained that too much democracy had been grafted onto the service.

FPCs were the most consistently criticised NHS committees. The majority of AHAs contended that the separation of family practitioner services and other health services needed review. A considerable proportion recommended that FPCs should become accountable to the AHA in the form of a sub-committee.

Consensus management and the consultative machinery was commended by only one AHA. Cornwall and the Scilly Isles AHA wrote, 'consensus has operated remarkably well in the service and the concept of the Chief Executive Officer is not commended'. However, the majority of AHAs reflected the views of the Oxford AHA which commented 'consensus method imposed on teams tends to be slow and to favour lowest-common-denominator advice or decisions'. Oldham AHA referred to the consulta-

tive procedure as the 'Achilles Heel' of the NHS planning system.

Ambivalent feelings were expressed about the principle of coterminosity. Lancashire AHA opposed the 'mandatory imposition of local authority boundaries ...'. Other AHAs requested a review of the need for coterminosity. Durham AHA recommended a review of the separation of the health and social service functions. Only one ATO submitted its own piece of evidence, and it is interesting to note that the views expressed there contradict the consensus of the AHAs. For example West Sussex ATO contended 'the coterminosity of boundaries with the County Councils is regarded as absolutely essential'.

THE DISTRICTS

Only ten district management teams (DMTs) submitted evidence, although again, a much greater number of advisory committees at this level voiced their opinions. Furthermore, since there is no membership authority at this level comparable with the RHA or AHA, the evidence from those administering the service at the local level is not great.

In general, the administrators at district level made recommendations consistent with their colleagues at regional and area level. The majority recommended the implementation of single-district areas; the rationalisation of relationships between FPCs and the rest of the NHS; and the co-ordination of health and personal social services. Some disagreement was again expressed concerning CHCs. One DMT devoted its whole submission to the problem of its relationship with its CHC, whilst another recommended that more power should be given to CHCs.

Evidence submitted by the Association of Chief Administrators of Health Authorities further illustrates that district administrators probably shared the opinion of their regional and area counterparts. The Association represents all regional, area and district administrators in England and Wales. They expressed a commitment to a comprehensive health service free at the point of access and concluded that the NHS must remain the responsibility of the Secretary of State, and be funded through general

taxation. They recommended that the regional level should remain and that below the region an autonomous health service authority with a fully integrated family practitioner service should be instituted. The Association conceded that these authorities would be similar to single-district authorities but they argued that coterminosity with local authority boundaries should not be the final determining factor. They discussed new methods of management by teams through consultation and consensus and concluded that these innovations, despite some drawbacks, needed to be allowed to develop. Consultation with the public on health matters was regarded as important, but the Association recommended a reappraisal of the role and representative nature of the CHCs.

The Association touched on some issues not generally covered by other administrators. For example, on industrial relations issues they argued for a better informed and co-ordinated management side of the Whitley Councils, and a greater speed and clarity in communication of agreements to local management.

THE SOCIETY OF ADMINISTRATORS OF FAMILY PRACTITIONER SERVICES

In general the RHAs, AHAs and DMTs presented a congruent view. However, it is illuminating to consider the representation of one of the committees of the NHS which contradicts their broad consensus. The Society of Administrators of Family Practitioner Services was of course unlikely to support the contention put forward by some health authorities that FPCs should become sub-committees of AHAs. The FPC administrators did not share the basic premise that prior to reorganisation, the health services were fragmented; they referred to the 'alleged....fragmented and divided Health Service'. As a consequence their evidence submission which dealt only with the administration of family practitioner services contradicted the evidence submitted by trade unions, consumer organisations, authority members and authority officials.

They did not feel they had enough control over necessary funds which had to be obtained through AHAs, RHAs and the DHSS. They recomm-

ended direct funding by the DHSS, and the designation of the FPC administrator as a first line not second line officer. They felt that machinery for complaints, so roundly criticised by CHCs and indeed by the Regional Administrators, had stood the test of time since they contended it was virtually that which had been in operation since 1913. The FPC administrator relied on 'tactful persuasion, e.g. persuading a doctor to accept on his list...an aggressive patient or an over-demanding family'. It was argued that this made for good relationships between administrators and practitioners which would be lost if AHA officials had direct control over practitioners' contracts. If services were administered directly by AHAs the FPC administrators felt that the professions would feel deprived of a voice in management and that this would lead to a deterioration in services and in relationships with health authorities.

The health authority officers and members were more circumspect in their submissions and less ideological than the trade unionists or the medical profession. Perhaps they were humbled by their position as the butt of all complaints about the 1974 reorganisation or perhaps, as they often state, they felt that the reorganised service needed longer to settle down before assessing its success or failure and before more radical and disturbing changes were recommended and implemented.

THE MEDICAL VIEW

The Commissioners could turn to the BMA submission and feel that this piece represented the view of the majority of the medical profession. It is the largest single organisation of doctors in the UK with a membership of 62,586 in 1977. Consistent with its status, the BMA submitted a lengthy document. They made some recommendations for reform, but made clear their opposition to some new departures in health care.

Structure

On structural issues they discussed the possibility of an independent corporation but rejected it on a number of grounds. Firstly, the NHS is funded almost entirely through general taxation, it dispensed 6% of the Gross National Product without commensurate earnings and was therefore not comparable with a nationalised industry. Secondly, it would add another level to an already over-burdened structure. Thirdly, a corporation might insulate the Secretary of State from criticism about the services. Fourthly, the BMA enjoyed the right of direct access to the Secretary of State and similar access might not be feasible with the chairman of a public corporation. Fifthly, quangos had not performed sufficiently well to recommend the creation of another such body. Thus where the Commission might have expected a defence of keeping politics out of medicine by the creation of a public corporation they received no such argument.

Below departmental level the BMA recommended the continuation of the RHA in broadly similar form with some slight alterations to the membership. The functional level was heavily criticised. Areas and districts were considered to be the main source of weakness: bureaucratic; over-staffed; and unable to differentiate where authority lay. The BMA supported the health authority view that the requirement that health and local authority boundaries should coincide was a hindrance rather than a help. Consequently they recommended only one level below the RHA which typically

would cover a population served by the community health services and supported by specialist services of the district general hospital, of approximately 250,000 people. The 'District Health Authority' should consist of 15 members: one third elected by local authorities; one third elected by NHS staff and a third nominated by the RHA. The BMA also recommended that the medical advisory structure which had removed much of the medical decision-taking from the profession, should be strengthened and made more effective.

Finance

The BMA, registered under the 1974 Trade Union and Labour Relations Act supported the trade union view that the health service was underfinanced. As illustration of their point, they too used international health expenditure comparisons. And as evidence for a further complaint that capital equipment was severely run-down, they referred to the 1974 Royal Institute of British Architects report which revealed an immediate requirement for expenditure of £100m merely for maintenance work on health service buildings.

Thus the BMA and other trade unions agreed that there was a financial shortfall, but the BMA offered different solutions. The BMA recommended a central discrete fund for the NHS, into which the Government would make payments on behalf of those unable to make provision for themselves, and to which the public would contribute through a basic compulsory payment to be made regularly by or on behalf of every member of the population, together with payments for use of the service. These recommended charges would include 'hotel charges' for hospitalised patients and increased prescription charges which the BMA argued would accrue far more revenue than the present two and a half percent figure.

Clinical Responsibility

As the established representative body of the medical profession, it was in areas other than finance and management, that the BMA asserted their distrust for some new departures in health care. For example, the BMA considered individual clinical responsibility to be threatened by the

growth of the concept of treatment by a health team; by the state wishing to control or supervise the standard of medical care; by the state wishing to control or supervise the cost of medical care in individual cases; and by the prospect of CHCs seeking to supervise decisions properly made by doctors. Doctors, it was argued, were and should continue to be primarily accountable both legally and clinically to their patients; and the consensus approach to decision-making was inappropriate in clinical matters. The BMA also expressed concern about threats to the confidentiality of the relationship between doctor and patient resulting from the new procedure for hospital complaints, and the increasing number of health personnel who have access to medical records.

The BMA argued for easy access to the general practitioner by the patient. Doctors recognised the value of the health team but felt that this must not interfere with the doctor-patient relationship. Furthermore there was no need, according to the BMA, for any new health service worker such as physician assistants, nurse practitioners or 'feldschers'. As a first contact point for the patient, the medical receptionist must be appropriately trained and neither make nor be asked to make clinical decisions.

Relationship with Other Services

In contrast to the social workers' view, the BMA wished to see the administration of health and personal social services reintegrated. Again supporting the trade union view, they recommended the establishment of an occupational health service for the NHS, and also a national occupational health service. They argued against the separation of private practice from the NHS, finding support, surprisingly perhaps, in the words of Aneurin Bevan in 1946 'What the Committee must try to procure, was that the specialist was induced...to spend all his time at the hospital...it would be disastrous if there grew up...a rash of nursing homes where the specialist intellectually isolated himself...'. They regarded the introduction of the 1976 Health Services Act as a retrograde step which would harm medicine and medical education.

Independent Contractor Status

The BMA argued in favour of the independent contractor status of family practitioners. This status, they said, enjoyed overwhelming support from the profession which would be lost if they became salaried professionals working from health centres. The BMA argued that the system of registration with an independent contractor provided continuity of care for patients; freedom of choice; advice about other medical services; independent assistance in dealing with other branches of health and social services; and preservation of confidentiality. The BMA's conviction that an independent contract *for* service rather than a contract *of* service preserved the standard and principles of general practice, had implications for the views put forward by health authorities, trade unions and CHCs, that FPCs should be abolished. However, the BMA argued that FPCs must be retained, for they provided experience and expertise in dealing with complaints and the special nature of family practitioner budgets together with impartiality essential to patients and doctors. In addition to their support for the independent contractor status, the BMA also felt that deputising arrangements were best left to each general practitioner to organise: a formal NHS deputising service, restricting the provision of medical services to normal working hours and employing other doctors to provide an 'out of hours' emergency service would have serious drawbacks. They argued that doctors would be unable to control the quality of care when they were off duty, and that experience of state controlled services indicated that such a service would be underfinanced and understaffed.

Morale

The BMA contended that the morale of the medical profession in the NHS was extremely low. This, they argued, was the result of underfinancing, decrepit buildings, excessive bureaucracy and the disappearance of the old trusting relationships between health workers, with the doctor increasingly regarded as just one of the team.

Financial stringency, increasing workloads, inadequate supporting staff

and under-capitalisation had led to a decline in the standard of patient care. The consultant was particularly affected argued the BMA, by the implementation of the Salmon Report which had removed the best and most capable nurses from the clinical sphere. In psychiatry and paediatrics, the consultant was particularly constrained by multi-disciplinary clinical teams. The complaints procedure as proposed by the Davies Committee would include the clinical decisions of the consultant which would further hinder his clinical freedom. The removal of private practice from the NHS would, it was argued, lead to a further malaise. In order to alleviate the problem the Commission was exhorted to recognise 'that the five years of undergraduate and 10 to 15 years postgraduate training which go to produce a consultant do not create "another health service worker" but the only individual in the hospital clinical field with the breadth of training and experience necessary for leadership and acceptance of ultimate responsibility'.

General practitioners were also, according to the BMA, crippled by low morale which resulted from the State not having taken opportunities during the 50s and 60s, to develop general practice; and a decline in the proportion of NHS expenditure devoted to general medical services. At the same time general practitioners were expected to deal with increased patient expectations, the development of other services such as social services, and the substantial transfer into the community of patients previously treated in hospital. Furthermore, GPs had to tolerate this increased workload whilst experiencing a substantial reduction in their own standard of living.

Manpower Planning

Manpower planning was regarded by the BMA as one of the most important topics for consideration by the Royal Commission. They deplored the lack of an adequate statistical data base for sensitive manpower planning. They recommend a major review of the manpower situation: it should then become the subject of annual review by an independent body. They argued that it was important to avoid the numerous and rigid assumptions which, for example, had resulted in the Todd Commission's projections

not being borne out.

Medical Career Structure

The medical career structure where the consultant-training grade ratio caused concern amongst many evidence givers, was also considered by the BMA. They felt that the bottle-neck at registrar level was unsatisfactory. The remedy, according to the BMA, lay not in the creation of a sub-consultant grade, but in the 'expansion of the consultant grade at a steady rate, realistically assessed to achieve a rational career structure within 10 years'.

Women doctors and overseas doctors were regarded as needing special consideration. The BMA recommended an increase in part-time opportunities for women. Dependence on imported medical manpower needed to be rationalised to ensure health care of an adequate standard as well as suitable careers for overseas doctors wishing to work in the country of their adoption.

Medical Education and Research

The BMA asserted that whilst facing the problem of providing adequate services to patients, medical education and research must continue to be properly funded. This point was supported and expanded in a short 'cri de coeur' from the Association of Professors of Surgery who maintained that clinical academic units were being squeezed by present policies. They argued that adverse salary differentials discriminated against university medical staff and had led to a deterioration in standards. RAWP, based on a sound principle was, in practice, dispersing facilities and destroying the centres of excellence. Government priorities placing emphasis on primary care were taking resources away from acute hospitals ignoring consideration of essential training and teaching facilities. The ban on private patients in NHS hospitals would remove research monies. The new medical advisory structure had diffused the voice of medical teaching personnel.

Although the BMA represented the majority of doctors, alternative views

on some issues were expressed by doctors through the Royal College of General Practitioners (RCGP), the Medical Practitioners Union (MPU) and the Socialist Medical Association (SMA). In contrast to the BMA's assertions, the RCGP maintained that morale in general practice was higher than in the 1950s. They welcomed the development of health care teams asserting that ultimate responsibility must lie with the GP, rather than viewing them as a constraint on clinical freedom. Their support for the independent contractor status of GPs accorded with the BMA but, their commitment to the NHS being reorientated to primary health care with the function and size of the hospital service dependent on the responsibilities of the primary health care sector was not a view shared by the BMA. The main recommendations of the MPU representing some doctors in the hospital and primary care sectors, included opposition to health service charges and opposition to the continuation and extension of private medicine, contradicting the recommendations of the BMA. The BMA and MPU agreed only in their commitment to the need for more finance for geriatric services and for the mentally ill.

THE NURSING VIEW

The main organisations representing the nurses view were the Royal College of Nursing (RCN) and the General Nursing Council (GNC). The RCN produced one of the most comprehensive pieces of evidence submitted by major organisations. Having consulted their members throughout the country, they made recommendations on a wide variety of topics, clearly expressing the nursing frame of reference.

As a backcloth to their more specific recommendations, the RCN dealt at some length with the problems of assessing the performance of the health service. They suggested that the NHS was largely an ill-health service. Measuring the quality of health services was hampered by lack of data, in particular morbidity data revealing chronic health problems. They argued that international comparisons were inadequate as measures of value for money. The main problem was to assess the amount of unmet ill-health in the community which had been revealed in a number of social research projects. The wide variety in morbidity and mortality across regions and social classes was described and the RAWP proposals welcomed. But again

the RCN argued that mortality rates were inadequate and described as 'a blunt instrument', when trying to measure needs and re-allocate resources.

Throughout their submission the RCN stressed the importance of long-term support for the chronic sick. The elderly in particular were considered to be high on the list of those with unmet health needs. The RCN commented 'There is a need for more chiropody services: it is more important to keep the elderly on their feet with their shoes on, than to provide geriatric beds'. Health needs arising out of social problems required more attention.

Within their submission they included comments on a thorny problem: professional responsibilities and personal ethics. Their main conclusion was that with the increased number of disciplines involved in treating one patient, the main ethical problem was that of confidentiality. They also expressed concern about extending the role of the nurse beyond her clinical competence and responsibility. Under this heading, the RCN touched on industrial action; they concluded that industrial action which affects clients and patients was contrary to the whole foundation and ethical code of a caring profession.

Structure

On structural issues the RCN rejected the idea of a health corporation using similar arguments to the BMA. They argued that the role of the DHSS which issued circulars on requirements within the NHS without suggestions as to how the finance should be produced, needed review. It had found unanimous agreement amongst its members that there were too many tiers. The recommended remedy was to have a unitary authority below the region, which should relate to the district in the present structure. Consensus management was recognised by the RCN as a sophisticated system of management with many problems, but on the whole the RCN was convinced of the value of joint consultation and consensus. However, in order to fulfil its potential, management and staff required a positive attitude and better preparation for consensus in practice. This support of consensus management also led the RCN to support proposals for more staff representation on health authorities. The RCN concluded

that CHCs through no fault of their own, lacked the means and expertise to fulfil their role and to make sure the service was responsive to local needs.

Manpower

The RCN was concerned that despite the fact that questions on manpower were often being asked, there was a lamentable lack of manpower studies and research. In particular, they recommended research to determine the balance of skills required within the nursing team. Under this heading, they also added their voice to that of the trade unions, recommending the provision of an occupational health service for NHS employees, in line with the Tunbridge recommendations of 1968. The Whitley Council system of setting NHS employees pay and conditions was thought to be appropriate, although in need of some improvement and reform.

Finance

The RCN took an unusual step on the issue of financial resources, for despite having requested a 'massive injection of new money' in 1974 it concluded that given the economic constraints of the 1970s, the increased unemployment and the high proportion of pensioners, spending would have to be curbed. Consequently, they suggested areas where saving could be made. These included rationalisation of the management structure; the redetermination of priorities in terms of cost effectiveness; the most effective allocation of use of and length of stay in hospital beds; a more careful development of hospital building and refurbishment, avoiding the dramatic changes in hospital planning which had occurred since 1962; and more careful control of expenditure on drugs. There was unanimous agreement in the RCN that charges for treatment at the point of delivery should not be introduced, although some consideration might be given to 'hotel' charges in hospital.

Family Practitioner Services

The RCN expressed a number of concerns here, for example, the anomalous position of doctors who have independent contracts for service find-

ing themselves working with a practice nurse whom they employ, a home nurse, a health visitor and a midwife employed by the AHA, and an attached social worker employed by a local authority. This divided lack of command and accountability had serious consequences and led to confusion. The RCN went further to recommend that whilst strongly supporting the concept of professional independence, they wished to see family practitioners brought within the aegis of the service in a way that would ensure accountability for money spent, rather than continue the present system of open-ended budgets. The development of health centres was also recommended.

Hospital Services

The RCN was anxious to dispel the myth quoted in evidence by the CHCs and the medical profession, that the Salmon Report recommendations had removed armies of nurses from the wards. They considered that a recognised nursing head provided the necessary cohesion and that functional management should continue. However, it was felt that bureaucracy had grown and delays in decion-making were occuring.

NHS and Other Services

The RCN stressed the importance of sociological and environmental factors in health and recommended that the health and personal social services should be under one authority. They expressed concern at what they saw as the decline in the school health service, welcoming the recommendations of the Court Report.

The RCN discussed private practice. They considered there were problems when private beds were within the NHS. There were difficulties in meeting the expectations of patients and the fear that preferential treatment might appear discriminating. Their general view was that private practice should be allowed to develop outside the NHS for it often provided care not provided by the NHS, but that private practice should not continue within NHS facilities.

Nurse Training

Since nurses form the largest professional group in the NHS, their education and training was regarded as vital to the service by both the RCN and the GNC which devoted the whole of its evidence submission to nurse training. The RCN urged the implementation of the Briggs Committee on nursing. Whilst supporting the idea of core basic training for all branches of nursing, the RCN was concerned that specialist care should not be lost. Both the RCN and the GNC expressed concern about the student nurse retaining employee status. The RCN recommended research into the possibility of new roles for nurses as consultants, but insisted that further education would be required for these nurses. Nursing auxiliaries should be trained on an in-service basis and, argued the RCN, duties should be laid down so that they are not exploited in times of cuts.

Doctors and nurses form the major part of the professional workers in the NHS and their evidence submissions must be accorded much weight. The evidence from other professional groups within the NHS (dentists, midwives, health visitors, ophthalmic opticians, physiotherapists) dealt mainly with issues relating to services they provided. It is not possible here to cover their opinions in depth, but only to note that the issues raised were not dissimilar to the professional issues raised by doctors and nurses: status; education and training; roles within the health care team; and finance for specific services. They did not on the whole comment on wider issues. One professional group which attracted much comment throughout the evidence submissions and which symbolised the problems of relationships between NHS and local authorities were the social workers. Hospital social workers differed from all the other major professional groups in the health service since their employing body, since 1974, has been the local authorities.

THE SOCIAL WORK VIEW

The organisation of social services, the role of the social worker within the multi-disciplinary clinical team, and the interface between health and personal social services were topics often discussed throughout the evid-

ence, but submissions from bodies closely involved with these contentious issues were slender.

The British Association of Social Workers (BASW), the Central Council for Education and Training in Social Work (CCETSW) and the Association of Directors of Social Services (ADSS) were keenly aware of problems at the interface of the NHS and the personal social services. Constrained by the major reorganisation of personal social services after Seebohm and of the NHS in 1974 they denied the need for further change. The oft-cited panacea of unifying the administration of health and personal social services was criticised. Their arguments against unification were supported firstly by reference to the Northern Ireland experience where social workers, and specifically the Northern Ireland branch of ADSS, found the amalgamation of the two services under Health and Social Services Boards unsatisfactory, and secondly by reference to the need for social services to relate closely to other services such as education and housing which in Great Britain are similarly functions of local government. Whilst denying the need for a unified system, the social work organisations stressed the need for close co-operation and argued that this would only be achieved through improved joint funding and planning, and through shared training of health and social service professionals.

ADSS welcomed joint financing as a novel method of injecting finance into services, but they were concerned that too much weight might be given to the health projects, committing social services to projects related to health services, whilst neglecting other significant areas. Furthermore, concern was expressed at some of the future revenue consequences for social service departments of projects initially financed by health authorities. ADSS and BASW stressed the importance of coterminosity in fulfilling the aims of joint planning and finance.

CCETSW argued that improved relationships at the interface of NHS and social services and within the overlapping multi-disciplinary clinical teams would result from some aspects of basic training being shared by health and social service personnel. This was advocated not only for professional social workers, doctors and nurses, but also for those in auxiliary roles in hospitals, health centres and social service departments.

The social work organisations supported the basic concept of the NHS, and welcomed the move from hospital to primary care emphasising that improved funding would be necessary to achieve this. But their submissions, influenced perhaps by a decade of change and reassessment, were defensive rather than innovative, offering limited help for the Commission's consideration of the social service input to the NHS and the health of patients.

THE VOLUNTARY ORGANISATION VIEW

The Commission received valuable evidence from national voluntary organisations. Some like the Consumers Association, the Patients Association and the National Association of CABs, are dealt with above under the patients' view. Most non-statutory organisations represent a specific client group and not surprisingly these bodies expressed the needs of the patients they represented and argued for improved services in these sectors. For example, the Campaign for Homeless and Rootless covered the health needs of the homeless: the Child Poverty Action Group restricted itself to the impact of health service charges; the low take-up of exemption from charges and the effect on those caught in the 'poverty trap': the National Childbirth Trust recommended improvements in antenatal care through dissemination of research and good practice, and through improved communication between professionals and patients. Action on Smoking and Health requested increased funding for anti-smoking campaigns and a hypothecated tax on cigarettes to be reserved for treatment of smoking-related diseases. The Disablement Income Group criticised the lack of financial support for the disabled, the unevenness of services across regions and recommended the development of comprehensive rehabilitation centres. MIND (National Association for Mental Health) submitted evidence on the needs of the mentally ill and the mentally handicapped, spelling out in detail ways in which services for them should be improved and developed.

The vexed question of the relationship between volunteers and trade unions was covered by a number of voluntary agencies. St.Johns Ambulance Brigade presented the unusual view of categorically supporting volunteers as cheaper than other workers concluding 'the NHS must function with the minimum full-time staff in all categories until the country can afford more'. The National Council of Social Service was more circumspect exhorting the development of a careful partnership between voluntary organisations and statutory agencies and the National Association of Leagues of Hospital Friends commented:

> 'We believe that the voluntary dimension has become firmly established as a permanent and integral part of the nation's health service. We are

not in competition with any part of or any member of the statutory health service, we have our own distinct role in it and it can no longer do without us'.

The majority of submissions from voluntary organisations are worthy of study in their own right, for they are written with conviction and commitment and cover a discrete comprehensive area. However, given the nature of their terms of reference, the Royal Commission were not committed to considering specific patient groups, but rather the functioning of the NHS as a whole, consequently it is difficult to assess the impact of evidence from these groups.

In an evidence analysis of this kind, we could not hope to cover all the myriad of organisations and issues that are vital to the NHS. In addition we have not covered the submissions from the health departments on which the Commission obviously heavily relied. The initial factual submissions from the health departments are open to view in the Public Record Office. Subsequent submissions are subject to the 30 year rule.

CONCLUSION

It is clear from the analysis that the Royal Commission would have been unable to reconcile the conflicting interests expressed by organisations representing NHS patients, workers and professionals. Areas of disagreement between these groups are numerous. For example, the consumer organisations, the health service trade unions, the administrators, the doctors and the nurses, argued for some form of unification of health and personal social services, but the social workers so directly involved in such a reform, argued against the suggestion. Similarly, the majority of organisations covered in this analysis argued in favour of family practitioner services being integrated further into the NHS, but the groups that are vital to such a reform, the doctors and the FPC administrators, rejected the idea.

Furthermore, conflicting views were expressed within discrete groups. The Royal College of General Practitioners disagreed with the BMA on the state of the morale of general practitioners. The Medical Practitioners Union and the Socialist Medical Association argued for the abolition of the independent contractor status, the retention of which was so heatedly defended by the BMA. Another example of disagreement occurred over the issue of health service charges where CHCs, AHAs, and DMTs in one geographical area held different views to their counterparts in other parts of the country.

However, there are issues on which the Commission must have been greatly helped by a clear consensus. All the major NHS organisations agreed that rationalisation of the management structure was required. None of them recommended radical change such as handing health service responsibility over to a public corporation or to local government. Support for a centrally funded health service was general, although reforms at the periphery, such as the increase or abolition of charges, and the increase or abolition of the National Insurance Contribution or its equivalent, were areas of debate.

Evidence was commissioned in 1976/77, the Royal Commission reported in 1979. In those three years they obviously drew heavily on the massive volume of evidence and their report reflects this. However, given the nature of the conflicts in the evidence outlined above, it was inevitable that the Commission would need to seek information from other sources. This they did by commissioning research, by visiting health service institutions in this country and abroad, and by talking to a wide range of individuals. Their own report represents a distillation of all the information received in this way and represents their collective judgement on the enormously difficult questions presented to them in the evidence.

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